A Multi-Level Examination of Cultural Competence in Community Health: An Organisational Case Study

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Submitted in total fulfilment of the requirements of the degree of Doctor of Philosophy

June 2016

Melbourne School of Population and Global Health

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The University of Melbourne

Produced on archival quality paper

Abstract

It is widely recognised both within Australia and internationally that consideration of cultural issues in health care is important in meeting the health needs of culturally and linguistically diverse groups. Increasing cultural competence depends on a multi-dimensional approach that addresses individual, professional, organisational, and systemic competence. Knowledge about organisational best practice related to cultural competence is still emerging and there is a strong need for further research.

Accordingly, the purpose of this PhD study is to address several gaps in the evidence base by contributing a deeper understanding of cultural competence and to provide evidence and guidelines to inform organisational cultural competence assessments. First, it aims to further our understanding of cultural competence within the community health context. Second, it aims to examine the outcomes and implications of conducting an organisational cultural competence assessment at a community health service. And, third, to evaluate the utility of an organisational assessment tool.

The conceptual framework underpinning this research consists of several interdisciplinary frameworks and models, namely: the social ecological model, health promotion principles, cultural competence frameworks and Andersen's behavioural model of health service use. Several frameworks and models were used in respect to the different aspects of the research. This PhD study adopts a qualitative approach to explore cultural competence within a community health service from client/carer, provider and organisational perspectives using semi-structured interviews and process evaluation.

Findings of this study indicate that participants considered the practice of providing culturally competent health services to be multi-dimensional and multi-level. Most staff participants viewed cultural competence as being an important aspect of their work; however, they also identified that at times there were challenges in providing culturally competent care. Decisions made by clients/carer participants to use health care services are based on multiple factors, of which culture may be one. Client/carer participants were more likely to identify other non-culturally related potential barriers to service use such as: long waiting lists, lack of knowledge of services available, language and communication difficulties, and procedural issues such as making appointments. From study findings, a conceptual model was developed encompassing key issues impacting health service utilisation for culturally and linguistically diverse groups to inform design of interventions and/or further research to improve cultural competence within health care settings.

Study findings also highlighted that the implementation of an organisational assessment of cultural competence at a community health service was a highly complex undertaking. Factors such as leadership, staff engagement, organisational inertia, organisational culture and resourcing were viewed as potential barriers or facilitators to the implementation of a cultural competence assessment tool and subsequent organisational efforts to improve cultural competence. Consideration of organisational factors, such as those highlighted by study findings, can inform the implementation of future organisational cultural competence assessments.

Additionally, findings regarding the evaluation of a cultural competence assessment tool indicated that despite the challenges and limitations of the tool, it was found to be an important mechanism to facilitate organisational reflexivity. In particular, it enabled identification of organisational strengths and gaps to provide an impetus for action to improve organisational cultural competence. The findings can be used to inform the future development and refinement of such tools to improve their effectiveness, accuracy and relevance.

Declaration

This is to certify that:

i. the thesis comprises only my original work towards the PhD

ii. due acknowledgement has been made in the text to all other materials used

iii. the thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices

Date ___________________

Signed ____

Preface

This PhD study was conducted within the context of a larger study called Teeth Tales, which was carried out by a research team from the Jack Brockhoff Child Health and Wellbeing Program, Melbourne School of Population and Global Health, University of Melbourne. Part of the team involved in the cultural competence organisational review component of Teeth Tales included Associate Professor Lisa Gibbs, Dana Young, Dr Elisha Riggs, Britt Johnson and myself. In addition, staff from the Population Health Unit of Merri Community Health Services (MCHS) and The Centre for Culture, Ethnicity and Health (CEH) were also involved and included: Maryanne Tadic (MCHS), Veronika Pradel (MCHS), Dr Christine Armit (MCHS), Michal Morris (CEH), Dr Pauline Gwatirisa (CEH), Pamela Rodriguez (CEH) and Eugenia Georgopolous (CEH). Additional people affiliated with the Teeth Tales study were: the late Professor Elizabeth Waters (University of Melbourne), Dr Martin Hall (North Richmond Community Health), Barry Hahn (Moreland City Council), Jane Foy (Moreland City Council), Nalika Peiris (Moreland City Council), the late Coralie Matthews (MCHS), Bradley Christian (University of Melbourne), Associate Professor Lisa Gold (Deakin University), Associate Professor Andrea de Silva (Dental Health Services Victoria), Dr Hanny Calache (Dental Health Services Victoria), Professor Mark Gussy (Latrobe University), Professor Richard Watt (University College London) and Associate Professor Iqbal Gondal (Monash University).

This PhD study is related to one component of Teeth Tales; the implementation of a cultural competence organisational review at a community health service, i.e. Merri Community Health Services (MCHS). In addition, a qualitative study was conducted as an adjunct to Teeth Tales to further understand the implementation of the CORe and additionally, access provider and client/carer perspectives of the significance of cultural background in community health service utilisation. This is further detailed in Chapter 5.

The contribution of other researchers to the data collection and data analysis is also described in Chapter 5 as follows. The document audit was conducted by Dr Pauline Gwatirisa, whom also subsequently examined and summarised the document audit data. Associate Professor Lisa Gold was primarily responsible for the design and analysis of the economic component of the study. Members of the research team, including the doctoral candidate, provided assistance with economic data collection.

This thesis includes one results publication with permission from the candidate’s PhD advisory committee and the co-authors on the paper. This paper was planned, prepared and executed by the doctoral candidate and primary author, Mandy Truong. The candidate contributed 85% of the content and wrote the initial and subsequent drafts. All authors developed the idea for the systematic review and contributed to the concept and design. The candidate conducted the searching and drafted the tables and figures. All authors contributed to the writing of the manuscript and read and approved the final manuscript:

> Truong, M., Paradies, Y., and Priest, N. (2014). “Interventions to improve cultural competency in health care: a systematic review of reviews.” BMC Health Services Research, 14:99.

Acknowledgements

I would like to acknowledge and express my gratitude to all that have helped me along this PhD journey. In particular, the last 2 or so years have had their additional challenges with having to navigate motherhood for the first time.

Firstly, I would like to thank all the clients/carers and staff from Merri Community Health Services for giving their time to be interviewed. I would like to thank Merri Community Health Services, in particular, Maryanne Tadic, Manager of the Population Health Unit, whom facilitated and provided vital support to many aspects of my research. I would also like to thank Dr Antoinette Mertins, Kerri Collier, and Kristy Sealby from MCHS for their assistance during the project.

A big thank you to my supervisors: Associate Professor Lisa Gibbs, Professor Yin Paradies and Dr Naomi Priest. Your guidance, feedback and support throughout this PhD is greatly appreciated. Thank you for having confidence in my ability to undertake this PhD. A special thanks to Lisa for her positivity, support, and encouragement, particularly after I returned to the PhD from maternity leave. Additional thanks to Professor Tony LaMontagne for his input as the initial Chair of the advisory committee and to the late Professor Elizabeth Waters for her contribution as part of my advisory committee. Thank you to Dr Karen Block for stepping in as Chair of the advisory committee at the end.

This PhD was funded by an Australian Postgraduate Award. Project funding was received from the Teeth Tales study. I feel privileged to have been given the opportunity to undertake this doctoral study.

One of the enduring things I will take away from this PhD experience is the wonderful people I have met and the friendships I have formed. You all inspire me to be a better researcher and human being. Thank you to Jessica Walton and Brigid Trenerry for their tremendous support in both professional and personal capacities. I would like to thank the other members of the Teeth Tales project team whom I worked closely with on CORe: Dana Young, Veronika Pradel and Pauline Gwatirisa. Other colleagues who have provided support and friendship along the way: Karen Block, Simon Crouch, Lara Corr and Alana Pirrone.

Thank you to my mum Trung and dad Tai for supporting me in your own way despite not entirely understanding why I have spent so much time at university! I genuinely appreciate all the sacrifices you have made to give me the life and opportunities I have had. You have instilled in me the importance of education and I hope you are proud of me. Also thanks to my sister Sandie and brother Ed for your continual support and love. Thank you to my extended family for your support. Also to my friends and their families, if it weren't for your support, love, and encouragement over many years, I wouldn't be the person I am today.

I would also like to acknowledge the time and efforts of my mum and mother-in-law, Ramona Chua, in providing child care to my daughter Amy for over 2 years to enable me to complete my PhD. Thank you for your love and care of Amy and our family.

And last but not least, I would like to express my deepest thanks to my husband Damien. Words cannot describe how grateful I am for your love and support. You and Amy both light up my life and make my life complete. All the difficulties and challenges are worthwhile knowing I have you in my life. I dedicate this thesis to you both (and the little one on the way!)

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Abbreviations and acronyms

CALD: Culturally And Linguistically Diverse

CORe: Cultural Competence Organisational Review

MCHS: Merri (formerly known as Moreland) Community Health Services.

MCC-SPEY: Moreland City Council's Social Policy and Early Years Branch

NHMRC: National Health and Medical Research Council

NRCH: North Richmond Community Health Services

VIC: Victoria (Australian State)

WHO: World Health Organisation

Key terms and definitions

Culture refers to the distinctive ideas, customs, social behaviour, products, or way of life of a particular nation, society, people, or period (Oxford English Dictionary).

Ethnicity refers to status in respect of membership of a group regarded as ultimately of common descent, or having a common national or cultural tradition; ethnic character (Oxford English Dictionary)

Community Health Services, in the Australian context, are health services that provide primary health care with a particular focus on people at risk of poorer health. They operate from a social model of health which acknowledges the social, environmental and economic factors that affect health, as well as the biological and medical factors (Victorian Department of Health & Human Services 2015).

Cultural competence refers to "a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations." pg. iv (Cross, Bazron et al. 1989).

Culturally and linguistically diverse (CALD) is a broad and inclusive descriptor for communities with diverse language, ethnic background, nationality, dress, traditions, food, societal structures, art and religion characteristics. CALD people are generally defined as those people born overseas, in countries other than those classified by the Australian Bureau of Statistics (ABS) as "main English speaking countries" (i.e. Canada, the Republic of Ireland, New Zealand, South Africa, the United Kingdom and the United States of America. (Ethnic Communities Council of Victoria 2012).

Determinants of health are factors or characteristics that bring about change in health, either for the better or for the worse.

Essentialism refers to the view that certain categories (e.g. racial groups, women) have an underlying reality or true nature that cannot be directly observed (Gelman 2005).

Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (World Health Organization 1986).

Health inequality is the generic term used to designate differences, variances and disparities in the health achievements of individuals and groups (Kawachi, Subramanian et al. 2002).

Health inequity refers to those inequalities in health that are deemed to be unfair or stemming from some sort of injustice (Kawachi, Subramanian et al. 2002).

Health promotion is the process of enabling people to increase control over, and to improve, their health (World Health Organization 1986). It includes a combination of health education and related organisational, economic and environmental supports for behaviour of individuals, groups, or communities that are beneficial to health (Green and Kreuter 2005).

Migrant/immigrant is any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country (UNESCO 2015).

Race refers to "a group of people, animals, or plants, connected by common descent or origin". Within a historical context, race has also been defined as a term used to classify any of the (putative) major groupings of mankind, usually defined in terms of distinct physical features or shared ethnicity, and sometimes (more controversially) considered to encompass common biological or genetic characteristics (Oxford English Dictionary 2015).

Social ecological model of health: a broad, overarching paradigm describing the influence of social and environmental factors on individual health behaviours and health outcomes (Stokols 1996).

Research outcomes

Project funding

2010-2016 (3.5 years full time equivalent) Australian Postgraduate Scholarship

2012-2013 University of Melbourne RHD Studentship ($20,000)

2012 Population Health Investing in Research Students' Training (PHIRST) funding, University of Melbourne ($1500)

Journal publications

Truong M, Gibbs L, Paradies Y, Priest N. and M. Tadic (under review). "Cultural competence in the community health context: 'We don't have to reinvent the wheel.'" Australian Journal of Primary Health.

Truong M, Gibbs L, Y. Paradies and N. Priest (accepted). ""Just treat everybody with respect": health service providers' perspectives on the role of cultural competence in community health service provision." Journal of Cultural Diversity.

Truong M, Gibbs L, Pradel V, Morris M, Gwatirisa P, Tadic M, de Silva A, Hall M, Young D, Riggs E, Calache H, Gussy M, Watt RG, Gondal I and E. Waters (accepted). "A cultural competence organisational review for community health services: insights from a participatory approach in Australia." Health Promotion Practice.

Gibbs, L., E. Waters, A. de Silva, E. Riggs, L. Moore, C. Armit, B. Johnson, M. Morris, H. Calache, M. Gussy, D. Young, M. Tadic, B. Christian, I. Gondal, R. Watt , V. Pradel, **M. Truong** and L. Gold (2014). "An exploratory trial implementing a community-based child oral health promotion intervention for Australian families from refugee and migrant backgrounds: a protocol paper for Teeth Tales." BMJ Open **4**(e004260).

Truong, M., Y. Paradies and N. Priest (2014). "Interventions to improve cultural competency in health care: a systematic review of reviews." BMC Health Services Research **14:99**.

Conference presentations

Truong M, Gibbs L, Young D, Pradel V, Morris M, Gwatirisa P, Tadic M, de Silva A, Riggs E, Hall M, Calache H, Gussy M, Watt RG, Gondal I, Waters E. (Poster). A cultural competence organisational review for community health services, *Health Services and Policy Research Conference*, December 2015, Melbourne.

Truong M, Paradies Y, Priest N. (Poster) Cultural competence in health care: a systematic review of the evidence, *Diversity Rx Conference*, March 2013, Oakland, California.

Truong M, Paradies Y, Priest N. Cultural competency: a systematic review of the evidence. *Population Health Congress*, September 2012, Adelaide, South Australia.

Truong M, Pradel V, Gibbs L, Morris M, Johnson B, Riggs E, Young D. 'Teeth tales partnerships: Improving child oral health through the development of the Cultural Competency Organisational Review (CORe) to enhance service access and delivery', *Health Promotion Extravaganza*, Health West Partnership, August 2012, Melbourne, Victoria.

Knowledge translation

2013-2016: Culturally competent optometry. Department of Optometry and Vision Science, University of Melbourne, Melbourne. (Invited speaker)

2013-2016: Health for culturally and linguistically diverse communities. School of Optometry (invited speaker), Deakin University, Waurn Ponds. (Invited speaker)

April 2015: Findings of the Cultural Competence Review (CORe). *Teeth Tales Show Case*, Merri Community Health Services, Victoria, Australia.

November 2014: Organisational cultural competence- the research evidence. *Cultural competence of mainstream health services and systems roundtable,* The Lowitja Institute, Melbourne. (Invited speaker)

October 2014: Cultural competence organisational review. *Teeth Tales Showcase*, University of Melbourne, Australia.

March 2013: Cultural diversity and health care provision in Australia. University of Michigan-Flint, Flint: Michigan, USA. (Invited speaker).

Chapter 1: Introduction and Overview

1.1 Research context

Globalisation and increasing migration and urbanisation have created a spotlight on the meaning and challenges of culture and cultural diversity. Geographical boundaries that historically isolated different populations and communities from one another are no longer barriers to large-scale population movements. States may struggle when confronted by a diversity of practices, viewpoints and political differences. Health and health care, in particular, are areas where diverse practices and beliefs can create challenges, tensions and misunderstandings. Governments, organisations and providers are increasingly aware of the need to address the impact of cultural differences on health and health care. Public health interventions need to recognise that the health of a society and of its members is partially determined by its values, cultures and beliefs (or those of sub-groups within it) and thus seek to alter those social norms that are detrimental to health (Blas and Kurup 2010).

According to the 2011 Australian Census, over 26% of the population was born overseas (Australia Bureau of Statistics 2013). Sixty-seven per cent of recent arrivals and 49% of longer-standing migrants speak a language other than English at home (Australia Bureau of Statistics 2013). Increasing levels of cultural and linguistic diversity in developed Western countries such as Australia and the United States can present challenges to the provision of inclusive and appropriate health services that meet the varied needs of culturally and linguistically diverse groups (Batalova and McHugh 2011, Australia Bureau of Statistics 2013).

In Australia, health inequalities between Indigenous populations and non-Indigenous populations have been widely documented (Australian Government 2009, Australian Medical Association 2009, Ride and Thomson 2010). In comparison, we know less about health inequalities for people from culturally and linguistically diverse (CALD)[1]

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[1] Culturally and linguistically diverse (CALD) is a broad and inclusive descriptor for communities with diverse language, ethnic background, nationality, dress, traditions, food, societal structures, art and religion characteristics. CALD people are generally defined as those people born overseas, in countries other than those classified by the Australian Bureau of Statistics (ABS) as “main English speaking countries” (i.e.

backgrounds. However, there is some evidence that people from CALD groups in Australia can experience poorer health status and health outcomes, for example, poorer mental health in children (Priest, Baxter et al. 2012), poorer oral health (Spencer and Harford 2008) and have difficulty in finding culturally appropriate health services in Australia (Manderson and Allotey 2003, Riggs 2010).

Cultural competence is an approach to improving the provision of health care to particular groups (e.g. CALD groups) in the community by increasing the awareness, knowledge and skills of health care providers and organisations and improving the effectiveness and accessibility of health services (Betancourt, Green et al. 2002). Increasing cultural competence depends on a multi-dimensional approach that addresses individual, professional, organisational, and systemic competence. Knowledge about organisational best practice related to cultural competence is still emerging and there is a strong need for further research.

1.2 Community health setting

In Australia, the community health model is a unique model of health that provides affordable primary health care to meet the needs of the local community it serves. Community health services combine the clinical and social models of health by providing clinical care as well as addressing the social and environmental determinants of health. Community health services are the second largest component of primary health care in Australia and generally take a broader approach to primary health care than general practice (Powell Davies, Perkins et al. 2009).

Community health services may be provided directly by government or indirectly through a local health service or community organisation funded by government (Productivity Commission 2015). Funding for community health services comes from a range of sources and is often under pressure when health budgets are stretched. Community health services are heavily reliant on public funding, therefore they are often required to demonstrate the benefits of their programs to government decision makers for funding and policy support to continue (Sindall 1992). Community health services in Victoria, Australia, are largely funded by the Victorian State Government (in

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Canada, the Republic of Ireland, New Zealand, South Africa, the United Kingdom and the United States of America. (Ethnic Communities Council of Victoria 2012).

2013-14 they funded ~60% of total revenue) (Victorian Department of Health & Human Services 2015).

The main areas of primary health care funded through community health are dental, allied health, counselling, nursing services and health promotion (Victorian Department of Health & Human Services 2015). The 88 Victorian community health services across the state provide universal access to services and prioritise access to people with particular health needs and those that experience disadvantage.

1.3 Study rationale

Culture provides a framework through which individuals and communities interpret the world. Therefore, cultural processes are central to the principles and practices of health care delivery. While cultural context is important in studying health and illness among minority ethnic communities, there is a need to ask: what is the *relative* importance of culture in understanding the health and illness of people? Additionally, given the breadth of health care settings and contexts, a one-size-fits-all approach to addressing the impact of culture on health care access and delivery is insufficient (Renzaho 2008, Wilson-Stronks, Lee et al. 2008).

The documentation of racial/ethnic health inequities, recognition of the fundamental ethnocentrism of contemporary Western health care, and acknowledgement of the different ways patients and families respond to illness and treatment, has lead to the development of the field of cultural competence. Cultural competence is used to describe a variety of approaches that aim to improve the effectiveness and accessibility of health services for people from CALD groups within the health care sector. There is some evidence to suggest that interventions to improve cultural competence have a positive impact on provider awareness, knowledge and skills (Beach, Price et al. 2005, Gallagher and Polanin 2015) as well as patient/client health outcomes (Fisher, Burnet et al. 2007, Hawthorne, Robles et al. 2008, Saha, Korthuis et al. 2013).

In order for approaches to improve cultural competence to be implemented successfully across the health system, change needs to occur at the systemic, organisational, professional and individual level (National Health and Medical Research Council 2006, Weech-Maldonado, Al-Amin et al. 2011). Government and accreditation authorities have mandated the incorporation of cultural competence in strategic planning of health services in Australia and some state government departments (Victorian Department of Health 2009, Victorian Department of Health 2011, Victorian Department of Health 2011, Victorian Auditor-General 2014). However, the extent to which these policies have been implemented in organisations and by what means is not well documented.

Achieving organisational cultural competence is a challenging proposition requiring multiple strategies at various levels. Organisations may need to regularly examine and monitor the accessibility and appropriateness of their services to ensure they are responding to the cultural and linguistic needs of their clientele or patient base. There are few published studies describing organisational cultural competence assessments and the extent to which these tools facilitated improved organisational cultural competence. Rigorous evaluation and understanding of the effectiveness and impact of organisational cultural competence assessment tools is thus required.

The Australian community health sector plays an important role in primary health care provision, particularly for CALD groups. In spite of this, there is a lack of research evidence related to cultural competence in the community health setting. There are few studies exploring the need to develop and manage culturally competent health services for people from CALD groups and few resources available for providers to ensure cultural competence (Renzaho 2008).

This PhD research seeks to address several gaps in the evidence base. First, it aims to further our understanding of cultural competence within the community health context. Second, it aims to examine the outcomes and implications of conducting an organisational cultural competence assessment at a community health service. And, third, to evaluate the utility of an organisational assessment tool in facilitating improvements in cultural competence.

1.4 Scope and setting

This PhD study was nested within the context of a larger study called Teeth Tales, which was a culturally competent community-based health promotion intervention for child oral health (Gibbs, Waters et al. 2014). (See Appendix A for a brief summary of Teeth Tales.) Part of this PhD is related to one component of Teeth Tales; the implementation of a cultural competence organisational review at a community health service, i.e. Merri Community Health Services (MCHS). In addition, a qualitative study was conducted as an adjunct to Teeth Tales to further understand the implementation of a cultural competence organisational review tool and access provider and client/carer perspectives of the significance of cultural background in community health service utilisation.

This PhD research adopts a qualitative approach to explore cultural competence within the community health setting from several perspectives: client, provider and organisational. The use of multiple methods, within a case study approach, enables the documentation of multiple perspectives, exploration of processes and dynamics of change, and the study of experiences and complexities of the topic.

As this research is situated within a larger study, its design and methodology were considered within the broader context of Teeth Tales and its organisational, research and stakeholder partnerships, including alignment with the policies and procedures of MCHS, the site of the case study.

1.5 Research aim and questions

This PhD study aims to contribute a deeper understanding of cultural competence within the community health context and to provide evidence and guidelines to inform organisational cultural competence assessments.

The research questions are:

1. What is the current evidence base relating to cultural competence interventions in health care?
2. What are health care service provider perceptions of the significance of cultural background in health care service utilisation and their understanding of cultural competence?
3. What are the factors associated with community health service utilisation by CALD clients/carers?
4. What is the impact of the implementation of an organisational cultural competence review on a community health service?
5. What is the utility of the Cultural Competence Organisational Review (CORe) tool in facilitating improvements in cultural competence?

1.6 Overview of thesis chapters

This first chapter of the thesis has provided a brief overview of the research context and the rationale for the study. It has also outlined the aim of the research, the research questions and the scope and setting for the study.

Chapters 2 and 3 provide the background to the study and review of the relevant literature. Chapter 2 outlines the background related to health care provision in Australia and describes the impact of multiculturalism on the Australian health care landscape and community health setting within which this PhD research is situated. Evidence related to racial/ethnic health inequities will be presented and the concept of the ‘social determinants of health’ will be introduced. Chapter 3 explores the concept of cultural competence and examines the various issues and approaches in order to provide a clear foundation for this research. It begins with a discussion of the concepts of culture, race and ethnicity and its relevance to, and implications for, health care service provision. This is followed by an examination of the different approaches to the concept of culture and a critical analysis of cultural competence, including a synthesis of the relevant literature.

The conceptual framework underpinning this research is described in Chapter 4. Several frameworks/models were used to inform the study design, analysis and interpretation of research findings. The first section of this chapter introduces the social ecological model in relation to health promotion principles. The second section of this chapter focuses on cultural competence frameworks and the Andersen behavioural model of health service use.

Chapter 5 will outline the research questions, objectives and methods used in this study as well as the methodological approach underpinning the study. This PhD research is comprised of different research stages and multiple methods. The research design consists of 3 components: a systematic review, a qualitative study, and an organisational cultural competence assessment and evaluation. For each component, the research process and methods will be outlined, including sampling, data collection and analysis.

Chapter 6 consists of a published paper presenting the findings from a systematic review of interventions to improve cultural competence in health care:

> Truong, M., Y. Paradies and N. Priest (2014). "Interventions to improve cultural competency in health care: a systematic review of reviews." <u>BMC Health Services Research</u> **14:99**.

This chapter provides an understanding of the international evidence base related to cultural competence interventions.

Chapter 7-9 comprise the research findings of the thesis. Chapter 7 presents the results from the qualitative study exploring cultural competence and the significance of cultural background in community health service utilisation from the perspectives of staff from MCHS. This chapter will describe the key themes identified by staff participants in accordance with the National Health and Medical Research Council (NHMRC) cultural competence model. Chapter 8 provides findings from interviews with clients/carers of MCHS. This component of the qualitative study seeks to further the understanding of the factors that affect health service utilisation by CALD people within the community health context. This chapter will describe the key themes identified by clients/carers of clients using MCHS services in accordance with Andersen's behavioural model of health service use. The first section of Chapter 9 describes the findings and outcomes from the implementation of the Cultural Competence Organisational Review (CORe) at MCHS. The second section provides an evaluation of the CORe tool as an organisational cultural competence assessment tool using the key principles outlined by Olavarria et al. (2009). Chapter 9 concludes with a discussion of the implications of the findings and recommendations for further research and evaluation in this area.

Chapter 10 integrates the key findings from the preceding three chapters with the empirical and theoretical literature. A conceptual model representing the 'influences on community health service utilisation by people from CALD backgrounds in Australia' will be presented. In addition, the 'congruency of community health and cultural competence' will be discussed within the context of change and uncertainty in the community health sector. This is followed by a section on 'diversity and intersectionality', which examines whether increasing globalisation, migration and hybridity of citizens necessitates a broader diversity lens, rather than a focus solely on culture per se. The topic of 'patient/client-centred care' and how it relates to cultural competence will also be remarked upon. This is followed by a section on 'cultural reflexivity' and a discussion related to 'organisational considerations'. The chapter concludes by considering the strengths and limitations of this research alongside its implications for research and practice. Recommendations for future practice and research in cultural competence are also provided.

The conclusions of the research will be summarised in Chapter 11. The key research findings will be briefly reviewed in relation to the research aim and questions.

Chapter 2: The Health Care Context

2.1 Introduction

This chapter and the following chapter will present the context for this study. This chapter outlines the background related to health care provision in Australia and describes the impact of multiculturalism on the Australian health care landscape and community health setting within which this PhD research is situated. Evidence related to racial/ethnic health inequities will be presented and the concept of the 'social determinants of health' will be introduced.

2.2 Health as a human right

The World Health Organisation has enshrined health as a fundamental right of every human being. That is: "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (World Health Organization 1946). The 'right to health' means that governments must generate conditions in which people can be as healthy as possible, including access to timely, acceptable, and affordable health care of appropriate quality (World Health Organization 2008). Furthermore, good health is an important resource that enables people to achieve other aims in life such as employment and better education.

The principle of non-discrimination also applies to the right to health. Health care facilities, goods and services should be accessible to everyone, regardless of personal characteristics and personal circumstances such as racial/ethnic background, age, socioeconomic status and sex. Conversely, bias and discrimination can lead to differences in access to the resources and opportunities for health for particular social groups (Whitehead and Dahlgren 2006). Traditionally, discriminated and marginalised groups often bear a greater share of health problems (Mackenbach, Stirbu et al. 2008, Williams and Mohammed 2009). Therefore, non-discrimination implies that governments should recognise and provide for the differences and specific needs of groups that face particular health challenges (World Health Organization 2008).

In the Australian context, the right to health has also been recognised. The Australian Charter of Health Care Rights was developed and endorsed by all Australian Health Ministers in 2008 and applies to all health settings across Australia, including public and private hospitals, general practice and community organisations (Australian Commission on Safety and Quality in Health Care 2008). It is guided by 3 principles: i) everyone has a right to access health care, ii) the Australian Government commits to international agreements that recognise health as a human right, and iii) Australia acknowledges and respects the different cultures and ways of life within Australian society. This includes the provision that health care should be respectful of individuals' culture, beliefs, values and personal characteristics.

The widespread recognition of the importance of health as a human right is an imperative for governments and institutions to act to ensure everyone has the right to enjoy the highest attainable standard of health. As such, it is necessary to distribute health resources equitably to create opportunities for access and also to remove barriers to achieving fair access for all. Providing the opportunity for each person to achieve his or her full health potential is a major public health challenge for societies and populations across the world. Indeed, there appears to be a widening divide in differences in health status between social groups (Whitehead and Dahlgren 2006).

2.3 Health inequities

Despite health being enshrined as a fundamental human right, research demonstrates the existence (and persistence) of inequalities and inequities in health status across different populations and within populations. These inequalities may be observed across a diverse range of health outcomes, including self-assessed health and wellbeing, mortality, morbidity and health behaviours (VicHealth Foundation 2008). Health inequalities may also arise from differences in access to and utilisation of health services (Turrell, Stanley et al. 2006, Commission on Social Determinants of Health 2008). Inequities in health are both directly and indirectly related to social, economic and environmental factors and structurally influenced lifestyles (Whitehead and Dahlgren 2006).

When describing differences in health status between groups, the most commonly used terms are: 'inequalities', 'inequities' and 'disparities'. Inequality and disparity are similar in meaning (inequality is preferred in Europe and Australia whereas disparity is used in the United States) in that they are defined by ‘difference’ without reference to the context, nature or direction of the difference (Ward 2009). On the other hand, ‘inequities’ refers to differences that are unfair, unjust and avoidable (Whitehead and Dahlgren 2006). In some instances inequalities and disparities have been used interchangeably with inequities and understood as health differences that are unfair and unjust (Whitehead and Dahlgren 2006). Henceforth, ‘inequities’ will be used in this thesis as the focus is on inequalities that are unjust and avoidable.

Equity in health is the converse of inequity in health and its goal is the elimination of unfair and avoidable systematic differences in health among groups defined socially, economically, demographically or geographically (Commission on Social Determinants of Health 2008). Equity in health is linked with equity in health care provision. Inadequate access to essential health services is a determinant of health inequities. As health is a human right, people have the right to have access to effective health care that reduces their suffering when sick, protects and prevents them from becoming ill and that helps them maintain their health when well (Whitehead and Dahlgren 2006).

Factors such as education, income and ethnicity are closely linked to people’s access to, experiences of, and benefits from health care (Commission on Social Determinants of Health 2008). For example, income insecurity and unemployment are associated with significant adverse effects on physical and mental health (LaMontagne, Keegal et al. 2010, Milner, Page et al. 2014). The relationship between these factors and health care access is often cyclic, for example, poor health care access can also lead to low education and low income and ethnicity drives differences in education and outcome (Peters, Garg et al. 2008, Phelan and Link 2015, Williams, Priest et al. 2016).

Health care systems, organisations and providers need to work towards the elimination of systematic differences in health status between groups on the basis of factors such as socio-economic status, ethnicity, age and gender. However, as Garrett and Lin (1990) ask: “Does having equal use of all health services constitute equity; or does equity mean achieving equality of health outcomes, recognizing the different cultural and linguistic groups may respond or relate to different strategies and services?” p. 372. This issue will be explored further in the next sections.

2.4 Racial/ethnic health inequities

There is a large body of international research showing the existence of racial/ethnic inequities in medical treatment, health service utilisation and patient-provider interactions (Nazroo and Karlsen 2001, Frohlich, Ross et al. 2006, Bhopal 2009). Research shows that immigrants from racial/ethnic minorities face greater barriers to accessing health care services compared to the majority population (Cass 2004, World Health Organization 2010, Drummond, Mizan et al. 2011). These barriers include language (Saha, Fernandez et al. 2007), cost (Sheikh-Mohammed, MacIntyre et al. 2006), health insurance status (Agency for Healthcare Research and Quality 2010), cultural appropriateness/familiarity (Lee and Vang 2010) and transportation (Scheppers, van Dongen et al. 2006, Drummond, Mizan et al. 2011). Barriers to health service use can occur at the provider, organisation and systemic level.

In Australia, health inequities between Indigenous populations and non-Indigenous populations have been widely documented (Australian Government 2009, Australian Medical Association 2009, Ride and Thomson 2010). In comparison, we know less about health inequities for people from culturally and linguistically diverse (CALD)[2] backgrounds. However, there is some evidence that people from CALD groups in Australia can experience poorer health status and health outcomes, for example, poorer mental health in children (Priest, Baxter et al. 2012), poorer oral health (Spencer and Harford 2008), higher rates of diabetes (Queensland Health 2012); and have difficulty in finding culturally appropriate health services in Australia (Manderson and Allotey 2003, Riggs 2010).

Research in this area is challenging due to the relatively sparse data available on race, cultural background and ethnicity. This is primarily due to a lack of data collected on these topics. In Australia, language spoken at home or ancestry are used as proxies for self-reported cultural background, race or ethnicity in major national data collections unlike in the United States and the United Kingdom where race and ethnicity is collected in the census (Williams and Jackson 2000, Australia Bureau of Statistics 2011, Australian Bureau of Statistics 2011, Office for National Statistics 2012). The

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[2] Culturally and linguistically diverse (CALD) will be used henceforth rather than racial/ethnic groups/minorities to reflect the most common nomenclature used by government, academic and non-academic institutions within Australia.

measurement of the ethnic and cultural diversity of the Australian population is primarily based on the use of a number of Census variables related to a person's origin, including: ancestry, country of birth, religion, year of arrival, Indigenous status and language. Hence, evidence of racial/ethnic health inequalities and inequities in Australia is still emerging.

Although there is a ‘healthy migrant effect’, whereby migrants often have better health than their counterparts upon arrival, this health advantage can deteriorate with increased length of stay in the host country (Anikeeva, Bi et al. 2010). Also, analysis of the Longitudinal Survey of Immigrants to Australia (Department of Immigration and Border Protection) indicates that immigrants with humanitarian visas have poorer self-reported health than immigrants from other visa categories, and that health of immigrants generally declines with duration of residence in Australia (Chiswick, Lee et al. 2006, Khoo 2010, Priest, Baxter et al. 2012).

Understanding racial/ethnic inequities in health also requires consideration of the relationship between racial/ethnic minority status, structural disadvantage and agency[3] (Karlsen and Nazroo 2002). Health problems are strongly linked to people’s social position within a society and migrants from racial/ethnic minorities tend to be more socially disadvantaged and more exposed to social exclusion and discrimination (World Health Organization 2010).

Despite the need for more evidence regarding racial/ethnic health inequities in Australia, it has been recognised by Australian governments and institutions that access to health services by people from CALD groups need to be strengthened (National Health and Medical Research Council 2006, Victorian Department of Health 2011). Thus, comprehensive strategies are required to reduce and eliminate racial/ethnic inequities in health care access and delivery. In order to achieve this, we need to address the range of factors that may potentially influence an individual or community’s access to and utilisation of health services.

Social and cultural influences that affect health outcomes for CALD groups are due to historical, political, environmental, hereditary and economic factors (Commission on

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[3] Agency refers to the capacity of an individual to act and make choices in any given environment.

Social Determinants of Health 2008). It is important to understand how people live and relate to their physical environment, how they maintain their cultural identity and how they feel valued as citizens as these factors all impact on physical and mental health. There is wide acceptance that a range of social factors are linked to the causes of ill health and the persistence of health inequities in societies (Marmot 2005). These are known as the ‘social determinants of health’ and will be described below.

2.5 Social determinants of health

The concept ‘social determinants of health’ describes the powerful factors in the social environment that impact on health at an individual level and population level. According to the World Health Organisation (WHO), social determinants are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life (Commission on Social Determinants of Health 2008). These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems which determine the distribution of money, power and resources at local, national and global levels. These in turn shape the social determinants of health, which are mostly responsible for health inequities seen within and between countries.

Social determinants of health can be considered in ten categories: the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport (Wilkinson and Marmot 2003). Other categories that have been identified as social determinants include: housing, income and income distribution, gender, race, disability, health services and Aboriginal status (Mikkonen and Raphael 2010). The ‘social gradient of health’ refers to evidence indicating that health inequalities are related to social inequities. Social position, which encompasses social class, gender, ethnicity, education, occupation and income, is a powerful influence on the type, magnitude and distribution of health in societies (Blas and Kurup 2010). People further down the social ladder (i.e. that experience greater social disadvantage) have shorter life expectancies and greater risk of disease compared with those closer to the top of the ladder (i.e. have greater social advantage). This social gradient exists both across and within countries.

Addressing the social determinants of health can increase people’s chances of living a healthy life. The three principles of action to address the social determinants as outlined by the WHO (2008) are; i) improve the conditions of daily life, ii) tackle the inequitable distribution of power, money and resources, and iii) measure the problem, evaluate action and expand the evidence, develop an appropriate workforce and raise public awareness of the social determinants. Achieving equity in health care means that everyone in need of health care is able to receive it in a form that is suitable to the individual, regardless of their social position or other socially determined circumstances.

Some have called for a health care sector reorientation towards action on the social determinants of health in order to eliminate health inequities (Baum, Begin et al. 2009, Browne, Varcoe et al. 2012). A key component of this reorientation involves ensuring health care services are available, accessible and acceptable. Issues related to ethnicity and cultural norms can impact on access to, use of, and benefit from health care services. Thus, a health care system that is responsive to these issues can improve access and reduce barriers to health care service access by people from CALD groups.

2.6 Role of health systems, institutions and organisations

The WHO has identified ‘health systems’ as a site for action to promote greater equity in health (World Health Organization 2010). Health systems provide services that influence health and are thus a vital part of the social fabric of a country, but also reflect the dominant social values of that country (Gilson, Doherty et al. 2007). As a consequence, the norms, values, and approaches of health systems can sustain practices that contribute to health inequity (Gilson, Doherty et al. 2007). For example, the lack of culturally sensitive health workers can distance cultural groups and contribute to disadvantage and isolation. Thus, health systems, institutions and organisations can be designed and managed to address health inequities by specifically tackling the circumstances of socially disadvantaged and marginalised populations. Addressing the different dimensions of health care access can improve health equity. For example, ensuring services are affordable for different socio-economic groups and also geographically located in areas of need.

A key action area highlighted by the Ottawa Charter for Health Promotion (further detailed in Chapter 4) is the reorienting of health services to become sensitive and respectful of cultural needs (World Health Organization 1986). This requires changes in professional education and training, and changes in the orientation and organisation of health services. This reorientation is necessary to address the dominance of the biomedical paradigm in the health care sector in many Western countries. This paradigm is oriented towards individualism, and privileges curative medicine over strategies that emphasise disease prevention and health promotion (Baum, Begin et al. 2009). There is a need for health professionals to understand and work collaboratively with traditional healing methods (Henderson and Kendall 2011). Within the wider social context, medical conservatism also reflects wider forces of social and political conservatism and resistance to alternative and unorthodox knowledge (Baum, Begin et al. 2009). Hence, members from CALD groups that understand their health within a different paradigm are likely to face difficulties accessing available health care that is appropriate for their needs.

Thus, the socio-cultural demographics of a population (and its migratory history if relevant) are important factors in the development of the health system, institutions and organisations and training of practitioners. As a result, it is important to understand the Australian social, cultural and political context and its impact on the health care system. This will be described in the next section.

2.7 Multiculturalism in Australia and its impact on health care provision

Australia is a culturally and linguistically diverse country with over 26% of Australians born overseas (Australia Bureau of Statistics 2013). Sixty-seven per cent of recent arrivals and 49% of longer-standing migrants spoke a language other than English at home (Australia Bureau of Statistics 2013). In the state of Victoria, 26.2% (just over 1.4 million) of Victorians were born overseas from more than 200 countries, of which almost 1.05 million were born overseas from non main English-speaking countries (Office of Multicultural Affairs and Citizenship 2013).

Migration is a major component of population growth in Australia. Between 1996 and 2013, Australia’s overseas-born population grew by 51.2% to 6.4 million (Department of Immigration and Border Protection 2013). In addition, there are increasing numbers of overseas-born residents from non-Western countries (e.g. China and India) migrating to Australia (Department of Immigration and Border Protection 2013).

In the past, Australia's approach to immigration was signified by the 'White Australia' Policy (Megalogenis 2015). The Federal Government passed the first laws restricting immigration to prevent 'non-Whites' from entering Australia in 1901. These laws and the White Australia Policy was designed to favour migrants from particular countries, i.e. English-speaking Anglo-Celtic countries and actively exclude migrants from regions such as Africa, Asia and Polynesia. There was a pervasive fear at the time that allowing migrants from these other 'races' would result in the contamination of class and racial equality in Australia (Megalogenis 2015). The White Australia Policy was formally abolished in 1972.

By and large, it was basically assumed that immigrants would assimilate into the mainstream culture and hence be able to access and utilise mainstream health services. In the late 1960s and early 1970s, a social welfare perspective on immigrant health emerged with a move towards broader analyses of ethnic communities and cultural relations (Garrett and Lin 1990, Access and Equity Inquiry Panel 2012). Reports such as the Immigration Survey of 1973 documented, for the first time, the relative disadvantage of immigrants in jobs, housing, medical insurance and health care (Garrett and Lin 1990).

Greater acceptance of non-Anglo European immigrants occurred gradually from the 1970s when the White Australia Policy was abolished. Multiculturalism gradually became recognised as being more than just minority languages and culture, but also about access to public services and equity in the allocation of public funds (Jupp 1989). It was increasingly recognised that rather than being a disadvantage, having a culturally and linguistically diverse society would bring economic and educational benefits to the country (Megalogenis 2015).

The introduction of a universal system of health care by the Whitlam government in the 1970s aimed to improve access to health services for immigrants as well as the general population. Policies and programs began to develop in order to improve accessibility for CALD communities such as the employment of bilingual staff in community health services (Johnson, Noble et al. 1999). The release of the Galbally Report '*Migrant Services and Programs*' in 1978 provided a new service orientation and set the framework for the next decade of ethnic health policy and programs at the federal level and as a result, new services were established (Garrett and Lin 1990, Access and Equity Inquiry Panel 2012).

During the 1980s it became a requirement of mainstream institutions such as hospitals and community health services to take measures to improve the accessibility of their services to meet the different needs of CALD groups (Jupp 1989, Garrett and Lin 1990). Language barriers were seen as a technical problem that could be overcome with interpreter and translation services, and ethnic health workers and other ethno-specific services were introduced to address cultural and structural barriers to access (Garrett and Lin 1990). These adaptations were perceived as being effective in improving access to health services. However, these health services were criticised for being influenced by political will, community demand and assumptions of differences between populations based on culture, rather than based on an analysis of actual community needs and establishment of current patterns of utilisation (Kelaher and Manderson 2000).

Government policy and funding changes in the 1990s led to the closure of ethno-specific services and a different model of health service delivery to CALD communities was adopted. The diversity and distribution of various immigrant populations made it unfeasible for all governments to provide ethno-specific services in all areas. Therefore, due to economic, managerial and institutional reasons, a model of health service delivery that promoted appropriate clinical and community based services within the mainstream health system was adopted (Bureau of Ethnic Affairs 1995, Allotey, Manderson et al. 2002). However, deficiencies in the level of quality of care to people from CALD backgrounds remained and there were concerns amongst community groups and health service providers that mainstream health services were unable to meet the diverse needs of people from CALD backgrounds (Minas, Lambert et al. 1996, Plunkett and Quine 1996, Markovic, Manderson et al. 2002).

Since the 2000s, cultural competence has gained increasing recognition in Australia, however it has not been embraced in a manner comparable to that experienced in the United States, Europe and Canada (Johnstone and Kanitsaki 2007). In the early stages, cultural competence in Australia largely focused on Indigenous cultural competence and cultural safety (Australian Health MInisters' Advisory Council's Standing Committee on Aboriginal and Torres Strait Islander Health Working Party 2004, Nguyen 2008, Farrelly and Lumby 2009). In 2006, the National Health and Medical Research Council released the report *‘Cultural Competence in Health: A guide for policy, partnerships and participation’* in recognition of the need for a framework and guide for the Australian context to address the challenges of providing health care to people from a broad range of CALD backgrounds (National Health and Medical Research Council 2006). The extent to which this policy has been adopted and implemented across different sectors and organisations is unknown. However, there are continuing signs that cultural competence is still a relevant issue as Australian government and accreditation authorities have mandated the incorporation of cultural competence in strategic planning of health services (Victorian Department of Health 2009, Victorian Department of Health 2011, Victorian Department of Health 2011).

In summary, the translation of perceived need into a health program has often relied on traditional Anglo-Australian concepts of service provision (Garrett and Lin 1990). Therefore, ethnic health policies and concerns have mainly focused on improving CALD groups’ access to existing mainstream health programs rather than the development of a broader primary health care approach to address CALD health needs (Garrett and Lin 1990, Gershevitch 2005). Ethnic health policy planning also neglected to address the social factors beyond ethnicity that disadvantaged immigrants.

Thus, issues are raised in relation to whether patterns of health care seeking are determined more by cultural beliefs and practices or by system-related barriers to access. And subsequently, whether the goal should be to improve access for people from CALD backgrounds to mainstream health services or to provide a variety of services that can reach different populations?

Australia’s health care system is a multi-faceted network of public and private providers, settings, stakeholders and supporting mechanisms (Australian Institute of Health and Welfare 2014). Therefore, it is beyond the scope of this PhD research to encompass all the different elements of the health system. Rather, this PhD research seeks to further the understanding of the issues related to health service provision and utilisation for people from CALD backgrounds within the primary health care setting, in particular community health. These settings will be described in the next sections.

2.8 Australia’s primary health care system

Primary health care refers to the first level of contact that individuals, families and communities have with the health care system. It includes health promotion, preventative care and rehabilitative services. Primary health care is delivered in a variety of settings, including general practices, community health centres, allied health services and non-government organisations.

The key goals of primary health care encompass equity of access to services and equity in health outcomes (World Health Organization 2008). There are five key principles within primary health care according to Sanders et al. (2011): equitable provision of services, comprehensive care, inter-sectoral action, community involvement and appropriate technology.

There is evidence that primary care (in contrast to specialty medical care) is associated with a more equitable distribution of health in populations and plays a critical role in preventing illness and death (Starfield, Shi et al. 2005). A strong primary health care system can lead to improvements in population health outcomes, reduced use of emergency services and lower overall heath care utilisation (Commission on Social Determinants of Health 2008, World Health Organization 2008). Easy access to primary health care services can ensure that health problems are addressed early in the progression of a disease or condition as people may delay help-seeking in the absence of accessible or effective primary health care (Duckett 2007, Brown, Vercoe et al. 2012).

Access to primary health services can be affected through factors such as cultural issues, English language proficiency, socioeconomic circumstance, geographic location and age (Productivity Commission 2015). International evidence indicates that the strengthening of primary health care services for disadvantaged populations can reduce health inequities (World Health Organization 2008). Thus, an equitable primary health care system is essential (Wilson 2008).

Primary health care is a key priority for State and Federal Governments in Australia (Commonwealth Department of Health 2010). In recent times, the Australian Federal

Government established Medicare Locals in 2011 to co-ordinate and deliver primary health services to meet local needs. However, the 61 Medicare locals were replaced in 2014 with a smaller number of Primary Health Networks when a different Government was elected in 2014. According to some, uncertainty in the political arena has contributed to difficulties in developing a comprehensive, efficient and multi-disciplinary primary health system (Duckett 2007, Corbett 2014, Di Natale 2014, National Rural Health Alliance 2014).

Australian primary health care consists of 4 main types of services and providers: general practice, community health services, private allied health providers, and Indigenous community controlled health services (Powell Davies, Perkins et al. 2009). A universal public health insurance scheme called Medicare includes funding for free or subsidised primary health care services by some health professionals such as doctors and optometrists. General practice funded via Medicare is the most consistent universal primary health care service accessed by the majority of Australians.

