ONE SIZE FITS FEW – From Cultural Incompetence to Contextual Sensitivity in Health Policy Development in Australia and Canada

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Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university. To the best of the author's knowledge, it contains no material previously published or written by another person, except where due reference is made in the text.

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Acknowledgments

The title of this thesis draws its inspiration from a report by Brenton Holmes, Australian Government Department of Parliamentary Services, who, in reviewing citizen engagement in public policy development in Australia commented

> "When it comes to the pursuit by public service agencies of engagement with marginalised groups and socially excluded citizens the epithet 'one size fits few' seems appropriate." (Holmes, 2011, p20).

He went on to quote a very relevant comment from a report of a United Kingdom Local Government and Development Group which noted that barriers to citizen engagement include cultural issues and "the attitudes of those involved". The report was referring to the public servants conducting the engagement activity.   As a former Australian Government public servant, I gained an interest in citizen engagement and had the opportunity to try to improve processes and attitudes in one small Agency. This interest has stayed with me and drove my choice of citizen engagement as the focus of my research. I explain more about my motivation in Chapter 1.

I am very indebted to my parents, Joyce and Peter Bladon who are wonderful examples of how to live a tolerant life. They opened their home to men and women from Hong Kong, Africa, India, Sri Lanka and Bangladesh: people who travelled to England for education and work experience to improve their own opportunities for advancement. This must have raised quite a few eyebrows in 1960s, small town, northern England but taught their children that all people are basically the same (and trying on saris was fun too). I will be forever grateful that they took that enormous leap of faith, becoming migrants who gathered up their family and few possessions and travelled to the other side of the world in search of better life opportunities for their five children. Starting from scratch, finding employment, working out what "bring a plate" means and how things are done Australian style would have been a challenge and no doubt worrying at times. Thanks Mum and Dad, you are indeed the giants upon whose shoulders I stand.

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Abstract

Australia and Canada have long and similar histories of accepting immigrants from an increasingly diverse range of countries, leading to the multicultural societies we see today. Both countries also share a commitment to citizen engagement in government business which, when combined with policies of multiculturalism, seek to enrich government policy by the input of the many and varied experiences and voices. However, despite these best intentions, the engagement of citizens of culturally and linguistically diverse (CALD) backgrounds in government business remains a challenge, particularly because of a lack of attention to 'culture' in policy making processes.

The concept of cultural competence is well known in the public sector. However, although mandatory Indigenous cultural competence training exists to varying degrees in both countries, there is no training for cultural competence relevant to other CALD citizens specifically. Similarly, although some jurisdictions offer support and guidance for citizen engagement, there is very little explicit guidance in either country when it comes to engaging with CALD background citizens.

This research is a comparative, cross country, case study which focusses on the health-related public sector in Australia and Canada. Drawing on analysis of government policy and interviews with health policy officers, this thesis examines understandings and applications of cultural competence, multiculturalism and citizen engagement at the Federal and State or Territory and Provincial government levels. Using a critical multicultural perspective, I examine whether paying greater attention to cultural competence could lead to better deliberative health policy development in multicultural societies.

A number of key findings arise from this research:

1. A critical multicultural perspective draws attention to systemic and individual assumptions which serve to stereotype CALD citizens and entrench exclusion and disadvantage. Application of a critical multicultural approach to health policy development supports questioning of institutional processes and procedures, as well as health policy officer assumptions and biases, for equitable health policy development.

2. Everyday understandings of culture as an unchanging catalogue of attributes which is somehow knowable are out of step with current anthropological thinking of culture as relational and meaning-centred and thus constantly changing. To suggest that a health policy maker could become competent in culture is therefore misleading.

3. The language of 'cultural competence' is unhelpful because it focusses on culture as ethnicity. It is timely to shift language to 'contextual sensitivity' for heightened awareness of citizens as individuals shaped by their histories, life experiences and current institutional structures. Awareness of the context surrounding CALD citizens removes the need to consider an individual as an ethnicity.

4. Resource constraints, multiple interests and competing priorities influence citizen engagement practices. Despite the presence of guidance and support in some jurisdictions, the current one-size-fits-all processes exclude CALD background citizens. A critical multicultural perspective applied to citizen engagement supports questioning of processes and procedures with a view to adoption of inclusive practices.

Whilst health policy is the focus of this thesis, ultimately these findings are applicable to all levels of government from Federal to local, and to all public policy domains.

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Part One: Introduction and Research Design

Chapter 1 Introduction: Cultural competency for health policy development in Australia and Canada

> "If we don't have at the table people of color and the diverse populations we serve, you can be sure that policymaking and program design are also going to be exclusionary as well…" (Betancourt et al., 2002, p5).

Australia and Canada have long and similar histories of accepting immigrants from an increasingly diverse range of countries, leading to the multicultural societies we see today. Governments of both countries also share a commitment to citizen engagement in government business which, when combined with multiculturalism, aims to enrich government policy by the input of the many and varied experiences and voices. However, despite the policy intentions of both countries there are still significant barriers to practice. One such consideration is the way in which policy makers are equipped to facilitate the inclusion of citizens of culturally and linguistically diverse (CALD) backgrounds in policy making. This thesis examines this issue by analysing the ways in which policy officers approach CALD citizens, and the nature of cultural competence in those interactions, focussing especially on citizen engagement in health policy development. Health policy is an important choice because health affects every individual and because the results of exclusion of CALD citizens from health policy making can range from the uncomfortable to the downright disastrous (Chu, 1998; Rice, 2007).

In this introductory chapter I will set the scene for the thesis, starting with some evidence of the negative effects of health policy on the healthcare provided to citizens of CALD backgrounds. I will then give an overview of the important issues in the thesis namely population diversity and multiculturalism in Australia and Canada, cultural competence,

and citizen engagement. The chapter concludes with a summary of the research design and methods and information about the structure of the thesis.

1.1 "This hospital killed my wife" and other stories: health policy in multicultural societies

In 1998 in Madison Heights, Michigan, an elderly lady of CALD background was admitted to hospital. She was accompanied by her non-English speaking husband, who refused an interpreter, and English-speaking son who acted as interpreter. Many members of the family and friends also attended the hospital to provide support. The husband refused to discuss care options with his seriously ill wife, something which concerned staff who were used to involving patients in decisions about their own care. Despite receiving all appropriate care, the elderly lady died. The "screaming and sobbing" of family and friends was judged to be disturbing and distressing to other patients and visitors and so hospital staff offered a private room within which to grieve. The private room was rejected as family and friends refused to leave the bedside of the patient. Subsequently, the hospital used security staff to eject the noisy group from the hospital. Three days after the patient's death her husband parked his van outside the hospital with a big sign saying "[This hospital] killed my wife" (Mott, 2003). This story highlights different understandings of decision making regarding care for family members, and different understandings of bereavement and grieving. There was a mismatch between the expectations of hospital staff and those of the husband, family and friends, resulting in tension and distress both for the grieving family and hospital staff.

This is not an isolated example of the misunderstandings that can arise when people of CALD backgrounds interact with the health care system. For instance, Cordia Chu reports that, in Australia, maternity care focusses on the antenatal period as the time when a mother-to-be is most vulnerable. Conversely, in China the postnatal period is considered the time when a new mother is most vulnerable. Traditionally, the Chinese postnatal period is characterised by specific "dietary and behavioural" rules which do not accord with Australian postnatal care programs (Chu, 1998, p129). The result is an increase in postnatal stress amongst mothers of Chinese background (Chu, 1998; Chu, 2005). In British Columbia, Canada, the failure of publicly funded prenatal care programs

to attract women from Punjabi backgrounds resulted in a rise in neural tube defects amongst babies born to these women, as well as risks to the health of the mother-to-be (Bhagat et al., 2002). The programs did not account for traditional Punjabi beliefs about preparation for childbirth. In several States in Australia, physical activity health promotion programs failed to attract women from CALD backgrounds, women who are at higher risk of contracting chronic diseases, such as cardiovascular disease and diabetes, and of poor mental health. The lack of participation was due to the programs not considering CALD women's views on what constitutes health or illness, and what physical activity means. Neither did the programs acknowledge cultural expectations that dictate women's use of their time; environmental issues such as safety; and ethnic-specific barriers to the uptake of physical activity such as modesty of dress and desire to participate in traditional activities but fear that those activities would not be understood in the host community (Caperchione et al., 2011; Caperchione et al., 2013).

These examples all show that different understandings of health, illness, health promotion, and health service delivery exist (Moxham and Pegg, 1998; Murray and Skull, 2005), creating one of several "hurdles" to equitable access to health care (Murray and Skull, 2005). Lorna Moxham and Shane Pegg (1998, p73) particularly emphasise that health is "invariably culturally defined" creating very different beliefs around health, illness, treatment and importantly the status of the healthcare worker. In the context of regional Australia, they argue that a failure to take these distinctions into account results in poor health service delivery to "Australia's diverse ethnic population" (Moxham and Pegg, 1998, p76).

Increasing population diversity and the difficulties that immigrants can face when trying to access government services highlight the importance of considering how health policy is developed to ensure that such policy can meet the needs of a diverse population. In spite of this, Don Lenihan argues that public policy usually follows a "one-size-fits-all approach" failing to consider the need for policy solutions to take into account diversity in society (Lenihan, 2012a, p7). This approach to health policy development excludes, or at best restricts access of, people from CALD backgrounds to the intended benefits of health policy. Health policy can thus contribute to a lack of equity – a point that was not lost on the CEO of a US public hospital whose words appear at the beginning of this chapter.

Starting from the assumption that community engagement in policy development can result in health policy that is more relevant to more people, the central research questions this thesis seeks to answer are:

What do governments, their health authorities and health policy officers understand by cultural competence and how is this operationalised for health policy development?

How is cultural competence applied to citizen engagement for health policy development?

Could paying greater attention to cultural competence enhance citizen engagement in health policy development?

To answer these seemingly simple questions, a number of lines of enquiry are pursued to identify understandings of culture and cultural competence; understandings and application of government policies of multiculturalism and citizen engagement; and the nature of health authority approaches to the development of culturally competent health policy officers and how this translates into citizen engagement practices.

In responding to the central research questions, my research involved analysis of government policy documents, interviews with health policy officers, and examination of the theoretical literature across a number of domains. The remainder of this chapter introduces the significant domains and provides more information about research design.

1.2 Australian and Canadian government responses to population diversity

Both Australia and Canada are known as countries of immigration (Levey, 2008a) having long histories of settlement by people from around the world. This history of initial colonial settlement, followed by continuing immigration, means that both countries have developed with populations that exhibit a rich diversity in terms of countries of origin, language, and cultural traditions. These introductory comments provide an overview of the nature of the two populations in order to demonstrate the diversity that influences this research.

In 2016 Australia's population exceeded 24 million people, comprising people of Aboriginal and Torres Strait Islander descent; Australian-born descended from convicts and colonial settlers; immigrants from all parts of the world; and Australian-born of immigrant parents. Whilst English is "not legally" the official language of Australia (Jupp, 2007, p22) it is considered by the Federal government to be the national language (Department of Social Services, 2016), and is the only language spoken by 81% of the population (Australian Bureau of Statistics, 2012).

The 2011 Australian Census highlights the diversity of Australia's population:

- A little over 30% of the population was born overseas;
- Nearly 50% of the population is either a first- or second-generation migrant;
- Half of all first-generation migrants and 20% of second-generation migrants speak a language other than English at home;
- More than 300 ancestries were reported;
- Recent arrivals (post 2007) are increasingly drawn from Asian populations especially India, China and The Philippines. The UK is the only European country represented in the top ten countries of origin for recent arrivals;
- 2.5% of the population is Aboriginal or Torres Strait Islander (Australian Bureau of Statistics, 2012).

The 2016 population of Canada, at approximately 36 million people, comprises First Nations, Inuit and Metis people as well as descendants of colonial settlers and later immigrants from around the world. Canada has two official languages – English and French – over 78% of all Canadians speak one of the two official languages (Statistics Canada, 2015). However, more than 6.8 million people speak a language other than English or French at home (Statistics Canada, 2011).

The 2011 Canadian Census highlights the diversity of Canada's population:

- Almost 21% of Canadians were born overseas (Statistics Canada, 2016);
- Just over 39% of the population is either a first- or second-generation migrant (Statistics Canada, 2015);
- More than 200 ancestries were reported;

- Recent arrivals (post 2006) are increasingly drawn from Asian and African countries and notably The Philippines, India and China. The UK is the only European country represented in the top ten countries of origin for recent arrivals;

- A little over 5% of the population is First Nations, Inuit or Metis (Statistics Canada, 2016).

This diversity of population prompted the Federal governments of both countries to put in place public policy recognising diversity in order to protect and support members of ethnic minorities. These policies are known collectively as "multiculturalism".

In Australia, multiculturalism as government policy appeared in the late-1970s, focussing first on migrant settlement issues and assimilation into the Australian community, later changing to a focus on integration and then, in the early 21st century, changing again to social inclusion of "all Australians" regardless of country of birth (Koleth, 2010, np). At the Federal level, multiculturalism is addressed through a policy framework. Not until 2016 did any Australian jurisdiction introduce legislation to support multicultural policy, this was the State of Queensland.

In Canada, multiculturalism entered the Federal government lexicon when, in 1965, the term "multiculturalism" was used in the report of the Royal Commission on Bilingualism and Biculturalism: a review that was initiated to strengthen recognition of the two "founding races" and "other ethnic groups" and their importance to the development of Canada (Yalden, 2011, p6-7). Prime Minister Pierre Trudeau is generally credited with the advent of multicultural policy when, in 1971, he established a policy which acknowledged the British, French and other diverse origins of Canadians, and emphasised the importance of ensuring that all Canadians of whatever background should be supported to "...overcome barriers to full participation in Canadian society." (Yalden, 2011, p7-8). The notion of integration appears to have been a key factor in Canadian policy since the 1960s, culminating in a commitment to a multicultural, equitable society enshrined in The Constitution Act 1982 (Can) which therefore confers legal status on multiculturalism in Canada (Yalden, 2011).

Multiculturalism is, though, a contested concept. This thesis will explore different interpretations of multiculturalism and assess where the Federal and State/Provincial governments of Australia and Canada fit within those interpretations.

1.3   Unpacking culture and cultural competence

After working with the family to resolve the immediate issue, the hospital identified in section 1.1 introduced a diversity program as a means of building a culturally competent workforce through education and greater community engagement. The hospital established a Diversity Council, and worked with community leaders and other experts to educate administrative and clinical staff, and other hospital associates, about the diversity of their community. This was complemented by visible awareness-raising events within the hospital and outreach to the community. Reporting on the training program, William Mott commented that "Because it is nearly impossible to become an expert on the customs of every culture the module highlights general skills needed to communicate with cultural groups other than one's own." (Mott, 2003, p340).

Mott's comment links 'culture' to 'customs' and implies almost unmanageable variability. 'Culture' appears in everyday policy terminology such as 'people from *culturally* and linguistically diverse backgrounds' and in 'multi*cultural*ism'. Since the core idea underpinning this thesis is culture and its relationship to health policy development, it is important to be clear about what the term 'culture' means and how it relates to the competencies needed by a health policy officer.

Public administration literature relies on a description of culture as "…the way of life of a body of people…" including "values, norms, belief systems, ways of thinking and acting, language…" and other inherited ideas, and the most common cultural identifiers are "…national origin, language, race, ethnicity, social class and gender…" (Hess and Billingsley, 2007, p55-56). This understanding fixes groups with a certain set of characteristics, viewed at a certain point in time, and fails to recognise both intra-group differences and changes in societies over time (Turner, 1993; Fontefrancesco, 2012). Drawing on the field of anthropology, a more up-to-date understanding of culture is of a "fluid, changeable, positional reality" (Fontefrancesco, 2012, p60). The debate about what constitutes culture and its relationship to multiculturalism will be expanded in this thesis. At this point it is sufficient to say that for the purposes of this thesis 'culture' is understood as "a dynamic process of shared meanings, located in and emerging from interactions between individuals" (Carpenter-Song et al., 2007, p1364).

Diversity within the policy audience demands that policy officers demonstrate a greater degree of competence in interactions with citizens in order to improve programs and services (Berry-James, 2012, p181). The concept of cultural competence is already recognised in the health sector, and is manifest especially in tertiary education and systems of care in the professions of nursing (Campinha-Bacote, 1999; Purnell, 2002), social work (McPhatter and Ganaway, 2003), and mental health (Cross et al., 1989).

Following this line of thought, Government organisations also need to demonstrate that they "value cultural diversity, have capacity to conduct cultural self-assessment, be able to manage the dynamics of difference, be willing to institutionalise cultural knowledge, be willing to adapt service delivery to diversity within a cultural context" (Berry-James, 2012, p186). Barry Checkoway neatly summarises this as four required skills namely self-awareness, awareness of groups different to one-self, "knowledge of the structures that affect relationships", and the skill to participate in "intergroup dialogue" (Checkoway, 2009, p12).

These authors introduce us to the idea that cultural competence goes beyond a simple dictionary definition. For example the Macquarie Dictionary definition of 'competence' is "adequacy; due qualification or capacity; sufficiency" (Delbridge, 2001) which the Oxford Dictionary expresses more simply as "the ability to do something successfully or efficiently" (Oxford Dictionary, 2017b). Both of these sets of words imply attaining a qualification to a specific and sufficient level. In this thesis I will show why these definitions are inadequate for today's multicultural societies and suggest an alternative.

1.4 Citizen engagement and deliberative democracy

Could health policy be enhanced if citizens of CALD backgrounds are engaged in the development of that policy? Deliberative democracy offers one possible response to this question. Deliberative democracy is a process by which governments are held to account through discussion with the people for whom they govern (Delli Carpini et al., 2004; Lukensmeyer and Torres, 2006; Stewart, 2009). As such it has been hailed as a "tool for citizen engagement" (Lukensmeyer and Torres, 2006, p20) and a precursor to citizen engagement (Delli Carpini et al., 2004) especially in culturally diverse settings and societies (Deveaux, 2003; Ercan, 2011; Ercan, 2017).

Susan Phillips and Michael Orsini argue that the term 'citizen engagement' is well chosen and meaningful (Phillips and Orsini, 2002). This term, they say, is based on the understanding that engagement is a two-way dialogue between citizens and government officials, characterised by "interactive and iterative" processes where 'citizen' means an individual exercising "their rights and responsibilities as citizens" (Phillips and Orsini, 2002, p3). Carolyn Lukensmeyer and Lars Torres agree, defining citizen engagement as a deliberative activity in which "citizens and public officials meet in an open process to clarify values, determine priorities and then shape public policy" (Lukensmeyer and Torres, 2006, p10). I agree with these complementary positions – deliberative citizen engagement can be distinguished from other forms of interaction between citizens and governments that limit participation to the giving or receiving of information but without any opportunity for citizens to influence government actions. For these reasons, in this thesis I use the term citizen engagement rather than any of the many other terms used to denote communication between governments and citizens.

As noted above, this research accepts the position that citizen engagement in policy development is beneficial. Whilst I am not alone in taking such a starting position, there are concerns that such uncritical acceptance can be limiting (Conklin et al., 2010). To address these concerns, I identify some of the difficulties of citizen engagement generally in Chapter 6, and the engagement of CALD citizens in health policy making specifically in Chapter 7. Introductory comment on the benefits and challenges of citizen engagement is at subsection 1.4.2 below.

1.4.1 Citizen engagement in Australia and Canada

In Australia, the 1976 Royal Commission on Australian Government Administration, led by the tireless economist and noted Australian public servant H.C. "Nugget" Coombs, recommended reform actions that would give citizens a greater connection to government (Holmes, 2011). Public sector reforms in the 1980s led to the recognition of citizens as service users, and the introduction of the idea of input from citizens into the development of government policy, most notably in the social welfare and environment sectors (Head, 2011). In the health sector, the Australian Federal Government acknowledged the importance of community input to the policy process by providing funds to establish the Consumers' Health Forum of Australia Inc. in the 1986/87 budget (Consumers' Health Forum of Australia, nd). Federal government commitment to citizen engagement was

reiterated in 2010 (Advisory Group on Reform of Australian Government Administration, 2010).

The Canadian government also has a long history of engaging with the community, for example between 1994 and 1997 the Health Forum sought citizen input into the suitability of Canada's health system. The Forum was reportedly a catalyst for greater public involvement in Canadian health policy (Ham, 2001), and certainly was a precursor to considerable activity on the part of Health Canada to entrench citizen engagement in health policy development. In 2001, the Canadian Government established a Royal Commission to review the Medicare system. This Commission included many face-to-face opportunities for the community to engage with the Royal Commission to help shape future policy (Commission on the Future of Health Care in Canada, 2002).

In terms of Federal policy, in 2000 the Canadian Privy Council released a *Policy Statement and Guidelines on Consulting and Engaging Canadians* setting out the importance of citizen engagement, and commenting on the difference between engagement and consultation (Smith, 2003, p37).

It is worth noting here that two Supreme Court of Canada findings, in 2004 and 2005, were to the effect that the Canadian Government had "a duty to consult" whenever government actions might adversely affect "Aboriginal or Treaty Rights" (Indigenous and Northern Affairs Canada, 2016). This decision, based on an interpretation of The Constitution Act 1982 (Can), resulted in the release of *Aboriginal Consultation and Accommodation. Updated Guidelines for Federal Officials to Fulfil the Duty to Consult* (Government of Canada, 2011) to guide citizen engagement activities relevant to Aboriginal people in Canada. Training for Federal public servants is a key feature of attention to the duty to consult and covers topics such as legal requirements, elements of meaningful consultation processes, and post-consultation evaluation (Indigenous and Northern Affairs Canada, 2016). Although this thesis specifically excludes consideration of engagement with Indigenous citizens, I will comment on how this latter work may have influenced thinking around inclusion of all citizens of CALD backgrounds.

1.4.2 The benefits and challenges of citizen engagement

Why would a government engage with its citizens? A central norm of deliberative democracy is that anybody who is affected by a government decision should be able to

participate in deliberations which help to shape that decision (Dryzek and List, 2003; Brackertz and Meredyth, 2009). There is general agreement that such engagement not only allows a government to gauge the views of its citizens (Goodin and Dryzek, 2006; Ankenya and Dodds, 2008), and permits a diversity of views to be heard, but also provides legitimacy for government policy (Ankenya and Dodds, 2008; Dryzek et al., 2009; Kahane et al., 2013). The resulting greater transparency and more equitable outcomes improves trust in government and drives both acceptance of decisions and behaviour change (Delli Carpini et al., 2004; Hendriks, 2012). As well, citizen engagement encourages sharing of knowledge across a greater number of people and thus, potentially, identification of a greater number of alternative solutions to an issue (Hendriks, 2012).

For citizen engagement to be meaningful and successful, participation must reflect the diversity of the population and the process must be equitable and fair. Among the benefits of including diverse opinions is the exposure it brings to other participants of a variety of views: not only is diversity in deliberation educational, but it helps to resolve conflict and create "shared meaning" (Turnbull and Aucoin, 2006, p5-8) by the transformative nature of this exposure to different ideas (Delli Carpini et al., 2004; Kahane et al., 2013). In the specific context of health policy development, additional benefits include heightened levels of awareness and understanding in the community of health issues, and stronger potential for input to the design of services for the disadvantaged (Palmer and Short, 2014) towards the ultimate goal of better health for all citizens.

Despite these benefits, citizen engagement has been criticised as an imperfect process particularly in relation to those most frequently included, that is, those who are largely represented by the dominant majority – the well-educated and articulate, generally white, Western, males – who can fit into a rational style of discussion (Bohman, 1998). Outcomes from citizen engagement are very dependent on getting the process right (Delli Carpini et al., 2004) and that process obviously includes participant selection. Labelling of some citizens as hard to reach for a variety of reasons including socio-economic disadvantage, age, gender, race or cultural background, health status, language and more (Sanders, 1997; Bishop and Davis, 2001; Von Lieres and Kahane, 2007; Brackertz and Meredyth, 2009; Kahane et al., 2013) by a system reflective of the dominant power and beliefs serves to exclude minority, disadvantaged or otherwise marginalised groups (Asumah, 2004; Fowers and Davidov, 2006; Stewart, 2009). The resulting participation

in health policy deliberations will be the poorer for the lack of diversity of people and perspectives.

The challenge to be inclusive is of immediate relevance to health policy officers responsible for citizen engagement. Not only must they operate within financial and time constraints, but they must take explicit steps to counteract disadvantage imposed by dominant belief systems (Asumah, 2004). They must also ensure that the many and varied, and often competing, views can be heard and balanced and brought together in respectful discussions based on mutual trust, understanding and a willingness to debate and compromise (Dugdale, 2008). The skills required of policy officers to achieve such an ideal outcome go beyond their skills as technical experts (Denhardt and Denhardt, 2000; Stewart, 2009) into the arenas of communication and relationship building (Dugdale, 2008). Competence in engaging with people from a diversity of cultural backgrounds would seem to be essential in any health authority that aspires to engage with all citizens in the development of health policy. This thesis will discuss how the promise of citizen engagement is actioned by health policy officers and their health authorities.

1.5   Research design and methods

In responding to the research questions posed above, this thesis uses health policy as a case study. Taking the health policy officer's perspective, the research compares the Australian experience with that of Canada, a country similar in history of migration and population diversity, basis of government, and healthcare system. In addition, experiences at both the Federal and State/Territory/Provincial levels of government provide another layer of comparison.

Insights into the experiences of health policy officers were obtained through interviews, during which I sought their views on engaging with citizens of CALD backgrounds and their understandings of cultural competence and its relationship to their policy development work. A hermeneutic lens was applied to these conversations. Hermeneutics is a process to assist understanding of another person's point of view, taking into account the historically-created prejudices of the listener which, when brought to bear on the conversation, creates a new understanding (Gadamer, 1989). The

hermeneutic process strives to allow the words of health policy officers to speak for themselves and reminds the researcher to be open-minded, to allow the conversations to flow whilst minimising assumptions or pre-judgements.

At a broader level, right across this thesis, my hermeneutic lens is my set of research questions – I looked at the meaning, application and potential to be found in the activity of citizen engagement for health policy making, particularly looking at cultural competence in such citizen engagement. I was interested to see if any fresh ideas or concepts have emerged in the field of citizen engagement in policy making.

Literature in the domains of public administration, deliberative democracy and citizen engagement, multiculturalism, and cultural competence shed light on some of the debates in these fields, and informed my thinking about some of the issues raised by health policy officers. The literature was supplemented by consideration of government policies on multiculturalism, citizen engagement and cultural competence, providing a means of comparison across countries and jurisdictions.

The conceptual framework within which the entire research is considered is 'critical multiculturalism'. This framework emphasises the way in which the powerful and privileged in society determine the values of that society and label 'difference', thus creating marginalised minorities. Critical multiculturalism examines structures in society that support the dominant majority at the expense of the marginalised minority, and pays attention to the way in which histories of both the dominant and subordinate feed into this situation. Critical multiculturalism seeks to empower minorities to challenge and transform constraining structures in order to restore social justice (McLaren, 1994; Giroux, 2000; May, 2009).

