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Research paper

Developing a cultural responsiveness framework in healthcare systems: an Australian example

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What is known on this subject

- Provision of culturally appropriate healthcare is a major issue for healthcare services worldwide, even when a major contributor to health disparities is a lack of culturally competent care.
- The Australian Charter of Healthcare Rights has the obligation to provide healthcare to all Australians, yet it is silent on issues of culturally appropriate care.
- Failure to consider a patient's cultural and linguistic issues can present risk(s) to healthcare providers and their clients.

What this paper adds

- Cultural diversity challenges are faced by health agencies.
- Barriers to effective participation that are experienced by culturally and linguistically diverse (CALD) communities in health services are identified.
- A cultural responsiveness framework is recommended for health service organisations to provide healthcare to CALD populations.

ABSTRACT

Australia has had over five decades of permanent immigrant settlement programmes, and faces the challenge of negotiating approaches to health service delivery that meet the needs of a diverse population. This paper reports the findings of a major review of one Australian state health system's cultural and linguistic diversity, cultural competence requirements, minimum standards and benchmarks. Drawing on the framework of the Australian Charter of Healthcare Rights, the review examined culture, cultural diversity and cultural competence in healthcare services for culturally and linguistically diverse (CALD) communities. Multiple sources of information were used, namely relevant literature, consultations with health service agencies, organisations working with CALD communities, and focus groups with consumer advisory bodies within health services. The findings identified the strategies adopted by healthcare services in delivering healthcare to CALD clients, and the barriers to accessing care and treatment. Cultural competence was not well defined, and caused confusion. The paper concludes by recommending a *cultural responsiveness framework* which can be more easily adapted by healthcare systems and staff.

Keywords: cultural competence, cultural responsiveness, culturally and linguistically diverse (CALD) communities, health service delivery

Introduction

More than 20% of the population of Australia were born in another country, and more than 50% of them originate from non-English-speaking countries in Europe, the Middle East, South America and Asia. When combined with their Australian-born children, this group constitutes about 40% of the total population. In 2006, the most recent year for which figures are available, 30.3% of the population of the state of Victoria were born overseas and represented over 150 countries, over 180 languages were spoken, and 20% of the population spoke a language other than English at home (Australian Bureau of Statistics, 2006).

The impact of settlement and acculturation varies widely depending on individual experiences and situations. Determinants of health and well-being such as housing, employment, education, community networks and supports, and access to essential services play a key role in the settlement timeframe. As a result, the health and well-being of culturally and linguistically diverse (CALD) communities depend on a complex balance of social, economic and environmental factors. Although immigrants and refugees often enter Australia with better physical health due to screening programmes (NSW Department of Health, 2004), they may have worse levels of mental health linked with the stressors arising from migration (Fozdar and Torezani, 2008; Babacan and Gopalkrishnan, 2005). Health problems may be compounded by lack of familiarity with Australian health services, even among those arriving from closely neighbouring countries such as the Pacific Islands. Consequently, many migrants experience difficulties in accessing appropriate health services because of physical, cultural, psychological and/or financial reasons (Henderson and Kendall, 2011).

It is well documented that cultural and linguistic backgrounds are among the major factors that shape the health outcomes of individuals. Varied language skills, cultural histories and practices, and the ability to participate in economic and social life all contribute to health outcomes and affect access to health services (Manderson and Reid, 1994). Culturally safe health services are non-threatening to the patient's identity and reflect the ability of systems to provide care for people with diverse values, beliefs or behaviours (Foronda, 2008; Betancourt *et al*, 2002; Ramsden, 1990, Cross *et al*, 1989). Healthcare systems and workforces should aim to provide such services if they are to deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background and linguistic proficiency. However, evidence indicates that services do not always provide what is needed. For example, public health providers have acknowledged that current models for health promotion in CALD communities are quite limited (Prasad-Ildes and Ramirez, 2006). Culturally competent bilingual health workers are a vital component in ensuring the effectiveness of culturally appropriate interventions in the management or prevention of chronic disease in CALD communities (Henderson *et al*, 2011).

