Cultural respect strategies in Australian Aboriginal primary health care services: Beyond education and training of practitioners

Abstract

Objective. There is little literature on health service level strategies for culturally respectful care to Aboriginal and Torres Strait Islander Australians. We conducted two case studies: , one Aboriginal community controlled, and one state government managed primary health care service to examine cultural respect strategies, client experiences, and barriers to cultural respect.

Methods. Data were drawn from 22 interviews with staff from both services, and four community assessment workshops, with a total of 21 clients.

Results. Staff and clients at both services reported positive appraisals of the achievement of cultural respects. Strategies included being grounded in a social view of health, including advocacy and addressing social determinants, employing Aboriginal staff, creating a welcoming service, supporting access through transport, outreach, and walk-in centres, and integrating cultural protocol. Barriers included communication difficulties, racism and discrimination, and externally developed programs.

Conclusions. Service level strategies were necessary to achieving cultural respect. These strategies have the potential to improve Aboriginal and Torres Strait Islander health and wellbeing.

Implications. Primary health care's social determinants of health mandate, the community controlled model, and the development of the Aboriginal and Torres Strait Islander health workforce need to be supported to ensure a culturally respectful health system.

Introduction

There are a number of frameworks for healthcare for Aboriginal and Torres Strait Islander peoples.[1] Some of these concepts, such as cultural awareness, cultural sensitivity, and cultural safety focus on the knowledge, attitudes, and/or skills of individual practitioners.[1] While it is important to address practitioner capabilities, given the extent of racism experienced by Aboriginal and Torres Strait Islander peoples accessing health care,[2] the ability of individual practitioners to ensure equity in access and health outcomes for Aboriginal and Torres Strait Islander peoples is limited by organisational, system, funding, and policy factors.[3, 4] In recognition of this, concepts such as cultural security, cultural competence, and cultural respect also examine health service and health system strategies.[1, 5, 6]

Nevertheless, literature on these constructs tends to gravitate towards the training of practitioners.[1, 7, 8] This is mirrored in New Zealand, where cultural safety has been largely conceptualised at the level of individual practitioners.[1, 3] This paper aims to complement the existing literature by examining service strategies to improve Aboriginal and Torres Strait Islander health.

This research is part of a five year project on comprehensive primary health care (CPHC) conducted in partnership with six PHC services, including one state managed and one community controlled Aboriginal and Torres Strait Islander health service. Comprehensive PHC is an approach to health careand health promotion underpinned by a social view of health, community participation, equity, and action on social determinants of health.[9, 10] A social view of health acknowledges that social, economic, and cultural factors influence people's health, and that individual or population interventions to reduce or treat illness or promote health must address social and contextual factors.[11] Relatedly, the social determinants are "the circumstances in which people are born, grow up, live, work and age,

and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics." [12, p. 1]

Comprehensive PHC was pioneered in Australia by the Aboriginal Community Controlled sector, and also underpins the community health services that developed from the 1973 Federal Community Health Program.[13]

In discussion with service staff, the research team selected the term 'cultural respect' to be used in the project, primarily to accord with the national document 'The Australian Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009' [14] (referred to as the CRF). The CRF defines cultural respect as, 'the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples' (p. 7). The CRF emphasises that "Cultural Respect is not confined to human resource management or training." [14, p. 13] The framework encompasses access, quality of care, and equity of health outcomes, including intersectoral action to address social determinants. The 'Action Agenda' contains strategies for practitioners, health services, and health systems, including embedding cultural understandings in training, Aboriginal and Torres Strait Islander workforce management plans, and ensuring effective Aboriginal and Torres Strait Islander input in governance structures.