1.5.1 Motivation

As a former Australian Government Public Servant of several decades standing I have worked in an environment of constant change, not just of governments but of policy focus, including an increasing commitment to the ideal of community involvement, and growing awareness of the needs of people from rural and remote Australia, from CALD backgrounds, and from situations of disadvantage. In my experience, over time Australian Government policy on the inclusion of the community in policy development has grown and deepened but has not been accompanied by much in the way of guidance

about how to engage with the community. This meant that each department was left to find its own way through the ever-increasing literature on citizen engagement, undoubtedly re-inventing the wheel and missing opportunities to improve its ability to turn more smoothly. No guidance was available on how to engage with citizens from CALD backgrounds. Staff development on diversity issues was confined to mandatory awareness of Aboriginal and Torres Strait Islander cultures delivered in a friendly, informative, lecture style. No similar awareness raising was mandated or delivered as far as citizens from CALD backgrounds were concerned.

For several years my responsibilities included engaging with the community to obtain input into a variety of policies being developed by Australia's National Health and Medical Research Council (NHMRC). Engagement generally meant seeking written submissions but the NHMRC did begin to branch out into open public meetings, and meetings to which community groups with a known interest were invited without any other filtering of attendance. These experiences were successful to varying degrees, but we took little time to reflect on and learn from each process and I do not believe that the Agency's procedures developed much as a result of these efforts. When I think back on my own experience as a policy officer attempting to engage with the community it is clear that our baby steps were unsophisticated, almost but not quite tokenistic, and almost entirely confined to known quantities in terms of community organisations with an interest in a particular policy topic. With rare exceptions, we did not seek out those people who did not have a voice in the standard process – people who were disadvantaged either by socio-economic status, geographic location, disability, sexual orientation, or cultural or linguistic diversity. With the benefit of hindsight, I see that this meant that processes were convenient to the bureaucracy but not necessarily the diverse community resulting in input that did little to challenge the received wisdom of the conservative, small-l liberal, market-driven society that is Australia. However, Australia is also a multicultural society of increasing diversity and hence my interest in pursuing this research topic in order to bring greater awareness to policy officers and the public sector about the nature of citizen engagement in policy development in a diverse environment.

Whilst much has been written about citizen engagement in general, there has been little emphasis on the specific inclusion of CALD citizens in deliberative processes and equally little about the policy maker's experience of citizen engagement within a multicultural

context. Even less is available on cultural competence in citizen engagement. Through this research, my contribution will be to fill that gap by examining cultural competence in citizen engagement for health policy development in multicultural societies.

Starting from an interest in cultural competence and citizen engagement, the central research questions were identified, refined and finalised following a review of the literature. Details of this review can be found in Chapter 2. It is important to understand whether, and how, health authorities enable inclusive, health policy development through culturally competent citizen engagement practice, in order to gauge the usefulness of cultural competence as a concept and as a policy tool. Drawing together the literature, government documents, and information from research participants enabled me to examine the concept of cultural competence, identifying strengths and weaknesses in the clarity of its conceptualisation, its application in practice, and its potential to support better health policy making. As a result of this examination, I concluded that the concept of contextual sensitivity not only offers a clearer meaning, but has greater current application, and more potential to help organise the thoughts and activities of health policy makers as they engage with citizens of multicultural societies. The value of addressing these research questions is in identifying structures that enable or hinder health policy officers in their task of developing health policy, in concert with all citizens in a multicultural setting. Celebrating the successes and noting what did not work so well are both means to learning how to improve health policy deliberations in the future, with the goal of achieving effective and efficient health policy for better health outcomes.

In comparing two countries and levels of government what matters is how we, as policy makers, can collectively learn from each other and ultimately improve health policy outcomes through the inclusion of culturally and linguistically diverse voices.

1.5.2 Thesis limitations

In this thesis references to culture, cultural groups, minorities, and people from culturally and linguistically diverse backgrounds specifically exclude people of Aboriginal (Australian and Canadian) and Torres Strait Islander (Australian) background. I excluded these groups on the grounds that engagement with Indigenous peoples raises a plethora of issues which would make the scope of the thesis unmanageable. I concentrate on that group of people who come from what is called "culturally and linguistically diverse"

backgrounds, whether linguistic background is non-English speaking or English speaking. This is important because there is cultural diversity amongst English speakers – think, for example, of English speakers from the Caribbean, from parts of Africa, and from former British colonies in Asia such as Malaysia, Hong Kong and Singapore.

In this thesis 'multicultural' refers to all those people who have left their country of origin to settle in Australia or Canada, whether as voluntary migrants, asylum seekers or refugees (whether or not they have English as a first language), and their children born in Australia.

The research takes the perspective of the health policy maker and looks at the principle of citizen engagement in health policy development in a multicultural setting. It is not the intention of this research project to canvass the views of individual citizens, whether from CALD backgrounds or not, nor to critique specific methods of citizen engagement. This thesis focuses specifically on the policies and structures that, by inference, demand health policy makers act in a culturally competent manner, and how those policies and structures are actually implemented. The impact of this on citizen engagement for health policy development is also considered.

The empirical data was drawn from interviews with health policy officers. These were semi-structured but, nevertheless, gave health policy officers the opportunity to speak about their experiences. Self-reporting runs the risk of introducing bias for several reasons: the desire to "say the right thing"; to present oneself in the best possible light; or to present one's organisation in a certain way, either positive or negative. Reflecting on the discussions and considering connections between what was said and existing policies may help to overcome the potential for bias.

As important as what was said, is what is not said. For example, this thesis points out that health policy officers did not always refer to existing policy frameworks. This may have been due to misunderstandings between interviewer and interviewee – for example did we understand the language each of us used in the same way – or to a shortage of time in the interview to cover all issues in sufficient detail. Discussion in the thesis focusses on the data that was gathered in relation to the research questions without trying to second guess what may have been left unsaid.

1.6   Thesis structure

This thesis is divided into three parts. **Part One** contains this introductory chapter and detail of the research design and methodology. Chapter 1 sets the scene and provides an overview of the important domains under consideration. Chapter 2 describes the literature review process, explains the rationale for choosing health policy as a case study, and sets out the conceptual framework of critical multiculturalism which guided consideration of the research questions. This is followed by a critical multicultural view of health policy. The chapter continues with a description of the conduct and analysis of empirical research, including the hermeneutic lens applied to fieldwork data, and the choice of Australia and Canada as the sites of research.

Part Two delves into the nature of cultural competence in health policy development in multicultural societies, illustrated by fieldwork findings. The chapters in this part include comparisons across countries, and Federal and State/Provincial jurisdictions. Chapter 3 will build an understanding of cultural competence as a concept and begins my focus on health policy development. Beginning with a discussion of the concept of 'culture', the chapter establishes an up to date understanding of culture and, based on this, a broader understanding of cultural competence. The chapter includes comparative reviews of Australian and Canadian government policies, both overarching and in the health sector, and critiques these from a critical multicultural standpoint. Chapter 4 discusses findings from interviews with health policy officers relating to their understandings and application of cultural competence in the health policy development context. The chapter discusses why the existing understandings and approaches are not suitable for the health policy sector, and argues for a new terminology of contextual sensitivity to replace cultural competence in order to move beyond stereotyping and systemic inequity.

Chapter 5 addresses structures of government in Australia and Canada that support multiculturalism. It articulates different understandings of multiculturalism and then describes how multiculturalism as a policy has evolved in both Australia and Canada. Using evidence from a review of government policies, the chapter provides comment on the perspective of multiculturalism that each Federal or State/Provincial government exhibits. Fieldwork data is used to illustrate how existing policy structures are implemented to further multicultural ideals in health-related public policy.

Chapter 6 introduces citizen engagement in policy development and how this relates to the theoretical background of deliberative democracy. The chapter offers insight into the relevance of a critical multicultural approach to citizen engagement and how this could appeal to bureaucrats seeking an inclusive, health policy development process. The chapter then goes on to describe Australian and Canadian governments' commitments to citizen engagement drawing on a review of government policies.

Finally, **Part Three** brings together the research project examining contextual sensitivity in citizen engagement for health policy development and presenting key findings. Chapter 7 explores citizen engagement for the inclusion of CALD citizens in health policy development. The chapter begins with a discussion of the application of citizen engagement for health policy development. This is followed by the specifics of citizen engagement in health policy at the Federal and State/Provincial levels, for which information is drawn from government policies. Themes emerging from fieldwork illustrate the everyday experiences of health policy officers around the engagement of CALD citizens. The chapter concludes with a comparison of Australian and Canadian experiences and comment on the value of a contextually sensitive approach to citizen engagement. Chapter 8 draws together conclusions presented in earlier chapters highlighting four key findings. The chapter continues with a comment on the implications of my conclusions for public administration and concludes with reflections on the research project and suggests directions for further research.

Chapter 2 Research Design and Conceptual Framework

"In fact history does not belong to us; we belong to it. Long before we understand ourselves through the process of self-examination, we understand ourselves in a self-evident way in the family, society, and state in which we live. The focus of subjectivity is a distorting mirror. The self-awareness of the individual is only a flickering in the closed circuits of historical life. That is why the prejudices of the individual, far more than his judgments, constitute the historical reality of his being." (Gadamer, 1989, p276-77)

"When cultural difference is defined relationally, difference and equality are not at odds with each other. Group interests do not necessarily conflict with the interests of the broader community. On the contrary, to the extent that a group's claims are targeted against structural inequalities, they are claims of justice and, as such, they may become interests shared by the community at large." (Awad, 2011, p44)

This chapter describes the research design and the conceptual framework that is used to guide consideration of the research project. It begins with presentation of the methods used to identify and analyse relevant literature, and continues with an explanation of the choice of health policy as a case study and discussion of critical multiculturalism as a conceptual framework. The chapter continues with a description of the empirical research design including the hermeneutic lens applied to fieldwork data, choice of sites of research and recruitment of research participants, and fieldwork methods. This is supplemented by discussion of the ethical issues pertinent to this research and my role as a researcher. Detailed analysis of the literature and fieldwork data is contained in each of the following chapters.

2.1 Review of literature and government documents

2.1.1 Literature review methodology and analysis

There are four domains central to the research questions contained in this thesis namely

1. Cultural competence

2. Multiculturalism

3. Citizen engagement

4. Public administration.

During May to November 2013 a search for literature in these domains was conducted. Literature retrieved in the English language, that addressed understandings of culture in policy, cultural competence and multiculturalism; or attention given to CALD participants in citizen engagement; or understandings and the application of cultural competence in policy development, was retained for review. The literature search had three strands. Firstly, articles contained in peer-reviewed journals, in English, of any date, were identified in the ProQuest, Science Direct, Web of Science, and APAIS databases. Secondly, the OECD iLibrary was searched for relevant references. Although this latter search returned quite a number of citations, they all drew on two reports and one handbook, each of which provided a useful overview of citizen engagement activities in OECD countries. Thirdly, noting that the ANU has a history of research into demography, immigration, multicultural studies and public policy dating back at least to the 1980s (Foster and Varghese, 2009), relevant monographs were identified by a general search of the ANU library. The literature retrieved helped me not only to understand the domains underpinning this research from a theoretical viewpoint, but also to refine the research questions. Search terms used can be found in Appendix 1.

The quality and availability of material was variable. For example, the topics of multiculturalism and cultural competence each brought up tens of thousands of references, many of which were not relevant to my research question. Narrowing down the field of enquiry, as shown in the search terms, was essential in order to find not only a manageable number of references but also those specifically relevant. Interestingly, "cultural competence" as a required competency is evident in the health service delivery

literature, particularly in the fields of nursing, social work and psychology, but was almost entirely absent from the public policy field.

As time passed additional references came to hand, especially through a process of checking references within retrieved literature. This often led to the identification of further material for consideration. This process continued throughout thesis development.

In order to manage the volume of literature, and for ease of access over the time of thesis development, I grouped references within the four domains noted above and around themes of similar ideas, such as arguments for and against a particular position. The important literature and arguments are presented in chapters 3 to 7.

2.1.2 Review of government documents

A further step towards answering the research questions was consideration of government policies and reports relevant to the topics of multiculturalism, multicultural health, citizen engagement, and cultural competence, published by the Federal and State/Provincial governments and health authorities included in this research project. I searched for specific policies addressing each of these four topics (for example the Queensland Health *Strategic Plan for Multicultural Health 2007-2012*) and looked at other key documents, such as legislation, Annual Reports or Ministerial Directions, to identify any reference to these four topics (for example The Canadian Constitution Act 1982 which refers to citizen engagement). On few occasions reference was made in these other key documents to additional policies which addressed one or more of the four topics under review. In those cases, those documents were also retrieved and reviewed. I only considered publicly available documents which I retrieved by searching government websites. These searches took place throughout 2013 and 2014 and were updated in 2017. The purpose of reading these policies and reports was to understand what structures and policies exist to support multiculturalism, citizen engagement, cultural awareness and cultural competence, and the development of inclusive health policy. The retrieved policies and reports were read with a view to identifying the policy position, enabling me to compare the stance taken in Australia and Canada and across levels of government. In addition, comparison across these jurisdictions supported identification of similarities and differences by country and

by level of government. My findings are reported as appropriate throughout chapters 3 to 7.

The content of the government policies and reports also allowed me to compare the government position on an issue with the empirical evidence. In particular, I was interested to know whether health policy makers drew on government policy (for example on citizen engagement) and procedures to support their work and, equally, whether there was any apparent tension between policy and the reality of work on the ground. Comment along these lines is included throughout the thesis as appropriate. It should be noted that interviews with health policy officers took place in 2014 and 2015 and discussions were measured against policies in place at that time. However, wherever updated policies were identified, these have been included in the government document review to show how jurisdictional processes may have changed.

2.2   Health policy making as a case study

Case study is a significant research methodology in the social sciences, including political science and policy studies (Vennesson, 2008; Seha and Muller-Rommel, 2016). However, there are many interpretations of what makes a 'case study', each dependent upon the discipline and theoretical perspective within which the researcher works (Platt, 2011; Blatter and Haverland, 2012). Joachim Blatter and Markus Haverland (2012, p6) particularly stress the value of case studies for drawing out "perceptions" and "motivations" to support understanding of actions. Their definition of a case study focusses on the importance of gathering a significant number of diverse observations for a small number of cases and subjecting those observations to concentrated scrutiny to identify relationships between those observations and "theoretical concepts" (2012, p19). The "richness" of context discovered through these diverse observations is best supported by data collection from multiple sources (Yin, 2003, p4). This research project embraces Blatter's and Haverland's (2012) goal, gathering observations through conversations with health policy officers, eliciting their thoughts, feelings and motivations about the impact of cultural competence in citizen engagement for health policy development. Following Yin (2003), this project draws on information obtained from published government documents as well as from interviews with health policy officers in order to place

perceptions and experiences within a policy framework. My reflection on these observations will help me to address the research questions posed in Chapter 1. My experience as a policy officer, with responsibility for citizen engagement in the Australian Federal health portfolio, suggested the choice of health policy as the vehicle for this research. In this section I will explain why health policy stands out as a useful case study to examine the issue of cultural competence for citizen engagement in policy development.

Before distinguishing health policy from public policy more generally let us first be clear about what constitutes public policy. George Palmer and Stephanie Short point out that 'policy' means a variety of things ranging from "very general" statements about proposed actions to "a specific statement of future intentions" or even "a set of standing rules…intended as a guide to action" (Palmer and Short, 2014, p24-25). Public policy has also been described as those actions and decisions taken by governments or government agencies, frequently influenced by politics, (Davis et al., 1993; Buse et al., 2012), as a means of providing information from governments to their citizens (Bishop and Davis, 2001; Stewart, 2009), and based on a "complex interplay of values, interests and resources" (Davis et al., 1993, p2). Palmer and Short encapsulate these thoughts in their definition of public policy as decisions made by governments "in the name of the people as a whole, with public resources, and they [the decisions] affect the public interest." (Palmer and Short, 2014, p25). Summarising public policy as a "purposive action" by government towards a stated goal, Gillian Walt includes in her consideration "implementation and enforcement" (Walt, 1994, p41). The common features of these definitions of public policy are purposeful decisions by governments, towards stated aims, influenced by external parties, and in the interests of the community as a whole.

There are many competing interests, all trying to influence decision making to have their needs met as a priority (Buse et al., 2012). In this environment governments have a hard task to ensure equity and fairness of policy and this imposes a burden on policy makers to be both "professional" and "neutral" (Alexander and Stivers, 2010, p579; Rice, 2007, p624). This is not to say that government officials should be value neutral. For example, Mitchell Rice argues to the contrary that policy makers should pay greater attention to those in greater need and should demonstrate social equity, defined as "…equity in the formation of public policy" in this regard (Rice, 2005, p67-68). This is no easy task, as

Cris Shore and Linda Wright caution that "dominant discourses" define the "terms of reference" for policy development thereby "disallowing or marginalizing alternatives" (Shore and Wright, 1997, p14). This leads to a situation where "keywords accumulate meanings historically" so that one meaning may predominate now but, if convenient, "previous meanings" can be reinstated (Shore and Wright, 1997, p14). That ideals of social equity are not always met is not necessarily through "malicious" actions (Alexander and Stivers, 2010, p580) but rather because policy makers work within a system that reflects the dominant culture, that is, it is culture blind (SenGupta et al., 2004; Rice, 2007). Jennifer Alexander and Camilla Stivers suggest that this frequently works to perpetuate disadvantage by maintaining an "out-group" (Alexander and Stivers, 2010, p583), whose characteristics are frequently viewed more negatively (SenGupta et al., 2004), leading to "tier based service provision" whereby the dominant group are provided with the best services (Gooden and Norman-Major, 2012, p353).

2.2.1 How is health policy different?

Walt argues that public policy development in the health context can mean different things to different people focussing variously on the policy content, the policy process, or power in the policy process (Walt, 1994). For example, health policy has been referred to simply as "principles that govern action directed towards given ends" (Sigmond, 1978, p60), or more comprehensively as "courses of action that affect the set of institutions, organisations, services and funding arrangements" for the health care system (Palmer and Short, 2014, p25). Walt criticises the majority of definitions of health policy because, she says, they only focus on health services. She prefers a definition which specifically acknowledges the interrelated nature of, and the many external influences on, health policy:

> "Health policy embraces courses of action that affect the set of institutions, organizations, services, and funding arrangements of the health care system. It goes beyond health services, however, and includes actions or intended actions by public, private and voluntary organizations that have an impact on health." (Walt, 1994, p41).

This comprehensive definition resonates for me because it reflects my experience of the health policy environment.

Thomas Oliver (Oliver, 2006) suggests a number of reasons why governments are interested in health-related public policy rather than allowing individuals to determine and manage their own health responses. Firstly, government intervention aims to prevent harm to others as a consequence of an individual's behaviour, for example passive smoking. Secondly, governments can provide benefits to those members of society who would otherwise be disadvantaged and, thirdly, governments provide legitimacy for moral issues that tend to polarise community opinion, such as the introduction of needle exchange programs. Lastly, government intervention contributes to a healthy population which is the basis of economic growth and social stability. Walt adds that governments will create a role for themselves in health policy making in order to "regulate, monitor and inspect" privatised or regulated services (Walt, 1994, p13).

There is agreement that health policy is complicated by a set of circumstances unique to the health policy sector. These include the influence of the medical profession, unparalleled in other policy fields (Walt, 1994; Howlett and Cashore, 2014; Palmer and Short, 2014); the monopolistic nature of health service provision meaning that patient choice is often limited if available at all (Coveney, 2010); the "interdependence" of health policy with other policy arenas (Walt, 1994, p5; Lenihan, 2012b); and the fact that health policy "touch[es] the lives of citizens very personally" and is by virtue of its inherently technical nature very complex (Street, 2014, p1). Finally, health policy is about life-sustaining or life-threatening decisions, again unparalleled in other policy arenas (Walt, 1994; Coveney, 2010).

The shared nature of funding for, and delivery of, health services further complicates the picture. The Federal governments of Australia and Canada provide funding to the States or Provinces and Territories for health expenditure, supplementing and complementing State/Provincial/Territorial allocations, and health services are delivered by a mix of public and private sector providers at the State/Provincial/Territorial or local government level (O'Reilly, 2001; Palmer and Short, 2014). This mix of funding and service delivery models can make it difficult to tease out which level of government is responsible for specific health policies. Indeed, this complexity was highlighted by policy makers interviewed for this research project at both levels of government, and in both countries.

Clearly articulated in Walt's (1994) definition of health policy above, health policy problems inevitably include relationships with other policy issues, and involve a balancing of priorities, influences, and choices which are rarely resource neutral (Sigmond, 1978; Buse et al., 2012). The interdependence of policy issues requires action at a number of levels of society – the individual alone can only do so much to affect her health. For example, access to transport, whether private or public, affects employment opportunities as well as access to healthcare services. An individual's ability to obtain employment affects income, which then influences the individual's ability to purchase and prepare nutritious food for good health. There will be limited benefit in health policy illustrating food groups and healthy diets if individuals are unable to afford the foods that are considered healthy.

Combined, these issues highlight health policy as a complex domain. Adding citizens as partners in decision-making further complicates health policy development; adding citizens of CALD backgrounds as partners is yet another dimension of complexity. As noted by Street (2014) above, health is an issue that is close to every citizen's heart, no pun intended. If health policy makers can find the right path to inclusion of CALD citizens in policy development, then there may be lessons for all policy makers.

2.3 Conceptual framework – Critical Multiculturalism

In Chapter 5 I address the concept of multiculturalism, describing and commenting on three different perspectives. One of those perspectives, critical multiculturalism, is the framework within which this research is placed. It is important for the reader to understand the concept of critical multiculturalism before proceeding, and so I will spend some time in this early chapter setting out the literature and indicating why I believe there are benefits to adopting such a framework. Additional discussion can be found in section 5.2 below.

Before going further, it is worth knowing that critical multiculturalism arises from the tradition of critical theory. Critical theory is based on an ontology of historical realism, meaning that structures in society are shaped by their social, political, cultural, economic, ethnic, and gender histories. Critical theory draws on this history to analyse ideologies,

assumptions and events that created societal structures as well as the implications of this history for a society's values (Bronner and Kellner, 1989; Guba and Lincoln, 1994; Morrow and Brown, 1994). Critical theorists argue that societal structures create "coercion, injustice, inequality and inequity" (Box, 2005, p11) and operate as a constraint on society because they serve to label some individuals as different (Guba and Lincoln, 1994). Writing in the field of public administration, Richard Box argues that what happens in society is always a result "of actions taken by those with money and power" (Box, 2005, p27), that is, those with the power to dictate societal structures are drawn from the ranks of the dominant ideology which not only places some people in privileged positions at the expense of others (Steinberg and Kincheloe, 2001) but also supports continuation of those societal structures to maintain that ideology and dominance of the privileged (Box, 2005). Box asserts that a critical theoretic approach to public administration prompts individuals to look at the historical context within which society has developed, and encourages the use of "critical reason" and "imagination" to consider alternatives rather than pursuing unquestioning acceptance of society as it is manifest (Box, 2005, p11-12). Failure to consider history presents two problems, according to Box (2005): firstly, he says, there is a risk that some voices in society would be excluded, such as those representing gender or race; secondly, he continues, failure to account for history would diminish our understanding of how history has shaped societal values – values which, in turn, dictate the structures in society that come to be dominant and accepted as givens.

Arising from this background, critical multiculturalism, sometimes referred to as insurgent or resistance multiculturalism, arose in the 1980s from the field of critical pedagogy (Kanpol and McLaren, 1995) in which leading authors wrote about a new way of looking at education in multicultural classrooms (see for example McLaren, 1994; Kincheloe and Steinberg, 1997; Giroux, 2000; Steinberg and Kincheloe, 2001). Many of these authors took their initial inspiration from the work of Paolo Freire who set out the parameters of a critical pedagogy in his home country, Brazil, a pedagogy that would liberate the peasants through literacy (Freire, 1972). The concern of critical pedagogists is not only to give space to non-white students to describe their lived experience, but also to ensure that the dominant, privileged, usually white-Western students question their own history and how it contributes to the way in which society is described and shaped by asking whose knowledge and history is represented in society, who does this privilege

and who is excluded (Giroux, 1995). Thus, critical multiculturalism examines "social struggles over signs and meanings" (McLaren, 1994, p53) and draws attention to the way in which social, cultural and institutional relations dictate meaning, meaning that is ascribed by the dominant ideological position (McLaren, 1994; Wear, 2003).

Critical multiculturalism proposes that society is characterised by power and privilege which not only determine the values of that society but also determine what constitutes difference and therefore who represents the dominant majority and who falls into the marginalised minority (McLaren, 1994; Giroux, 2000; Steinberg and Kincheloe, 2001; Burton, 2002; Wear, 2003). Analysis of "power structures and socio-historical constructs" (Nylund, 2006, p29) brings understanding of how society is shaped, how knowledge is produced, and how some come to be viewed as inferior to others (Steinberg and Kincheloe, 2001). McLaren (1994) and Goldberg (1994) argue that those people who are labelled different, or less equal, are subsequently excluded from the opportunities available to the dominant majority. Wendy Martineau describes this as being "rendered invisible by the dominant meanings of a society" (Martineau, 2012, p170). Exclusion, or invisibility, results when the definition of difference is set by the dominant norms and values – if you are not like us then you are different – thus privileging some whilst disempowering others (Fleras, 2002). Stephen May goes on to point out that not all differences are equal because some individuals have more choices than others and some individuals are "differentially constrained" by "structural forces" such as racism, colonialism and capitalism (May, 2009, p43). In arguing that consideration of culture always takes place within a "discourse of power and inequality", May urges reflection on ethnicity and culture without the essentialising labels that frequently accompany thinking about ethnic identity to the exclusion of consideration of structural inequalities (May, 2009, p42).

Drawing on its roots in critical theory, several authors have noted the transformative potential of critical multiculturalism (Guba and Lincoln, 1994; Goldberg cited in Kanpol and McLaren, 1995, p11; Valadez, 2001; Giroux, 1988; May, 2009). This transformation is brought about by examining and questioning the way in which history has shaped society, and continues to shape an individual's responses to society. As Dawn Burton expresses it, "difference is always a product of history, power, culture and ideology" (Burton, 2002, p210) which Barry Kanpol and Peter McLaren argue should be examined

in the context of a theoretical framework that addresses "oppression, resistance and liberation" (Kanpol and McLaren, 1995, p4). Critical multiculturalism acknowledges the role of history in the development of experience and therefore meaning (McLaren, 1994), in the development of an individual's identity (Shohat and Stam cited in Turner, 1993, p418), and exposes the historical background to relationships (Kanpol and McLaren, 1995; Giroux, 2000; Matustik, 2002). According to Henry Giroux, a task of critical multiculturalism is, therefore, to focus attention on the role of history, language and institutions in the production of discrimination (Giroux, 2000), and to allow individuals the space to set out and take control of their own histories in order to participate in the dominant political system (Giroux, 1995).