This paper is based on the findings of a project commissioned by the Victoria Department of Human Services (DHS) that aimed to develop and implement a review of cultural and linguistic diversity and cultural competence reporting requirements, minimum standards and benchmarks for health services. Thus this paper first explores the role of culture, cultural diversity and cultural competency in healthcare services, then reports on the findings of key stakeholder consultations conducted using interviews and focus group, and finally proposes a conceptual framework for creating culturally responsive health service organisations that addresses the challenges of cultural diversity in healthcare systems.

Background

Frameworks for health and diversity in Australia and Victoria

Australia and the state of Victoria are governed by a set of principles that provide for checks and balances in healthcare systems, to guard patient rights, ensure a duty of care and provide systems of risk minimisation and quality evaluation. As the health governance mechanisms are complex and detailed, a description of them is beyond the scope of this paper. However, two key frameworks are relevant, namely the Australian Charter of Healthcare Rights and the Australian Council on Healthcare Standards using the tool EQUiP 4 accreditation standards and guidelines.

The Australian Charter of Healthcare Rights

Australian healthcare systems in all states and territories have an obligation to provide healthcare to all Australians. The Charter of Healthcare Rights is built upon the principles of human rights and social justice, namely access, safety, respect, communication, participation, privacy and comment. Although the Charter is strong on rights, it is silent on issues of culturally appropriate care. It may be argued that these rights can incorporate notions of culture in care, but this is not explicitly stated in the Charter, so in reality this requires strong advocacy on the part of the patient. Unfortunately, culturally diverse patients are often disadvantaged in mainstream systems and are unable and unlikely to advocate for their own welfare in healthcare.

Australian Council on Healthcare Standards using the tool EQUiP 4 accreditation standards and guidelines

A number of standards provide a framework for health and allied health service provision in Australia. These include the Australian Council for Healthcare Standards (ACHS), the Quality Improvement Council (QIC) and the International Organization for Standardization (ISO). ACHS's mission is to 'improve the quality and safety of healthcare' through an independent assessment process. The Evaluation and Quality Improvement Program (EQUiP 4) provides a framework for safety and quality for healthcare providers, and sets out standards in three broad areas, namely clinical, support and corporate. There are 14 mandatory standards, but none of them specify cultural diversity. Standards relating to cultural diversity are listed under *Consumer Focus (non-mandatory)* in Article 1.6.3, which states that:

> The organisation makes provision for consumers/patients from culturally and linguistically diverse backgrounds and consumers/patients with special needs.

Although there is recognition of CALD consumers in the provision of health services in Australia, meeting this obligation is largely left to the service providers. Healthcare systems may indeed be operating within the equity principles. However, by not recognising the unique spiritual, cultural and linguistic needs of the CALD communities, they are excluding the neediest consumers (Ramsden, 1990; Eckerman *et al*, 1992). Therefore we contend that the standards relating to cultural diversity in the accreditation processes of health services in Australia are weak and cannot be relied upon as a mechanism to ensure culturally appropriate care.

The Victorian Government multicultural affairs policy framework shapes the internal policies and strategies of the department. The Cultural Diversity Guide (Department of Human Services, 2006) provides the skeletal framework for planning and reporting. A number of commonalities are evident in each of the different cultural diversity planning and reporting areas deriving from the Guide. These include understanding clients' needs, access to services by CALD communities, the responsiveness of services to cultural diversity, language services, cultural sensitivity, appropriate workforce and recruitment and training, consumer participation, and overall promotion of multiculturalism or a commitment to cultural diversity values. Implementation of the policy is based on historical developments in service provision or policy areas within the department, the Commonwealth State Agreements and the presence of National Service Standards. The shortcomings of this system relate to a non-legislative base for cultural diversity and a self-regulatory, non-mandatory framework and the internal and external resources available to services to support cultural diversity planning and implementation within each health service provider.