There is only sparse literature reporting how health services can achieve cultural respect. Inala Indigenous Health Service reported success using five strategies: employing Aboriginal staff, a culturally appropriate waiting room, cultural awareness talks to staff, promoting the service to the Aboriginal community, and intersectoral collaboration (eg interagency network meetings).[15] A review of Aboriginal maternal and child health interventions[16] identified factors characterising successful programs: community-based or community controlled services, providing a broad spectrum of services, integration with other services, outreach and home visitation, a welcoming environment, flexibility in service delivery and appointment

times, having an appropriately trained workforce, valuing Aboriginal and Torres Strait Islander staff, provision of transport, and provision of childcare or playgroups.[16] Another evaluation of an Indigenous maternity clinic found that continuity of carer, Indigenous liaison support, and cultural sensitivity skills, such as good communication and awareness of cultural norms were key factors in achieving cultural respect.[17]

A mainstream service, Hunter New England Health employed a multi-strategy initiative to address individual and institutional racism, including: staff cultural respect workshops, a leadership committee and collaborative groups that guided initiatives, implementing a counter racism policy, Aboriginal Employment Strategy, and Aboriginal Health performance improvement program, improving Aboriginal identification, and fostering partnerships with Aboriginal organisations.[4]

The current study sought to address this limited examination of health service cultural respect strategies, drawing on two case studies of Aboriginal services. We conducted interviews with staff, and workshops with clients to answer the following questions:

1. What service-level strategies were used to achieve cultural respect?
2. What were Aboriginal and Torres Strait Islander clients' experiences of cultural respect?
3. What barriers reduced the ability of services to be culturally respectful?

Context

The six PHC services who participated in the wider project were selected to maximise diversity and because the research team had a sufficient relationship with the service to make an in-depth five year study feasible. The two Aboriginal-specific services were Central Australian Aboriginal Congress, an Aboriginal community controlled organisation in Alice Springs, who requested to be identified in publications, and a South Australian state

government managed Aboriginal Health Team. The two sites vary substantially in size and disciplines employed (see Table 1).

[Insert Table 1 about here]

Central Australian Aboriginal Congress ("Congress") was founded in 1973, initially as an advocacy organization that later came to provide PHC services. It is one of the oldest and largest of the 152 Aboriginal community controlled health services across Australia.[18] The CRF highlights the community controlled sector as having demonstrated effectiveness in providing holistic and culturally sensitive health services to Aboriginal and Torres Strait Islander peoples.[14] Congress services include a medical clinic, male health centre, female health centre, children's health services, and a social and emotional wellbeing service.

The Aboriginal Health Team is a team of Aboriginal Health Workers who facilitate Aboriginal and Torres Strait Islander people's access to health services, and deliver programs on health promotion, women's health, men's health, youth health, and early childhood.

Methods

This paper draws on service staff interviews and group workshops with clients.

Staff Interviews

Semi-structured interviews were conducted with key PHC personnel in 2009-2011. Ethics approval was received from Flinders University' Social and Behavioural and the Aboriginal Health Research Ethics Committees. Questions were developed by the research team and piloted on three practitioners and one manager (all non-Aboriginal). Question wording was refined following the pilots. Questions covered equity of access, efforts to reduce health inequalities, community participation, action on social determinants, and community and advocacy work.

Eight interviews were conducted with the Aboriginal Health Team, and 14 with Congress staff, inclusive of managers, practitioners, and a Congress community board member (*N* = 22, 17 Aboriginal, 5 Non-Aboriginal). Four interviews were conducted by an Aboriginal researcher (Edwards). Participants gave written consent, and interviews generally lasted 45-60 minutes, and were audio recorded and transcribed.

Community Assessment Workshops

Since cultural respect can only be judged by those who are receiving care,[19] it was important to gather client views. This was achieved through Community Assessment Workshops, where groups of clients were convened in a workshop using a structured process and asked to discuss and rate aspects of the health service.[20] These workshops were based on Community Capacity Workshops,[21] which were chosen as they had been used successfully with different cultural groups, including Aboriginal and Torres Strait Islander health teams.[22] The community assessment workshops were an adaption of this method to gain clients' ratings of nine PHC service qualities,[20] including cultural respect. Ethics approval was received from the Southern Adelaide Clinical, Aboriginal Health, and SA Health Human Research Ethics Committees. The workshop was piloted at a non-participating PHC service and the research team evaluated and refined the method.