Some health care services (particularly specialist services) are established where practitioners decide to work, not necessarily where the population is, or the populations with the greatest needs are (Health Workforce Australia 2012). In contrast, not-for-profit health services within the community sector are typically located where services are needed and are strongly influenced (if not run) by local community groups and clients. In general, consumers and communities have a low level of influence in primary health care. However, they have significant input in community health sector organisations (McBride and Wilson 2014). The community health model of service provision will be described in the next section.

2.9 Community health model of health service provision

According to Rosen et al. (2010), community health is defined as “a range of community-based prevention, early intervention, assessment, treatment, health maintenance and continuing care services delivered by a variety of providers” p107. Community health services combine the clinical and social models of health by providing clinical care as well as addressing the social and environmental determinants of health. While there is some overlap with primary health care services, they have differing roles and organisational structures (Rosen, Gurr et al. 2010).

In Australia, the community health model is a unique social model of health that provides affordable primary health care to meet the needs of the local community it serves. Community health services are the second largest component of primary health care and generally take a broader approach to primary health care than general practice (Powell Davies, Perkins et al. 2009). Community health organisations recognise the importance of social, environmental and economic factors that affect health and are guided by the principles of social justice and equity (Telford, Maddock et al. 2006).

Advocates of community centred health services believe health services are more accessible and person-centred than other primary health care services, particularly if they are strongly influenced by communities, if not run by communities themselves (McBride and Wilson 2014). This can facilitate the tailoring of services in a way that is sensitive and appropriate to the needs of vulnerable and disadvantaged groups specific to the local community. They are able to provide multi-disciplinary, comprehensive and integrated primary health care. The funding model (block funding rather than fee-for-service) also enables the freedom to develop innovative models of care (McBride and Wilson 2014).

Community health centres were initially established by the Australian Commonwealth Federal Government under the Community Health Program in 1973 with the goal of encouraging a shift towards prevention, a focus on local communities and emphasis on primary care (Baum, Fry et al. 1992). The focus was on providing multi-disciplinary primary care with less emphasis on the biomedical model (i.e. doctors and hospitals) and more on health education and promotion, allied health, outreach programs and community engagement. However, the development and organisation of community health centres across Australia is diverse, partly due to differences in local and state political, economic and ideological conditions (Owen and Lennie 1992, Rosen, Gurr et al. 2010). As a result, in some states, community health services were less connected with the local community and adopted a more biomedical orientation in linking with hospital services (Baum, Fry et al. 1992).

A wide range of funding arrangements for community health services across the country has created challenges for the co-ordination and development of services (Duckett 2007). Community health services may be provided directly by government or indirectly through a local health service or community organisation funded by government (Productivity Commission 2015). There is no longer dedicated federal government funding for community health, hence they are forced to compete with acute hospital care for funding (Rosen, Gurr et al. 2010). Thus, funding for community health services is often under pressure as health budgets are stretched. As community health services are heavily reliant on public funding, they are often required to demonstrate the benefits of their programs to government decision makers for funding and policy support to continue (Sindall 1992).

Community health services in Victoria, Australia, are largely funded by the Victorian State Government (in 2013-14 they funded ~60% of total revenue) (Victorian Department of Health & Human Services 2015). The main areas of primary health care funded through community health are dental, allied health, counselling, nursing services and health promotion (Victorian Department of Health & Human Services 2015). The 88 Victorian community health services provide universal access to services and prioritise access to people with particular health needs and those that experience disadvantage.

The Australian community health sector plays an important role in primary health care provision, particularly for CALD groups. In spite of this, there is a lack of research evidence related to cultural competence in the community health setting. There are few studies exploring the need to develop and manage culturally competent health services for people from CALD groups and few resources directing providers to ensure cultural competence (Renzaho 2008). In addition, the quantum and range of multicultural health research and evidence is limited and uneven, with some communities and health issues invisible or unrepresented (Garrett, Dickson et al. 2010).

2.10 Conclusion

This chapter has provided the background and context to this study. The existence and significance of health inequities and its relationship to the social determinants of health has been outlined. The impact of multiculturalism on health care provision in Australia and the role of community health services in providing health care to people from CALD groups were also discussed.

The organisation and management of health systems and all its elements influence health and thus can be altered to address and reduce health inequities. An equitable primary health care system is essential in addressing health inequities experienced by disadvantaged people from CALD groups. Further research is needed to establish whether increasing cultural competence can improve quality of care and health outcomes for people from CALD groups. In particular, more evidence related to cultural competence in the community health sector is needed as it plays a vital role in primary health care provision for CALD communities.

The next chapter will provide further context to this research by introducing the field of cultural competence.

Chapter 3: Cultural Competence and Health Care

3.1 Introduction

This chapter explores the concept of cultural competence and examines the various issues and approaches in order to provide a clear foundation for this research. It begins with a discussion of the concepts of culture, race and ethnicity and its relevance to, and implications for, health care service provision. This is followed by an examination of the different approaches to the concept of culture and a critical analysis of cultural competence, including a synthesis of the relevant literature.

3.2 Culture, ethnicity and race

Definitions of culture, ethnicity and race are contested (Smedley and Smedley 2005). However, *culture* generally refers to knowledge, beliefs, traditions, values, or the way of life of a particular people, society or nation and *ethnicity* refers to groups of people who have common cultural traits that distinguish them from those of other peoples (Smedley and Smedley 2005). *Race* can be considered a multi-dimensional socio-political construct that comprises the notion of essentialised innate difference based on phenotype/ancestry and/or culture, and that intersects with other forms of privilege/oppression (AAA Executive Board 1998, Paradies 2006). It is critical to recognise that these concepts should not be considered fixed or essential characteristics that people ‘have’, but rather dynamic processes that need to be understood through reference to place and history (Kleinman and Benson 2006, Chattoo and Atkin 2012). Whilst each term is distinctive, there appears to be some conceptual overlap in the sharing or commonality of features or traits by members of cultural, ethnic or racial groups. Ethnicity and culture are more closely connected with each other than with race, but differ in that ethnicity encompasses cultural traits or traditions possessed by people that share a common descent or ancestry whilst culture refers to the behaviours and customs shared by groups not necessarily with a common origin. Ethnicity also involves a system of shared meanings developed with a particular social, economic, historical and political context (Watt and Norton 2004).

The concept of ‘race’ originated in relation to perceived biological differences and the notion that members within a racial group share distinguishing physical characteristics such as skin colour. With advances in scientific knowledge (particularly in the field of genetics), the evidence that ‘racial’ groups differ biologically and physiologically has been largely refuted (Bhopal 1997, Lee, Mountain et al. 2001, Foster and Sharp 2002). A wide variation in physical characteristics within as well as between racial groups is now recognised, with extensive international migration leaving the concept of distinct ‘racial’ groups unsustainable (Senior and Bhopal 1994). Thus, race is a social construction that represents an ideology or worldview (Smedley and Smedley 2005). Despite falling into disrepute as a legitimate scientific category, race continues to have social and political meaning, and is still relied upon as a social category in contemporary society, for example in public policy (Yanow 2015) and medicine (Bhopal 2009).

Historical research on race and health, much of which was racist and unethical (Bhopal 1997), has contributed to contemporary challenges in defining ethnicity and race as well as problematic assumptions in the categories themselves. For example, the use of ‘ethnicity’ in health care has also been criticised for othering and essentialising immigrant, minority ethnic communities, such as by defining them through stereotypes of culture, religion and tradition, rather than considering individuals in their own right (Chattoo and Atkin 2012). In health science, the concept of culture is problematically intertwined with understandings of race. There has been a tendency within health care to equate culture with race and ethnicity which limits culture to a term that is defined narrowly in terms of difference based on visible or audible markers such as dark skin, accents or surnames (Lee, Mountain et al. 2001, Drevdahl, Canales et al. 2008). Hence, and consistent with historical debates, culture as a concept has been defined in a way that can essentialise difference and disadvantage particular groups and communities (Ahmad and Bradby 2007, Jenks 2010). Some refer to a new ‘cultural racism’ or ‘culturalism’[4], whereby people of immigrant origin who might be different from the native-born in terms of culture (e.g. language, dress) are perceived as a threat to national identity and dominant, mainstream cultural values (Jayasuriya 2003, Chattoo and Atkin 2012). In Australia, examples of this are seen when particular groups are singled out for

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[4] Culturalism refers to the idea that individuals are predominately determined by their culture, particularly in determining individual and societal behaviours.

having a culture perceived to be incompatible with the ‘Australian way of life’ (Bastian 2012, Soutphommasane 2013).

Although some scholars have rejected essentialist notions of culture (Jenks 2010, Hester 2012, Good and Hannah 2014), problematic conceptions of culture still remain in use by some within academia (Jahoda 2012, Kagawa-Singer 2012) and institutions such as government, education and criminal justice (Yanow 2015). However, there continues to be a lack of agreement over the definition of ‘culture’ (Jahoda 2012). In addition, the culturalism seen within conservative politics towards the end of the 20th century has resulted in depoliticised issues of inequality and social disadvantage (Jayasuriya 2003).

3.2.1 Use of ‘culture’ in health

In the literature, there are differing views on the merits of understanding culture in health and health care. On one hand, knowledge of the specific cultures of ethnic minority groups can be useful in informing health practitioners about different values, beliefs and practices that exist (Kelleher 1996, Kirmayer, Rousseau et al. 2008). Some scholars believe that acquiring cultural knowledge can minimise cultural dissonance and improve patient-provider communication in order to anticipate barriers to access, increase compliance with medical treatment, and produce better health outcomes (Salimbene 1999, Leininger and McFarland 2002). In contrast, others have cautioned against viewing culture as something prescriptive as this approach can reinforce stereotypes and labelling (Gregg and Saha 2006, Drevdahl, Canales et al. 2008). Additionally, approaches that promote a check-list or series of ‘dos and don’ts’ that define how to treat a patient of a given cultural/ethnic background can lead to assumptions that may adversely influence how treatments are offered to patients and how diseases are investigated (Good, James et al. 2001, Kleinman and Benson 2006). This approach can lead to stereotyping or an over-emphasis on cultural factors and related misunderstandings. For example, an ethnographic study that explored clinician and patient perspectives regarding decision making about amniocentesis found that the clinicians conveyed ‘clinical myths’ about Latino culture (e.g. being religious, fearful, fatalistic and superstitious) and its effect on amniocentesis decision making which contradicted with researchers’ observations and interviews with the Latina patients (Hunt and de Voogd 2005).

In culturally diverse societies, the dominant culture, which is commonly perceived as ‘normal’ and the benchmark against which other cultures are measured, regulates which problems are recognised by social systems including the health system and what kinds of social or cultural differences are worthy of attention (Pon 2009, Kirmayer 2012). In addition, professional ideologies and institutional practices construct and reinforce dominant cultural notions of normalcy. There is a tendency within health care to associate culture in health with predominantly negative assumptions about migrant customs and norms, and that these cultural differences constitute a barrier to clinical practice (Hunt and de Voogd 2005, Johnstone and Kanitsaki 2008). It is also problematic when definitions of culture appear to encourage prediction of behaviours, or create distance between people by focussing on ‘otherness’ (Qureshi, Collazos et al. 2008). Emphasising cultural difference to explain inequalities and differences in health status or use of health services can serve to pathologise ‘culture’ and promote victim blaming (Hunt and de Voogd 2005, Ahmad and Bradby 2007). On the other hand, a focus on treating each individual as unique and thus avoiding the use of stereotypical knowledge about behaviour traits can ultimately reinforce a depoliticised understanding of cultural difference (Jenks 2011). This avoids in-depth examination of the social and historical conditions leading to inequalities (including the impact of institutional racism) and draws providers away from reflecting on their own cultural positions and biases.

The arguments presented thus far suggest that it is neither possible nor desirable to ignore race, culture and ethnicity altogether. Despite the challenges and contradictions inherent in these categories, culture has continuing popularity in the post-modern age as a broad concept with multiple meanings. Culture provides a framework through which individuals and communities interpret the world, negotiate their own health behaviours and make decisions in relation to health service utilisation. Therefore cultural processes remain central to the principles and practices of health care delivery. However, focussing on ‘culture’ should involve more attention to the role played by factors such as acculturation and migration (Berry 2005, Berry 2008). Moreover, while cultural context is important in studying health and illness among minority ethnic communities, a more politicised and contextual notion of ‘culture’ is needed (Shaw 2005, Bhui, Ascoli et al. 2012). There is a need to ask: what is the *relative* importance of culture in understanding the health and illness of people? This PhD research seeks to examine this issue.

3.3 Influence of cultural background on health and health care

Health and health care, in particular, are areas where diverse practices and beliefs can create challenges, tensions and misunderstandings. Governments, organisations and health providers are increasingly aware of the need to address the impact of cultural differences on health and health care. However, shifting demographics in developed Western countries such as Australia and the United States can present challenges to the provision of inclusive and appropriate services that meet the varied needs of culturally and linguistically diverse groups (Batalova and McHugh 2011, Australia Bureau of Statistics 2013). The dominance of the biomedical paradigm in many Western countries can also create barriers to health care service access for some members of CALD groups. This section will explore in some detail the influence of cultural background in health and health care in terms of its contributions to health inequities and the culture of health care providers and organisations.

3.3.1 Cultural differences

There is a substantial body of literature related to the influence of cultural beliefs and values on patient-practitioner relationships and their subsequent effect on health outcomes (Schouten and Meeuwesen 2006, Shahid, Finn et al. 2009). Misunderstandings and miscommunications arising from cultural differences may lead to: wrong or sub-optimal treatment, poor patient compliance, reduced access to health care services, poorer health outcomes/health inequalities as well as racism and stereotyping. Studies have also shown how a patient's cultural background can influence practitioner communication and decision-making (Hudelson 2005, Rosenberg, Kirmayer et al. 2007, Paradies, Truong et al. 2013). For example, generalisations and stereotypes of patients are often made that may unintentionally influence assessments and treatment decisions (Hunt and de Voogd 2005, Paradies, Truong et al. 2013).

Cultural differences are also associated with health inequities due to histories of racism, discrimination and exclusion that continue to maintain structures of inequality and inequity (Kirmayer 2011, Durey and Thompson 2012). History shows that definitions of race and culture are political in nature and have been used in the marginalisation of disadvantaged groups (Ahmad 1996, Chattoo and Atkin 2012). One of the legacies of colonialism is that biomedicine is the dominant paradigm for defining health and illness and the delivery of health care in many countries around the world. As a result, research into the cultural dimensions of health among minority groups tend to be framed by biomedically defined disease categories (Lambert and Sevak 1996).

3.3.2 Culture of health care providers and organisations

Education and training of health practitioners within Western countries such as Australia generally incorporate Western values about health beliefs and health practices (often the biomedical model) without explicitly examining the Western cultural framework on which such values and practices are based.[5] Western biomedicine has an inherent value system, reflecting the society in which it originates and currently functions. Hence, when people from non-Western societies migrate to Western societies they are confronted with a health system which may differ and conflict with their own health beliefs and practices.

Medical anthropologists have been critical of approaches to culture that are essentialist and that focus on the exotic ‘other’. There is often a focus on the patient/client’s cultural diversity without acknowledging or examining the complications that Western culture itself brings to clinical care (Harvey 2008). For example, in the ground-breaking book ‘*The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*’, a young child’s life is irreversibly and tragically impacted by a ‘collision’ between Hmong culture and U.S. medical culture (Fadiman 1997). The author describes how the uncompromising attitudes and lack of empathy towards Hmong culture by treating doctors and institutions contributed to the medical tragedy that ultimately left a 4 year-old child in a persistent vegetative state.

In addition, there is an underlying assumption that biomedical knowledge is *truth* and hence medicine perceives itself as a ‘culture of no culture’ (Taylor 2003). Therefore, references to cultural differences are ultimately assumed to be ‘differences’ from the ‘neutral objectivity’ of the Western biomedical paradigm.

Within Australia, beliefs about the role of culture in health and illness behaviour have often taken place in the context of discussions of the health of immigrant Australians (Manderson and Reid 1994). In comparison, the health and illness behaviour of Anglo-

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[5] It is important to recognise that there is also diversity among ‘Western’ countries due to the presence of different health systems and cultural frameworks.

Australians is seen as ‘scientific’ and ‘culture-free’. People who are regarded as ‘different’ by virtue of their country of birth, name, ethnicity, first language or race are presumed to have distinctive problems, needs and challenges in relation to their health care utilisation and compliance with treatments and interventions (Manderson and Reid 1994). Addressing issues related to language and communication (e.g. translated materials, interpreter services) are often considered to be the main ways of resolving barriers to access and utilisation of health services.

A voice often missing from debates about the importance of culture in health care is that of patients/clients from CALD groups. Garrett et al.’s (2008) qualitative study of non-English speaking patients’ perspectives on acute care suggests that cultural competence was about responsive and compassionate caring as well as respect, empathy and effective communication. They found that ethnicity-based customs, beliefs and practices were at times important for the participants in the study. However, broader personal and social factors contributed most significantly to their experiences and constructions of illness. Studies by Ngo-Metzger et al. (2003) and Tucker et al. (2003) also found similar results. Studies by Johnston and Herzig (2006) and Renzaho (2008) showed a dissonance between health care providers and patients in their understanding of culture and its relationship to health. For example, in Johnston and Herzig’s (2006) study of Mexican agricultural workers and US health care providers, the Mexican agricultural workers emphasised structural dimensions of labour migration as the most relevant factor in shaping their patient-provider interactions (e.g. low wages, long work hours and barriers to health care access). In contrast, the US health care providers tended to focus on the ‘cultural characteristics’ peculiar to their patients (e.g. superstitions and use of faith healers).

As discussed in the next section, the existence of racial/ethnic health inequities (as outlined in Chapter 2), recognition of the fundamental ethnocentrism of contemporary Western health care and understanding the different ways patients and families respond to illness and treatment has lead to the development of cultural competence.

3.4 Cultural competence

The most frequently cited definition of cultural competence is Cross et al. (1989)’s definition: “a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations” (pg. iv). This definition encompasses the significance of organisational and systems level policies and practices which impact on health care access and delivery. Cultural competence is used to describe a variety of interventions that aim to improve the effectiveness and accessibility of health services for people from CALD groups. Health professionals, educators and social scientists developed this approach largely in response to the recognition that cultural and linguistic barriers between health care providers and patients can affect the quality of health care delivery (Beach, Saha et al. 2006). Cultural competence is predominantly targeted at immigrant populations from non-English speaking countries with limited exposure to Western cultural norms (Saha, Beach et al. 2008). Cultural competence also involves a greater recognition of the contribution made by sociocultural factors to lifestyle behaviours and racial/ethnic differences in health beliefs, lifestyle behaviours and health practices (Chin 2000). Cultural competence interventions frequently discussed in the literature include: interpreter services, recruitment and retention of minority staff, staff training and administrative and organisational flexibility and adaptability (Brach & Fraserirector, 2000).

In the United States, the prominence of cultural competence within health policy and practice is largely attributed to federal and state regulations calling for culturally competent care (Office of Minority Health 2013). Similarly, government and accreditation authorities have mandated the incorporation of cultural competence in strategic planning of health services in Australia (Victorian Department of Health 2009, Victorian Department of Health 2011, Victorian Department of Health 2011, Victorian Auditor-General 2014). In Australia, the National Health and Medical Research Council released a guide to help policy makers and managers to integrate cultural issues in the planning and delivery of health care services across all levels of the health system (National Health and Medical Research Council 2006).

3.4.1 Cultural competence frameworks and models

Since its introduction in the 1980s, numerous cultural competence frameworks and models have been developed. Many models include dimensions of knowledge (e.g., understanding the impact of culture on health care delivery), attitudes (e.g., having respect for variations in cultural norms) and skills (e.g., eliciting patients’ explanatory models of illness) (Saha, Beach et al. 2008). Over time, the scope of cultural competence has expanded beyond the interpersonal interactions between practitioners and patients/clients to include organisational and systemic cultural competence. Although the most often cited definition of cultural competence is that of Cross and colleagues (1989), there is no single widely accepted and definitive conceptual cultural competence framework/model (Butler, McCreedy et al. 2016). The literature contains many analogous terms/concepts (e.g. culturally appropriate care, cultural awareness and multicultural education) that add to the complexity in this field.

Cultural competence frameworks/models vary in their approach and application. Some published cultural competence frameworks/models take a multi-level approach (Cross, Bazron et al. 1989, National Health and Medical Research Council 2006) whereas others focus on individual level cultural competence (e.g. (Campinha-Bacote 2002, Purnell 2002)). Some are discipline specific (Culhane-Pera, Reif et al. 1997, Qureshi, Collazos et al. 2008) whilst others are inter-disciplinary (Selig, Tropiano et al. 2006). In addition, cultural competence has taken root outside of the health sector, e.g., in education (McAllister and Irvine 2000) and business (Johnson, Lenartowicz et al. 2006).

Cultural competence frameworks that are too prescriptive are less likely to result in change if the local context is not taken into account and/or local communities are not consulted (Uttal 2006). The meaning of culture in one location or amongst a population will reflect a particular historical, social and political context and therefore may not be applicable to other places or peoples. It may be useful at the individual level to understand the impact of cultural differences in health care interactions. However, health inequities exist at a population level and therefore require broader issues of power and structure to be considered (Drevdahl, Canales et al. 2008).

This PhD research is underpinned by two cultural competence frameworks: Cross' (1989) framework of cultural competence and the National Medical Research Council's (2006) cultural competence model. They are described in Chapter 4.

3.4.2 Cultural competence training

Educational programs have been designed to inform health providers about the importance of understanding patients'/clients' cultural context, to promote positive attitudes and teach appropriate skills in cultural competence. However, this is not without considerable challenges, including: overcoming learner resistance, choosing an appropriate conceptual framework that does not promote stereotypes, and fostering self-reflection (Boutin-Foster, Foster et al. 2008). A study by Jenks (2011) found that cultural competence educators found it challenging to present specific examples that highlight the relevance of cultural difference whilst discouraging health providers from assuming that all members of a particular group were the same. Shaw and Armin (2011) also argue that culturally appropriate health care is becoming disconnected from its social justice origins as it becomes rationalised by, and more firmly embedded in, the operations of the private health care sector.

Cultural competence training is variable in terms of its design, delivery, content and outcomes (Price, Beach et al. 2005, Gallagher and Polanin 2015). A strong and positive link between cultural competence training of health providers and patient/client health outcomes has not been established (Beach, Price et al. 2005, Lie, Lee-Rey et al. 2011). A recent meta-analysis of educational interventions designed to enhance cultural competence in professional nurses and nursing students found varied effectiveness; with the pretest-postest synthesis indicating a statistically significant, moderate program effect and the treatment-control synthesis indicating a non-statistically significant, yet positive program effect (Gallagher and Polanin 2015).

There are limitations to cultural competence training. Knowledge of patients' cultural values and practices does not mean the provider can predict behaviours and clinical outcomes. Clinical interactions are also shaped by differences in social position and power. Focusing on culture and diversity, particularly that of the patient/client, can distract providers from examining their own personal values, attitudes and privilege, and the impact they have on the patient-provider relationship. For example, blaming factors such as a lack of understanding of cultural difference for miscommunication and lack of compliance does little to explain the reason for such problems when they occur between patients and providers of the same culture (Drevdahl, Canales et al. 2008).

According to Jenks (2011), most of contemporary cultural competence education (in the United States context) has rejected a 'list of traits' approach and instead aims to produce health providers that are 'open-minded' and able to treat each patient as an individual. However, Jenks also argues that cultural competence education is unlikely to reduce racial/ethnic inequities in health without a concomitant focus on the broader social and economic conditions, and power differentials that underlie health inequities. It is also important to understand the role that White privilege[6] plays in the development and maintenance of beliefs, social structures and practices by the dominant White group (Tyson 2007). On a broader level, political action is required to make real transformations to reduce health inequities and create a more socially just health care environment for all.

3.4.3 Evidence in the field of cultural competence

There is an abundance of international literature related to cultural competence and the importance of its integration into all levels of health care. Health care professions and institutions have produced legal, ethical and moral obligations for providing culturally competent care (Multicultural Mental Health Australia 2010, Office of Minority Health 2013). However, it is still an emerging field as there are no ‘best practices’ that have been defined, no clear agreement on the goals of training, and little statistical evidence that cultural competence actually has a substantial effect on health outcomes and inequities (Jenks 2010, Gallagher and Polanin 2015, Butler, McCreedy et al. 2016).

Existing reviews have examined cultural competence and related concepts within health care settings such as nursing (Pearson, Srivastava et al. 2007, Gallagher and Polanin 2015) and mental health (Bhui, Warfa et al. 2007) as well as within health care systems (Anderson, Scrimshaw et al. 2003). Some reviews have focused on either provider outcomes (Beach, Price et al. 2005, Gallagher and Polanin 2015) or patient/client outcomes (Lie, Lee-Rey et al. 2011) while others have examined specific health conditions such as diabetes (Hawthorne, Robles et al. 2008).

There have been some studies related to cultural competence in the Australian context, most of them within the Indigenous health sector. A review of Indigenous cultural training for health workers in Australia found that the evidence for the effectiveness of Indigenous cultural training programs was poor (Downing, Kowal et al. 2011). A recent review of interventions to improve cultural competence in health care for Indigenous peoples in Australia, New Zealand, Canada and the USA also found a lack of evidence on the effectiveness of interventions to improve health outcomes (Clifford, McCalman et al. 2015).

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[6] White privilege refers to the unearned societal advantages that White people benefit from, often unconsciously (McIntosh 1988, Tyson 2007).

A study by Renzaho (2008) found that developing culturally competent services were limited by: state government funding and service agreements, lack of partnership and organisational collaboration, incomplete assessment of needs and underutilisation of available services. The provision of health and welfare services to CALD communities was found to be generalist in nature, adopting a ‘one approach fits all’ type model of service delivery (Renzaho 2008). Health care utilisation by CALD communities was associated with the migration process, settlement and adaptation to the host country, which varies according to an individual’s or family’s experience. The importance of taking into account the pre-migration experiences of members of CALD groups has also been noted (Galligan, Boese et al. 2014).

To date, reviews have highlighted a lack of robust evidence pertaining to the relationship between cultural competence and improved provider/organisational behaviors or patient/client health outcomes (Anderson, Scrimshaw et al. 2003, Beach, Price et al. 2005, Lie, Lee-Rey et al. 2011). There is also a lack of consensus on the most effective ways of improving cultural competence and a dearth of evidence linking cultural competence interventions with direct improvements in patient health outcomes and subsequent reductions in racial/ethnic health inequities (Vega 2005). Despite its popularity among academics and policymakers alike and general agreement within the academic literature that cultural competence and health inequalities are important interrelated concepts, moving from theoretical models to effective interventions has proven difficult (Drevdahl, Canales et al. 2008, Malat 2013). This may be due to a number of key issues, which are explored below.

3.4.4 Criticisms of cultural competence

There are several main criticisms levelled at the field of cultural competence. The first is related to its terminology and the perceived lack of a clear definition of the concept of culture in cultural competence. The term ‘competence’ implies that being culturally competent means being good at knowing about other cultures (i.e. other than White) and how to use this knowledge to interact with people from different cultural backgrounds. It also implies that whiteness is the standard by which cultures are compared and differentiated (Pon 2009). This results in ‘othering’ and a lack of reflexivity, with models that use cultural definitions to account for difference at the risk of promoting essentialism (Johnson, Bottorff et al. 2004, Gregg and Saha 2006, Hester 2012).

Assumptions about culture can also perpetuate stereotypes that mark ethno-cultural groups as outsiders and problematic. For example, an Australian study of health care staff (e.g. nurses, interpreters, health service managers) and patients/carers found that cultural racism, particularly English language proficiency, was used as a social marker to classify, categorise and negatively evaluate people from CALD backgrounds (Johnstone and Kanitsaki 2008).

Focusing on cultural differences may distract from broader factors such as poor education and poverty which may play a greater role in the ill-health outcomes of some individuals and groups in the community (Gregg and Saha 2006). Health inequities are produced by numerous complex factors, yet actions to eliminate poverty, insufficient housing and racism, for example, are imprecise and intractable. Cultural competence may serve to cast inequality as a seemingly inevitable product of difference from the norm, whilst masking the conditions that produce such inequalities, and reinforcing power and privilege of the dominant group over others, despite greater acceptance of ‘cultural difference’ (Jenks 2010). Rather than relying on cultural competence to address health inequities, some have called for greater efforts to address the social determinants of health beyond the domain of clinics and health care organisations (Drevdahl, Canales et al. 2008).

Some cultural competence models are also criticised for not encouraging providers to reflect upon their own values, attitudes and beliefs; both personal and professional (Wells 2000, Kumagai and Lypson 2009). This is important because evidence suggests that health care providers’ unconscious (implicit) racial bias may influence their decision making when treating patients (Paradies, Truong et al. 2013).

The lack of an empirical foundation is viewed by some as a fundamental flaw in its conceptualisation. Without clear definitions, the concept of cultural competence derives its meaning primarily from common goals rather than a rigorous theory of the role of culture in medicine (Park 2005, Lo and Stacey 2008). Perhaps this is why there has been difficulty translating models of cultural competence into practice and a lack of evidence of substantial improvement in patient health outcomes (Lie, Lee-Rey et al. 2011). Saha et al. (2013) state that cultural competence gained prominence largely based on expert opinions about its theoretical benefits rather than empirical research.

However, it would be challenging to develop a definition or framework/model of cultural competence that is applicable across a diverse range of health care contexts and settings. Changing social, environment and political circumstances also make it necessary to refine and advance existing definitions and frameworks/models. Thus, it is important that those working in the field are explicit about the definition and/or framework/model of cultural competence being used.

3.4.5 Cultural competence - moving forward

Despite these criticisms, abandoning cultural competence altogether would be a step in the wrong direction. Ignoring the influence of culture on health service access and delivery could lead to cultural blindness or worse. Cultural blindness refers to the view that all people, regardless of race or culture, should be treated the same. Hence, health care services traditionally used by the dominant culture are universally applicable to all people regardless of their cultural background (Cross, Bazron et al. 1989). This perspective ignores cultural strengths, encourages assimilation and can result in blaming the victim for their problems (Cross, Bazron et al. 1989). A reconceptualisation of cultural competence that explicitly places issues of race, racism, power and privilege at the centre may be what is required, rather than abandonment of the approach (Hester 2012, Malat 2013).

Furthermore, there is some evidence to suggest that interventions to improve cultural competence have a positive impact on provider awareness, knowledge and skills (Beach, Price et al. 2005, Gallagher and Polanin 2015) as well as patient/client health outcomes (Fisher, Burnet et al. 2007, Hawthorne, Robles et al. 2008, Saha, Korthuis et al. 2013). A study by Saha et al. (2013) of primary care provider cultural competence in HIV care found that higher provider cultural competence scores were associated with more equitable care and outcomes across racial/ethnic groups.

Health care interventions solely aimed at the individual level (i.e. that focus on practitioner characteristics) may have limited scope for change in the broader context of organisational and structural factors. Cultural competence interventions which include changes at both the individual and organisational levels are more likely to result in sustained change as staff may be influenced by an organisation’s commitment and actions in relation to cultural diversity. Interventions that target multiple leverage points along a patient/client’s pathway of care show promise in improving health outcomes.

However, more evidence related to interventions directed at organisations, microsystems and policies is needed (Chin, Clarke et al. 2012). This PhD research aims to address the gap in the evidence base related to organisational-level interventions. The next section will outline the literature and evidence related to organisational cultural competence.

3.5 Organisational cultural competence

Providing inclusive and appropriate services that meet the varied needs of culturally diverse groups can be a challenge for health care and social services. Organisations that strive for cultural competence can lessen the impact of the language and cultural barriers that reduce equitable access to services by CALD communities. In order for culturally competent policy and plans to be implemented successfully across the health system, change needs to occur at the systemic, organisational, professional and individual level (National Health and Medical Research Council 2006, Weech-Maldonado, Al-Amin et al. 2011).

Cultural competence should not only be reflected in the delivery of health services, but should occur across organisational systems in general and be integral to policy, administrative practices and service delivery (Adamson, Warfa et al. 2011). Organisations that endeavour to be culturally competent need to actively design and implement services that are appropriate and responsive to the needs of their patients/clients. There should be a commitment among the leadership of the organisation and embedded key performance indicators, supported by allocated resources. Organisational cultural competence may be measured by; the cultural and linguistic diversity of staff, whether an organisation’s mission statements acknowledge and support cultural diversity, encouragement of staff training in cultural issues, and how welcoming the social and physical environment is to clients (Geron 2002). Some view organisational cultural competence as an ongoing process of organisational transformation along a continuum (Cross, Bazron et al. 1989, Weech-Maldonado, Al-Amin et al. 2011).

Previous work has shown a relationship between perceptions of organisational cultural competence and the cultural competence of staff (Darnell and Kuperminc 2006, Paez, Allen et al. 2008, Srivastava 2008). For example, a US study of primary care providers and their clinics by Paez et al. (2008) found that providers who reported that their clinics had adopted recommendations made in the Culturally and Linguistically Appropriate Services (CLAS) standards (e.g. culturally diverse staff, cultural diversity training) were more likely to have attitudes and behaviors that were culturally competent. Another US based study by Darnell and Kuperminc (2006) of public mental health agencies found that agencies with culturally competent mission statements and training had significantly higher employee perceptions of organisational cultural competence. As such, staff may be influenced by an organisation's commitment and actions in relation to cultural diversity.

Some policy initiatives and instructions related to organisational cultural competence have been based on little empirical evidence about the organisational factors related to the delivery of culturally competent care (Guerrero 2012). There are few published studies investigating the issues of cultural competence at the organisational level or in-depth case studies of health organisations in relation to organisational cultural competence. For example, Adamson et al. (2011) conducted a case study of a large mental health service organisation using a cultural competency needs assessment. They explored staff perceptions of cultural competence and the integration of cultural competence principles into their organisation. However, there was no mention of a cultural competence plan or intervention. Another study found that cultural competence was needed at multiple levels inside and outside of an organisation and that the involvement of clients, staff, organisations and the community all play an important role in creating and maintaining a culturally responsive service delivery system (Chow and Austin 2008). A study by Bowen (2008) reported the piloting of a document review instrument to assess cultural competence best practice at a paediatric facility in Canada. It found that results from the document review confirmed with the information obtained by interviews, a focus group and observational methods. However, self-assessment results (health service accreditation self-assessment ratings and survey of patient-centred care) were higher compared with the document review findings.

Achieving organisational cultural competence is a challenging proposition requiring multiple strategies at various levels. As organisations embark on the journey towards improving cultural competence, it would be prudent to consider the barriers and enablers to organisational change and implementation to ensure greater chance of success in implementation and change.

3.5.1 Barriers and enablers to organisational cultural competence

Potential barriers and enablers to promoting organisational cultural competence are multi-dimensional and multi-level. Barriers to cultural competence may be directly related to health care workers (e.g. routines and attitudes); the health care organisation (e.g. work environment and time constraints); and the nature of the health care system (e.g. health care financing) (Beune, Haafkens et al. 2011). Organisational efforts to improve cultural competence need to consider these different levels to increase the likelihood of success and sustained change (Grol and Wensing 2004).

Barriers to cultural competence among health care staff include: lack of leadership and accountability within the organisation, lack of information and useful data, insufficient funding and low staff motivation (Dogra, Betancourt et al. 2009). A study of a Canadian hospital by Srivastava (2008) found that despite a significant organisational commitment to diversity, cultural competence in clinical care was lacking in practice. Although various initiatives such as diversity policy and mandatory training for all staff were implemented, not everyone viewed this positively. Therefore, despite leadership commitment and a mandated organisational approach to change, its translation to practice and service delivery was not guaranteed. Adamson et al. (2011) explored staff perceptions of cultural competence and the integration of cultural competence principles into their organisation. They found that although there was evidence that clinical staff were engaged in culturally competent activities and many have attended training, there was little understanding at the corporate level. They suggested that it was not enough that only direct service practitioners undergo training, but those that plan and administer the policies of the organisation also require enhanced cultural competence.

Other studies have shown varying degrees of adoption of culturally competent practices among organisations (Stork, Scholle et al. 2001, Guerrero 2012). A review of behavioural health organisations in five states in the US found varying degrees of implementation of cultural competence standards (Stork, Scholle et al. 2001). A study of substance abuse treatment programs in the United States found varying degrees of adoption of culturally competent practices which were dependent upon external (e.g. financing) and internal (e.g. managers' cultural sensitivity) organisational pressures

(Guerrero 2012). A higher degree of adoption was associated with high dependence on external funding and regulation.

Studies of organisational cultural competence have found that fundamental shifts in an organisation’s operating assumptions may be required to make their services and organisations more culturally appropriate. For example, Uttal et al. (2006) found that organisational cultural competence can be improved by shifting the philosophy of service delivery from a client-centred to a community-based orientation. They discovered that a holistic, community-based orientation was more suitable for the Latino immigrant community than the more typical individualistic, client-centred approach. This also demonstrates the need for interventions that are informed by the local communities that an organisation serves.

Health care organisations are complex, and when there is fragmentation and lack of coordination they are often unresponsive, inaccessible, lack continuity and do not provide equitable services to meet the needs of diverse populations (Castillo and Guo 2011). A case study by Chow et al. (2008) examining the organisational context of a social service agency seeking to become more culturally competent concluded that management support is essential in facilitating organisational change. They found that changes emerged slowly over time and that considerable planning and organising was required in order to foster cultural competence. For example, committee members in the group met for years before they were able to gain the support needed to develop a strategic plan. They also emphasised the importance of the need for organisational self-assessment for the ongoing monitoring of organisational cultural competence. Hence, long term commitment and strong leadership support is necessary to facilitate organisational change.

Broader systemic level factors are also important to promoting cultural competence. A study of substance abuse treatment programs in the United States found that factors related to external funding and regulation were associated with the degree of implementation of culturally responsive practices. That is, public funding and Medicaid may have had a significant influence in pressuring community-based programs to develop culturally responsive policies and procedures in order to fulfil institutional directives (Guerrero 2012, Guerrero and Kim 2013).

Organisations may need to regularly examine and monitor the access and appropriateness of their services to ensure they are responding to the cultural and linguistic needs of their clientele or patient base. For example, government and accreditation authorities have mandated the incorporation of cultural competence in strategic planning of health services in Victoria, Australia (Victorian Department of Health 2011, Victorian Department of Health 2011). Translating policies and frameworks into effective programs and interventions in real world settings and maintaining them is a difficult and complicated long-term process. Hence, the choice of framework(s) and tools used to assess and facilitate change play a crucial role.

3.5.2 Tools to promote organisational cultural competence

The increasing recognition of the importance of cultural competence has led to a burgeoning number of cultural competence frameworks and tools available globally and in Australia to assist health practitioners and health organisations improve their ability to provide culturally appropriate services (Cross, Bazron et al. 1989, Olavarria, Beaulac et al. 2005, Harper, Hernandez et al. 2006). However, as a recent review identifies, many organisational assessment tools are limited by their narrow focus on individuals as opposed to organisations (Trenerry and Paradies 2012).

There are available tools internationally that measure organisational cultural competence for community health and social service organisations (Olavarria, Beaulac et al. 2009), however few are entirely relevant to the Australian context. There are few tools have been developed which are appropriate for use within a community health setting and that take into account the Australian context of service delivery, underpinned as it is by a universal health care system. One organisational tool produced within Australia was developed with a ‘risk reduction’ approach aligned with hospital settings which focussed primarily on patient-clinician relationships (Victorian Department of Health 2009), whilst another tool focussed on improving service delivery to Aboriginal children, families and communities (Government of South Australia 2006).

Furthermore, there are few published studies describing organisational cultural competence assessments and the extent to which these tools facilitate improved organisational cultural competence. Recent papers have described organisational cultural competence evaluations at a single community health centre (Cherner, Olavarria et al. 2015) and one hundred and twenty-five hospitals (Weech-Maldonado, Dreachslin et al. 2012). Cherner et al.'s (2015) in-depth evaluation of a community health centre used multiple data sources and included the perspectives of multiple stakeholders whilst Weech-Maldonado et al.'s (2012) study describes the development and validation of a comprehensive survey tool. Neither of these two studies reported on the creation and/or implementation of a plan to address the findings of the organisational cultural competence assessment(s). Fung et al. (2012) developed a multi-year cultural competence plan following an organisational review at a large mental health care institution in Ontario, however, the outcomes of implementing the cultural competence plan were not reported.

Reviews of cultural competency assessment tools indicate that further research is needed to determine if their use facilitates improved organisational cultural competence and improved service delivery (Harper, Hernandez et al. 2006). A review by Trenerry and Paradies (2012) found seven publicly available organisational cultural competency assessment tools with operationalised domains and sound theoretical development. The majority of tools were found online rather than in published academic literature and it is unknown to what extent they have been evaluated and what their impacts have been on organisations. Rigorous evaluation and understanding of the effectiveness and impact of organisational cultural competence assessment tools is thus required. This PhD research seeks to address this gap by evaluating the implementation and impact of an organisational cultural competence tool.

3.6 Conclusion

This chapter has summarised the key issues related to the field of cultural competence. It has outlined the debate surrounding definitions and applications of the terms race, ethnicity and culture in the health care literature. To summarise, it is important that ethnicity and culture are not perceived as fixed or essential characteristics that people 'have', but rather as dynamic processes of self-identity and differentiation that involve the negotiation of boundaries of inclusion and exclusion between groups (Chattoo and Atkin 2012). Culture matters in health care because it contributes to racial/ethnic health inequities. Social disadvantage, discrimination, social exclusion and the dominance of the biomedical paradigm in mainstream health services can act as barriers to health service utilisation for members of CALD groups.

This chapter has also provided a critical understanding of cultural competence. Critiques of the field of cultural competence underlie the need to be explicit about the definition of ‘cultural competence’, from the patient/client, practitioner, organisational and systems perspectives within the broader socio-environmental context of the community/society of concern. Knowledge of how patients/clients, staff and organisations understand cultural competence within a particular health care setting/context is important to guide the design and implementation of strategies to improve cultural competence. An objective of this PhD study is to explore cultural competence from the perspectives of patients/clients and health care staff (Chapters 7 and 8).

Although a shift away from knowledge acquisition about static, group-based cultural differences is required, a focus on unpredictable, individual-based difference may not be the answer. A decontextualised approach to culture, separated from any social or political context, reinforces simplistic notions of culture (Jenks 2011). Issues such as racism and bias in health care are ignored, thus undermining a central purpose of cultural competence efforts: reducing racial/ethnic inequities in health. More attention to issues such as White privilege and the culture of biomedicine and their impact on patients/clients from CALD backgrounds are needed. Health practitioners, organisations and systems should be encouraged to be more self-reflective about their norms, practices and attitudes.

Interventions to promote cultural competence should include consideration of individual, organisational and systemic factors as the attitudes and practices of practitioners and organisations are inextricably linked. Facilitating improvements in organisational cultural competence involves choosing an appropriate tool to assist with assessment, planning and monitoring of change and anticipating potential barriers to implementation and organisational change. This research includes an evaluation of the utility of an organisational cultural competence tool (Chapter 9).

Despite the current lack of evidence related to cultural competence interventions and resultant improvements in patient/client health outcomes, it is still being promoted in health professional education and government health policy. The NHMRC cultural competence policy “recognises the need for a culturally competent evidence base in health promotion and health service delivery, supported by research into cultural competence issues and leading to culturally competent monitoring and evaluation" (National Health and Medical Research Council 2006). This PhD research seeks to address this aspect of the policy in the community health setting. The next chapter describes the conceptual framework underlying this PhD thesis.

Chapter 4: Conceptual Framework

4.1 Introduction

This chapter will outline the conceptual framework underpinning this thesis. As outlined in previous chapters, people from CALD backgrounds can experience poorer health status and health outcomes than the rest of the population. One way to reduce and eliminate racial/ethnic inequities in health care access and delivery is to alter the organisation and management of health care services and organisations for these groups. It was identified in Chapter 2 that the field of cultural competence has the potential to address racial/ethnic health inequities. Interventions to promote cultural competence should address the individual, organisational and systemic influences on health care provision and utilisation. More research is needed to develop an evidence base for interventions to promote organisational cultural competence, particularly in community health.

A social ecological model of health together with health promotion principles is needed to understand the multiple levels that impact community health service access and delivery, and hence target areas for action. Thus, the overall conceptual framework for this research is underpinned by a number of related models and frameworks. Several frameworks were used to inform the study design, analysis and interpretation of research findings. The first section of this chapter introduces the social ecological model in relation to health promotion principles. The second section of this chapter focuses on cultural competence frameworks and the Andersen behavioural model of health service use.

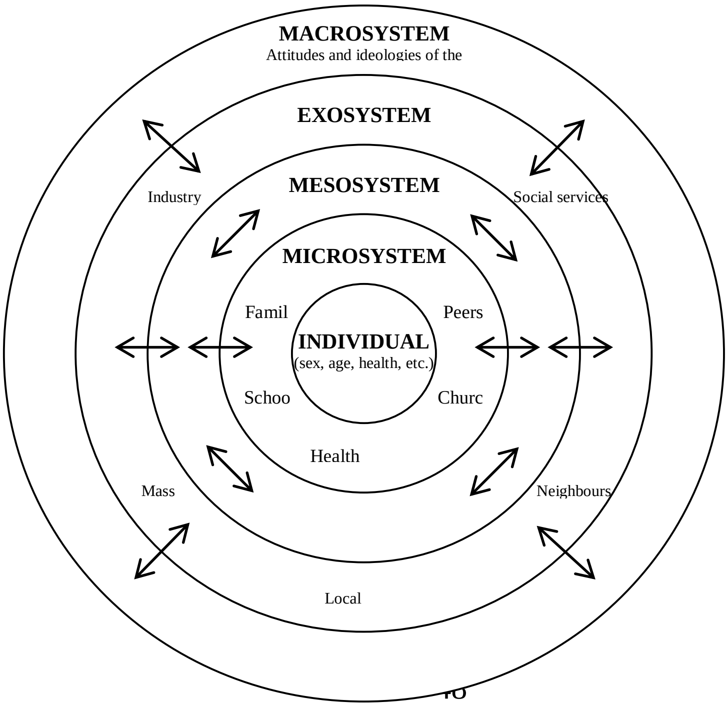
4.2 Social ecological model

The social ecological model of health is a broad, overarching paradigm describing the influence of social and environmental factors on individual health behaviours and health outcomes (Stokols 1996). It demonstrates the need for a broad understanding of health as not simply the absence of injury or illness, but as encompassing a range of social and economic factors (Commission on Social Determinants of Health 2008).

Several scholars have contributed to an ecological way of thinking in health, with Bronfenbrenner's model (1979) one of the most widely quoted in the literature. Bronfenbrenner's ecological model for human development was first introduced in the 1970s and became a theoretical model in the 1980s (Bronfenbrenner 1979). The visual depiction of his model is a series of concentric or nested circles, each of which represents a level of influence on human development i.e. the individual is in the middle and surrounded by the microsystem, mesosystem, exosystem and macrosystem (See Figure 4.1). These levels are outlined below:

- *Microsystem*- A person's immediate personal circumstances, complex interrelations between the individual and other persons, the nature of the links and interactions and the direct and indirect influences on the individual.
- *Mesosystem*- interconnectedness and linkages between settings that the individual interacts with e.g. family, workplace, community and health service organisations.
- *Exosystem*- events that occur that the individual may or may not participate in but have an effect on the person's immediate environment.
- *Macrosystem*- generalised patterns of ideology and organisation of social institutions common to a particular culture or subculture that reflect the complex of nested, interconnected systems.

Figure 4.1: Bronfenbrenner's ecological theory of development (McLaren and Hawe 2005) p. 10



Within a given society or social group, the structure and substance of the micro-, meso-, and exosystems tend to be similar and the systems function in similar ways. However, they may differ when comparing different social groups, for example, by social class, ethnicity, and religion, country and region.