The importance of cultural diversity and cultural competence in healthcare systems

The most articulated understanding of cultural diversity comes from UNESCO's Universal Declaration on Cultural Diversity, which was adopted unanimously in 2001. It promotes cultural diversity to the level of the common heritage of humanity, implying that it is 'a source of exchange, innovation and creativity ... as necessary for mankind as biodiversity is for nature' (UNESCO, 2002). The term *cultural and linguistic diversity* refers to the range of different cultures and language groups represented in the population. In the Department of Human Services (DHS) Plan, this term is used interchangeably with the term *multicultural.* Organisations that deliver healthcare to indigenous populations prefer that the needs of Australian Aborigines be considered separately, rather than under the framework of cultural and linguistic diversity (Department of Human Services, 2006, p. 43). The issues of cultural diversity are often addressed through *cultural competence.*

Although the notion of cultural competence is not conclusive, there is an agreement in the academic community about its definition as suggested by Cross *et al* (1989). The National Quality Forum (2002) notes issues relating to standardised frameworks including logic and definition of cultural competence. The complexity of conceptualising and applying cultural competence to healthcare has resulted in the absence of standardised frameworks, measures, benchmarks and evidence of longitudinal outcomes of cultural competence interventions. Although there is a case for the benefits of cultural competence from a clinical and business standpoint, the major challenge remains that of how to define, assess and measure it (Betancourt *et al*, 2002; Brach and Fraser, 2000). The main criticism of cultural competence is that, rather than treating culture as a dynamic changing factor, it encourages the reification of culture as a static entity which risks the perpetuation of cultural stereotypes (Gregg and Saha, 2006). Furthermore, it does not theorise power or critique systems of oppression such as racism, sexism, ageism, heterosexism and ableism (Sakamoto, 2007). It can even be construed as a new form of racism by 'otherising' non-whites by deploying modernist and absolutist views of culture, while not using racialist language (Pon, 2009). Contrary to this notion, it may

be seen as a medium in which to recognise and challenge racism, discrimination and other forms of oppressive practices (Papadopoulos *et al*, 2004). In determining the relevance of cultural competence to health and well-being it is noted that cultural competence in healthcare emerged, in part, as a means of addressing racial and ethnic inequalities that may lead to health disparities. To this end, several studies (both Australian and international) have documented the benefits of a culturally competent healthcare system and emphasised that it has the potential to reduce health disparities among populations from CALD backgrounds. However, conclusive evidence for the efficacy of cultural competence framework(s) in reducing health disparities is scarce.

However, there is a degree of consensus that those responsible for the design and delivery of healthcare have not done enough to ensure the responsiveness of the Australian healthcare system to the health and care needs of minority racial and ethnic groups, and that much more needs to be done. We attribute this to underlying and 'largely unacknowledged layers of resistance to the principles and practice of cultural diversity in healthcare that, in turn, are underpinned by the largely unacknowledged phenomenon of "new racism", also called "cultural racism"' (Johnstone and Kanitsaki, 2006, pp. 176–86). This is extremely difficult to challenge and confront, as it has become embedded in the common sense of individuals and the culture of institutions, making it difficult to make a case to policy makers. This, in conjunction with a lack of hard data demonstrating the inequities and disparities at the forefront of service delivery, has made it difficult to be responsive to the healthcare needs of the CALD population.

Method

The project was undertaken at the invitation of the Victorian Department of Human Services (DHS), which required an exploration of how health services, including all public hospitals and other health service providers in the state, provided health services appropriate to the cultural diversity of the population in their geographical locations. The nature of the project was complex and needed multiple methodologies. It required a qualitative approach as the inquiry focused on understanding practice related to cultural diversity planning and reporting. We adopted a grounded theory approach which is 'an inductive, theory discovery methodology that allows the researcher to develop a theoretical account of the general features of a topic while simultaneously grounding the account in empirical observations or data' (Martin and Turner, 1986, p. 141; Graneheim and Lundman, 2004). This approach allowed us to gain participants' perspectives on cultural and linguistic diversity and cultural competence reporting requirements, minimum standards and benchmarks. This knowledge was then used to build our theories from patterns and relationships that we observed, rather than starting with an assumption about cultural diversity reporting or indicators.

