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Diversity in the context of multicultural Australia: Implications for nursing practice

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CHAPTER TWENTY

Diversity in the context of multicultural Australia: Implications for nursing practice

Akram Omeri and Lynette Raymond

LEARNING OBJECTIVES

Upon completion of this chapter, the student should be able to:

outline the cultural and linguistic demographic characteristics of Australia's diverse population groups;

describe the evolution of Australia's immigration and multiculturalism policy for all Australians;

explore the major multiculturalism policy directions and their impact on the healthcare system and practice domains in Australia;

examine how the diverse cultural and social structural influences impact on health access and outcomes for multicultural Australia;

understand the importance of addressing the inequities in the provision of healthcare services in Australia and in contemporary nursing practice;

examine the impact of evidenced-based transcultural nursing knowledge as it relates to the promotion of health and wellbeing of people from culturally and linguistically different backgrounds in Australia.

KEY WORDS

Australia's multiculturalism, cultural diversity, poverty, rural-remote, refugees, age, disability, culturally competent and congruent care

INTRODUCING MULTICULTURAL AUSTRALIA

Cultural and social structures, such as race, religion, language, education, ethnicity, and economic status are major influences on peoples health and wellbeing. The Australian people represent a wealth of cultural diversity. The term culture in this chapter is used in the broad sense to mean the cultural and social structural dimensions or institutions in the environment that influence the development of an individuals beliefs, values and behaviour patterns.

In addition to the Indigenous population, Australia's cultural diversity has increased through immigration. Australia has one of the largest proportions of immigrant populations in the world, with an estimated 24% of the total population (4.96 million people) born overseas (Commonwealth of Australia 2008). Well over half of these, one in seven Australians, were born in a non-English-speaking country (Australian Institute of Health Welfare (AIHW 2008). In excess of 200 cultural and linguistic groups are represented in today's Australian population (Commonwealth of Australia 2007).

Diversity exists too in the wide range of contexts and environments in which people live. Variations in land, climate and settings compound diversity in social and cultural characteristics of people, as reflected in the diversity of settings in which health care is delivered. Health care is delivered in rural-remote areas, in community health settings, in the home, and in a number of acute settings within or outside hospitals in urban settings.

The purpose of this chapter is to inform student nurses and to develop in them an awareness of the benefits and challenges of diversity, with the aim of promoting the delivery of nursing care to diverse populations in culturally meaningful and safe ways. The desired outcomes are to:

create an incentive for nurses to pursue transcultural nursing studies in order to further their sense of knowing about diversity beyond multiculturalism

build upon the existing transcultural nursing knowledge through research and to understand the implications of culture-specific knowledge for improving nursing practice

develop sensitivity and self-awareness towards cultural diversity that brings unity, respect for other person, fairness for each other, and benefits for all.

Issues on Indigenous communities are not discussed in this chapter as this topic is addressed elsewhere in this book.

The term multicultural is used by the Australian Government to describe the cultural and linguistic diversity that exists in Australian society (Commonwealth of Australia 2007). From an historical perspective, Australia's policies on immigration have evolved in response to social changes and a commitment to the development of society as a whole. Since 1947, Australia's immigration policies have shifted between phases of assimilation, integration, multiculturalism, mainstreaming, to inclusiveness and being united in

diversity.

Insert Table 20.1: Periods in immigrant policy development

(Commonwealth of Australia 2008: 1)

The principles of Australia's multiculturalism emphasize the importance of valuing differences, and utilizing the cultural knowledge and skills of people from different backgrounds (Commonwealth of Australia 1999, 2003, 2008). The policy is intended for all Australians, not just for those people from non-English speaking backgrounds.

Multicultural Australia United in Diversity Policy 2003-2006 is based on four principles:

Responsibility for all - all Australians have a civic duty to support those basic structures and principles of Australian society, which guarantee us our freedom and equality and enables diversity in our society to flourish;

Respect for each person - all Australians have the right to express their own culture and beliefs and have a reciprocal obligation to respect the right of others to do the same;

Fairness for each person - all Australians are entitled to equality of treatment and opportunity. Social equity allows us all to contribute to the social, political and economic life of Australia; and

Benefits for all- all Australians benefit from the significant cultural, social and economic dividends arising from the diversity of our population. Diversity works for all Australians (Commonwealth of Australia 2007:1).