Recruitment was conducted by service staff who provided information about the workshop to clients. Staff were asked to maximise diversity of participants in terms of age, gender, and services used. Edwards also conducted significant advertising of the workshops at Congress.

Three workshops were held at Congress due to its large size, and because attendance was difficult to achieve (13 participants attended in total, 10 female, 3 male). One Aboriginal Health Team workshop was held, with eight participants (6 male, 2 female). Transport was arranged by the health service. Transport assistance was offered for some Congress

workshops, though no clients took up this offer. Participants gave written consent, and were provided with a small reimbursement. Three researchers facilitated each workshop, including one Aboriginal facilitator. Participants rated the service on nine service qualities, including cultural respect. For each service quality participants were provided with five statements that varied from low to high achievement, and were asked to select as a group the statement they felt most accurately described the service. Groups typically came to a consensus with little facilitation, taking into account the experiences of all participants.[20] The service quality was then assigned a rating from 1 (low achievement) to 5 (high achievement) corresponding to the statement selected, as shown in Table 2. Details of the other service qualities are available elsewhere.[20] Participants were asked to discuss their reasons for selecting the statement and what they would change to improve achievement of the service quality. Workshops lasted 3 to 3.5 hours, and were audio recorded and transcribed.

[Insert Table 2 about here]

Analysis

A team approach was taken to thematic analysis using NVivo software. Codes were developed, discussed and revised during regular team meetings (Freeman, Baum, Lawless, Jolley, Javanparast, and Edwards) ensuring rigour through constant monitoring of analysis and interpretation.[23] Consensus on key themes was arrived at by discussion at these meetings. Analysis of cultural respect was led by two Aboriginal researchers (Edwards and Luz) and Freeman. Findings were fed back and discussed at service staff meetings, and reports sent to clients, to share how the findings were reported back to the service. Quotes were selected that best illustrated themes from the staff or client perspective.

Results

The staff interviews and community assessment workshops yielded findings on 1) how staff and clients assessed the achievement of cultural respect, 2) a range of cultural respect strategies, and 3) barriers that impacted cultural respect. Themes (strategies and barriers) were present for both services, although different in scope and nature, and in both staff interviews and the community assessment workshops, providing complementary or assenting, but not conflicting perspectives.

1. Achievement of cultural respect

Staff from both services felt they were successful in establishing cultural respect. Staff based this judgement on feedback from the community, feeling clients were empowered enough to provide feedback when cultural respect isn't achieved:

> *"People are pretty open ... here we'll soon be tapped on the shoulder and say this is not right or I'm not happy with this. I think I'm reassured that we've got a constant flow of people through. If we weren't doing this properly our numbers would soon drop through the floor."* (Staff member, Congress)

Clients were very positive about tservices' achievement of cultural respect. Participants in two Congress workshops provided a rating of 5/5 (see Table 2). Participants from the third Congress workshop, and the Aboriginal Health Team workshop, provided a rating of 4/5.

2. Strategies that enhanced cultural respect

Services cited a number of strategies that enabled cultural respect, outlined and grouped below.

Social view of health

The CRF is explicitly based on a social view of health.[14] A social view of health meant workers took social factors into account in their interactions with clients. For example: ,

> *"We are often working not just with individuals, but with their families and carers. Often complex medical and social problems, homelessness and housing being one of them. Education, if they've got kids. … we tend to work closely with all those agencies that actually provide some of those direct services - Centrelink, Housing, hospitals"* (Staff member, Congress)

Staff from both services felt an organisational commitment to a social view of health necessarily underpinned cultural respect:

> *"What we see presenting at the door, and wanting assistance, is a reflection of what's happening in society. What's happening in terms of the social determinants of health. That is, high levels of unemployment amongst Aboriginal people, the education disadvantage of Aboriginal people … people are coming to us because of those things. And then the kinds of services that we deliver are about trying to rectify that, as well as advocating a policy about getting some of those structural changes made and improvements in those areas."* (Staff member, Congress)

Advocacy. A social view of health informed advocacy efforts, ranging from Congress' collective action on issues such as alcohol and violence, through to advocacy for clients on housing and welfare at both services.