Participants and data collection

First, consultations were held with the DHS advisory committee which consisted of key stakeholders, including representatives of large and small health providers, DHS staff, consumer representatives and health advocacy groups. Secondly, interviews with 28 selected health service providers in metropolitan, regional and rural areas were undertaken. These interviews covered a range of questions, including barriers that confronted the delivery of culturally appropriate services. The interviews were recorded with participants' approval and transcribed verbatim. Thirdly, six focus groups with members of consumer advisory bodies within health service providers, including culturally diverse patients, were undertaken. This triangulation confirmed information sourced through initial consultations and interviews with health service providers.

Data analysis

Data were analysed by drawing themes from the responses of participants from consultations, interviews and focus groups. These were then cross-checked with each other until all responses had been validated and common themes identified (Martin and Turner, 1986; Graneheim and Lundman, 2004).

Ethics

We undertook this work for the Department of Human Services. It was decided to treat this as consultations, and therefore we were not obliged to submit an application for ethical clearance. The project was conducted according to the protocols of the National Health and Medical Research Council (2006) and Victoria University Human Ethics Committee.

Findings

The following findings are summarised from the data collected.

Management of cultural diversity in healthcare services

Participants from health services were asked a number of questions relating to how services develop an understanding of the needs of people from CALD backgrounds, what policies and practices they adopt to meet those needs, how they ensure that the staff have professional capability for cultural competence, and how they receive feedback on satisfaction from CALD clients about the responsiveness of the health service to their needs. A number of challenges were identified by agencies in response to cultural diversity in their services. Key challenges are reported within the model of the National Health and Medical Research Council (2006) (see Box 1).

Health service providers responded to these challenges in diverse ways with the purpose of meeting their clients' needs. They identified wide-ranging practices relating to cultural sensitivity along a continuum from being *very sensitive*, meaning that cultural diversity was highly relevant, to being *not particularly sensitive*, meaning that there was low relevance to cultural diversity. Some, particularly metropolitan, health service providers demonstrated a substantial level of commitment and resources to culturally competent healthcare delivery, with full-time translation and language service officers or the formation of CALD-specific health services in response to community need, such as a Refugee Health Service or Vietnamese Maternity Clinic.

Language services and particularly the use of interpreters were identified as one of the ways to respond to cultural diversity. The language services were variable and included in-house interpreters during office hours, online booking services and language policy development. For example, one health service had five language services-related policies, whereas others utilised external agencies or on-call/telephone interpreters. On the other hand, some rural and regional

Box 1 Key cultural diversity challenges faced by health agencies using the NHMRC model

Systemic:
- Capturing cultural diversity in patient-centred care systems
- Problems with data, measurement of performance, indicators and benchmarks
- Tools and instruments for assessment of cultural competence in health settings
- Use of biomedical models of service delivery systems which prevent holistic approaches to treatment (e.g. utilisation of traditional methods of healing)
- Absence of appropriate resources to embed and follow cultural diversity guidelines
- Invisibility of cultural diversity in major systems and procedures (e.g. policies and accreditation)
- Treatment of cultural diversity as 'add-on' and token to overall work of health services
- Integration and mainstreaming of diversity initiatives has resulted in loss of focus on cultural diversity

Organisational:
- Planning and reporting on cultural diversity
- Managing cultural diversity among competing priorities
- Lack of understanding of cultural competence and failure to incorporate cultural diversity into all areas of core business
- Lack of support from the central office about cultural diversity responsiveness
- Absence of benchmarks and guidelines for successful outcomes in cultural diversity
- Lack of critical mass of some ethnic communities in regional areas to justify cultural diversity needs
- Lack of appropriate data and information on CALD clients

Professional:
- Need to deliver culturally responsive services in busy environments
- Lack of training of professionals for cultural diversity (e.g. doctors, nurses, other staff)
- Effectiveness of interpreters or appropriateness of translations
- Absence of specialists and expertise to support cultural diversity work
- Difficulties with cross-cultural training (e.g. high costs, lack of impact across agencies)
- Lack of interpreters in some languages, or regions

Individual:
- Lack of understanding of cultural competence in health service settings
- Prejudicial attitudes to particular ethnic groups
- Cultural diversity initiatives seen as 'special' treatment of ethnic groups
- Inability to understand and work with cultural issues (e.g. male consent for female patients)

services rarely used them. It was noted that information was translated in different languages and often related to treatment of a particular disease rather than the service concerned. At some health services, staff completed a voluntary form agreeing to assist in emergency interpreter/translation.