Attaching a label of difference operates to place some people in a subordinate position to those people who are deemed to meet the norm. Critical multiculturalism refuses to accept labels, preferring instead to examine how those labels were developed, by whom and for whose benefit, how they are interpreted, and what alternatives for understanding exist (Burton, 2002). Thus critical multiculturalism provides a framework to examine dominant hegemonies and those labelled "different" to understand social structures that create "patterns of domination and subordination" (McLaren, 1994, p58). As Stephen May and Christine Sleeter describe it, solidarity across communities will only be achieved when everybody understands the oppression of others, understands the history of themselves and others, in the process exposing power relations (May and Sleeter, 2010). To achieve this, society needs, they say, an awareness of "normative assumptions" and "institutional practices that characterise them" (May and Sleeter, 2010, p11).

A further strength of critical multiculturalism is that it draws on the forward thinking aspect of critical theory which "critiques contemporary society whilst envisioning possibilities" (Burton, 2002, p210), allowing critical multicultural theorists to move beyond simply identifying and questioning power structures to seeking ways to redress this situation. May describes this process as "naming" and "actively challenging" injustice (May, 2009, p35).

Giroux (1995) and CarolAnn Daniel (Daniel, 2008) both argue that critical multiculturalism also provides a framework for moving away from a focus on minorities to a focus on the political system and how it has been shaped by history and language.

Giroux argues that the dominant political system effectively makes "inequity invisible" and therefore promotes disadvantage (Giroux, 1995, p114). In Giroux's words critical multiculturalism intends to "strip white supremacy of authority and legitimacy" in order to identify the structures of power that "racialize the social order" (Giroux, 2000, p326). David Nylund agrees that critical multiculturalism provides a space for a challenge to whiteness as a socially-constructed norm, with its "normalizing discourse" that operates to subjugate some people (Nylund, 2006, p36). May also notes that the "invisibility of Whiteness" characterises what he describes as the colour blind nature of public policy (May, 2009, p44).

Importantly, critical multiculturalism seeks to empower minorities, to value and "re-value" different knowledge (May, 2009, p43), and to challenge and transform or rebuild the systems and institutions, especially Eurocentric ideologies, that entrench subordination and discrimination (Goldberg, 1994; McLaren, 1994; Giroux, 2000; Fleras, 2002; Prins and Saharso, 2013). Such transformation would hasten a winding back of the "effects of repressive and constraining power" (Goldberg, 1994, p30) and restore social justice (Burton, 2002). Kanpol and McLaren comment further that the power of "Western forms of hegemony" is in shaping people living within that political system, a power that makes it hard for those people to see ways in which they could act differently (Kanpol and McLaren, 1995, p2). In healthcare specifically, Joan Anderson and colleagues add that "Western science" is "the norm" against which all other beliefs are measured (Anderson et al., 2007, p297).

Giroux (1995, p112-116) suggests that critical multiculturalism may be seen by the dominant order as a threat to their position, not only because it "embraces multiple identities" and "diverse cultural traditions", but also because critical multiculturalism has a "moral and ethical" tone rather than a market-based tone. Critical multiculturalism uses culture as the vehicle to demonstrate that cohesive society does not need to be built on a single, common culture but rather that recognition of all cultures as of equal worth and worthy of equal support is a solid basis for political legitimacy through a "universal right to cultural self-definition and self-production" (Turner, 1993, p425). Similarly, Kanpol and McLaren (1995) suggest that people would gather around issues of common concern and form a common bond around that issue regardless of cultural background. Giroux describes this as "unity-in-difference" which can only be achieved if society rejects

"essentialising and separatist" language that deems some cultures "tolerable" to others (Giroux, 2000, p338). Kanpol and McLaren go on to argue that a dominant ideology will always seek to explain why some "differences matter over others" noting that wherever identity sets up a "we" there must always be a relationship of power between the "we" and others (Kanpol and McLaren, 1995, p8-9).

When societal structures continue unquestioned it seems inevitable that some citizens will be disadvantaged, especially those that seemingly do not conform to the dominant norms. The examples given in Chapter 1 show how CALD citizens can be disadvantaged by healthcare systems which do not acknowledge the different ways in which health and illness can be experienced by people of CALD backgrounds. Thus far, in this section I have described critical multiculturalism as a framework that can shine a light on societal structures which may serve to exclude some citizens as beneficiaries of public policy. According to both Will Kymlicka and Barry Hindess, the external environment is mirrored within the political system ensuring that internal agency culture, and therefore practices, benefit the dominant group in society further entrenching disadvantage to minority groups (Kymlicka, 1995; Hindess, 2008). A critical multicultural approach can be used to shine a light *into* the government health sector, exposing those internal structures and procedures that support the development of health policy, but which may put the needs of some citizens ahead of others in order to maintain dominance of the privileged and powerful. A critical multicultural framework offers a powerful tool to health policy makers to reflect on their own assumptions and positions in society with a view to developing more inclusive health policy and citizen engagement. Such examination opens the possibility of greater understanding between healthcare organisations and CALD background citizens, with a view to reducing disadvantage exacerbated by the implementation of the healthcare system.

2.4 A critical multicultural view of health policy

In a multicultural society the consideration of culture in health policy development cannot be overlooked because care-giving and receiving is profoundly affected by cultural issues (Buse et al., 2012; Napier et al., 2014). Different values about what constitutes good health, customs addressing for example the delivery of health services to women,

language difficulties, and power hierarchies in different cultural communities all affect the development and delivery of health policy (Buse et al., 2012). In the health policy context, critical multiculturalism offers a pathway to greater understanding about how the accepted policies and procedures of health authorities operate to marginalise CALD citizens. This understanding is achieved by raising awareness of how the dominant norms and values of a society became dominant and how the policies arising from these norms and values, along with their associated "standards and structures", contribute to "institutional or structural discrimination" making it unlikely that health policy will meet the health needs of minority groups (Fuller, 1997, p154-156). This process moves the policy maker's thinking away from a focus on the cultural practices of the minority and towards the effects of marginalisation on the individual (Daniel, 2008). Jeff Fuller suggests that health policy makers' awareness can be greatly assisted if minority groups participate in the "political processes of the health system", so as to communicate directly their needs and contribute to potential solutions (Fuller, 1997, p157). Equally, health policy makers and their leadership must be willing and open to hearing the views of minority groups. Fuller's position is supportive of deliberative citizen engagement in health policy development.

Public policies are only useful if they are both sensitive to, and meet the needs of, the audience they purport to serve (Davis et al., 1993; Hess and Billingsley, 2007), therefore it is crucial to identify the policy development process most appropriate for the issue under consideration. As John Coveney says, the best method of health policy development is the one that will work best for the topic under consideration (Coveney, 2010). From a critical multicultural perspective, an appropriate policy development process must enable structural discrimination to be identified, named, and addressed. This requires attention be given to how a problem is represented, in the process exposing the assumptions and values of society (Coveney, 2010).

Isabel Awad argues that equitable access to health policies and programs can be addressed best when intended policy beneficiaries are identified in relation to other similarly situated groups rather than along cultural lines (Awad, 2011). Her approach is to ensure that <u>all</u> people with low income or <u>all</u> people with low levels of education are identified without the need to fall back on ethnicity as a discriminator.

The challenge that Coveney's and Awad's approaches present lies in the expectation that the policy maker is neutral, thoughtful, and enabled to undertake a critical multicultural process of enquiry. In my view these characteristics are difficult to demonstrate, not necessarily because of ill will but because of the influence that institutional values and structures have on the way in which policy makers are enabled to carry out their responsibilities. This puts the onus on policy makers as individuals to search for information to broaden their understanding of the policy audience, and especially to be aware of their own assumptions about the policy audience (Alkadry, 2005; Young, 2010) in the pursuit of "open and inclusive" health policy that is "transparent, accessible and responsive to as wide a range of citizens as possible" (Organisation for Economic Cooperation and Development, 2009, p24).

It is hard to say that one set of interests in health policy development is more influential or challenging than another. Nevertheless, drawing on my own experience as well as discussions with health policy makers, I would suggest that the most difficult factor to manage is that of cultural diversity because it cannot be bound and labelled and therefore it is questionable whether culture can ever be 'known'. Knowing your policy audience is sound advice but when that policy audience is so diverse I wonder how the policy officer can be expected to achieve this knowledge.

On the face of it, policy officers have some work to do to harness not only the strengths that immigrants bring to a country but the strength that can be gained through collaboration with the community. But let us not be hasty in pointing the finger of blame at the health policy officer. Developing health policy is usually about aggregate populations even though the resulting policy will impact on individuals or groups differently. Pressures of time and priorities, limited financial and personnel resources, and electoral cycles all impinge on the policy officer's work making it hard to take into account the specific needs of CALD background individuals. Empirical data from both Australia and Canada confirmed that, whilst developing health policy should be straightforward because it entails a step-wise process from defining the problem, to identifying solutions, to implementation and evaluation, the 'difference lens' is not often applied in health policy development. Indeed, attempting to balance the different lenses – of budgets, gender, age or culture – can be overwhelming. My own experience of nearly

three decades as a policy officer in the health sector tells me that policy officers are not making excuses.

2.5 Conduct and analysis of empirical research

2.5.1 Design

This research is a comparative case study of Australian and Canadian policy making for diversity in health, comprising government policy document reviews and interviews with key informants. As well as comparing two countries, I also compared two levels of government within and across countries, namely the Federal with the State and Territory (Australia) and Provincial (Canada) levels of government. Empirical data was gathered through interviews with health policy officers in both countries and at both levels of government.

A hermeneutic lens, described below, was applied to transcriptions of interviews to support understanding of the data. Having identified the key concepts of citizen engagement, public policy, multiculturalism and cultural competence I allowed the relationships between these concepts to unfold through my discussions with health policy officers and examination of their governing policy frameworks. This enabled me to report and compare the policy frameworks and everyday stories of health policy officers to add richness to the theoretical literature. Comparisons across countries and levels of government can provide useful insights as I discuss in Section 2.5.3 below. Making sense of these concepts through the experiences of health policy makers in a selected number of jurisdictions will, I hope, contribute to a greater understanding of cultural competence in citizen engagement for health policy development in a multicultural society – an understanding that could enable health policy development to be demonstrably inclusive. The following sections describe and justify the research design in more detail.

2.5.2 The hermeneutic lens

In this thesis, empirical data is considered through a hermeneutic lens, specifically the hermeneutics of Hans-Georg Gadamer. Simply put, hermeneutics is the science of interpretation and Gadamer believed that the key to interpretation was "coming to an understanding" about a text or event (Gadamer, 1989, p4-5). The point to Gadamer's (1989) hermeneutics is that hermeneutics is not a method to reach understanding but

rather a process to identify the conditions under which understanding can be reached. However, coming to an understanding is neither simple nor a single-person activity. Gadamer stated that each person has their own prejudices, or pre-judgements, which are formed by her or his own history, creating a "historical horizon" (Gadamer, 1989, p306). Attempting to understand another person's point of view is always through a historically-created, prejudicial, lens which, when brought to bear on understanding, creates a new horizon of the present, necessarily mediated by one's past history. This bringing together of past and present horizons he described as a "fusion of horizons" (Gadamer, 1989, p306). Gadamer (1989) argued that meaning is not fixed, that the meaning a listener ascribes to a comment has many possibilities which are drawn from the listener's own history and experience. In order to identify differences and achieve understanding Gadamer (1989) highlighted the need to ask questions: questioning facilitates discovery of another person's experience but does not require the questioner to set aside her own historical horizon, or even to take on another person's perspective at the expense of her own. In the process of achieving understanding, Gadamer (1989) stresses that the questioner must be open minded, willing to communicate and not to pre-judge what the other party to the conversation may say or think. This requires the questioner to remain open-minded to possibilities beyond preconceived ideas, that is, the questioner is setting aside her own prejudices and is truly seeking knowledge. The conversation that is demonstrated by the back and forth of question and answer serves to transform the conversationalists into a "new community" with a new understanding through a shared common language that has been developed through conversation on the topic under discussion (Gadamer, 1989, p378-79). Gadamer's focus on the fusion of horizons alerts the questioner to be aware of the differences between herself and the person being questioned. The difference between the two people must be taken seriously if they are to avoid assigning layers of value to people's ideas. This is a particularly apt warning in multicultural societies where the dominant majority considers some cultures, and notably their own, better than others.

I chose Gadamer's hermeneutics because I believed this approach to be especially pertinent to a comparative case study of this nature. Notably, this approach supported my conversations with health policy makers, asking questions and listening to their answers without ascribing meaning that would be relative to my historical horizon, but rather taking the meaning of health policy officers' actual words from reflection on the

transcripts. The conversations between us, using some questions as prompts, aided the backwards and forwards of question and answer to achieve a greater understanding of each health policy officer's position. In other words, the hermeneutic lens supported the collection of a number and diversity of observations, drawn from my interactions with health policy officers. Reflection on those observations helped me to gain an understanding of the thoughts, feelings and motivations of health policy officers relative to the application of cultural competence for citizen engagement in health policy development.

2.5.3 Choice of Australia and Canada as comparisons

My research is comparative of experiences in Australia and Canada at both the Federal and State/Provincial levels of government. Cross country comparison can be useful in several ways. Firstly, comparison between countries supports identification of contrasting approaches to a policy topic. Secondly, knowing these contrasts exist facilitates identification of the reasons for the differing approaches, and therefore deeper comparison of the conditions that may be similar or different between countries. Finally, comparison between countries supports assessment of the relative success of the approaches identified, with a view to learning lessons from others (Marmor et al., 2005). This research project will identify whether contrasting approaches to the application of cultural competence to citizen engagement for health policy development exist and, to the extent that differences do exist, identify any lessons that can be drawn from those contrasting approaches.

Australia and Canada were chosen as the research setting because they have many similarities. Firstly, both countries have been termed "immigrant democracies" meaning that they both have large immigrant populations as a feature of their settlement and development (Levey, 2008a, p4). Details of population diversity were described briefly in Chapter 1 and can be found in more detail at Appendix 4 along with general information about each jurisdiction. Secondly, both countries are similar in terms of mode of government – both are federations of States (Australia) or Provinces (Canada) and Territories (Australia and Canada), and government is based on the Westminster system of democracy. Both countries have vast geographies which impose challenges for communication, transport, health infrastructure and health service provision noting the distances to, and remoteness of, some communities. Both countries have systems of

publicly funded universal health care combined with private sector service provision for which tax payers meet the cost through private health insurance.

The choice of State and Provincial governments was purposeful. In Australia, the Australian Capital Territory (ACT) and Queensland were chosen because both governments have explicitly committed to open government and citizen engagement.

Whilst government responsibilities vary a little between Queensland and the ACT because of the difference in governance between States and Territories in Australia, both governments provide policy leadership – an important point of similarity. Both jurisdictions have diverse migrant populations and both governments have made explicit public commitments to citizen engagement and multiculturalism. The ACT government's challenge is to offer all services to a growing population but from a limited revenue base. The Queensland government's challenge is to offer services in a State where the population is growing, but remoteness and access in terms of transport and telecommunications are not equal. Initial scans of the ACT and Queensland government and health authority websites appeared to offer a significant amount of publicly available information about policies relating to multiculturalism, citizen engagement and multicultural health.

Whereas the ACT government delivers all health services, the Queensland government has devolved and decentralised much health service and funding to sixteen Hospital and Health Services (HHS). Queensland Health operates more as a 'head office' than as a central office for health policy, resulting in shared health policy development between Queensland Health and the sixteen HHS according to the function in question. Because of this structure of health policy development in Queensland, the Metro South Health HHS was included as part of this research project. Metro South Health serves a population of around 1 million people, or 23% of Queensland's population, spread over 3,856 square kilometres, taking in areas as diverse as Brisbane metropolitan, Logan City, and rural areas down to the border of New South Wales (Metro South Health, 2017).

In Canada, British Columbia and Ontario were chosen because both Provinces have diverse populations, and both have challenges in terms of distances and remoteness within the Province. British Columbia government and Health Ministry websites provided sufficient information to show commitments to multiculturalism and citizen engagement.

Whilst Ontario government websites were not as illuminating, additional factors influencing the choice of these two Provinces were the number of examples in the literature which confirmed a strong government commitment to citizen engagement in British Columbia, and the growing commitment to citizen engagement in Ontario as demonstrated by the Premier's communication about the Open Government initiative (Wynne, 2016).

In Ontario, as with Queensland, health services are funded through a decentralised model of Local Health Integration Networks (LHIN). For this reason, the Toronto Central LHIN was included in this research project. Whilst the Toronto Central LHIN is geographically small, measuring a number of city blocks, it is the most diverse of the LHINs. The population of 1.2 million residents live in a high density completely urban setting which contains the highest percentage of immigrants anywhere in Canada (Toronto Central LHIN, 2016).

2.5.4 Research Participants

Fieldwork for this research comprised interviews with a number of senior policy officers from health authorities in both countries, to ascertain their experiences of cultural competence for citizen engagement and health policy development in a multicultural society. In order to obtain a spread of responses, health policy makers at both the Federal and State/Territory/Provincial levels of government were invited to participate. Participants in all jurisdictions were recruited to meet two parameters: firstly, their actual experience of face-to-face citizen engagement (at least one), and, secondly, their level of seniority within the organisation (Director or equivalent and higher). It was my intention to be able to speak candidly with participants to obtain their views and I felt that seniority would overcome any potential reticence that a more junior officer might experience.

Research participants were recruited through a lengthy process of contact and referral wherein I made contact with key informants in all jurisdictions. The purpose of speaking to key informants, who were selected based on their responsibility for multicultural health or citizen engagement, was to seek advice about potential participants. These key informants provided an entrée to each health authority, guiding me through organisational structures and providing suggestions of senior staff who could be approached with a view

to participation. At times the recruitment process was frustratingly slow as one person referred me to another, and that one to yet another, before I stopped at the right door.

Given the seniority of research participants, I felt that their knowledge of organisational policies and procedures should be sufficient to ensure the collection of relevant empirical data without having to interview many or all senior officers in each health authority. I also took a pragmatic approach to sample size, recognising that senior officers have limited time to devote to activities that are outside their formal duties. For these reasons the sample size was limited to 12 health policy officers, that is, two from each of the six jurisdictions. Ultimately this goal was not achieved in Canada, where informants within the Federal health authority consistently advised me that citizen engagement was restricted to regulatory matters and that the multicultural nature of the population, or of respondents, was neither specifically considered nor recorded. For this reason, the Federal Canadian position relies on the best information at the time, drawn from a Federal health research organisation that had a well-publicised commitment to citizen engagement. It is worth informing the reader that, towards the conclusion of this research project, Health Canada made a change to its approach to citizen engagement. Although this was too late to be included in the thesis, I have acknowledged this change in section 7.4 below.

Nevertheless, a total of 12 people were interviewed as follows:

Level of Government	Australia	Canada
Federal	2	1
State/Territory/Provincial	4	5

As noted above, some participants were drawn from the HHS and LHIN of Queensland and Ontario respectively to ensure access to the best information from people active in the field. Each participant was assigned a number which has been used throughout this thesis to identify the participant, country and level of government concerned. Thus, direct quotes are attributed as, for example, "Participant #2, Australia, Federal". A full list of participants can be found at Appendix 2 without the addition of code numbers in order to

maintain a measure of confidentiality. Again, for reasons of confidentiality, in this thesis the word "State" as an Australian jurisdiction includes reference to the Australian Capital Territory Government. The same protocol has not been applied to Canadian jurisdictions because no Canadian Territories were included in this research.

2.5.5 Interview Methods

According to Earl Babbie, unstructured interviews are appropriate to field research, relying on a general plan of inquiry rather than a specific set of questions, permitting conversation for which the interviewer "establishes a general direction" and pursues specific topics raised by the respondent (Babbie, 1992, p293). I diverged from Babbie's protocol, preferring instead semi-structured interviews guided by a series of questions used as conversation prompts (see Appendix 3). In my view this was the most efficient way to manage interviews with senior policy officers, ensuring that key topics were discussed whilst maintaining a free-flowing conversation during which the participant could raise issues for discussion. The interview questions were developed to ensure that each of the research questions was addressed at some point during the interview. In some cases, interviewees provided information without the need for every question to be asked. The interviews, which lasted approximately sixty minutes, were conducted either face-to-face or by telephone (one instance), and were recorded and transcribed to support accurate analysis of the information. A verbatim transcript was made of each interview in order to support examination of "personal experience in depth" (King and Horrocks, 2010, p143) and participants were given the opportunity to review and correct the transcripts prior to completion of the analysis. As Nigel King and Christine Horrocks say (2010, p148) "language in the spoken form is almost always messier than it is in writing". Thus, the transcript provided to participants included repetition, incomplete sentences and gaps in a train of thought. Whilst a few participants commented with amusement on how inarticulate this made them appear, any suggested corrections were confined to errors such as misspelt names or unclear jargon or technical terms.

Interviews were conducted over an extended period of time in 2014 and early 2015. Interviews in the ACT (Australian Federal and Territory governments) were conducted during February to April 2014. Interviews in Queensland were held in February 2015. Interviews in British Columbia and Ontario (Canadian Federal and Provincial

governments) were conducted in person during July and August 2014. One Provincial interview was conducted by telephone in September 2014.

Each transcript was read multiple times, initially as a reminder about the content of the conversation and, subsequently, in order to understand content and highlight themes. These themes, which were manually coded, were identified as a result of repetition across interviews where the issue was also "relevant to the research question" (King and Horrocks, 2010, p150).

In order to answer the research question "could paying greater attention to cultural competence enhance citizen engagement in health policy development" I was interested to discover health policy officers' views about how the idea of cultural competence had developed in the public sector; whether and how cultural competence played a part in citizen engagement for health policy development including its impact on recruitment of citizens; and whether and how health policy officers were supported to engage with citizens of CALD backgrounds.

Detailed analysis identified several themes arising from the interviews such as the nature of legislation as a driving force and the division of responsibilities between Federal and State and Provincial governments. Although these themes were consistent across interviews and therefore across countries and levels of government, I identified both points of similarity and difference between countries and between Federal and State/Provincial jurisdictions. For example, all participants commented on the importance of positive leadership from higher echelons in the organisation, but there were differences reported at the Federal and State/Provincial levels about the degree of leadership that interviewees felt they received. Similarly, whilst all participants acknowledged the importance of cultural competence some felt that as culture was constantly changing, cultural competence was ultimately unattainable, whilst others felt that cultural competence could be attained. Values related themes were also expressed: in Australia many responses reflected a sense of acknowledgement and respect coupled with frustration at the lack of leadership and resources, whereas many Canadian responses reflected compliance with legislative requirements, collegiality and leadership support. These values did not cross countries although they did cross jurisdictions within a country. All of these themes will be discussed in chapters 3 to 7.

Whilst deliberation with Aboriginal (Australian and Canadian) and Torres Strait Islander People (Australia) is outside the scope of this thesis, a number of participants spontaneously discussed cultural competence in connection with Indigenous populations. This stood out as an unexpected issue and so I have included discussion of this in Chapter 4.

2.5.6 Ethical issues

Prior to commencing fieldwork, the research plan and associated Participant Information Sheet were submitted to the Australian National University Human Research Ethics Committee for consideration. The Committee gave approval in October 2013 (Protocol Number 2013/508).

After reading the Participant Information Sheet and being given an opportunity to ask questions about the research and intended use of any information they may provide, participants signed a Consent Form prior to formal interviews taking place. Participants were given the opportunity to decide how their contribution would be acknowledged: only one participant asked for anonymity. However, as thesis writing proceeded and I started to quote direct comments, I realised that given the small number of participants it could be possible to match comments and participants without much trouble. I decided that this was not necessarily a good thing given the candour of many of the participants, particularly when talking about their own organisations. For this reason, I have chosen to use a general system of attributing comments by simply referring to participant number, country of origin and level of government. This does not remove the problem entirely but does have the effect of creating a larger pool of potential speakers from which the comment was drawn.

2.5.7 My role as a researcher

In Chapter 1 I described my motivation for undertaking this research drawing on my significant experience in the Australian Public Service. My informal conversations with key informants as part of the recruitment process contributed significantly to my learning about each policy environment and served to remind me that, whilst my first-hand knowledge of health policy making in the public sector may be useful in terms of speaking on equal terms with research participants, it should not be used as the yardstick against

which to judge those conversations. As a researcher, an awareness of my own values and beliefs was thus brought to the fore.

I chose to interview health policy officers and to focus on their experiences rather than the experiences of CALD background citizens. Throughout this process I needed to be aware that my background might influence my sympathies for participants and contribute to a bias in questions and analysis. To mitigate against this risk, I prepared a series of topics to be used as conversation starters, sought approval of the transcript to ensure accurate citation at a later date, and used a system of coding to ensure that all ideas on a particular topic were highlighted for analysis.

A further potential bias in analysis and reporting could have arisen if I found myself drawn to particular participants because of, for example, their enthusiasm or their track record in citizen engagement as opposed to others who may be less enthusiastic or experienced. To mitigate against this risk, wherever feasible I have tried to ensure that all jurisdictions are represented in comments provided as evidence of an argument. This is not foolproof of course, for example because some jurisdictions are not as active as others.

The question of cultural competence in health policy development is central to this thesis and will be discussed in detail in the next chapter.

Part Two: Cultural Competence for Deliberative Health Policy

Chapter 3 Dancing an attitude - Cultural competence for health policy development

> "Culture is performed…each performance is located in and related to the larger social discourses of meaning from which we gather narrative threads, symbols and ritual possibilities – a combination of tradition and imagination. This process can be thought of as 'improvisational'… This is what we do: we dance an attitude"
> (Laird, 2000)

In the previous chapter I discussed the choice of Australia and Canada as the sites for this research, noting especially the multicultural nature of both countries. Before examining cultural competence in multicultural policy and in citizen engagement for health policy development I want to explore the meaning of 'cultural competence' in some detail. This concept is often used to denote a necessary skill to support interactions with people from culturally and linguistically diverse (CALD) backgrounds, a skill that some authors, noted below, say can be taught, learnt, attained and maintained. This chapter will address two parts of the first research question exploring what governments and their health authorities understand by cultural competence and how this is operationalised for health policy development. I will start by breaking the concept down into its components of culture and competence to enable a definition of cultural competence that I believe is relevant to health policy officers.   I will then review how cultural competence is understood in the literature, and within governments and the government health sector, illustrated by my findings from the review of government documents.

3.1 Culture – static attributes or shared understandings?

Before embarking on a discussion about cultural competence it is essential that we share an understanding of the meaning of 'culture'. This is no easy task as Alan Barnard and Jonathon Spencer point out in their review of the history of this term from an anthropological standpoint: they note that it is almost impossible to create a hard and fast definition given the many and opposing ideas over two centuries of debate (Barnard and Spencer, 1996). They comment that within anthropology culture is seen as "plural and relativistic" meaning that there are many cultures in the world and a person is the product of her culture, shaped and influenced by the environment surrounding her (Barnard and Spencer, 1996, p136). Too often, though, culture is described as "integrated patterns of human behaviour" that include "language, thoughts, communications, action, customs, beliefs, values" (Anderson et al., 2003, p68), frequently reduced to "a catalogue of ideas and practices" (Baumann, 1999, p25) said to define cultural groups. Loong Wong comments that this perspective on culture predominates in the fields of business and management (Wong, 2010), a point that is pertinent to this research project. The drawback of this narrower perspective is that these attributes are determined by the dominant majority and serve to define culture as bounded and closed, unchanging and static (Prato, 2009), fixed at a particular point in time (Carpenter-Song et al., 2007; Fontefrancesco, 2012) thus essentialising groups of people within society (Lyshaug, 2004; Galeotti, 2009). As well as essentialising cultures, this bounded view places one culture in an inferior position to another (Fontefrancesco, 2012). Giroux adds his support for a shift away from the idea of culture as a list of attributes when he talks of "unity-in-difference" which can only be achieved if society rejects "essentialising" and "separatist" language that deems some cultures "tolerable" to others (Giroux, 2000, p338).