To gain a deeper understanding of the historical perspectives of multicultural policies, students are encouraged to refer to the many recommended references provided.

The remainder of this chapter will explore a number of Australia's diversity characteristics, along with the implications they have both individually and collectively for nursing practice.

CHARACTERISTICS OF DIVERSITY

Economic status: Impact of poverty on health

As a welfare state, Australia prides itself on meeting the health needs of all Australians, not just those economically advantaged. This approach to health services is based on the belief that a healthy society is a wealthy society. The International Council of Nurses (ICN 2004a, b) states that poverty and health are linked in four ways:

- ill health leads to poverty
- poverty leads to ill health

- good health is linked to higher incomes
- higher incomes are linked to good health.

Income is a key factor in relation to poverty, but other factors are also significant for good health. In a broader definition of poverty, such things as access to health services, clean water, sanitation, literacy levels and infant mortality (United Nations Development Programme (UNDP) 2002, 2003) are included. Poverty and disease are inextricably linked in a direct correlation with wealth, the poorer the person the greater the incidence of ill health, the richer the person the less frequent the incidence of ill health. Disease often further impoverishes the poor (Freudenberg 2000 cited in McMurray 2007; AIHW 2008). In addition, cultural factors in combination with poverty are recognized as having a significant impact upon health (Fuller et al 2004; Royal College of Nursing Australia 2004; Senate Community Affairs References Committee 2004; International Council of Nurses 2004a, 2004b; AIHW 2008). Socioeconomic and environmental factors, such as low income, poor housing, overcrowding, job insecurity, unemployment, few community resources, poor education, social exclusion, reduced social approval and self-esteem, are known to have an impact upon health. While government policy can have a significant impact upon health by redistributing wealth and ensuring access to health services, poor social and economic circumstances contribute to disempowerment and hopelessness among the poor and serve to keep the poor in ill health (Schrader 2004).

Language diversity

Culture is a shared experience that is mediated through language and other symbols. Australia's national language is English, with a further 200 languages spoken among the more than 200 diverse cultural and linguistic groups they represent. Spradley (1979) states that language is an important cultural expression and the major means for humans to share, construct and understand the world around them. He goes on to say that, the decoding of cultural symbols and identification of meaning involves the discovery of relationships between the symbols, their usage and the cultural context in which they are expressed. Accordingly, language needs to be understood in relation to the cultural and social structures that influence the development of an individual's beliefs, values and behaviour patterns (Spradley 1979).

In response to the diversity of languages that exist in Australia, a number of both government and non-government interpreter and translator language support services and resources are currently available for both health care workers and clients of health care services. There are benefits to accrue from a health care workforce that is either bilingual or multilingual, particularly one that reflects the demographic language characteristics of Australia's population as a whole.

Education

Educational attainments are known to influence an individual's lifestyle choices, employment opportunities, and perceptions of health and well-being.

Given the diverse knowledge and skill levels that exist in Australia's population, health care workers when planning, developing and delivering educational programs and services, need to take into consideration the age, language, culture and educational background of the target population.

Working in collaboration with the intended recipients of resources and services during the planning, development and delivery stages enhances the effectiveness of the information provided and health outcomes for all population groups (McMurray 2007).

Religion

The religious, spiritual and philosophical beliefs adopted by people influences the way that individuals, families, and community groups respond to significant life events such as birth, illness, death and dying, as well as their behaviours to maintain health and wellbeing.

There is diversity in the religious affiliations of Australians; they comprise 26 % Catholic; 19% Anglican; 19% other Christian denominations. Major non-Christian religions comprise 6% and include Buddhism 2.1 %, Hinduism 0.8 %, Islam 1.7 %and Judaism 0.5 % (Commonwealth of Australia 2008).