4.2.1 Social ecological approaches to public health and health promotion

Bronfenbrenner’s ecological model has been used within the fields of public health and health promotion. There have been generic models (Stokols 1996, Hovell, Wahlgren et al. 2009) as well as applications to specific health issues such as oral health (Fisher-Owens, Gansky et al. 2007). The model has been adapted to reflect the context of the discipline in which it is being applied, for example in health promotion the seminal ‘ecological model for health promotion’ by McLeroy et al (1988) shows the circles representing the ‘intrapersonal’, ‘interpersonal’, ‘organisational/institutional’, ‘community’ and ‘public policy’ levels (Richard, Gauvin et al. 2011). Hence, in order to promote health at the individual level, both individual and socio-environmental factors should be targeted. Individual behavioural change and societal change is reciprocal in that the environment controls or sets limits on behaviour and thus changing the environment results in behaviour change, but, at the same time, the behaviour of individuals, communities and organisations influences their environments (Green, Richard et al. 1996, Green and Kreuter 2005).

The social ecological model of health identifies a broad range of factors known to influence the implementation of health promotion programs by organisations, such as those in relation to the organisational context (e.g. organisational culture, policies and processes) (Riley, Taylor et al. 2003). Personal attributes and circumstances such as cultural background are also contributing factors, for example the interaction between an individual’s cultural attributes and the social environment of a health service organisation may influence their general health and wellbeing. Applying a social ecological model to health interventions can improve their effectiveness by integrating all the constitutive components (Richard, Gauvin et al. 2011).

Proponents of the social ecological model believe that multidisciplinary and multi-level interventions are the most effective approaches for facilitating long-term improvements in health (Richard, Gauvin et al. 2011). There is growing evidence that health interventions are most effective when change is targeted at multiple levels, for example in smoking cessation and diabetes self-management (Sallis, Owen et al. 2008). Health practitioners and organisations need to recognise that individual health behaviours and lifestyle choices are influenced by multiple features of the environment as well as different individual characteristics and personal circumstances.

The social ecological model has been criticised for being too complex and comprehensive, and lacking in guidance on how to set priorities given limited resources and scope for action (Green, Richard et al. 1996, Sallis, Owen et al. 2008). Whilst the models broaden perspectives and prompt consideration of complexity, there is a lack of specificity about which particular variables and mechanisms to study and in what order. Another limitation is the absence of theoretical concepts that can be used to create testable hypotheses to explain, predict and potentially control the phenomena of interest (Grzywacz and Fuqua 2000). There are also numerous methodological issues associated with evaluation of multi-level interventions (Hawe 2015). Social ecological principles indicate complex interactions of personal, social and community characteristics that are difficult to manipulate experimentally, hence applying experimental study designs and in-depth evaluations can be challenging (Sallis, Owen et al. 2008).

Despite these criticisms, advocates of the social ecological model believe that attempts to understand complexity in interventions may alert us to dynamics in the change process that have not been previously understood and thus help us find ways to improve intervention effectiveness (Hawe, Shiell et al. 2009, Trickett and Beehler 2013). It can also provide knowledge of local community conditions, in terms of history, norms, settings, resources and networks, to enable the design of interventions that draw on local resources or capacity to address identified community issues (Trickett, Beehler et al. 2011). Insight into the dynamic interaction of individuals with their environment across space and time can be gained to understand the diverse forces affecting health (Lounsbury and Mitchell 2009). Thus, a social ecological model is ideal for addressing community health-related issues. The relationship between community health and social ecology will be outlined next.

4.2.2 Social ecology and community health

The community health model is a holistic, social ecological approach to health that provides affordable primary health care to meet the needs of the local community it serves, particularly those that are disadvantaged (e.g. people from CALD groups)

(McMurray and Clendon 2011, Victorian Department of Health & Human Services 2015). Community health services operate from a social model of health that acknowledges the social determinants that affect health, as well as biological and medical factors (Victorian Department of Health & Human Services 2015). Promoting the health of the community is multifaceted and community health activities are often undertaken at many different levels; for individuals, families, groups and entire communities (McMurray and Clendon 2011).

The social ecological model is a key perspective underlying this PhD research as it is a key framework underpinning the community health model of health care (McMurray and Clendon 2011). Another important principle underpinning community health is health promotion (Baum, Fry et al. 1992, Community Health Australia 2011, Productivity Commission 2015). The next section will discuss the principles of health promotion.

4.3 Health promotion principles

Health promotion is "the process of enabling people to increase control over, and to improve, their health" (World Health Organization 1986). As such, health promotion aims to address the social, economic political, cultural environmental, behavioural and biological dimensions that impact on health and quality of life (Glanz, Rimer et al. 2008). Health promotion encompasses wellbeing as a whole, not just focussing on individuals' healthy life-styles. Increasing emphasis is being placed on achieving social and structural changes at the community and systems levels that will ultimately support change at the individual level.

Approaches adopting health promotion principles have the potential to address community-wide and population-wide inequalities. Widespread behaviour change in populations necessitates a full range of effective interventions, from 'downstream' interventions focussed at individuals to 'upstream' interventions focused on public policies (Riley, Taylor et al. 2001, Thompson 2014). Multi-level and multi-sectoral interventions are also necessary because of the complex interdependencies of the elements within a social ecological model. Hence, interventions designed to improving health outcomes must be directed at different levels within an organisation or system (e.g. practitioner, policy and planning), and at multiple sectors (e.g. health, education, and welfare).

4.3.1 The Ottawa Charter

In 1986, an agreement was signed at the First International Conference on Health Promotion with the goal of achieving ‘Health for All’ by the year 2000 and beyond. Named the “Ottawa Charter for Health Promotion” (World Health Organization 1986), this landmark agreement outlined a series of actions and strategies for international organisations, national governments and local communities to advocate for greater promotion of health. In the Ottawa Charter, health promotion is underpinned by the principles of peace, social justice, equity, ecosystem health and empowerment as well as a ‘whole of government’ and settings approach (Hancock 2011).

The Ottawa Charter outlines five key action areas which focus health promotion efforts at several levels: i) building healthy public policy, ii) creating supportive environments, iii) strengthening community actions, iv) developing personal skills, and v) reorienting health services. The final action area refers to the goal of building a health system that contributes to the pursuit of health through involvement of individuals, community groups, health professionals, health service institutions and governments. It emphasises that health services need to “embrace an expanded mandate which is sensitive and respects cultural needs” p.3 (World Health Organization 1986). It also mentions the need for a change in health services to focus on the whole individual.

In the context of a social ecological model of health together with health promotion principles, an understanding of the multiple levels that impact health service access and delivery, and hence target areas for action, can be developed. This can be aligned with the cultural competence frameworks underpinning this research as outlined later in this chapter.

The notion of “transforming health policy, planning and delivery so it is suitable for a culturally diverse Australia” p.5 (National Health and Medical Research Council 2006) aligns with the action area of reorienting health services to become sensitive and respectful of cultural needs, as outlined in the Ottawa Charter. This requires changes in professional education and training, and change in orientation and organisation of health services. Efforts to address circumstances of cultural and linguistic diversity with efficacy, sensitivity, inclusivity and efficiency can be directed by a cultural competence approach.

4.3.2 Health promotion interventions

Evidence of the long-term effectiveness of individual-level health promotion interventions to alter behaviour change has previously been limited, leading to greater focus on the multiple settings and social contexts that shape behavior, including social and cultural dimensions (Richard, Gauvin et al. 2011). The effectiveness of a health promotion intervention will depend on its appropriate fit with the specific population, the health issue of concern and the environmental context (Green and Kreuter 2005, McLaren and Hawe 2005, Bartholomew, Parcel et al. 2011). Hence, a program needs to be focused at a local level so it can be more adaptable and sensitive to particular customs, cultural variations and circumstances. There is evidence that universal health intervention programs may not have the same desired outcomes when applied to different groups of people (Garcia 2006).

The integration of the social ecological model in the design of health promotion interventions and research is occurring steadily. Richard et al. (2011) conducted an archival analysis of the literature on physical activity and consumption of fruits and vegetables to determine the extent to which an ecological approach has been integrated into research and practice in these domains. They found that the level of influence of intervention targets had become more diversified with time, reaching targets in higher levels in the hierarchy such as organisational and community targets. Thus, evidence is still emerging in this area. Analytic methods need to take into account the complexity of dimensions at the higher levels, such as organisational characteristics, and interrelationships between all the different levels and dimensions (Richard, Gauvin et al. 2011).

At the level of the organisation, specific areas of concern include: how organisational characteristics can be used to support behavioural changes; the importance of organisational change; and the importance of organisational context in the diffusion of programs (McLeroy, Bibeau et al. 1988, Weiner, Lewis et al. 2009). Organisations are important sources and transmitters of social norms and values. If the missions and goals of organisations are incompatible with a program’s objectives and activities, then it may not survive in the longer term. This can be both wasteful and harmful for several reasons; wasteful because programs often require substantial financial and human resources to implement, premature termination can be disruptive to an organisation and individual staff, and termination can reduce trust among staff in an organisation or with the community (McLeroy, Bibeau et al. 1988, Rye and Kimberly 2007). Important organisational processes operate during program implementation that can affect the degree of implementation and the depth and breadth of institutionalisation. Organisational changes are necessary to support long-term change in policies and practices and are also an essential component of creating an organisational culture that is supportive of cultural competence.

4.4 Cultural competence frameworks

As outlined in Chapter 2, the Victorian capital city of Melbourne comprises a culturally and linguistically diverse population. Governments, organisations and providers are increasingly aware of the need to address the impact of cultural differences on health and health care. Adaptations need to be made by both the migrant groups entering a new life where their culture is no longer the dominant one, and community and health professionals that work and interact with these groups.

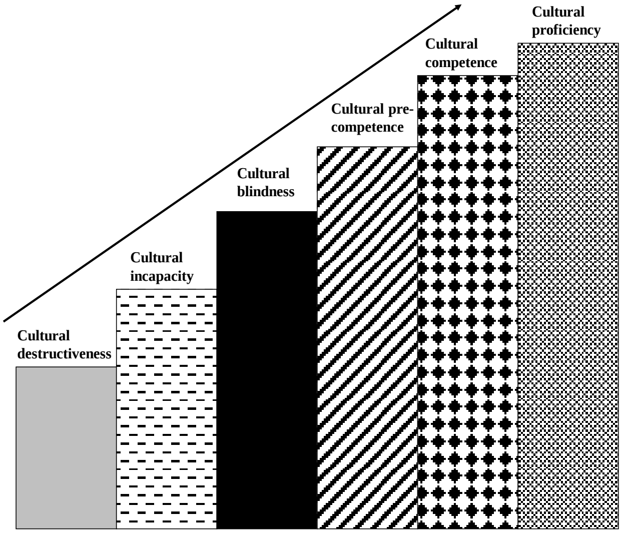
The field of cultural competence is an approach to understanding and addressing barriers to health care service utilisation for members of CALD groups. It proposes that health care systems, organisations and providers take account of the dominant cultural framework influencing organisational systems and service delivery, and the linguistic and cultural needs of the diverse population they serve in order to improve the accessibility and effectiveness of health care services for CALD groups. Cultural competence interventions may be focused at the patient-practitioner level or more broadly at the organisational level.

The next section will outline the cultural competence frameworks underpinning this PhD research, namely Cross' (1989) framework of cultural competence and the National Medical Research Council's (NHMRC) (2006) cultural competence model. Both frameworks were used to inform the Teeth Tales study, the larger research project within which this PhD is situated. Cross's model largely informs the organisational case study component (Chapter 9) and the NHMRC model informs the qualitative study (Chapter 7). This will be further detailed below and in the next chapter (Chapter 5).

4.4.1 Cross et al.'s cultural competence framework

Cross et al.'s (1989) frequently referenced framework of cultural competence was initially intended as a philosophical framework with practical ideas for improving mental health service delivery to racial/ethnic minority children in the United States (Tiatia 2008). It emphasises that cultural competence is a developmental process and should be viewed as a goal to which individuals, organisations and systems can strive rather than something one either possesses or not. According to Cross et al. (1989) cultural competence is positioned on a continuum, with six points ranging from cultural destructiveness to cultural proficiency. (See Figure 4.2.)

Figure 4.2: Cross' cultural competence continuum (Waters, Gibbs et al. 2008) p.39



The framework suggests that to improve cultural competence and work towards cultural proficiency, actions must be taken at the practitioner, organisation, and system level to significantly impact on service delivery. It identified five essential elements of a culturally competent system: 1) value diversity; 2) have the capacity for self-assessment; 3) be conscious of the dynamics when cultures interact; 4) have institutionalised cultural knowledge; and 5) have developed adaptations to diversity.

In order for an organisation to become culturally competent, attitudes, policies and practices within an organisation need to be developed and improved over time. This process of development should involve all levels of the organisation (i.e. board members, policymakers, administrators, practitioners and clients). Planning for improvements in cultural competence should involve: organisational assessment, support building, facilitating leadership, developing resources, and setting goals and action steps (Cross, Bazron et al. 1989). Training, experience, guidance and self-evaluation is also needed to lay the foundations for long-lasting change in attitudes, policies and practices.

Since Cross et al.’s (1989) framework was published over 25 years ago, it has been one of the most commonly used and referenced models in the field of cultural competence. It offers an organisational and individual framework to evaluate and monitor initiatives to strengthen cultural competence, emphasising cultural competence as a continuing developmental process. The relevance of this framework to contemporary times may be questioned in relation to, for example, some of the labels used in the cultural competence continuum (e.g. cultural destructiveness- individuals and organisations in this phase view culture as a problem and believe the ‘lesser’ cultures should be eradicated or suppressed). It is unlikely that present day health service organisations are in this phase (the most negative end). However, historically, there were instances whereby programs/agencies/institutions actively participated in cultural genocide (Cross, Bazron et al. 1989). In addition, it is possible that health care staff hold negative beliefs/attitudes about culture and view their culture as being more superior to others. Thus, showing these negative phases of the continuum remind us of the deleterious effects of culturally **in**competent care.

The Cross continuum (Figure 4.2) depicts a linear trajectory, implying that organisations should move along each point in a linear manner. However, change occurs in a complex interplay between practice and policy within the context of the social, political and economic environment and the culture of the system (Cross, Bazron et al. 1989). As a result, progress may not occur so smoothly in reality. Increasing cultural competence should be viewed as a *continuous goal* that is achieved through incremental change and constant monitoring and evaluation, rather than emphasising a linear progression along the continuum.

4.4.2 NHMRC cultural competence model

In 2006, the NHMRC released the report *‘Cultural Competence in Health: A guide for policy, partnerships and participation’* in recognition of the importance of cultural issues in health care and the need for a framework and guide in the Australian context (National Health and Medical Research Council 2006). This report defined cultural competence as more than an awareness of cultural differences, with a focus on the capacity of different components of the health system to improve health and wellbeing by integrating culture into health service delivery.

The NHMRC guide focuses on four domains- systemic, organisational, professional and individual and provides a model for cultural competence that can be applied to health promotion and public health programs across health systems and organisations. The following principles underpinning the model are founded on the individual's universal human right of access to health care (National Health and Medical Research Council 2006):

- engaging consumers and communities and sustaining reciprocal relationships;
- using leadership and accountability for sustained change;
- building on strengths- know the community, know what works; and
- a shared responsibility- creating partnerships and sustainability.

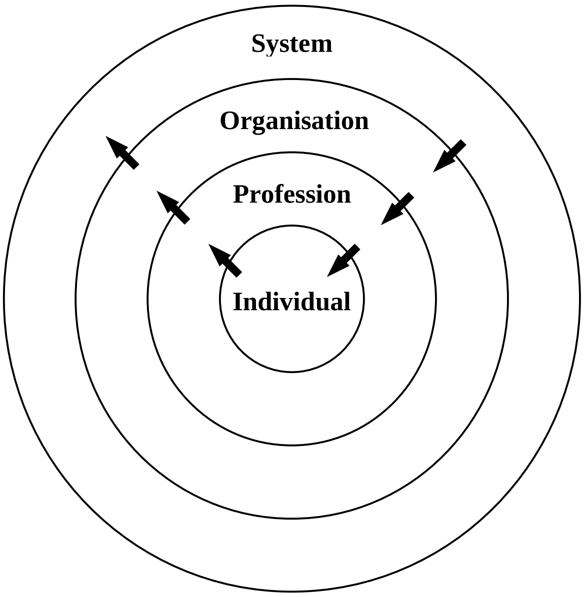
The NHMRC model underlines the needs for capacity and conviction to cultural competence at the systemic and organisational levels to direct, support and acknowledge culturally competent practice at the individual and professional levels (see Figure 4.3). There is also mention of the interplay and interrelatedness between the four levels and the need for clear delineation of responsibility at each level, as described below:

- The *individual* dimension refers to the knowledge, attitude and behaviours defining culturally competent behaviour. Individual health workers also need a supportive workplace.
- The *professional* dimension refers to the development of cultural competence standards and provision of professional development by professions to guide and educate practitioners.
- At the *organisational* level, a culture is created where cultural competence is considered core business across the whole organisation. Partnerships are formed with community groups and other agencies to make policies and processes culturally appropriate and relevant to the local context. There is a commitment to diversity management among staff and adequate provision of resources and training for staff to provide culturally competent care.

- Effective policies and processes, mechanisms for monitoring and sufficient resources at the *systemic* level are vital to supporting cultural competence at the other three levels. Support for community development and encouragement of programs that actively engage CALD individuals and groups is essential.

(National Health and Medical Research Council 2006)

Figure 4.3: NHMRC dimensions of cultural competence model (2006) p. 31



The NHMRC model complements Cross' cultural competence framework by placing cultural competence within the Australian context. The guide and model were based on a literature review, results of qualitative research commissioned for the project, analysis of written submissions on the issues and national consultations involving the Australian health, community and ethnic communities' sectors.

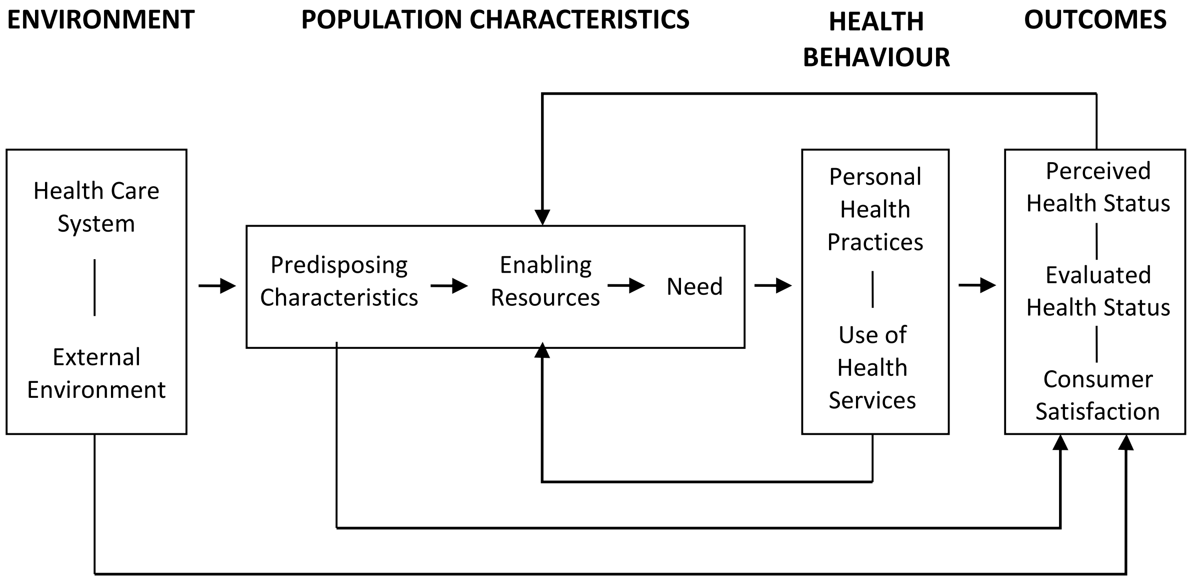
The degree to which the NHMRC policy has been adopted and implemented across different sectors and organisations is unknown. However, there are ongoing signs that cultural competence is still a relevant issue as government and accreditation authorities have mandated the incorporation of cultural competence in strategic planning of health services in Australia (Victorian Department of Health 2009, Victorian Department of Health 2011, Victorian Department of Health 2011).

Overall, many cultural competence frameworks (including the ones used in this research) use the (individual) health care provider and/or health care organisation as the point of reference. In comparison, theories and models of health care utilisation or health care seeking behaviour tend to use the recipient of care (i.e. patient or client) as the reference point. In addition, factors other than culture can influence decisions made by patients/clients to use health care services. Therefore, when considering health care utilisation from the patient/client perspective, a health care seeking behavioural model is appropriate. Andersen's behaviour model of health service use is described in the next section.

4.5 Andersen's behavioural model of health service use

The Andersen model of health service use (initially developed in 1968 and since revised several times) is one of the most frequently used frameworks for studying the determinants of health service use (Babitsch, Gohl et al. 2012). It suggests that people's health service use is "a function of their predisposition to use services, factors which enable or impede use, and their need for care" p.1 (Andersen 1995). This model utilises a systems approach (thereby aligning with the social ecological model) to integrate a range of societal, health service system, and individual factors associated with decisions to use health services. The model shows the multiple influences on patients' health services' use and includes feedback loops showing how outcome affects subsequent health behaviours (Andersen 1995). The model is summarised below (Figure 4.4).

Figure 4.4: Andersen's behavioural model of health service use (1995) p. 8



Predisposing characteristics are categorised as demographic factors, social structures and health beliefs that influence health service use behaviour. Demographic factors such as age, gender, genetic factors and psychological characteristics may influence the likelihood that particular people will need health services at particular points along the lifespan. Social structures include measures such as education, occupation and social networks. These features determine a person's status in the community and their ability to cope with emerging problems, including the resources to address them (Andersen 1995). Health beliefs refer to attitudes, values and knowledge in relation to health and health services which impact on perceptions of health service need and use.

Enabling resources are financial and organisational factors that serve as conditions enabling service utilisation and are grouped as community resources and personal resources. Personal resources that enable health service use include income, insurance and transport. Community resources refer to the health personnel and facilities available to people in the community. Organisational factors such as types of services, location of services and types of health care providers available will also influence health service use. Provider-related factors such as provider characteristics that interact with patient characteristics to influence utilisation (e.g. gender, age, race/ethnicity, communication style) are not included as a separate category in the model. However, Phillips et al. (1998) have emphasised provider characteristics as being an important factor due to the recognised importance of physician decision making.

Need refers to both perceived need (an individual's view of their own health and functional state, their experience of any ill health and their judgement of whether professional help is required) and evaluated need (professional judgement about people's health status and their need for medical care) (Andersen 1995). Andersen acknowledges that both perceived and evaluated need are not based purely on some measure of pathology or disease but are also influenced by social factors. Perceived need helps us understand help-seeking behaviour and treatment compliance whereas evaluated need is related to the kind and amount of treatment provided during medical care.

Andersen and colleagues hypothesised that the three categories of predisposing, enabling and need would, to varying degrees, explain health service use depending on the type of service being examined. For example, hospital services treating serious health problems would be explained predominantly by need and demographic characteristics whereas more discretionary services such as dentistry would be predominantly explained by social structure, health beliefs and enabling factors (Andersen 1995).

In later revisions of the model, environmental variables under the headings: health care system and external environment were included. The *health care system* characteristics are the policies, resources, organisation and financial arrangements that influence the accessibility, availability and acceptability of medical care services (Phillips, Morrison et al. 1998). The *external environment* factors include physical, political and economic factors. Outcomes of health care use, including *consumer satisfaction*, were also added due to the influence of current use on future use. Health behaviour encompasses *personal health practices* (e.g. diet and exercise) and *use of health services* as they influence health outcomes.

Andersen's model provides a useful way of conceptualising the many different factors that may influence health service use and how they are interconnected. Andersen's model includes recognition of the broader social and environmental factors that can influence health service utilisation. Other models/theories related to health utilisation such as the Health Belief Model (1952), Young's (1981) choice-making model, Parson's sick role (1951) and Suchmans' (1965) stages of illness mainly focus on individual characteristics, perceptions and behaviours. For example, the Health Belief Model (HBM) focuses on individuals' perceptions of four variables: susceptibility, severity, benefits, and barriers and the combination of beliefs predicts health behaviours (Rosenstock 1966). Young's choice-making model incorporates four components determining health service choice: perceptions of gravity of illness, knowledge of home treatment, faith in treatment and accessibility of treatment (Young 1980). Broader socio-environmental variables are not explicitly referenced in either the HBM or choice-making model and are thus too narrow in scope for this PhD study. Another strength of the Andersen model is its applicability to a broad range of health services and health conditions (Babitsch, Gohl et al. 2012).

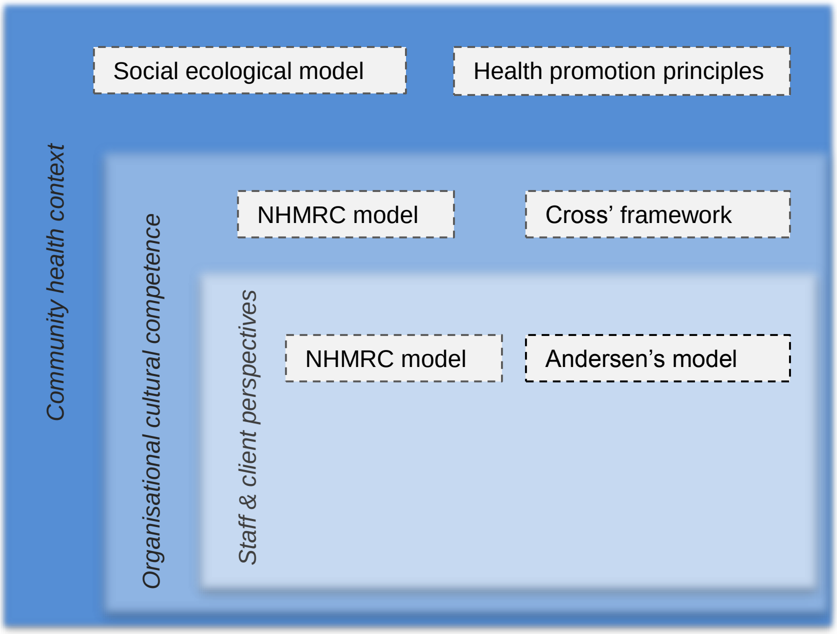
Andersen intended for the model to be able to both predict and explain service use. It is a framework for analysis and understanding of the relationships among patient, health care service and environmental factors that influence utilisation. It is not designed to be mathematical model and hence does not specify the exact variables and methods to be considered. However, understanding the factors that affect health service utilisation can help identify reasons for differences in utilisation, consumer satisfaction and outcomes. This may assist in formulating programs and policies that encourage appropriate utilisation whilst promoting cost-effective health care (Phillips, Morrison et al. 1998).

Decisions made by patients/clients to use health care services are based on multiple factors, of which culture may be only one among many. Some factors may be more influential than others in impacting upon the choice to seek health care services, and this may change depending on the nature of health care need and the services available. Andersen's model of health service use indicates that the determinants of health care use are multi-level- consisting of individual, organisational, and systemic factors. This aligns with the social ecological model, health promotion principles and cultural competence frameworks that also underpin this research.

4.6 Alignment of conceptual framework with study components

The alignment of the conceptual framework with the study's context/setting and components is shown in Figure 4.5. (Further details of the study components are provided in the next chapter.) The community health context within which this PhD study is situated is underpinned by the social ecological model and health promotion principles. This case study of cultural competence within community health is informed by Cross' cultural competence framework and the NHMRC cultural competence model. Staff and client perspectives of cultural competence and community health service utilisation align with the NHMRC model and Andersen's behavioural model of health use.

Figure 4.5: Alignment of conceptual frameworks/models with study components



4.7 Conclusion

This chapter has summarised the key models/frameworks guiding this research: the social ecological model, health promotion principles, cultural competence frameworks and Andersen's behavioural model of health service use. (See Figure 4.5 and the next chapter for further details.) A social ecological model of health together with health promotion principles underpins the community health setting and in turn, the health promotion action areas frame the strategies for reorientating services towards increased cultural competence. It is important to develop a multi-level understanding of cultural competence that takes into consideration patient/client perspectives and the organisational and environmental context/setting.

Cross' cultural competence framework and the NHMRC cultural competence model were chosen for this PhD research as they emphasise the multi-level aspects of cultural competence that will be explored in this research. It stresses that cultural competence is a developmental process whereby culturally competent attitudes, behaviours, policies and practices need to be developed and strengthened over time. These models also informed the development of the Teeth Tales study within which this research is situated (Gibbs, Waters et al. 2014).

A cultural competence framework situated within a social ecological model assists in understanding the multi-dimensional and multi-level factors that impact on health service provision to people from CALD backgrounds. The principles of health promotion align with the goals of cultural competence, in particular the reorientation of health services and systems to be respectful and responsive to cultural needs. Andersen’s model, which also aligns with a social ecological model of health, places the client as the central focus, thus demonstrating that the determinants of health care utilisation are multi-level, consisting of individual, interpersonal, organisational, community and systemic factors. The integration of the conceptual framework with the study components is shown in Figure 4.5. This will be explored in more detail in the Results and Discussion chapters.

The following chapter describes the design of the PhD study in order to explore the themes identified here and in previous chapters.

Chapter 5: Research Framework and Methods

5.1 Introduction

As outlined in Chapter 1, this PhD occurred within the context of a larger study called Teeth Tales. One component of this PhD is part of Teeth Tales and another component is an adjunct to Teeth Tales. As a whole, this research seeks to address a research gap by contributing a deeper understanding of cultural competence within the community health context.

The preceding chapters of this thesis comprise the background to this study, a critical review of the relevant literature, and conceptual framework underpinning the thesis. Chapter 2 described the context to the study by outlining the significance of health inequities for CALD groups and the impact of multiculturalism on health care service provision in Australia. The important role of the community sector in ensuring equitable primary health care for CALD groups was also underlined. Chapter 3 summarised the key issues related to the field of cultural competence and provided a critical understanding of cultural competence. The evidence gaps suggest the need for a further understanding of cultural competence from the perspective of health care workers and patients/clients who are the recipients of these health services. It also identified a need for more evidence related to the processes and outcomes involved following implementation of organisational cultural competence assessments and interventions. As this area of research is multi-level and multi-dimensional, several conceptual frameworks are used to inform the study design, and analysis and interpretation of findings, as outlined in Chapter 4.

This chapter will outline the research questions, objectives and methods used in this study as well as the methodological approach underpinning the study. This PhD research is comprised of different research stages and multiple methods. The research design consists of 3 components: a systematic review, a qualitative study, and an organisational cultural competence assessment and evaluation. For each component, the research process and methods will be outlined, including sampling, data collection and analysis.

5.2 Research aim, questions and objectives

The aim of this PhD study is to contribute to a deeper understanding of cultural competence from the perspectives of health care providers and clients from CALD backgrounds within the community health context, and to provide evidence and guidelines to inform future organisational cultural competence assessments.

The research questions are:

1. What is the current evidence base relating to cultural competence interventions in health care?
2. What are health care service provider perceptions of the significance of patient/client cultural background in health care service utilisation and their understandings of cultural competence?
3. What are the factors associated with community health service utilisation by CALD clients/carers?
4. What is the impact of the implementation of an organisational cultural competence review on a community health service?
5. What is the utility of the Cultural Competence Organisational Review (CORe) tool in facilitating improvements in cultural competence?

The objectives to answer the research questions and meet the research aim are:

i. To systematically review the current evidence base for interventions to improve cultural competence;
ii. To explore cultural competence and the significance of cultural background in community health service provision from the perspectives of staff in a community health service;
iii. To explore the factors that affect health service utilisation by clients from CALD backgrounds within the community health context;
iv. To describe the findings and outcomes following implementation of an organisational cultural competence assessment at a community health service;
v. To describe the barriers and facilitators to implementation of an organisational cultural competence assessment; and
vi. To evaluate the utility of an organisational cultural competence assessment tool.

5.3 Study design

The following sections will outline the theoretical perspective that provides the overarching philosophy for the study, followed by a description of the research approach, setting and methods employed in the investigation.

5.3.1 Methodological approach

This PhD study is underpinned by a social constructionist epistemology. Social constructionism refers to the view that our observations and knowledge of reality are socially constructed, "being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" p. 42 (Crotty 1998). Social constructionism claims that while the world exists independent of human consciousness, objects, and relationships are attributed meaning by humans beings when they engage with them through social practices and constructions (Crotty 1998). This process of engagement is one of construction rather than discovery. Therefore, society and its institutions are not given, but in some (wide) sense socially created (Alvesson 2009).

From a social constructionist viewpoint, meaning (or truth) is neither objective nor subjective (Crotty 1998). Different people may construct meaning in different ways, even in relation to the same phenomena. This means that all ways of understanding, and the categories and concepts we use, are historically and culturally relative (Burr 2015). Hence, it is important to recognise that we cannot assume that one way of understanding something is better or nearer the truth than other ways. Social constructionism also argues that ways of thinking can lead to the imposition of particular systems of knowledge upon other cultures and populations and that our current accepted ways of understanding the world are "a product not of objective observation of the world but of the social processes and interactions in which people are constantly engaged with each other" (Burr 2015).

An implication of the social constructionist epistemological stance is the need for the researcher to acknowledge and examine their own involvement (including their beliefs and assumptions) in the research process. This in turn requires reflexivity on the part of the researcher in order to understand, at least in part, the nature and significance of their influence on the research process and findings. This will be discussed later in the chapter.

Social constructionism insists that we take a critical stance toward our taken-for-granted ways of understanding the world and ourselves (Burr 2015). In this vein, it is worth noting that our understanding of cultural competence is underpinned by some key assumptions. Firstly, that patients/clients are influenced by their social and cultural background and hence may present their symptoms differently, have different thresholds for seeking health care, have different expectations about their health care and have unfamiliar beliefs that influence whether or not they are compliant with medical treatment (Betancourt, Green et al. 2005). Secondly, socio-cultural differences between providers and patients/clients influence patient satisfaction, adherence to medical treatment and health outcomes (Ferguson and Candib 2002). And thirdly, enhancing cultural competence can improve quality and reduce racial/ethnic health inequalities (Smedley, Stith et al. 2003).

Despite the popularity of cultural competence as a concept and a commitment to supporting the practice of cultural competence, it does not appear to be achieving its promise of reducing health inequities (Hester 2012). Perhaps this is partly due to the assumptions we make about the significance of culture for CALD patients/clients, whereby the focus is placed on cultural deficiencies, with the implication that disadvantages are due to CALD people’s inappropriate or incompatible beliefs and practices (Malat 2013). This PhD study aims to take a critical stance towards assumptions such as these that have appeared in this field. This research uses a broad social ecological lens to further understand cultural competence in practice and the factors affecting health service utilisation for patients/clients, which includes culture-related factors, among others. In order to facilitate this process, a case study approach was utilised.

The case study research approach is based on a constructionist paradigm and is compatible with a social constructionist epistemology because it involves accessing different perspectives and enables the exploration of processes surrounding complex relationships and issues (Baxter and Jack 2008). This study seeks to explore and understand perceptions of cultural competence and its relation to health service utilisation from different perspectives within the community health setting.

5.3.2 Case study approach

Case study research can be conducted within the qualitative, quantitative or mixed method tradition and employs a variety of methods and data types. According to Yin (2009), case study research refers to “an empirical inquiry about a contemporary phenomenon (e.g. a “case”), set within its real-world context” p.18. It involves the process of conducting systematic and critical inquiry into a case, exploring it from multiple perspectives, in order to gain greater knowledge of a particular project, policy, institution or program (Simons 2009). The primary aim of case study research is to generate an in-depth understanding of a particular case of interest in order to generate knowledge and/or inform policy development, professional practice and civil or community action (Simons 2009). Thus, this approach is suited to addressing the objectives of this PhD study.

Case study research allows researchers to explore individuals, organisations, interventions, relationships, communities and programs, while supporting the deconstruction and subsequent reconstruction of various phenomena (Baxter and Jack 2008). Case study research focuses on real-life contexts where the researcher has little control over events, which contrasts with experimental research designs where conditions can be controlled and manipulated by the researcher (Yin 2009). Due to the uncertain boundary between the phenomena being studied and its context, case study research enables a degree of adaptability and flexibility in research design as people, relationships and events change (Yin 2012). This is certainly true when conducting research in organisations where the researchers cannot control all events and processes.

A variety of data sources can be used to study a case, ensuring that an issue is explored through multiple lenses to allow for diverse perspectives to be revealed and understood. The use of multiple data sources also enhances data credibility (Patton 2002). Within case study research, different sources of data can be integrated as each source is one piece of the ‘puzzle’, with each piece contributing to the researcher’s understanding of the whole phenomenon (Baxter and Jack 2008). This can strengthen the findings as various parts of data are synthesised to gain a greater understanding of the case.

5.4 Research context

This PhD research has occurred within the context of a larger study called Teeth Tales, which is a culturally competent community-based health promotion intervention for child oral health (Gibbs, Waters et al. 2014). Part of this PhD is related to one component of Teeth Tales; the implementation of a cultural competence organisational review at a community health service, i.e. Merri Community Health Services (MCHS). In addition, a qualitative study was conducted as an adjunct to Teeth Tales to further understand the implementation of the CORe and additionally, access provider and client/carer perspectives of the significance of cultural background in community health service utilisation. As mentioned earlier in Chapter 3, greater input from the client perspective (and health care staff to a lesser extent) in the field is required, thus the PhD candidate sought to address this gap in the field by conducting interviews with clients and staff.

5.4.1 Teeth Tales study

The Teeth Tales study was located in urban Melbourne, Victoria, Australia. It was built upon a strong and enduring partnership between the University of Melbourne researchers from the Jack Brockhoff Child Health and Wellbeing Program, Melbourne School of Population and Global Health and Merri Community Health Services and in particular, it's Population Health Unit (formerly Health Promotion and Research). The two organisations worked closely together, with input from other stakeholders, in the development phase of Teeth Tales through to implementation of the main intervention.

The findings of the first phase of Teeth Tales were integrated with the prior evidence base of effective interventions, using socio-environmental models of health, a culturally competent framework and health promotion principles to develop an intervention and evaluation plan. The main intervention comprised a peer education and support program and a reorientation of dental and health services through a cultural competence organisational review. An existing evidence-informed tool suitable for use in the community health setting was not available at the time. Consequently, the Cultural Competence Organisational Review (CORe) was developed. The aim of the CORe was to provide organisations with a profile of their current policies and practices in relation to service delivery to CALD groups (including refugee and migrant communities) and to facilitate the re-orientation of services delivered by community health and local government to strengthen organisational cultural competence. Ultimately, the CORe contains a combination of existing tools together with questions developed specifically for the Teeth Tales study. The PhD candidate was not involved in the development of the CORe, however, she did contribute to subsequent minor modifications following its implementation during the main intervention study.

The Teeth Tales intervention was piloted at North Richmond Community Health and implemented at Merri Community Health Services, Moreland City Council's Social Policy and Early Years Branch and the McCaughey VicHealth Centre for Community Wellbeing (University of Melbourne). All are located in Melbourne, Victoria, Australia. This PhD research is a case study of one organisation: Merri Community Health Services (MCHS).

Teeth Tales was funded by an Australian Research Council (ARC) linkage grant involving investigators from the University of Melbourne, La Trobe University, Deakin University, Merri Community Health Services and Dental Health Services Victoria. ARC partner organisations were: Moreland City Council, Victorian Arabic Social Services, Arabic Welfare, and Pakistan Australian Association Melbourne. Additional partners who joined the study were: the Centre for Culture, Ethnicity and Health (CEH), North Richmond Community Health and Yarra City Council.

5.4.2 Study setting

The Teeth Tales study was geographically situated in the local government area (LGA) of Moreland in Melbourne, Victoria. Moreland LGA was chosen as the intervention site for the study as it has a large refugee/migrant population and also because MCHS is in Moreland. The census population of the City of Moreland in 2011 was 147,244 of which 29% came from countries where English is not the first language. Overall, 34% of the population was born overseas, and 29% were from a non-English speaking background, compared with 31% and 24% respectively for the Greater Melbourne area. Twenty five per cent of Moreland's population arrived in Australia within the last five years. Overall, 61% of the overseas born population arrived before 2001, and 25% arrived during or after 2006, compared with 61% and 23% respectively for Greater Melbourne (Moreland City Council 2015).

5.4.3 Merri Community Health Services (MCHS)

MCHS is a community health service that serves a community of over 160,000 residents in the City of Moreland. It was formed in 1994 through an amalgamation of two health centres in the Coburg and Brunswick areas. It provides health, community and advocacy services and programs from 12 sites in the City of Moreland and in the Northern Suburbs of Melbourne. A Board of Management governs the Service while internal management is organised through service units, with General Managers and Managers. Their vision is to "make a positive difference in people's lives by being an innovative and integrated Health, Community and Advocacy service provider".

The PhD candidate worked with staff from MCHS and researchers from the project team on the implementation of the CORe. The PhD candidate attended meetings and activities relevant to the CORe that occurred at MCHS and the University of Melbourne.

5.4.4 Ethics approval

Ethics approval was obtained from the University of Melbourne Human Research Ethics Committee (ethics approval 1033207.2). Ethics approval for the PhD candidate's involvement in the implementation of the CORe and addition of the qualitative interviews was obtained through subsequent amendments.

5.5 Research approach

A qualitative research paradigm underpins the epistemological and methodological approach of this PhD study. Qualitative research seeks to understand how people make sense of their lives by studying the lived experiences of a variety of people under different circumstances (Yin 2015). To achieve this, qualitative research often combines multiple methods and perspectives to understand a topic of interest. This contrasts with 'mixed methods' research which uses both qualitative and quantitative methods to explore a phenomenon (Leech and Onwuegbuzie 2009).

Research in the field of cultural competence has employed different methods to understand its multi-level and multi-dimensional features. For example, qualitative studies exploring perspectives of cultural competence in clinical practice (Harrison and Turner 2011, Park, Chesla et al. 2011), quantitative studies measuring health care providers' cultural competence (Chun, Yamada et al. 2010, Hudelson, Perron et al. 2010) and organisational cultural competence (Weech-Maldonado, Dreachslin et al. 2012) and evaluations of organisational cultural competence assessments (Fung, Lo et al. 2012, Cherner, Olavarria et al. 2015).

This PhD research adopts a qualitative approach to explore cultural competence within the community health setting from several perspectives: client, provider and organisational. The use of multiple methods, within a case study approach, enables: the documentation of multiple perspectives, exploration of processes and dynamics of change, and the study of experiences and complexities of a topic.

As this research is situated within a larger study, its design and methodology were considered within the broader context of Teeth Tales and its organisational, research and stakeholder partnerships, including alignment with the policies and procedures of MCHS, the site of the case study. The Manager at MCHS, who was also part of the research team of Teeth Tales, acted as the main contact and was regularly consulted during the development and conduct of the PhD study. The support of the Manager and other key staff at MCHS was vital to this research. This was largely facilitated by the strong relationship between the researchers and community health services, and the Teeth Tales study's community-based participatory research (CBPR) orientation, which focuses on the relationship between research partners and involved an equitable partnership between researchers and the community (Israel, Schulz et al. 1998, Gibbs, Gold et al. 2008). A CBPR approach is also strongly aligned with cultural competence (Gibbs, Waters et al. 2014). For example, both participatory research and cultural competence build on strengths and knowledge within communities and develop collaborative partnerships/relationships between researchers/practitioners and the community (Williamson and DeSouza 2007).

As this research consists of 3 components: systematic review, qualitative study and evaluation of an organisational assessment, the methods will be described in further detail for each component. This will be presented following a section considering the researcher context.

5.5.1 Researcher context

Within the research process, researchers themselves bring with them their attitudes, beliefs, knowledge and perceptions of how the world works. This is shaped by factors such as cultural background, social class, education and life experience. Therefore, it is important for researchers to critically question and reflect upon their own personal and professional background and how this influences the research process. In this section, I will reflect upon my background, motivations for conducting the research, and challenges and learnings in the field experienced during this PhD journey.

Reflexivity in research refers to the process of researchers engaging in explicit, self-awareness of their own role in the research (Finlay 2002). Being reflexive means acknowledging that the research is part of the setting, context and culture that they are trying to understand (Liamputtong and Ezzy 2005). As a health care professional trained and practising within the biomedically-oriented health system, explicitly recognising my role in the research process has been challenging at times. However, I had begun a practice of professional self-reflection (as part of my optometry practice) and have come to understand reflexivity to be an important part of any practice, whether clinical or research based.

I feel that I have lived most of my life in two different, but overlapping spheres. I identify as first generation Vietnamese Australian, and am the eldest of three children. My parents fled Vietnam on a boat in the late 1970s following the end of the Vietnam War and I spent the first 4 years of my life in New Zealand before arriving in Melbourne, where I have resided ever since. At present, I would describe myself as female, middle-class, tertiary educated, working as both an optometrist and researcher. However, I come from a working class family and grew up in (what was then) a predominately White neighbourhood in the eastern suburbs of Melbourne, Victoria, Australia. My parents left Vietnam with very, very little English and being the first in the family with a Western education and proficient English language skills, I was relied upon for much of my adolescence and teenage years to help my family navigate life in Australia. During my early adolescence I very much wanted to fit in with my predominately White friends and not stand out as being someone ‘different’. During high school (which was much more diverse) I gradually became more accepting and proud of my ‘ethnic difference’. I studied Optometry at the University of Melbourne and spent my first decade as an optometrist working in various locations, including urban, country and overseas.

Being someone from a CALD background, but also having been wholly educated in Australia and working within a Western biomedical health system, I have often felt a clash of ‘cultures’, both personally and professionally. I have felt the frustration of interacting with patients who have different beliefs and attitudes about their eye health. I have experienced the difficulty of trying to conduct a relatively rigid eye examination on patients whom I did not share a common language and/or understanding of optometric practice. However, I have also felt empathy many times trying to counsel patients who were not given the time, respect and appropriate information by other health providers. I occasionally imagine my own parents, who have been in the situation of trying to navigate a foreign health system with little English and experience with societal norms, and the difficulties and challenges they have faced over the years.

Issues relating to cultural competence have rarely been raised or given attention within my profession in Australia. Therefore, I had not previously heard of the concept prior to beginning my Masters in Public Health in 2009. Once I was made aware of the literature on cultural competence and related fields, I decided to pursue further research in this area. I passionately believed that advancing cultural competence was critical to improving patient-practitioner relationships, health service provision and consequently better health outcomes. I conducted a pilot study exploring optometrists’ perceptions of cross-cultural encounters in clinical practice which started my interest in research (Truong and Fuscaldo 2012). It confirmed to me that this was an important issue worth pursuing.

Prior to this doctoral research, my connection with research, academia and community health was very limited. The majority of research conducted in optometry is related to the biological, medical, and physical sciences, and the majority of optometrists work in private practice (e.g. independent practices and corporate retail stores). I was unable to conduct my research within optometry, however, an opportunity presented itself in the form of the Teeth Tales study and I felt it was an avenue through which I could broaden my knowledge and experiences.

I became involved in the project team after the conclusion of the pilot component of the study. I attended regular research meetings and became responsible for the CORe component of the main intervention study. I was fortunate to be working within a study underpinned by strong relationships between the researchers, community health services, cultural partners, the community, and relevant State and local government agencies. I was allowed to attend internal committee meetings at MCHS (as an observer) that were related to the planning, implementation and monitoring of strategies to improve organisational cultural competence, during July 2012 to December 2014. During meetings I was introduced as a researcher and my role was explained as pertaining to the Teeth Tales study and the CORe component in particular. I was mindful at all times that I was an observer and did not provide any input unless asked by others. However, I was aware of the potential impact of my presence during meetings.