Not only is the static, trait-based approach deterministic, but it is consistent with society's understanding of culture (Street, 1993) as can be seen in news reporting. For example, in Canada a cab driver acquitted of a crime was subject to vilification and abuse which his lawyer described as a "grotesque stereotype" based on the man's "Arab race and Muslim religion" which people understood to "mean he is prone to sexually assault a vulnerable woman" (Tutton, 2017). In Australia, recent news reported tensions in Victoria's Venus Bay where local residents described seasonal Chinese tourists digging for shellfish as "Asians" and "ethnics" who had a "culture to take everything" but without contributing

to the local economy. An anthropologist studying this situation described the comments as based on "longstanding ingrained stereotypes we have about Asian people in Australia" (Pepper, 2017).

Another short-coming of this trait-based approach is that it does not acknowledge diversity within as well as between cultures, such as religious affiliation, gender identity, sexual orientation, or health status, which operate to produce sub-cultures within cultures (Hess and Billingsley, 2007; Racher and Annis, 2007). Neither does this approach make allowances for the way in which people change (Carpenter-Song et al., 2007) under the influence of time, environmental factors, relationships, migration and so on. Arguing for greater recognition of the differences between individuals within cultures Mohamad Alkadry says that no two people have the same lived experience and hence could not really be said to have the same culture. For example, individuals may share an identity, such as black American, and this may shape their experiences but, he contends, this is not the same as sharing a culture (Alkadry, 2005). Similarly, David Napier and colleagues suggest that just because groups of people share an attribute (eg a country of birth) does not mean that all people in the group necessarily share the same beliefs (Napier et al., 2014). John Capitman adds strength to this view when he argues that membership in a social group changes over time, resulting in changes in a person's social relationships over time (Capitman, 2002). Capitman (2002) cites an example of a person who shifts from young and able today to older and disabled at some future point. Accompanying this change in situation is a change in the way society views the individual. The common thread in all of these views is that culture is something that is given meaning through interactions between people and therefore can be expressed as "always contextual" (Laird, 2000, p107). This means that each of us displays a culture depending on the situation in which we find ourselves. For example, I would respond to people differently in situations where I act as mother, daughter, student, school board member and so on. In other words I "dance an attitude" (Laird 2000, p103) according to the situation.

In some instances the idea of race is substituted for that of culture, along with the implication that all people of a particular race must share the same culture and therefore the same values and ideals (Carpenter-Song et al., 2007; Alexander and Stivers, 2010). However, many authors have argued that the concept of race is a difficult one that has transitioned from its, now largely discredited, biological basis meaning people who share

physical characteristics to a social basis, that is people who share a common ancestry (Bhopal, 2004; Ford and Kelly, 2005). Regardless of this apparent re-definition, these authors caution that biology still underpins the meaning of "race" and the term should be used sparingly. In agreeing, I would argue that using race or common ancestry to define culture simply brings us right back to the bounded, fixed notion of culture. Health policy officers need to be aware of this to avoid falling into the same trap.

The Lancet Commission on Culture and Health (Napier et al, 2014) recognised the many assumptions in traditional definitions of culture. The authors argue that this does not account for what is taken "for granted", and recommended a definition of culture that acknowledges this dimension

> "The shared, overt and covert understandings that constitute
> conventions and practices, and the ideas, symbols, and concrete
> artifacts that sustain conventions and practices, and make them
> meaningful." (Napier et al., 2014, p1610)

Taking a different approach, Michele Fontefrancesco has mapped the change in anthropological thinking away from the basic list of attributes to consideration of culture as a "fluid, changeable, positional reality", de-emphasising culture as bounded in favour of recognising a series of relationships or networks within which individuals operate (Fontefrancesco, 2012, p60). She says that culture should be thought of as:

> "knowledge in motion, where people are places of contact, creation,
> propagation of knowledge towards other individuals that, in their turn,
> are also places of contact, creation and propagation of knowledge
> towards other individuals" (Fontefrancesco, 2012, p61-62)

Others also argue for an understanding of culture that is relational and "meaning-centred", such as Brian Street who notes that "culture is an active process of meaning making and context over definition, including its own definition" (Street, 1993, p25) and Elizabeth Carpenter-Song and colleagues who offer their understanding of culture as

> "a dynamic process of shared meanings, located in and emerging from
> interactions between individuals" (Carpenter-Song et al., 2007,
> p1364).

Joan Laird also takes the approach that culture is "not measurable or generalizable" but is "an individual and social construction, constantly evolving", "constantly in motion, changing in meanings and definitions" (Laird, 2000, p103-107).

Noting that culture should not be essentialised (Roseberry, 1992), and the general agreement with Fontefrancesco's view that culture should be recognised as fluid (Phillips, 2007; Delanty, 2011), Ruth Dean goes on to argue that the changeable nature of culture occurs because the definition or construction of culture is dependent on the changing social and political context within which culture is considered and defined (Dean, 2001). In this situation, Adital Ben-Ari and Roni Strier suggest that constantly shifting views about culture put people from CALD backgrounds into the category of being "unknowable" because, they say, we can never pigeon-hole a person into a specific cultural category for all time (Ben-Ari and Strier, 2010, p2164). For this reason, Anne Phillips recommends that people should be seen as "agents" and not "captives of culture" (Phillips, 2007, p176). Both Laird and Alexander and Stivers also add a focus on the individual. Laird (2000), echoing Gadamer's (1989) comments on prejudice, argues that the individual should shift focus away from herself as the centre and be more open minded about the beliefs and experiences of others. Alexander and Stivers propose that viewing people first and foremost as "citizens", sharing "values to which they are committed", will help to break down perceived barriers based on pre-conceived notions of culture and may lead to less stereotyping (Alexander and Stivers, 2010, p587). This is akin to Robert Young's "postcolonial challenge" to "see all people as human beings" (Young, 2012, p39) and is a view that requires health policy officers to demonstrate considerable self-awareness about their own backgrounds and the organisational structures and processes that serve to categorise and label individuals.

One last point about how culture is viewed. Phillips believes that the term "culture" has become code for "non-Western" or "minority" groups (Phillips, 2007, p29). William Roseberry agrees, arguing that consideration of culture is usually based on Western or Euro-centric assumptions about what constitutes culture, cautioning against this attitude in favour of challenging such assumptions (Roseberry, 1992). Anderson and her colleagues apply this criticism specifically to healthcare, warning that "Western science" is "the norm against which the Other is assessed and culture is 'read'" thus culture is never "neutral" (Anderson et al., 2007, p297).

Roseberry suggests that we need to rethink "cultural production and understanding" (Roseberry, 1992, p846) in a way that identifies not only different ways of doing things (social, domestic and political) but questions the links between Western and non-Western

cultures that result in a (non-Western) culture being described as Other. Roseberry (1992, p846) also notes the need to challenge assumptions about Western history in the context of "intercultural contrasts and connections". This means that we must consider more carefully the potential impact of history in one society on the progress and history of another, a point which is consistent with a critical multicultural perspective. Roseberry (1992) goes on to say that any consideration of society must take into account power imbalances and the ways in which a colonised culture responds to Western intrusion.

For this thesis I chose to adopt the flexible understanding of culture expressed by Carpenter-Song et al (2007). This approach fits within a critical multicultural framework because it affords the opportunity to identify the contradictions between the essentialist list of attributes and the actual lived experience of individuals. With this knowledge we can refuse to accept the bounded, Western or Euro-centric descriptions of culture in favour of greater reflection about people as humans, shaped by their histories and with many alternative ways of generating knowledge and responding to society. By taking this position, I accept Roseberry's (1992) challenge to move away from Western or Euro-centric assumptions about what constitutes culture.

3.1.1 The meaning of health policy making

Before moving away from discussion of the nature of culture I want to emphasise a specific point. Napier et al (2014), Fontefrancesco (2012) and Carpenter-Song et al (2007) all argue that culture is about making meaning. In the health policy context, when policies are enacted they become part of the fabric of society that add to the meaning of health in that society. Health policy officers therefore create meaning in society through the policies they develop and implement. I have already shown, in Chapter 1, that understandings of health in society vary and mismatches between those understandings can cause difficulties for both policy maker and citizen. Developing health policy therefore places a responsibility on the shoulders of health policy makers to ensure that the meaning they are creating is understood by citizens in the way that policy makers intended. The problems identified in those earlier examples show that this is not always happening. My research explores the role of cultural competence in citizen engagement as a means to support the development of health policy that is meaningful to citizens.

3.2   Understanding cultural competence

Most references to cultural competence in the literature centre on an understanding of culture as a shared heritage based on ethnicity (Carpenter-Song et al., 2007). Margo Bailey gives one such definition as "respect for, and understanding of, diverse ethnic and cultural groups, their histories, traditions, beliefs and value systems" (Bailey, 2005, p177). Similarly, Terry Cross defines cultural competence only in relation to the US First Nations People (who were the focus of his work) (Cross et al., 2000). However, there are definitions that do not follow this path. Maria Jirwe and colleagues define cultural competence as having the appropriate skills and knowledge to interact with people from other groups (Jirwe et al., 2006) where those groups are not defined. Laurie Anderson and colleagues acknowledge that cultural groups include "racial, ethnic, religious or social" adding that competence is the "capacity to function effectively" in the context of peoples' values, beliefs and needs (Anderson et al., 2003, p68). In the public administration field, Rice defines cultural competence as "operating effectively in different cultural contexts and providing services that reflect the different cultural influence of constituents or clients" (Rice, 2007, p626).

An example from within Canadian public administration is the definition contained in a 2010 literature and scoping review of core competencies for anti-racism and diversity trainers, commissioned by the British Columbia (BC) Government. The report notes that the term "cultural competence" is used "frequently in North American health care research and practice" and refers to "the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of health care; thereby producing better health outcomes" especially where individuals include those disadvantaged by reason of cultural background (Parker-Toulson and Harrison, 2010, p2).

A dictionary definition of 'competence' is the "ability to do something successfully or efficiently" (Oxford Dictionary, 2017a). Thus, following my understanding of culture above, cultural competence should mean having the ability to successfully or efficiently contribute to the creation of meaning through interactions with people in and from different contexts.

Carpenter-Song and colleagues make the point that cultural competence is required of both individuals and institutions which must promote practices to "meet the needs of a diverse population" (Carpenter-Song et al., 2007, p1363). Cross also identifies the need for organisational cultural competence which he says is "…a congruent set of policies, structures, practices and attitudes which come together in an organization and enable the organization to effectively work in cross-cultural situations." (Cross et al., 2000, p15). Others suggest that an organisation must demonstrate "cultural appropriateness", "cultural accessibility" and "cultural acceptability" in terms of policies, programs and services offered (Rice, 2007, p232) and require "those who set policy and control resources" to commit to organisational change (McPhatter and Ganaway, 2003, p105).

Nelly Oelke and colleagues also agree with the need for institutional cultural competence, arguing that the result of a cultural competence embedded within the system is the support it will provide for "appropriate behaviour" thus ensuring better practice and service delivery (Oelke et al., 2013, p370). In the healthcare context, and from the client's point of view, systemically, cultural competence is about having a "strategy to eliminate ethnic disparities in health care" (Betancourt et al., 2003, p294). However, it is interesting to note that Betancourt and his colleagues fall back on ethnicity as the delineator of cultural grouping. To achieve organisational cultural competence it is essential to have leadership support (Oelke et al., 2013) as well as methods and means to enforce implementation of standards and collection of data (Betancourt et al., 2002).

It would be difficult for employees, in this case health policy officers, to demonstrate skills leading to inclusiveness if they, themselves, were not operating in an inclusive environment. Nicola Pless and Thomas Maak argue that a "culture of inclusion" is vital to ensure that employees from a diversity of backgrounds are engaged and valued and their views are given legitimacy "opening up new vistas" for the strength of the organisation (Pless and Maak, 2004, p130). This inclusion is all the more important when considering the point made by Alexander and Stivers that policy officers work in a "value-infused context" (Alexander and Stivers, 2010, p587) making it nearly impossible for them to make decisions outside the usually accepted boundaries of the institution. This is exactly the situation that critical multiculturalism seeks to overturn by highlighting the structures, including processes and procedures, which entrench disadvantage.

It is worth taking a short detour to look at one approach to managing diversity in the workplace by way of an example. Pless and Maak (2004, p130) have suggested a model for culture change based on the moral theory of recognition, underpinned by the principle that "'doing' requires 'being'". The authors set out four stages to build a culture of inclusion, namely, to raise awareness and create understanding; develop a vision; rethink key management principles and concepts; and adopt human resources systems and processes including competencies of inclusion (Pless and Maak, 2004). The culmination of this model is an "intercultural point of view" achieved by reciprocal understanding, a standpoint of plurality and mutual understanding, trust and integrity, grounded in the principle of recognition (Pless and Maak, 2004, p131-135). Importantly, Pless and Maak make the point that a corporate culture of inclusion is "about recognizing the individual self as a unique person and as a different other" and that a healthy corporate culture makes room for celebrating both individual differences and team achievements which, they say, creates solidarity and confidence in the workplace (Pless and Maak, 2004, p132). According to Pless and Maak, these actions need to be embedded in the organisation's culture in order to ensure behaviour change. This example is useful for highlighting again the role of self-awareness.

Considering the need for both individual and institutional cultural competence, and arguments in the context of culture as fluid, changeable and relational, I can now move the definition of 'cultural competence' away from a simple consideration of interactions between people of different countries of origin to a more active sphere in which both individual and organisational self-awareness play a part. Thus, drawing on the work of Ben-Ari and Strier (2010) I can summarise cultural competence as

> Acknowledging the presence of, and respecting and valuing,
> difference and diversity in order to be able to work effectively with
> people from other cultures.

This definition does not limit culture, difference or diversity to ethnicity alone. For the health policy officer it is important to remember that we are each the Same and Other in different contexts, and so awareness must include awareness of history which shapes an individual's view of life and the health system and how each person came to be in the place they are.

Considering the term 'cultural competence', there are many different terms for the concept of cultural competence – terms such as "ethnic-sensitive" and "multicultural practice" (Williams, 2006, p210). Others suggest "cultural advocacy" described as a higher goal because it encapsulates "lifelong learning" and "action for social justice" (Oelke et al., 2013, p369). Another preferred term is "cultural proficiency", defined as transforming knowledge about individuals and groups into standards, policies and practices (Martis, 2012, p13). Cultural proficiency is said to encompass the skills of the individual and the capacity of the institution and system within which the institution and individual are located (Martis, 2012).

Taking a critical theoretic approach, Larry Ortiz and Jayshree Jani refer to "contextually competent practice" in their critical assessment of social work education (Ortiz and Jani, 2010, p186). They propose that understanding the context within which an individual is situated is important for understanding the pressures on that person, the structures that cause disadvantage for that person, and therefore the ways in which a social worker could address institutional blockers as well as immediate problems. I will return to the matter of terminology in Chapter 4.

I will now look in more depth at a critical multicultural approach to cultural competence.

3.2.1   A critical multicultural approach to cultural competence

There is some agreement that a reliance on cultural competence as a concept is fraught with difficulty, especially the idea of *competence* which could encourage responses to lists of supposed traits ascribed to certain cultural groups. As noted earlier, this essentialising and fixing at a point in time fails to recognise intra-group difference or, indeed, the structures in society that place one group subordinate to another (Wear, 2003; Jenks, 2010; Hester, 2012; Napier et al., 2014). Both Angela Jenks (2010) and Rebecca Hester (2012) point out that essentialising groups by focussing on culture means that no attention is given to the historical, social and political forces that shape a society – in fact this essentialising operates to categorize groups in order to manage them and reinforce the existing social structure. Linda Hunt agrees, adding that culture is seen as something that can be "diagnosed", "controlled" and treated (Hunt, 2001, p135) ensuring that the dominant order becomes the 'us' against which all others must

measure up (Hunt, 2001; Jenks, 2010). All of these criticisms have influenced my consideration of culture and cultural competence as discussed in this chapter.

Writing of the USA, Herbert Marcuse argued that race conflict had overtaken class conflict but, at the time, this was of little concern to the dominant capitalist establishment which believed that "deviation is easily contained" when race is the focus (Marcuse, 1969, p64). Hester (2012) more recently put the case that culture has become a proxy for race thus entrenching new forms of racism, and suggests that health care practitioners must be taught about how their behaviour, conditioned by their own historical and social influences, contributes to continuing discrimination against minorities. I agree with Hester, and extend her argument to include the need for vigilance and thoughtfulness amongst health policy officials. Hester goes on to highlight the institutional and individual imbalances of power and the way in which these can work to "reproduce domination" and entrench health inequities (Hester, 2012, p288).

Also writing in the health context, Napier and colleagues warned that policy makers could "become culturally blind" (Napier et al., 2014, p1622) to the structures that influence burden of disease. This would result in policy makers being oblivious to systemic factors such as inequity of and differential ability to access services (Chu, 1998), and power differentials between the health system and its clients (Oelke et al., 2013), compounding disadvantage experienced by people of CALD backgrounds. As Laird reported, our own knowledge "can obscure our views and privilege our own representations" over those of the people with whom we interact (Laird, 2000, p109).

Much critical multicultural work has been carried out in the field of education including education in the health sector. In her review of social work education in the USA, Daniel (2008) highlights the value of a critical multicultural approach to learning. Its power, she says, is in providing students with the skill to understand and transform society by understanding sources of oppression which are linked to culture. Notably, Daniel points out that learning must be part of an "ongoing faculty dialogue" and "sustained" which means it is not the sort of skill that can be provided in a "sensitivity workshop" (Daniel, 2008, p34). Looking at cultural competence in medical education, Delese Wear argues that without a focus on the historical, social and institutional structures that govern the way people behave, the doctor-patient relationship will be too narrowly focused (Wear,

2003). Wear emphasises the need to critically analyse and identify the "historical, cultural and economic conditions that contribute to illness" as well as inequities and injustices within the doctor-patient relationship, calling on health care practitioners to scrutinise their own beliefs (Wear, 2003, p551-552). Thinking this way guides the medical student towards examining the effects of power and privilege in order to challenge assumptions and biases.

Ortiz and Jani (2010) take a similar approach to tertiary social work education, removing a focus on stereotyping and racial assumptions in favour of an assessment of the institutions in society and the ways in which they operate to dominate individuals resulting in disadvantage. Ortiz and Jani emphasise that social workers need to consider not just the race of a person but also the entire context of the individual such as social class, gender, educational level and so on. This focus on the whole person, coupled with a keen assessment of societal institutions which impose disadvantage, enables the social worker to aim for social justice through transformation of those societal institutions whilst also addressing the immediate needs of the client.

Izumi Sakamoto applies a comparable approach to health policy institutions, arguing they need to conduct a "critical examination of [their] own knowledge base" in order to acknowledge power relations and structural oppression and thus "decolonise" the institution (Sakamoto, 2007, p109-10). Only by doing this will an institution be able to reshape its processes to include the lived experience of its clients with a view to improving policy development.

Hunt offers a definition of cultural competence focussing on the individual:

> "skills to explore the existence of differences in basic assumptions,
> expectations and goals"

noting that the goal is not to "reach competency" but to engage "in an on-going process" to "hone and apply skills for self-awareness and respectful recognition" (Hunt, 2001, p136). Hunt demands this "reflexive attentiveness" be applied to any interaction and not just those between a health care provider and a CALD background patient (Hunt, 2001, p136). She says this on the grounds that every person is an individual shaped by their own set of historical and social conditions and, thus, every interaction is shaped by culture that is not known to the other party(ies) to the interaction.

Charles Husband offers further support for this perspective noting that all communication happens within a power context and that "transcultural communicative competence" requires a "reflexive, self-awareness" that allows the individual to identify and explore the power relations and ideological assumptions in society (Husband, 2000, p233). Husband insists that in any profession the "norms and certainties" must be challenged in order to "disrupt routine and habit" and "nurture change and flexibility" (Husband, 2000, p233-234).

Drawing these arguments together, cultural competence must encompass both individual skills and the institutional environment. To be culturally competent as an individual a health policy officer must be able to acknowledge, value and respect diversity and difference and communicate with that in mind. The health policy officer must also be aware of her own background and baggage, as well as the institutional structures that may entrench disadvantage by disempowering or ignoring the needs of citizens from CALD backgrounds. The health policy officer must question the structures and processes that dominate interactions and mitigate against just health policy outcomes. This requires a critical multicultural understanding of the institutional environment coupled with self-awareness. Drawing on these influences I can now expand earlier definitions of cultural competence to encompass all of these aspects. Cultural competence in health policy development is:

> Acknowledging, respecting and valuing difference and diversity,
> always questioning and challenging assumptions held by individual
> health policy officers and the health system within which they work,
> to work effectively with people from other cultures and to remove
> structural barriers to equitable health policy.

This is the definition that I will use throughout this thesis. I will now move on to consider how cultural competence could be achieved.

3.3 "Cultural competence is a journey not a destination"[1]

There is general agreement that achieving a level of cultural competence is not a once-off activity but something that needs to be revisited and updated (Ferguson and Campinha-Bacote, 1997; Purnell, 2000). Josepha Campinha-Bacote calls this a process of "becoming" rather than "being" culturally competent (Campinha-Bacote, 1999, p203). Whilst agreeing with this general position, Dean finds offensive the idea that a person can become competent in another person's culture because, she says, such a claim simply reinforces "our own dominant, egocentric position" (Dean, 2001, p629). Dean argues that our knowledge of other cultures can only ever be "partial" and the focus should instead be on "seeking understanding and building relationships" where understanding means also of our own histories and assumptions in order to erode "our own resistance and bias" (Dean, 2001, p628). The best approach according to Dean is one in which each of us remains open minded and interested in learning but always "tentative about what we understand" (Dean, 2001, p629).

Nevertheless, there is agreement that cultural competence encompasses skills that can be taught and learned (Ben-Ari and Strier, 2010) and that an individual can move along a continuum representing varying levels of knowledge and skill (Campinha-Bacote, 1999; McPhatter and Ganaway, 2003). Such a continuum is clearly depicted in several models of cultural competence developed specifically in the healthcare setting, discussed in section 3.4 below. There is also agreement that knowledge and skills need "frequent learning, relearning and unlearning" (Rice and Mathews, 2012, p28; Oelke et al., 2013) and must be both improved and maintained over time (Wu and Martinez, 2006; Racher and Annis, 2007) as the individual moves forwards or backwards along the continuum (Perry and Southwell, 2011). Any skill learnt today will necessarily need to be reviewed and therefore progression, both forwards and backwards, along the continuum of competence is a helpful way of thinking about the skill of cultural competence. Knowing that skills can be developed and redeveloped should, I suggest, remove pressure to be all-knowing about a cultural group at any one time and enable health policy officers to continue to ask questions and to seek understanding.

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[1] BONILLA, J., LINDEMAN, L. & TAYLOR, N. 2012. Educating for and assessing cultural competence. *In:* NORMAN-MAJOR, K. A. & GOODEN, S. T. (eds.) *Cultural Competency for Public Administrators.* Armonk: ME Sharpe.

Whilst attaining cultural competence might be the "response" to the "dilemma" of the potential for misunderstandings between people of different backgrounds (Williams, 2006, p210), it is also acknowledged that attaining cultural competence is a "daunting task" at both the organisational and individual level requiring a "focussed, systematic, reflective process" (McPhatter and Ganaway, 2003, p107). Both Melanie Tervalon and Jann Murray-Garcia and Capitman argue for a measure of cultural humility, that is, an acknowledgement that there are things we do not know (Tervalon and Murray-Garcia, 1998; Capitman, 2002). To this can be added the need for an openness to learning and a willingness to set aside one's own cultural preferences in the pursuit of knowledge (Racher and Annis, 2007).

David Kahane argues that training in cultural sensitivity is essential for "intercultural dialogue" in order to understand other people, and that such training should be "maintained" (Kahane, 2003, p19). The Australian National Health and Medical Research Council (NHMRC) agrees, identifying the importance of cross-cultural training as a "context for interaction not as a tool to assume behaviours or attitudes" (National Health and Medical Research Council, 2006, p4)[2]. Rice expresses the view that public administration courses should have compulsory elements of cultural competence training to enshrine the need to recognise and understand the cultural context of public sector work (Rice, 2007) in order to work in a "diverse multicultural environment" (Rice, 2005, p74). Yet others suggest that policy makers should be representative of the diverse population they serve as a means of understanding diversity (Burton and Tryman, 2005; White and Rice, 2005).

Earlier, I referred to the idea of a continuum of competence. An example can be found in the Developmental Model of Intercultural Sensitivity (DMIS), developed by Milton Bennett for the workforce training sector (Bennett, 2004). The DMIS has six stages of development, grouped under the headings of ethnocentrism and of ethnorelativism – a term he coined. Ethnocentrism is demonstrated by denial of cultural difference, by setting up defences against difference (that is 'us' and 'them' where 'we' are superior), and finally by minimizing the importance of cultural difference. For a person who has a more ethnorelative orientation, the stages of development are acceptance of cultural difference,

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[2] Disclosure – the author of this thesis supervised staff who supported the NHMRC's expert committee responsible for developing this publication.

adaptation of a person's style to take difference into account, or by integrating other cultural views into the person's own worldview. Bennett is careful to point out that the DMIS is not about "…cognition, affect, or behaviour" but rather about how movement in the individual's underlying "worldview" can open possibilities for greater intercultural sensitivity and therefore to the "potential for more intercultural competence." (Bennett, 2004, p11). Bennett's proposition fits within a critical multicultural approach to cultural competence.

According to Mitchell Rice and Audrey Mathews, cultural competence will only be achieved if an organisation, or an individual, moves through a vital process of "learning about other cultures", recognising how culture interacts with an organisation's programs and policies, and then integrates that knowledge into policies and practices (Rice and Mathews, 2012, 24-25). In earlier work, Rice (2007) developed a framework to assist public administration organisations to move towards organisational cultural competence. Based on a self-assessment, this "cultural audit" is intended to highlight organisational "values, symbols, rules and routines" that may create barriers to equitable access, and guide the development of new principles or values (Rice, 2007, p629). The ensuing organisational response would be based on cultural appropriateness, accessibility and acceptability, so that structural barriers are removed in order to deliver appropriate services that are acceptable to the target group. Napier and colleagues (2014) add to the discussion by arguing that, in the health context, training must be extended beyond traditional health service providers to administrative staff, service managers, receptionists, and so on in order to provide an appropriate, holistic health care experience. All of these approaches exhibit features of a critical multicultural approach.