Religious diversity has enormous implications for the planning, development and delivery of mainstream health services. Religious ceremonies may involve family members, requests for a religious representatives or prayer sessions during hospitalization or procedures. In compliance with the codes of ethical and professional nursing practice (ANMC 2008) and competency standards for nurses (ANMC 2006), nurses are required to demonstrate respect for the beliefs and values of diverse cultural groups in their care. Knowledge of different cultural rites and ceremonies and accommodation of such requests is one example of how a nurse can demonstrate respect for diverse beliefs, values and lifeways.

Health and well-being

The World Health Organization (WHO) defines health as a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity (McMurray 2007). The degree to which a society experiences health and well-being is largely dependent upon the social and cultural structures in place to support the nations most vulnerable population groups.

Groups such as the very young, the very old, and the very poor, newly arrived refugees, and people living with a disability are undeniably a nations most vulnerable and in need of support at a far greater level than other population groups. Compared with those who

have social and economic advantages, disadvantaged Australians are more likely to have shorter lives, higher levels of disease risk factors and lower use of preventive health services (AIHW 2008).

Research has found that most migrants enjoy health that is at least as good as, if not better than, that of the Australian-born population and that they often have lower death and hospitalization rates, as well as lower rates of disability and lifestyle-related risk factors (AIHW 2002 cited in AIHW 2008). This effect is believed to result from two main factors. First, a self-selection process including those who are willing and economically able to migrate, excluding those who are sick or disabled and second, the result of a government selection process which involves certain eligibility criteria based on health, education, language and job skills.

Age

Australia's 2006 census findings reported that 13 % of the population are aged 65 years and over, and 2% are 15 years of age or younger. Based on current birthing and immigration trends, Australian Bureau of Statistics (ABS) projects that aged persons will comprise 26-28 % of the population by 2051, whereas, those people under the age of 15 years will decrease to represent 13 % of the population. At 30 June 2006, the older people from non-English-speaking countries numbered over 583,200, compared with 370,000 from the main English-speaking countries and 1,780,400 who were born in Australia. In 2006, the most common countries of birth for non-English-speaking older people were from Italy (113,900) and Greece (57,200) (Australian Bureau of Statistics (ABS) 2007g). In 2004, approximately 300,000 people were found to be aged 85 years and over, comprising 1.5 % of the population (Commonwealth of Australia 2008).

Definitions of aging among different cultural groups can be vastly different from mainstream and dominant cultures in Australia and elsewhere, hence the nurse needs to include cultural assessment in their practise in order to provide culturally congruent, safe and competent care. Older people often have to contend with negative stereotypes, prejudice and discrimination. Such attitudes are forms of ageism, that is, the systematic devaluing of a group of people on the basis of a characteristic in common. Ageism is similar to racism or sexism, in that generalized judgments are made about people as a group rather than as individuals. Ageism can be challenged by nurses, as we become conscious of the need to eliminate discrimination (Clark McCann 2004). Australia's 2006-2009 Department of Health Ageing Corporate Plan expresses a vision for better health and active ageing for all Australians. Top priorities for achieving this vision can be summarised as; focusing on prevention and early intervention; ensuring choice and access to quality age care services; improving health of Indigenous Australians.

Refugees and asylum seekers

Between 1998 and 2002, over 600,000 refugees and displaced people resettled in Australia. The quota resettled in the Humanitarian Program in 2002-03 was 12,000. Four

thousand of these places were reserved for the refugee category (Department of Immigration and Multicultural and Indigenous Affairs 2002b). In January 2004, the Australian Government announced that it would seek to increase migrant and humanitarian settlement in regional Australia. In 2004-05 the department funded Integrated Humanitarian Settlement Strategy (ISHS) assisted the settlement of refugees in regional Australia (Commonwealth of Australia 2007). As a result the Australian Governments Refugee and Special Humanitarian Programme increased the annual intake of refugees to 13,500 per annum. In 2007-08 the top five countries of origin of offshore refugee and Special Humanitarian Program entrant were from Burma, Iraq, Afghanistan, Sudan and Liberia (Refugee Council of Australia (RCOA) 2008).