Barriers to effective participation of CALD communities in health services

Information sourced through consultations and focus groups revealed that members of CALD communities experienced a number of barriers when accessing health services (see Box 2).

These barriers are indicative of the lack of ability of Victorian health systems to respond to the health needs of CALD communities effectively. These barriers are also part of health trajectory determinants causing health disparities among migrants, refugees and other minority groups (Edberg *et al*, 2011) and leading to institutional racism (Allan *et al*, 2004). This is a clear example of a healthcare system not providing a culturally safe and/or competent service, but instead creating mistrust and apprehension among CALD communities (Brach and Fraser, 2000), as a result of which the services are not used and treatable illnesses/diseases may not be identified sufficiently early (O'Connell *et al*, 2007).

Health service providers developed an understanding of CALD clients through secondary and primary sources and responded to the challenges of cultural diversity through a variety of initiatives (see Boxes 3 and 4).

Role of cultural diversity policies and practices, benchmarks and standards

Participants identified a wide range of policies regarding cultural diversity, including the *Cultural Diversity Guide* developed centrally by the DHS or through accreditation processes to individually tailored hospital guidelines (Department of Human Services, 2004). Uptake of policies in general was dependent on their nature (mandatory, recommended or voluntary). Although there was acceptance of DHS policies at a rhetorical level, consultations revealed varying degrees of practice. Some health services saw it as integral to their service planning and delivery, whereas others regarded it as an issue of compliance with minimum practice. One metropolitan respondent commented on how important it was to have culturally responsive policies and practices, stating:

> We acknowledge that it is often when women have babies that it is the first time these people come into contact with the hospital service, so it's very important to get it right [talking about providing services to newly arrived immigrants from Horn of Africa and Burma].

Different perspectives on translating policy into practice were also noted. For example, a manager from a metropolitan health service provider was proficient in relaying various policies pertaining to cultural diversity. Yet, in practice, consultations with the Chief Interpreter revealed that funding barriers and technology problems hampered the provision of these services. The issue of population base was identified as an important factor in policy implementation. Health service providers servicing a wider group of CALD clients in many instances felt a greater responsibility to be culturally responsive to their demographic, so greater resources were dedicated to being culturally responsive. Some providers with smaller CALD population bases from rural and regional areas relied for support on accessing external services, such as on-call interpreters.

All of the health service providers mentioned the DHS's *Language Services Policy,* which recognises effective communication as essential to the delivery of high-quality services (Department of Human Services, 2005). The policy outlines the necessary requirements to enable people who cannot speak English, or who speak only limited English, to access professional interpreting and translating services when making significant life decisions and when essential information is being communicated. In addition, a wide range of practices were also mentioned which aimed to provide culturally sensitive services to clients. The key tangible

Box 2 Barriers to effective participation of CALD communities in health services

Lack of English language skills
Low literacy levels, including health literacy as well as reading and writing in English
Absence of interpreters to participate in Cultural Diversity Committee (CDC)
Lack of knowledge about health systems
Lack of confidence in their own abilities/skills, and a lack of engagement by health services
Issues relating to negotiating systems
Bureaucracies and power to contend with
Lack of time
Distances required to be travelled, especially in rural and regional areas

Box 3 Methods used by health services to obtain information about CALD clients

Information and data analysis
This includes demographic profiles. All health services used Australian Bureau of Statistics data, with the exception of one provider who commented that 'it was too unreliable to use.' Also other information sources were utilised, such as reports from the Department of Immigration and Citizenship (DIAC) and other community research.