Ben-Ari and Strier (2010) express caution about the nature of training to attain cultural competence. First, they express concern that cultural competence training has not paid sufficient attention to the relationship between an individual's view of "Self" and that individual's view of "Other" and this, they argue, is unhelpful because an individual's view of "Self" is inextricably linked to the relationship with and definitions of "Other". Second, they caution that learning about cultural differences on one occasion, such as at a training course, effectively turns those who are culturally different into an object that can be studied and learnt about and this, it is argued, could cause more harm than good by fixing the trainee's views to a certain point and time. Support for this argument is also

found in Tervalon and Murray-Garcia (1998). Given earlier comments about culture as changeable, fluid, with intra-group differences, this latter concern is a real one and must influence any thinking about the development of training in cultural competence.

3.4   Cultural competence for health policy development

In his review of cultural competence in US public administration, Rice concluded that the concept of cultural competence was late to receive attention and thus was slow to develop (Rice, 2007). In part, he said, the reason for this was a view that identifying and acting on difference did not sit well with the idea of the neutral public administrator, which thus forced scholars of public administration to look to other disciplines, such as health, for guidance (Rice, 2007). In particular, the work of Terry Cross in the field of mental health is seen as highly influential (Chin, 2000) and I will refer to this in more detail below.

Both in public administration generally (Rice and Mathews, 2012) and across the breadth of the healthcare sector there is agreement that provision of culturally appropriate policies, programs and services is essential to achieving good outcomes. Discussion in the health literature can be found in aged care (Applewhite, 1998; Capitman, 2002); social work (Williams, 2006); child welfare (McPhatter and Ganaway, 2003); nursing (Dudas, 2012; Bourque Bearskin, 2011); and American Indian/Alaskan Native youth mental health (Goodkind et al., 2010). Lack of organisational support, leadership and skills have been identified as barriers to the delivery of culturally competent health services (Gill and Babacan, 2012; Oelke et al., 2013).

Diversity within the policy audience (the population) forces public policy officials to demonstrate a greater degree of competence in interactions with citizens in order to improve programs and services (Berry-James, 2012). RaJade Berry-James proposes that government organisations need to demonstrate that they "value cultural diversity, have capacity to conduct cultural self-assessment, [are] able to manage the dynamics of difference, [are] willing to institutionalise cultural knowledge, [and are] willing to adapt service delivery to diversity within a cultural context" (Berry-James, 2012, p186). Checkoway identifies four specific skills to support such an approach, namely self-awareness, awareness of groups different to one-self, "knowledge of the structures that

affect relationships", and the skill to participate in "intergroup dialogue" (Checkoway, 2009, p12).

As discussed in Section 2.2, health policy is complicated by a number of factors which set it apart from the general field of policy development. The factors include the challenge of health as highly technical coupled with the fact that health affects every single person; the presence of many powerful lobby groups (not the least of which represents the medical profession); and the nature of responsibility for health shared between Federal and sub-national governments in Australia and Canada. There is one more challenge for health policy officers particularly relevant to people from CALD backgrounds. Known as the "healthy migrant effect", it has been documented that voluntary migrants (and I suggest some refugees but not necessarily all) usually arrive in their new country in good health. However, the "healthy migrant effect" is open to question as it has been argued that some migrants suffer a deterioration in health status, over time, that cannot be explained by their socioeconomic status alone (Sime, 2016). Changes in health can result from a mix of circumstances such as the stresses of being a migrant and difficulty in accessing health services as a result of "physical, cultural, psychological or financial" reasons (Gill and Babacan, 2012, p46); lack of support networks; discrimination; and even the presence of sub-clinical disease prior to immigration (Ronellenfitsch and Razum, 2004).

Health policy officers need to be alert to these cautions and remind themselves that culture is not a static list of attributes but fluid and changeable over time and in different relationships, remembering that each CALD citizen is also a member of other groups such as the ageing, visually impaired, physically disabled and so on. Taken together, these challenges suggest that health policy should be replete with models of cultural competence that are well known and activated amongst health policy makers so that health policy, and deliberative health policy development, can be equitable and fair for all citizens. Let me first describe these models before looking at implementation in the Australian and Canadian health sectors.

3.4.1 Models of cultural competence in the health sector

The NHMRC recognised the importance of cultural competence to health care policy because of the potential such competence could have in addressing health inequities. The

NHMRC also recognised the need for all levels of the health system to subscribe to cultural competence as the underpinning for policy and practice. To this end, the NHMRC developed a model of cultural competence for "policy, planning and practice" in health (National Health and Medical Research Council, 2006, p9). The four dimensions of the model are:

- Systemic – policies, procedures and resources are in place to maximise inclusion of citizens from CALD backgrounds
- Organisational – cultural competence is "valued as integral to core business" and resources are available to ensure skill development
- Professional – cultural competence is recognised as essential to "education and professional development"
- Individual – the organisation supports the achievement and demonstration of culturally competent "knowledge, attitudes and behaviours" and provides support for health professionals working with CALD communities (National Health and Medical Research Council, 2006, p30).

The model is supported by practical advice on implementation, including examples based on a health promotion case study. This is the only example of cultural competence in health policy that came to light.

Conversely, the disciplines of nursing, social work and mental health seem to be better organised in terms of cultural competence in professional education and culturally sensitive interactions with clients. Each of these three disciplines requires a close understanding of the client's lifeworld in order to provide effective care and advice. While service delivery and health policy development are different in terms of client contact, the similarities of audience and intent are sufficient to make it worthwhile looking at these clinical models to see what can be learnt from them.

Models in nursing

The field of nursing is rich with models of cultural competence and some, according to their developers, can apply equally to policy makers as to service providers. In their review of nine models of cultural competence taken from North America, Britain and New Zealand, Jirwe and colleagues identified four consistent themes: an awareness of diversity, a willingness to care for other people, "non-judgemental openness", and "enhancing cultural competence as a long term process" (Jirwe et al., 2006, p9). Embedded in these themes are a number of requirements such as awareness of self and

other, and knowledge and understanding of other cultures. Along with these important similarities, Jirwe's team discovered a number of differences which, given the geographic placement of the models reviewed, was suggested could be the result of "socio-cultural, historic and political" influences (Jirwe et al., 2006, p14). For example, the North American and British frameworks defined cultural competence in the context of nurse-patient interactions between people of different ethnic backgrounds, whereas the New Zealand frameworks took a much broader view of culture to incorporate sub-cultures beyond ethnicity such as the homeless. Not surprisingly the ethnicity of the groups in focus also varied, from Hispanic, Latino and African-American (North America) to Indian, Pakistani and Caribbean (British) to Maori, the homeless, the mentally ill (New Zealand). Jirwe's team concluded that there is a "broad range of attitudes, knowledge and skills" required of nurses and nurse educators (Jirwe et al., 2006, p15).

In 1995, Larry Purnell developed a framework for culturally competent care, initially intended as a "clinical assessment tool" (Purnell, 2002, p193). A short time later the framework was expanded and titled the Purnell Model of Cultural Competence. Purnell describes the model as "an ethnographic approach to promote cultural understanding about the human situation during times of illness, wellness and health promotion." (Purnell, 2000, p40). The model is based on 19 assumptions, some directed at the care giver and some at the care recipient, but all reflecting the need for awareness of the caring environment, the individual's own background and thought processes, the importance of learning, and respect for all individuals regardless of their background (Purnell, 2002). The Purnell Model is depicted as five concentric circles, the outer three of which (moving inwards to the centre) represent community, family and the individual. The next circle is split into 12 "pie-shaped" domains representing aspects of human life – overview/heritage, communication, family roles and organisation, workforce issues, biocultural ecology, high-risk behaviours, nutrition, pregnancy and childbearing practices, death rituals, spirituality, health care practice, and health care practitioner. Each domain is linked by an arrow to the domain on either side showing the inter-connectedness of the domains. The fifth and innermost of the concentric circles is an empty disc representing what we do not know about a cultural group. Outside the concentric circles sits "global society" and underneath lies a "saw-toothed" line which represents a continuum of behaviour from the "unconsciously incompetent", to "consciously incompetent", "consciously competent" and finally to "unconsciously

competent" (Purnell, 2002, p194-195). Purnell (2000) claims that the model can apply to all healthcare disciplines and in settings as diverse as home care and acute care, as well as health care practitioner education (not only nurse education), administration of health care institutions, and in research.

Campinha-Bacote developed "The Process of Cultural Competence in the Delivery of Healthcare Services" (Campinha-Bacote, 1999). The process is formed when cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire – depicted as five overlapping circles – form a central point of intersection. The point of intersection in the very centre is the process of cultural competence and is reliant on the "interdependent relationship" between the five concepts (Campinha-Bacote, 1999, p203-204). This process provides a framework that healthcare providers can use to test where they (or their staff or organisation) sit in terms of cultural competency. The continuum of competency according to Campinha-Bacote (1999, p206) is "…culturally incompetent, culturally aware, culturally competent, or culturally proficient".

Lisa Bourque Bearskin uses a relational lens to describe how the process of attaining cultural competence can be strengthened through the concept of cultural safety. She believes that all nursing decisions must be made against the background of cultural safety, recognising why and how health disparities have occurred, and the "social, political and historical context of health-care" (Bourque Bearskin, 2011, p553). This approach, she argues, will identify attitudes and biases that may affect health care. Bourque Bearskin's approach to culturally competent nursing, which is redolent of a critical multicultural approach, is captured in the acronym RESPECT:

> "R- Reflect deeply on your own cultural values and beliefs.
>
> E- Examine and question assumptions and biases in practice.
>
> S- Share and recognize ethical space of nurse-patient relationship.
>
> P- Participate and celebrate cultural uniqueness.
>
> E- Engage in relationship building.
>
> C- Create open, and trusting environments.
>
> T- Treat people with dignity and compassion." (Bourque Bearskin, 2011, p557)

Models in mental health

In 1989 Cross developed a "system of culturally competent care" for minority children who were experiencing mental health disorders (Cross et al., 1989). This work has been described as "pivotal" (Chin, 2000) and foundational (Martis, 2012) in its influence in the health care sector. At the heart of Cross' model are five elements which are applicable not just to the individual but, for the first time, to an institution, namely valuing diversity, "capacity for cultural self-assessment", awareness of the dynamics of interactions between cultures, "institutionalized cultural knowledge", and "developed adaptations to diversity" (Cross et al., 1989, pv). Cross developed a continuum of cultural competency to guide organisations in their assessment of their responses to cultural difference. The continuum contains six levels moving from the most negative to the most positive: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, and cultural proficiency (Cross et al., 1989). Cross proposed that an agency must reflect on its "attitudes, policies and practices" and make changes to address deficiencies thereby becoming more culturally competent (Cross et al., 1989, p17).

Cross subsequently extended his work to address cultural competence in the care of young people in First Nations communities with mental health problems (Cross et al., 2000). Using a model wherein a balance of context with mind, body and spirit is highlighted, Cross made slight adaptations to the five essential elements for this new context – they are valuing diversity, awareness of one's own cultural values, understanding the dynamics of difference, development and use of cultural knowledge, and adaptation to the culture. This last element, Cross says, is crucial to ensure that service providers work with the community's culture.

Models in social services

In social welfare, Anna McPhatter and Traci Ganaway (2003) draw on the discipline of change management to develop a five-stage model which can be applied at the organisational or individual level. The stages of pre-contemplation, contemplation, preparation, action, and maintenance correspond to levels of knowledge exhibited by either the organisation or the individual, and move along a continuum from lack of awareness that there is a problem, to identifying the problem but not acting, thinking about making some changes, actively seeking to change, and finally incorporating

changed behaviours as a matter of course. The model sets out strategies that could be adopted at the organisational and individual level for each of these five stages. McPhatter and Ganaway (2003) explicitly acknowledge the difficulties presented when some social welfare professionals are further along the continuum than their colleagues, and offer strategies to assist in this situation.

Steven Applewhite draws on the mission of social work in the aged care setting to protect "the dignity and worth of the person" and ensure "social justice" (Applewhite, 1998, p7). In so doing, he falls back on the "values, knowledge and skills of the profession" to set a framework for culturally competent care in this setting (Applewhite, 1998, p7). To become culturally competent, Applewhite identifies a number of actions including valuing diversity, respecting individual's backgrounds and choices, obtaining knowledge relevant to the backgrounds of elderly clients from minority groups, displaying skills in communication, making "cultural assessments", and developing "new knowledge areas, methods and skills that are culturally appropriate" (Applewhite, 1998, p7-9). Applewhite (1998, p13) calls this a "cultural learning process". Applewhite's framework contrasts with that of McPhatter and Ganaway (2003) in that it seems to depend on the individual entirely, both in terms of identifying a need/problem and undertaking appropriate learning/training. His reliance on the ethical dimension of membership of the profession as an incentive to enhance skills and knowledge ignores the need for organisational leadership and seems to assume that there will never be a renegade aged care worker, that all will be highly ethical employees at all times.

Cathryne Schmitz and colleagues (2001) focus on teaching social work students how to operate in a multicultural environment. They identify three stages of learning, commencing with the "multidimensional" in which the student learns about the history of the culture she is dealing with, including the "impact of oppression" (Schmitz et al., 2001, p613). The next stage sees students enter into discussions with others to heighten their awareness not only of other cultures but also about the borders their own culture might erect. Thirdly, at this point they say students are ready to investigate working in a multicultural environment through interrogation of the literature. It is only at this point that the student is sufficiently open to understanding various concepts such as culturally sensitive practice.

3.4.2 Key points arising from these models

There are similarities in the approaches set out above:

- Acknowledgement that both the individual and the organisation share responsibility for ensuring that they are culturally competent.
- Existence of a continuum of skill levels along which individuals and organisations can and should move.
- A model developed in one healthcare discipline can be applied in other healthcare disciplines including policy development.
- Cultural competence should be embedded in health professional training.
- Cultural competence is a continuous learning process that requires an amount of self-awareness.

The literature is clear that cultural competence is an essential skill in the health sector and there are a number of models that could be adopted or adapted for use in a health policy setting. It is time to look now at how cultural competence is described and supported within government in Australia and Canada. The next three sections look at cultural competence in Federal and State/Provincial government policy and in Federal and State/Provincial health authorities respectively, reviewing their policies and providing comment from a critical multicultural perspective. In the following sections I will address the question: *What do governments and their health authorities understand by cultural competence and how is this operationalised for health policy development?* The next chapter will look at health policy officers' understandings of cultural competence.

3.5 How Australian and Canadian governments "do" cultural competence

Federal and State/Provincial government health authorities work within a broader policy context set for them by overarching Federal and State/Provincial governments. This section reviews policy at the Federal and State/Provincial government levels. Sections 3.6 and 3.7 look in more detail at the health authorities themselves.

3.5.1 Australia

How do governments in Australia, both Federal and State/Territory approach the issue of cultural competence? At the Federal level there is no single, whole-of-government policy addressing cultural competence as a skill. In this vacuum, the Australian Public Service

Value of Respect notes that relationships with the public must be respectful of people "including their rights and their heritage" (Australian Public Service Commission, 2016).

In the Australian Capital Territory (ACT), the Territory-wide *ACT Multicultural Framework 2015-2020* (ACT Community Services Directorate, nd) is intended to assist ACT Government agencies to "deliver services" to people of CALD backgrounds, and requires Directorates to "develop detailed plans" to this end. There is no mention of cultural competence specifically but there is recognition that "public contact positions" will need to be trained in the "appropriate delivery of services and programs to a culturally diverse client group" (no pagination in original).

Engaging Canberrans: A guide to community engagement addresses skills to enable engagement with people from CALD backgrounds under the heading of communications (ACT Government, 2011). The guide includes both support for "bilingual and multilingual staff to seek accreditation for their language skills" and "staff training on cross cultural awareness and the use of interpreters", the latter of which is said to be "fundamental" to the success of engagement and which can be obtained through "training and practice in the long term" (p77). Although this *Guide* refers to "cross-cultural training" for non-Indigenous staff and "cross-cultural communication skills" (p77) when working with CALD communities, the *Guide* does not use the term cultural competence.

In the State of Queensland, at the time of the initial identification of government documents, the following were reviewed.   *A Multicultural Future for all of us Multicultural Policy 2011* (Department of Communities, 2011a) and its supporting *Queensland Multicultural Action Plan 2011-2014* (Department of Communities, 2011b) identify cultural competence amongst government staff as one of four core outcomes. The *Action Plan* includes attendance at cross cultural training and cultural competence training as performance indicators (p3-5). The Queensland Government *Language Services Policy*, in place at that time, mentions the need for staff to have cross-cultural skills and the ability to work with translators (Department of Communities, 2011c, p5) as does the 2014 updated policy (Department of Aboriginal and Torres Strait Islander and Multicultural Affairs, 2014, p5).

Additionally, *Engaging Queenslanders: An introduction to working with culturally and linguistically diverse (CALD) communities* notes that "cross-cultural expertise takes

many years to develop" (Department of Communities, 2007, p1). The booklet notes that "cross-cultural competence" is important not only for public servants but also for "funded organisations" to ensure that all aspects of an agency's engagement with the community is appropriately managed (p12-13). The booklet addresses cultural competency in some detail in the context of ensuring that public servants have the capacity to work across cultures. Drawing on research in Queensland it presents a model of cultural competence that "public sector officials be knowledgeable about members of diverse communities; self-reflective recognising personal or professional biases; and able to integrate their knowledge and reflection with their practical skills" (p16). Importantly the booklet notes that staff may not be aware of the way their own values, biases and communication style can affect interactions with others, and be equally unaware of the way in which policy is based in dominant cultures, meaning that explicit thought needs to be given to ways of tailoring government programs to the needs of people from different cultural backgrounds including the use of alternative treatment methods (p16).

More recently, and after the date of my interviews with health policy officers in Queensland, the State of Queensland restructured its response to multiculturalism, enacting legislation and establishing a multicultural policy and action plan applicable across government. The resulting *Queensland Multicultural Policy. Our Story Our Future* was developed to "translate the Multicultural Queensland Charter into actions" but does not refer to cultural competence, preferring instead the terminology of "cultural capability" (Department of Communities Child Safety and Disability Services, 2016a, p9). The supporting *Queensland Multicultural Action Plan 2016-2017 to 2018-2019* places a deadline on "training in cultural awareness" (Department of Communities Child Safety and Disability Services, 2016b, p4).

The Queensland Government *Language Services Policy,* updated to reflect the new multicultural policy environment, focuses on working with interpreters and includes technical information such as contract requirements (Department of Communities Child Safety and Disability Services, 2016c). The *Policy* repeats the multicultural policy requirement that staff should be trained in cultural awareness.

There is no advice on the Queensland Government "Community Engagement" website pertinent to CALD citizens and the link within the Online Community Engagement

Guideline (the only guideline available) referring to the Engaging Queenslanders series of resources simply brings the reader back to the Community Engagement webpage (Queensland Government, 2017). In section 6.4, I comment further on this earlier Engaging Queenslanders series and its relevance to CALD citizens.

3.5.2 Canada

How does the Canadian situation compare with Australia? Although the Canadian Constitution Act 1982 (Can) sets the tone for multiculturalism (discussed at section 5.6) and citizen engagement (discussed at section 6.5) in Canada, the Constitution does not refer to cultural competence. As in Australia, whilst the Canadian Public Service *Values and Ethics Code for the Public Sector* identifies behaviour that treats "every person with respect and fairness", values diversity, and encourages "respectful communication" and engagement (Treasury Board of Canada, 2011, p5) there is no reference to cultural competence.

The British Columbia (BC) Government diversity framework entitled *Reflecting our Communities: Building a Diverse Public Service 2012* (the *Diversity Framework*) notes that although diversity is generally considered along "culture, ethnic and gender lines" the BC Public Service is expanding this definition to incorporate a variety of differences including geographic, social and "life experiential" (BC Public Service, 2012, p3). The *Diversity Framework* asks "…how culturally competent are we…" and "…does a higher percentage of visible minority employees equate to more equitable access to services…" (p8). The *Diversity Framework* acknowledges that the small successes of the past must be built on in order to improve responses to diversity. To do this, the *Diversity Framework* incorporates performance requirements at senior levels relating to diversity inclusion and management, and demands increased internal public sector awareness of diversity issues. Although the *Diversity Framework* is inwardly focussed, there is an acknowledgment that public servants need support to enhance their interactions with the diverse BC population.

The *Diversity Framework* is linked to the BC Government Corporate Human Resources Plan *Being the Best* (BC Public Service, 2014). *Being the Best* reports on achievement of the 2012 goals including the activity of improvement of "diversity awareness" through the provision of diversity training, the use of a "diversity lens" during recruitment, and a

focus on diversity during "Public Service week" (p10). *Being the Best* acknowledges "respect for diversity" (p16) as a key leadership skill but leaves open the question about how this will be achieved on an ongoing basis. Cultural competence is not mentioned.

In response to a reported shortage of anti-racism and diversity trainers and the lack of formal standards for such training, the BC Government, through its Ministry of Citizens' Services, commissioned a literature and scoping review of the core competencies that should be included in train-the-trainer programs (Parker-Toulson and Harrison, 2010). The review noted that anti-racism response training in BC "is a best practice" (Parker-Toulson and Harrison, 2010, p26) thus the shortage of trainers was obviously a concern for the continuation of this best practice. The review described the shift over time in language from the negative connotations of "anti-racism" to a more positive "cultural competence" approach, where cultural competence refers to the trainee's awareness of his or her own cultural baggage as well as the environment within which discrimination occurs, categorised as internal and external knowledge (Parker-Toulson and Harrison, 2010, p5-7).

Moving across the country, the Ontario Public Service has now published two Service-wide Strategic Plans addressing diversity and inclusion. The first *Three-Year Strategic Plan 2009-2011* stated "We want to be a culturally competent organization that is sensitive to, and accepting of, the cultural differences of each employee and customer" (Ontario Public Service Diversity Office, 2009, p6). One strategy to achieve this was to ensure "…diversity training is available to all staff" (p6). Examples of this commitment included a range of specific networks (such as the Black Ontario Public Service Group and the East Asian Network Group); and a manager training course on "diversity and inclusion" (p7). However, the second Strategic Plan – now called an Inclusion Plan – whilst continuing to support employee networks and diversity training does not mention cultural competence (Ontario Public Service Diversity Office, 2013).

To summarise, no government in Australia or Canada at the Federal or State or Provincial level has a whole-of-government policy that explicitly refers to cultural competence. In both Australia and Canada culture seems to relate only to ethnicity with the exception of the BC government which takes a broader more flexible view.

There was no evidence from my discussions with health policy officers (see Chapter 4) that any of these Australian or Canadian documents play a part in their thinking. None were referred to by name, and only BC health policy officers acknowledged the support they receive from the BC government relative to citizen engagement generally. Even in this latter case, cultural competence was not raised as an area of support from the Provincial government.

3.6 Australian health sector approaches to cultural competence

This section contains a description of existing Australian Federal and State health authority policies of cultural competence. Section 4.1 contains health policy officers' insights into the ways in which these policies, or indeed absence of policies, support deliberative health policy development.

3.6.1 Australian Government Department of Health

There is no Department-wide policy on the importance of cultural competence as a skill. However, the Department of Health *Agency Multicultural Plan* addresses the key objective "capability" in terms of cultural competency especially the provision of training for all staff to ensure they have the "skills and knowledge needed to effectively engage with people from culturally and linguistically diverse backgrounds" (Department of Health, 2012a, p9). Recognising the importance of the external environment, the *Plan* also says the Department will "encourage" service providers working with the Australian Department of Health to "build up their cultural competency" (p9).

3.6.2 ACT Health Directorate

The lack of Territory wide policy is more than made up for in the ACT Health Directorate's *Coordinating Framework 2014-2018* for multicultural health. The *Coordinating Framework* calls for both individual and organisational cultural competence noting that "policies and systems" must "support and facilitate individual cultural competence" (ACT Health Directorate, 2014, p13). The *Coordinating Framework* defines cultural competence in health care as "an awareness and responsiveness to differing cultural values and beliefs in relation to health and illness, the responsibilities of the individual and the health care provider, and to the health system overall." (p13). Key focus area 6.6 addresses the development and maintenance of

"linguistic and cultural competence in the ACT health workforce" through actions such as providing "essential" cultural awareness training during staff orientation and ensuring that language skills are nurtured and appropriately used (p29).

The Health Directorate's *Consumer and Carer Participation Framework* defines cultural responsiveness as "the capacity to respond to the healthcare issues of diverse communities" (ACT Health Directorate, 2011, p22). The *Framework* identifies a number of enablers of "meaningful consumer and carer participation" which include awareness of "cultural differences, values or preferences" (p9), provision of "culturally sensitive and competent services" and "cultural awareness training" (p10). The list of barriers to consumer and carer participation includes reference to health professionals who are "culturally insensitive or ignorant" (p11). The *Framework* limits the definition of cultural awareness training to "Training for non-Indigenous Australians to increase their understanding of Aboriginal and Torres Strait Islander cultures and to develop their skills to become culturally competent at both a personal and professional level." (p22)

3.6.3 Queensland Health

The most important evidence supporting cultural competence within Queensland Health is contained within the *Guide to Implementing the Queensland Multicultural Policy 2011 and Language Services Policy in a health context Attachment A* (Queensland Health, nd). The *Guide* describes a culturally competent organisation comprising 8 interdependent elements based on four foundations of management commitment, quality standards, culturally inclusive systems and services, and cross cultural capabilities. Recommendations for a culturally competent workforce include integration of cross cultural training into all training courses, both internal and external, as well as targeted training, advocacy for improved professional cross-cultural training at the tertiary level, and annual reporting. The *Guide* stipulates that cross-cultural training is about specific cultural groups but excluding Aboriginal and Torres Strait Islander cultures. It should be noted that this *Guide* draws on superseded Queensland Government frameworks of multicultural policy and has not been revised in light of the new *Multicultural Recognition Act 2016* (Qld).

The Department's *Cross Cultural Learning and Development Strategy 2009-2012* (Queensland Health, 2010a) addresses one of the eight elements of a culturally competent

organisation as set out in the *Guide* – culturally competent staff. The *Learning and Development Strategy* draws on the results of stakeholder consultation and a 2012 literature review, the key findings of which are contained in a *Background Paper* (Queensland Health, 2010b) which supported development of the *Learning and Development Strategy*. The *Background Paper* provides detail about a definition of cultural competence, policy drivers, effectiveness of and barriers to effective cross cultural training, and examples of training opportunities in Queensland and other jurisdictions.

The *Learning and Development Strategy* contains several relevant priorities namely "conduct specific cross cultural training"; integration of cross cultural capabilities into "non-cross cultural training programs" delivered by the department and by external providers; "build the cultural competency" of the future health workforce for the State; and "ensure a quality approach to cross cultural training" (Queensland Health, 2010a, p6). The *Learning and Development Strategy* sets out actions and key performance indicators for each of the priority areas. The actions are underpinned by five "cross cultural capabilities" that Queensland Health has deemed essential in order "to be culturally competent": they are self-reflection, cultural understanding, context, communication and collaboration (p3) and must be reflected in all training programs.