Refugees may have experienced severe deprivation, trauma and torture that can lead to post-traumatic stress disorder (PTSD), a condition that can profoundly affect a persons health and capacity to resettle. There is a body of literature on the medical and psychological responses of people to war and conflict that includes Afghan refugees in Australia (Harris Telfer 2001, Procter 2004b, 2004c, Silove et al 1998, Steel & Sil 2001, Sultan & OSullivan 2001). The specific factors that impact on resettlement of refugees are poorly understood outside of relief agencies (Khamis 1998; Summerfield 2000).

In their study of Afghan refugees in NSW, Australia, Omeri, Lennings, Raymond (2006) identified a number of issues of central concern to this group including emotional responses to trauma, migration, and resettlement experiences; culture-specific health maintenance strategies; barriers impeding access to and appropriateness of Australian health care services. The findings have relevance for improving the quality of culture-specific health care for the Afghan community in Australia.

Disability status

The way disability is defined and understood has changed in the last decade. Disability was once assumed as a way to characterise a particular set of largely stable limitations. The World Health Organisation has moved toward a new international classification system the International Classification of Functioning, Disability and Health (ICF) (ICF 2001), emphasises functional status over diagnosis.

The ICF focuses on analysing the relationship between capacity and performance. If capacity is greater than performance then the gap should be addressed through both removing barriers and identifying facilitators. It specifically promotes Universal Design a concept that serves to identify facilitators that can benefit all people. Disability is now seen as a contextual variable, dynamic over time and in relation to circumstances.

In 2003, 1 in 5 (20%) people in Australia reported having a disability (SDAC 2003, cited in Commonwealth of Australia 2008). The rates were found to be the same for men as women. The number of people indicating that they had a disability increased with age. Furthermore, an ABS survey revealed that 6% of Australia's population was reported as having a profound or severe core activity limitation that required assistance with self-

care, mobility or communication (Commonwealth of Australia 2008).

Insert Table 20.2 Disability rates – 2003

Commonwealth of Australia 2008

The change in defining disability calls for a change in the provision of health care services and nursing practice and services. It requires a shift from preventative and enabling services to promoting and developing the level of functioning of people who were initially classified differently. Nurses need to be aware that different cultural groups respond differently to a person living with a temporary or permanent disability.

Rural-remote inequalities

People living in rural and remote areas tend to have shorter lives and higher levels of illness and disease risk factors than those in major cities (AIHW 2008)

The problem of poverty and disadvantage for people in many rural and regional areas across Australia is evidenced by generally lower incomes, reduced access to services such as health, education and transport, as well as declining employment opportunities. These factors are compounded by the problems of distance and isolation (Royal College of Nursing Australia 2004; AIHW 2008).

The provision of services to rural and remote areas is problematic due to distance, low service density and the social and cultural adaptation needed to make them effective (Jong et al 2005). Jong et al (2005) highlight the need for improved primary healthcare, and access to expert multidisciplinary services in a coordinated fashion for rural and remote populations. These authors called for cooperation between governments for the successful development of pathways with innovative information systems, to improve interaction between services to address inequalities in care in rural Australia.

Following an increase in regional humanitarian settlement recommended by the report of the Review of Settlement o Services for Migrants and Humanitarian Entrants in 2004. Recommendation 29 of the Report proposed that the department: seek further opportunities to settle humanitarian entrants in regional Australia; and, liaise more closely with stakeholders regarding regional locations where employment opportunities exist and appropriate services and community support exist or may be developed.

As a result many newly arrived immigrants and refugees transfer to country locations for employment and affordable housing. however, social support networks and access to culturally appropriate services are reduced (Department of Immigration, Fact sheet 97).

CULTURALLY COMPETENT NURSING CARE FOR CULTURALLY DIVERSE POPULATIONS

Culture reflects the values, beliefs, customs, thoughts, actions, communications and belief systems of racial, ethnic, religious or social groups. Competence, on the other hand, implies a capacity to function within the cultural context and pattern of behaviour, of a designated group, community or an institution. Combining these concepts enables a system, community, institution or group of professionals to develop a congruent set of behaviours and policies to function effectively in a culturally diverse situation.