I endeavoured to maintain a constant awareness of my presence and conduct during the entire research process, particularly my interactions with staff and clients, out in the 'field'. I kept a notebook for field notes and self-reflection during the research process and had regular meetings with my supervisor and the research team (every 2-4 weeks) where I was able to de-brief and discuss any issues. I was very privileged to be given the opportunity to conduct my research in this setting, thus it was important to uphold and honour the trust that underpinned this position.

The next section will outline the methods for each of the three components of the PhD study (summarised in Table 5.1).

Table 5.1: Summary of research questions, study components and methods

Research question	*Objective*	*Component*	*Method*
1	i	Section 1 - Cultural competence systematic review	Systematic review
2	ii	Section 2 - Health care provider and client/carer perspectives	Qualitative semi-structured interviews

3	iii	Section 2 - Health care provider and client/carer perspectives	Qualitative semi-structured interviews
4	iv, v	Section 3 - Implementation, outcomes and evaluation of cultural competence review	Staff survey, document audit, process evaluation
5	vi	Section 3 - Implementation, outcomes and evaluation of cultural competence review	Evaluation of CORe assessment tool

5.6 Section One: Interventions to improve cultural competence-systematic review

In this study, both a broad review of relevant empirical literature (Chapters 2 and 3) and a systematic review of reviews of cultural competence interventions have been conducted. The systematic review is described in full (including detailed methods) in a published peer-reviewed academic paper that forms Chapter 6. It met objective:

i. To systematically review the current evidence base for interventions to improve cultural competence.

The remainder of this chapter will explain the methods associated with the other two aspects of empirical research carried out. Section Two consists of the study comprising qualitative interviews with clients/carers of clients and staff of MCHS. Section Three comprises the findings from the implementation of the CORe at MCHS and an evaluation of the CORe tool.

5.7 Section Two: Exploring cultural competence and community health service utilisation from health service provider and client/carer perspectives.

This component of the research sought to meet the following objectives:

ii. To explore cultural competence and the significance of cultural background in community health service provision from the perspectives of staff in a community health service

iii. To explore the factors that affect health service utilisation by patients/clients from CALD backgrounds within the community health context

The reasons for using qualitative semi-structured interviews as a research method will be outlined. The sampling and recruitment of interview participants will be described and data collection, analysis and interpretation will be detailed.

Qualitative methods were used to address these research objectives because they were the most suitable to exploring the experiences of participants (Liamputtong and Ezzy 2005, Bourgeault, Dingwall et al. 2010). Qualitative research is focussed on understanding people's behaviour from the viewpoint of the meanings and interpretations ascribed by them rather than the researchers' predetermined categories of analysis. It enables researchers to study and explain the complex mix of economic, political, social and cultural factors which influence health and disease, and how communities and individuals understand and interpret health and health care (Baum 1995). Of the qualitative techniques available, interviews were the chosen method of data collection as it allowed the in-depth exploration of client and staff experiences in relation to cultural competence and health service utilisation.

5.7.1 Interviews

Interviewing is one of the most commonly used methods in health-related qualitative research (Liamputtong and Ezzy 2005). They allow the researcher to enter into another person's perspective in order to explore the complexity and in-process nature of their experiences and the meanings and interpretations they ascribe to them (Liamputtong and Ezzy 2005). Interviews can provide more detail about an individual's understanding and experiences than can be gained through other methods such as focus groups. Semi-structured interviews permit the participant to describe what is meaningful and salient for them, whilst ensuring the main issues concerning the study are included in the conversation.

5.7.2 Role of the researcher in interviews

In qualitative research, the influence of the interviewer on the production of the interview narrative must be recognised (Liamputtong and Ezzy 2005). The interviews with staff and clients/carers in the study were conducted with a stance of ‘empathetic neutrality’. Empathetic neutrality refers to being non-judgemental towards the thoughts, emotions and behaviours of people one encounters whilst communicating understanding, interest and caring (Patton 2002). During the interviews I tried to convey a manner of openness, interest and sensitivity. I endeavoured to observe, describe and interpret the interviews as they occurred without directly involving my own experiences or judgements. With participants, particularly clients/carers, I was aware of the potential personal and professional differences that could contribute to an unequal power relationship. I reassured all participants that their involvement in the interviews was entirely voluntary and confidential and would not affect their work (staff) or use of health services at MCHS (clients).

As the researcher is the instrument of data collection in qualitative inquiry, it is the responsibility of the researcher to carefully reflect on, manage, and report potential sources of bias and error (Patton 2002). There was a possibility that some client/carer participants would view me as being able to influence the organisation or act on their behalf if they provided particular feedback. I had to be careful in explaining that whilst I was sympathetic to any issues they had, that I was not in a position to directly act on their behalf. There was also a danger of potentially misrepresenting what participants said; therefore, I endeavoured to clarify comments during the interview, in addition to asking permission (at the end of the interview) to contact them again if further clarification was required.

Having never personally worked in or used services at a community health service, I tried to position myself as a learner/novice during each interview and sought an interaction with the participants in which they informed me of their perspectives and experiences. This was more difficult to achieve with participants who were familiar with me (due to our mutual involvement in the Teeth Tales study) and knew of my role as a researcher in Teeth Tales. Nonetheless, I still adopted a stance of empathetic neutrality that conferred a sense of open-mindedness and curiosity.

5.7.3 Interview participants

Semi-structured interviews were conducted with staff from MCHS and clients/carers of clients who utilise services from MCHS. These interviews aimed to explore in detail individual understandings and perspectives, allowing new themes and ideas to be developed (Liamputtong and Ezzy 2005). A range of interview participants was sought in order to compare understandings and perspectives of the role of cultural background in health care service access and delivery from provider, administrator and client/carer viewpoints. Individual interviews were conducted to maintain privacy and confidentiality.

5.7.4 Sampling and recruitment

Participants were recruited through the organisation using purposive sampling techniques. The aim of sampling in qualitative research is not to generalise about the distribution of experiences or processes but to generalise about the nature and interpretative processes involved in the experiences (Liamputtong and Ezzy 2005). Purposive sampling seeks to select information-rich cases to examine meanings, interpretations, processes and theory (Liamputtong and Ezzy 2005).

The recruitment process was conducted in close collaboration with managers from the organisation in order to ensure that MCHS' privacy and confidentiality procedures and policies were respected and followed during the research process. It was advised that clients of MCHS that had given prior permission to the organisation to be contacted for feedback be recruited. In order to capture a range of perspectives, it was anticipated that approximately 20 client/carer and staff participants in total would be interviewed in order to achieve saturation. Saturation refers to the point at which no new information (i.e. properties, dimensions, actions/interactions, consequences) seems to emerge during coding (Strauss and Corbin 1998).

Additional participants were recruited if there was a need to confirm or clarify emerging themes. As a result, 27 participants were interviewed in total (14 staff, 4 clients, 1 carer, 7 parents of clients and 1 who was both a client and parent of a client). Some general topics for discussion were identified a priori, whilst other themes were expected to emerge from the interview data.

Clients

The Population Health Unit manager and Quality Program manager from MCHS advised that clients from their existing client satisfaction database could be invited to take part in interviews with the PhD candidate. Clients on this specific database had given consent to be contacted for a secondary purpose (the primary purpose for consenting to be listed on this database is to provide feedback on MCHS services through a client satisfaction survey).

The sampling criteria was developed by the PhD candidate and primary PhD supervisor Lisa Gibbs in consultation with the Population Health Unit manager of MCHS. The criteria were: adult clients from a refugee/migrant background who had used MCHS services in the past 1-2 years, or adult carers/guardians/parents of clients from a refugee/migrant background who had used MCHS services in the past 1-2 years. The Quality Program manager provided a list of clients that appeared to meet this sampling criteria. A letter of notification of the study, signed by Population Health Unit manager, was sent to clients selected from the specific database by the PhD candidate (See Appendix B). The letter advised the client that the PhD candidate may contact the client about the study and that if they did not want to be contacted then they should email or phone the manager or PhD candidate. Follow up phone calls with the clients were conducted 1-2 weeks later by the PhD candidate to introduce the study, and ask whether the client/carer would like to voluntarily participate in an interview.

Staff

The Population Health Unit manager asked permission from the managers of several work teams whether she and the PhD candidate may attend a team meeting to invite staff to participate in interviews. At the meetings, staff were introduced to the Teeth Tales project and qualitative study and it was explained that the interviews were voluntary and anonymous. Plain language statements and consent forms were distributed and staff were instructed to contact the PhD candidate if they were interested in being interviewed. Several staff from MCHS who were previously acquainted with the PhD candidate were also invited to participate in an interview as they were involved in the implementation of the cultural competence review. Voluntary participation and confidentiality was assured to all participants.

5.7.5 Interview process

Interviews were conducted with staff and clients/carers from February 2013 to July 2013. Interviews took place either face-to-face (in a public space) or via telephone. All interviews were conducted in English and ranged in duration from 15 minutes to 1.5 hours. Prior to each interview, the PhD candidate tried to help participants feel comfortable with the researcher and study. All participants were given an opportunity to ask questions. Full, informed consent (either written or verbally recorded) was provided by each participant. (See Appendix C for copies of Plain Language Statements and Consent forms used for interview participants.)

All interviews (except one client participant who declined) were digitally recorded and transcribed by the PhD candidate. Participant language (in English) was preserved in transcriptions, including sentence structure, syntax and use/choice of words, regardless of technical accuracy. Digital recordings were uploaded to a password-protected computer. Hard copies of transcriptions were kept in a locked filing cabinet. All interview participants were given codes for anonymity. As much as possible, information that may identify individuals was removed from quotes.

5.7.6 Interview guide

An interview guide was developed prior to data collection. An interview guide lists the questions, issues and topics that are to be explored in order to ensure the same basic subject areas and topics are followed in each interview (Patton 2002). It is a flexible guide that allows the interviewer to word questions spontaneously, adapt particular questions to suit the conversational flow and help focus discussion on the particular subject or issue of interest.

The semi-structured interview guides (See Appendix D) were developed based on the literature and discussions between the PhD candidate and her supervisors. All participants were asked several demographic questions during the interviews. These included; age, self-identified ethnic/cultural background, length of stay in Australia, and languages spoken. Staff were also asked how long they had worked at MCHS and their program area/work unit.

For clients, the interview questions explored information relating to their experiences accessing and using services at the organisation, and whether they encountered any cultural differences between themselves and the staff. They were also asked whether they noticed anything different at MCHS in the past year and whether they were aware of any changes to the services. In keeping with an inductive approach, it was decided that questions related to service use at MCHS be kept general in nature at the beginning rather than pre-empt discussions about cultural background. After the most salient issues related to service utilisation for the clients/carers were explored, questions specifically about cultural background and cultural differences that the client/carer may have experienced with staff or the organisation were asked if these topics had not already been raised by the client/carer.

For staff, interview questions explored topics relating to cultural competence, from a general perspective and also how it related to the staff member's work duties. They were also asked about their thoughts on the organisation's overall cultural competence and their awareness of any current organisational initiatives to increase cultural competence. For staff that were involved in the implementation of the CORe there were additional questions relating to the CORe, such as their perspectives on the barriers and facilitators to the implementation of the CORe.

5.7.7 Data analysis and interpretation

Inductive analysis was used to analyse the interview data (Patton 2002). Using an inductive approach to analyse qualitative data primarily involves detailed readings of raw data to derive concepts, themes or a model through which interpretations can be made (Thomas 2006). Concepts and theories about what is happening are grounded in and emerge from direct field experiences rather than being imposed a priori as in the case of formal hypothesis and theory testing (Patton 2002). Coding consists of conceptualising and reducing data, elaborating categories in terms of their properties and dimensions, and relating them through a series of prepositional statements (Strauss and Corbin 1998).

In analysing the data, I engaged with the audio recordings, transcriptions, interview experiences, and the empirical and theoretical literature. I transcribed all audio recordings verbatim, read and coded all transcripts, and developed categories to arrange the data. Qualitative analysis software HyperResearch 3.5.2 was used for data management and initial coding. Primary PhD supervisor A/Prof Lisa Gibbs separately coded a sub-sample of transcripts. We then compared and discussed the coding to explore similarities and differences, before reaching consensus on coding. As themes and constructs emerged during analysis, I returned to the interview transcripts and conceptual frameworks to further my understanding of patterns and concepts. Patterns, consistencies and ambiguities within the data were discussed with all supervisors at several meetings to develop the main themes.

Analysis for the first qualitative results chapter (Chapter 7) is concerned with health care provider perspectives of cultural competence and the significance of cultural background in community health service utilisation. The findings related to how health care providers perceive and experience cultural competence in their provision of services to CALD clients were found to align with the NHMRC cultural competence model. The NHMRC model provided a useful framework for considering the multi-level factors that affect the ability of health care service providers and organisations to provide culturally competent health care services to clients and the community. In the second qualitative results chapter (Chapter 8), the findings related to the multi-level factors affecting health service utilisation by clients/carers from CALD backgrounds were found to align with Andersen's behavioural model of health service use. In this model the client is the central focus and enables exploration of the multi-level and multi-dimensional determinants of health care utilisation. Findings were examined to help understand the reasons for phenomena described, both immediate structural conditions and larger, macro conditions (Strauss 2003).

Direct quotations are a basic source of raw data in qualitative inquiry, revealing participants' depth of emotion, the ways they have organised their world, their thoughts about events and behaviours, their experiences, and their basic perceptions (Patton 2002). Hence, the most appropriate and illustrative quotes were chosen for inclusion.

5.7.8 Limitations

I disclosed to interview participants that I was a researcher from a university but did not explicitly mention my cultural background or other personal and professional details unless asked by the participants. Nonetheless, my personal background may have influenced data collection, and also data analysis in several ways. First, participants may have been influenced by my affiliation with MCHS (through involvement within a research study involving the university and the MCHS) despite having identified as being an employee of the university and not MCHS. Second, some participants were already familiar with me and the research project Teeth Tales, which may have influenced their responses to some questions. Additionally, my physical appearance (south-east Asian features) may have also had some influence on participants' responses.

5.8 Section Three: The implementation, outcomes and evaluation of the cultural competence organisational review

This component of the research sought to meet the following objectives:

iv. To describe the findings and outcomes following implementation of an organisational cultural competence assessment at a community health service;
v. To describe the barriers and facilitators to implementation of an organisational cultural competence assessment
vi. To evaluate the utility of an organisational cultural competence assessment tool.

As previously stated, the study design and data collection tools were developed before the PhD candidate entered the study. Once the candidate became involved in the study, she became responsible for co-ordinating the collection and analysis of the CORe data and reporting of findings to the organisations. This was conducted with the assistance of other research team members. The components of the CORe and the process and procedures of its implementation will be outlined below, followed by details of the data collection and analyses that are relevant to this PhD. The section will conclude with an outline of the key elements and data sources used for evaluating the CORe tool.

5.8.1 Components of the cultural competence organisational review (CORe)

The CORe consists of: i) *measures* to assess an organisation's cultural competence, ii) *templates and guidelines* for planning and implementing actions to enhance organisational cultural competence, iii) *resources* to guide action planning i.e. best practice statements, CEH tip-sheets and a list of relevant literature, documents and recommended websites.

The CORe comprises a staff survey and document audit to assess an organisation's overall cultural competence along seven domains: 'Organisational vision and values, ‘Governance’, ‘Planning, monitoring and evaluation’, ‘Communication’, ‘Organisational infrastructure and partnerships, ‘Staff development’, and ‘Services and interventions’. See Table 5.2 for a summary of the components of the CORe.

Table 5.2: Summary of Cultural Competence Organisational Review (CORe) components

Type of component	*Component of CORe tool*	*Content*
Measures	1. Staff survey	44 questions in relation to: indication of work section/level, and the 7 organisational cultural competence domains (i.e. organisational vision and values, governance, planning, monitoring and evaluation, communication, organisational infrastructure and partnerships, staff development, and services and interventions), plus several free-text comments sections
	2. Document audit	61 specific indicators across the 7 organisational cultural competence domains (as for the staff survey)
Template/guideline	Action planning templates	Guidelines/templates for: i) selection of cultural competence strategies, ii) organisational alignment, ii) 12-18 month action plan for implementation
Resource	Resources for planning	CORe best practice statements CEH cultural competence tip-sheets List of websites and documents related to cultural competence

5.8.2 The implementation of the CORe at MCHS

The CORe was implemented at MCHS during September 2011 and September 2013. The process of implementing the CORe at MCHS consisted of four phases as outlined in Figure 5.1.

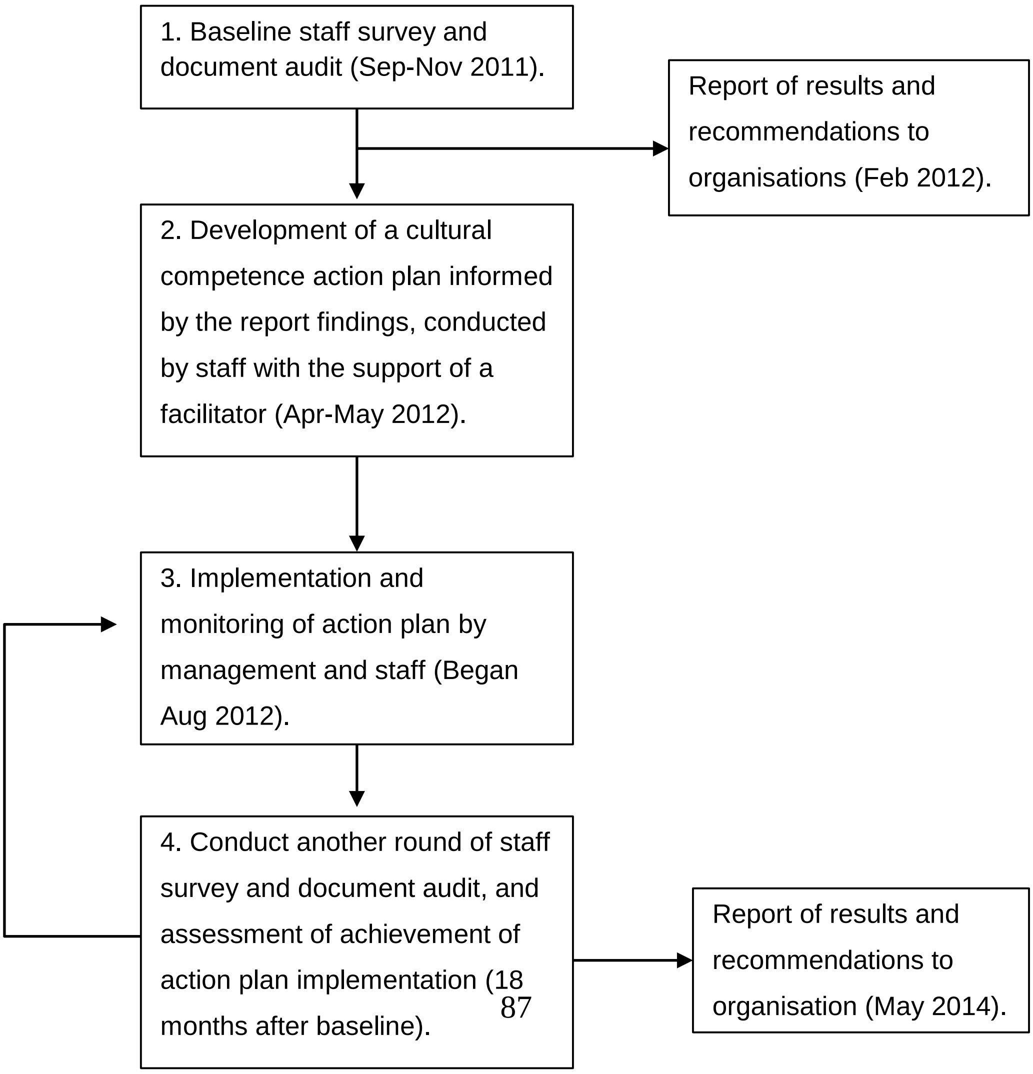
In the first ‘assessment’ phase (i.e. baseline), the staff survey and document audit were conducted by the organisation with the aid of the PhD candidate and other project team members (from the university and CEH). Results were compiled in the form of a report, with recommendations for strengthening organisational cultural competence. The report provided the organisation with feedback regarding practice and policy aspects of organisational cultural competence, and identified areas for improvement.

During the second ‘planning’ phase, the report was used by the organisation to develop and implement an organisational cultural competence plan to strengthen the organisation’s cultural competence. The action planning committee reviewed the CORe results and decided which strategies were appropriate, relevant and achievable for the organisation.

The third ‘action’ phase refers to the implementation and monitoring of the cultural competence actions by management and staff.

The final, fourth ‘repeat assessment’ phase (i.e. follow up), occurred approximately 18 months after the first assessment, whereby the staff survey and document audit were conducted again to assess progress and impact of action plan(s) and provide feedback for future action planning and implementation.

Figure 5.1: Flow diagram of summary of CORe phases



5.8.3 Data sources, collection and analysis procedures

The data collected and analysed during the first and fourth phases of the CORe were from cross-sectional staff surveys and organisational document audits, as summarised separately below. The PhD candidate was responsible for some aspects of data collection and analysis. (See Table 5.3 for a summary of data collection timelines and persons primarily responsible for each section.)

Table 5.3: CORe data collection summary

	Baseline staff survey	*Baseline document review*	*Economic costing*	*Follow up survey*	*Follow up document review*
Data collection timeline	September 2011	November 2011	October 2012	July/August 2013	September 2013
Person primarily responsible for data collection and analysis	Mandy Truong (PhD candidate)	Dr Pauline Gwatirisa (CEH)	A/Prof Lisa Gold	Mandy Truong (PhD candidate)	Dr Pauline Gwatirisa (CEH)

5.8.4 Staff survey

The survey for staff and managers captures their perspectives on the organisation's cultural competence. In the staff survey, each cultural competence domain has a series of closed-ended questions followed by an additional 'comments' section which allowed respondents the option of providing additional feedback. The staff survey contains questions including "To what extent do you think the organisation's vision and values reflect the diversity of the community?" and "How often do representatives of diverse cultures actively participate in decision making within your organisation?" The survey was anonymous and confidential and took approximately 15 minutes to complete. (See Appendix E for a copy of the staff survey.)

5.8.4.1 Data collection

Survey data was collected at two time-points: baseline (in September 2011) and follow up (in July 2013). At baseline, the survey was available both via an online link and in hard copy, and at follow up it was available via an online link (hard copies were available upon request). Data at each time-point was cross-sectional as data collection was anonymous. It was decided by the project team that anonymous identification numbers would not be used as it was important for the survey to be totally anonymous and in recognition of relatively high staff turnover at the organisation.

At both time-points, an email was sent by the Chief Executive Officer (CEO) of MCHS to all MCHS staff introducing the study and inviting all MCHS staff to complete the CORe staff survey via an online survey tool (See Appendix F for a copy of the emails). Two subsequent reminder emails were sent by the CEO to all staff. At baseline, the PhD candidate and three other project team members attended a managers' meeting to introduce the study and provide hard copies of the CORe survey to managers for distribution to their teams. This procedure was not repeated at follow up as it was assumed that most staff and managers already had prior knowledge of the survey and/or cultural competence review.

5.8.4.2 Data management

Data from surveys returned in hard copy format were entered by hand into an Excel spreadsheet that had already been populated electronically by the Excel output from the online survey created in *Lime Service* (an online survey generation and distribution tool). Ten per cent of hardcopy data was double-checked by another researcher to check the accuracy of data entry. Data was cleaned according to a protocol developed by another researcher in the project team who conducted data coding and analysis for the pilot study.

5.8.4.3 Data analysis

Data was preliminary cleaned and coded in Excel then transferred to Stata V.11.0 for final cleaning, coding and analysis. Demographic characteristics and prevalence of key categorical variables were calculated using descriptive statistics. Assessments were conducted for each domain and a level of cultural competence was assigned to the organisation for each domain, based on Cross et al.'s (1989) "Cultural Competence

Continuum” (see Chapter 4, Figure 4.2). The ratings were designed to provide an indication of the level of cultural competence rather than an absolute score. The cut-offs for the cultural competence ratings were determined by the PhD candidate in consultation with other project team members. For example, a rating of ‘*Competence*’ was given if all questions from the staff survey receive highly positive responses from participants (i.e. above 80%). A rating of ‘*Near competence*’ was given if there was a mixture of highly positive and moderate responses (i.e. 60-80%) from participants. A rating of *‘Pre-competence’* was given if the majority of questions received low to moderate responses (i.e. below 60%). The category ‘*Near competence’* was created to indicate a mid-point between ‘*Pre-competence’* and *‘Competence’* to provide extra sensitivity to reflect the changes in the organisation that were taking place. (See Figure 5.2) An organisation may already be operating at a relatively high level of cultural competence, therefore rather than losing sensitivity because of the ceiling effect, it can give the organisation a sense of achievement and provide motivation to progress along the continuum.

Figure 5.2 Cultural competence levels

More complex analysis such as multivariate modelling was not possible due to poor data quality. The reasons included: no formal psychometric testing (i.e. validity and reliability) of survey questions; responses to questions were not pre-coded and a numerical scoring system was not formulated; the survey consists of a combination of behaviour, beliefs, knowledge and demographic questions; there was no consistent use of question type(s) either within the domains or across the whole survey; and all questions were either nominal or ordinal (rather than interval)- thus limiting the range of methods of statistical analysis that could be utilised.

Subsequently, an exploration of the utility of the CORe as an organisational cultural competence assessment tool was conducted as a further contribution to the evidence base. (See Section 5.8.9 for further details.)

5.8.5 Document audit

The document audit involved a checklist-type review of current MCHS documents (including policies, procedures, plans and assessment of tools) using a template that was designed for the study. Documents were audited on the basis of their relevance to the template's cultural competence domains and their indicators. (See Appendix G for a copy of the document audit template.)

5.8.5.1 Data collection

The audit was conducted through a guided interview process with one or more senior managers and took approximately 2-3 hours to complete. Dr Pauline Gwatirisa from the Centre for Culture, Ethnicity and Health (and the Teeth Tales project team) was primarily responsible for the collection and analysis of the document audit information. The document audits were undertaken with a senior quality officer from MCHS (with input from other staff where required) through a guided interview. The staff member provided examples of policies and plans in accordance with the indicators, rather than an extensive list.

5.8.5.2 Data analysis

The information from the document audit was examined and summarised according to each organisational cultural competence domain by Dr Gwatirisa to determine the extent to which the documented policies and systems met the CORe cultural competency guidelines within the seven key domains identified above. A level of cultural competence was assigned by the Dr Gwatirisa to the organisation for each domain, based on Cross et al.'s (1989) "Cultural Competence Continuum". The ratings were designed to provide an indication of the level of competence rather than an absolute score. For example, a rating of '*Competence*' was given if the evidence provided (including organisational policies, procedures and plans) satisfactorily demonstrated: i) the organisation's commitment to cultural competence in all indicators within the domain, and ii) the organisation was able to demonstrate that there was an organisation-wide response to cultural competence that incorporates both planning and reporting directives. A rating of '*Near competence*' was given if there was evidence of the organisation's commitment to cultural competence in most indicators while there was insufficient evidence for some indicators. A rating of *'Pre-competence'* was given if there was a lack of evidence for the majority of indicators within the domain and/or the organisation was unable to demonstrate that there was an organisation-wide response to cultural competence that incorporated both planning and reporting directives. (See Figure 5.2)

5.8.6 Economic costing

A/Prof Lisa Gold (Deakin University) from the Teeth Tales project team was primarily responsible for the design and analysis of the economic study associated with the CORe. Members of the research team, including the PhD candidate, provided assistance with data collection.

5.8.6.1 Data collection

Items of resource use were identified at the start of the CORe process, for example staff time and printing costs. This list was re-examined at mid-point and the end of the process for completeness. Data on time use allocated to the CORe tasks was reported by each of the people involved at the end of 12 months (12-month recall). Organisational records were accessed for expenditure and staff salary rates. Meetings at MCHS were held to discuss issues related to costing and to arrive at consensus on time allocation for tasks. Materials used during the implementation of the CORe were recorded in project records.

5.8.6.2 Data analysis

Calculations were conducted in Microsoft Excel. Time was valued at the position-specific salary (including all labour on-costs) of those involved, using salary rates from 2015. Administrative costs were valued at market rates for the production of paper surveys and for administration of online surveys. All costs were valued in 2015 Australian dollars (A$1 = US$0.705 as at 10/11/2015).

5.8.7 Dissemination

Reports outlining the findings of MCHS's organisational cultural competence assessment, undertaken at both baseline and follow up were provided to MCHS. The PhD candidate was primarily responsible for drafting and finalising both reports, with assistance from the research team. The baseline findings were used to inform the development of cultural competence action plans to be implemented by a working party (comprising managers and staff) within the organisation. The follow up findings were designed to enable MCHS to monitor and review progress towards improving organisational cultural competence.

5.8.8 Process evaluation of the CORe implementation

The process and outcomes of the implementation of the CORe at MCHS were evaluated using interviews with staff (described earlier in Section 2), observation, and review of documentation (such as field notes and meeting minutes). The process evaluation was used to address the research objective:

v. To describe the barriers and facilitators to implementation of an organisational cultural competence assessment

5.8.8.1 Observation

The PhD candidate attended committee meetings that were related to action planning and implementation of the CORe actions/strategies at MCHS as an observer. The candidate was not an active participant in the meetings as they were discussions on organisational processes, procedures and actions. The candidate did make reflective notes on occasion, during and after meetings. However, names were not recorded and no audio-visual material was produced. The purpose of attending these committee meetings was to gain a sense of the processes involved in the action plan implementation phase in relation to the CORe, which was occurring within the broader Diversity Plan[7]. The candidate attended quarterly committee meetings for almost 2 years (except for a period of 8 months due to maternity leave). Confidentiality of the organisation and staff were maintained at all times.

5.8.8.2 Review of documentation

The PhD candidate reviewed organisational documentation such as meeting agendas and minutes as well as other associated documentation relevant to the meetings to provide further context and insight into organisational processes and procedures relevant to the organisation's experience in implementing the CORe. The findings and outcomes of the implementation of the CORe at MCHS are presented in Chapter 9.

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[7] The Diversity Plan is a strategic population planning initiative that sets the overall direction and goals for the organisation in relation to diversity planning and practice (i.e. supporting and encouraging service delivery that is responsive to and respectful of diverse groups). It is a government requirement associated with the Home and Community Care program.

5.8.9 Evaluation of the CORe assessment tool

Another focus of exploration was the utility of the CORe as an organisational cultural competence assessment tool. This was used to address the following research objective:

> vi. To evaluate the CORe tool as an organisational cultural competence assessment tool

As highlighted earlier in this thesis (Chapter 3), there are multiple tools available to conduct organisational cultural competence assessments. However, it is unknown to what extent they have been evaluated and what their impacts have been on organisations undertaking the assessments. Thorough evaluation and understanding of the acceptability and feasibility of organisational cultural competence assessment tools is thus required.

According to Olavarria et al. (2005, 2009), there are several key elements to consider when choosing a suitable assessment tool: i) its fit/alignment to cultural competence theory, guidelines or standards, ii) its reliability and validity, iii) its comprehensiveness, and iv) its practicality and feasibility. Similar elements have also been identified by others in the literature (Harper, Hernandez et al. 2006, Trenerry and Paradies 2012). A self-assessment of organisational cultural competence must critically examine the attitudes, practices, policies and structures within an organisation (Olavarria, Beaulac et al. 2005). Tools that are valuable in this field are thorough evaluation instruments but also provide a blueprint for actualising cultural competence at the organisational level (Dreachslin, Jean Gilbert et al. 2013). Where possible, a set of standards or benchmarks should be identified and adopted in order to compare, monitor and evaluate changes in cultural competence.

5.8.9.1 Data sources

Several data sources were used in the evaluation of the CORe. They were:

- researcher experiences and observations made in the course of undertaking the study (also including feedback from staff of MCHS, other research team members and stakeholders);
- CORe data e.g. survey response data, survey completion rates and missing data

- review of verbal and written communication regarding the use of the CORe (e.g. notes from meetings and email correspondence); and
- review of relevant academic and grey literature related to organisational cultural competence assessment tools and survey research.

Using Olavarria et al.’s (2009) four key elements as a guide, these data sources were analysed to evaluate the CORe as an organisational assessment tool. This is presented in Chapter 9.

5.9 Conclusion

This chapter has detailed the study design, methodological foundation, research questions and objectives for this PhD research. It outlined how a social constructionist epistemology, case study approach and multiple method data collection enabled the range of research objectives to be addressed. A social constructionist lens allows different perceptions and meanings of the same phenomena to emerge. This is demonstrated by the use of qualitative interviews to explore the experiences of participants and an inductive approach to data analysis.

This research uses both self-report and third-party based assessments, which is a particular strength of the study. A common methodological limitation of previous studies is the reliance on self-report measures only (Paez, Allen et al. 2008, Hudelson, Perron et al. 2010, Weech-Maldonado, Dreachslin et al. 2012). It is anticipated that findings from this research will: i) inform the development and implementation of cultural competence interventions to reduce barriers to service utilisation and thus improve health outcomes for people from CALD backgrounds, and ii) provide recommendations and guidelines for future use of organisational cultural competence assessments such as the CORe.

Following the next chapter that comprises a systematic review of systematic reviews of cultural competency interventions, the subsequent three results chapters will present the PhD study findings. This will began with findings from qualitative interviews with staff from MCHS, followed by findings from interviews with clients/carers from MCHS, and, in the third results chapter, detail about the implementation, outcomes and evaluation of the CORe.

Chapter 6: Systematic Review

This chapter addresses research question 1 and will present a systematic review of reviews of cultural competence interventions. As highlighted previously, existing reviews have examined the association between cultural competence and various health outcomes, and within different health care settings. The objective of this systematic review is to gather and synthesise existing reviews of studies in the field to form a comprehensive understanding of the current evidence base. It is presented in full as a published peer-reviewed academic paper. (See Appendix H for the actual published version.)

6.1 Interventions to improve cultural competency in healthcare: a systematic review of reviews

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Abstract

Background

Cultural competency is a recognized and popular approach to improving the provision of health care to racial/ethnic minority groups in the community with the aim of reducing racial/ethnic health disparities. The aim of this systematic review of reviews is to gather and synthesize existing reviews of studies in the field to form a comprehensive understanding of the current evidence base that can guide future interventions and research in the area.

Methods

A systematic review of review articles published between January 2000 and June 2012 was conducted. Electronic databases (including Medline, Cinahl and PsycINFO), reference lists of articles, and key websites were searched. Reviews of cultural competency in health settings only were included. Each review was critically appraised by two authors using a study appraisal tool and were given a quality assessment rating of weak, moderate or strong.

Results

Nineteen published reviews were identified. Reviews consisted of between 5 and 38 studies, included a variety of health care settings/contexts and a range of study types. There were three main categories of study outcomes: patient-related outcomes, provider-related outcomes, and health service access and utilization outcomes. The majority of reviews found moderate evidence of improvement in provider outcomes and health care access and utilization outcomes but weaker evidence for improvements in patient/client outcomes.

Conclusion

This review of reviews indicates that there is some evidence that interventions to improve cultural competency can improve patient/client health outcomes. However, a lack of methodological rigor is common amongst the studies included in reviews and many of the studies rely on self-report, which is subject to a range of biases, while objective evidence of intervention effectiveness was rare. Future research should measure both healthcare provider and patient/client health outcomes, consider organizational factors, and utilize more rigorous study designs.

Keywords

Cultural competency, Healthcare, Health outcomes, Health disparities, Minority health, Systematic review

Background

Cultural competency is a broad concept used to describe a variety of interventions that aim to improve the accessibility and effectiveness of health care services for people from racial/ethnic minorities. It developed largely in response to the recognition that cultural and linguistic barriers between healthcare providers and patients could affect the quality of healthcare delivery. The targeted groups were mainly immigrant populations from non-English speaking countries with limited exposure to Western cultural norms [1].

Since its introduction in the 1980s, the range of cultural competency frameworks and models has burgeoned. Many models include dimensions of knowledge (e.g., understanding the meaning of culture and its importance to healthcare delivery), attitudes (e.g., having respect for variations in cultural norms) and skills (e.g., eliciting patients' explanatory models of illness) [1]. Over time, the scope of cultural competency expanded beyond the interpersonal domain of the practitioner-patient/client interaction to include organizational and systemic cultural competency. Although the most often cited definition of cultural competency is that of Cross and colleagues [2], there is no one widely accepted and definitive conceptual cultural competency framework. The literature contains many analogous terms/concepts (e.g. culturally appropriate care, multicultural education) that add to the lack of clarity in this field.

There is an abundance of international literature related to cultural competency and the importance of its integration into all levels of health care. In the United States, the prominence of cultural competency within health policy and practice is largely attributed to federal and state regulations calling for culturally competent care (Office of Minority Health, 2001).

Existing reviews have examined cultural competency and related concepts within health care settings such as nursing [3] and mental health [4] as well as within health care systems [5]. Some reviews have focused on either provider outcomes [6] or patient/client outcomes [7] while others have examined specific health conditions such as diabetes [8].

These existing reviews highlight a lack of robust evidence pertaining to the relationship between cultural competency and improved provider/organizational behaviors or patient/client health outcomes. There is also a lack of consensus on the most effective ways of improving cultural competency [9] and continuing debate as to whether interventions to improve cultural competency can lead to a reduction in health disparities caused by racial/ethnic discrimination [10]. The aim of this systematic review of reviews is to gather and synthesize existing reviews of studies in the field to form a comprehensive understanding of the current evidence base that can guide future interventions and research in the area.

For this review of reviews, interventions to improve cultural competency are defined as those that aim to: improve the accessibility and effectiveness of health care for people from racial/ethnic minorities by increasing awareness, knowledge and skills of health care providers or patients as well as modifying policies and practices of organizations. These interventions may be focused at the health care provider-patient/client level (e.g. interpersonal interactions) or more broadly at the organizational level (e.g. integration cultural competency into policies, plans and processes). Interventions that meet this definition may also be referred to in this paper by other terms such as culturally appropriate care and multicultural education if these terms are utilized in specific reviews.

Methods

Search strategy

In November 2011 the following databases and electronic journal collections were searched from 2000 to 2011: Medline, Cinahl, Eric, PsycINFO, Proquest (Dissertation/Theses), Scopus and the Cochrane Systematic Review Database. Reference lists were hand-searched for other reviews. Key websites (i.e. www.diversityrx.org, www.nccc.georgetown.edu, www.minorityhealth.hhs.gov, www.ceh.org.au, www.hrsa.gov, www.nice.org.uk) were also searched. In July 2012 the search was updated to include recent studies published up to June 2012. See Additional file 1 for search terms used.

As cultural competency did not achieve popularity until the late 1990s and government policies mandating cultural competence did not occur until the early 2000s [11], a search timeframe of 2000–2012 was chosen.

Inclusion and exclusion criteria

A review was considered eligible for inclusion if it met the following criteria: i) included quantitative, qualitative or mixed methods studies, ii) was written in English, iii) included studies involving: health care/service providers/practitioners/clinicians, health administrators, support staff and patients/clients/health service users, iv) included studies utilizing any strategies or interventions to improve cultural competency (e.g. training programs or workshops or educational courses), v) included studies involving intervention settings or services related to the health sector (e.g. hospitals, community health services, educational institutions teaching health related courses), vi) included studies that used one or more outcome measures at an individual level (e.g. survey), organizational level (e.g. programs) or system level (e.g. policies).

Reviews were excluded if they described cultural competency in other non-health settings (e.g. education system), were conducted prior to the year 2000, or did not contain a methods section that included information on: search strategy, number of included studies, and details of studies.

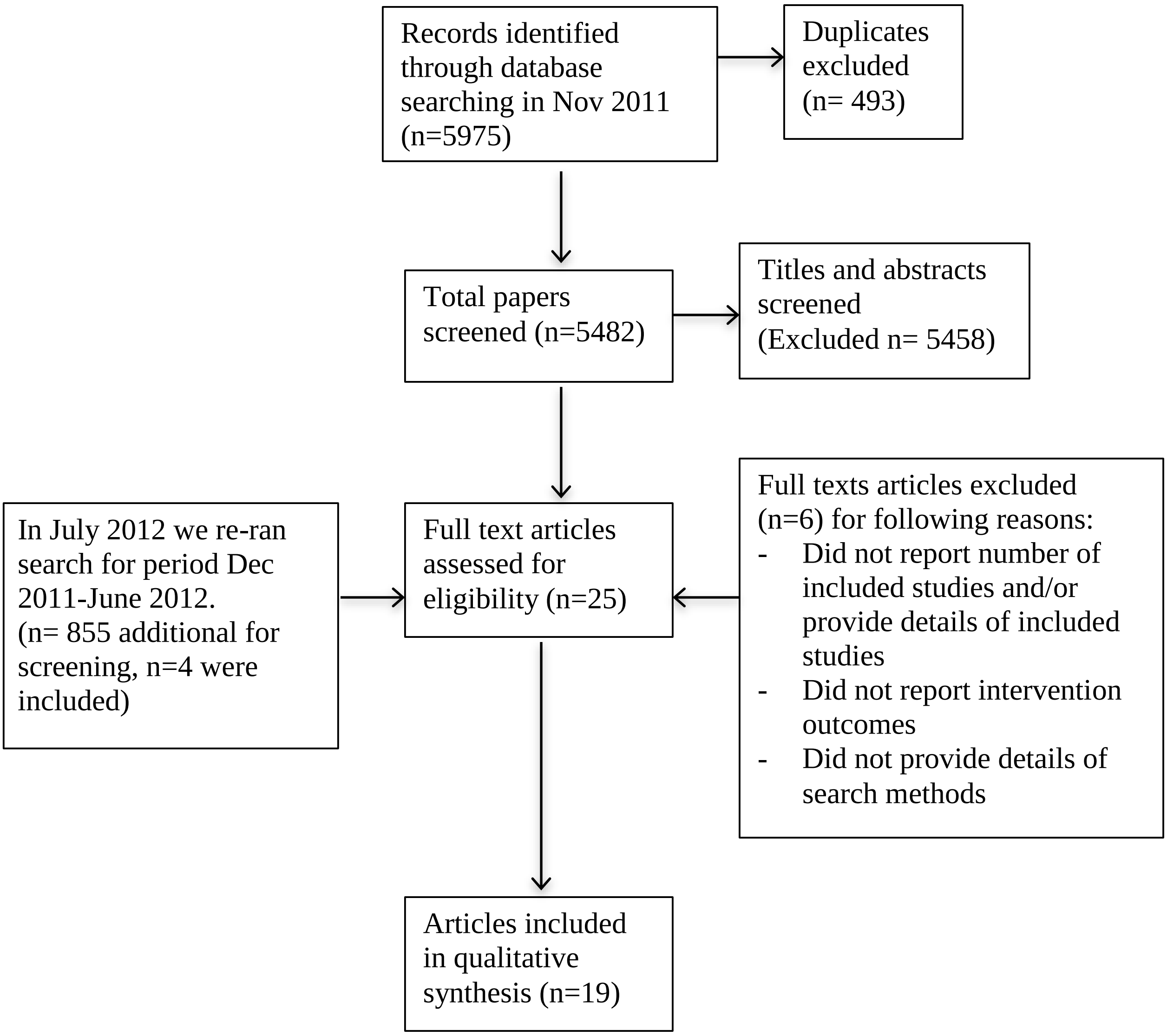
Quality of the review and synthesis of results

Each review was critically appraised independently by two authors using the health-evidence.org tool for reviews [12]. This tool consists of ten questions to assess the quality of the review using commonly accepted evidence-informed principles. Reviews were given a quality assessment rating of weak, moderate or strong.

Identification of reviews

The total search identified 6,830 results. Based on the inclusion and exclusion criteria, titles and abstracts were screened for eligibility by the first author. Full texts were retrieved for all reviews where inclusion was in doubt. To reduce the potential for bias in the screening process, the second author independently screened 10% of the total identified titles and also extracted data for 10% of the reviews that met the inclusion criteria. There was no difference in agreement between reviewers. See Figure 1: PRISMA flow diagram for a flow chart summary of the search and inclusion/exclusion process.

Figure 1 PRISMA flow diagram search process – initial search conducted December 2011.



Data extraction and analysis

Data extracted from the included reviews was entered into an Excel 2011 spreadsheet under the following headings: author(s), year of publication, health care setting/context, definition/concept/framework of cultural competence, method of review (e.g. database(s) searched), inclusion/exclusion criteria, number of papers included, type of papers reviewed, outcomes of papers reviewed, study quality assessment, major findings, recommendations and quality/critical appraisal of review.

Data extracted from the reviews was descriptively analyzed using Excel 2011. Meta-analysis was not conducted due to the heterogeneity of the reviews and their included studies. Analysis focused on: types of interventions and study outcomes.

Results

Overview of reviews

Searching yielded a total of 6,830 titles, of which 19 met the inclusion criteria and were extracted for analysis (Table 1) [3-8,13-25]. The main reasons for exclusion were: articles were commentary or opinion pieces, articles were of primary studies, review articles examined cultural competency assessment tools and review articles but did not include any studies with interventions. Six review articles were excluded for not providing information on search strategy and details of included studies [26-31].