Satisfaction/quality questionnaires and surveys and Patient Satisfaction Monitor
Although this was identified as a useful instrument, a number of informants commented on the lack of breakdown of comments based on ethnicity, language and culture.

Direct contact
This includes engaging with client family members and other community agencies.

Hospital admission
Criteria provided background of country of birth, whether an interpreter is required, and language spoken at home. In addition, admission trends provided a long-term picture of the status of CALD communities in relation to hospital admissions. Some noted the online booking system data and database which is reported to the Executive and the Board and is linked up with the business case development system.

Individual care plans
These provide for specific needs of individuals and these are tailored, taking into account cultural factors relating to food, religious practices, approaches to treatment and medicine.

Team consultation environment
Some health services identified environment of teamwork which enabled sharing of information, and consultation on key policy programme design. This worked well when there was a designated officer for cultural diversity.

Networking
Health services had consultations with different community and local ethnic/refugee groups. In some instances these community groups were represented on the cultural diversity committees.

Box 4 Examples of health service providers' responses to cultural diversity

Volunteers
A pilot program to welcome CALD patients by CALD volunteers to make them feel comfortable.

Video conferencing
Standardised instructions to streamline all of the information to patients because interpreters are not available at all times to everyone. This is currently being examined.

Cross-cultural training as part of the orientation process

Cultural diversity planning
This has been incorporated into major policies, such as the risk management system, including guidelines such as the appropriate use of interpreters.

ones that were identified were food, language services, signage, respect for rituals, appropriate treatment of family and extended kin, and celebration of diversity days at work. The level of organisational support was identified as the key factor affecting how proactively an understanding of cultural diversity practices was developed across an organisation.

The following key factors were identified in relation to responsiveness or a lack of it to cultural diversity:

- supportive or unsupportive organisational structures
- the numbers of CALD clients presenting for service (i.e. the CALD population base)
- the presence of staff positions devoted to cultural diversity.

Two factors were instrumental in the number and quality of cultural diversity practices in health service settings: first, the employment of a dedicated position

to cultural competence such as Cultural Diversity/Transcultural and Language Service Officer, and secondly, leadership and organisational support from the executive team, which then filtered through planning, policy and service delivery.

The participants indicated that the benchmarks and standards for cultural diversity were uncharted territory in healthcare systems. Cultural competence appeared to be in place in theory, but seemed vague to health practitioners, and there was little evidence of actual practice. There was evidence of ad-hoc system uptake, such as interpreters or language services, but these were not comprehensive. The difficulty in implementing standards appeared to be due to the lack of application of cultural competence theories to practice. In addition, poor attention to health service accountability and monitoring areas, tokenistic treatment of cultural diversity measures, high staff turnover, privacy policies, measurement problems, and a lack of data on diversity and the perception of its collection as onerous, and a lack of appropriate training, were also evident. In the absence of appropriate measures, standards or benchmarks, many participants did not know how culturally responsive their services were.

Discussion

Responding to ethno-cultural, religious and linguistic diversity is a complex and challenging area for health services. Nevertheless, health services responded in a variety of ways and in response to multiple factors. Key stakeholders made several suggestions about barriers to services. The main one was the need to address the non-mandatory nature of cultural diversity, which can be perceived as optional and therefore of less importance. Participants reported that it tended to be linked with other factors, such as risk, quality and patient charter, and was not seen as an area worthy in itself. Many felt that a mandatory arrangement, such as in the accreditation processes or the use of legislation, might mean that more attention was paid to cultural diversity as a separate and important issue. Other suggestions were related to issues of justice and fairness to reduce disparities in health outcomes.

Improvements in cultural responsiveness required a whole-organisation approach with service users in mind. Ad-hoc and fragmented service responses demonstrated a need for commitment from leadership and appropriate allocation of resources within health systems to address cultural diversity. It was suggested that measurement of organisational performance for cultural diversity needed to be strengthened, and that industry benchmarks and standards were required. Many suggestions linked cultural diversity with quality assurance and safety policies, as existing policies did not include culture as a factor.