Cultural competence has been defined as a set of congruent behaviours, practices, attitudes, and policies related to embracing cultural differences that are integrated into a system or agency or among professionals (Mays et al 2002:139). Cultural competence also means having the knowledge, awareness and sensitivity of culture sufficient to meet the culture care needs of individuals, families, groups and communities. It involves respect for difference and a desire to learn from and accept diversities.

Having discussed diversity and its implications for culturally competent nursing care, the following descriptions includes a summary of skills needed for the planning, development and delivery of culturally competent nursing care. These guidelines have been adapted from (Andrews & Boyle 2008).

Cultural self-assessment, enables nurses to develop an awareness of their own cultural values, attitudes, beliefs, and practices. These insights enable one to overcome ethnocentric tendencies and cultural stereotypes, which are often vehicles for perpetuating prejudice and discrimination. Cultural self-assessment is the foundation for culturally competent and culturally congruent nursing care.

Cross-cultural communication, is identified as one of the most important landmarks in cultural assessment in establishing a culturally congruent care plan. Therefore, it is necessary to examine the ways in which people from various cultural backgrounds communicate with one another. In addition to oral and verbal communication, messages are conveyed nonverbally through gestures, body movements, posture, tone of voice, and facial expressions,

Non-verbal communication, patterns vary widely across cultures. Therefore, nurses must be alert for cues that convey cultural differences in the use of silence, eye contact, touch, space, distance, and facial expressions. Cultural influences on appropriate communication between individuals of different genders also need to be considered. Non-verbal behaviours are culturally significant and failure to adhere to the cultural code may be viewed as a serious transgression. Violating norms relate to appropriate male-female relationships among various cultural may jeopardize the nurses therapeutic relationship with clients and their families.

Touch, deserves careful consideration. While we recognize the often-reported benefits in establishing rapport with clients through touch, including the promotion of healing

through therapeutic touch, physical contact with clients conveys various meanings cross-culturally.

Space and distance, are significant in cross-cultural communication. The perception of appropriate distance zones varies widely among cultural groups. In the early 1960s, Edward Hall pioneered the study of proxemics, which focuses on how people in various cultures related to their physical space. Although there are intercultural variations, the intimate distance in interpersonal interactions ranges from 0-18 inches. At this distance, people experience visual detail and each others odor, health, and touch. Personal distance varies from 15-4 feet, the usual space within which communication between friends and acquaintances occurs. Nurses frequently interact with clients in the intimate or personal distance zones. Social distance refers to 4-12 feet whereas anything greater than 12 is considered public (Andrews Boyle 2008; Hall 1963 cited in Andrews Boyle 2008).

IMPLICATIONS FOR PROVISION OF CULTURALLY COMPETENT NURSING AND HEALTH CARE

Based on an internet survey Andrews & Boyle 2008 reported on 2 major categories of cultural competence, organizational cultural competence and individual cultural competence.

'Organizational competence requires a defined set of values and principles and demonstration of behaviours, attitudes, policies and structures that enable people to work effectively cross-culturally. Individual cultural competence refers to a complex integration of knowledge, attitudes, beliefs, and encounters with those from cultures different from ones own' (Andrews & Boyle 2008: 16)

Cultural competence in nursing has been defined as a process, as opposed to an end point, in which nurses continuously strive to work effectively within the cultural context of an individual, a family, or community with diverse cultural backgrounds (Andrews Boyle, 1997, 2008, Campinha-Bacote, 2003, 2008). Campinha-Bacote (2003) suggests '...that the process involves the integration of cultural desire, cultural awareness, cultural knowledge, cultural skill and cultural encounter' (Campinha-Bacote 2003 p.14).

Assuring culturally competent nursing and healthcare is the responsibility of systems, agencies and institutions (Omeri 2003). There is a growing understanding revealed in the literature that organizations providing culturally and linguistically appropriate services (i.e. culturally competent services) have the potential to reduce cultural and ethnic health disparities (Anderson et al 2003).

The nursing profession is responsible for developing cultural competence in its practitioners, not only in its novitiates, but also on a continuing basis as measured by the demonstration of requisite skills, knowledge and attitudes. However, there is no agreement as to how continuing competence should be monitored, nor is there any provision for continuing education in transcultural nursing for faculty and nurse

administrators.