Table 1 Summary of 19 included reviews

Author & year of publication	Health context	Definition of cultural competence	Sources (years of search)	Number of included papers	Type of papers	Outcomes	Was study quality assessed?	Major findings (review authors' conclusions)	Review quality
Anderson et al. 2003	Healthcare systems	Based on Cross et al. 1989 definition: 'a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals and enable effective work in cross-culturally situations'	Medline, Eric, Soc Abs, SciSearch, Dissertation Abs, Soc Sci Abs, Mental Health Abs, Healthstar. English only. (1965–2001)	6	Intervention studies	1) Patient satisfaction, health status 2) utilization of health services	Yes	Could not determine the effectiveness of any of these interventions, because there were either too few comparative studies, or studies did not examine the outcome measures evaluated in this review: client satisfaction with care, improvements in health status, and inappropriate racial or ethnic differences in use of health services or in received and recommended treatment.	Moderate-strong

Beach et al. 2005	Health professionals (physicians and nurses). Most studies located in the United States.	Cultural competence has been defined as “the ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences”(Cooper et al. 2002) by recognizing the importance of social and cultural influences on patients, considering how these factors interact, and devising interventions that take these issues into account (Betancourt et al. 2003).	Medline, Cochrane, Embase, EPOC, RDRB/CME, Cinahl (1980–2003)	34	RCTs, controlled, pre & post	1) Provider outcomes: knowledge, attitudes, skills 2) patient outcomes: satisfaction, behaviors, health status 3) cost effectiveness	No	Cultural competence training shows promise as a strategy for improving the knowledge, attitudes, and skills of health professionals. However, evidence that it improves patient adherence to therapy, health outcomes, and equity of services across racial and ethnic groups is lacking. It is difficult to conclude from the literature which types of training interventions are most effective on which types of outcomes. Also difficult to determine which types of knowledge, attitudes & skills are impacted by training.	Moderate-strong

Bhui et al. 2007	Mental health. All studies located in North America.	Aim of the paper is to develop a meaning of CC	Ingenta, Medline via Ovid, Medline via Pubmed, Medline Plus, Health Outcomes, HealthPromis, HSTAT, DocDat, National Research Register, NLM Gate- way, Cam, ReFer and Zetoc. (1985–2004)	9	No RCTs. Qualitative & quantitative papers	1) Provider outcomes 2) evaluations of implemented models of CC	No	There is limited evidence on the effectiveness of CC training and service delivery. Few studies published their teaching and learning methods. Only three studies used quantitative outcomes. One of these showed a change in attitudes and skills of staff following training. No studies investigated service user experiences and outcomes.	Moderate-strong

Chipps et al. 2008	Health professionals working in community-based rehabilitation including mental health and primary care. All studies located in North America.	"The ability to effectively provide services cross-culturally" (Diller 1999). Cultural competence training programs aim to increase "cultural awareness, knowledge, and skills leading to changes in staff (both clinical and administrative) behavior and patient-staff interactions" (Brach & Fraserirector 2000). Cultural competence includes the capability to identify, understand, and respect values and beliefs of others (Anderson et al. 2003).	CINAHL, Medline, Pubmed, PsycINFO, SABINET, Cochrane, Google, NEXUS, and unpublished abstracts (1985–2006)	5	RCTs, quasi-experimental, evaluation studies	1) Provider outcomes: cultural knowledge and attitudes, cultural competence, 2) patient health outcomes: satisfaction, behaviors, health status	Yes	Positive outcomes were reported for most training programs. Reviewed studies generally had small samples and poor design. 3 of the 5 studies reported on patient/client satisfaction.	Strong

Downing et al. 2011	Health care workers in Australia	Throughout this review, the term ‘indigenous cultural training’ will be used to describe training that is concerned with assisting health workers to provide health care that is accessible, meaningful and useful to indigenous/other minority groups in terms of their social, emotional and cultural wellbeing as well as physical health.	CINAHL PLUS, MEDLINE, Wiley InterScience, ATSIHealth and ProQuest.	9	Not reported	1) Provider outcomes: knowledge, attitudes, awareness,	No	There is scant evidence for the effectiveness of indigenous cultural training. The only study to assess knowledge and attitudes before and after training with a control group found no effect. Three studies also documented positive post-training reports but it is unclear if this relates to any change in practice as a result of the training. No information was available with which to assess systemic differences between the programs that did and did not produce (perceived) changes.	Moderate

Fisher et al. 2007	Health care provision to non-White racial and ethnic groups in the United States.	Cross' definition for cultural competence. Definition of cultural leverage: a focused strategy for improving the health of racial and ethnic communities by using their cultural practices, products, philosophies, or environments as vehicles that facilitate behavior change of patients and practitioners.	Medline, Cochrane, Web of knowledge, The New York Academy of Medicine Grey Literature Report (1985–2006)	38 (35 unique studies)	RCTs, pre-post, controlled	1) Patient outcomes: health behaviors 2) access to health care system 3) provider: cultural competence	Yes	The interventions reviewed increased patients' knowledge for self-care, decreased barriers to access, and improved providers' cultural competence. Interventions using cultural leverage show promise in reducing health disparities, but more research is needed.	Moderate

Forsetlund et al. 2010	Health care for ethnic minorities. Most studies located in the United States.	To collect and summarise in a systematic and transparent manner the effect of interventions to improve health care services for ethnic minorities	Cochrane Library, MEDLINE, EMBASE, British Nursing Index, ISI Social Sciences/Science Citation Index (SSCI/SCI) and Research and Development Resource Base (RDRP).	19	Randomized controlled	Quality of health care services, use of health care services, patient health or the quality of life for patients.	Somewhat	Educational interventions and electronic reminders to physicians may in some contexts improve health care and health outcomes for minority patients. The quality of the evidence varied from low to very low. The quality of available evidence for the other interventions was too low to draw reliable conclusions.	Moderate-strong

Harun et al. 2012	Cancer care to ethnic minority women. All studies located in the United States.	Defines “patient-centred care”: involves integrating patient preferences and values to guide clinical decisions and management, and it is thought to facilitate improved patient satisfaction, communication with providers, safety, costs and efficiency in the health-care system.	Medline, PsycINFO, EMBASE and Cochrane	7	Randomized controlled, non-randomized, mixed-method experimental	Communication with health providers, decision-making, treatment adherence, general patient participation, treatment knowledge	Yes	Of the 37 selected studies, only 18 included valid outcome measures. Employing a combination of multiple strategies is more likely to be successful than single interventions. The impact of the interventions on participation was varied and effectiveness may hinge on a variety of factors, such as type of intervention and study population characteristics. Given the paucity of studies, it is difficult to draw conclusions about the effectiveness of the different interventions for this broad patient group.	Moderate-strong

Hawthorne et al. 2008	Community-based or hospital-based settings. Diabetes education for ethnic minority groups. Most studies located in the United States.	’Culturally appropriate’ health education is defined here as education that is tailored to the cultural or religious beliefs and linguistic skills of the community being approached, taking into account likely literacy skills (Overland 1993).	The Cochrane Library, MEDLINE, EMBASE, PsycINFO, CINAHL, ERIC, SIGLE and reference lists of article (prior to 2007).	11	RCTs	Patient: health status, behaviors, satisfaction, knowledge.	Yes	Culturally appropriate diabetes health education appears to have short-term effects on glycaemic control and knowledge of diabetes and healthy lifestyles. None of the studies were long-term, and so clinically important long-term outcomes could not be studied. No studies included an economic analysis.	Strong

Henderson et al. 2011	Chronic health conditions. Most studies located in the United States.	Culturally safe services were originally defined as those where there is no assault on a person's identity caused by the fact that service delivery methods or processes are alien to the person's culture (Ramsden 1990).	CINAHL, MEDLINE, Joanna Briggs Institute, Cochrane Library, Lippincott, Williams and Wilkins Collection, PubMed, ProQuest, Dissertations and Theses, and Google Scholar (1999–2009)	24	RCTs and controlled trials	1) Utilization of health services 2) patient outcomes: satisfaction, health behaviours, health status 3) provider outcomes: awareness, cultural competency	Yes	The review supported the use of trained bi-lingual health workers, who are culturally competent, as a major consideration in the development of an appropriate health service model for culturally and linguistically diverse communities. Four studies reviewed involved cultural competency training for healthcare providers and all 4 indicated that cultural competency training was beneficial. Nevertheless, the translation of cultural knowledge into practice remains problematic.	Moderate

Kehoe et al. 2003	Health care for ethnic minority groups. Most studies located in the United States.	CC involves the actual integration of congruent behaviors, attitudes and policies, within the delivery of health care in cross-cultural situations. (Office of Minority Health 2000)	Medline, Cinhahl (1980–2001)	14	RCTs, quasi-experimental	Patient outcomes: health status, health behaviors	Yes	A small number of studies demonstrated significantly improved outcomes for patients with diabetes mellitus, drug addictions, sexually transmitted infections and other health problems, after receiving culturally competent or relevant interventions. Few studies examined long-term effects of interventions on health outcomes.	Moderate

Kokko 2011	Nursing. Participants in the studies were from Australia, Denmark, Finland, Germany, Norway and Sweden.	Cultural competence is defined as a set of skills and behaviors that enable a nurse to work effectively within the cultural context of a client/patient (Leininger 2002, Papadopoulos 2006).	MEDLINE and Cumulative Index to Nursing and Allied Health Literature (CINAHL) databases (2000–2009)	7	Qualitative	1) Provider outcomes: cultural knowledge, personal growth, nursing student's practice, preparedness for cultural competence in nursing	No	The results of the present study demonstrate that participating in overseas student exchange programs increased the nursing students' preparedness to be culturally competent.	Weak-moderate
Lie et al. 2011	Health care professionals. Most studies located in the United States.	Not reported	MEDLINE/PubMed, ERIC, PsycINFO, CINAHL and Web of Science databases (1990–2010)	7	Intervention studies	Patient outcomes: satisfaction, behaviors, health status	Yes	Study quality was low to moderate. Effect size ranged from no effect to moderately beneficial. There is limited research showing a positive relationship between cultural competency training and improved patient outcomes.	Strong

Lu et al. 2012	Cancer screening involving Asian women. Most studies located in the United States.	Not reported	MEDLINE, EMBASE, Cochrane Database of Systematic Reviews, Cochrane CENTRAL Register of Controlled Trials, CINAHL, CancerLit, DARE Database of Reviews of Effects, PsycINFO, ABI Inform, ERIC, Social Sciences Abstracts, Sociological Abstracts, Health Technology Assessment Database (University of York), Proquest Dissertations and Theses, and KUUC Knowledge Utilization Database (University of Laval)	37	Randomized control trial (including cluster randomized trial, and randomized controlled crossover trial), non-equivalent control group, or prospective cohort.	Breast cancer screening, cervical cancer screening, and those studies targeting both breast cancer and cervical cancer screening	Yes	Our review found that intervention studies varied greatly by study population and geographic area. Therefore we could not arrive at a conclusive and generalizable conclusion on effectiveness of any one particular intervention. Only eighteen of the included studies reported effectiveness based on completion of mammograms or pap smear, either by self-report and/or verified through clinical record. While some studies demonstrated the effectiveness of certain intervention programs, the cost effectiveness and long-term sustainability of these programs remain questionable.	Moderate-strong

McQuilkin 2012	Nursing. Participants in the studies were mostly from the United States	Evidence of awareness of personal culture, values, beliefs, attitudes and behaviours; demonstrated ability to assess cross-cultural variations; and to effectively perform requisite skills needed to assess and communicate with individuals from other cultures (Cavillo et. al, 2009).	Health and Psychosocial Instruments, CINAHL Plus with Full Text, ERIC, Health Source: Nursing/Academic Edition, MEDLINE, PsycINFO, EBSCO, COCHRANE, CINAHL, reference lists from identified articles.	37 (16 interventions)	Case study, expert opinion, comparative descriptive, quantitative, systematic review	1) Increased self-awareness of their own values, attitudes, beliefs and behaviors that compose their culture, 2) increased skill in assessment and communication with persons from other cultures, and 3) ability to provide an assessment of transcultural differences	Yes	Findings demonstrated that international immersions provided optimal experiences to develop cultural competence alone, but more effective when combined with other strategies. International immersion experiences can increase student self-awareness, cross-cultural communication and assessment skills, and ability to assess cultural differences. The evaluation measures described in the literature were consistently student self-perception rather than observed development of the student's cultural competence.	Moderate

Pearson et al. 2006	Nursing	Definition: “the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural and linguistic needs” (Betancourt et al. 2002)	CINAHL, Medline, Current Contents, the Database of Abstracts of Reviews of Effectiveness, The Cochrane Library, PsycINFO, Embase, Sociological Abstracts, Econ lit, ABI/Inform, ERIC and PubMed. The search for unpublished literature used Dissertation Abstracts International. (prior to 2005)	19	Quantitative, qualitative, reviews	1) Patients: health status, satisfaction 2) nurses: 3) organisations 4) systems	Yes	The results identified a number of processes that would contribute to the development of a culturally competent workforce. Appropriate and competent linguistic services, and intercultural staff training and education, were identified as key findings in this review.	Moderate -strong

Smith et al. 2006	Mental health professions. All studies were located in the United States.	Not reported	Dissertation Abstracts, ERIC, HealthSTAR, Medline, Mental Health Abstracts, Programme Applique’ a’ la Selection et a’ la Compilation Automatiques de la Litte’rature, PsycINFO, Social Sciences Abstracts, Social SciSearch, Sociological Abstracts via SocioFile, and Social Work Abstracts (1973–2002)	Meta-analysis 2 n = 37	Outcome studies	Meta-analysis 2- provider outcomes: multicultural counseling competence, racial identity, racial prejudice, client-counselor relationship	Yes	Multicultural education interventions were typically associated with positive outcomes across a wide variety of participant and study characteristics. Multicultural education interventions that were explicitly based on theory and research yielded outcomes nearly twice as beneficial as those that were not.	Moderate-strong

Sumlin & Garcia 2012	Diabetes management involving African American women in the United States	Cultural competence, or tailoring, is defined as “the process of creating culturally sensitive interventions, often involving the adaptation of existing materials and programs for racial/ethnic subpopulation.”	PubMed, Cumulative Index to Nursing and Allied Health Literature, the Cochrane Review database, and The Diabetes Educator journal index.	15	RCTs and quasi-experimental designs	Dietary outcomes, weight loss, changes in metabolic control (A1C), lipids, blood pressure, and cholesterol	No	Of the 15 studies, 6 showed significant improvements in food practices, and 8 showed significant improvements in glycaemic control as a result of the interventions. It is not clear what components of the 15 interventions were most effective. Most studies did not report the duration of the sessions, thereby making comparison of “intervention dose” impossible. In addition, variations across the studies in content and methods used do not point to specific recommendations for clinicians or educators to adopt or avoid.	Moderate-strong

Whittemore 2007	Diabetes management involving Hispanic adults in the United States.	Not reported	CINAHL, Medline, PsycINFO (1990–2006)	11	RCTs, pre-post design	Patient outcomes: clinical, behavioral and knowledge	No	The majority of studies in this review reported significant improvements in select clinical outcomes, behavioral outcomes, or diabetes- related knowledge.	Moderate-strong

The majority of reviews (n = 15) were published between 2007 and 2012. Reviews focused on a range of health care settings/contexts, including: health professionals, community rehabilitation, nursing and health systems. A range of study designs were included in the reviews, including randomized controlled trials, pre and post designs as well as qualitative studies. Most reviews provided a definition of cultural competency or related concept. The number of studies included in each review varied between 5 and 38. Smith et al.’s [19] review consisted of two meta-analyses, of which only the second meta-analysis (n = 37) met the inclusion criteria. (The first meta-analysis consisted of retrospective survey studies that did not report outcome measures.) Thirteen reviews assessed the quality of studies using critical appraisal tools such as the Oxford Centre for Evidence Based Medicine [13].

Interventions to improve cultural competency

Types of interventions to improve cultural competency included in the reviews were: training/workshops/programs for health practitioners (e.g. doctors, nurses and community health workers), culturally specific/tailored education or programs for patient/clients, interpreter services, peer education, patient navigators and exchange programs.

Seven of the 19 reviews focused solely on healthcare provider cultural competency interventions [6,7,13,14,17,19,23] whilst six reviews examined only culturally competency interventions aimed at patients/clients [8,18,20-22,24]. Three reviews included studies that examined organizational level interventions such as culturally adapting health programs for patients and employment of bilingual community health workers [5,15,16]. One review focused primarily on interventions directed at health care personnel and/or organizations, although interventions targeting both health personnel and patients were also included [25]. Another review looked at the structures and processes that support the development of culturally competent practices [3]. Evaluated models of cultural competence in mental health were reviewed by Bhui et al. [4].

Study outcomes

There were three main categories of study outcomes amongst the reviews: provider-related outcomes, patient/client-related outcomes and outcomes related to health service access and utilization. Evaluations of implemented models of cultural competency [4] and cost-effectiveness [6] were also examined.

Provider outcomes

Measured provider outcomes focused on knowledge, attitudes and skills related to cultural competency. In Beach et al.’s [6] review, knowledge refers to information about general cultural concepts such as the impact of culture on the patient-provider encounter or culture-specific knowledge such as traditional cultural practices. Attitude outcomes measured by studies included cultural self-efficacy (assessing learner confidence of knowledge and skills in relation to ethnic minority patients), attitudes towards community health issues, and interest in learning about patient and family backgrounds [6]. Skills included communication skills or use of treatment plan. In contrast, Smith et al.'s [19] review used multicultural counseling competence as their main outcome measure while Kokko [17] included studies examined nursing students' cultural knowledge, personal growth and nursing practice.

Patient/client outcomes

There were a variety of patient/client outcomes reported, including physiological outcomes such as blood glucose, weight and blood pressure [8] as well as outcomes such as patient satisfaction and trust [7], knowledge of cancer screening and knowledge of health conditions [15]. Behavioral outcomes such as dietary and exercise behaviors were also examined in three reviews [15,18,21]. Other reviews looked at primarily patient-focused interventions to improve breast and cervical cancer screening among women [24] and to improve participation in cancer treatment processes [22].

Health service access and utilization outcomes

Outcomes related to health service access and utilization included use of bilingual community health workers, interpreters, and patient navigators. These interventions were designed to influence individuals' ability to access the resources of health care organizations by bridging the cultures of the organizations and those of the target communities [15].

Cost-effectiveness of interventions was considered in three reviews [6,8,24]. Beach et al. [6] noted that only 4 of 34 studies included in their review addressed the costs of cultural competence training. No studies in Hawthorne et al.'s [8] review measured the cost effectiveness of their interventions, although some included a rough estimate of costs. Two studies in Lu et al.'s [24] review reported cost information. These reviews noted this as an important limitation of studies they examined.

Major findings of reviews

Provider related outcomes

Six of the eight reviews that examined healthcare provider interventions found some evidence of improvement in provider outcomes such as knowledge, skills and attitudes in relation to cultural competency [6,15-17,19,23].

Patient/client related outcomes

Seven of the nine reviews that examined patient/client-related outcomes generally found evidence of some improvement in health outcomes. Hawthorne et al.'s [8] review of culturally appropriate diabetes health education found short-term effects (up to one year) on glycemic control and knowledge of diabetes and healthy lifestyles. However, long-term effects (one year or more) were not examined by any studies. Whittemore [20] also reviewed culturally appropriate interventions in relation to diabetes, but for Hispanic populations only, finding evidence of significant improvements in selected clinical outcomes, behavioral outcomes and diabetes-related knowledge in the majority of studies. Sumlin & Garcia [21] found significant improvement in food practices and glycemic control amongst African American women with Type 2 diabetes following use of culturally competent food-related interventions. Kehoe et al.'s [18] review also found that culturally relevant interventions improved patient/client outcomes for conditions such as diabetes and drug addiction. Lie et al. [7] found a positive relationship between cultural competency training and improved patient/client outcomes. Chipps et al.'s [13] review included three studies measuring patient/client satisfaction, with only one of these three studies finding increased satisfaction of clients with their counselors. Reviews by Harun et al. [22] and Lu et al. [24] found mixed results, and hence were unable to draw generalizable conclusions in relation to patient participation in treatment and cancer screening, respectively.

Outcomes related to access and utilization of health services

Four of five reviews that included studies related to health service outcomes found some evidence of improvement. Fisher et al. [15] reviewed a range of interventions to narrow racial disparities in primary and tertiary health care settings, grouped into three categories: patient behavioral change, access to care, and health care organization innovation. They found that interventions using culturally specific patient navigators and community health workers were among the most successful. Henderson et al. [16] reviewed a range of culturally appropriate interventions to manage chronic disease among racial/ethnic minorities, also finding support for the use of trained bilingual health workers to promote greater uptake of disease prevention strategies. From a healthcare systems perspective, Anderson et al. [5] found a lack of both quantity and quality of studies focused on improving cultural competency. Pearson et al. [3] found that appropriate and competent linguistic services and intercultural staff training and education were key in developing effective culturally competent practices in nursing. Forsetlund et al. [25] found that education interventions and electronic reminders to physicians may improve health care and health outcomes for minority patients. However, the quality of evidence for these interventions was graded as low to very low.

Other outcomes

Bhui et al.'s [4] review included studies that evaluated implemented models of cultural competence; essentially organizational approaches. They concluded that culturally competent care and services at the organizational level is addressed in different ways depending on the local context, for example managed care and insurance based service models in the United States may not to translatable in settings where services are dependent on government funds.

Quality of studies within reviews

The majority of reviews noted methodological limitations of studies. This limited conclusive statements about the effectiveness of interventions to increase cultural competency. The main methodological criticisms of the studies by the reviews were: small samples [13], poor methodological rigor [7,13,15], no or few long-term studies [8,18], no economic analysis of interventions [6,8], reliance on self-report measures [19], lack of detail about interventions [7,19], lack of patient outcome measures [4-6,15] and lack of objective provider measures related to change in practice [14,17].

Some reviews reported the quality/strength of evidence supporting the outcomes measured [5-8,15,25]. For example, Beach et al. [6] graded the strength of evidence for each outcome type based on its quality, quantity, and consistency (grades A – D). In their review, evidence of impacts on provider knowledge were graded A compared with provider attitudes which were graded B.

Recommendations of reviews

Twelve of the nineteen reviews concluded that further research (e.g. more rigorous trials and evaluations) was required to determine the effectiveness of interventions to improve cultural competency for providers and patients/clients. The reviews found that many of the studies were difficult to compare as different frameworks of cultural competency were used and studies often lacked a standardized and validated instrument to measure cultural competence [6]. Most reviews concluded that training had positive impacts on provider outcomes. However, it was difficult to determine exactly what types of training interventions were most effective in relation to particular outcomes [6,13,19]. A need for research into long-term outcomes [8,18] was identified along with the need to consider other factors that facilitate cultural competency, such as links with community organizations [3,15]. It was also recommended that cost-effectiveness be assessed [8,24].

Limitations of reviews

Some of the reviews focused on one type of intervention such as diabetes education for patient outcomes [8] or health provider cultural competency training [14]; one type of study outcome such as patient outcomes [7]; one type of study design such as randomized controlled trials [25]; or a particular study population such as Hispanics [20], Asian women [24] or nurses [17]. Although it may be more feasible for a review to focus on a particular group of health providers or type of health care setting, it limits generalizability and applicability of the findings. Many studies were heterogeneous in outcome and interventions, making statistical synthesis and analysis difficult [13].

According to Smith et al. [19], their meta-analysis was limited by: studies with single-group pre-to post-test assessments (e.g. [32,33], studies rarely reporting disaggregated data, and predominantly self-report measures (e.g. [34,35].

It is also difficult to determine the extent to which knowledge and skills learnt from training/programs are translated into practice and how they impact on patient/client outcomes [5,17]. Provider outcomes determined by self-report are subject to multiple threats to internal validity [36] and hence limit the conclusions made regarding impact on provider practice [19] and ultimately on patient outcomes.

The literature includes a diverse range of populations (e.g. African American, Hispanic/Latino, and Asian), health care settings (e.g. community centers, hospitals and academic medical centers) and interventions (e.g. culturally tailored programs for particular racial/ethnic groups and provider training). However, the majority of studies were based in the United States. Two reviews limited their included studies to only those conducted in the United States [15,21].

Heterogeneity of reviews and studies

Meta-analysis was not conducted in this review of reviews due to the heterogeneity of the reviews and their included studies. Intervention effects were also difficult to determine as only some reviews described outcomes in terms of statistical significance and effect sizes [5,6,8,13,19]. Some reviews noted that studies rarely provided sufficient information on the curriculum or format, or details of the providers involved (e.g. age, race, gender, prior training) making it difficult to conclude from studies which types of training interventions were most effective for which groups and in producing which particular outcomes [6,7].

Critical appraisal of reviews

All reviews were critically appraised by two authors using the health-evidence.org tool for reviews [12] and companion tool dictionary [37]. This process was reliant on the author’s prior knowledge and experience of the topic, research principles and study design methods. There were minor disagreements between authors and consensus was reached through discussion. Reviews were predominantly of moderate-strong quality (overall assessment of review quality is included in Table 1).

Design of reviews

All reviews had a clearly focused question in relation to the population, intervention and outcomes. Appropriate inclusion criteria to select primary studies were used by the majority of reviews. The majority of reviews described comprehensive search strategies, although some were slightly limited in scope [4,14,15,20]. For example, Kehoe et al. [18]’s search strategy consisted of only two electronic databases. The number of years covered by the search strategies was 20 years or more by the majority of reviews. Two reviews [16,17] covered 10–11 years, one review searched between 2005–2011 [23], and one review [14] did not provide this information.

Methodological rigor of reviews

The methodological rigor of studies was identified and described in thirteen reviews [3,5,7,8,13,15,16,18,19,22-25]. The methodological rigor of primary studies using an assessment tool/scale was conducted by all these reviews except for two [18,19]. Nine reviews reported the use of two or more reviewers to assess each study for methodological quality [6-8,13,15-17,22,24]. Most reviews used appropriate methods for combining and comparing results across studies. However, Pearson et al.'s [3] results were not well presented.

Discussion

This systematic review of reviews has identified a number of key issues and limitations in what is currently known about interventions to improve cultural competency within healthcare. There was considerable heterogeneity amongst the reviews in relation to interventions used, patient populations, health provider populations, health contexts/settings as well as processes and outcomes of care. This reflects the complexity of the area and its translation to practice and research. Overall, positive effects were reported by most reviews, particularly in relation to provider outcomes. However, it remains unknown exactly what types of interventions are most effective, for whom, in what context, and why.

Reviews that compared different types of interventions, e.g. Henderson et al. [16] and Fisher et al. [15], found that the use of culturally trained health workers was the most effective. However, rather than being comparable, many of the primary studies in these reviews were a mixture of study designs focused on various interventions.

The included reviews were generally difficult to compare as different definitions and frameworks of cultural competency or related concepts were used. Some reviews did not provide a definition [4,7,19,20,24]. The lack of uniformity in terminology and definition reflect the many variations of terms and definitions used in relation to cultural competency at present. This is likely a key contributing factor to the lack of consensus on the best ways to develop, implement and evaluate cultural competency interventions. Developing such consensus regarding terminology and definitions, with a view to improving evidence of effective cultural competency interventions is thus an important area of future work both theoretically and empirically.

Mixed findings were found by two reviews [22,24]. In their review of breast and cancer screening among Asian women, Lu et al. [24] determined that the effectiveness of interventions to promote screening depended on factors such as the type of intervention, methods of program delivery, study setting and ethnic population. Harun et al.'s [22] review of interventions to improve participation in treatment found that the impact of these interventions was varied amongst the seven included studies. Both reviews found that patterns of intervention design and results of effectiveness were heterogeneous, therefore it was difficult to generalize the effectiveness of particular interventions for particular patient/client groups.

Organizational context

Cross-cultural interactions are likely structured and shaped by the worldviews and past experiences of not only the staff and clients but also the culture of the organization, which is embedded in and produced by policy frameworks, organizational arrangements and physical settings of the organization [38]. Interventions to improve cultural competency need to consider the individual and organizational contexts and the interplay between them. Training programs may need to be tailored to particular groups, for example physicians would need particular knowledge and skills specific to their clinical tasks that would be inapplicable for reception staff.

It is likely that cultural competency training as a stand-alone strategy is insufficient to improve patient outcomes without concurrent systemic and organizational changes [7,9,39]. Embedding cultural competency in organizational policy documents such as position statements and strategic plans are more likely to result in sustained change within organizations. There should be a commitment among the leadership of the organization and embedded key performance indicators supported by allocated resources.

There is some evidence of a relationship between the cultural competence of health practitioners and the cultural competence of organizations [39,40]. Providers may be influenced by their organization’s commitment and actions in relation to cultural diversity and vice versa. A study found that providers with attitudes reflecting greater cultural motivation to learn were more likely to work in clinics with more culturally diverse staff and those offering cultural training and culturally adapted patient education materials [40].

In recognition that different components of the health system influence health outcomes, some models of cultural competency advocate a multi-level approach [2,41]. Although some studies have shown that culturally competent practices among organizations are adopted to varying degrees [42,43], more research is needed in this area. Grol et al. [44] found that empirical evidence of the effectiveness and feasibility of most theoretical approaches to produce change in health care was limited. Dreachslin et al. [45] found a paucity research on organizational behaviour in the healthcare and general management literature. A more recent review by Parmelli et al. [46] showed limited available evidence regarding effective strategies to change organizational culture in health care. Barriers and incentives to organizational change should be considered when designing and implementing an intervention to increase the likelihood of success and sustained change [47,48]. Issues related to organizational readiness for change and innovation also require consideration before implementing organizational cultural competency interventions [49]. Understanding the reasons for adoption and spread of innovation can assist with addressing the difficulties of organizational change [50]. Planning and implementation of cultural competency interventions should acknowledge the interaction between an intervention and the setting. Organizational cultural competence involves an understanding of the strengths and weaknesses of the health care organization and the unique needs of the people it serves.

Beyond self-assessment

Self-assessment was the most common approach to assessing cultural competency, which is a subjective measure subject to a range of biases [36]. The assessment tools were mostly process and survey tools, including patient satisfaction and provider self-assessment questionnaires as well as self-administered organizational checklists. Many of these tools have not been validated [51]. Self-rating at the individual level may be affected by the respondents' level of cultural awareness and is subject to biases such as social desirability [52]. Broader organizational and systemic approaches to cultural competency should consider assessments of cultural competency that include objective measures such as document review [52]. Moving beyond self-assessment is a necessary step towards developing a stronger evidence base for the use of cultural competency related interventions to improve patient/client health outcomes. In addition, more research is needed to determine how well both individual-level and organizational-level guidelines for cultural competency are followed by those directly involved in service delivery [53].

Broader issues of culture, racism and privilege

Academics have asked whether cultural competency can be achieved without focusing on issues related to racism and white privilege [54,55]. Concepts related to racism, bias and discrimination were noted in some reviews, [3,5,6,14,15,23], although none were measured as outcomes in studies. Two of the 34 studies in Beach et al.'s (2005) review included mention of these concepts in their education content. Factors such as structural inequalities and racism may have a greater impact on health disparities between particular groups than cultural differences [56].

Self-reflection and awareness of one's professional and personal culture is an important component of cultural competency [57]. Of the seven reviews that focused on provider outcomes, four discussed these concepts [13,14,17,23]. This is despite these self-reflexive elements being critical to cultural competency. Cultural awareness alone is inadequate for addressing the effects of structural and interpersonal racism on health disparities. Cultural awareness training has been criticized for increasing stereotyping and reinforcing essentialist racial identities [58]. Reflexive antiracism training is a promising alternative to cultural awareness training that reflects upon the sources and impacts of racism on society whilst avoiding essentialism and negative emotional reactions associated with White guilt [59].

There is a tendency within healthcare to equate culture with essentialized notions of race and ethnicity, which can lead to practices that separate culture from its social, economic and political context [10]. Narrow conceptualizations of culture and identity may limit the effectiveness of particular approaches, and a focus on specific cultural information may inadvertently promote stereotyping. Care must also be taken to avoid over-focusing on ‘culture’. Although cultural differences may worsen the problem of differential access and discrimination, broader factors such as poor education and poverty may play a greater role in the poorer health outcomes of some individuals and groups in the community [60]. However income and race/ethnicity as risk factors for health disparities can overlap and discrimination is often a driver of socio-economic disparities [61].

Limitations

A limitation of this review is that there may be primary studies in the field that are not included by existing reviews in the literature as this was a review of reviews rather than a review of primary studies. There were only 22 primary studies cited by more than one review. This is likely due to the relatively narrow focus of some reviews e.g., by health condition, minority groups or type of outcome (i.e. patient or practitioner). Another limitation is that only reviews published in English were included. Given that the timeframe for this review was 2000–2012 it is possible that reviews published prior to 2000 were not included. However, cultural competency did not achieve popularity until the late 1990s and government policies mandating cultural competence did not occur until the early 2000s [11].

The search strategy could have been improved by adding more patient-related terms (e.g. migrant and refugee) and applying a more sensitive search filter for systematic reviews. It is possible that some reviews were excluded as a result, however it is unlikely that the overall findings would be significantly different as this paper includes reviews from various health care contexts and health care provider and patient populations as well as different types of studies and cultural competency interventions.

It is difficult to make a general statement about the strength of the effect of interventions as the reviews assessed their studies differently. Different critical appraisal tools were used by authors and a majority of reviews noted methodological limitations of studies in their reviews, which limited their ability to make conclusive statements about the effectiveness of interventions. In order to determine the strength of the effect, an assessment of all primary studies of the included reviews using a single critical appraisal tool to determine the effectiveness of their interventions and an assessment of quality and bias of each individual study is required. However this is beyond the scope of this paper.

Conclusion

This systematic review of reviews of interventions to improve cultural competency within healthcare settings has synthesized all recent reviews in order to improve our understanding of the current evidence base and guide future research in this area. The majority of reviews found moderate evidence of improvement in provider outcomes and health care access and utilization outcomes. However, there was weaker evidence for improvements in patient/client outcomes.

This review has highlighted the breadth and complexity of research in this area as well as the popularity of this area as shown by the number of published reviews found during the period January 2000-June 2012, and particularly from 2007 onwards. Despite this popularity, it is clear that the evidence base is relatively weak, and there continues to be uncertainty in the field. First, there is no uniform definition or framework of cultural competence that is accepted across the spectrum of health contexts/settings either within or between countries. Many terms are used interchangeably with cultural competency (e.g. cultural safety, cultural awareness, cultural responsiveness). Second, there are many potential outcomes from cultural competency interventions, as indicated by the variety of measures utilized in reviews, but very few validated tools to assess cultural competency in the published literature [51,62]. Third, a lack of methodological rigor is common amongst the studies included in reviews. Moreover, many of the studies rely on self-report, which is subject to a range of biases, while objective evidence of intervention effectiveness was rare.

Future reviews should be explicit about their definition or framework of cultural competency and what constitutes a culturally competent intervention, whether at the individual-level, organizational-level or systemic-level. Reviews should also examine multiple outcomes at all three levels where possible due to the multi-dimensional nature of cultural competency interventions and the complexities in translating cultural competency into practice. Further development and assessment of organizational cultural competency models and assessment tools is needed [63].

Multi-level interventions should consider the different contexts (e.g. government policy vs. community issues) and cultures (e.g. individual vs. organizational) that can affect the implementation and success of interventions to improve cultural competency. Issues related to organizational change and understanding the mechanisms by which health innovations are adopted should also be taken into account. There is also need for research to examine the time and resources required to implement interventions in addition to identifying the most feasible and effective approaches [6]. This is particularly important for organizational or systemic approaches where cost-benefit/effectiveness is an important consideration.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

All authors developed the idea for the systematic review and contributed to the concept and design. MT conducted the searching and drafted the tables and figures. All authors contributed to the writing of the manuscript and read and approved the final manuscript.

Acknowledgements

MT was supported by an Australian Postgraduate Award during the preparation of this manuscript. NP was supported by an NHMRC postdoctoral training fellowship (628897) and the Victorian Health Promotion Foundation during the preparation of this manuscript.

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6.2 Conclusion

This chapter addressed research question 1. Findings from this systematic review indicate that interventions to improve cultural competence are associated with some improvement in patient/client outcomes, provider outcomes and health care access and utilisation outcomes. It identified that further development and assessment of organisational cultural competence models and tools is needed. Additionally, further research into the different contexts and factors that affect implementation of multi-level cultural competence interventions and organisational change would be beneficial.

Chapter 7: Health Care Service Provider Perspectives On Cultural Competence

7.1 Introduction

This chapter addresses research question 2 and will present the results from the qualitative study exploring cultural competence and the significance of cultural background in community health service utilisation from the perspectives of staff from Merri Community Health Services (MCHS). As indicated in previous chapters, this study has been guided by cultural competence frameworks, health promotion principles and the social ecological model. The gap in the literature related to provider health perspectives on cultural competence and its implications was also outlined (Chapter 3). The systematic review of reviews in the previous chapter found that interventions to improve cultural competence can improve provider-related outcomes such as knowledge, skills and attitudes and patient-related outcomes. However, there appears to be some difficulty translating cultural competence frameworks and interventions into practice.

7.2 Interviews

Individual interviews were conducted with 14 staff. The participants were all female, aged between 25 and 66 years, and working in the areas of: dental services, counselling, reception, physiotherapy, occupational therapy, diabetes education, health promotion and management. The self-identified cultural backgrounds of staff participants included: Australian (used in common Australian vernacular as a proxy for White) and various European countries (e.g. Italy, Greece, Malta and Turkey).

7.3 Findings

The themes that emerged from the analysis of interview data will be reported according to the cultural competence model in the Australian National Medical Research Council guide '*Cultural competency in health: A guide for policy, partnerships and participation'* as described in Chapter 4 (NRMRC 2006). (See Figure 4.3) Integral to the model is the need for capacity and commitment at systemic and organisational levels to direct, support and recognise culturally competent practice at an individual or professional level. Additionally, a clear delineation of levels of responsibility and the interrelationship between these levels is required. The theme ‘language and communication’ crosses several different levels i.e. individual, professional and organisation, and hence is considered as a separate theme.

Individual level

Health care provider cultural competence entails an awareness and acceptance of cultural differences, an awareness of their own cultural values, knowledge of the influence of culturally-based beliefs and practices on health and the ability to adapt practice skills to fit client’s cultural context (Cross, Bazron et al. 1989). Individuals also need a desire and commitment to providing culturally competent care, in addition to working within a supportive organisational environment. Most participants in the study demonstrated an awareness of and sensitivity to their clients’ cultural background and its impact on service access and delivery.

Cultural background

There was general agreement among staff participants that clients’ cultural background was relevant and important in their work, particularly as the surrounding community was very culturally and linguistically diverse. Having knowledge of certain cultural beliefs and practices was seen as useful by some participants as it can increase the efficiency of client consultations and provide insights into attitudes to some aspects of health.

> *And even things like knowing when Ramadan is, or different festivals and that sort of thing. Everyone knows after Easter you generally see a few more holes in kids’ teeth because it’s Easter… And also understanding their diet. And their cultural beliefs and behaviours, you can always learn from something. (S03)*

Most participants indicated a willingness to learn about other cultural practices and adapt their care in consideration of different beliefs and practices. For example, participants said that they tried to accommodate their clients’ requests, such as when female clients requested female staff. However, some commented that working with CALD clients was particularly challenging when clients’ attitudes and practices conflicted with the recommended treatment and management of their health problems.

> *There are problems with diabetes for Ramadan when people are fasting and they are on insulin and those sorts of things. We have to talk about that, most people even though people are…excused from fasting if they have a specific condition, most of the people want to fast so we have to try and work around that and adjust the insulin … accordingly. (S06)*

Some staff participants appeared to experience frustrations and challenges when dealing with culturally diverse clients. For example, one participant described situations where clients that shared a similar cultural background with her tried to take advantage by leveraging their CALD status.

> *Sometimes they might try to be manipulative over it, they might feel that you can look after them a little bit more. (S09)*

This indicates that there are potential downsides to having staff with the same CALD background as their clients.

A couple of participants did not believe that cultural background was relevant to or impacted on their work and that they treated everyone the same.

> *Unless you have a mental disability or something like that, then you might adapt it but ethnicity wise, no, it's all the same. I don't think I do anything differently. (S03)*

> *It has nothing to do with culture. It's personalities. We're all the same. (S01)*

However, they then proceeded to give examples of instances where culturally-based beliefs or practices were apparent and influenced their work and interactions with clients.

> *They will tell us: "I cannot be booked with a man because that's against the religion", and we will accommodate for that. But it's in the personality. It has nothing to do with culture. Cos [sic] you can have your own same race sitting there and they can be a real pain in the neck, and the next person will be as nice as possible. Some people are over-demanding but you just learn to accommodate and go on. (S01)*

Perhaps this contradiction indicates a general discomfort with discussing cultural aspects in the fear of appearing prejudiced or discriminatory, or may stem from the ambiguity in what ‘sameness’ means. Sameness may mean ‘equally fairly’ or ‘justly’, therefore treating everyone equitably rather than strictly in the same way.

Staff participants’ understanding of cultural competence

Most staff participants had heard of the term ‘cultural competence’ and demonstrated an understanding of the concept at the interpersonal level, i.e. that cultural and linguistic barriers between providers and clients can affect the quality of health care provided and that strategies are needed to work more effectively in cross-cultural situations. Some had a more detailed understanding of cultural competence than others and were better able to articulate its meaning and relevance to their work. Most participants described their understanding of cultural competence at the interpersonal/practitioner level in terms of having an awareness that cultural beliefs and practices can impact on clients’ health behaviours and that they should be sensitive and respectful of these beliefs.

> *I think it’s really important to acknowledge the differences in cultural…experiences that people have [brought] to this organisation because of what happened in the past for everything… I think there needs to be a big awareness of people’s past, what they come with their past, from their cultural grouping from their religious beliefs. So I think all of that is really important in the work that we do because otherwise it’s really difficult to engage people and keep them coming. (S10)*

Recognition and understanding of clients’ migratory and acculturation experiences can enhance health providers’ ability to provide culturally appropriate and relevant health care services.

Many of the participants were not from Anglo/White cultural backgrounds and some used their own ethno-cultural identity as a way of discussing the issues related to cultural competence. For example, one participant described how she could empathise with clients from a migrant background that struggled to speak English as her parents also had a similar experience.

> *I think if you’ve got experience, like I said I have, in terms of my parents being migrants…if you’ve got that type of thing you’re sort of more*

> *understanding. Maybe some people who work here don't have that behind them and have found it a bit harder, a bit more difficult. And then it obviously takes them a little longer to sort of understand the types of patients that come through here. (S08)*

The hiring of culturally diverse staff is a common suggestion within organisational cultural competence frameworks/models (Cross, Bazron et al. 1989, National Health and Medical Research Council 2006, Weech-Maldonado, Al-Amin et al. 2011) as it is assumed that having staff from diverse cultures results in better awareness and understanding of cultural differences and thus makes patients/clients more comfortable using a service. However, there are potential limitations to this approach as middle-class values and professional socialisation can preclude health workers from critically considering how race, gender and class play out in the provision of health care (Johnson, Bottorff et al. 2004). Staff from CALD backgrounds can have their perspectives shaped by the dominant values and ideologies of the mainstream health care system and cannot be presumed to be more culturally competent than other staff from the dominant cultural group.

Whilst the majority of staff participants had previously heard of the term cultural competence, some struggled to describe their understanding of the concept.

> *Sort of understanding and knowledge around certain, any person's background or country of origin, things like that. And things that go with that. Like, some countries have more common religions, they do certain things, or just behaviours that are sometimes associated with those cultures. (S02)*

> *Now I'm really struggling. Cultural competence definition. I suppose I would define, I think of it in terms of cultural awareness and just being open minded and appreciative of the cultural practice that might impede our work cos people need to show through cultures and the way they might see our role, their role. (S10)*

This may be due, in part, to some overlap and confusion with related terms (e.g. cultural responsiveness, cultural sensitivity, and cultural safety) (Grant, Parry et al. 2013). Some participants discussed concepts related to cultural competence such as ‘client-centred care’.

Rather than ‘knowing about’ different types of patients/clients that providers may encounter, a shift to ‘learning from’ the client could be a better approach (Hollinsworth 2013). Other models advocate a similar approach, for example, patient-centred care (Gerteis 1993) and the explanatory models approach (Kleinman and Benson 2006). This could reduce the tendency to stereotype individuals based on their perceived cultural grouping and also avoid over-emphasising cultural differences at the expense of more salient factors such as income and insurance status. As one participant said:

> *If you need culturally specific information, if it’s relevant to need to know that and you’re not sure, then that person is the best source of information. (S05)*

However, a move towards an individual understanding of difference may direct attention away from a social understanding of difference and hence potentially prevent any recognition of the social production of health inequality (Jenks 2011). In addition, placing the responsibility on the patient/client for educating staff can be problematic.

Self-reflection and self-awareness

Reflexivity is a vital component of being a culturally competent health practitioner. Undergoing a process of self-reflection enables the practitioner to understand the impact of personal and professional cultural identities on his/her practice (National Health and Medical Research Council 2006). An awareness of the influence of one’s own biases and assumptions can help avoid stereotyping and ‘othering’ of clients (whether conscious or unconscious). One participant mentioned self-awareness and self-refection as being important.

> *We all come with our sets of beliefs and assumptions and cultural baggage and if it’s relevant to the presenting problem then it’s appropriate to with permission and in a gentle manner, without being confrontational, enquire about certain beliefs and you come from [the] perspective of being ignorant and wanting to know [be]cause it could be relevant.” (S05)*

The participant also made the important point that just because a client is from a CALD background, it does not necessarily mean that their culture is an important factor in the problem being addressed.

Another participant considered this in terms of how she would want to be treated if she were a client.

> *Just knowing within myself how I'd prefer to be treated. And how I'd want to be treated if I wasn't from um, I would go into another country or visiting another country. (S07)*

The participant emphasised that it was important not to make assumptions about people.

Strategies for being culturally competent

Participants described a range of strategies they employed when encountering clients from CALD backgrounds. Other colleagues often provided support and advice for challenging situations.

> *I mean we all learn from each other here. You might see one of the other [staff] handle certain situations and then you think oh yeah that's a good approach and then you take that on yourself next time you're in the same situation and vice versa and then we might even discuss it after the patient's gone. We discuss what worked for me, what worked for you and maybe try this next time, maybe try that. Yeah we work on each other's feedback. (S08)*

Some highlighted the need to take a calm and relaxed approach in order to communicate with clients with low English proficiency and by using "simple words" and "simple English". Most participants mentioned that the organisation provided interpreter services (e.g. face-to-face and telephone) when required.

> *Just speaking a bit slower and clearer. We also had a chart so if people come they can point to what they want, so there would be pictures of a bus. That was useful. And not presuming. Like you don't presume that people understand, also yelling at people, a lot of people think that*

> *yelling makes them understand better but it actually makes it worse. (S07)*

One participant mentioned treating people with universal values such as ‘respect’ and ‘dignity’ regardless of cultural background, particularly as she felt that no one could not be expected to know everything about every culture and also that it was not necessarily relevant for every client. Additionally;

> *Each person within a given culture will have their own way of doing things, their own opinions and ideas and beliefs so rather than going and finding out information on the internet that may not apply to this person. (S05)*

Therefore, being culturally competent is not about knowing everything about each culture but recognising there are differences, respectfully engaging with others, and not making assumptions based on their perceived cultural background. As Dreher & MacNaughton (2002) argue, having knowledge about different cultural groups may help us to understand the behaviour of individual patients and families but it does not allow us to make assumptions about their clinical behaviour.

Professional level

Cultural competence is an important component in the education and professional development of health care providers (National Health and Medical Research Council 2006). In this study, levels of understanding of cultural competence appeared to be linked, in part, to the participants’ professional background. Participants with professional backgrounds such as counselling and diabetes education seemed to be more familiar with the concept of cultural competence than those with roles in areas such as dental services and reception. In addition, staff who were involved with the cultural competence organisational review (CORe) project were also more familiar with cultural competence.

Cultural competence training

Discussions in relation to cultural competence training were varied amongst participants. Some participants had never had formal training in cultural competence whilst others had prior experience with training, some as part of their professional education. Most participants reported never having had cultural competence related training at MCHS. Some mentioned the need for more staff training in relation to developing cultural competence.

> *I think maybe offering training to staff and I think the training needs to come from someone from a different cultural background, culturally diverse background rather than, just, you know, someone speaking about this is what we have to do and this is why we do it. I think that will help. (S07)*

However, some mentioned potential difficulties with training in relation to time and resources.

> *I think sometimes there are barriers and then people feel logistically like if we're trying to implement something like cultural awareness training for all staff, we have clinicians that have target hours they have to meet in a day, and you know, who's going to fund that training if [it's] expected to come out of program areas. (S14)*

Issues related to the costs and effectiveness of cultural competence training need to be considered as there is considerable variability in cultural competence training and only a moderately positive link between cultural competence training of health providers and client/patient health outcomes (Beach, Price et al. 2005, Gallagher and Polanin 2015).

One participant suggested that the level of cultural competence amongst staff varied across the organisation and indicated that training to bring frontline staff to a similar standard across the organisation was important.

> *I think also building a culture of cultural competence in the organisation, so I think it's one of those things that's good, for other people to see it in practice, so if clinicians see other clinicians doing certain things or practices then they're more likely to, for it to become a norm, almost like it's embedding a culture of cultural competence which I think is important. And how it's done, I think it needs, it'll be multifaceted and it will take time, but it would be things like training, policies that support cultural competence and accessibility of target groups, ongoing support*

> *for staff whether it's not just a one off training but it's having ongoing professional development, or workshopping or discussion around it in team meetings and all staff forums. (S13)*

A multi-dimensional and multi-level approach may be effective rather than solely relying on individual training.

Organisational level

At the organisational level, cultural competence needs to be valued as integral to core business and consequently supported and evaluated with the necessary skills and resources (National Health and Medical Research Council 2006). Overall, there were mixed responses in relation to participants' perceptions of the organisation's cultural competence. Most participants felt that staff and management across their organisation valued and respected diversity. They felt that the organisation was making positive changes to improve their provision of services to the culturally diverse community. Examples given included: recruiting more diverse staff, providing workshops to staff about different cultural groups, and greater engagement with community groups.

Organisational values and culture

Some participants believed that staff within the organisation were aware of the culturally diverse clientele and assumed that those working within a community health organisation were comfortable and happy working with people from diverse backgrounds.