Although there were greater calls for mandatory and stronger whole-of-government approaches, many suggested that the systems developed needed to have flexibility to suit the multi-faceted Victorian context. Many cautioned that strengthening of the systems was not about developing a ‘one size fits all’ model, but rather about developing one that has rigour, integrity, accountability and flexibility.

In view of the above findings, we propose a cultural responsiveness framework for healthcare organisations to deliver culturally responsive services to CALD clients. For the reasons noted earlier in this paper, we strongly recommend a move away from *cultural competence* and towards *cultural responsiveness*, due to the variability of definitions, the complexity of its dimensions, and the different levels of understanding of the term across the health sector. It enables a less technical, more concrete method of responding to CALD patients at both a relational and institutional level. It also enables the addressing of the broader social determinants of health factors. Health services faced several challenges, including the absence of benchmarks and guidelines, planning and reporting on several aspects of delivery, including culturally appropriate care to CALD consumers, for successful outcomes in cultural diversity. We believe the cultural responsiveness framework to be sufficiently broad in scope to address the tacit and overt nuances at both the individual level and the systemic level.

Cultural responsiveness framework

Cultural responsiveness is often identified as a strategic means of responding to people within the context of their own cultural background (see Figure 1). It is intended to be more responsive than cultural competence because it encourages response to situational

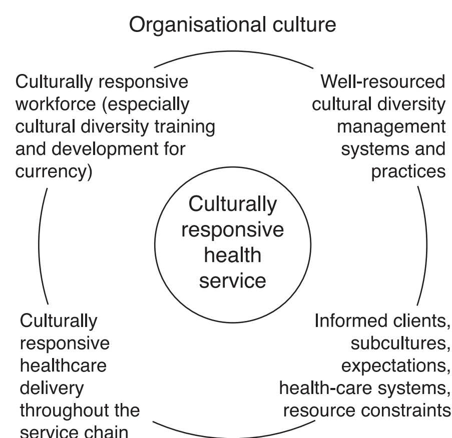

Figure 1 Cultural responsiveness framework in healthcare systems.

applications of cultural knowledge and is less technical in nature. It has emerged as a challenge in person-centred planning processes, and incorporates diverse elements, including relationships, self-awareness, safety and identity (Williams, 2007). (Cultural responsiveness includes *cultural safety*, which is defined as 'safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need', where there is 'shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening') (Williams, 1999, pp. 213–14). Overall cultural responsiveness is a highly reflective learning process that aims to bring about behavioural changes and practice improvements. Incorporating different dimensions of culture into healthcare, it can be used as a framework for a political response to marginalisation and addressing health inequalities (Johnstone and Kanitsaki, 2007).

In organisations, cultural responsiveness extends cultural competence to include the framework of relationships, including those with clients, their values, their support networks, and the community from which they come. Cultural responsiveness occurs after cultural competence has been achieved (Werkmeister-Rozas and Klein, 2009). We build on the National Health and Medical Research Council (2006) model and the framework of Werkmeister-Rozas and Klein (2009), and extend it to include cultural diversity and propose the following definition:

> Cultural responsiveness is an outcome of an organisation's ways of managing cultural diversity by achieving cultural competence through relevant policies, procedures and resources.

In order to deliver culturally responsive healthcare, health services need to create and maintain a particular kind of *organisational* culture that features *well-resourced cultural diversity management systems and practices, a culturally responsive workforce, culturally responsive service delivery systems* and *informed clients.*

Well-resourced cultural diversity management systems and practices

A culturally responsive organisation needs to put in place well-resourced cultural diversity management systems, ensure that the policies, procedures and standards are actually followed rather than used as lip service, and measure cultural responsiveness and compare it against industry benchmarks using tools such as EQUiP 4 (Australian Council of Healthcare Standards, 2006). Cultural responsiveness needs to be led by example and enforced at operational level through quality improvement systems, risk management, patient care, complaints processes, and admission and discharge processes. These should be supported by adequate resources. It is important to note that cultural diversity management systems can only be effective if relevant policies and procedures are actually followed. Often a lack of resources does not enable the well-intended actions. Measurement of the effectiveness of a cultural diversity management system is vital for ascertaining how culturally responsive an organisation is, and how it compares with its competitors.