CONCLUDING REMARKS

Meeting the healthcare needs of diverse populations in Australia is one of the greatest challenges faced by nurses and healthcare professionals. This chapter has provided an overview of population trends relating to cultural and linguistic diversity and the ways it impacts on the role and function of nurses and healthcare professionals. It has highlighted issues relating to globalization and the impact of poverty on health and subsequent disadvantage of some populations in accessing health and other services. Furthermore, the impact of policy directions on healthcare and education were discussed. Culturally congruent, safe and competent nursing and health care were proposed as a way to improve nursing practice and health outcomes for diverse population groups. This chapter also highlighted the importance of transcultural nursing knowledge and its application for nursing practice in an attempt to improve the health and well-being of the diverse populations in Australia.

Reflective questions

1. What are some of the factors influencing healthcare of diverse populations in Australia? Reflect upon those discussed in this chapter.
2. How can poverty be defined? How is it linked to health and well-being outcomes?
3. Take some time to think about your own cultural beliefs in relation to health and healthcare. How might your own beliefs be similar or different from someone from another culture?
4. How can nurses embrace diversity to enhance workplace practises?

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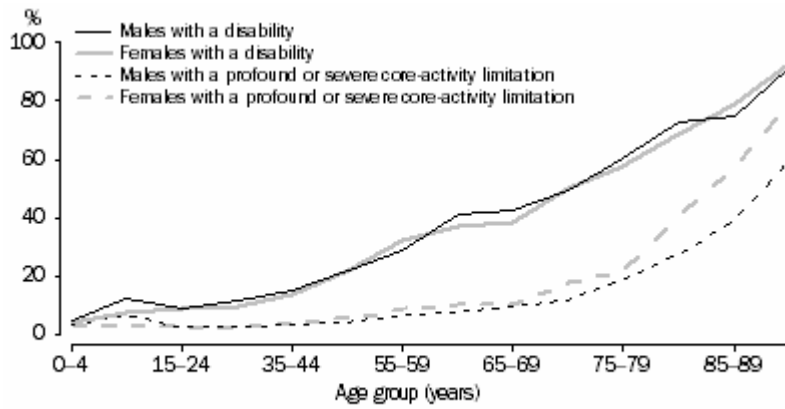
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Table 20.1: Periods in immigrant policy development

	Policy	Features	Health policy implication
1945–70	Assimilation	Predominantly White Australian Anglo-Saxon policies	Absence of government assistance
1970–80	Integration	White Australia Policy relaxed and gradually abandoned Some cultural characteristics tolerated	Relevant services provided Welfare needs of migrants being addressed
1980–89	Multiculturalism	Pluralistic approach to immigration Policies to limit discrimination on racial and ethnic grounds Cultural and ethnic diversity becoming more accepted in Australian society Cultural identity, social justice and economic efficiency were adopted	Provision of various health services Equality of access to culturally appropriate services
1983	Mainstreaming	Redirecting service delivery from marginal to a central base Concern of government institutions based on social equity and access; economic efficiency and cultural identity	Promotion of culturally sensitive health services Equality of access to health services by immigrants
1999	Inclusiveness	Diversity Multicultural policies built upon civic duty, cultural respect, social equity and productive diversity The term multiculturalism to remain Inclusiveness	Promotion of culturally sensitive health services Equality of access to health services by immigrants
2000–2008	United in Diversity	National Agenda for a multicultural Australia Policy framework including: All Australians are expected to have a “loyalty to Australia and its people, and to respect the basic structures and principles underpinning our democratic Society. These are: Constitution, Parliamentary democracy, freedom of speech and religion, English as the National language, the rule of law, acceptance and equality (Commonwealth of Australia 2008: 1). The current Rudd Labor Government has re-affirmed their support for the relevance and constitution of Australia’s Multiculturalism Policy.	Main components of Multicultural Australia: United in Diversity Policy 2003–2006 responsibility, respect, fairness and benefits for all.

Table 20.2 Disability rates – 2003



Source: ABS data available on request, Survey of Disability, Ageing and Carers.

(Commonwealth of Australia 2008)