Actions in the Queensland Health *Strategic Plan for Multicultural Health 2007-2012* address cultural diversity training for staff, especially leadership training, as well as integration of cultural diversity into all training courses, and the implementation of a "Safe Services, Diverse Communities" training package aimed at front line staff working with members of the community (Queensland Health, 2007, p8).

It should be noted that, at 17 March 2017, all the above documents can still be found on the Queensland Health website despite the introduction of the *Multicultural Recognition Act 2016* (Qld), Charter and new multicultural policy and action plan. There is no advice on the Queensland Health website about when updated information will be available.

3.6.4 Metro South Health

The Metro South Health *Consumer, Carer and Community Engagement Plan 2016-2019* notes a commitment to "engaging…in a respectful, culturally appropriate and meaningful way" (p24) as well as providing "multicultural and diversity training" to staff (p16)

(Metro South Health, 2015). In addition, David Eastgate, Director of the Health Equity and Access Unit at Metro South Health confirmed by email that Metro South Health is in the process of developing a multicultural health plan which is likely to include actions to improve cultural awareness (2017, 7 February).

3.7 Canadian health sector approaches to cultural competence

This section contains a description of existing Canadian Federal and Provincial health authority policies of cultural competence. Health policy officers' comments at section 4.2 provide insights into the workings of these policies.

3.7.1 Health Canada

Health Canada does not have a policy on cultural competence. However, public health in Canada is managed by a separate agency, the Public Health Agency of Canada, which published a set of *Core Competencies for Public Health in Canada.* The *Core Competencies* include a section addressing "diversity and inclusiveness" identifying "socio-cultural competencies required to interact effectively with diverse individuals, groups and communities. It is the embodiment of attitudes and practices that result in inclusive behaviours, practices, programs and policies." (Public Health Agency of Canada, 2008, p5). Diversity in the *Core Competencies* includes "social variation" among the population, which could be inferred to mean a broader than ethnicity view of culture (p10).

Of the three competency statements under the heading of diversity and inclusiveness, the use of "…culturally relevant and appropriate approaches with people from diverse cultural…backgrounds" (p21) is pertinent. Culturally-relevant and appropriate is defined as "Recognizing, understanding and applying attitudes and practices that are sensitive to and appropriate for people with diverse cultural…backgrounds…" (p10). The competencies are aimed at both managers and practitioners in public health and whilst the term cultural competence is not used in this document the intent is clear.

The Canadian Institutes of Health Research (CIHR), a federal health agency similar to Australia's NHMRC, whilst not having an Institute-wide policy on cultural competence, does embed this skill in its work. For example, the *Strategy for Patient Oriented Research*

Patient Engagement Framework lists cultural competence as a key feature of supportive, safe environments for patient engagement (Canadian Institutes of Health Research, 2014).

3.7.2 BC Ministry of Health

The BC Ministry of Health *Framework for Core Functions in Public Health* was the subject of a 2003 workshop at which "knowledgeable leaders, policy makers and practitioners" provided comment on a draft Framework (Ministry of Health Services, 2005, p87). One of the many comments made was the need to develop inter-cultural competence in health authorities. The *Framework* addresses this issue under the heading of "Public health capacity" and calls on both Provincial government and health authorities to invest in ensuring that public health staff have the necessary skills to carry out their duties. These skills "Core Competencies for Public Health Professionals" include "cultural competency" (p103).

3.7.3 Ontario Ministry of Health and Long-Term Care

The Ministry of Health and Long-Term Care does not have an overarching policy on cultural competence. Cultural diversity is mentioned in other documents but cultural competence does not appear. For example, the *Guidance Document for Declaration of Values: ECFAA Requirement* advises the inclusion of "reasonable representation" at consultations including "cultural organisations" (Ministry of Health and Long-Term Care, 2010, p3), and points to a core value of patient-centred care of "respect for cultural diversity" (p5).

Similarly, neither the *Health Equity Impact Assessment (HEIA) Workbook* (Ministry of Health and Long-Term Care, 2012a) nor the *Public Health Unit Supplement* (Ministry of Health and Long-Term Care, 2012b) to the *Workbook* make mention of the skills needed by the assessing official despite the heavy focus on culture as a determinant of inequity.

3.7.4 Toronto Central Local Health Integration Network (LHIN)

The Toronto Central LHIN *Integrated Health Services Plan 2016-2019* includes, as an action in addressing the goal of improved patient experience, a commitment to "culturally appropriate and culturally competent" care (Toronto Central LHIN, 2016, p29).   Key populations listed in the *Services Plan* are the ageing, Aboriginal people, Francophone people, newcomers, refugees, people affected by mental health and addiction issues, and

the LGBT community. Cultural competency in the plan relates only to Aboriginal and Francophone people.

In summary, both the ACT and Queensland health authorities recognise cultural competence as an individual and organisational skill requirement. Queensland Health has developed a detailed plan for the inclusion of training for staff and adopts a critical multicultural perspective of self-reflection and awareness of the need for inclusive health systems.

No Canadian health authority demonstrates a critical multicultural approach. The limited focus on cultural competence focusses only on individuals to the exclusion of organisations. Where cultural competence is not mentioned there is, at least, recognition of the need to take into account cultural diversity in the community.

Conclusion

In this chapter I have defined culture as a dynamic process of shared meanings, located in and emerging from interactions between individuals. I have defined cultural competence as acknowledging, respecting and valuing difference and diversity, always questioning and challenging assumptions held by individual health policy officers and the health system within which they work, to work effectively with people from other cultures and to remove structural barriers to equitable health policy. I have examined models of cultural competence concluding that a continuum approach is useful because it encourages skills growth and re-growth as notions of culture are revisited and revised.

In public administration there are few models of cultural competence that relate specifically to policy development. In health service delivery there are many models of cultural competence with common features of responsibility shared between the individual and the organisation, a continuum of skill levels, applicability to different fields of endeavour, and continuous learning embedded within professional development that demands a level of self-awareness.

A number of observations arise from the review of government documents. Firstly, only the BC government, BC Health Ministry, Queensland Health and the ACT Health

Directorate demonstrate a focus on cultural competence. In Queensland and the ACT, this is despite the lack of an overarching State government policy.

Secondly, with the exception of the BC Public Service Agency and the Public Health Agency of Canada, Federal and State/Provincial governments and health authorities view culture as a descriptor of ethnicity. Thirdly, no government acknowledges the potential for intra-group difference, and finally, no government addresses cultural competence as both an individual and organisational requirement.

Based on this evidence, State and Provincial health organisations seem to address the need for cultural competence better than their Federal counterparts. However, only the ACT and Queensland health authorities specifically acknowledge the need for a culturally competent organisation to complement culturally competent individuals.

Only the BC government and Queensland Health demonstrate a critical multicultural approach to cultural competence. In Canada's case, the lack of a critical multicultural approach is despite the presence of legislative frameworks such as the Constitution which provides a structure within which to develop processes for identifying and addressing cultural issues in health policy.

This chapter has focussed on the presence or absence of government policy for the acquisition and maintenance of cultural competence as a skill. The next chapter will consider these policies further by drawing on empirical evidence before I propose an alternative way of looking at cultural competence which I suggest could be more helpful to health policy officers.

Chapter 4 From cultural incompetence to contextual sensitivity for health policy development

"Cultural competence is a lifelong journey and a lifelong learning…unless you are part of that culture you will never be completely competent. … I feel competent at being culturally aware and being culturally safe." (Participant #4, Australia, State)

"I think there's an awareness… I think people get it. What they don't get is how to translate that into everyday." (Participant #3, Australia, State)

"Cultural competency…is best described as insight into where you're coming from and your understanding of how you can see through another's eyes if that's possible." (Participant #12, Canada, Provincial)

In the previous chapter I examined the concepts of culture and cultural competence, reporting especially how cultural competence is understood in the literature, within governments and the government health sector. In this chapter I examine critically how health policy officers understand cultural competence and operationalise policy frameworks to support their work.

I observe that such policies as do exist in both Australia and Canada, and at both the Federal and State and Province levels of government, are not utilised either by individual health policy officers or their agencies. Despite this, health policy officers, by and large, have a good grasp of cultural competence as a concept and seem to be clear about how this relates to their work. After setting out Australian and Canadian experiences and providing a comparison, I will discuss why the existing approach to cultural competence falls short of providing a framework for consideration of cultural and linguistic diversity in citizen engagement for health policy development and, subsequently, suggest an alternative approach built on a critical multicultural perspective.

4.1 Cultural competence in practice – the Australian experience

In the next two sections I seek to respond to the question: *What do health policy officers understand by cultural competence and how is this operationalised for health policy development?*

Sections 3.5 and 3.6 have shown that no Australian government at any level has a cultural competence policy which is translated into policy at the health authority level. In the Australian Federal and State health authorities examined for this research, whilst there are no specific policies of cultural competence, there are subject-specific health policies (such as multicultural health) which refer to the importance of cultural competence.

Given this, what do Australian health policy officers understand by cultural competence and how do their authorities operate in a culturally competent manner in accordance with their own policies. These issues will now be addressed through the words of those health policy officers.

4.1.1 The meaning of cultural competence

Cultural competence as a term is recognised by health policy officers in Australia at both levels of government, and each could express their understanding of what cultural competence means. For example

> "It's beyond awareness. It has to start with awareness…making sure that the considerations in policy development take into account the different views, the different enablers and the different barriers of different cultural groups and that the implementation also takes that into consideration…" (Participant #2, Australia, Federal)

This perspective encompasses both the process and the outcomes of policy development. Not only does this speaker note the importance of considering multiple views of health, but also emphasises the ways in which culturally and linguistically diverse (CALD) background citizens may be helped or hindered by their own beliefs about the health system. How health policy is implemented is crucial to its success and so acknowledgement of this aspect reflects an understanding of policy development as a complete cycle of activity.

Other participants focussed only on their own awareness of difference

> "I think for me that would involve understanding the group that we
> were dealing with, and I think having an understanding of their
> motivations and their attitudes and their behaviours so that if you're
> developing policy, you actually understand what policy interventions
> and what policy levers you need to put in place to actually influence
> their behaviours and I guess you can't do that unless you understand
> what's driving those behaviours". (Participant #6, Australia, Federal)

This health policy officer suggests that understanding why a group of people behave a certain way will assist in tailoring health policy to achieve a desired outcome. However, this approach does not make allowances for intra-group difference nor for the many variables, beyond CALD, that can explain why an individual approaches health care in a certain way. This policy officer seems to assume that the right health policy will direct CALD citizens to behave in the way that the health authority dictates, thus putting the policy officer and health authority in a position of dominance over the CALD citizen who must toe the line.

A different approach is taken by the following respondent

> "My first word is respectful: so, knowledgeable so that I could be
> respectful, and appropriate, and safe, and welcoming, understanding
> and trustworthy, so I think it's a kind of a combination of those
> things." (Participant #1, Australia, State)

This speaker focuses on the policy officer's behaviour and attitudes towards people of CALD backgrounds. The attributes mentioned form a set of personal skills that make up what this respondent believes is a culturally competent health policy officer. This policy officer appears to be taking sole responsibility for the development of culturally competent health policy, not acknowledging the role of the health authority as a partner in the process.

A more holistic approach was offered by another health policy officer

> "I think it means that the care giver and the system put the patient in the centre and…when treating their health care…as a physical and emotional and spiritual and... that they include culturalness in that… Being aware that if there's a mismatch that could be cultural" (Participant #3, Australia, State)

Whilst this speaker attempts to balance personal awareness with an enabling system, the speaker's conclusion is that 'cultural' issues could be the reason for any mismatch. Although "mismatch" was not defined, it can reasonably be assumed to mean a mismatch in expectations between the health care system and the patient as policy beneficiary. This policy officer intimates that the health care system is the decider about the presence or absence of mismatches, thus putting the system in a position of judgement over the policy beneficiary.

One health policy officer took the issue of self-awareness to another level by noting that

> "…there are always going to be limitations there because…I can't possibly hope to understand all of the factors that these people face in their daily lives. I can try and learn as much about them as I can…but there's a barrier there. I haven't lived it." (Participant #6, Australia, Federal)

This response recognises that a health policy officer cannot know everything about a CALD background citizen although, at the same time, indicating a willingness to learn at least something. This response demonstrates not only self-awareness but also a measure of humility about a lack of knowledge of the lived experience of people from CALD backgrounds.

Whilst discussing the nature of cultural competence, none of the health policy officers referred to existing policy or in-house definitions of cultural competence. Despite this, health policy officers have a good sense of what cultural competence means with some acknowledging the need to take into account structural and historical barriers. This latter focus is an important aspect of a critical multicultural approach to health policy development.

4.1.2 Support for attaining cultural competence

This section addresses support for health policy officers in the context of a policy framework for the development and implementation of cultural competence. Discussion of policy frameworks which may support the development of expertise in multicultural health (see sections 5.3 to 5.5) and citizen engagement (see sections 6.3 and 6.4) are addressed later in this thesis.

Despite the presence of the Queensland Health cross-cultural learning and development strategy (Queensland Health, 2010a), the importance of attaining a level of cultural competence was not mentioned by Queensland based participants. Neither did any other Australian health policy officer raise the issue of attaining cultural competence until they were prompted. In discussion one health policy officer noted that

> "It [cultural competence] underpins our work. …cultural safety, cultural awareness, cultural competence, it underpins everything…there's just no point in having a conversation with anyone about what we're trying to achieve if that's not right there from the word go." (Participant #4, Australia, State)

At the Australian State government level this health policy officer is describing cultural competence as a crucial element of the work. The comment illustrates an understanding of the importance of cultural competence in the health policy arena. On the other hand, some health policy officers noted

> "I'm not sure that we're all that well informed about how to understand our CALD community as well as we could…" (Participant #1, Australia, State)

> "I think there's an awareness but …it's just not always done. …I think people get it." (Participant #3, Australia, State)

These three comments reflect a tension between knowing that cultural competence is important and the reality on the ground. In the first instance, the comment shows an underlying assumption that the health system, health policy officers, and health policy beneficiaries share agreement about the importance of cultural competence. The latter two comments give the lie to this assumption, illustrating not only a lack of knowledge amongst health policy officers but also, perhaps, an inability to act in a culturally competent manner.

When specifically asked whether it was possible to become culturally competent, only one health policy officer was clear that "It is possible" (Participant #2, Australia, Federal) but added that the working environment in government presented two sets of difficulties for the attainment of cultural competence. First "…the operational context…within government doing policy is firstly they need to be responsive to the government of the day", and work "in the public domain" may be overridden by the Minister's views (Participant #2, Australia, Federal). Secondly, "…the way that…policy officers are trained in large departments may not take that into account because it's [participant hesitates] there's the culture." (Participant #2, Australia, Federal). The view was also expressed that policy officers in some government departments may be more culturally aware because of the nature of that department's work programs, for example immigration policy (Participant #2, Australia, Federal).

These comments raise three particular issues. Firstly, they serve to underscore my earlier observation about ability to act, showing a certain amount of pessimism amongst health policy officers about improving their skills, either because of decisions made at higher levels or because of a lack of attention in training programs. Secondly, this health policy officer raises the idea that organisational culture, meaning the practices within the institution, influences behaviour. In this instance, it is suggested that the organisational culture does not give sufficient attention to cultural diversity such that it would be included in training programs. Thirdly, the comment on the relative merits between departments of having or not having a skill of cultural competence could be seen as defensive – I do not need this skill, but they do because their work is obviously with CALD citizens – which could simply be justification for a personal lack of knowledge or action.

After being asked specifically about attaining cultural competence, some health policy officers commented that knowledge and skills needs may change over time making cultural competence an unattainable, but nevertheless aspirational, goal requiring continuous learning

> "It's almost like keeping up with technology isn't it…it's [culture] changing all the time" (Participant #2, Australia, Federal)

> "I think you can build cultural competence, but I think you would be naïve to think that you know it all and that you can't be better

informed or that you shouldn't continue to take advice or to learn from others. I think you can be culturally competent, but I think there are degrees." (Participant #6, Australia, Federal)

These Australian Federal government health policy officers offer the perspective that cultural competence is something of a moving target. Whilst both imply a need for constant review, the second comment above seems to leave the door open to the claim that cultural competence is attainable if only at a certain, less than the highest, level. The comments made at this level of government reflect awareness of the complexity of cultural competence: the reference to keeping up with technology is a useful metaphor for the nature of culture as changeable.

These Australian Federal views can be contrasted with the views of Australian State government health policy officers who were very clear that attaining cultural competence is not possible

> "I think not one hundred percent unless you're part of that culture yourself. It's an endless learning process." (Participant #5, Australia, State)

> "Definitely not. …for me awareness and safety are absolutely achievable but competence is not. Cultural competence is a lifelong journey and a lifelong learning…unless you are part of that culture you will never be completely competent." (Participant #4, Australia, State)

These health policy officers were unequivocal in their answers – competence in culture is not attainable. The responses indicate that being aware of cultural difference is not the same thing as understanding the subtleties of difference, and reflect the discussion in Chapter 3 that culture is changeable and, equally importantly, is a very personal lived experience. These comments suggest thoughtful health policy officers.

There was yet another perspective at the State level, that

> "Competence is not a knowledge…it's a concept they've got to be competent about and then they need to be able to find out...find the knowledge…I think it's about resourcing them how to know…how to get access to knowledge when stuck and also identifying 'this is a cultural issue'." (Participant #3, Australia, State)

This comment indicates that competence is a process of finding out rather than the actual knowledge itself. This health policy officer identifies the role of the authority in

supporting staff to find information but puts the onus on health policy officers to identify when culture might be an influence in a policy context. The informant does not discuss how the health policy officer should identify that culture is the influence rather than, say, socio-economic status or level of education. There seems to be an implication here that culture is identifiable by certain attributes displayed by policy beneficiaries and, if those attributes can be identified then the policy officer will not be "stuck" any more.

Whilst appreciating that attaining a level of cultural competence required a state of constant learning and openness, some health policy officers felt that addressing population diversity could be quite "overwhelming" because of "conflicting messages" (Participant #3, Australia, State) brought about by the need to consider "the budget, the gendered lens, the disability lens, the child lens, the carer lens, the multicultural..." (Participant #3, Australia, State). One health policy officer referred to "cheat sheets" from previous professional training which aided "…read up before you go…" because "I think it is a difficult thing, that often it's knowledge that you don't use every day, and so it needs to be somehow readily available for when you need it." (Participant #1, Australia, State).

Although this latter comment seems to reflect a notion of culture as a knowable list of unchanging attributes, overall Australian health policy officers exhibit an understanding of culture as changeable, requiring skills that would be developed and reinforced over time.

4.1.3 Organisational cultural competence

Although individual health policy officers have expressed a clear understanding of the concept of cultural competence they go on to report a lack of implementation amongst their colleagues. When asked where on the cultural competence continuum they thought health policy officers sat, Australian health policy officers responded that

> "…they recognise the differences but unless it's an issue…in the area
> that they're working on then they may not go any further…
> (Participant #2, Australia, Federal)

> "I don't think it's really embedded in people's practice…"
> (Participant #5, Australia, State).

These comments illustrate that culture needs to be "an issue" before it is addressed and that cultural competence is not a routine consideration in practice. Both of the above comments indicate an organisational culture that lacks focus on cultural diversity, resulting in decisions which dismiss culture as an important consideration in health policy development. These health policy officers had picked up on this atmosphere

> "...in our day-to-day practice we still don't do enough in relation to making sure that the cultural awareness is built into all the things we do. ...it's got to get across the culture of the organisation…"
> (Participant #2, Australia, Federal)

> "…internally though I'd say it's [consideration of cultural issues] done pretty poorly..." (Participant #5, Australia, State)

Despite this there was confidence in the intelligence of individual health policy officers

> "I think people get it. What they don't get is how to translate that into everyday." (Participant #3, Australia, State)

> "Acknowledging there is difference…[but not] really knowing what to do with it" (Participant #4, Australia, State).

What these comments show is that health policy officers believe themselves to have an understanding of the importance of acknowledging cultural diversity, but do not know how to apply their observations to the task of developing health policy. If this is the correct interpretation, organisational culture is neither nurturing nor supporting the application of cultural competence to policy development. This is a demonstration of the way in which organisational culture, as discussed above, can be an impediment to health policy development – the staff are, in effect, recruited for their knowledge and then left without support. An alternative interpretation is that the health policy officers are, themselves, uncertain about how to take cultural diversity into account and transfer this concern to all health policy officers – after noting first, of course, that they, as individuals, really do understand what cultural competence is all about.

At this stage I am inclined to say that there is truth in both interpretations for the following reasons. Both the ACT and Queensland health authorities have policies addressing the need for cultural competence in health policy development, the former in the context of multicultural health policy and the latter as a learning and development strategy, so we know that policy frameworks exist in the State jurisdictions at least. Bearing in mind

earlier comments about how overwhelming addressing population diversity can be because of the many influences in policy development, and the fact that none of the health policy officers referred to policy frameworks, it is therefore more good luck than good planning that policy officers are aware of the need to exhibit a measure of cultural competence. This awareness has not translated into any degree of comfort or additional expertise in being able to apply a cultural lens to health policy. Shortly I will turn to the matter of training, but for now it is possible to say that Australian health policy officers do not appear to find support in existing policy frameworks.

Another reason for discomfort became apparent when Australian health policy officers mentioned skills levels amongst the leadership team

> "The culture of cultural awareness may not be present unless, of course, the people in leadership positions are aware themselves…" (Participant #2, Australia, Federal)

> "…hierarchy is built on seniority where generally the people who are most resistant are at the top…" (Participant #2, Australia, Federal)

> "…the people upstairs aren't nearly as culturally safe or aware or competent in safety and awareness as people like us working directly with the communities…so policies or resources…are not developed with consultation with the communities that they're addressing." (Participant #5, Australia, State)

Organisational culture depends on the actions of a leadership team which includes modelling appropriate behaviours, the lack of which could lead to a perceived lack of support from senior staff. These responses show that, across both levels of government, health policy officers are less than complimentary about the direction they receive from senior staff, whilst at the same time indicating the need for leadership from the top. It is small wonder that health policy officers feel overwhelmed when the organisational environment is neither open nor conducive to discussion about CALD issues, even in the face of existing policy frameworks.

4.1.4 Reliance on staff for culture-specific input

One Australian health policy officer spoke of a reliance on agency staff from diverse backgrounds

> "I think the best thing that government agencies can do is to look within themselves at how they employ and engage in terms of making

> sure that you…try and make the staff representative of the community that you're looking to deal with. …we do have a richness in terms of people's backgrounds, but we probably don't harness that as well as we could." (Participant #2, Australia, Federal)

This health policy officer is indicating that, not only should an organisation's staff be reflective of the community they serve, but those staff should be called upon to provide advice and support within the organisation relevant to the cultural group from which they are drawn.

Two observations can be drawn from this discussion. Firstly, the apparent lack of in-house support forces health policy officers to look amongst their own staff for insights into the ways of cultural groups. This comment indicates both a commonly held understanding of culture as knowable, and that a staff member from a particular background could know everything there is to know about all people from a similar background. The literature reviewed at section 3.1 makes it clear that there are intra- as well as inter-group differences; that individuals change over time with the influence of relationships, environmental factors, and so on; and that sharing an attribute does not necessarily mean shared beliefs (see for example Hess and Billingsley, 2007; Racher and Annis, 2007; Carpenter-Song et al., 2007; Napier et al., 2014). The literature also makes it clear that culture is not fixed but is fluid, changeable and relational (see for example Carpenter-Song et al., 2007; Fontefrancesco, 2012). Taken together, these arguments preclude a situation where one staff member can know everything about a particular group. For this reason, reliance on staff should be approached cautiously.

Secondly, this health policy officer is looking internally for a solution because there is no policy framework to provide the required support. Relying on staff at hand to provide answers puts pressure on individual staff to speak with an authority they cannot have, and therefore risks development of inappropriate policy solutions.

This aspect of cultural competence was not raised by Australian State based health policy officers.

4.1.5 Training for cultural competence in the Australian health sector

It seems reasonable to expect that policy frameworks calling for cultural competence will make provision for staff training, an expectation that was not met. Across both levels of government, training for cultural competence was not available in-house

> "There isn't a lot of [in-house training] at the moment. We still do mandatory training on bullying and harassment and that sort of awareness which, of course, touches on cultural competencies and being aware of what you're saying." (Participant #2, Australian, Federal)

> "I'm not saying that's not being thought about by someone else but no-one's mentioned that to me." (Participant #3, Australia, State)

The first of these two responses links cultural competence training with more general training noting that being careful of one's speech is a significant component of cultural competence. It may be that the absence of specific cultural competence training is recognised by this participant, who sought to ameliorate the deficiency by suggesting that skills could be obtained by other means. However, being mindful of the content of conversations is not the entire picture as was shown by the various models of cultural competence discussed at Chapter 3. The second participant is waiting to be told, a perspective that suggests a lack of personal responsibility for the development and application of cultural competence.

The absence of in-house training pushes interested policy officers to look to external service providers

> "I know training is available if staff would like it. …through the Public Service Commission or through other commercial courses there is training in cultural awareness" although "…Often that's not seen as particularly useful, by managers…unless they have a particular focus" (Participant #2, Australia, Federal)

This policy officer advised that, whilst some external courses are available, supervisors discount such training unless they can see a specific link to the work in hand. The absence of in-house training and the poor commitment to external training shows not only that such training is not given priority but also a lack of commitment within the health authority to addressing CALD issues. This comment also indicates potential for confusion between improving knowledge, namely cultural awareness, and improving skills, namely cultural competence.

State health policy officers made a link to Indigenous cultural competence training

> "In my orientation a couple of years ago there was Aboriginal and Torres Strait Islander training. I don't believe there was multicultural training at that time." (Participant #5, Australia, State)

> "We certainly have cultural awareness for Aboriginal and Torres
> Strait Islanders, and that's mandatory training for everybody."
> (Participant #1, Australia, State)

These comments report the presence of Indigenous cultural awareness training and show that health policy officers make a distinction between cultural awareness training relevant to CALD groups and that relevant to Indigenous people. That mention of this came up without prompting shows the importance placed on awareness of Indigenous culture and that health policy officers are well aware of this priority. Equally it highlights the absence of cultural competence training relevant to CALD background citizens.

One policy officer referred to tertiary education as a vehicle for training

> "I can't speak from experience whether nursing, whether doctors,
> whether they cover any sort of cultural practices besides Aboriginal
> and Torres Strait Islanders. But I know certainly through my
> experience in Uni there was very, very little. The only kind of
> experience we had with it was from the Head of [name of Department
> and University]…she is very passionate…" (Participant #5, Australia,
> State)

This policy officer is saying that the cultural awareness gained at University was completely dependent on the fact that a particular member of the teaching staff had a passionate interest about cultural awareness and built this interest into teaching programs. Obviously not every health policy officer is going to benefit from such passion and teaching, leaving a potential gap in the knowledge base of recruits that is not currently filled by health authorities.