Culturally responsive workforce, especially cultural diversity training and development for currency

Understanding of cultural diversity and the benefits of adopting culturally responsive means of meeting the healthcare requirements of CALD clients is an important consideration for the health service workforce. This should be introduced through induction and reinforced through compulsory cultural diversity learning and training for the development of all staff (Papadopoulos, 2006). The position descriptions of staff should also portray commitment to cultural diversity and ongoing training. This process should be underpinned by cultural diversity management systems and relevant policies and procedures to provide a solid foundation to support a culturally responsive workforce. The investment made in workforce through these processes will achieve the dividends through better patient care, satisfied clients, efficient use of resources, and job satisfaction for health professionals.

Culturally responsive healthcare delivery throughout the service chain

From the moment a client comes into contact with the healthcare service, the cultural diversity management systems are under scrutiny. For example, when a patient is admitted to a healthcare facility, the treatment should be provided in a manner that is considerate of his or her cultural needs, especially in terms of decision making about care in critical circumstances. It is important to communicate information in a culturally safe manner and in the personal cultural context of the patient, especially information about their medical condition and relevant procedures. Overcoming miscommunication can have positive effects on the quality of care received by patients, patient satisfaction and patient health outcomes (Bischoff, 2003; Johnstone and Kanitsaki, 2007; Kelly and Bancroft, 2007; Markova and Broome, 2007). Healthcare services can also rely on bilingual community health workers (CHWs) to draw upon their community connections and ability to act in culturally appropriate ways to bring together communities and health systems (Henderson *et al*, 2011).

Informed clients

Informing patients about their rights and obligations can engender a level of confidence in the care that they

receive. Often incoming patients have little or no knowledge about how healthcare systems operate, especially how limited resources can restrict ability to meet the needs of English-speaking clients, let alone those with special language and cultural needs. A recent Australian study found language to be a major challenge for health service providers and community organisations in communicating with CALD communities on health information, and that there is a need for face-to-face interaction supported by visual aids and other graphic information that addresses problems of literacy (O'Mara *et al*, 2011).

Making basic information available in CALD patients' own language, especially hospital admission and discharge procedures, visiting arrangements, dietary options, prayer rooms, inpatient care, medication, role of hospital staff, what to do after they leave hospital, and self-management of a medical condition upon their discharge can reduce anxiety and may decrease the number of unnecessary visits to the hospital. Informed patients often feel that their cultural identities are recognised and considered in the care they receive. In addition, patients who are better informed about their options and who understand the evidence behind certain approaches to care may have better health outcomes (Ginsburg, 2002).

Conclusion

Australia faces a major challenge in meeting the healthcare needs of CALD clients in line with the Australian Charter of Healthcare Rights. A fundamental shift is required in the workings of health service organisations if this challenge is to be met. A culturally responsive framework can provide avenues for healthcare services to meet the needs of CALD clients and fulfil the guidelines of the Charter. For this to take place, it is important to consider a whole-organisation approach, as otherwise initiatives remain marginal and not integrated to the agencies' overall systems. Leadership is needed at the highest level in an organisation; without a champion at senior level, initiatives take a long time to implement and do not receive appropriate attention. Following this, staff at all levels should be provided with professional development opportunities to develop and/or enhance their cultural capabilities. Thirdly, healthcare delivery systems should be based on an inclusive practice in care planning, including but not limited to linguistic, dietary, spiritual, family, attitudinal and other cultural practices. Finally, continuing consumer participation, especially the involvement of culturally diverse consumer, carer and community members in the planning, improvement and review of programmes and services, is critical to the successful delivery of healthcare in a culturally responsive manner. These considerations need to be accompanied by strategic planning, reporting, monitoring and evaluation processes. If the evaluation of cultural diversity is embedded into health services' quality and risk management systems, it will be strongly implemented.

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CONFLICTS OF INTEREST

None.

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