Social determinants of health. The services' actions on social determinants are described elsewhere.[24] The following example highlights how addressing social determinants is part of cultural respect, because otherwise programs may not equally benefit Aboriginal and Torres Strait Islander peoples:

> "*You can have people on what's a really expensive maintenance health program, that requires a high level of commitment to a healthy lifestyle, a clean living sort of thing, and there's no ability for them to provide housing within that. So you've got people who are homeless, or living in very overcrowded situations, with no ability to control*

their diet, or fluid intake, because they're living in large groups of people, and they are the key factors to if you do well on that program or not." (Staff member, Congress)

Congress, due its size, resources, and direction and support of the community controlled board, was able to have a more extensive scope of work, collaborating with other sectors on housing, alcohol, and violence.

Clients were able to articulate the benefits ofservices based on a social view of health:

"*[The Team] has helped me out a lot through letters and support for court and that. Just helped me out with drug and alcohol, all sorts of things.*" (Client, Aboriginal Health Team)

Aboriginal health professionals

Staff and clients at both services felt Aboriginal health professionals were key to ensuring cultural respect. Aboriginal staff helped to reduce clients' anxiety and enhance communication:

"It's more comfortable dealing with Aboriginal Health Workers. You can relate to them." (Client, Aboriginal Health Team)

"You can speak to an Aboriginal Health Worker about concerns and get them to support you." (Client, Congress)

Staff valued recruiting workers from the local community for their local knowledge, ability to speak local languages, and as a form of empowering the local community.

At both services, Aboriginal health workers or liaison officers accompanied clients to external appointments to ensure clients' comfort and confidence and to advocate on their

behalf. This was seen as critical to mitigate the racism and poor treatment clients sometimes experienced: .

> "*We've had to bat for people in hospital under horrible circumstances where they've been treated really badly…we had this one situation with a mother that was accused of stealing stuff and she had two other babies removed from her care and the nurses were talking top note about it so that everybody could hear. And in turn everybody was looking at her and making all sorts of judgements about her, and making her feel so terrible.*" (Staff member, Aboriginal Health Team)

Both services expend considerable effort in training, the Aboriginal health team through the establishment of a health workforce training centre, and Congress through a registered Aboriginal Health Practitioner training branch.

Welcoming atmosphere

There was concerted effort by the services to be welcoming:

> "*We try here to make this place a friendly place, one that shares information and empowers the clients.*" (Staff member, Congress)

Clients reported feeling welcome. Seeing and knowing other people who use and work in the service provided a sense of belonging:

> *"There's always someone there that you know, another family member or an old school chum or people you've played football with, and you've got that companionship there. If you were going to the doctor's surgery uptown and then just sitting there, oh god, I'm wishing to get out of there super quick."* (Client, Congress)

Aboriginal and Torres Strait Islander spaces. Both services had Aboriginal signage, artwork, and flags outside and inside the buildings. Staff saw this as vital to make the service visible and welcoming.

Strategies to support access

Achieving access is a vital component of cultural respect.[14] Both services had strategies to improve access, including transport, outreach and home visitation, and walk-in services.

Transport. Aboriginal and Torres Strait Islander peoples experience greater transport disadvantage than non-Aboriginal people, including in metropolitan areas, due to barriers to receiving drivers' licences and car ownership,[25] which compounds inequities in health and access to health care.[25] Both services provided transport for internal and external appointments. This was seen as critical to enhancing access:

> *"I have four vehicles. Initially we had one and I said, "No, we need four". "Well, we don't have the funds." I said, "Well, we need to find the funds". Because if you're going to expect us to increase our Aboriginal community people to access our services, we need to have funding there because transport is a big issue."* (Staff member, Aboriginal Health Team)

It was common for clients to emphasise their need for the transport, such as:

> *"It's the transport for me, yeah. It helps me get down to see the doctor, and medications and that."* (Client, Aboriginal Health Team)

The camaraderie described above also extended to the transport services. Clients reported gaining social benefits from the bus services:

> "*I get in the bus, "How are you going? How you are today? How you been? What's going on brother?" And it makes your entire insides feel good, and so you know you're going to start off with a good day.*" (Client, Aboriginal Health Team)

Outreach and home visiting. Congress reported outreach programs for chronic conditions and frail, aged, and disabled community members. Both services reported a limited amount of home visitation, acknowledging that it "*cost[s] a huge amount of money to do that, but it's the only way that you can actually engage these clients*" (Staff member, Congress). Home visitation at both services was most often linked with maternal and infant health programs.