> *People don't come to community health because they want to make a fortune. Wrong door! So they actually have good hearts, they have a good conscience here, they are generally very interested in communities. And really very self-driven and they put in way, way, above the hours they're paid for. (S10)*

Participants who were involved in the cultural competence review were more positive about the organisation's cultural competence and its' progress within the area than others. This is possibly due to their direct involvement in this work compared with staff that are less directly engaged.

> *I think I am positive in the sense that we have got some good runs on the board and we are seen as one of the leaders probably from other community health centres in terms of cultural competency. But I think there's always things we can do better and more innovatively and there's always better ways of reaching the community. (S12)*

There is some evidence showing a relationship between the cultural competence of health practitioners and the cultural competence of organisations (Paez, Allen et al. 2008). Therefore, individual and organisational commitment to cultural competence is important in order to direct, support and acknowledge culturally competent practice (National Health and Medical Research Council 2006).

Fitting into the mainstream

Organisational culture and norms can also impact on staff members' experiences working within the organisation. A participant described her experience of having to fit into the 'mainstream', i.e. the culture of the organisation, and that this was a challenging process.

> *For me personally it was…. I done a lot of work and also psychologically to fit in, the mainstream, I have to do more than everybody else. (S04)*

> *Yes, some clients are really racist. And they say, you know, that is part of the challenge for us, for people with colour. Women. So, as I said, I do have the skill to deal with that… but emotionally it can be hurtful. It can be hurtful. And it involves a lot of feeling and emotions and stuff and I have got the space to say, to talk about my feelings. (S04)*

Despite describing her work at the organisation as highly rewarding, she appeared to experience a continuing struggle for acceptance amongst some co-workers and also some clients. There is growing awareness and documentation of discrimination and prejudice against health care providers, particularly those that are foreign-born or trained (Louis, Lalonde et al. 2010, Gyi 2011, Jain 2013, Terry and Lê 2013). This includes discrimination in training, recruitment and career progression opportunities (Priest, Esmail et al. 2015). Whilst there is an awareness and respect for cultural differences, this has its limitations. There is still an expectation that clients and staff should integrate and fit within the mainstream or dominant system. A common feature of organisational cultural competence is recruitment of diverse staff and diversity management,[8] whereby cultural diversity amongst staff is seen as a positive feature for clients and employees (National Health and Medical Research Council 2006, Dreachslin, Jean Gilbert et al. 2013). However, employing diverse staff alone is insufficient. Organisations need to create environments that are safe and supportive of diverse staff, and all employees should be trained in strategies to reduce conscious and unconscious biases, stereotypes, and discriminatory behaviour (Priest, Esmail et al. 2015).

Although many staff participants commented on the importance of respecting and having awareness of clients' cultural background and how it may affect their interactions with clients, there was less discussion of the effect of the organisation itself on staff experiences and clients' health care seeking behaviour. The focus was mainly on making clients more comfortable and adherent to the health worker and organisation's procedures and recommendations i.e. integrating them into the existing organisation. One staff participant described culture as something that may "*impede the way we work*" *(S09).*

Although some participants acknowledged that they too had a culture, particularly those from a migrant background, it did not generally lead to a critical analysis of the organisation or their individual work practices nor an examination on how organisational policies and practices could be changed to make improvements.

Organisational procedures and processes

Some participants felt that the organisation provided sufficient support to accommodate clients' cultural needs whilst others felt that more support was needed, such as providing more time in appointments. Some participants identified organisational processes and procedures, e.g. making appointments and filling forms, as being potential barriers to access for members of CALD groups.

> *People who don't speak English very well or have a different background have a bit of trouble accessing the services and they just won't go if it's too hard. (S02)*

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[8] Diversity management refers to the practice of addressing and supporting the diverse characteristics of employees within an organisation. For example, age, gender, race, physical ability and ethnicity.

Institutional structures and practices in health care create the conditions for interactions between clients and staff. The emphasis of most health care organisations is on providing uniform and efficient services. Restrictions on available appointments, rigid schedules and timing may cause difficulties for people that do not fit easily into mainstream routines and the culture of efficiency that characterises most mainstream health services. Policies and procedures related to service delivery may also have an impact on clients.

> *It's also awkward because our restructure, where clients may always have seen me or may have known me over the years because I've been here many years they sort of wonder [why] they can't see me now. Why they have to have a Greek interpreter when I'm in the next room. (S09)*

Even if some health workers are sympathetic and wish to be more flexible in their service delivery, they may be constrained by an organisation's policies, practices and resources.

Some participants also mentioned the physical environment of the organisation and envisaged that some clients may not feel welcomed as there was only signage in English and few posters with pictures of non-Anglo Saxon people.

Language and communication

Language and communication were identified as important factors by most participants. These factors can be considered on two levels: at the individual level in terms of interactions between staff and client, and at the organisational level in terms of clients' interactions with organisational processes and procedures (e.g. making appointments, filling in forms).

Language and communication- facilitators and barriers

Some participants mentioned that language difficulties could create barriers to service access and delivery, both in terms of English speaking proficiency and understanding the language of the 'health system'. Hence, it was important to make CALD clients comfortable using their services by accommodating their needs as best as they could.

> *We sort of need to be sympathetic and understanding to the people that come into this centre that they do have a language barrier and that we*

> *need to help them as best as we can instead of making them feel uncomfortable and as if there's something wrong with them. (S08)*

One participant spoke of a 'double disadvantage' for newly arrived migrants who had both low English proficiency and difficulties navigating the health system, as well as the burden of trauma and difficulties resulting from their migration experience.

> *They are disadvantaged in many ways and double disadvantage because the language, the system, and then the issue that they faced, whatever issue, it could be loss and grief, domestic violence, child rearing. (S04)*

Participants who spoke a language other than English observed that it made interactions easier when they were able to use their language skills with clients that did not speak English well. However, some bilingual staff participants felt that their bilingual language skills and cultural knowledge were not acknowledged and fully utilised by the organisation.

> *Sometimes I feel like I've got this knowledge and its not used in terms of culture, in terms of knowledge. A lot of other cultures. I think I could be useful in many ways in terms of information. (S04)*

Thus, simply employing culturally diverse staff is not enough, but ensuring that their additional knowledge and skills (e.g. language skills) are used to enhance the capacity of organisations to provide culturally competent services.

All participants said that they were supported to use interpreters. Phone and face-to-face interpreter services were utilised within the organisation. However, some observed that other staff may not utilise them appropriately as they had observed communication difficulties at reception which had resulted in difficult interactions between staff and clients.

> *But booking or having to contact to make an appointment, the interpreting service is never used and it sounds really unprofessional and I [have] witnessed clients coming and standing at reception trying to communicate, a CALD client and the receptionist is… getting frustrated,*

> *voices are being raised, using arm movements. It could all be managed better with the use of an interpreter even when they come in. (S05)*

A range of strategies is needed to address the potential barriers created by language and communication difficulties. Correct and appropriate use of professional interpreter services and bilingual staff are important approaches, in addition to evaluation of the usability of organisational processes and procedures.

Systemic level

Support for cultural competence at the systemic level should be reflected in policies, procedures, as well as mechanisms for monitoring, and sufficient resources (National Health and Medical Research Council 2006). Among some participants there was discussion of the nature of health service provision within the context of the community health model.

The Community Health model of health care service provision

Some participants commented on how rewarding it was to work at MCHS because it respected and embraced diversity, and they expressed their commitment to working in community health and addressing the needs of CALD groups in the community, and felt this was shared by other colleagues. They felt that there was a social justice element in the organisation and that they endeavoured to address broader social determinants of health.

> *I think that people working in community health kind of have a good understanding of social justice principles and therefore things like diversity and embracing cultural competence, people value that. I think that we are steps ahead from sectors like private sector, perhaps other government sectors as well. I do get the feeling that people get 'it' in community health. (S13)*

However, there were concerns amongst some that the community health model of care was changing to a focus on acute care and that perhaps it may not exist in future, and that this would have a negative impact on clients.

> *The whole climate of community health has really changed. Like it's much more corporate…And you know because we're now much more*

> *accountable in terms of paperwork, we probably see less clients and spend less of our hours at work with the community than when we used to. (S10)*

The perception of an increasing trend towards 'corporatisation' in the community health sector was viewed negatively by some participants. In contrast, others tended to view the issue in more pragmatic terms.

> *I think there are people within the sector who are at varying stages of maybe having some philosophical issues around that change. But I also think there's been increased transparency and accountability which is also a positive thing. Which has meant that maybe there needs to be some refocussing but that doesn't then mean you, because I think it means working with the more disadvantaged communities and the need to be responsive is still there, but it is a tension between the model, and then how it gets funded and that's still being played out. (S14)*

This may be reflective of a global paradigm shift in health care whereby health care is increasingly being viewed as a commodity and subject to market forces (Sanders, Baum et al. 2011). Some people may associate the adoption of a more corporate or business orientation in health care with a less compassionate and sympathetic approach. Others may take a more pragmatic approach and focus on the potential benefits.

Funding constraints and pressures

The participants in the present study discussed the organisational and system constraints that impacted on their ability to provide culturally competent care. For example, funding was noted as being a potential impediment to culturally competent practices as well as barriers such as bureaucratic processes and administrative tasks that take time away from seeing clients.

> *And I think nearly all the programs are under pressure, long waiting lists, and now that there are cut backs around the corner. (S06)*

> *People have really good intentions of embracing difference and embracing cultural diversity, but the reality is the government push for bums on seats and efficiency, cost efficiency is, going to be really, these*

> *sorts of things. And because we're now much more accountable in terms of paperwork, we probably see less clients and spend less of our hours at work with the community then when we used to. (S10)*

Focusing on individual cultural competence may mask a lack of organisational and systemic cultural competence, which act as much stronger influences on service utilisation by CALD clients.

Most considered that this was beyond the control of the organisation as it was determined by outside agencies such as the government. Despite government policy support for strengthening primary health care, this has not translated into increased investment in community health (Lawless and Baum 2014). Funding for community health services has faced uncertainty and reduction in funding since the late 2000s, with potential negative impacts on the most marginalised and disadvantaged in their communities (Cohealth 2014). In light of this, there was concern amongst some participants that changes occurring in the health care sector would negatively impact on their service provision.

7.4 Limitations

There were several limitations to this component of the study. Sampling for the staff participants did not extend beyond what was advised by the organisation's representatives. The Population Health Unit manager asked permission from the managers of several work teams whether she and the PhD candidate may attend team meetings, for several teams, to invite staff to participate in interviews. Several staff from MCHS who were previously acquainted with the PhD candidate were also invited to participate in an interview as they were involved in the implementation of the cultural competence review. Staff from other program areas within the organisation may have different experiences and perspectives. All staff participants were female, reflecting the predominantly female staff make up of the workforce at the organisation. Despite this, there was diversity in terms of cultural background, age, and occupation. Caution is needed when applying the findings to staff from other community health service organisations.

7.5 Conclusion

This chapter addressed research question 2 of the PhD study. It has presented the results of the interviews with the staff from MCHS. The findings indicate that the practice of providing culturally competent health care services within the community health context is multi-dimensional and multi-level. Cultural competence was an ambiguous concept for some participants and there were some challenges in providing culturally competent care. The majority of participants seemed to view culture as something that was static and as something that belonged to the other – i.e. the client. This was evident in participants' discussions of cultural awareness in terms of clients' beliefs and practices, although some were a little hesitant describing these different beliefs and practices, perhaps trying not to generalise or stereotype.

Most participants viewed cultural competence as being an important aspect of their work and the organisation's responsibilities and expressed a commitment to helping the diverse community. It was acknowledged that the organisation was taking steps to improve their service provision to the culturally diverse community. However, participants identified potential barriers to providing culturally competent care that were related to difficulties with language and communication (at the individual and organisational level), organisational procedures and procedures that may be confusing or inflexible, and systemic constraints due to funding restrictions and administrative requirements.

It is also important for organisations to be aware that staff from CALD backgrounds may have negative experiences that are related to their cultural differences. This was highlighted by a staff participant's struggle for acceptance amongst some co-workers and also some clients. Organisations should create environments that support diverse staff, foster open communication between staff and raise awareness of the effects of conscious and unconscious bias and discriminatory behaviour.

The level of cultural competence training was variable amongst the staff interviewed, therefore improvement in this area may assist with ensuring a more consistent level of cultural competence across the organisation. Others areas (e.g. policies to support cultural competence) should also be addressed in order to embed a 'culture of cultural competence' in the organisation.

The NHMRC cultural competence model is a useful framework for considering the multi-level factors that affect the ability of health care service providers and organisations to provide culturally competent health care services to clients and the community. The factors create and support competency along each of the four dimensions; individual, professional, organisational and systemic. The system supports the organisation and the organisation and profession support the individual. In addition, the individual informs the organisation, profession and system by applying his/her knowledge, commitment and capacity for action.

Comprehensive strategies to improve the provision of culturally competent care to people from CALD backgrounds requires an understanding of staff perspectives of cultural competence and its implementation in practice. In addition to improving individual staff's cultural competence, greater focus on organisational factors (e.g. flexibility in service delivery) and broader systems (e.g. adequate funding of services) is needed to address the barriers that can impede the ability of staff to provide culturally competent health services.

Chapter 8: Factors Affecting Community Health Service Utilisation- The Client/Carer Perspective

8.1 Introduction

Following on from the previous chapter, which presented MCHS health care service provider perspectives on cultural competence, this chapter presents the results from interviews with clients/carers of MCHS. This component of the qualitative study addresses research question 3 and seeks to further the understanding of the factors that affect health service utilisation by CALD people within the community health context. This chapter will describe the key themes identified by clients/carers of clients using MCHS services in accordance with Andersen's behavioural model of health service use. As previously indicated in the background chapter, Andersen's model is one of the most frequently used frameworks for studying the determinants of health service use. It suggests that the determinants of health care use are multi-level - consisting of individual, organisational, and systemic factors. This aligns with the social ecological perspective, a key conceptual framework underpinning this thesis.

8.2 Interviews

Individual interviews were conducted with 13 clients/carers of clients (4 clients, 1 carer, 7 parents of clients and 1 who was both a client and parent of a client). The participants included 4 males and 9 females, were aged between 30 and 83 and used the following services: physiotherapy, respite, occupational therapy, diabetes education, psychology, paediatric services and activity groups, speech therapy and podiatry. Their self-identified cultural backgrounds were: Italian, Lebanese, Korean, Turkish, Pakistani, English/Caucasian and Maltese. Some were immigrants to Australia and others were born in Australia but came from a non-Anglo-Celtic background. All interviews were conducted in English, as all participants were able to speak English to some degree. Clients, carers and parents of clients were all represented.

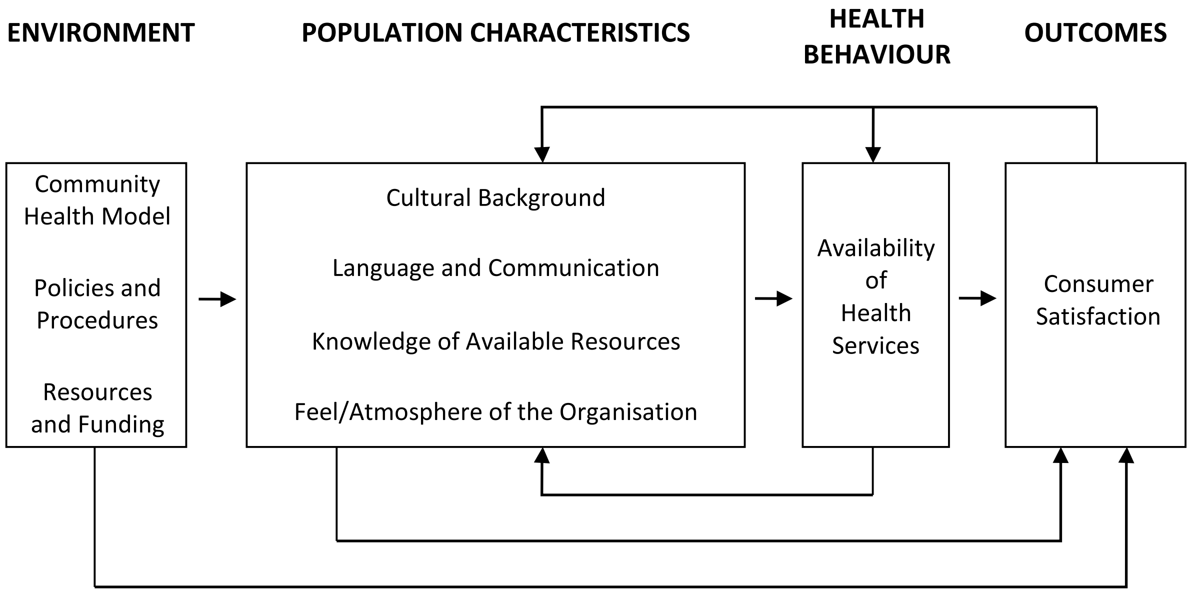
8.3 Findings

The themes that emerged from the analysis of the interviews will be reported according to Andersen's behavioural model of health use (see Figure 4.4). They are summarised in

Figure 8.1 below. Interview data regarding health service utilisation were general in nature, hence a general model of health service use was used to interpret the data rather than a culturalist framework. A culturalist framework is one that emphasises the importance of culture in determining behaviour. Some argue that a focus on cultural differences and problems of communication draws attention away from the social, political and historical issues related to race and health that, when operationalised, work to separate and exclude minorities (Culley 1996, Vertovec 1996, Smye and Browne 2002).

In keeping with the social ecological model whereby the individual is in the centre and the systemic level is the furthest layer or tier from the centre, the themes will be reported firstly with ‘Outcomes’ (i.e. at the individual level) and the ‘Environment’ (i.e. systemic level), last. However, it is noted that in Andersen’s model, the different levels are depicted with the Environment to the far left and the Outcomes to the far right.

Figure 8.1. Summary of relevant themes from interview data in accordance with Andersen’s Behavioral Model of Health Service Use (Phase 4) (Andersen 1995).



Outcomes

According to Andersen's model, 'Outcomes' refers to clinical assessments made by health professionals, people's perception of their health status and the population's satisfaction with the care they receive (Andersen and Davidson 1997). The feedback loops in the model (Figure 4.4) indicate that changes in health outcomes will alter people's health behaviour and population characteristics, and vice versa. For example, improvements in health practices will alter people's need for health services, and/or improvements in health outcomes will change people's need for services.

Consumer satisfaction

Client satisfaction

Satisfaction with health services describes how individuals feel about and judge the health care they receive. In this study, most of the client participants were very satisfied with their experiences at MCHS, and MCHS staff were positive about their interactions with their CALD clients (as described in the previous chapter).

> *They really understood me, and they cared about my son as well. He wasn't just a number sort of thing. They always fitted me in. They were readily available on the phone. (C13)*
>
> *(Regarding activity groups): The few times that we've been and I sort of said, no, she's not coming, I don't want the men. But after that they did that, the men took the guys out and the women took the girls. I suppose sometimes they don't have enough volunteers that do that. But they may have had a lot of volunteers that were able to do that. (C06)*
>
> *Oh that's good. So they listened to you? (Interviewer)*
>
> *There was a girl group so I was happy. Yeah, they were good for me. (C06)*

Hence, most client participants were satisfied with the services provided by the organisation because they felt welcome, well treated and listened to.

Health Behaviour

‘Health Behaviour’ refers to personal health practices such as diet, exercise, and self care that may also interact with the use of formal health services, which in turn influences health outcomes. In general, client/carer participants did not mention their own health beliefs and practices and how these may impact on their access and use of services at MCHS. Some mentioned that it was an individual’s personal choice to use the services in relation to other people in their community who didn’t access the service. Waiting lists was a common issue mentioned by participants as being a potential barrier.

Use of health services

Availability of services i.e. waiting lists

Waiting lists for some services were perceived to be very long and were a concern for some participants. Some were happy to wait whereas others were not.

> *Make long, long list. Very long list. I know sometimes give 2 years. Maybe I am die before I fix my teeth! (C01)*
>
> *I’m happy to wait because wherever you go it’s pretty much the same in Melbourne, Australia at the moment when it comes to anything that’s provided by the government. (C11)*

Services at MCHS are provided free or at low cost to clients, hence some client participants were content to wait for their appointments. Although most were grateful that they were able to access services at no or low cost, some clients/carers were unhappy with a perceived lack of services, long waiting lists, and having to pay a small fee (e.g. $8) for some services/activities. Some participants also said that the amount and types of services available had decreased over the years. Some felt that services were not as flexible as they used to be e.g. less home visits, female physiotherapists, and activities. These issues were all viewed negatively as they were seen as barriers to service access. Some participants felt that more funding for services should be provided by the government because *“the community should be helping people, and doesn’t take the money from people” (C01).*

> *I wish that the government make… because Coburg is a big suburb and old suburb too and that's why they should give... more money to make more better, more female physiotherapists, more rooms. (C04)*

Population characteristics

According to Andersen's model, population characteristics that influence health service utilisation encompass; people's predisposition to use services, factors which enable or impede use, and people's need for care. These include individual level (e.g. age, gender, ethnicity, education and occupation) and community level (e.g. types and availability of health personnel and health care facilities) factors. Themes related to population characteristics that influence client participants' health service utilisation will be described in this section.

Predisposing characteristics

Cultural background

In general, client participants did not feel that their cultural background affected their experiences at MCHS.

> *They're good. They understand this is [because] most of their customers, probably all their patients, clients… Coburg is very multicultural… and maybe they're used to the different ethnic groups. (C09)*

Participants did not mention 'cultural differences' as an issue they experienced with staff at MCHS unless prompted by the interviewer. However, one client did mention culture in relation to the timeliness of service delivery.

> *Ah, Australia culture is (light laughter) they not hurry. Yeah, they never hurry. Yeah, and in my culture, everything is a hurry and it is very fast. If you know, if everything service, everything finish today. (C10)*

When specifically asked about whether clients felt their cultural background affected their health service utilisation or whether they experienced any cultural differences between themselves and staff at MCHS, some did not seem to understand the nature of the question.

Some participants spoke about other people they knew in the community that chose not to use the services at MCHS despite their recommendations. One participant speculated that some people's cultural needs were too difficult to be accommodated by the organisation.

> *There have been some cultural differences [for] some of my friends and that's the reason they left it because they thought their cultural needs were too big and hard to meet…. Someone will say "oh but it's not right for the men and women to be mixed if they're Muslims" and they don't like the women to, but though it's a female dominated place anyway, they still didn't like that. (C07)*

Need

The perceived need for health services encompasses how people view their own general health and functional state as well as how they experience physical and psychological symptoms such as pain and worries about their health (Andersen 1995). Individuals must also judge the magnitude of their health problems and consider whether it is of sufficient importance to see professional help. Perceived need is also largely a social phenomenon which is influenced by social structure (e.g. education, occupation and ethnicity) and health beliefs (e.g. attitudes, values and knowledge about health and health services) (Andersen 1995). Hence for some clients, no matter how much a service tries to accommodate different requests, whether cultural, religious or otherwise, some people will choose not to access a service.

> *I got a next door neighbour, he's looking after his mum. I said: "Why don't you bring her here? We got people that speak Spanish in there." He said to me: "Oh, I don't think she's interested about these things." [I said:] "We all coming in there we happy. I'm asking you, come have a look. They have physio, it can help her. You don't have to stay here. We can look after her. We look after each other." He said: "No". Fair enough. (C02)*

And conversely, some people will continue to access services even if little, or no, accommodation of their 'difference' is made.

Enabling resources

Community and personal enabling resources must be present for service use to take place (Andersen 1995). Availability of health personnel and health care service facilities is important, in addition to people having the means and knowledge of how to get to these services and how to use them. Factors such as health insurance, income, travel and communication can be important. Travel and geographic location were rarely cited by study participants as a potential barrier, perhaps because MCHS delivers services at many different locations throughout the community.

Language and communication

Language and communication were identified as important factors to health service use by some client participants. This theme corresponds to two categories in Andersen's model: 'predisposing characteristics' and 'enabling resources'. When asked, the majority of participants did not feel like they experienced any language difficulties, and they were offered interpreters when needed. However, some felt that it was easier to communicate with staff that shared a similar cultural background and/or language as it was easier for them to explain things.

> *…like when I'm talking to the counselor, she's Turkish, I'm more comfortable. (C04)*

Although professional interpreter services were available, there were mixed responses in relation to their effectiveness.

> *We have used a few interpreters. Some of them are quite good. But, sometimes it can be a bit confusing. Yeah, they're quite good but sometimes if you can have a person that speaks Italian it's better because you not going from one person to another. (C03)*

For some participants the use of bilingual staff was preferable to professional interpreters.

Knowledge of available services

Some participants commented that the level of awareness of available services at MCHS and communication between program areas needed improvement.

> *How do you find out what is available within the service? I don't know if it's on a booklet or something that says all the services but I don't really know all the services that you offer... because a lot of people don't know what's available and making 50 thousand phone calls to find them. Like I did actually. I rang around a lot before I found out what the services actually can do. (C03)*

Difficulty finding information about the existence and availability of health services can be a barrier to accessing services. Promotion of services among existing clients and the wider community may improve access for some clients.

Feel/atmosphere of the organisation

Participants described the physical environment and atmosphere of MCHS' sites. Most were happy with the services provided by MCHS because they felt welcome, treated well and listened to.

> *It's a good environment, friendly people, so they wanna come in here. (C02)*

However, some participants felt that things had changed in the past few years and that it was more 'business-like' or 'corporate'. According to one participant, this affected her desire to use the services as she felt less comfortable.

> *I think things have changed since [they] become Merri. I liked it before it became Merri, because now it's got more of a business feeling to it. I thought before it was more friendly, a warm environment whereas now it feels more…what's the word I'm looking for? Um, more business orientated. (C07)*

Concerns about an increasing 'corporatisation' of the organisation were also mentioned by some staff participants. An understanding of the environment of a health service, both social and physical, can help us recognise and explain some factors that affect service use (Warin, Baum et al. 2000).

Environment

The Andersen model also acknowledges the external environment (including physical, political and economic components) as an important input for understanding health service utilisation. Broader systemic level elements such as the ‘Health Care System’, involving policies, resources, organisation, and financial arrangements, also impact on individual clients’ access and use of health services.

Health Care System

The Community Health model of health care service provision

Some participants commented on the inclusiveness of the organisation and the commitment of staff to their health and wellbeing. Client participants felt that staff at MCHS really cared about them and that they received better care compared to other health care organisations they had experienced.

> *Yes, beautiful, very good because I think health community look after you. That’s good. When you need it you come. Nobody stop you. You come by yourself and you see. (C01)*

The underlying values and culture of an organisation and how it manifests in their service delivery is an important determinant of the community’s use of services. In particular, if services are flexible and adaptable, and staff are welcoming of all different clients, then factors such as cultural background, that have been shown to be barriers to access in some instances (Graham, Bradshaw et al. 2009, Lee and Vang 2010), are no longer a concern.

Policies and procedures

Some client participants found the processes involved with making appointments and filling forms quite onerous. This was also identified as a potential barrier to access by some staff participants.

> *They tell me to ring this number to make appointment. What? Why do I have to ring this number? They have to do for me, to make appointment for me. (C12)*

Staffing issues (e.g. rearrangement of staff) were noted by some client participants as potentially having a negative impact on service accessibility.

> *I think things have changed since [the organisation] become Merri… just the atmosphere at the office and how they keep rearranging staff. (C07)*

The re-arrangement of staff has the potential to affect continuity of care.

External environment

Resources and funding of services

Some participants commented on funding restraints that were experienced by MCHS and which affected service provision. Some felt that the amount and types of services available had declined over the years, for example, less home visits. Most participants considered that this was beyond the control of the organisation as it was determined by outside agencies such as the government.

> *I wish that the government make… because Coburg is a big suburb and old suburb too and that's why they should give maybe… more money. They can make more better, more female physiotherapists, more rooms. (C04)*

The accessibility of health services is highly dependent on funding and resources. The availability, acceptability and convenience of services are also influenced by the requirements of funding bodies and government regulations. This is certainly the case for community health services, which are not-for-profit and provide services at no or low cost to clients.

8.4 Limitations

There were several limitations to this component of the study. Sampling for the client/carer participants did not extend beyond what was advised by the organisation's representatives. It is less likely that those with negative experiences would have been comfortable having their name on a contact list for providing feedback. However, some participants did provide some negative feedback in relation to MCHS. People in the community who were not clients of MCHS were not recruited, therefore there may be other unknown reasons people have for not using MCHS services.

It was not possible to purposively recruit participants with no or limited English language proficiency as information regarding preferred language spoken was not recorded on the list of clients prepared to provide health service feedback. All participants spoke English to some degree and some were born and raised in Australia (e.g. second generation migrants). Despite this, there was diversity in terms of cultural background, age, and gender. Caution is needed when applying the findings to non-clients, clients with no English speaking skills, or clients from other community health service organisations.

8.5 Conclusion

This chapter addressed research question 3 of the PhD study. It has presented the results of the interviews with clients/carers of clients from MCHS. The findings indicate that factors affecting community health service utilisation are multi-dimensional and multi-level. There were various potential barriers to service use identified by client participants: language and communication difficulties, long waiting lists, lack of knowledge of services available, cultural differences, feel/atmosphere of the organisation, and procedural issues such as making appointments. In addition, broader organisational/systemic level determinants such as resources and funding and the model of health service provision were also mentioned.

Clients’ cultural background did not appear to be a salient issue for the client participants. Although the interaction of these factors with culture, language and migration have the potential to negatively impact on service utilisation, it is possible that if the essential needs of clients are met, then their cultural needs are also largely met. Culture is often invisible and may only surface when problems arise, thus if clients’ needs are met then cultural influences may remain largely hidden. The type of health service being considered will affect the relative importance or impact of each factor/theme (Andersen 1995). Hence in the case of community health, which is inclusive of all clients regardless of cultural background, language, sexuality, age, and socio-economic status, individual predisposing characteristics may be of lesser importance than other factors.

This chapter also highlights the utility of an inductive approach to the study. If the interview questions only specifically focused on those related to a culturalist framework, then conclusions about the importance of cultural background may have been overstated. By employing a general line of questioning, it allowed the salient factors from the perspective of clients/carers to emerge. Decisions made by patients/clients to use health care services are based on multiple factors, of which culture may be only one. Some factors may be more influential than others in impacting the choice to seek health care services, and this may change depending on the nature of the health care need and services available.

Andersen’s model of health service use enables the conceptualisation of health service use for a particular group or population (or health organisation). It is also important to consider how these factors interact and influence each other. A health service organisation can use a framework such as Andersen’s model to examine the factors affecting service utilisation using staff and client/carer/community feedback. This can assist the design and implementation of programs/interventions to improve health service utilisation and health outcomes.

Chapter 9: Evaluation of the Cultural Competence Organisational Review (CORe)

9.1 Introduction

This chapter will address research questions 4 and 5 of the PhD study. The first section of this chapter describes the findings and outcomes from the implementation of the CORe at Merri Community Health Services (MCHS). The barriers and facilitators to the implementation of the CORe will also be discussed. The second section provides an evaluation of the CORe tool as an organisational cultural competence assessment tool using the key principles outlined by Olavarria et al (2009). The chapter will conclude with a discussion of the implications of the findings and recommendations for further research and evaluation in this area.

9.2 Findings and outcomes from the implementation of the CORe at MCHS

The CORe was implemented at MCHS between September 2011 and September 2013. Results of the staff surveys and document audits will be described, in addition to the economic costing of the CORe intervention. Findings from qualitative interviews with staff from MCHS will provide further insight into the experiences of implementing CORe at MCHS, in particular identified barriers and facilitators to implementation and organisational change.

9.2.1 Staff survey results

Cross-sectional surveys of staff perceptions of the organisation’s cultural competence provided a ‘snapshot’ at two time-points: baseline in September 2011 and follow up in July 2013. Ratings were assigned to each domain in order to provide an indication of the level of cultural competence rather than an absolute score.

Response rates

At baseline, 170 staff and management (response rate 57%) from MCHS participated in the CORe staff survey with 137 of 170 completing the survey in full. At follow up, approximately 18 months later, 109 staff and management from MCHS (response rate

33%) participated with 93 of 109 completing the survey in full. There were no significant differences in participant characteristics at baseline compared to follow up. As the survey was anonymous, responses were unmatched and treated as cross-sectional. The staff turnover at MCHS was 15.5% for 2012/2013 according to the Human Resources manager at MCHS (email communication). Demographic data obtained from the surveys were unable to be compared with human resources employee data for MCHS to determine sample representativeness because such data were not available.

Sample characteristics

At baseline, 24.7% of survey participants were board, executive or management compared with 22.6% of participants at follow up. At baseline, 72.0% of survey participants were born in Australia and 28.0% born overseas compared with 72.6% and 27.4%, respectively, at follow up. In relation to level of education, 14.7% of survey participants completed year 12 or less at baseline compared with 11.8% at follow up. See Table 9.1 for full details of participant information at baseline and follow up.

Table 9.1: Characteristics of participants in staff survey and responses rates

		Baseline, n	%	Follow up, n	%
Participants (response rate)		170	(57)	109	(33)
Role in organisation	Board/exec	3	2	1	1
	Management	34	23	22	22
	Staff-perm	110	73	73	72
	Staff-casual	3	2	6	6
Place of birth	Australia	108	72	74	73
	Overseas	42	28	28	27
Have contact with community	No	21	12	21	19
	Yes	129	76	81	74
	N/A	20	12	7	6
Time at organisation	Less than 2 years	42	28	39	38

	2 to 5 years	58	39	23	23
	6 to 10 years	27	18	22	22
	More than 10 years	23	15	18	18
Years of education	Year 10 or less	6	4	3	3
	Year 11	3	2	2	2
	Year 12 or equivalent	13	9	7	7
	Technical apprenticeship	20	13	17	17
	University degree	57	38	29	28
	Postgrad degree	51	34	44	43
Speak language other than English at work	No	123	72	85	78
	Yes	27	16	17	16
	N/A	20	12	7	6

Survey results

Findings are presented according to the organisational cultural competence domains addressed in the survey: ‘Organisational vision and values’, ‘Governance’, ‘Planning, monitoring and evaluation’, ‘Staff development’, ‘Organisational infrastructure and partnerships’ and ‘Services and interventions’. See Table 9.2 for a comparison of ratings[9] for baseline and follow up staff surveys.

Table 9.2: Baseline and follow up staff survey results

Domain	**Baseline 2011** **Overall level of cultural competence**	**Follow up 2013** **Overall level of cultural competence**
Organisational Vision & Values	Competence	Competence
Governance	Pre-competence	Near competence

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[9] ‘Rating’ used in this context refers to a categorisation rather than a numerical ranking.

Planning, Monitoring & Evaluation	Pre-competence	Near competence
Communication	Pre-competence	Pre-competence
Staff Development	Pre-competence	Near competence
Organisational Infrastructure & Partnerships	Pre-competence	Near competence
Services & Interventions	Competence	Competence

As indicated in Table 9.2, staff perceptions of MCHS' organisational cultural competence shifted to a higher category in 4 of 7 domains at follow up compared to baseline. For the domain 'Communication', the rating was 'pre-competence' at both time-points and for the domains 'Organisational vision and values' and 'Services and interventions', the rating was 'competence' for both time-points.

9.2.2 Document audit results

The document audit collected evidence about the organisation's policies and procedures that relate to cultural competence. The relevant information was collected by MCHS staff member(s) and assessed by Dr Pauline Gwartirisa from the Centre for Culture, Ethnicity and Health (CEH). Following the audit, ratings were assigned (by the CEH staff member) to each domain to provide an indication of the level of cultural competence rather than an absolute score. See Table 9.3 for a comparison of ratings for baseline and follow up document audits.

Table 9.3: Baseline and follow up document audit results

Domain	**Baseline 2011** **Overall level of cultural competence**	**Follow up 2013** **Overall level of cultural competence**
Organisational Vision & Values	Pre-competence	Competence
Governance	Near competence	Competence
Planning, Monitoring & Evaluation	Pre-competence	Competence

Communication	Pre-competence	Near competence
Staff Development	Pre-competence	Near competence
Organisational Infrastructure & Partnerships	Near competence	Competence
Services & Interventions	Near competence	Near competence

Comparison of document audits results at baseline and follow up indicated a positive change in organisational cultural competence in relation to policies and procedures in 6 of 7 domains. One domain, ‘Services and interventions’, remained the same at ‘near competence’.

9.2.3 Economic costing of CORe

The total cost of implementing the CORe at MCHS was $20,233. This includes time from a range of stakeholders (e.g. staff from MCHS, the University of Melbourne and CEH) and material costs. By far the greatest cost to the implementation of the CORe was the investment of time from a range of stakeholders, which came to a total of $19,983 within a 12-month period. This formed 98.8% of the total $20,233 total cost. Material costs (i.e. printing and survey administration) made up the remainder.

There were additional costs related to the research aspects of the CORe, which were mainly time involved to discuss the CORe at research team meetings by the full research team. These costs are classified as research costs and therefore not included in the total cost quoted above as these were not viewed as being part of an operational format of the CORe.

Limitations of economic costing

The reliability of the data is limited by the recall method of the data collection. All are estimates.

9.2.4 Action planning and implementation

During baseline and follow up CORe assessments, the findings and recommendations of the baseline CORe assessment were incorporated into the organisation’s Diversity Plan, which is a component of the organisation’s strategic plan. The Diversity Plan includes consideration of diversity related to (but not limited by): people from Aboriginal and Torres Strait Islander backgrounds, people from culturally and linguistically diverse (CALD) backgrounds, people with dementia, people living in rural and remote areas, and people experiencing financial disadvantage (including people who experience or are at risk of homelessness) (Victorian Department of Health 2011).

The strategies chosen to improve organisational cultural competence included: piloting and evaluation of staff cultural awareness training, participation in diversity initiatives, development of a clients' rights brochure, and inclusion of questions related to cultural competence in the Client Satisfaction Survey. Some actions are ongoing (beyond the initial 12-month period), such as strengthening of partnerships and collaborations with community groups and Aboriginal and Torres Islander agencies to improve service access for their members. The incorporation of strategies into an organisation-wide plan occurred with senior management support and reporting accountability. The CORe actions within the Diversity Plan were monitored as a part of quarterly Progress Reports written and submitted to the Department of Health Home and Community Care funding program.

9.2.5 Process evaluation – qualitative interview findings

Implementing change at the organisational level is challenging and there are numerous factors that have the potential to influence change within an organisation, for example, organisational culture, leadership, staff motivation and adequacy of funding/resources (Dogra, Betancourt et al. 2009, Beune, Haafkens et al. 2011). Findings from the qualitative interviews exploring the experiences of implementing the CORe at MCHS are presented as three main themes: leadership and commitment from management and staff across the organisation, implementation and dissemination, and resourcing.

Leadership and commitment from management and staff across the organisation

Leadership and commitment were nominated by participants as important determinants facilitating the implementation of the CORe at MCHS.

> *Commitment and engagement of staff across the organisation were also viewed as important because if staff aren't engaged then they don't value it. That's going to be a barrier." (S13)*

An organisational committee, which was established to drive this work, involved 'champions' across the organisation. In addition, executive level support was provided, which was also viewed as vital to the success of the process. Leaders set an organisation's strategic orientation/direction, which in turn determines how and where an organisation will invest its human and financial resources (Dreachslin, Jean Gilbert et al. 2013). Coordination and leadership at the higher level provided the necessary support for staff across the organisation to implement changes on the ground.

Variations in staff behaviour mean that even with strong policies and guidelines in place, individual practices across an organisation may differ. A few participants discussed the issue of organisational culture, viewing cultural change within an organisation as an "incremental" and "ongoing process". One participant felt that it was important to try and *"build a culture of cultural competence in the organisation… so if clinicians see other clinicians doing certain things or practices then they're more likely to… for it to become a norm"* (S13).

Implementation and dissemination

Participants noted that implementation of actions and communicating the work of projects such as the CORe to staff across MCHS was challenging for a number of reasons. Firstly, it was difficult to find time in staff's busy work schedules (e.g. clinicians seeing clients all day may not have time allocated for things such as cultural competence training). Secondly, there were logistical challenges related to the size and multi-site structure of the organisation, meaning that changes to practices and procedures were unlikely to occur uniformly across the entire organisation.

> *I don't think you can find a one size fits all about how you increase people's understanding (of cultural competence). (S14)*

Thus, there was a view that different approaches were needed depending on the program area and level of cultural competence amongst staff across the organisation.

Thirdly, organisational inertia was identified as an important factor. Organisational change appeared to occur at a slower rate than initially intended or planned. For example, there was a need to trial different cultural competence training approaches before rolling out more broadly across the organisation. Thus, participants reflected on the need to be strategic with actions in order to maintain staff engagement and positivity. Some actions need time in order to effect change, particularly cultural change within an organisation (Scott, Mannion et al. 2003). Sustained change is important, rather than a *"tick box kind of thing" (S12).*

> *It is very slowly evolving, and just the experience in trying to make a recommendation about cultural awareness [training] is a case in point I guess. Spend all this time gathering all this stuff together and presenting it and then, 'oh but, money's always an issue so if you could come away and give us another option'. You think you're working towards something and then something's going to happen but it's still just a matter within the process of it happening. (S11)*

Although there was some frustration with the perceived lack of progress with some actions, it was understood that the process of implementing organisation-wide changes would take longer than intended. This was considered alongside the danger of having "*people frustrated by the process*" and the need to keep people engaged whilst there was a *"sense of a momentum of change that is being built up and its quite positive in the organisation" (S12).*

The inclusion of the CORe within the MCHS Diversity Plan (also linked to the organisation's strategic plan) was significant because it provided a mechanism through which CORe's recommended actions could be incorporated within an over-arching plan and hence applied across the organisation. It resulted in cultural competence being viewed as an organisational priority and part of *"core business" (S14).* Monitoring and reporting requirements have helped with coordination of actions across the organisation.

Resourcing

Issues relating to resources and funding were identified as important factors for the implementation of the CORe as MCHS is a not-for-profit organisation and is reliant on external funding for its programs and projects. Provision of funding is often contingent upon organisations meeting specific criteria/requirements associated with service planning and delivery. Thus, review and monitoring by external accreditation bodies and applications for funding streams such as Home and Community Care are significant in providing incentives for organisational change.

According to the participants, community health services such as MCHS are required to continually apply for funding to sustain programs and services. Much time is spent working on funding submissions and meeting the programming and reporting requirements of grants. This in turn affects decision-making, prioritising, availability of services, and flexibility.

> *Resourcing and funding is a barrier to change because the focus is on clinical hours and number of clients… But with hard to reach groups there is more complexity which [we] can't capture or factor into the reporting. Changes mean less control for the organisation. (S14)*

Less control of how resources are used (i.e. decreased organisational autonomy) may result in compromises being made to service delivery in terms of less flexibility and adaptability in service provision. This can negatively impact on client health outcomes if the funding requirements do not align with client and community needs. More pressure is also being placed on the organisation in terms of increasing accountability and transparency. However, some participants viewed this in a more negative light than others. Some adopted a positive and optimistic outlook, using terms such as "efficiency", "business model", "demonstrate quality and impact", "evaluation" and "productivity" to describe the need to adapt to the *"sweeping reforms that are happening" (S14)* and to *"move with the times" (S13).*

The process of implementing the CORe at MCHS was challenging at times, for both MCHS staff and project team members, even with the presence of a strong organisational commitment to improving organisational cultural competence. Factors such as leadership, staff engagement, organisational inertia, organisational culture and resourcing were viewed as potential barriers or facilitators to the implementation of the CORe. Although individual staff or organisational committee(s) had the desire to implement programs, other drivers such as the government policy context, the leadership's strategic orientation/direction and availability of resources were critical to provide the necessary support and infrastructure for organisational change.

9.3 Summary

This section addressed research question 4. The results presented thus far provide information regarding the level of organisational cultural competence at MCHS at two time-points over the period September 2011 and September 2013 and the experiences of implementing the CORe. The survey and document audit findings at baseline indicated a moderate level of organisational cultural competence at MCHS. At follow up, there appeared to be an overall positive trend in organisational cultural competence for both policy and practice. However, the staff survey and interview data suggested some variability in perceptions of organisational cultural competence amongst staff at MCHS.

There were some discrepancies between the staff survey and document audit according to domain. For example, for the domain 'Governance', at baseline the staff survey was rated 'pre-competence' and the document audit was rated 'near competence'. This could indicate a lack of staff awareness/knowledge of the level of cultural competence embedded within policies related to governance. In contrast, for the domain 'Organisational vision and values', at baseline the staff survey was rated 'competence' and the document audit was rated ' pre-competence'. This could indicate that although a cultural competence plan was absent at the time, the staff felt that the organisation had a general commitment to respecting cultural diversity.

The results of the CORe need to be interpreted with some caution due to the limitations of the CORe tool. A clear limitation was that the ratings assigned to each cultural competence domain were not precise and required some subjective determination by the person/s conducting the assessment. The survey samples were unmatched and cross-sectional and the response rate was lower at follow up (33%) compared with baseline (57%), thus limiting representativeness. The document audit was completed by different MCHS staff (and primarily one person at each time point), thereby potentially impacting the responses. In addition, the survey questions and document audit indicators do not align exactly for each domain. For example, for the domain 'Services and interventions', the staff survey has two questions for this domain: 'to what extent does your organisation ensure services are accessible to culturally diverse communities?' and 'to what extent does your organisation expect you to take into consideration clients' cultural factors or migration related experiences in your service delivery?' whereas for the same domain in the document audit, there are eight indicators under the two sub-headings 'Client, family and community input' and 'Screening, assessment and care planning'. (The limitations of the CORe will be discussed in more detail in the next section).

Despite its limitations, the CORe was able to provide a mechanism for MCHS to conduct an organisational assessment and assist with planning actions to improve organisational cultural competence. The incorporation of the CORe within the Diversity Plan, in addition to having reporting accountability and senior management support, increased the likelihood of long-term change and enabled the provision of resources to implement the chosen actions. It is also important to recognise that this is an ongoing process that may involve overcoming barriers along the way such as lack of commitment/engagement amongst some staff and slow implementation/dissemination of changes. Conducting an organisational assessment can itself require considerable resources, mainly in terms of staff time. Thus, awareness of these issues and planning in advance is beneficial.

Conducting an organisational assessment (and taking steps to facilitate organisational cultural competence) can be a challenging endeavour for a variety of reasons. An assessment tool must be able to capture the multi-dimensional and multi-level nature of cultural competence, whilst also being user-friendly and effective in facilitating change across an organisation. The next section will provide a critical analysis of the utility of the CORe tool in assessing organisational cultural competence.

9.4 Evaluation of the CORe tool

As highlighted earlier in this thesis (Chapter 3), there are multiple tools available to conduct organisational cultural competence assessments. However, it is unknown to what extent they have been evaluated and what their impacts have been on organisations undertaking the assessments. Thorough evaluation and understanding of organisational cultural competence assessment tools is thus required. This section addresses research question 5.

According to Olavarria (2009), there are several features to consider when choosing a suitable assessment tool: i) its fit/alignment to cultural competence theory, guidelines or standards, ii) its reliability and validity, iii) its comprehensiveness, and iv) its practicality and feasibility. A self-assessment of organisational cultural competence must critically examine the attitudes, practices, policies and structures within an organisation (Olavarria, Beaulac et al. 2005). Tools that are valuable in this field are thorough as evaluation instruments but also provide a good blueprint for actualising cultural competence at the organisational level (Dreachslin, Jean Gilbert et al. 2013). Where possible, a set of standards or benchmarks should be identified and adopted in order to compare, monitor and evaluate changes in cultural competence. An evaluation of the CORe in relation to these key features is presented below.

9.4.1 Fit/alignment to cultural competence theory/frameworks

An organisational assessment tool should be underpinned by a strong theoretical basis. This may be an academic theory (e.g. Leininger's (2002) Culture Care Theory) or a set of theoretical or practice-based standards (e.g. National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare). If there is a set of standards/benchmarks that need to be applied, then the assessment should directly evaluate the attainment of these standards/benchmarks (Dreachslin, Jean Gilbert et al. 2013).