In order to make up for the lack of formal training, health policy officers pursued other means to inform themselves. For example

> "Not formally, just based on the experience with the Samoan
> community and the other experienced team members with their
> various communities, but no formal training." (Participant #5,
> Australia, State)

This interviewee confirms that no formal training was received but that information was gleaned through a specific community group and by consulting other team members who had worked with community groups. There is something to be said for consulting a group of people with whom a policy officer needs to work: conversations would allow the policy officer to tease out specific issues around, for example, means of communication and best

approaches to the group. There is also benefit in speaking with experienced team members. However, caution should be exercised on both of these counts. As discussed in Chapter 3, there is diversity within groups and so no one person can be said to be the custodian of all knowledge about a particular group of people.

State health agencies, particularly, expected individual policy officers to display cultural awareness as a matter of course

> "It's what we're employed for, to work in a culturally safe manner. I think the expectation is that we know how to find out, at least." (Participant #4, Australia, State)

> "We would hope that when they're [policy officers] writing a clinical policy that they would use their experience and knowledge of those different cultural groups to inform that policy." (Participant #1, Australia, State)

> "I'd expect them to be considering cultural impact on the health episode…" (Participant #3, Australia, State)

Each of these comments illustrate organisational expectations and assumptions that health policy officers already have the skills to address cultural issues, but it is apparent from my discussions that few health authorities are doing anything to support skill development. Although one participant reported keeping 'cheat sheets' from professional training, I have already observed that professional training at the tertiary level is unreliable as a source of knowledge.

Health policy officers were keenly aware that they themselves were not experts in the health issues facing CALD background citizens. Knowing they needed to seek information, humility was expressed by health policy officers who felt that honesty in acknowledging a lack of knowledge, or asking members of a particular CALD community for guidance, was a useful way to gather information

> "…you just have to be honest if you don't know…and basically seek their [community members] advice and support in educating you, so that's kind of being respectful as well. I think having possibly those generic skills of humility…to have those conversations, being open because you don't necessarily have that knowledge - that rings quite nicely with me." (Participant #1, Australia, State)

> "Being open about that [lack of knowledge] to the community that you're engaging with." (Participant #4, Australia, State)

These comments further highlight the lack of training, to the extent that some health policy officers feel their only recourse to learn what they need to know is to the community.

These discussions have revealed a divide between health policy officers and their managers. On the one hand policy officers see the importance of the application of CALD cultural competence to their work but, on the other hand, managers gloss over this importance and sometimes deny access to training. When health authorities do not follow through by providing the training that their own policies demand, staff will struggle to attain any level of cultural competence with consequent impact upon their ability to develop health policy meaningful to CALD citizens.

Although training is absent across both levels of government, some health policy officers mentioned increasing internal awareness of cultural diversity

> "It certainly has been brought more to our attention and consciousness with the development of the new [name] Unit…" (Participant #1, Australia, State)

> "I do believe there is an increasing acknowledgement that we need to work in a culturally safe way." (Participant #4, Australia, State)

These comments refer to in-house attempts to raise awareness of cultural issues amongst staff, either through a formal policy unit or by other means. Whilst these comments were offered in somewhat defensive tones they do show that, at the State government level, health authorities have begun a process of raising the profile of CALD health issues.

The lack of training for CALD cultural competence cannot be explained by an absence of policies mentioning cultural competence because such references do exist. That Australian participants were spontaneous in discussing Indigenous cultural competence suggests that health authorities attach some importance to this issue. It is a deficiency at both levels of government in Australia that this same thinking has not been applied to consideration of CALD cultural competence.

4.2 Cultural competence in practice - the Canadian experience

Sections 3.5 and 3.7 have shown that addressing cultural competence in Canada is patchy at best. There is no single policy on cultural competence and, whilst the skill is mentioned in some health policies, there is no coordinated effort. Where cultural competence is mentioned, this is as an individual skill – organisational level requirements are not mentioned. With the exception of the BC Public Service Agency and the Toronto Central Local Health Integration Network (LHIN) which take a broader approach, culture is considered to be reflective only of ethnicity. Where they existed, Canadian health policy officers did not mention any policy frameworks, suggesting that the written policies play little part in their everyday responsibilities. The exception to this was the Toronto Central LHIN where cultural competence seems to have a higher profile.

In this environment, what do Canadian health policy officers understand by cultural competence and how do their authorities operate in a culturally competent manner in accordance with such policies as exist. Canadian health policy officers provided insights into these issues.

4.2.1 The meaning of cultural competence

As in Australia, cultural competence is a term recognised by Canadian health policy officers. However, a noticeable difference is that Canadian health policy officers made more comment about the context of interactions and the need for self-awareness

> "Understanding the context around those individuals, the history, the way that they've interacted within the healthcare system and some of the potential challenges…the awareness and skills to reach out and to create culturally appropriate material or outreach tools to ensure that their participation is encouraged." (Participant #11, Canada, Federal)

> "Cultural competency…is best described as insight into where you're coming from and your understanding of how you can see through another's eyes if that's possible." (Participant #12, Canada, Provincial)

These comments express a relationship between the health policy officer's life experience and her perceptions of other people, resulting in the need to tailor communications. These perspectives demonstrate alertness to the influences that shape a person's interactions and the need to suspend judgement and be open minded in the pursuit of a policy objective.

An interesting thought was offered by one health policy officer who identified the need for "understanding around the context of Western medicine compared to the approach in their [client's] countries of origin." (Participant #10, Canada, Provincial). Although this could be implied by the first comment above, it was interesting that somebody chose to highlight Western medicine in particular, thus showing an appreciation of influences on policy officers as well as those on CALD citizens.

Another health policy officer offered this understanding of cultural competence

> "Always framing the interaction with somebody from a different culture by explaining what you mean by your terms, by explaining what you understand from your own experience and then asking the question of 'what is your experience, how do you interpret this, what does it mean?'" (Participant #9, Canada, Provincial)

This response also indicates a thoughtfulness and an interest in seeking information. What this response adds, that others did not, is a direct line of communication with a CALD background citizen, communication that is driven by the policy officer who presents a set of meanings and seeks a response from the citizen. This approach appears to seek a shared understanding of an issue, but would need to be implemented cautiously to mitigate the difference in power and standing between the policy officer and the CALD background citizen. This power differential extends to what the policy officer does with the information received – is it accepted as stated or judged in some way against the policy officer's own yardstick?

Another perspective on cultural competence, one that focuses on the citizen, was offered

> "Cultural competency is understanding how some people might have some unique factors and characteristics and limitations which might make it harder for them to access or benefit from general services." (Participant #10, Canada, Provincial)

This comment highlights the need to consider the citizen as an individual and take into account the influences that may affect individual responses to health care. This is a useful reminder about the importance of context and the need to find out more about the individual, beyond ethnicity, in order to support development of appropriate health policy.

Yet another perspective on cultural competence presented a more legalistic view

> "That combination of the knowledge of that standard [the Constitution] and behaving in a way that demonstrates you are knowledgeable about what's happening." (Participant #8, Canada, Provincial)

> "There's a standard to adhere to. Our biggest standard is the Constitution… There could be other agreements…like codes of conduct or standards of practice or ethical guidelines…professional practice standards, Acts, laws… Competence in my mind would be how we measured ourselves, how we performed against those measures and targets." (Participant #7, Canada, Provincial)

These responses identify standards that must be adhered to, standards which could exist at a number of levels within an organisation, which are regulated either by law or possibly industry self-regulation, and which dictate a policy officer's behaviour. This approach to cultural competence presents a striking difference to the Australian situation where no insight into policy frameworks was offered. This perspective is process-oriented and focussed on behaviour that is distinctly measurable against a standard. These comments suggest that some health policy officers see the policy framework as helpful. Alternatively, the framework could be seen as a series of boxes to be ticked as each stage is completed. Which of these is the best interpretation will only be apparent when the whole picture is known.

Regardless of the foregoing, one health policy officer admitted that cultural considerations had been one-sided

> "Most of our experience with cultural competency has been on the Aboriginal side up till now." (Participant #9, Canada, Provincial)

The Canadian policy framework includes mandatory requirements to consult with and accommodate Aboriginal people, so it is not surprising that this would have been an organisational focus. I think the preceding discussion, though, shows a thoughtfulness amongst policy officers that needs to be explained. If these comments are not the product of organisational focus then they must arise from the intellect of individual health policy officers. Later in this section I will look at training provided to health policy officers: that discussion will either add to or otherwise explain the positions taken by health policy officers.

This discussion has shown that, as in Australia, health policy officers have a good understanding of cultural competence despite the absence of in-house policies. Worthy

of note is the emphasis that Canadian health policy officers place on acknowledging their own backgrounds and the context surrounding the CALD citizen as influences in health policy development. Some Canadian health policy officers made explicit mention of national policy frameworks, notably in the context of compliance with standards.

4.2.2 Support for attaining cultural competence

This section addresses support for health policy officers in the context of a policy framework for the development and implementation of cultural competence. Discussion of policy frameworks which may support the development of expertise in multicultural health (see sections 5.6 to 5.8) and citizen engagement (see sections 6.5 and 6.6) are addressed later in this thesis.

When asked whether it was possible to become culturally competent, Canadian Provincial health policy officers were almost unanimous in seeing cultural competence as unattainable but nevertheless aspirational

> "I think it's an aspiration. It's the checks and balances and
> confirmations and just continuing to check yourself at the door... I
> think it's an ongoing process." (Participant #7, Canada, Provincial)

This comment expresses the idea of something to aim for, but which requires constant thinking and re-thinking along the way. This comment supports earlier comments about the meaning of cultural competence because it demonstrates a continuing and thoughtful process. It also gives voice to a key idea in the literature about cultural competence, that attaining cultural competence is not a once-off process.

One Provincial health policy officer added the view that

> "…you also need to be coached through doing those actions in
> different contexts… That is really challenging and…I don't think
> we're there and we won't be there for a while." (Participant #9,
> Canada, Provincial)

This comment says that cultural competence may be attainable at some point in the future but only after considerable effort and with considerable support. This is a useful reminder that cultural competence is not a solo activity, that health policy officers need support and guidance from their health authorities.

As was the case in Australia, Canadian health policy officers are keenly aware of their own lack of knowledge

> "If you're a policy maker you might think that you have competence
> and understanding about a certain culture and you may be wrong but
> not know it." (Participant #12, Canada, Provincial)

This comment makes explicit the point raised in Chapter 3 that one person cannot know everything about a particular group of people. That this was mentioned shows an awareness on the part of some health policy officers that their own assumptions may be incorrect. Not everybody agreed

> "Everybody doesn't have to understand everything about
> everything…but I think policy has to leave scope for how it gets
> translated, adapted and applied in different cultural contexts and
> different circumstances" (Participant #10, Canada, Provincial).

This comment seems to let the policy officer off the hook – she does not need to know it all – and puts responsibility for adaptation onto policy implementers. This approach implies that health policy can be developed without taking into account cultural issues and raises uncertainty about when, and by whom, such consideration should take place.

Nevertheless, the benefits of a culturally competent approach to health policy development were articulated. For example

> "This ability to understand that while cultural competency is on the
> front end of how you start, the end result is outcomes that are
> improved because you have more equitable access to care…"
> (Participant #9, Canada, Provincial)

Reviewed together, these comments show some tension within Provincial government health policy processes. Whilst one view is that somebody else will take care of cultural issues, the opposing view is that the policy developer must take care of cultural issues in order to reap the benefits of the policy development process. This observation is concerning when viewed in the context of the Constitutional policy framework which, I suggest, is only front of mind for some Provincial health policy officers. Equally concerning is the possibility that some policy officers feel undirected and uncertain about how to tackle consideration of cultural issues. This is likely to be a direct result of the lack of focus on cultural competence as a skill within Canadian health authorities.

In terms of in-house initiatives, two matters were raised. Firstly, one Provincial Canadian health policy officer spoke of a pilot project involving coaching for individual officers and teams to assist them to evaluate program effectiveness and identify opportunities for improvement. This pilot project revolved around "self-reflective practice" and the participant could see benefits in using this methodology in the context of attaining cultural competence (Participant #7, Canada, Provincial). Secondly, an Agency head was especially mentioned for efforts in encouraging staff to visit the geographic areas that the Agency's policies were serving in order to understand the issues faced by a diverse community. As the health policy officer reported "Your own maybe biases or lenses start to kick in and you become hyper conscious of what a day might look like in that neighbourhood." (Participant #9, Canada, Provincial). These two examples show that there are some initiatives at the Provincial level that could support the development of cultural competence amongst health policy officers.

This discussion has shown that Canadian health policy officers are, overall, supportive of the need to develop a measure of cultural competence, and recognise a continuum of knowledge and the importance of continuous learning. In some health authorities there is a level of uncertainty about who should be culturally competent but, again, overall health policy officers agree that they should be culturally competent in order to deliver equitable health policy.

4.2.3 Organisational cultural competence

When asked where on the cultural competence continuum health policy officers sat, Canadian health policy officers were hesitant to pass judgement. Two specific comments were made

> "Yeah, I think so [around the middle of the continuum]" (Participant #11, Canada, Federal)

> "Policy makers need to be at that end of the continuum around the awareness of differences and challenges, but at the same time policy makers also have to be focused on the good of the population." (Participant #10, Canada, Provincial)

Referring to several models of cultural competence discussed in Chapter 3, the 'middle' approximates a state of awareness of difference. Thus, these two comments give a similar view that Canadian health policy officers are aware of difference. The second response

expands on this by adding that it is the broader population, rather than cultural sub-groups, that are the subject of health policy developers' considerations. A reticence to judge their peers may indicate an unwillingness to suggest that colleagues are less than culturally competent. It may also be a sign that health policy officers think themselves less than culturally competent and thus not in a position to judge others. The second comment above adds another dimension of tension, namely whether to focus on the special needs of specific groups or on the population as a whole. This comment is a clue to conflicting demands on the health policy officer to develop health policy for the greatest number of citizens but not to forget that some citizens have extra challenges.

The second comment above could be explained another way. This health policy officer may feel that admitting to being less than wholly culturally competent is not acceptable and attempts to explain the situation by pointing out that the population under consideration is the whole population and not sub-groups, thereby implying that a lesser degree of cultural competence is quite acceptable.

The impact of conflicting demands was expressed by several Canadian health policy officers when they discussed the policy environment

> "We are now seeing generations of immigrants who are becoming part of the cultural fabric that we need to also try to look at…how does that change the way we communicate or how does that change the way we potentially develop policies or develop programs." (Participant #11, Canada, Federal)

> "I think for policy makers they have to make that connection between why competence in understanding populations is going to have an impact on the outcomes that they've been traditionally looking at for a long time." (Participant #9, Canada, Provincial)

Along with recognition of diversity in these responses, both highlight the implications of diversity for the ways in which health policy is made and communicated. These comments articulate an awareness of the impact of change and the need to consider policy processes.

Canadian health policy officers have clear understandings of the concept of cultural competence but seemed hesitant to judge their organisations in terms of overall implementation. What was missing from comments by Canadian health policy officers was any criticism of their organisation's internal culture in the context of considering

cultural diversity. This is quite different to the views expressed by Australian health policy officers. Instead, these Canadian participants highlighted a need to consider the changing policy environment whilst, for some, at the same time commenting on the need for health policy to address large, rather than specific, populations. Alongside acknowledging the benefits of culturally competent health policy development, a number of Canadian health policy officers articulated a critical multicultural understanding of the ways in which policy beneficiaries can be disadvantaged by a health system which reflects the needs of the dominant majority.

4.2.4 Reliance on staff for culture-specific input

Canadian health policy officers at both the Federal and Provincial levels of government spoke of a reliance on Agency staff with diverse backgrounds, either as resources for other staff or as the first line of scrutiny

> "Last year there was a presentation that was sponsored by our HR department of [Agency] staff who [are] 'part of visible minorities' to speak to their roles in government…" (Participant #11, Canada, Federal)

> "We have a multicultural staff as well, so we certainly have our staff do review of materials and content to help us with the tone and relevancy." (Participant #7, Canada, Provincial)

> "I think we're lucky too as an organisation in that…we're multicultural – our own staff. Many of our current staff remain or were very closely tied to the health community…many still work in the community…" (Participant #8, Canada, Provincial)

These three comments show a reliance on in-house staff to provide information to other staff about specific cultural groups, whether in a training setting or as program advisers. The third comment above goes on to say that benefits are to be gained when staff retain their links to the community, although it was acknowledged that "we need to make that connection a bit stronger and consistent" (Participant #8, Canada, Provincial).

Whilst a multicultural staff and links to the community were presented favourably by Canadian health policy officers, as in Australia these comments reflect poorly on the health authorities concerned for the same two reasons. Firstly, the reliance on in-house staff as educators and scrutineers implies an understanding of culture as common to all members of a particular group and unchanging, a commonly held view of culture which

further implies that one staff member can know all there is to know about a particular cultural group. This understanding is out of step with my definition of culture as fluid and changeable for the reasons discussed in Chapter 3. Secondly, and mirroring the Australian situation, Canadian health policy officers are looking to their own resources to fill a gap that exists because of the absence of policy around cultural competence relevant to CALD background citizens.

4.2.5 Training for cultural competence in the Canadian health sector

In Canada, as in Australia, training to develop cultural competence relevant to CALD background citizens is non-existent

> "I'm not aware of [training in cultural awareness] but I think that we're really tapping into an area here that's definitely been underserviced or underemphasised…" (Participant #11, Canada, Federal)
>
> "No there weren't [any training courses or toolkits]." (Participant #10, Canada, Provincial)

Both of these comments illustrate the absence of training programs, although the first health policy officer says more by acknowledging the deficit within the organisation. This additional statement shows a thoughtfulness about the deficit, whether or not that thoughtfulness was prompted by our discussions.

Although CALD cultural competence training was missing, a number of Provincial health policy officers spontaneously mentioned the presence of Indigenous cultural competence training

> "So what we decided around our cultural competency approach for Aboriginals was that we provide a one day, we sort of made it mandatory for all staff…to attend." (Participant #9, Canada, Provincial)
>
> "All Ministry employees are expected to take the Indigenous Cultural Competency training…the training is extraordinary" (Participant #12, Canada, Provincial)

These comments report not only the availability, but also the mandatory nature, of Indigenous cultural competence training. The spontaneous mention of Indigenous cultural competence training highlights the importance placed on and the keen awareness of Indigenous cultural awareness. On the other hand, the priority placed on Indigenous

cultural competence also serves to draw attention to the absence of cultural competence training relevant to CALD background citizens. This is similar to my findings in Australia.

Mention was made of the value of collaboration with community-based leaders in order to

> "bridge that 'us' to the face to face…[because]…they're in most cases already very culturally aware." (Participant #8, Canada Provincial)

and that sometimes it is necessary to work with

> "the representatives or connectors in the community to help us facilitate…that interaction with the public." (Participant #7, Canada, Provincial)

These comments reflect the view that community leaders know more about their community than policy officers do and are thus a good source of guidance. These health policy officers are looking outside their own organisations for guidance, an action in common with Australian State health policy officers.

Canadian health policy officers were pragmatic in their assessment of the potential for training courses to provide benefit to staff. One health policy officer thought it was difficult to see

> "…whether those skills that are acquired through just one sporadic or one-off kind of event will then translate themselves into behaviours… I'm not sure how you develop that, how you test for that and how you then could state 'well this individual is exhibiting all of those competencies'." (Participant #11, Canada, Federal)

and another said

> "I think you have to be familiar with the ideas. You have to practice them. You have to be in an environment where you get the chance to practice them. You have to have coaches and mentors to understand what it means, who really drive home why it's important. I think it's a value that organisations need to take seriously." (Participant #9, Canada, Provincial)

Both of these responses illustrate doubts about the benefits of training courses. In the first instance, the comment casts doubt on the influence of one-off training on behaviours and how expected behaviours could be measured. In the second instance, the comment

proposes that training needs to be backed up by practice and supported by people who can make sure that learnings are applied continuously and correctly. It may be that Canadian health policy officers are familiar with training that ticks boxes but does not translate into any change in behaviour of individual staff. My experience with Indigenous cultural competence training in the Federal Australian context is that it is viewed as something a staff member must be seen to be doing but is quickly forgotten in the absence of immediate application and continual reinforcement.

The lack of formal training programs could be explained by the lack of formal policies of cultural competence which should drive necessary training programs. Such a conclusion needs to be put beside the fact that some Canadian health authorities provide formal Indigenous cultural competence training, leading me to think that there is not a complete absence of consideration of cultural diversity within those organisations. The lack of training in cultural competence relevant to CALD citizens is, for some, perplexing because of the focus that is given to Indigenous cultural competency. This is a good point to stop and consider the apparent lack of connection between inclusion of Aboriginal (Australian and Canadian) and Torres Strait Islander (Australia) people and inclusion of people from CALD backgrounds.

4.3 Relationship between Indigenous cultural competence training and CALD cultural competence training

Australian health policy officers did not offer any assessment of Indigenous cultural competence training. However, Canadian health policy officers did comment on the strengths and benefits of Indigenous cultural competence training. It is curious then that attention to cultural competence in Indigenous cultural issues in Canada does not appear to have influenced the same health authorities to pay more attention to the cultural and linguistic diversity of many more of their policy beneficiaries.

It is even more curious in light of the comments of one Canadian health policy officer who explained that, despite the "Indigenous Cultural Competency" training label, Aboriginal people were not usually "included in the cultural box" in terms of policy development, rather cultures are Punjabi or Cantonese for example (Participant #12, Canada, Provincial). The difference between Aboriginal people and people from CALD

backgrounds is the level of governance, in that Aboriginal people have local, provincial and national governing bodies. For example, in health in British Columbia (BC) there is a First Nations' Health Authority which is represented on a variety of collaborative committees and is a permanent part of strategic decision making. This view was supported by other Canadian health policy officers who, in discussion, referred to "…engaging with the multicultural groups and the First Nations' Health Authority." (Participant #7, Canada, Provincial).

In mentioning cultural competency relating to Aboriginal and Torres Strait Islander cultures in Australia and Canada, a number of health policy officers made it clear that their experience in cultural competence to date had really been about Indigenous issues

> "Certainly cultural awareness…most people would launch into that's about Aboriginal and Torres Strait Islander people." (Participant #1, Australia, State)

> "Most of our experience with cultural competency has been on the Aboriginal side up till now." (Participant #9, Canada, Provincial)

These comments illustrate the point clearly, noting that in both countries cultural competency is linked to consideration of Indigenous health issues. This probably explains why, without prompting, health policy officers raised issues relevant to Indigenous people despite my being clear that this subject was out of scope for my research. In particular, mandatory training for Aboriginal and Torres Strait Islander cultural awareness (ACT and Queensland) or Indigenous Cultural Competence (BC) was raised.

Both Australian and Canadian agencies have policies relating to consideration of Aboriginal and Torres Strait Islander health issues and engagement with Aboriginal and Torres Strait Islander people. In many cases this is a clear and well understood part of agency business processes

> "We have a policy management cycle and…as part of that process…every new or revised policy…we do an Aboriginal and Torres Strait Islander Impact Statement. … We have a formal process … that no policy can be…finalised and okayed until it's actually got the views of the Aboriginal and Torres Strait Islander Policy Unit to say that the views of that community have been provided…" (Participant #1, Australia, State)

> "…we've been focusing on developing clearer guidelines for involvement of Aboriginal people in research. That's very much now a known kind of policy…there are specific imperatives for consultations for Aboriginal people." (Participant #11, Canada, Federal)

> "…we now have a First Nations Authority in BC in its formative stages. We have them represented at the collaborative committees…it brings the voice to the table which I think is really key for that strategic level decision making." (Participant #12, Canada, Provincial)

These comments all refer to the consideration of Indigenous issues and views as part of the health policy development cycle, a process that has been formalised by governments and health authorities through impact statements, guidelines, and inclusion in committee memberships. These actions demonstrate that formal Indigenous policy frameworks have enabled support to be provided to health policy officers in both Australia and Canada, especially at the State and Provincial levels of government.

The influence of consideration of Aboriginal and Torres Strait Islander cultural issues on Australian State health policy officers should not be underestimated. References to 'cultural safety' (Participant #4, Participant #5, Australia, State) in their understandings of cultural competence indicate that this concept, particular to Aboriginal and Torres Strait Islander cultural awareness (Downing et al., 2011), has been integrated into health policy officer thinking. 'Cultural safety' is also used in the Canadian context (Bourque Bearskin, 2011) and was mentioned by one Canadian Provincial health policy officer (Participant #9, Canada, Provincial). This use of language is a further indication of the emphasis placed on Indigenous cultural competence, so much so that the language has been adopted in the context of broader definitions of cultural competence.

Some Canadian Provincial health policy officers reported the usefulness of Indigenous Cultural Competence training to consideration of people from other cultures, noting that the training raised awareness about "How we treat each other" (Participant #8, Canada, Provincial) and that the training was broadly applicable "even though it was intended to be quite focussed" (Participant #8, Canada, Provincial). These comments show that health policy officers have taken their learnings and thought more broadly about what that awareness means for their interactions with people from CALD backgrounds. Such insights were not obvious in Australia although one Australian health policy officer did hope that a new policy unit would provide assistance in CALD cultural competence by

"…modelling off [the Agency's Indigenous] cultural awareness
training...." (Participant #1, Australia, State)

These comments show a level of optimism amongst Provincial and State health policy
officers that they can apply their learning more broadly, and that in-house initiatives could
improve CALD cultural awareness in the future. Regardless of these views, no health
authority at the Federal or State/Provincial level in either Australia or Canada has any
obvious commitment to introduce cultural competence training relevant to non-
Indigenous cultures.

In concluding section 4.2 I noted that some policy officers found the lack of CALD
cultural competence training perplexing, given the high profile of Indigenous cultural
competence training. Two health policy officers specifically observed that the focus on
culturally competent interactions with culturally diverse citizens was skewed towards
consideration of Indigenous issues

"…can [we] be more mindful and be more welcoming of that input in
terms of some of our visible minorities and different cultures, aside
from Aboriginal First Nations culture." (Participant #11, Canada,
Federal)

"…why is it that for the rest of our multicultural community we don't
have that mechanism?" (Participant #1, Australia, State)

The Canadian Federal health policy officer asks whether it is possible to be more alert to,
and welcoming of, input from CALD citizens. To put the second comment in context,
this Australian State health policy officer was discussing the formal processes that applied
to consideration of Indigenous issues and input, and wondered why those policy
mechanisms were not in place for consideration of CALD issues. Both of these health
policy officers showed their puzzlement at the situation they were describing.

In summary it is possible to conclude that the presence of known policy frameworks and
associated tools, such as impact statements and procedural guidelines, can and have
affected the way in which Indigenous cultural competence has been addressed. This is
clearly demonstrated at the State and Provincial health levels in both countries. However,
the connection between Indigenous cultural competence and CALD cultural competence
in the minds of health policy makers is not clear. Some use the language of Indigenous
cultural competence when considering cultural competence more broadly, but it is not

obvious that Indigenous cultural awareness has resulted in enhanced cultural competence for CALD communities. The lack of strong policy frameworks for consideration of CALD policy issues, such as those described above for consideration of Indigenous policy issues, suggests that one potential driver of change is missing.