Walk-in services. The Aboriginal Health Team operated a walk-in service, where clients could access health workers without an appointment. Staff saw this as vital to a responsive service:

> "*Our service has an "open door policy" as we respond to clients without them making an appointment to see a health worker… The clients come to us when they need to have their health needs met.*" (Staff member, Aboriginal Health Team)

There is some evidence that walk-in clinics improve access and timeliness, though not necessarily equity of access in mainstream clinics.[26] The main clinic at Congress had previously operated solely as a walk-in service. When it became evident that waiting times were unacceptably high, a "*hybrid system*" was introduced of walk-in, practitioner-made appointments, and advanced access appointments where appointments are only released on the day, a system found to improve timeliness, patient satisfaction, and continuity of care, [27] The necessity of a walk-in service was highlighted:

> *"A lot of the services that are provided are provided with an expectation that people live in houses, are used to turning up for appointments, have that sort of sense of time*

management, that if you make an appointment two months in advance that that's something that people can keep track of. Congress … [recognises] people are going to have problems ... Not always, but for a large part of the community, particularly the homeless." (Staff member, Congress)

Cultural protocols

The CRF highlights the need to integrate cultural protocols. [14] Services had a number of strategies to ensure cultural protocols were observed.

Gender specific services. The need for gender specific professionals and services was argued by clients and staff at both services. The Aboriginal Health Team ran separate Men's groups and Women's groups. Congress has separate men's (Ingkintja) and women's health (Alukura) branches. The male health branch reported that:

"We've had guys coming from 400/500 km to come here. - I've asked these guys, "You've got a clinic back home?" They say, "No there's only women in there and we want to talk about men's stuff". (Staff member, Congress)

Cultural advisory board. At Congress, Alukura's formal cultural advisory board comprises eleven traditional grandmothers who strive to ensure services remain culturally respectful and adheres to 'Grandmothers' Law'. Staff expressed benefits of this guidance, although it has sometimes led to conflicts with younger generations, highlighting the complexity of integrating cultural protocols:

"One of the prime examples is having partners at the birth, - we've got these grandmothers who very, very strongly say 'No way, it's women's business, men are not allowed to be involved in any aspect of it', and then you've got clients saying, 'Well now I want my partner at the birth, want them to be involved, they need to take on the role of the father'."(Staff member, Congress)

Cultural events. Bush camps, cultural days, or reconciliation events were seen as valuable ways of connecting to the community, providing a chance for people to draw on culture, and increase social connectedness. Bush trips were highly prized by clients as a "*really great healing process*" (Client, Congress):

> "*Camps are good - like it was really good man, because we're stuck in the city for a long time... We're black fellas man, and we need to escape. We're sick you know. We're sitting in a state for white fellas looking at us – you know, we jump on the bus full of white fellas and all that, and you just want to escape sometimes.*" (Client, Aboriginal Health Team)

Clients praised the cultural ceremonies, chance to talk, and do something with their hands, like fish and make boomerangs. Clients also described the positive impact public celebrations had on their pride and wellbeing:

> "*For NAIDOC week, when we had that march in town there, when we went to the big park. I watched a lot of people on the outside, watching us, the white fellas … You can read it on their faces, "Wow these people are powerful." They're walking in the main street. … [It made you] so proud it'd make you fly*." (Client, Aboriginal Health Team)

3. Barriers that reduced cultural respect

Both services identified barriers to achieving cultural respect, including issues of communication, racism, and externally developed programs.