In the absence of Australian cultural competence standards such as the CLAS, the Teeth Tales project team drew on several models/frameworks to guide the design of the CORe: the Cross (1989) cultural competence model, the Australian National Medical Research Council's (2006) cultural competence guidelines and the Lewin Group's (2002) 'organisational cultural competence assessment profile'. The Cross model and NHMRC guidelines have been described earlier (see Chapter 4). The Lewin Group's (2002) assessment profile was used to guide the development of the document audit template in particular. It emphasises the use of multiple data collection methods and different response formats in organisational assessments to demonstrate rigor in conducting organisational reviews.

The development of the CORe was also informed by consultations and focus groups with health service providers, key stakeholders (e.g. community service managers) and community group representatives (e.g. non-government organisations representing refugee and migrant communities). This ensured that the questions and indicators used were relevant to organisations within the health and community sector in Australia.

9.4.2 Reliability and validity

Ideally, cultural competence assessment tools should undergo some level of empirical testing. However, reviews of organisational cultural competence assessment tools have noted that very few tools have been empirically tested (Harper, Hernandez et al. 2006, Trenerry and Paradies 2012). This may be due, in part, to the challenges related to the ability of organisational assessment tools to measure complex and multi-layered concepts such as cultural competence in the organisational context (Trenerry and Paradies 2012). Validity refers to the ability of an instrument to measure what it is intended to measure and reliability is the degree to which the questions consistently measure the same phenomenon on different occasions (Colton and Covert 2007). The validity and reliability of a measure is important because an assessment tool is of little utility if it is psychometrically unreliable or invalid (Olavarria, Beaulac et al. 2005).

The validity of a measure is dependent upon how we have defined the concept it is designed to measure (De Vaus 2002). Hence, it is essential that the developers of a tool and its respondents have a similar understanding of cultural competence. Concepts, such as cultural competence, are abstract summaries of whole sets of behaviours, attitudes and characteristics which we see as having something in common (De Vaus 2002). However, people may have different understandings of cultural competence depending on, for example, their professional practice and personal life experiences. As the CORe was designed by stakeholders and project staff working in the community sector, a shared understanding of organisational cultural competence was present. However, it is not certain that all survey respondents understood and responded to the measures uniformly.

One of the difficulties of developing valid questions is knowing how to interpret the potentially different meanings of people’s responses (De Vaus 2002). In the CORe survey, there was some ambiguity in the terms used in the questions. For example, question 19 asks: “*How often do representatives of diverse cultures actively participate in decision making within your organisation?*” ‘Actively participate’ and ‘decision making’ may be interpreted differently by different respondents. For example, one interpretation may be based on participation at executive level whereas another may be related to providing input into specific programs. ‘Representatives of diverse cultures’ may refer to diverse staff members, community leaders or people from non-government community organisations. Hence, it is possible that the same question can be interpreted and answered differently. Indeed, responses to this question by respondents from MCHS suggested a degree of ambiguity: 47.1% answered ‘don’t know’ and 14.7% did not choose a response. Understanding the results of this question is difficult as we cannot be exactly sure how respondents interpreted the question and the response categories. Hence, the use of more specific questions is required.

The reliability of a measure relates to whether a person understands or interprets a question or concept the same way on different occasions or whether there are other characteristics of the respondent that can influence their responses to a question (e.g. demographic factors such as age and sex). A significant event can change a respondent's opinion; for example, a new staff member may witness a negative interaction between a CALD client and staff member that may influence their responses to a cultural competence survey, particularly if it is administered very soon after the incident.

The wording of questions can also impact a measure's reliability. Asking questions on issues for which people have no opinion or have insufficient information can lead to inaccurate responses (De Vaus 2002). It is also advisable to avoid questions about which respondents are unlikely to have an opinion or knowledge or to ensure that 'don't know' options are provided. This option was included in the CORe survey for the majority of questions. The results of the survey showed relatively high percentages of 'don't know' for some questions (up to 55% at baseline). Rather than excluding these responses, a high proportion of 'don't know' is relevant in this instance as it can be an indication of a lack of cultural competence. For example, question 23 asks: "*To what extent does your organisation incorporate cultural competence in its plans?*" At baseline, 39% of respondents at MCHS answered 'don't know'. Thus, potentially highlighting a gap that could be addressed.

However, the inclusion of the category 'don't know' presented several challenges to statistical analyses. The decision of whether to exclude or include this response category in analyses was not straightforward. It may be easy to justify excluding a low percentage (e.g. 5% or less) of respondents choosing 'don't know'. However, a higher percentage may be relevant and necessary to include in the findings. As the survey was not pre-coded, it was problematic deciding how to utilise the category 'don't know'. If the choice was made to include the category and treat the variable as categorical (rather than ordinal or interval), then the range of statistical analyses available becomes more limited (De Vaus 2002). It could even be reasoned that the question be regarded as 'don't know' versus 'know' (combining all the other 4 categories, i.e. not at all, a little, a fair bit, a lot). However, this was also conceptually problematic as the reasons respondents chose ‘don’t know’ were potentially varied. The category ‘don’t know’ should be treated with caution because respondents may select this option for several reasons: genuinely don’t know, respondent fatigue, social desirability or because none of the alternatives are adequate (De Vaus 2002). As a result, such issues arising from statistical analysis of the staff survey data will have implications for further development of the tool (more detail provided later in this chapter).

9.4.3 Comprehensiveness

An organisational cultural competence assessment must be comprehensive in order to reflect the different organisational aspects involved in the delivery of services to CALD people. According to Olavarria et al. (2005), three key levels should be covered: the administrative level (i.e. governance), the service level (i.e. programs offered and their delivery), and the individual level (i.e. administrative and clinical staff). The CORe covers 7 key organisational cultural competence domains with 44 questions in the staff survey and 61 specific indicators in the document audit that cover the individual, administrative and service levels.

Tools should also be assessed for relevance to the health service context/setting as there is no one size fits all assessment tool that can be applied uniformly across organisations and settings (Olavarria, Beaulac et al. 2009). A key strength of the CORe was that it was developed specifically for the Australian health and community sector. Many of the available tools have been largely developed within the US context and their particular standards for organisational cultural competence.

Assessment tools that use a variety of response formats and include multiple methods for data collection are more likely to accurately reflect actual practice (Trenerry and Paradies 2012). The response format of questions has important implications for the depth and breadth of information assessed and the potential for bias. The CORe survey utilised different response formats depending on the type of question. Knowledge questions such as question 20: “*Does your organisation have policies that support cultural competence?*” had the response categories ‘yes’, ‘no’ and ‘don’t know’. Perception/opinion questions such as question 15: “*To what extent do you think the organisation’s vision and values reflect the diversity of the community?*” had the response categories ‘not at all’, ‘a little’, ‘a fair bit’, ‘a lot’ and ‘don’t know’.

9.4.4 Practicality and feasibility

An important element of an assessment tool is that it is practical and feasible. This includes features such as the user-friendliness of the tool and whether academic concepts have been translated into terms that are relevant to organisations within their particular and unique organisational settings (Trenerry and Paradies 2012). This also encompasses the accessibility of the data to be collected and whether the information requested can be collected in a timely and inexpensive way (Olavarria, Beaulac et al. 2005). It needs to be accurate and comprehensive, yet also straightforward and efficient.

Feedback at MCHS staff meetings indicated that completion of the survey and document audits were relatively quick and straightforward. The use of a low-cost online survey program assisted with survey administration and data collection. The staff survey was anonymous and confidential to reduce the effect of social desirability bias and in recognition of high turnover in many community-based organisations. However, this prevented a longitudinal analysis. In addition, representativeness of findings is limited by the voluntary nature of participation (although all staff were invited to participate).

The CORe was a pragmatic and straightforward tool that collected limited information to assess organisational cultural competence and guide the design, implementation and monitoring of strategies to improve cultural competence. A more comprehensive assessment could be conducted by an external agency but this may be beyond the resources and capacity of not-for-profit community service organisations.

9.4.5 Additional considerations

Moving beyond self-assessment has been identified as an important aspect of cultural competence and organisational assessment, as factors such as social desirability bias may result from self-administration (Trenerry and Paradies 2012, Truong, Paradies et al. 2014). Organisational assessments that include a process for documenting and discussing practices, processes and outcomes is preferable to those that rely entirely on self-assessment (Trenerry and Paradies 2012). Gathering information from multiple perspectives will also provide a broader view of an organisation and the use of external facilitators can assist in reducing bias by providing some independence to the assessment process. The use of subjective measures only may lead to confusion between organisational intent and practice (Bowen 2008). The implementation of the CORe at MCHS involved external facilitators as part of the Teeth Tales study, however this may not be a feasible option for some organisations with limited resources.

The CORe tool could be enhanced by the addition of a mechanism to obtain and incorporate client and community feedback into the findings and subsequently to inform action planning. Whilst client and community feedback was used to inform the development of the CORe, obtaining client feedback was not part of the survey or document audit. However, if organisations have existing client feedback mechanisms in place, they can use these results to inform the assessment and action planning. Inclusion of a tool to collect client/community feedback may be of value for organisations that do not have pre-existing tools/mechanisms for obtaining such information.

Despite its limitations, the CORe shows promise as an organisational cultural competence tool. The implementation of the CORe at MCHS has demonstrated that it is a practical and feasible tool that can provide an assessment of organisational cultural competence in terms of policy and practice. It highlighted MCHS' strengths and areas for improvement and provided a mechanism for action planning and regular monitoring. This appears to be lacking in other organisational assessment tools (Bowen 2008, Cherner, Olavarria et al. 2015).

9.4.6 Limitations

There are some limitations to this evaluation of the CORe. First, there is a degree of subjectivity in the assessment of the tool as it is largely reliant upon the experiences and observations of the PhD candidate in the course of undertaking the study. There may be different/contrasting experiences unknown to the candidate that may inform the evaluation. Second, a standardised or formal evaluation instrument was not available/found that was relevant and appropriate to use in this context. However, a range of information sources was used to inform the evaluation (i.e. review of written and verbal documentation, interviews, observations, survey data and review of literature).

9.5 Summary

The basic challenge of any measurement/assessment of organisational cultural competence is to reliably and accurately capture it’s meaning in a way that is both practical and feasible (Geron 2002). This evaluation of the CORe as an organisational cultural competence assessment tool provides evidence of its usefulness at a medium sized community health service, while acknowledging its limitations. This information can be used to inform further development of the CORe and other organisational cultural competence assessment tools. The key strengths of the CORe are: use of multiple methods to collect information (staff survey with quantitative and qualitative items, and a document audit), user-friendliness (i.e. relatively quick and straightforward to administer), contains resources to assist with action planning, and has capacity for regular monitoring and review to evaluate organisational change.

On the other hand, the CORe does not provide a comprehensive assessment. The staff survey was designed to capture staff perceptions of organisational cultural competence rather than provide an objective measure and it is cross-sectional rather than longitudinal. However, it may be modified to enable longitudinal comparison while maintaining respondent confidentiality. Results are a simple summation of scores in each section that are not weighted to reflect potential differential impacts within or across sections. The document audit was limited by the senior staff member’s knowledge of the range of organisational policies and procedures and it is not a content analysis of actual documents/plans or an assessment of the extent of implementation of policies and procedures.

In relation to the CORe results, the subjective nature of the ratings means that it provides an indicative rather than absolute score. Organisations are encouraged to discuss the findings and ratings and to develop a consensus on the meaning of items and the actions they can take in response to the assessment within the context of their organisation. The CORe was designed to provide a mechanism for organisational reflexivity, highlighting strengths and identifying gaps in order to provide an impetus for action to improve organisational cultural competence. The implementation of the CORe at MCHS was able to achieve this as it assisted MCHS in devising strategies to improve access and service delivery for CALD clients. Follow up approximately 18 months later indicated an improvement in staff perceptions of organisational cultural competence and improvement in policies and procedures.

Quantitative data analysis beyond descriptive statistics may be useful from an academic perspective, but may not be of relevance or be meaningful to the organisations undertaking the assessment. For example, the criterion for assessment on a Likert-type scale and resultant scores are largely subjective and it may be ambiguous as to what a particular score indicates (Trenerry and Paradies 2012). A numerical score may not be meaningful unless there is a standard benchmark with which it can be compared and/or some explanatory context and background. As cultural competence is a process and continuum rather than a finite endpoint, the main goal is for the organisation to be moving in a positive direction.

9.6 Recommendations for future development of the CORe

At the time of writing, the CORe tool is available online (at no cost). It is also being revised with plans to convert it into an interactive online assessment tool to be administered by CEH, a partner in the development of the CORe. The PhD candidate has been in discussions with CEH staff to assist with further development of the tool. CEH intends the CORe to have the capacity to provide organisations with a numerical score/rating. In light of this, the PhD candidate has made the following suggestions during discussions with CEH:

- Re-consider each item in the staff survey and document audit to ensure its usefulness as an indicator of organisational cultural competence in light of any new policy or planning requirements. Re-word items to enhance clarity if required.
- Consider converting the staff survey and document audit into multi-item summative scales (via a scaling process) to provide numerical values associated with rating items that can produce a total score or composite scores (Colton and Covert 2007).
- Conduct psychometric testing of measures to demonstrate validity and reliability. For example, use of item analysis or factor analysis to ensure the questions are a good measure of what they are intended to measure and test-

retest reliability which involves testing the survey with the same group on two separate occasions to see if their responses are the same or very similar.

- Review document audit indicators for overlap or cross-over to reduce the amount of indicators overall.

In addition, it was recommended that a client/community feedback tool (new or existing resource) be included or referenced on the website.

9.7 Conclusion

This chapter addressed research questions 4 and 5 of the PhD study. The findings indicate that conducting an organisational assessment of cultural competence can be a complex undertaking given the multi-dimensional and multi-level nature of cultural competence. However, organisational reflexivity is an important aspect of cultural competence as it allows an organisation to measure its strengths and identify areas for improvement in relation to how they are effectively addressing the needs of CALD groups in the community. An assessment can provide a baseline from which future work can be implemented, monitored and evaluated. As cultural competence is a continual process, an assessment with regular monitoring and evaluation allows for strategic planning with short and long term goals.

Findings from qualitative interviews indicated the importance of leadership and commitment from management and staff to ensuring successful implementation of the CORe. Receptivity to the findings of an assessment and having sufficient interest to motivate further action in developing cultural competence is vital. Factors such as organisational inertia and flexibility in approaches are also important, in addition to having adequate resources for implementing new programs or procedures. Future research on the organisational conditions that increase the likelihood of organisational change may be beneficial.

This evaluation of the CORe addresses an important gap in the literature as it can inform the future development and refinement of such tools to improve their effectiveness, accuracy and relevance. Future research could involve evaluating the CORe as a self-guided assessment process. Despite the challenges and limitations of organisational cultural competence assessment tools, they are important in providing a mechanism for organisational reflexivity and building support and awareness for further work in the area. In addition, they enable the measurement of change over time and can create a metric for quantifying cultural competence and permitting comparisons between organisations.

Chapter 10: Discussion

10.1 Introduction

The aim of this PhD study was to deepen the understanding of the significance of cultural competence in community health within Australian contexts, and provide recommendations for further work in this area. Preceding chapters have reviewed the existing evidence relating to cultural competence and presented the results of a case study investigating cultural competence at a community health service from client, provider and organisational perspectives. Additionally, an evaluation of the utility of an organisational cultural competence assessment has also been presented.

The background/literature review in Chapters 2 and 3 identified a need for further research examining the multi-dimensional and multi-level aspects of cultural competence in community health and the gap in evidence related to organisational cultural competence evaluation. Chapter 4 provided the conceptual framework underpinning this research and Chapter 5 outlined the study design and research methods utilised. Chapter 6 consists of a systematic review of reviews of cultural competence interventions in health care. Chapters 7 and 8 presented the findings from qualitative interviews with staff and clients of Merri Community Health Service (MCHS) and Chapter 9 presented the findings of the implementation of an organisational cultural competence assessment at MCHS as well as an evaluation of its utility as an organisational assessment tool.

This chapter integrates key findings from this PhD study with those from the relevant empirical and theoretical literature. A conceptual model representing the ‘influences on community health service utilisation by people from CALD backgrounds in Australia’ will be presented. In addition, the ‘congruency of community health and cultural competence’ will be discussed within the context of change and uncertainty in the community health sector. This is followed by a section on ‘diversity and intersectionality’ which examines whether increasing globalisation, migration and hybridity of citizens necessitates a broader diversity lens, rather than a focus solely on culture per se. The topic of ‘patient/client-centred care’ and how it relates to cultural competence will also be remarked upon. This is followed by a section on ‘cultural reflexivity’ and a discussion related to ‘organisational considerations’. The chapter concludes by considering the strengths and limitations of this research alongside its implications for research and practice.

10.2 Influences on community health service utilisation by people from CALD backgrounds: a conceptual model

This thesis has addressed several research objectives and highlighted the importance of individual, organisational and system level factors that can influence community health service utilisation by clients/carers from CALD backgrounds. Consideration of these factors can assist with the design and implementation of strategies to improve organisational cultural competence.

It is important to recognise that cultural influences are often implicit in people's behaviours, as unconscious, shared predispositions, rather than deliberate attempts to be distinctive (McMurray and Clendon 2011). Behaviours and beliefs are not always expressed in the same way by all who claim memberships in a cultural group, despite there being some commonalities amongst members. Additionally, individual expressions of attitudes, beliefs and behaviours will vary according to age, gender, personal experiences, circumstantial factors, and they are, in turn, influenced by family, group and community influences (McMurray and Clendon 2011).

However, culture does play an important role in health care provision and utilisation as cultural differences between patients/clients and health providers/organisations are associated with racial/ethnic health inequities (Chapter 3). Thus, reducing health inequities experienced by CALD groups involves recognising and addressing the role that cultural background plays in health care provision and utilisation.

To explain the interrelationships and interconnections between the multi-level factors influencing the provision of culturally competent health services within the community health context, a conceptual model is presented based on the findings of this study and elements of the conceptual framework (Chapter 4)- Figure 10.1 p.191. The model also draws on McLeroy et al.'s (1988) ecological framework for health promotion (informed by Broffenbrenner's (1979) ecological framework) and is structured in layers from individual (in the centre) to systems (outermost layer). In doing so, it shows how these factors can act as facilitators or barriers to health service utilisation for people from CALD backgrounds in one single consolidated model.

The conceptual model places the individual at the centre (as does Andersen's behavioural model of health use), which contrasts with other organisational cultural competence models which position the provider or organisation as the central focus (for example, see National Health and Medical Research Council (2006) and Castillo & Guo (2011)). The model shares some similarities with Fung et al.'s (2012) organisational cultural competence framework which shows the interactions between patients, services providers, communities and the health care organisation but is broader as it encompasses other community level factors such as funding bodies and relationships with other health and social service agencies, and macro/system level factors such as public policy and regulations. The model also shares similar levels of influence in relation to interventions to reduce racial health inequities as outlined by Chin et al. (2012).

The layers of the model (from innermost to outermost) are:

- Patient/client level influences (e.g. clients' personal characteristics)
- Interpersonal level (e.g. provider/client interactions)
- Organisational level (e.g. vision and values, leadership, policies & procedures)
- Community level (e.g. funding, political context, community demographics)
- Systems (e.g. structure of health system and positioning of community health model)

Figure 10.1: Multi-level and multi-dimensional influences on community health service utilisation by people from CALD backgrounds in Australia (Truong 2016).

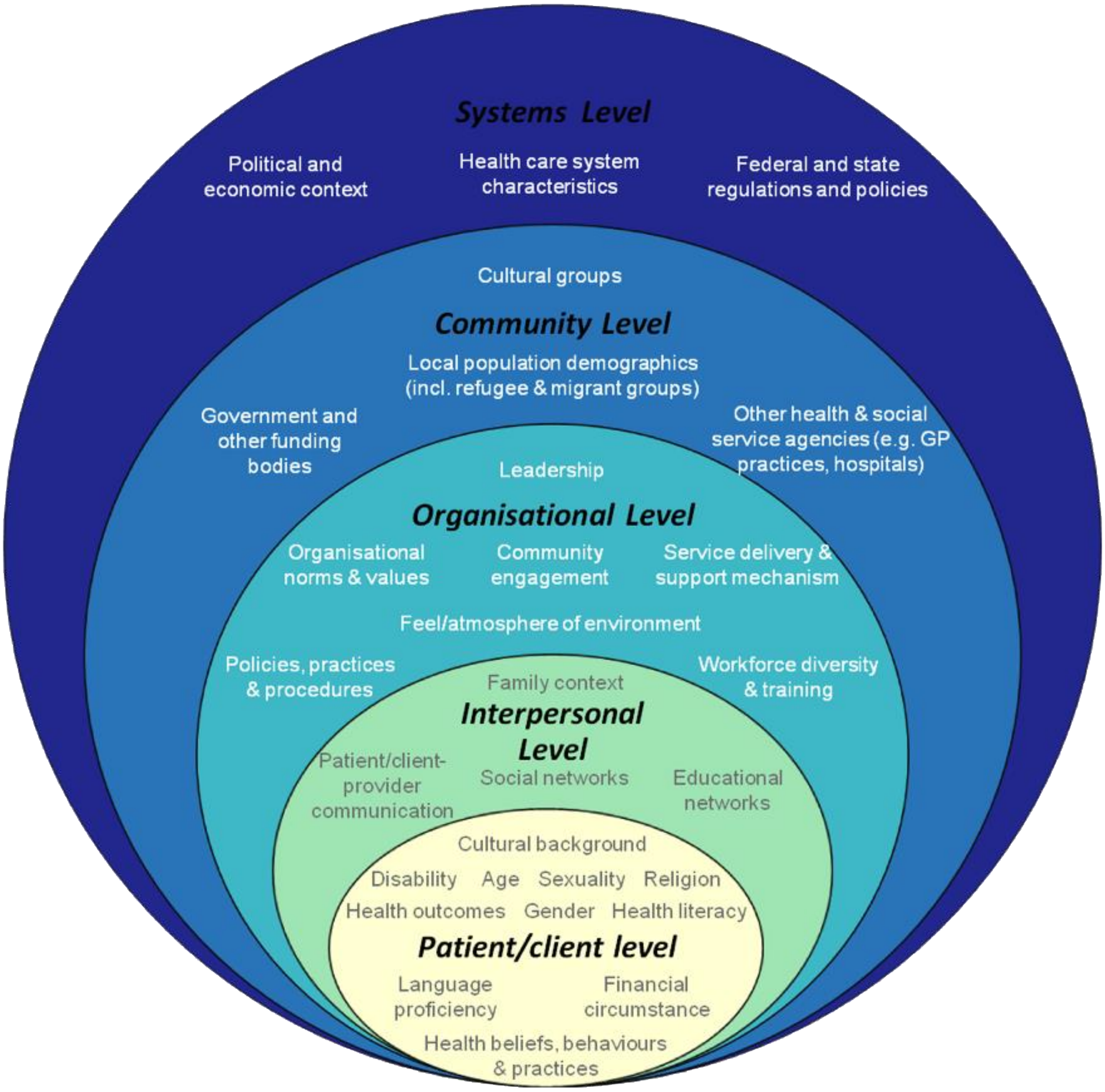

Figure 10.1 lists the potential (but not exhaustive) factors within each layer of the conceptual model. At the ‘Patient/client level’, it is important to consider the personal context that influences an individual’s decision to use a health service such as cultural background, geographic location, financial situation, health literacy, English language proficiency and religion. For example, if a patient/client is from a particular religious group which limits interactions based on gender, then the person may not use the service if their requests for specific practitioners (e.g. female or male) are not met.

At the ‘Interpersonal level’, factors such as family context, social networks and client-provider communication may also be influential. For example, if friends or family members recommend or provide encouragement to use particular services then it may persuade an individual to make an appointment. Interactions with friendly and caring staff may also increase the likelihood that follow up or future appointments are attended.

The values, policies and practices of an organisation (‘Organisational level’) can determine whether clients from CALD backgrounds feel comfortable utilising services. An organisation that values and respects cultural diversity can engage with clients and/or community groups to review the appropriateness and relevance of their services.

The broader ‘Community level’ is also an important influence on health service utilisation. The availability and sustainability of funding for interventions to improve cultural competence are important. In addition, strong relationships with other health and social service agencies (e.g. refugee and migrant services, councils) are vital in addressing other social determinants of health. Furthermore, factors at the ‘Systems level’ are vital because the use of regulatory policies, procedures and laws can determine the health of the community (Kickbusch and Gleicher 2012). For example, policies (such as giving refugees priority access to services) can affect access to health service resources through the establishment of eligibility criteria and restrictions on how funds can be used.

Decisions made by patients/clients from CALD background to use health care services are based on multiple factors, of which culture may be one amongst many. Hence, the use of a model that situates the patient/client in the middle with the different levels/layers is necessary to ensure that the patient/client’s unique context is recognised and taken into consideration rather than assumed to be largely determined by individual cultural factors. A social ecological perspective integrated with a cultural competence framework emphasises the multiple dimensions (e.g. physical, social and cultural environment, personal attributes), multiple levels (e.g. individuals, groups, organisations), and complexity of human situations (e.g. cumulative impact of events over time) (McLaren and Hawe 2005). There is an assumption of interaction and connectedness among the levels and therefore improvement at the individual level is dependent upon action at the other levels.

The conceptual model presented here can be utilised by community health organisations in Australia and other similar organisations within the health and community sector as a reference or guide for considering issues that impact on health service utilisation by people from CALD backgrounds. This may assist with the design of interventions to improve cultural competence and further research in the area.

10.3 Congruency of community health and cultural competence

Whilst the qualitative study in this PhD study was originally conducted in order to understand the impact of cultural background on health service utilisation by members of CALD groups, it emerged that clients were much less conscious of the impact of their cultural background on health service utilisation compared with staff. This suggests that if clients' essential needs are met, then issues related to cultural background play a less significant role. Overall, client participants were very positive about their experiences at the community health service, and staff were positive about their interactions with their CALD clients. Clients were not made to feel different or othered, therefore they felt comfortable with the health services. This contrasts to patients/clients in other similar studies (Shahid, Finn et al. 2009, Marino, Minichiello et al. 2010, Komaric, Bedford et al. 2012, Beach, Saha et al. 2016). A review of barriers to health service utilisation found that many of the barriers identified by studies of ethnic minorities were 'universal' in nature and can affect any individual, such as long waiting lists (Scheppers, van Dongen et al. 2006).

Conditions within social environments provide the context for interactions between persons and their environment. Individuals are more likely to feel empowered and in control of their life and their health within a supportive social environment. People are less able to access health resources if they are disadvantaged and/or disempowered. Thus, an organisation that demonstrates a commitment to providing services to a diverse community can create an environment whereby clients feel comfortable accessing services. For example, a qualitative study exploring client views of cultural competence in primary health care encounters in New Zealand found that 'feeling welcome and acknowledged' was important for participants when utilising health care services (Thomas 2007). Such a welcoming environment helps to build trust between patients and providers, with patients who trust their providers being more likely to adhere to treatment and attend follow up appointments (Trachtenberg, Dugan et al. 2005, Wroth and Pathman 2006, Nguyen, LaVeist et al. 2009).

The vast majority of client participants in the qualitative study found the organisation to be welcoming and friendly. However, some staff and client participants felt that the organisation had changed over the years and had more of a “business-feeling” and was more “business oriented”, which was viewed unfavourably because it was associated with being less warm and friendly and less client-focussed. Some staff participants also felt that the climate of community health was changing and becoming more corporate. There have been concerns (since the 1990s) of changes that have resulted in a shift in Australian community health services from primary health care to primary medical care, requiring services to function in more clinical, illness-oriented roles rather than their more traditional community and public heath roles (Thompson and Dunn 2002).

The incorporation of a corporate/business approach in the health care sector came about due to the increasing dominance of neoliberalism[10] in the 1970s and 1980s. Whilst neoliberalism was initially directed towards the financial and commercial sectors, it came to promote a market economy in social sectors such as health care, education and social security, which were formerly the responsibility of the state (Sanders, Baum et al. 2011). The dominance of market-oriented policies in industrialised countries has influenced the design of health reforms. The use of economic frameworks such as cost-effectiveness analysis to define priority interventions enables governments to make rational economic choices and prioritise services. However, its use also narrows the scope of primary health care to a set of technical interventions that ignore the determinants of ill-health and exclude comprehensive approaches (Sanders, Baum et al. 2011). Such market-oriented health reforms have had an adverse impact on the potential for primary health care to be implemented effectively and have undermined health care provision in the public sector (Koivusalo and Mackintosh 2004, Commission on Social Determinants of Health 2008).

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[10] Neoliberalism refers to an approach that emphasizes the value of free market competition in which the control of economic factors is shifted from the public sector to the private sector. It advocates for freedom of trade and capital with minimal state/government intervention, adhering to the view that the free market provides the most efficient allocation of resources.

As highlighted by this PhD study, community health organisations are not immune from increasing commercialisation within the health sector. Although there were mixed views among interview participants on the impact of a more business-orientated approach within community health, there should be an awareness that commercialisation in the health sector is associated with higher levels of ill health and exclusion (Koivusalo and Mackintosh 2004). When health care is viewed as a commodity rather than a public good, the functions of community mobilisation, intersectional action and advocacy are unlikely to be rewarded or encouraged by the broader health system (Sanders, Baum et al. 2011). This presents a threat to the community health sector, which operates from social ecological models that address broad determinants of health to promote health equity rather than focussing on narrow interventions.

Community health sector values are grounded in philosophical beliefs of social justice and empowerment, which are congruent with health promotion principles (Chapter 4). The core values underpinning community health are also largely congruent with providing culturally competent care. For example, ensuring services are culturally and linguistically appropriate, being proactively responsive to the cultural and linguistic diversity of individuals, families and communities within the catchment area, and working in partnership with local communities (Victorian Department of Health 2014).

Earlier in Chapter 2, the following issues were raised: i) are patterns of health care seeking determined more by cultural beliefs and practices or by system-related barriers to access, and ii) is the goal to improve health service access for people from CALD backgrounds to mainstream services or to provide a variety of health services that can reach different populations?

The findings of this PhD research indicate that these should not be ‘either/or’ questions. Both cultural beliefs and system-related barriers have an impact on service provision and utilisation for people from CALD backgrounds. System-related barriers were more frequently identified as barriers to community health service utilisation than cultural differences in this case study. Access to mainstream primary health services for people from CALD backgrounds should have some flexibility and adaptability to cater for as broad a range of people as possible, *in addition* to providing a variety of health services. Thus, primary health care should continue to be delivered through different service providers, including community health organisations.

Victoria is fortunate to have an established network of community health services (32 independently registered and 56 as part of public health services e.g. hospitals) (Victorian Department of Health & Human Services 2015). However, funding uncertainty in the sector has the potential to adversely affect the most marginalised and disadvantaged in the community (Cohealth 2014). The continuation of community health services is vital in order to ensure the delivery of integrated, comprehensive and inclusive primary health care that is available to all, irrespective of race, religion, social status and other factors, including ability to pay for care (Community Health Australia 2011). A community-oriented primary care model that is highly committed to equity and social inclusion (with special attention given to the most vulnerable) is also well placed to address other areas of diversity, as explained below.

10.4 Diversity and intersectionality

During the process of implementing the CORe, particularly during the action planning process, MCHS contemplated cultural competence within a broader framework of 'diversity'. Staff in the committee reflected that other groups in the community may also have difficulty accessing services, such as GLBTI (gay lesbian bisexual transsexual intersex) people and that addressing different aspects of diversity, not only 'cultural', would be more appropriate. This may be due in part to the increasing momentum within the Australian health care policy context towards addressing diversity and discrimination in the community (Victorian Department of Health 2011, Victorian Auditor-General 2014). For instance, the Health and Community Care (HACC) program in Victoria (funded by the Victorian State Government) established a HACC Cultural Planning Strategy (in 1997) to support HACC-funded organisations to better meet the needs of HACC-eligible people from CALD backgrounds. This program was evaluated in 2007 and the Department's response to the recommendations of the evaluation was to focus on diversity in a broader sense (Victorian Department of Health 2011). Subsequently, a policy of Diversity Planning and Practice was developed in 2011 to guide organisations and services such as MCHS in applying a 'diversity lens' when planning to improve equity of access to services in consideration of diverse characteristics such as age, sexual orientation, cultural background, gender identity and socio-economic status (Victorian Department of Health 2011).

This shift from a culturalist framework to a diversity orientation also coincides with increasing interest and scholarship in the field of intersectionality, which refers to the study of multiple and intersecting systems of oppression and privilege (Hankivsky and Christoffersen 2008). It proposes that "gender, race, class and sexuality simultaneously affect the perceptions, experiences, and opportunities of everyone living in a society stratified along these dimensions" p.179 (Cole 2009). Different social categories depend on each other for meaning, and thus, mutually construct one another and interact to shape outcomes (Cole 2009, Bauer 2014). Thus, it is not enough to focus on a single dimension.

Intersectionality aligns with social constructionism, arguing that categories such as race, gender and class are socially constructed (Mullings and Schulz 2006). Thus, it frames social inequities as the result of the intersection of differences that are generated and maintained by individuals, communities and institutions. An intersectional approach can be used to better understand health inequities based on race, class and gender. According to Kelly (2009), the integration of intersectionality theory within the biomedical paradigm in research on health inequities has the potential to assist in eliminating health inequities as it incorporates the complexity of individuals' differences in the conduct of clinical research. In addition, it brings direct attention to the role of social and political power in creating social injustices that create and maintain health inequities.

Furthermore, some have advocated for the integration of intersectionality theory to better understand the social determinants of health (Hankivsky and Christoffersen 2008), immigrant health in the United States (Viruell-Fuentes, Miranda et al. 2012) and population health research (Bauer 2014). The incorporation of intersectionality into cultural competence education has also been recommended (Powell Sears 2012).

Given the multiplicity of factors and influences that form and shape peoples' lives, what is actually important or causative varies in every context and situation (Barn 2008, Hollinsworth 2013). Although culture and ethnicity may be significant, they do not completely represent the various categories of meaning that actively create and sustain the health experiences of patients/clients (Powell Sears 2012, Kang and Bodenhausen 2015). Therefore, by solely focusing on culture (through cultural competence), other social categories such as social class, sexuality and age, which also influence health experiences and outcomes, may be ignored or understated (Powell Sears 2012).

The intersectionality paradigm has been applied in areas such as HIV/AIDS to facilitate better understandings of under-researched groups and relationships, and to inform the design of interventions. For example, a study by Collin et al. (2008) illustrated the complex interconnections between race/ethnicity, gender, class and the stigma of mental illness and its implications for HIV risk. An intersectional perspective was used to tackle masculinities and structural factors (e.g. race and class inequalities) that shape health in the Making Employment Needs Count pilot program (Raj, Dasgupta et al. 2014). The program demonstrated the potential effectiveness in addressing behavioural and structural risks for HIV among African American heterosexual men by providing ‘gender-equity counselling’ combined with assistance obtaining or maintaining stable housing and employment (Raj, Dasgupta et al. 2014).

Furthermore, using a diversity lens may be more relevant and appropriate moving forward given globalisation and the increasing hybridity of citizens across the world. This is particularly pertinent in countries such as Australia and the United States, which have a long history of immigration, where the population consists of both recent arrivals and long standing migrants (going back several generations). Thus, individuals who share the same CALD background may have different social statuses, experiences and needs depending on factors such as immigration status, intergenerational social class, education and geographic location.

Whilst it is acknowledged that an intersectional paradigm introduces further complexity by moving beyond singular categories of identity, it may be a more effective approach to reducing health inequities by addressing the structured inequalities and power differentials in society that occur across different dimensions. Thus, it has the potential to create more accurate and inclusive knowledge of the diverse health experiences and needs of people which can inform the development of systematically responsive and socially just health systems and policies (Hankivsky and Christoffersen 2008). An intersectional framework can also be used as a guide for teaching, research and clinical practice in health care as it can align with patient- or client-centred care and help to overcome the problem of cultural essentialism in cultural competence (Powell Sears 2012).

10.5 Cultural competence and patient/client-centred care

Patient- or client- centred care has been promoted as a way of improving health care access and quality for people from CALD groups (Beach, Saha et al. 2006, Epstein, Fiscella et al. 2010). In patient-centred care, the health care provider elicits and engages a patient/client's values, beliefs and experiences, including cultural values and perspectives, to individualise the care they provide (Hunt 2009). Thus, "patients are known as persons in the context of their own social worlds, listened to, informed, respected and involved in their care" (p.100) and are helped to be more active in their health care journey (Epstein and Street 2011).

Although patient-centred care and cultural competence have grown out of separate traditions, they have many similarities (Beach, Saha et al. 2006, Hera 2013). Patient-centred care focuses on how practitioners should interact and communicate with patients to evaluate health care from the patient's perspective and then adapt care to meet the particular needs and expectations of individual patients. On the other hand, cultural competence evolved in response to addressing cultural and linguistic barriers between providers and patients/clients with the ultimate goal of eliminating racial/ethnic health inequities. Both frameworks aim to improve quality of care, however, the primary goal of the patient-centred care movement is to provide individualised/personalised care whereas the cultural competence movement aims to increase health equity by focussing on disadvantaged CALD groups (Beach, Saha et al. 2006).

In the qualitative study, some staff participants questioned the utility of cultural competence and suggested that an individualised, rather than a culturalised, approach may be more appropriate and relevant. One participant mentioned treating people with universal values such as 'respect' and 'dignity' regardless of cultural background, particularly as she felt that she could not be expected to know everything about every culture and also that it was not necessarily relevant for every client. This understanding of cultural competence appears to be based on a categorical or 'list of traits' approach to cultural competence.

It is widely recognised in the field of cultural competence that a categorical or 'list of traits' approach is problematic and unhelpful (Kleinman and Benson 2006, Jenks 2011, Hollinsworth 2013). Thus, a patient-centred care approach would be more effective at the interpersonal level rather than a categorical-type cultural competence approach. More recent approaches to cultural competence focus on basic communication skills, awareness of cross-cutting cultural and social issues, and health beliefs that are present in all cultures (Epner and Baile 2012). These can be considered as 'universal' human beliefs, needs, and traits. This approach relies on identifying and negotiating different styles of communication, decision-making preferences, roles of family, sexual and gender issues, and issues of mistrust, prejudice, and racism (Betancourt 2006, Kleinman and Benson 2006, Jenks 2011).

While both patient-centred care and cultural competence address issues related to health care at the organisational and system level, the former focuses on more general aspects of health care quality such as flexibility with appointments and obtaining patient feedback. On the other hand, cultural competence also includes attention to issues related more specifically to barriers experienced by CALD groups such as language assistance for patients with limited English proficiency.

The alignment of efforts to improve cultural competence and patient-centred care have the potential to improve health care provision for all patients, not just those from a CALD background. A systematic review of the effectiveness of cultural competence programs in ethnic minority patient-centred health care by Renzaho et al. (2013) found that, amongst 13 included studies, patient-centred care programs that incorporated a cultural competence component increased practitioners' knowledge, self-reported practice and patient satisfaction. However, no studies reported any significant findings in relation to patient health outcomes. In consensus with the systematic review of reviews in this PhD study (Chapter 6), more research is needed to establish whether patient-related health outcomes are improved as a result of cultural competence and patient-centred care interventions.

In summary, a cultural competence framework that incorporates principles of patient-centred care (at the interpersonal level) to avoid stereotyping and essentialising patients/clients may be more effective and acceptable to both providers and patients/clients than a categorical approach. Health care organisations and providers can adopt both patient-centred care and cultural competence so that health care services meet the needs of all patients, including CALD groups and those of other disadvantaged groups (Beach, Saha et al. 2006). At the broader organisational, community and system levels, a more focussed approach on addressing the specific barriers to health care provision and utilisation by disadvantaged members of CALD groups would be appropriate.

10.6 Cultural reflexivity

When specifically asked whether clients felt their cultural background affected their health service utilisation or whether they experienced any cultural differences between themselves and staff at MCHS, some did not seem to understand the nature of the question. Very often we live within our culture without knowing its existence and influence (Yan 2010). In contrast, the majority of staff participants felt that health service utilisation was influenced by cultural differences. Hence, it was more visible for those in power and authority. Some argue that discourses of culture can work to justify and maintain health inequities when those in power and authority designate their own social practices as the norm while labelling the practices of marginalised or minority groups as abnormal (Pon 2009, Aronowitz, Deener et al. 2015).

An interesting finding that emerged was related to the diversity of staff at the organisation. Some staff from CALD backgrounds noted that they used their own cultural and experiential knowledge to help their clients adapt to a new culture they themselves have successfully acclimated to. However, one participant in the study revealed that she had experienced challenges fitting into the ‘mainstream’ culture of the organisation. She felt that she had to work harder to be accepted by some co-workers and some clients than “everybody else”. In addition to the positive aspects of having CALD background staff, there needs to be consideration of the effects of racism against staff by other staff and patients/clients (Louis, Lalonde et al. 2010, Mapedzahama, Rudge et al. 2012, Jain 2013).

The interviews with staff at MCHS shed light on how health providers engage with a culturally diverse community. Indeed, there are challenges of translating cultural competence into clinical settings. Prominent medical anthropologist Arthur Kleinman, one of the first in medicine to highlight the importance of culture in patients’ illness experiences, recently reflected that:

> *"…what was meant to humanise care by providing greater space for lay voices and practices appeared to be doing just the opposite. It unintentionally reduced complex, vivid lives into limiting and biased cognitive stereotypes. To make matters worse, certain aficionados fetishized the illness narratives per se as symbols and stories, divorcing meaning from economic, emotional and relational context of the lived experience of suffering; and emphasizing storytelling and interpretive practices over the actual experience of illness." p.1376 (Kleinman 2013)*

However, rather than abandoning culture altogether, culture needs to be put into context. This requires researchers and practitioners to pay close attention to local practices, social interactions, and shared meanings (Aronowitz, Deener et al. 2015). Hence, policies, frameworks and guidelines directing culturally competent service provision need to be adapted to the local context incorporating input from practitioners on the ground and local community members and groups. It is also necessary to understand the social structures, e.g. historical, economic and geographical, that interact with local behaviours and meanings. Being *culturally reflexive*, i.e. understanding culture in a textured, nuanced and structurally situated way, can reveal the contradictions of culture, its internal variability and how external conditions can enable, constrain and transform local cultural arrangements (Aronowitz, Deener et al. 2015).

Health systems should recognise that individuals and families may have more urgent concerns than their health status, such as unemployment and access to good housing and education. Thus, making progress towards health equity should involve exploring partnerships with community agencies that will engage patients/clients more effectively where they live and work in addition to indirectly mitigating factors that contribute to significant illness and disability (Wong, LaVeist et al. 2015). For example, in the Teeth Tales pilot study, newly arrived immigrants and refugees were difficult to engage in the oral health study due to their time being devoted to more urgent needs such as gaining employment and learning to drive. In the main intervention component of the Teeth Tales there was more success accessing and recruiting families to participate in free dental screenings and oral health education (delivered by peer educators). These families were from more established cultural groups and were more likely to been settled in Australia for at least several years, in addition to the direct involvement of these community cultural groups in the study (Gibbs, Waters et al. 2015). Additionally, the material support and credibility of the partnership underlying Teeth Tales advanced the community health organisation's efforts to address the social determinants of oral health.

It should also be acknowledged that there are limits to providing patient-centred and culturally sensitive care. Some practices cannot be accommodated within institutional or clinical norms. However, it is important to seek negotiated and mutually acceptable solutions where possible (Hunt 2009). Self-reflection is important from both an individual and organisational perspective to ensure the best possible health outcomes for patients/clients and the community (Cross, Bazron et al. 1989, National Health and Medical Research Council 2006).

10.6.1 The impact of unconscious bias

Reflexivity should include consideration of the potential impact of conscious and unconscious bias on patient-provider interactions, clinical decision-making and health service delivery. Instances of discrimination (perpetrated by staff or the organisation toward client participants) were not found in this study, however it is possible that clients and/or providers did not perceive incidences of discrimination when they occurred or did not report instances of discrimination. There are challenges in the assessment of discrimination such as issues related to perception bias and the potential role of personality characteristics (Lewis, Cogburn et al. 2015). However, there is evidence in the literature of the existence of discrimination by providers and organisations and that this is a contributor to health inequities (Smedley, Stith et al. 2003, Klonoff 2009). Social psychological research indicates that racial biases can occur both explicitly and implicitly, without intention or awareness (Dovidio, Penner et al. 2008). Unconscious bias has been shown to be associated with poor communication on the part of health care providers and biased clinical decision-making (Paradies, Truong et al. 2013, Butler, McCreedy et al. 2016).

The evidence in this field of research suggests that it is possible for providers to unintentionally provide care that is not entirely culturally competent as well as for patients/clients to be unaware of providers' biases and assumptions and its' potential impact on patient-provider interactions. For example, a study by White-Means et al. (2009) suggests an association between cultural competence and Implicit Association

Test scores. That is, those with the strongest preference for Whites are also those with the lowest values of self-perceived cultural competency. A study by Cooper et al. (2012) found that clinical implicit race bias and compliance stereotyping are associated with markers of poor provider-patient communication and poorer ratings of interpersonal care, especially among African American patients. Hence, strategies to improve cultural competence should include consideration of the role of conscious and unconscious bias and its contribution to health inequity (Burgess, van Ryn et al. 2007, Teal, Gill et al. 2012).

10.7 Organisational considerations

Cultural competence should be viewed as a goal towards which organisations can strive, thus, becoming culturally competent is a developmental process (Cross, Bazron et al. 1989). Organisational reflexivity is an important aspect of cultural competence and an organisational assessment can provide a baseline from which future work can be implemented, monitored and evaluated. As demonstrated by this PhD study, an assessment to determine an organisation’s level of cultural competence is essential to provide a reference point from which progress can be measured and evaluated. Other important aspects related to organisational cultural competence are: implementation, organisational readiness, organisational change and organisational culture. Whilst it is beyond the scope of this PhD study to comprehensively examine the empirical and theoretical literature related to these topics, further research on these topics is required to inform future work in the field of organisational cultural competence.

10.7.1 Implementation and organisational readiness

It is widely acknowledged that in order for culturally competent policies to be implemented across the health system, change needs to occur at multiple levels. As highlighted by the findings in Chapter 9, the process of conducting an organisational cultural competence assessment and subsequent facilitation of strategies to improve organisational cultural competence across an organisation is a complex undertaking that requires considerable investment of resources (in particular, staff time). As such, implementation of tools such as the CORe requires organisational capacity, sufficient resources and consideration of factors that may assist or impede implementation, given that effective implementation is associated with better outcomes (Durlack and DuPre 2008).

Attention to the process of implementation can help ensure the successful application of interventions and programs in real-world settings that improve the health and wellbeing of populations (Fixsen, Naoom et al. 2005, Durlack and DuPre 2008). How an intervention is implemented can influence its outcomes. Findings from five metal-analyses reviewed by Durlack and DuPre (2008) found that preventative health promotion programs for children and adolescents with better implementation resulted in mean effect sizes two to three times larger (in terms of outcomes). A study by Guerrero & Kim (2013) found that organisational factors such as public funding, leadership and climate for change, were associated with the degree of implementation of programs associated with cultural competence among addiction health services programs. Thus, consideration of barriers and facilitators can potentially improve the implementation of organisational cultural competence interventions, and subsequent outcomes.

In addition, assessment of an organisation’s cultural competence readiness is important as interventions are more likely to succeed if the organisation as a whole is ready for change. Cultural competence readiness refers to an organisation’s capacity to deliver effective health services to the diverse population it serves (Whaley and Longoria 2008). An assessment of the organisational environment (e.g. attitudes, policies and practices) and the context within which it operates is a necessary step in facilitating cultural competence. In addition, consideration of community norms also allows an organisation to strike a balance between benchmarks/standards and the pragmatic challenges reflected in an organisation’s daily operations (Whaley and Longoria 2008).