Communication

Staff and clients discussed cross cultural communication barriers, particularly at Congress, which is situated in a regional centre with four main language groups, and also receives visitors from other language groups. This made flexible and timely interpreter services very

difficult to achieve, and Congress was advocating for better interpreter services. Communication issues were also evident in terms of differences in views of health, and the kind of language staff used that sometimes resulted in unsatisfactory communication:

> *"When I listen to those nurses talking to the people, it's just the language they use, you know. It's not the language our people use."* (Staff member, Congress)

Racism

Both services reported experiences of racism and discrimination from mainstream services with whom they co-ordinated. The long history of (ongoing) racism towards Aboriginal and Torres Strait Islander peoples,[28, 29] and personal experiences of racism had led to distrust of non-Aboriginal health professionals for some clients:

> *"I can't go to a white fella because I don't trust them anymore because of what's been happening to me in my whole life of going to the doctors."* (Client, Aboriginal Health Team)

Participants relayed experiences of discrimination at mainstream services, such as this example where the doctor was critical of the entitlements available:

> *"... because of the Closing the Gap, he said, "Why do I have to write this on your medication?" And he goes, "Why do you black fellas get everything for free?* (Client, Aboriginal Health Team)

Another client reported seeing a doctor for a leg injury, and experienced the following racism:

> "*And I heard the doctor say, "It must be payback." I said, "What?" He said, "You're all fighting. You're all scumbags.*" (Client, Aboriginal Health Team).

Staff talked of the need to raise cultural awareness at other services, have their clients' voices heard, make complaints when clients were not treated appropriately (especially when clients did not feel empowered enough or had literacy barriers to making complaints themselves), and accompany clients to mainstream appointments. Staff also tried to vet and build relationships with non-Aboriginal practitioners or services, and only work with those that were culturally respectful.

Externally developed programs

Staff reported some externally developed programs as a threat to cultural respect. A Congress worker described one such program:

> "*Now this funding's come along but again it's to address high risk groups that's based on a research project that occurred overseas. It's not our population. It has determined who and how many staff get employed.*" (Staff member, Congress)

Staff from the Aboriginal Health Team reported that some SA Health programs expected a degree of English language literacy and paperwork that not all Aboriginal and Torres Strait Islander clients could meet.

Discussion

The two services used a range of strategies to ensure cultural respect. The strategies we identified reinforced some reported in the literature: the importance of Aboriginal and Torres Strait Islander staff,[15, 16] ensuring the service is welcoming to Aboriginal and Torres Strait Islander people,[15, 16] access strategies such as the provision of transport, flexible appointment times, and outreach and home visitation.[16] The findings also point to less commonly emphasised strategies for cultural respect, such as integration of cultural protocols, advocacy, and action on social determinants.

Congress and the Aboriginal Health Team were very different in structure (one being community controlled, the other government managed), size and scope, and in terms of the disciplines employed and programs provided. Nevertheless, there was considerable overlap in the strategies used, and the barriers to achieving cultural respect. Congress benefitted from its greater size, resources, and community control to develop strategies on a larger scale (for example, greater collective advocacy) than the smaller, government-managed Aboriginal Health Team.

The importance of a social view of health in achieving cultural respect highlights the need for continued advocacy for this approach.[30] The Australian health system is largely dominated by a biomedical model, focused on individuals, illness causation and treatment regimes, which informs how health services function and health professionals practice.[31] By contrast, comprehensive PHC incorporates in its strategies addressing the social determinants of health, that contribute to ill health.[15, 24] Comprehensive PHC can frame Aboriginal health services to be more accessible, responsive, and culturally respectful.[32]

Our findings also highlight the need for flexible responses to local needs. Social determinants, access barriers, and cultural protocols will vary between Aboriginal and Torres Strait Islander communities. A strength of Congress's community controlled model is the freedom and capacity to respond to the local situation, and incorporate local knowledge into program development and service delivery. The success of the government-managed Aboriginal Health Team in establishing cultural respect strategies in the absence of community control appears to be due to the strong advocacy efforts by key staff members to obtain necessary resources, and the service's commitment to comprehensive PHC principles, including responsiveness to the local community. As the Alukura example shows, cultural protocols cannot be seen as a straight forward addition separate to other governance and practice. To engage with this strategy fully requires addressing conflicts. Future research

could examine the processes community controlled and other organisations use to do this constructively.