10.7.2 Organisational change

Issues related to organisational change and innovation should be considered before implementing any kind of organisational cultural competence intervention (Williams 2011). Understanding the reasons for adoption and spread of innovation can assist in addressing the difficulties of organisational change (Greenhalgh, Robert et al. 2004). Studies have highlighted the multiple factors present at different levels of the health care system that can act as barriers to change, such as time constraints, financing, lack of leadership and staffing (Dogra, Betancourt et al. 2009, Beune, Haafkens et al. 2011).

Merri Community Health Services, the organisation chosen as the case study for this PhD research, had already demonstrated readiness and motivation for organisational change by being involved as a partner in the Teeth Tales study. Other organisations with a lower degree of cultural competence readiness may require preliminary work (e.g. workshops to introduce cultural competence to foster employee/management engagement) prior to an organisational assessment or introduction of cultural competence interventions/programs to build awareness and support. Organisational development efforts that involve issues of power and justice have the potential to bring struggle and conflict into the workplace (Nybell and Gray 2004). For example, a study of three child welfare agencies in the United States showed that cultural competence can mean disparate and conflicting things to differently positioned members of each organisation (Nybell and Gray 2004). A study of an Australian regional health service found that some staff may react negatively to cultural competence training if forced to attend, highlighting a need for a multi-strategic approach extending beyond the training itself to address issues of resistance and negativity (Hunter New England Health Aboriginal and Torres Strait Islander Strategic Leadership Committee 2012).

10.7.3 Organisational culture

One way to frame organisational change is to discuss it within the concept of ‘organisational culture’. This concept has been used in relation to cultural competence, as stated in the NHRMC (2005) policy on cultural competence in health: “A culture is created where cultural competency is valued as integral to core business and consequently supported and evaluated” p.30.

As expressed by interview participants in this study (Chapter 9), managers and executives of organisations are needed to drive change. However, staff members also need to be engaged in the process and motivated to modify their usual practices. Employee engagement and empowerment will result in greater motivation to achieve individual and organisational change (Halm 2011). An understanding of an organisation’s culture and/or subcultures may elucidate how different parts of an organisation operate to assist the design and implementation of strategies for improving health care delivery and outcomes (Kondrat, Greene et al. 2002, Konteh, Mannion et al. 2009).

Despite the increasing attention and importance placed on organisational culture and change in health care, Dreachslin et al. (2004) found a paucity of research on organisational behaviour in the health care and general management literature. A more recent review by Parmelli et al. (2011) showed limited available evidence regarding effective strategies to change organisational culture in health care. More specifically, a systematic review of racial disparities interventions from 1979-2011 found that only 3% focused on organisations and 0.1% on policy in particular (Clarke, Goddu et al. 2013).

A systems approach to cultural competence may be considered as a way of addressing the different multi-level and multi-dimensional aspects of cultural competence. One example of this approach is the academic discipline of organisational behaviour. Organisational behaviour refers to the study of the impact that individuals, teams, culture, climate and infrastructure have on organisational performance (Dreachslin, Jean Gilbert et al. 2013). According to Dreachslin et al. (2013), a systems approach to cultural competence is more likely to produce lasting and measureable improvement in health provision to CALD groups because all parts of the organisation are working together to achieve a common goal. Organisational behaviour drives a culture of inclusion that results in culturally competent care and better health outcomes for diverse patients/clients (Dreachslin, Jean Gilbert et al. 2013).

10.8 Strengths, limitations and directions for further research

This PhD study has demonstrated an effective methodology for understanding cultural competence from the perspectives of health care providers and clients/carers from CALD backgrounds within the community health context. Knowledge of how clients, staff and organisations understand cultural competence within a particular health care setting/context is important in guiding the design and implementation of strategies to improve cultural competence. In addition, the evaluation of the CORe tool contributes knowledge to inform organisational cultural competence evaluation and monitoring.

The use of a case study approach has enabled the experience and complexity of a specific setting to be studied in depth and interpreted within its particular organisational context. It has also allowed the documentation of multiple perspectives as interviews were conducted with a variety of clients/carers and staff. This research approach has enabled the exploration of the process and dynamics of implementation and change to determine the factors that impacted upon the use of the CORe and its outcomes. The research design provided flexibility with data collection when timelines within the study changed and also permitted the adaptation of research methods to what was most appropriate at the time.

Whilst there may be a limitation in the ability to draw generalisations from the findings to inform policy, it has identified the multi-level and multi-dimensional factors that should be considered in this area of work. The conceptual model presented earlier in this chapter (Figure 10.1) may be used by community health services (and other similar organisations in the health and community sector) to map the potential barriers and facilitators to health service utilisation for members of CALD groups. There may be some universal and more specific factors that can be identified and used to inform the development of interventions to improve service access and delivery.

The conceptual frameworks and research methods utilised in this research can inform future work in this field as there is a potential for *analytic generalisations* to be drawn from this study. Analytic generalisations, in contrast to *statistical* generalisations (that generalise to populations), use a study's theoretical framework to establish a logic that may be applicable to other situations (Yin 2012).

This thesis has taken a critical stance towards assumptions underpinning aspects of the cultural competence field. Culture needs to be recognised as a contested and flexible category, whereby cultural norms can provide a useful guide to understanding how behaviour is negotiated.

Organisations provide the context in which human behaviour at workplaces occur. Therefore, organisational culture, vision and values, readiness for change and leadership will determine how organisations respond to initiatives to build cultural competence. It is important to recognise that organisational cultural competence is an ongoing process and not always linear, therefore it may involve overcoming barriers such as inadequate resources, lack of commitment/engagement amongst some staff, and slow implementation/dissemination of changes.

The findings of this research contribute to addressing the evidence gap in relation to the utility and impact of organisational cultural competence assessments. The evaluation of the CORe addresses an important gap in the literature as it can inform the future development and refinement of such tools to improve their effectiveness, accuracy and relevance. However, this was an observational study without a control group, therefore the extent of any influence of the CORe on organisational outcomes cannot be definitively demonstrated, nor whether any influence on organisational policies and practices persisted beyond the follow up period. Additional longitudinal and comparative research is required to investigate organisational change in the longer term and its impact on patient/client outcomes. There is also a need to examine the organisational conditions that relate to organisational readiness for change in relation to cultural competence.

Future comparative research using tools such as the CORe would be required to investigate the utility of organisational assessments in measuring, facilitating and monitoring change. Further research relating to the usefulness of these tools in improving client health outcomes is also necessary. Examination of the impacts of other dimensions of diversity (e.g. using an intersectionality approach) on health care utilisation may also be beneficial.

Greater commitment to, and resourcing of, community health program evaluation is needed to build an evidence base to support the role of community health in delivering services to people from CALD backgrounds. This PhD study makes a contribution to health services research in community health. It provides some evidence for community health practices and programs to build a case for continual and improved funding in the sector. Investment in evaluation of community-based primary health services has traditionally been low compared with other sectors, therefore more support (in terms of resources and expertise) is needed to broaden the evidence base and foster knowledge translation in relation to culturally competent practice (Jolley, Lawless et al. 2007).

10.9 Conclusion

This chapter has considered the findings of this study in the context of the existing empirical and theoretical literature. It has also discussed the implications of these findings for further examination of the issues related to this topic area, as well as the study’s strengths, limitations and implications for further research.

A model for cultural competence in community health has been presented, which shows the different factors that can act as facilitators or barriers to health service utilisation for people from CALD backgrounds. It has been argued that community health guiding principles and cultural competence are largely congruent, and that changes to the community health sector due to neoliberalism and increasing commercialisation have the potential to negatively impact upon the provision of services to CALD groups.

The increasing interest in diversity and intersectionality also indicates a potential shift away from cultural competence to a broader framework which encompasses more social categories and how they intersect and operate simultaneously to sustain inequalities and inequities. In addition, individualised models of health care such as patient-centred care are gaining prominence. Whilst patient-centred care is likely to be more effective than a categorical-type cultural competence approach, it has the potential to divert attention away from the broader social, economic and environmental determinants of health, unless pursued in concert with a cultural competence approach.

Reflexivity at both individual and organisational levels is an important aspect of cultural competence, with organisational assessment being vital in providing a baseline from which future work can be implemented, monitored and evaluated. This is a complex undertaking, and attention to aspects such as readiness, implementation and organisational change are important.

The next and final chapter concludes the thesis by briefly reviewing its key findings in relation to the PhD’s research aims. It will also provide a summary of the contributions to understanding cultural competence in the community health context and the utility of organisational assessment in organisational cultural competence.

Chapter 11: Conclusion

The existence of health inequities experienced by people from CALD backgrounds has been well documented in the international literature. Barriers to health service access can occur at the provider, organisational and systemic levels and are related to factors such as language and communication, geographic location, cultural appropriateness/familiarity, discrimination and resources/funding.

The field of cultural competence was developed to address health inequities experienced by people from CALD groups by improving the effectiveness and accessibility of health services. There is some evidence indicating that interventions to improve cultural competence have a positive impact on provider awareness, knowledge and skills as well as patient/client health outcomes. Cultural competence interventions which include change at both the individual and organisational levels are more likely to result in sustained change.

More evidence related to cultural competence in the community health sector is needed as it plays a vital role in primary health care provision for CALD communities in countries such as Australia. In addition, there is a need for further research into organisational cultural competence evaluation and monitoring.

The primary aim of this research was to gain an understanding of cultural competence from the perspectives of health care providers and clients from CALD backgrounds within the community health context, and to provide evidence and guidelines to inform future organisational cultural competence assessments. In exploring cultural competence within the community health context, it was revealed that the practice of providing culturally competent health services was multi-dimensional and multi-level. As a consequence, the implementation of an organisational assessment of cultural competence was a complex undertaking.

This research has added substantially to the current evidence base concerning cultural competence in the community health context and the utility of organisational assessment in organisational cultural competence. The use of qualitative methods situated within a case study approach has allowed the experience and complexity of this topic to be studied in depth and advanced our understanding of the issues impacting upon community health service utilisation by people from CALD backgrounds. It is hoped that the conceptual frameworks and research methods developed in this thesis can inform future work in this area.

Findings from interviews with staff indicated that the practice of providing culturally competent health care services within the community health context is multi-dimensional and multi-level. For some participants, cultural competence was an ambiguous concept, while the majority of participants seemed to view culture as something that was static and as something that belonged to the other – i.e. the client. Although most participants viewed cultural competence as being an important aspect of their work, there were challenges identified in providing culturally competent care at times.

Decisions made by clients/carers to use health care services are based on multiple factors, of which culture may be only one. Findings from the client/carer interviews make an important contribution as the development of cultural competence has largely been based on provider and academic perspectives. Somewhat surprisingly, clients' cultural background did not appear to be a salient issue for client participants in this study. Clients were more likely to identify other potential barriers to service use such as: language and communication difficulties, long waiting lists, lack of knowledge of services available, and procedural issues such as making appointments. The interaction of these factors with culture, language, and migration have the potential to negatively impact on service utilisation. However, it is possible that if the essential needs of clients are met, then their cultural needs are also met or become less significant. Culture is often invisible and may only surface when problems arise, thus if clients' needs are met then cultural influences may remain largely hidden. These findings highlight the strength of the inductive approach used in this study as questions related to service use for client participants were not solely focussed on issues related to cultural differences.

Based on the research findings, conceptual frameworks and empirical literature, a conceptual model was developed to represent the multi-dimensional and multi-level influences on community health service utilisation by people from CALD backgrounds (Figure 10.1). This model can be used as a reference or guide for the consideration of issues that impact health service utilisation and thus assist with further research and/or the design of interventions to improve cultural competence.

The findings and outcomes of the implementation of the CORe tool highlight the barriers and facilitators to implementation of an organisational assessment at a community health service. Even in the presence of a strong organisational commitment to improving organisational cultural competence, the process of implementing the CORe at MCHS was found to be challenging at times. Factors such as leadership, staff engagement, organisational inertia, organisational culture and resourcing were viewed as potential barriers or facilitators to the implementation of the CORe. Drivers such as the government policy context, the leadership's strategic orientation/direction and availability of resources were critical to provide the necessary support and infrastructure for organisational change. Consideration of organisational factors, such as those highlighted by this research, can inform the implementation of future organisational cultural competence assessments in order to potentially improve their outcomes.

The evaluation of the CORe tool contributed evidence of the utility and impact of organisational assessment in facilitating efforts to improve cultural competence. Despite the challenges and limitations of the CORe, it was found to be an important mechanism to facilitate organisational reflexivity- highlighting strengths and identifying gaps to provide an impetus for action to improve organisational cultural competence. The findings of this evaluation are being used to assist with further development of the CORe tool. There are plans to convert it into an interactive online assessment tool to be administered by CEH, a partner in the development of the CORe.

As noted in the previous chapter, findings from this research indicate a number of areas for further research, including longitudinal and comparative research to investigate organisational change in the longer term and its impact on patient/client health outcomes. In addition, examination of other dimensions of diversity (e.g. using an intersectionality approach) on health care utilisation may also be beneficial in ongoing efforts to achieve health equity for patients from a range of diverse backgrounds.

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Appendices

Appendix A: Teeth Tales project summary

Teeth Tales was a culturally competent community-based health promotion intervention for child oral health that aimed to prevent early childhood caries and promote positive oral health behaviours. It consisted of two components: a peer led oral health education program and a reorientation of dental and health services through a cultural competence organisational review. The study was located in urban Melbourne, Victoria, Australia.

Earlier qualitative research conducted in response to concerns for the oral health of children from refugee and migrant backgrounds in the Moreland and Hume local government areas of Melbourne led to the development of a community-based oral health intervention. These findings (i.e. the first phase of Teeth Tales) were integrated with the prior evidence base of effective interventions, using socio-environmental models of health, a culturally competent framework and health promotion principles to develop an intervention and evaluation plan. Subsequently, an exploratory trial was conducted (i.e. final phase of Teeth Tales) to implement a community-based oral health promotion intervention for Australian families from refugee and migrant backgrounds to address oral health inequities.

Peer lead oral health education program

The peer led oral health education program consisted of trained peer educators delivering oral health education to parents/carers followed by a site visit hosted by Merri Community Health Services (MCHS). Peer educators from the same cultural and linguistic background as the participants delivered the program in culturally appropriate settings. Peer educators were recruited from the Lebanese, Iraqi and Pakistani communities and trained in partnership with cultural organisations. Families with children aged 1-4 years old were recruited by the peer educators using purposive and snowball sampling methods.

Eligible families were invited to a recruitment day where they completed a baseline survey and each child received a free child dental screening. Recruited families were allocated to either the intervention group or comparison group according to their residential address. The intervention group received the peer led community oral health education sessions. All families were contacted by the peer educators 18 months after baseline data collection and invited to return for a follow up child dental screening and to repeat the parent survey.

Cultural competence organisational review

The Cultural Competence Organisational Review (CORe) was developed to provide organisations with a profile of their current policies and practices in relation to service delivery to CALD groups (including refugee and migrant communities) and to facilitate the re-orientation of services to strengthen organisational cultural competence. The CORe contains a combination of existing tools together with questions developed specifically for the Teeth Tales study.

Baseline and follow up staff surveys and document audits were conducted at each participating organisation. Process data and organisational documentation was used to evaluate and monitor the experience of CORe within the organizations.

More details of the CORe are provided in Chapters 5 and 9 of this thesis.

Appendix B: Letter to clients/carers

Dear Mr/Mrs ______________________

We would like to let you know about a research project that is being conducted by the University of Melbourne in partnership with Merri Community Health Services (MCHS) to see how services can be improved and easy to use for families from a migrant background.

The researcher, Mandy Truong, would like to speak to families who live in Moreland and have used any of the MCHS services in the past 1-2 years, including accessing the services for their child(ren). She is interested to hear about a range of experiences of the services, both good and not so good.

Your name is on our list of people who are happy to give client feedback so you may receive a phone call from Mandy Truong. She will ask if you are willing to talk to her about MCHS services either by telephone or in person. This will take about 20-30 minutes and is a chance for you to give feedback about MCHS. Whatever you tell Mandy will be kept confidential. When she writes her reports your name will not be included. We will not even know who participated. The information from the interviews will help us to improve services at MCHS. Your information may also help other organisations who want to use the research findings to improve services for people from migrant communities. However, it is completely fine if you do not want to take part. This is completely voluntary. Either way, your use of services at MCHS will not be affected.

If you want to be involved in this project just let Mandy know when she calls. If you do not want to be involved you can also let Mandy know or you can contact our Population Health Manager, Maryanne Tadic and say that you do not want Mandy to call. Maryanne's contact details are: phone 93892270 and email: MaryanneT@mchs.org.au Mandy's contact details are: mobile 0402 111249 and email: mtr@unimelb.edu.au

Thank you.

Yours sincerely,

Maryanne Tadic

Manager, Population Health Unit

Merri Community Health Services

Appendix C: Plain language statements and consent forms

Plain Language Statement for MCHS staff and management

Teeth Tales- Cultural Competence Organisational Review

You are invited to participate in the above research project, which is a university-community-government partnership project which aims to promote child oral health in refugee and migrant communities in Melbourne.

A component of the Teeth Tales research project is a cultural competence organisational review (CORe). CORe was developed to assess the accessibility and cultural appropriateness of health and community organisations and identify ways to enhance their services. This part of the study will examine the impact of CORe on the organisation.

What you will be asked to do?

You will be asked to participate in an interview, either via telephone or face-to-face at a time convenient for you. The interview will occur during CORe's action plan & implementation phase, which has been incorporated into MCHS's Diversity Plan, sometime between February and April 2013. In the interview you will be asked your views on the organisation's cultural competence and how cultural competence may relate to your work practices. You will also be asked your views about the CORe project. The interview is expected to take about 30-60 minutes. With your permission, the interview will be audio-recorded so that we have a clear record of what we discuss.

Are there any risks?

The interviews will be independently conducted by Mandy Truong, a PhD student from the University of Melbourne. Your participation will not affect your employment at MCHS. All of the information that you give to us will be treated confidentially. Your name and contact details will be kept in a separate, password-protected computer file away from any data that you supply. This will only be able to be linked to your responses by the researcher. All data will be stored for five years after the research has been published and then will be destroyed.

In any publication, your real name will not be used. We will remove any references to personal information that might allow someone to guess your identity; however, you should note that as the number of people we seek to interview is small, it is possible that someone may still be able to identify you. You are free to withdraw from the research at any time.

Are there any benefits?

The information from the interviews will help us evaluate the CORe project conducted at MCHS. This can help us strengthen CORe for future use in other organisations seeking to increase service access and appropriateness for people from refugee and migrant communities.

To take part, please show that you have read and understood this information by signing the accompanying consent form and either send it to the address below or contact Mandy Truong directly. The researcher will then contact you to arrange a mutually convenient time for you to participate in an interview.

For further information please contact

Mandy Truong
The McCaughey Centre, Melbourne School of Population Health
University of Melbourne
mtr@unimelb.edu.au, mobile 0402111249, ph. 90358286

This project been approved by the Human Research Ethics Committee, The University of Melbourne (ID: 1033207.1)

Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on ph: 8344 2073, or fax: 9347 6739. This project is funded by the Australian Research Council.

McCaughey Centre, School of Population Health

Consent form for staffparticipants

Project: Teeth Tales- Cultural Competence Organisational Review

- The details of this project have been explained to me, and I have been provided with a written plain language statement to keep.
- I understand that '*Teeth Tales'* is a research project and the cultural competence organisational review (CORe) is a part of this.
- I understand this consent form will be retained by the project.
- I understand that participation is voluntary and that I can refuse to consent.
- I understand that I can withdraw from the study at any time.
- I understand that I will be participating in an interview either face-to-face or via telephone.
    - I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;
    - I have been informed that with my consent the interview will be audio-taped and I understand that electronic records and audio-tapes will be stored at University of Melbourne and will be destroyed after five years;
    - My name will not be included in any publications arising from the research;
    - I have been informed that a copy of the research findings will be forwarded to me, should I agree to this.

I consent to the interviews being audio-taped	☐ yes ☐ no **(please tick)**
I wish to receive a copy of the summary project report on research findings	☐ yes ☐ no **(please tick)**

Participant name: ....

Address (for the summary of results to be sent): ....

Email Address (for the summary of results to be sent): ....

Contact number: ....

Participant signature: ______________________________Today's Date: __ __ / __ __ / __ __ __ __

Teeth Tales- Cultural Competence Organisational Review

You are invited to take part in the Teeth Tales research project which is being conducted in the Moreland area. The project has been designed to find the best way to help families keep the teeth of their young children healthy.

Part of the Teeth Tales study involves working with Merri Community Health Services (MCHS) to see how services can be improved to make them easier for people in the community to use and more culturally suitable for families with a migrant background.

What you will be asked to do?

You will be asked to take part in an interview, either by telephone or in person, at a time and place convenient to you such as a local library, park or cafe. In the interview you will be asked about your experiences using Merri services, particularly in the past year. The interview is expected to take about 30-60 minutes. With your permission, the interview will be recorded with a tape recorder so that we have a clear record of what we discuss. An interpreter can also be arranged to assist with the interview if needed.

Are there any risks?

The interviews will be conducted by Mandy Truong, a student from the University of Melbourne. She does not work at MCHS. Your involvement is anonymous and will not affect your use of services at MCHS. All of the information that you give to us will be treated confidentially. Your name and contact details will be kept in a separate, password-protected computer file away from the interview information. All data will be stored for five years after the research has been published and then will be destroyed.

Information from the interview may be used in a presentation or article published in an academic journal. Your real name will not be used. We will remove all of your personal details from the information so it is unlikely that someone can guess your identity; however, the number of people we plan to interview is small, it is still possible that someone may be able to identify you. You are free to withdraw from the research at any time.

Are there any benefits?

The information from the interviews will help us assess whether Teeth Tales helps to improve services at MCHS. This can help us make improvements for other organisations who want to use Teeth Tales to improve services for people from migrant communities.

To take part, please show that you have read and understood this information by signing the accompanying consent form and either send it to the address below or contact Mandy Truong directly. *You can also consent verbally before the interview*. The researcher will then contact you to arrange a convenient time for you to participate in an interview.

For further information please contact:

Mandy Truong
The McCaughey Centre, Melbourne School of Population Health
University of Melbourne
mtr@unimelb.edu.au, mobile 0402111249, phone no. 90358286

This project been approved by the Human Research Ethics Committee, The University of Melbourne (ID: 1033207.1)

Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on ph: 8344 2073, or fax: 9347 6739. This project is funded by the Australian Research Council.

McCaughey Centre, School of Population Health

Consent form for participants – MCHS clients
Project: Teeth Tales- Cultural Competence Organisational Review

- The details of this project have been explained to me, and I have been provided with a written plain language statement to keep.
- I understand that '*Teeth Tales'* is a research project.
- I understand this consent form will be retained by the project.
- I understand that participation is voluntary and that I can refuse to participate.
- I understand that I can withdraw from the study at any time.
- I understand that I will be participating in an interview either by telephone or in person and that an interpreter will be arranged if needed.
  - I understand that the interview will be audio-taped if I agree, and I understand that audio-tapes will be stored at University of Melbourne and will be destroyed after five years;
  - In understand that my name will not be used in any publications arising from the research;
  - I understand that a copy of the research findings will be forwarded to me, if I request this.

<u>I consent to this interview being audio-taped</u>	☐ yes ☐ no **(please tick)**
<u>I wish to receive a copy of the summary report on research findings</u>	☐ yes ☐ no **(please tick)**

Participant name: ....

Address (to send summary research results): ....

Email (to send summary research results): ....

Contact number: ....

Participant signature: ______________________________Today's Date: __ __ / __ __ / __ __ __ __

Appendix D: Interview guides for staff and clients/carers

INTERVIEW QUESTIONS FOR STAFF

Basic demographic questions

- Age
- Race/ethnicity
- Work roles at MCHS
- Years working at MCHS

Cultural competency- general

- Have you heard of cultural competency? What is your understanding of cultural competence?
- Do you think this is relevant to the work that you do at Merri? How so?
- Some people say that patients and clients should all be treated the same. What do you think about that?

CC and work

- Have you ever had any training in cultural competency? Was this at Merri or at another place? What was it like?
- In your area of health care, do you think people's cultural background influences their health beliefs and practices? Can you give me an example?
- Does this impact on your work? How?
- In your area of health care, do you think people's cultural background influences their access to services? Can you give me an example?
- Does this impact on your work? How?

CC and Merri and CORe

- What do you think about Merri's overall cultural competency?
- Have you heard of the Teeth Tales project?
- Did you do the cultural competency survey in September 2011? What did you think about it?
- Are you aware of any current organisational initiatives to increase cultural competence in the organisation? Do you have any thoughts on it?

Final

- Do you have any other thoughts or comments?

Do you mind if I contact you later on if I need to clarify anything?

INTERVIEW QUESTIONS FOR CLIENTS

Basic demographic questions

- Age
- Race/ethnicity
- Years being client of MCHS

Service experiences

- What services do you use at Merri Community Health Services? How often do you visit Merri?
- How have you found them?
- What good experiences have you had at Merri?
- Have you had any not so good experiences at Merri? Why was that?

Cultural differences

- How do you feel when you go to Merri?
- What makes it easy to use the services? And what makes it hard to use the services?
- Have you or people from your family had any cultural differences between yourself and Merri staff when you were using their services? How did that affect you? How did the staff at Merri act?

Changes to the organisation

- Have you noticed anything different at Merri in the last year? Were there any changes to Merri? Any changes to the services you used there?
- What do you think of those changes? Has it affected you in any way?
- Are there any changes you would like to see at Merri? How do you think they could do better?

Final

- Do you have any other thoughts or comments?

Do you mind if I contact you later on if I need to clarify anything?

Appendix E: CORe staff survey

CORe

Cultural Competency
Organisational Review

Staff Survey

Authors

The Organisational Cultural Competency Assessment was developed in partnership by Merri Community Health Services, the McCaughey Centre and the Centre for Culture, Ethnicity and Health using a combination of existing tools and tools developed specifically for the Teeth Tales study.

INTRODUCTION

Our organisation is participating in an organisational cultural competency assessment.

We would like your input to help us better understand our organisation and explore ways in which the cultural appropriateness of the organisation and accessibility of services can be enhanced.

We invite you to complete this short questionnaire about our organisation. The survey should take approximately 15 minutes to complete. Some participants may also be invited to participate in a focus group discussion to help us understand the results and to develop an action plan for our organisation, or in an interview to discuss your views about cultural competence.

Participation is voluntary. All of the information that you give to us will be treated confidentially. Individual results will not be identifiable and will not be linked back to you.

WHAT IS CULTURAL COMPETENCY?

Provision of accessible and appropriate service to people from culturally diverse communities is currently referred to in the literature as `cultural competence'.

Culturally competent health organisations:

- work in partnership with communities to identify and respond to diverse community need,
- deliver fair, accessible and appropriate care,
- enrich organisations and communities with shared understandings and connections
- remain dynamic and accountable in response to community advice through a variety of continual improvement programs.

We would like you to respond/comment on the organisation's *cultural competence* in relation to these definitions.

PARTICIPANT INFORMATION

1. Which organisation are you from? ____

2. Which Division/Program Area do you work in? ___________________________________

3. What is your main role in the organisation?

   ☐ Executive/Board

   ☐ Manager/Team Leader

   ☐ Staff (permanent/fixed-term)

   ☐ Staff (casual)

   ☐ Volunteer

   ☐ Student

4. As a part of your role, do you have direct contact with clients/members of the community?

   ☐ Yes

   ☐ No

5. How long have you been at this organisation?

   ☐ Less than 2 years

   ☐ 2 to 5 years

   ☐ 5 to 10 years

   ☐ More than 10 years

6. What is the highest level of education that you have completed?

   ☐ Year 10 or less

   ☐ Year 11

   ☐ Year 12 or equivalent

   ☐ Technical apprenticeship or diploma

   ☐ University degree

   ☐ Post Graduate degree

7. Which country were you born in?

   ☐ Australia

   ☐ Overseas- ▼ (Please answer below)

Which country were you born: ______________________________

What year did you arrive in Australia: _ _ _ _

8. Do you speak a language other than English?

   ☐ No, I only speak English

   ☐ Yes, I also speak ____
   (Please specify which Language/s)

9. Do you speak a language other than English at work?

   ☐ No

   ☐ Yes -*Please specify*: __________________________________

   ☐ Not applicable

10. Which ethnicity/ancestry do you belong to or most identify with?

____

11. To what extent do you think being culturally competent is important to the work that you do?

    ☐ Not at all

    ☐ A little

    ☐ A fair bit

    ☐ A lot

    ☐ Don't know

12. To what extent do you think it is important that your organisation is culturally competent?

    ☐ Not at all

    ☐ A little

    ☐ A fair bit

    ☐ A lot

    ☐ Don't know

ABOUT YOUR WORKPLACE

13. Thinking about the site or office you spend the most time in, please rate how welcoming you feel it is.

(Consider aspects such as the physical space, posters, signage, reception etc)

a) FOR STAFF

- ☐ Not at all
- ☐ A little
- ☐ A fair bit
- ☐ A lot
- ☐ Don’t know
- ☐ Not applicable (N/A)

b) FOR CLIENTS

- ☐ Not at all
- ☐ A little
- ☐ A fair bit
- ☐ A lot
- ☐ Don’t know
- ☐ Not applicable (N/A)

14. Are any of the following present within your organisation?

	Yes	No	Not sure	N/A
Signage regarding accessing interpreter services	☐	☐	☐	☐
Translated messages for people	☐	☐	☐	☐
Posters with pictures of people that reflect the cultures living in the local community	☐	☐	☐	☐
Reception staff that reflect the cultures living in the local community	☐	☐	☐	☐
Client feedback mechanisms	☐	☐	☐	☐

Do you have any additional comments on this section?:

____

____

____

____

ORGANISATIONAL VALUES

These questions ask you to think about your organisational values and how these are put into practice within your organisation.

15. To what extent do you think the organisation's vision and values reflect the diversity of the community?

☐ Not at all

☐ A little

☐ A fair bit

☐ A lot

☐ Don't know

16. To what extent is cultural competency a priority within your organisation?

☐ Not at all

☐ A little

☐ A fair bit

☐ A lot

☐ Don't know

17. How responsive do you believe your organisation is to the needs of people from diverse cultural backgrounds?

☐ Not at all

☐ A little

☐ A fair bit

☐ A lot

☐ Don't know

18. To what extent does your organisation provide you with sufficient support (eg. time and resources) to work with people from culturally diverse backgrounds?

☐ Not at all

☐ A little

☐ A fair bit

☐ A lot

☐ Don't know

☐ N/A

Do you have any additional comments on this section?:

____

____

GOVERNANCE

Cultural competence requires an organisation-wide approach to planning, implementing and evaluating services for clients of culturally diverse backgrounds. Meaningful consultation and participation strategies will help to develop service quality and improve access. Capacity building programs can offer support for community representatives to provide advice on ways to improve services.

Policies and systems serve to guide the actions of the board, management, staff, volunteers and students, in order to ensure a consistent and responsive approach.

19. How often do representatives of diverse cultures actively participate in decision making within your organisation?

☐ Not at all

☐ A little

☐ A fair bit

☐ A lot

☐ Don’t know

20. Does your organisation have policies that support cultural competence? *(e.g. access and equity policies)*

☐ No → **(Go to question 22)**

☐ Don’t know → **(Go to question 22)**

☐ Yes ▼

21. If yes, how often do you feel that your organisation’s cultural competency policies are implemented?

☐ Not at all

☐ A little

☐ A fair bit

☐ A lot

☐ Don’t know

Do you have any additional comments on this section?:

____

____

PLANNING, MONITORING & EVALUATION

Services that effectively meet the needs of clients and communities in a culturally competent way must remain dynamic to population change. A key element of this process involves the collection of demographic information for analysis and influence of key decisions across the organisation.

22. To what extent does your organisation consult with culturally diverse communities on planning, service development, monitoring and evaluation?

☐ Not at all

☐ A little

☐ A fair bit

☐ A lot

☐ Don’t know

23. To what extent does your organisation incorporate cultural competence in its plans? *(eg. Strategic Planning documents)*

☐ Not at all

☐ A little

☐ A fair bit

☐ A lot

☐ Don’t know

If you do not have direct contact with clients go to question 30

24. During intake and assessment, does your organisation collect the following demographic information from clients:

	Yes	No	Not sure	N/A
Country of birth	☐	☐	☐	☐
Ethnicity	☐	☐	☐	☐
Languages spoken at home	☐	☐	☐	☐
Need for an interpreter	☐	☐	☐	☐
Year of arrival	☐	☐	☐	☐
Migration status *(eg refugee/ non-refugee)*	☐	☐	☐	☐

25. For planning purposes, does your organisation collect the following organisation wide information:

	Yes	No	Not sure	N/A
Interpreter usage data	☐	☐	☐	☐
Local demographic diversity profile	☐	☐	☐	☐

26. To what extent does your organisation monitor and utilise this information to better enhance service delivery?

☐ Not at all

☐ A little

☐ A fair bit

☐ A lot

☐ Don’t know

Do you have any additional comments on this section?:

____

____

____

COMMUNICATION

Culturally competent communication is critical for all aspects of service delivery. It can break down barriers, improve access to services and support better health outcomes for clients.

27. Across your organisation, to what extent do staff communicate with people from culturally diverse backgrounds?

☐ Not at all

☐ A little

☐ A fair bit

☐ A lot

☐ Don’t know

28. In the last six months, what proportions of your clients have needed language assistance?

☐ None → (**Go to question 30)**

☐ Less than 10%

☐ 11% - 30%

☐ 31 – 60%

☐ More than 60%

☐ Don’t know

29. When working with these clients, what language services did you use? *(Tick all that apply)*

☐ Telephone interpreter

☐ Face-to-face interpreter

☐ Bilingual staff member from your organisation

☐ Bilingual staff member from another organisation

☐ Client’s family member/friend

☐ Visual materials (*eg posters, flyers etc)*

☐ Translated written materials

☐ None

☐ Not applicable

☐ Other, *please indicate:* ______________________________

30. When communicating with clients who require language assistance, which of the following are carried out by staff in your organisation

	Yes	No	Not sure
Clients are informed of their rights regarding choice of an interpreter	☐	☐	☐
Staff ensure interpreters adhere to ethical standards	☐	☐	☐
Feedback processes are in place to report the standard of interpreter service	☐	☐	☐
Staff ensure only accredited interpreters are used	☐	☐	☐
Staff give clients the opportunity to feedback their level of satisfaction with interpreter services	☐	☐	☐
Staff allow a longer appointment time with an interpreter for clients who prefer to speak a language other than English for their first appointment	☐	☐	☐

Do you have any additional comments on this section?:

____

____

____

____

STAFF DEVELOPMENT

Cultural competence is not a given; it requires all staff to have access to and support for ongoing skills development, training and knowledge. Human resource management areas such as staff recruitment, support and appraisal, all contribute to a culturally competent workforce.

31. Does your organisation offer staff training to develop cultural competence?

    ☐ No ► **(Please go to question 35)**

    ☐ Don't know ► **(Please go to question 35)**

    ☐ Yes ▼

32. Is cultural competence training a part of staff induction training?

    ☐ Yes

    ☐ No

    ☐ Don't know

33. Is the cultural competence training mandatory for all staff?

    ☐ Yes

    ☐ No

    ☐ Don't know

34. How long ago did you last attend cultural competence (or cultural awareness/diversity) related training at this organisation?

    ☐ In the last 6 months

    ☐ 6-12 months

    ☐ 1-2 years

    ☐ 2 years +

    ☐ never attended cultural competence related training

35. Would you like to further develop your skills in working more effectively with people from culturally diverse backgrounds?

    ☐ No → **(Go to question 37)**

    ☐ Yes ▼

36. If yes, please select from the following options:
    (Tick all that apply)

☐ Governance

☐ Planning, monitoring and evaluation

☐ Communication

☐ Staff development

☐ Partnerships

☐ Services and interventions

☐ Ethno - specific training *(eg. Cultural considerations when working with Burmese clients)*
-Which groups?
____

Do you have any additional comments on this section?:

____

____

____

PARTNERSHIPS

Culturally competent partnerships enable organisations to address common goals, achieve sustainable resource use and share learning.

37. How important do you think it is for your organisation to work in partnership with culturally diverse groups?

    ☐ Not at all

    ☐ A little

    ☐ A fair bit

    ☐ A lot

    ☐ Don’t know

38. To what extent do you have partnerships or close working relationships with organisations representing culturally diverse groups (*eg Migrant Resource Centre, Foundation House, ethno-specific groups or agencies)*?

    ☐ Not at all

    ☐ A little

☐ A fair bit

☐ A lot

☐ Don’t know

☐ Not applicable

39. In relation to you working with culturally diverse communities, do you find that any of the following act as barriers? *Please respond to all*

Is this a barrier?	Not at all	A little	A fair bit	A lot	Not applicable
Time constraints	☐	☐	☐	☐	☐
Lack of confidence	☐	☐	☐	☐	☐
Inadequate knowledge	☐	☐	☐	☐	☐
Inadequate experience working with diverse communities	☐	☐	☐	☐	☐
No access to an interpreter	☐	☐	☐	☐	☐
No access to meeting space	☐	☐	☐	☐	☐
Not a priority for my division/program area	☐	☐	☐	☐	☐
Not a priority for my organisation	☐	☐	☐	☐	☐
Not a priority for our diverse communities	☐	☐	☐	☐	☐

Do you have any additional comments on this section?:

____

____

____

____

SERVICES & INTERVENTIONS

Health services will be more effective if they acknowledge and work with clients' cultural knowledge, life experience and community resources. The capacity of a health worker to improve a client's health status will be enhanced if the worker can integrate culture into clinical practice.

40. To what extent does your organisation ensure services are accessible to culturally diverse communities?

☐ Not at all

☐ A little

☐ A fair bit

☐ A lot

☐ Don't know

If you do not have direct contact with clients go to question 42

41. To what extent does your organisation expect you to take into consideration clients' cultural factors or migration related experiences in your service delivery? *(eg. traditional practices, migration status, experiences of torture or trauma)*

☐ Not at all

☐ A little

☐ A fair bit

☐ A lot

☐ Don't know

OVERALL REFLECTIONS

Provision of accessible and appropriate service to people from culturally diverse communities is currently referred to in the literature as `cultural competence'.

Culturally competent health organisations:

- work in partnership with communities to identify and respond to diverse community need,
- deliver fair, accessible and appropriate care,
- enrich organisations and communities with shared understandings and connections
- remain dynamic and accountable in response to community advice through a variety of continual improvement programs.

42. How would you rate your organisation's cultural competence?
(Please circle a number below, where 1 = poor and 10=exceptional)

1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

43. What are your organisation's strengths in relation to cultural competence?

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44. What is needed to improve the level of cultural competence in your organisation?

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THANK YOU FOR TAKING THE TIME TO FILL IN THIS SURVEY

If you have any further comments please feel free to write them below:

____

____

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Appendix F: Emails to staff of MCHS

Teeth Tales
-Applying the Learnings

To all staff,

Merri Community Health Service will undertake a cultural competence organisational review (CORe) over the next few months to ensure we are doing everything we can as an organisation to be accessible and responsive to clients from diverse cultural backgrounds.

The first step is an online survey for all staff to complete as part of this review. The purpose is to gather information on our organisation's strengths and weaknesses in responding to cultural diversity. It will take approximately 15 minutes to complete.

It is a confidential process, with the University of Melbourne collecting and analysing the data and reporting them back to all staff as group results. The Centre for Culture, Ethnicity and Health will be helping us to use the results to develop organisational action plans. This is a voluntary process and your decision whether to participate or not will not affect your employment. However, participation is encouraged as this will only be a useful process if the majority of staff complete the survey. This will inform the development of the organisational action plans that will reflect the needs, strengths and cultural competence of our organisation.

It would be greatly appreciated if all staff could complete the online survey by clicking the link below:

http://teethtales.limequery.com/66366/lang-en

by Wednesday 21st September 2011.

If any staff member would prefer to complete the survey in hard copy form they will also be available onsite, and are to be returned in the envelope provided.

Kind Regards,

Teeth Tales
-Applying the Learnings

To all staff,

Merri Community Health Service began a cultural competence organisational review (CORe) in 2011 to ensure we are doing everything we can as an organisation to be accessible and responsive to clients from diverse cultural backgrounds.

This staff survey is a follow up to the baseline staff survey conducted in September 2011. The purpose of this survey is to assess the organisation’s progress since the first survey was conducted and provide feedback on current plans and actions. It is not necessary for you to have completed the first survey in September 2011 to participate in this one.

It is a confidential process, with the University of Melbourne collecting and analysing the data and reporting them back to all staff as group results. This is a voluntary process and your decision whether to participate or not will not affect your employment. However, participation is encouraged as this will only be a useful process if the majority of staff complete the survey. It will take approx. 15 minutes to complete.

It would be greatly appreciated if all staff could complete the online survey by clicking the link below:

https://teethtales.limequery.com/index.php/726198/lang-en

by Friday 9 August 2013.

If any staff member would prefer to complete the survey in hard copy form please contact Mandy Truong via email mtr@unimelb.edu.au or phone 9035 8286.

Kind Regards,

Appendix G: CORe document audit template

CORe Document Audit Scoring Sheet

The Cultural Competency Organisational Review (CORe) document audit scoring sheet is part of the Cultural Competency Organisational Review (CORe) tool which was developed in partnership by Merri Community Health Services, the University of Melbourne and the Centre for Culture, Ethnicity and Health.

The document audit scoring sheet is designed to facilitate an audit of current organisational documents (including policies, procedures, plans and assessment of tools). Using the CORe framework, documents are to be reviewed on the basis of their relevance to the cultural competence domains and their indicators. Examples of how to complete the sheet are given below (in red). Refer to the Introduction to CORe-Scoring guidelines for more information.

Domain	**Cultural competence indicator**		**Evidence and information provided**	**Level of evidence for each domain** ***Organisation-wide policy***, e.g. policy ***Planning directive***, e.g. strategic plan ***Reporting directive***, e.g. performance indicator, accountability measure	**Score for each level of evidence** 0=insufficient evidence 1=partly addressed 2=addressed completely
Organisational values	Leadership, investment	Individuals at executive level have responsibility for implementing and monitoring cultural competence initiatives			

		Teams or committees of mid-level or high-level staff are assigned responsibility for coordinating cultural competence activities.			
		Funding is allocated to cultural competence.			
		Staff are aware of the cultural competence plan and implement it in their work.			
		There are public materials that express the organisation's commitment to cultural competence.			
	Information/data related to cultural competence	Mechanisms are in place to collect and disseminate information on cultural competence, including relevant data sets and resources.	*Some data sets are used by the organisation e.g. ABS data,*		
		The organisation conducts regular self-assessments of its progress.	*This is not done on a regular basis.*		
		Regular community needs assessments are conducted	*Focus groups are conducted occasionally in relation to specific services/programs. Client feedback surveys are available at reception.*		

	Organisational flexibility	Administration and service delivery adaptations are tailored to the population of the service area, including adaptations to improve access to care.	*Focus groups are conducted occasionally in relation to specific services/programs. Client feedback surveys are available at reception.*		

Governance		Boards and advisory committees are representative of groups served by the organisation Community members are provided with financial and other necessary supports for their involvement in governing and advisory committees. Regular reports are provided to stakeholder’s on cultural competence issues and activities		**Organisation**: ***Comments:*** **Action**: ***Comments:*** **Reporting:** ***Comments***	

	Board development	Board members participate in ongoing education on cultural competence.			
	Policy	Cultural competence is included in policies on: • personnel recruitment and retention • training and staff development • language access and communication • management of grievances and complaints • community and client input and participation			

Planning, monitoring and evaluation	Client, community client, community and staff input	Culturally and linguistically diverse communities are represented on relevant planning and monitoring committees. Staff, clients and relevant communities have input into cultural competence plans. Staff, clients and relevant communities have input into the monitoring and evaluation of cultural competence activities. Staff and consumers actively participate in planning, monitoring and evaluation.		**Organisation**: ***Comments:*** **Action**: ***Comments*** **Reporting**: ***Comments***	
	Plans and their implementation	Planning documents, including budget allocations, address cultural competence issues. A cultural competence plan is created and implemented.			

	Collection and use of information	Data collected from and about clients and target communities is used to inform planning. All areas of the organisation (e.g. policy, programs, operations) collect and have access to relevant data. The implementation and results of cultural competence activities are monitored and evaluated as part of quality improvement processes.			
Communication	Understanding different community needs and	There is a system to identify and record population and client language preferences, literacy levels and level of English proficiency. Staff receive training in cross-cultural communication.		**Organisation**: ***Comments***	

		Staff apply effective communication techniques with diverse groups.		**Action**: ***Comments***: **Reporting**: ***Comments:***	

	Culturally appropriate oral communication	Staff are trained in the appropriate use of qualified interpreters. Protocols are established for when and how to elicit sensitive information from clients. Clients can communicate in their preferred language/dialect at point of first contact and at all levels of interaction with the organisation. Clients can understand translated material.			

	Culturally appropriate written communication	Printed, online and audiovisual materials are appropriate to the literacy of target populations. • Quality review mechanisms are established to check the integrity of translated materials. • Culturally appropriate ways to disseminate written materials are identified. • Clients understand written materials.			
Staff Development	Training commitment	Training in cultural competence is regarded as a core competency in quality improvement efforts. There is a training program for staff development in cultural competence.		**Organisation**: ***Comments:*** **Action**: ***Comments*** **Reporting**: ***Comments***	

	Training content	Cultural competence training needs are assessed. Community input is obtained regarding staff training. The quality of staff training is assessed. Staff demonstrate cultural competence in knowledge, skills, attitude and behaviour (both generally applicable and related to specific groups).			
	Staff performance	Cultural competence is incorporated into job descriptions. Staff performance evaluations are conducted in a culturally competent manner.			
Organisational infrastructure	Finance and budgets	There is an overall budgetary allocation and investment in cultural competence activities, aligned with the organisation's strategic plan. Persons are designated to monitor the need for additional resources or funding.	.	**Organisation**: ***Comment:*** **Action:** ***Comments:*** **Reporting:** ***Comments***:	

	Technology	Appropriate technologies are used to facilitate communication between clients and service providers. Staff are trained to use the organisation’s information system to collect, enter and use data related to cultural competence, in a consistent and standardised way.			
	Links and partnerships	Formal and informal alliances are formed with community and other partners to address issues related to cultural competence. Internal coordination between departments facilitates the delivery of culturally competent care. There is evidence of appropriate use of and referral to partner agencies.			

Services and Interventions	Client, family and community input	There are policies and plans regarding client, family and community input. Workers obtain client, family and patient advocate input regarding care planning and treatment, as appropriate. Care and treatment plans are agreed upon by clients and families, and may be amended with client/family input as appropriate. Community input is obtained for community-level interventions.		**Organisation**: ***Comment***: **Action**: ***Comment*** **Reporting**: ***Comment***	

	Screening, assessment and care planning	Guidelines and tools are used to elicit cultural and demographic factors relevant to clients’ health and health behaviors. Data is routinely available on cultural and language needs, populations and clients served. Screening, assessment and care planning reflect cultural and ethnic considerations. Prevention, treatment and maintenance plans reflect factors related to cultural competence.			

	Treatment and follow up	Practice guidelines and treatment frameworks account for differences related to culture and traditional beliefs and practices, as appropriate. Health education is provided at client and population levels on issues that are related to the community. Treatment processes and outcomes related to culturally and linguistically diverse clients are regularly assessed as part of a quality improvement program. Outreach services are provided to target populations to facilitate access to care.			
Partnerships and networks				**Organisation** ***Comments:*** **Action** ***Comments:*** **Reporting** ***Comments:***	

Appendix H: Systematic review (published version)

Author/s:
TRUONG, MANDY

Title:
A multi-level examination of cultural competence in community health: an organisational case study

Date:
2016

Persistent Link:
http://hdl.handle.net/11343/119576

File Description:
A Multi-Level Examination of Cultural Competence in Community Health: An Organisational Case Study