The employment of Aboriginal and Torres Strait Islander staff, particularly from the local community, was a central strategy for achieving cultural respect, and also supported being welcoming and integrating cultural protocols. Aboriginal and Torres Strait Islander people are underrepresented in the health workforce: comprising 0.9% of the health workforce, but 1.9% of the population.[33] Continued attention is needed to improving opportunities for higher education, vocational training, and state and territory Aboriginal and Torres Strait Islander health workforce strategies and action plans.[34]

Implications for practice

Our findings suggest that, beyond cultural education for individual practitioners, there are a range of strategies services can use to improve Aboriginal and Torres Strait Islander peoples' experience of cultural respect. While there will necessarily be adaptation to the local context, some strategies, such as ensuring the service is welcoming, is based on a social view of health, and supports access and availability are likely to be universal. There are also clear implications for the health system as a whole – a need for strong policies supported by implementation plans, avoiding top down programs and allowing local flexibility, and greater fostering of an Aboriginal and Torres Strait Islander health workforce. The CRF is clear that cultural respect incorporates addressing the social determinants of Aboriginal and Torres Strait Islander health.[14] Given the scope to effect health improvements through tackling social determinants[35], supporting primary health care services' mandate and capacity to do this often difficult and politically challenging work[24] is important.

Durey et al.[36] concords with our findings in their description of resultant distrust for those who had experienced racism in health services, and it is important for the whole health system to counter racism and distrust. [14, 24, 35]

Limitations of the study

The in-depth nature of the research limited participation to a small number of case study services. A fuller survey of Aboriginal and Torres Strait Islander health services would likely identify additional strategies and barriers. The community assessment workshops only involved current clients. There may have been Aboriginal and Torres Strait Islander people who did not use the services, possibly because they did not feel they were culturally respectful. Lastly, measurement of the relationship between the cultural respectfulness of care and consequent health outcomes would be methodologically extremely difficult and was beyond the scope of this study. Lie et al.'s[37] review of patient outcomes associated with cultural competence training indicated a lack of high quality studies, indicating such research is much needed. . Further research could include a more systematic investigation of strategies different types of services use and the impacts of these strategies from the point of view of staff and service users.

Conclusion

Organisational strategies and policies to improve access, incorporate cultural protocols and a social view of health, address social determinants of health, and make the service welcoming have the potential to improve Aboriginal and Torres Strait Islander health and wellbeing. Comprehensive primary health care provides a supportive base for the achievement of such strategies. It forms the basis of the community controlled model which needs to be acknowledged and celebrated. Supporting these models of service, and the development of

the Aboriginal and Torres Strait Islander health workforce, are key to ensuring Australia develops a culturally respectful health system.

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Table 1

Characteristics of the two Aboriginal and Torres Strait Islander case study PHC services

	Approximate # of staff (FTE)	Budget (p.a.)	Main source of funding	Examples of disciplines employed
Aboriginal Health Team	12 (10.8)	$0.5m	SA Health	Aboriginal health worker, PHC worker
Congress	320 (188)	$20m	Dept. of Health & Ageing	Medical officer, psychologist, social worker, youth worker, midwife, nurse, Aboriginal health worker, pharmacist

Table 2

Definition of cultural respect and statements used in the community assessment workshops

Rating	Statement
1	The service doesn't demonstrate any understanding or respect of people's culture.
2	The service has some signs or art or leaflets which show that it is aware of different cultures. But it doesn't really do anything that makes it a safe and respectful environment for all.
3	The service makes an effort to make it a safe and respectful environment for all, but it doesn't change the way it works to match people's culture.
4	The service values and respects people's culture. It tries where possible to work in a way that matches people's culture.
5	The service goes out of its way to value and respect people's culture. It is flexible and welcoming and is excellent at working in a way that supports and values people's culture.