4.4 Comparing experiences in Australia and Canada – the status of cultural competence in health policy development

In this section I will bring together the findings of the preceding discussions. A comparison of the Federal and State and Province health sectors in Australia and Canada will enable me to draw conclusions about understandings of cultural competence, support for attaining and establishing organisational cultural competence, the reliance on individual staff to provide culture-specific input, and the nature of training to achieve cultural competence.

Most health policy officers across all jurisdictions felt that health policy makers in general were far from being able to claim more than moderate levels of cultural awareness, sufficient to recognise diversity in the community but uncertain about how to take this into account in health policy development. Nevertheless, each one was able to articulate a clear idea of cultural competence and pass judgement, although sometimes hesitantly, on their own organisation in terms of levels of competence amongst staff. Canadian health policy officers expressed, more strongly than their Australian counterparts, the need for definitions of cultural competence to include the context surrounding individual CALD citizens. Despite the presence of policy frameworks in some State and Provincial jurisdictions, only some Canadian health policy officers referred to these frameworks. Excluding Indigenous cultural competence training, there is no formal skill development in the area of interacting with citizens of CALD backgrounds and some Australian State policy officers in particular felt let down by their leadership teams who did not appear to model what the policy officers felt were appropriate behaviours. Canadian Provincial health policy officers did not describe similar concerns about their leadership teams.

All in all, health policy officers across both countries and both levels of government seem to have an innate sense of what is fair and certainly have a strong commitment to equity and fairness in health policy. Although the BC Ministry of Health is an example of a

culturally competent organisation with culturally competent, trained and supported staff, this training only extends to Indigenous Cultural Competence. The Toronto Central LHIN is an example of an organisation with strong, culturally competent leadership which flows down to support for individual staff and a culturally competent approach to the work program.

Across all jurisdictions and both levels of government there is acknowledgement that cultural competence is a complex issue requiring considerable thought and continuous learning. In general, health policy officers expressed the nature of culture as changeable although Australian health policy officers were more explicit about this.

Both Australian and Canadian health policy officers across all jurisdictions are aware of the limitations of their own knowledge.

On the job support was more evident in the Canadian Provincial health sector where strong leadership and a trial of self-reflective techniques were held up as examples of a shift towards a culturally competent approach to CALD background citizens. Australian State health policy officers felt let down by their organisations, and in some cases by their superiors, and so found themselves doing the best they could with little or no support.

Both Australian and Canadian health policy officers described tensions in their work. At the Australian State level the tension was between the various lenses that need to be applied to health policy development (eg age, gender, ethnicity), whereas at the Canadian Provincial level the tension was between developing health policy for large populations versus sub-sets of the population. These factors not only show the complexity of the policy development task but were also presented as potential reasons for the less than adequate attention to CALD cultural competence.

Across all jurisdictions and both levels of government there is a degree of reliance on individual staff to know what the right thing to do is, and then to do it. Additionally, individual staff are sometimes called upon to provide education, guidance or policy input relevant to a particular cultural, ie ethnic, group. As noted earlier, the difficulty in this approach is that it assumes that one staff member holds all the necessary knowledge about a particular CALD group, an assumption that relies on the commonly held view that 'culture' can be identified by a list of attributes invariably held by all of its members. A

number of health policy officers across all jurisdictions indicated an understanding that culture is not static but, nevertheless, were willing to draw on individual staff as 'experts' for advice and training. This action emphasises the lack of formal support within organisations such that health policy officers look to their own resources and colleagues for assistance.

The lack of follow through for policies that do exist is demonstrated in the lack of, or inadequate training in, cultural competence. No jurisdiction in either country or at any level of government provides training in cultural competence relative to CALD citizens. The mandatory Indigenous Cultural Competence training in the ACT, Queensland and BC only seems to have had a flow on effect in BC where the interactive course is many hours long, requires active participation by staff, and is reported to have influenced thinking more broadly.

In Australia, Federal health policy officers are not being provided with system support in the form of training to develop skills of cultural competence. Although training in Indigenous cultural issues was made available in State-based agencies, there was no sense that this was a sufficiently powerful tool to prompt health policy officers to think about their interactions with people from other cultural backgrounds. Further, some Australian health policy officers, as reported, rely on their client groups to teach them what they need to know.

The Canadian picture is different. At the Federal level efforts are in place to raise awareness amongst health policy officers, even if this is somewhat informal and partially reliant on contributions from staff members themselves. This latter is a difficult issue given that I have already acknowledged that culture is changeable and relative and so it is not possible for one staff member to know everything about a particular cultural group. Despite this objection, at least some effort is being made. However, like their Australian State counterparts, Provincial health policy officers also look outside the agency to the community for guidance in addressing matters of cultural and linguistic diversity.

Training is not a fool-proof answer though. Despite noting the importance of supporting skill development through education and training, Canadian policy officers question whether the benefits of a training course can be realised without additional continuing support.

4.4.1 A critical multicultural view of cultural competence in health policy development

In summary, and reviewing the evidence from a critical multicultural perspective, it appears that Australian and Canadian Federal and State/Provincial health authorities pay no attention to cultural competence relevant to CALD background citizens. This despite the presence of some policy frameworks, notably at the Australian State level and through the Canadian Constitution, that suggest the opposite should be the case.

Although some individual health policy officers in both countries, and at both levels of government, showed an understanding of the way in which policy structures can disadvantage CALD citizens, it appears they are not supported to formalise their thinking nor to question or challenge those structures. Particularly paradoxical is the way in which some Australian State and Canadian Federal and Provincial health authorities have embedded procedures to address Indigenous health issues and input into the policy development processes, but this has not influenced similar actions relevant to CALD background citizens. To balance this critique, whilst I have cited health policy officers who acknowledged the need for greater personal awareness and greater organisational responsibility, none of these health policy officers suggested they might have an active role in changing organisational structures. This is interesting given the seniority of the health policy officers interviewed, a seniority which suggests that many, if not all, of them have the capacity to influence in-house policies such as those addressing cultural competence. In fairness to the health policy officers, I did not specifically ask them what their role could or should be in developing in-house policies and so their lack of discussion cannot necessarily be interpreted as an inability or unwillingness to act.

Shore and Wright argued that policies are "classificatory devices" that set the norms through which the community is managed (Shore and Wright, 1997, p10). This classification serves to pigeon-hole people and "empower some and silence others" (Shore and Wright, 1997, p10). My observations show that CALD citizens are effectively silenced when policy is developed within the frame of reference of the dominant majority. This systemic flaw also means that health policy officers are not enabled to think about and include CALD citizens in engagement activities. Health policy officers try to make up this deficit by drawing on their own resources, sometimes using their colleagues as points of reference or as teachers. This path is fraught with difficulty, not the least

because individual staff have their own histories and biases which will colour the views they embrace. Structurally, Australian and Canadian health authorities at both levels of government are promoting one-size-fits-all health policy development (excluding Aboriginal and Torres Strait Islander people) with a focus on the dominant majority to the disadvantage of citizens or groups who are seen as different in some way. With this approach, health policy development will continue unchallenged and untroubled by those citizens who are seen as different by virtue of their CALD background.

In the next section I will look at assumptions about cultural competence and propose a different way to look at the inclusion of CALD considerations in health policy development.

4.5   Cultural competence – language as help or hindrance?

In Chapter 3 I defined culture as a dynamic process of shared meanings, located in and emerging from interactions between individuals. The dynamism of interactions means that cultural competence must not only be an acknowledgement and valuing of, and respect for, difference and diversity, but must be supported by continuous questioning and challenging of assumptions held by individuals and the health system. The objectives of cultural competence are therefore two-fold: to assist health policy officers to work effectively with people from other cultures; and to remove structural barriers to equitable health policy.

As discussed in Chapter 3, the literature is clear that attaining cultural competence must neither be perceived nor pursued as a once-off activity but rather accepted as a continuum of learning, un-learning and re-learning, allowing continuous skills growth and re-growth as ideas of culture are revisited and revised over time. Additionally, noting the way in which structural barriers can impede the development of equitable health policy, there is good argument to say that it is essential that cultural competence is not seen simply as a skill required of individual public servants but also as something required at the organisational level. Health sector public administration can learn something from health service delivery, which recognises the importance of cultural competence as a responsibility shared between the individual and the organisation built on self-awareness,

and comprising a continuum of skill levels developed through continuous learning embedded within professional development.

Whilst health policy officers understand cultural competence as a skill to enable them to communicate with people from varying backgrounds, in many instances this understanding derives from their own intelligence and thoughtfulness and, in a few cases, professional development prior to their entry into health policy work (for instance an earlier career in nursing). Despite the presence of a variety of statements in policy documents which acknowledge the importance of cultural competence as a skill, none of the health policy officers I spoke with have experienced cultural competence training relevant to CALD citizens, and no authority at either level of government is pursuing such an initiative.

I find myself wondering whether the language of 'cultural competence' is more of a hindrance than a help to a critical multicultural approach within health authorities. I observe that when 'cultural competence' is raised as an issue two results are likely. Firstly, many people instantly think only of Indigenous cultures and, secondly, competence is taken to mean a skill that can be taught and obtained once and for ever. Both of these assumptions are erroneous in the health policy development setting.

In the first instance, although one Canadian Provincial health policy officer explained the reasons for not including Aboriginal people in the general 'culture' basket (as discussed above) there was no such rationale offered in Australia. Except for this one explanation, none of the health policy officers I spoke with offered a view that suggested that culture did not include both Indigenous and broader CALD backgrounds. Despite this, although some Australian State and Canadian Provincial health authorities do address Indigenous cultural competence in training initiatives, the same attention is not given to the very large and increasingly diverse populations of CALD background citizens. Any discussion of cultural competence is automatically taken to pertain to Indigenous cultures to the exclusion of all others. Thus, there is no overt recognition that health policy officers need to demonstrate a cultural competence relevant to CALD background citizens, or even that CALD background citizens may be disadvantaged by the health system in similar ways to the disadvantage experienced by Indigenous citizens.

The difficult question I ask is whether it is possible to dispense with the word 'culture' in this context? On the one hand its presence alerts the health policy officer to the need to think more deeply about the people to whom health policies are addressed because it carries with it the implication that not all citizens derive from the dominant culture. On the other hand, as long as culture is used to define a person there is a danger that it will further entrench pre-conceived ideas about who that person is and how they are likely to, or should, behave. These are the very assumptions that need to be challenged by health authorities and their policy officers. There is very little evidence from my discussion with health policy officers that the word 'culture' is critical to their thinking about policy solutions. Only on rare occasions has a specific ethnicity been identified as demanding of special attention because of the health behaviours those citizens brought from their country of origin (for example the iCON project in BC discussed in Chapter 7).

Whilst it is important to identify citizens as having CALD backgrounds, because this may influence their interactions with the health system as well as their health needs (Murray and Skull, 2005), it is equally important that this not be used to direct health policy thinking about potential policy solutions because any such solutions are likely to be based on preconceptions. However, with the exception of the iCON program, it is clear from my discussions with them that health policy officers are not encouraged to consider cultural diversity when developing policy solutions. Because of this reality it seems unreasonable to highlight the notion of 'culture'.

I turn now to the second assumption, that cultural competence is a once-off skill that can be taught and held without amendment. The term 'competence', referring to holding a specific skill needed to carry out one's duties, is well known terminology in public sector circles and frequently the basis of performance reporting. Such competencies are attained in a number of ways, including attending training courses, and are accompanied by the expectation that having been trained the public servant is now competent in that specific matter, for example health policy development. This one-dimensional view does not recognise explicitly the need for regular updating of skills, and certainly does not recognise that some so-called skills are not attainable in the sense of having or not having the skill.

4.5.1 A new language

In 2012, Gurjeet Gill and Hurriyet Babacan presented their framework of 'cultural responsiveness' for the health sector (Gill and Babacan, 2012). The framework encompasses the workforce, the institution, management systems, and the health care user and is underpinned by organisational culture reflected in "well-resourced cultural diversity management systems and practices, a culturally responsive workforce, culturally responsive service delivery systems and informed clients" (Gill and Babacan, 2012, p53). The framework focusses on changing behaviour within organisations and relies on a whole-of-organisation approach to the integration of cultural considerations in service planning and delivery, supported by CALD citizen engagement in decision making. The authors argue that cultural responsiveness "encourages response to situational applications of cultural knowledge" by focussing on the context of the healthcare user including "relationships…values…their support networks and the community from which they come." (Gill and Babacan, 2012, p52-53). The new language was intended to bring together the existing multiple, and often contradictory, understandings of cultural competence, recognise the complexity of culture in health, and provide a "less technical, more concrete" approach to CALD patients (Gill and Babacan, 2012, p52).

My criticisms of the framework as presented by Gill and Babacan (2012) are twofold. Their emphasis on "compulsory cultural diversity learning and training" (Gill and Babacan, 2012, p53) contains an underlying assumption that culture is knowable and, despite their paper initially acknowledging the opposite view, there is no discussion which challenges that assumption. Secondly, the authors' call for cultural diversity management programs within institutions stresses the importance of adequate resources but does not include any dimension of questioning of internal processes and procedures that exacerbate disadvantage or operate to exclude CALD citizens. This latter point is important in view of criticisms made by health policy officers of the barriers created by their own organisations' internal culture. The change in terminology to "cultural responsiveness" does little other than suggest a higher visibility for cultural diversity in health and particularly does not advocate for significant change to institutional processes that exclude.

Language is a tricky issue. As Kate Burridge and Tonya Stebbins point out "language works because we are all agreed on what signs mean" (Burridge and Stebbins, 2016, p10). They also point out that all words have certain accepted meanings or connotations which are based on "experiences, beliefs and prejudices about the contexts in which words" are used (Burridge and Stebbins, 2016, p118), and that sometimes the meanings we attach to a word can be "negative or pejorative" rather than positive (Burridge and Stebbins, 2016, p131). I have observed that 'cultural competence' invokes what I consider to be negative frames of reference and so, despite some trepidation and for reasons I will expand on in this section, I suggest that the term 'cultural competence' should not be used in the health sector to refer to that set of skills enabling interactions with, or consideration of issues relevant to, CALD background citizens. Instead, I propose that a new term 'contextual sensitivity' be substituted in order to direct attention towards the context surrounding the CALD background citizen and away from any single attribute such as age, gender or ethnicity.

Since culture does not play a big part in health policy development considerations, I advocate that the 'culture' of cultural competence be dispensed with in favour of a focus on the 'context' which shapes the experiences of health policy beneficiaries. It has been argued that when culture is the focus of attention other factors that influence health such as "social isolation, poverty, age, gender or immigrant status" are ignored (Manderson and Reid, 1994, p11). Kent Buse and colleagues support this argument, noting that culture is just one of the contextual or "systemic factors" that have an impact on the way health policy is developed (Buse et al., 2012, p11).

The importance of context on health is illustrated in the ground breaking work of Professor Michael Marmot, endorsed by the World Health Organization through its Commission on Social Determinants of Health (CSDH, 2008). The social determinants of health include the "daily living conditions under which people are born, grow, live, work and age" and are influenced by political and economic structures in society (CSDH, 2008, p26). Social determinants of health are "influenced by policy choices" (Palmer and Short, 2014, p276), making it important for health policy makers to pay attention to the "relational, or structural" context of health (Palmer and Short, 2014, p340). Palmer and Short (2014, p340) make the point that structures in society reflect unequal power relations and that inequities in health will only be addressed when these "complex"

relations are transformed. Highlighting context also addresses criticisms of health policy makers as culturally blind (Napier et al., 2014), by removing consideration of an individual as an ethnicity and opening the door to more general consideration of the structure of society and an individual's needs in different situations.

A number of authors in the field of critical multiculturalism agree that understanding context is vitally important. As discussed at section 2.4, literature in domains as diverse as health (Wear, 2003; Nylund, 2006; Ortiz and Jani, 2010) and marketing (Burton, 2002) all point to the importance of understanding context. As Burton says "difference is always a product of history, power, culture and ideology" (Burton, 2002, p210). Kanpol and McLaren add that relationships are also "geopolitically specific" (Kanpol and McLaren, 1995, p100). Focussing on the broader context of the individual enables "capturing the 'voice' or the 'lived experience' of marginalized individuals and groups" in order to understand the context within which a person operates (Ortiz and Jani, 2010, p186).

Consideration of context can be used in the same way to turn the focus inwards into the health authority, to examine the structures with which the CALD citizen interacts, to identify those that may cause or exacerbate exclusion. An example in the health policy context comes from Health Canada (Atlantic Region), which provides guidance to its staff to enable assessment of health policies for elements of exclusion in the structural domain (Shookner, 2002). In this guidance, amongst others elements of exclusion, "departmental silos…secretive/restricted communications, rigid boundaries" were identified (Shookner, 2002, p5). Also in Canada, the Winnipeg Regional Health Authority similarly identifies the relationship between health care delivery and organisational structures and policy as potentially discriminatory, and presents a series of questions to assist health policy officers to think through the issues (Martis, 2012). Although not specifically identified as such, these two Canadian approaches have tones of a critical multicultural approach because of the attention given to potentially discriminatory organisational structures. Summarising the benefits of a critical multicultural approach, May and Sleeter identify the need for broader awareness of societal debates in order to identify "normative assumptions" and the "institutional practices that characterize them." (May and Sleeter, 2010, p11). As the Canadian examples demonstrate, health policy officers and their organisations can benefit from this broader awareness of the society within which they

operate, turning the lens on themselves to identify internal processes and procedures that disadvantage CALD citizens.

Turning to the 'competence' of cultural competence – or even contextual competence given my preference for context over culture – as discussed above this term is taken to mean a proficiency about or in something. As long ago as 1959, Charles E. Lindblom wrote that developing public policy was an incremental rather than rational process, characterised by "muddling through" a plethora of information including past policy choices, competing goal values, and priorities (Lindblom, 1959). Influenced by Lindblom, amongst others, and writing of health policy analysis specifically, Lawrence Brown argued that "learning denotes mastery" over something or some knowledge (Brown, 2010, p657). He says that "in policy there is no body of knowledge…and mastery lies beyond reach" such that policy makers can "learn that" something happened, or "learn about" the workings of something, but that "learning to…is quite another matter" (Brown, 2010, p657). Brown (2010, p657-658) proposes that policy makers are engaging in "policy groping" when they engage in "searching, sifting and speculating" on information which may then lead to insights. Brown's perspective reminds us that acquiring knowledge about a policy topic is not straightforward. It involves a process of examining and reflecting on information, listening to interested parties, and discarding that which is not useful, to arrive at a considered view.

'Competence' suggests that something can be taught, learnt, repeated in the workplace and measured. How can this concept be applied to culture which, as I discussed in Chapter 3, is constantly evolving as society changes? I suggest that it cannot – that culture is not something that can be taught, learnt and repeated, and so implying that a health policy officer can become 'competent' in culture is misleading. Following Brown's lead, I suggest that learning *about* culture through that process of searching, sifting and speculating is not the same as exhibiting competence in the sense of competence as proficiency. Policy groping has quite a nice ring to it because, in this situation, it is suggestive of the complexity of cultural diversity.

I am just as concerned that the use of 'competence' when linked to a broader notion of 'context' implies that it is possible to become proficient or knowledgeable about a specific group within the population. For all the reasons given above, I prefer to replace

'competence' with 'sensitivity' thereby implying the need for consciousness or awareness.

In summary, removing reference to culture and to competence and replacing them with context and sensitivity leads to the new term of contextual sensitivity to describe that skill applicable to health policy officers and their organisations. In Chapter 2 I proposed that the hardest influence to manage in health policy development is cultural diversity because of the unbounded, ever-changing nature of culture. Contextual sensitivity encourages a health policy officer to consider the needs of policy beneficiaries without the profusion of stereotypes of ethnicity or culture. A contextually sensitive health policy officer will engage with individuals to understand why they hold certain views, or do or do not engage in certain health-related behaviours. To get to this information requires a suspension of assumptions and judgements, an open-mindedness, and discussion. Learning to be contextually sensitive will be as much about learning about one-self, one's attitudes and assumptions and how they have been shaped by histories, time and environments, as it will be about identifying the nature of the policy audience in all its diversity.

The other part of the partnership is the health authority itself. Contextually sensitive organisations can be understood as organisations that open up their own processes and procedures to scrutiny in exactly the same way, identifying those that serve to disadvantage or exclude some citizens from the benefits that health policy intends to bestow.

When applied to both individuals and organisations, this new language flags a new approach to health policy development. Contextual sensitivity embodies the principles of a critical multicultural framework, alertness to histories combined with a questioning of assumptions and structures, for the ultimate benefit of both the health authority and the CALD background citizen.

Conclusion

In this chapter I addressed part of the first research question examining health policy officer understandings of cultural competence and how they operationalise existing policy frameworks to support health policy development. In both Australia and Canada, health

policy officers' views of cultural competence are both inward looking to themselves, and outward looking to their policy beneficiaries and the context surrounding their policy beneficiaries. Their grasp of this concept shows that they understand the importance of questioning their own assumptions and considering other points of view in order to ensure health policy is meaningful for people from different cultures and contexts. Their insights demonstrate a critical multicultural focus, even though this is intuitive and not learned, for instance through formal education or in-house awareness programs.

Training within health bureaucracies in both countries and at both levels of government is patchy. The most obvious training focusses on Indigenous populations only, and the availability and uptake of this, and more general training, is not guaranteed. This presents a difficulty for health policy officers who are required to demonstrate skills to carry out their functions but seem to receive little help to achieve those skills.

Australian and Canadian health authorities at both levels of government rely on internal staff as both educators and reviewers of policy material. This action feeds the assumption that one person can know everything about a particular cultural group and exposes an agency to the potential for error or inequitable health policy. Similarly, both Australian and Canadian State/Provincial health authorities draw on members of the community to provide local knowledge. There is a risk in this approach of placing the person consulted in the position of expert, something which cannot be guaranteed given the potential for intra-group difference.

With the exception of the Canadian Constitution, none of the existing policy frameworks which address cultural competence or cultural diversity were referenced either by the Australian or Canadian health policy officers who participated in this research, suggesting that the written policies play little part in their everyday responsibilities. In addition, the language of cultural competence conjures up images of Indigenous communities to the exclusion of CALD communities. It seems appropriate to dispense with the word 'culture' in this situation in favour of a focus on the context surrounding the individual health policy beneficiary.

Similarly, the language of competence implies the ability to attain a skill, to demonstrate that skill, and be measured against performance criteria. As culture is a changeable concept influenced by many things including time and environment, it is misleading to

suggest that a person can become competent in culture. It is appropriate to dispense with the word 'competence' in this context and replace it with a focus on sensitivity. I conclude that the term 'cultural competence' is unhelpful and should be replaced by the term 'contextual sensitivity' in order to focus on the individual as a whole person rather than an ethnicity.

Contextual sensitivity puts the onus on both the health authority and the health policy officer to be conscious of context, not only the current context within which health policy beneficiaries live but also past context which has shaped their experiences of health and government. Contextual sensitivity demands consideration of the ways in which CALD citizens are labelled and disadvantaged by the dominant health system. This is a key part of a critical multicultural framework.

In the next chapter I will examine government policy on multiculturalism, commenting on the perspective taken, health policy officers' understandings and actions, and the potential for application of contextual sensitivity.

Chapter 5 Contextual sensitivity in multicultural societies: prospects and challenges for health policy development

> "If multiculturalism is implemented as "food and festivals", it may seem like we are embracing multiculturalism, but what do we do when the ethnic buffet or cultural lesson is finished? What has anyone really learned about each other's cultural and structural realities? What, if anything has changed in terms of societal power relations?" (Plaut, 2010, p89).

This chapter commences with a short history of migration to Australia and Canada as a means of introducing multiculturalism as government policy. I will then give an overview of multiculturalism, introducing three perspectives on the concept. I argue that two of these perspectives reflect a multiculturalism built on the generally held notion of culture "as a catalogue of ideas and practices" (Baumann, 1999, p25) that are said to define cultural groups in which "cultural, religious and ethnic diversity" are seen as synonymous (Hindess, 2008, p85). I will also argue that these perspectives perpetuate a majority White, Western position thus creating minorities as Other. The third perspective, critical multiculturalism, seeks to overcome these criticisms by focusing on structures and relationships within a more fluid and changeable notion of culture.

The majority of this chapter examines findings from my document review of policy frameworks for multiculturalism in both Australia and Canada, at both levels of government and within health authorities. I will comment on which of the three perspectives of multiculturalism each jurisdiction and health authority takes. Of necessity my document review will address the presence or absence of strategies for 'cultural competence' because this is the term used in government. However, I will relate my findings to my preferred approach of contextual sensitivity. Insights from health policy officers will be used to illustrate discussion where appropriate.

5.1   Immigration – the growth of diversity

Population diversity is a direct result of the effects of migration upon a receiving country. Migration law specifies who is 'in' and who is 'out' by categorising people into those permitted to enter and those who are not, thus separating "outsiders" from those who are acceptable to the national image (Dauvergne, 1999, p38). Immigration is a balancing act for both the receiving country and the immigrant. For the immigrant, learning what is expected of them and making sense of a new country means measuring up to expectations that have been set by the dominant culture (Kymlicka, 1995; Li, 2003; Chandra, 2012). For the receiving country, decisions must be made about whether to affirm the dominant culture in its position or embrace pluralism through public policy such as multiculturalism (Scheffler, 2007). The governments of Australia and Canada have responded through policies of multiculturalism which I will now review in brief.

5.1.1 Multicultural Australia

Initially, Australia managed cultural diversity by excluding people from countries that did not fit the British ideal – this discriminatory White Australia Policy was made possible by the *Immigration Restriction Act 1901* (Levey, 2008b) which has been described as an expression of isolationism brought about by fear "of cultural transformation" (Kukathas, 2008, p31).

After World War II, restrictions were lifted somewhat to enable resettlement of refugees, notably Eastern Europeans who had the outward appearance of the British.   These immigrants were expected to assimilate into Australian society by taking on the English language and Australian cultural norms, that is "Anglo-conformity" (Levey, 2008b, p4; Kukathas, 2008). At the same time, the government was justifying the need for a larger population and "a stronger manufacturing sector to safeguard national sovereignty." (Vasta, 2006, p19). To respond to this need, post-war migration not only targeted traditional Britain, but expanded to include migrants from the Baltic and Slavic countries, Germany, The Netherlands and Scandinavia (Vasta, 2006). In the 1950s and 1960s migrants were increasingly drawn from Southern Europe.

The White Australia Policy was abandoned in the 1970s, at a time when Australia's approach to immigration was affected by events elsewhere in the world. Noteworthy amongst these influences were Britain's entry into the European Union and resulting

closer ties to Europe, and the growth in numbers of Vietnamese refugees for whom Australia was an attractive destination (Mann, 2012). In the 1970s and 1980s successive Australian governments used increased immigration as a population building tool to drive economic growth (Inglis et al., 1994), a policy which "assumed much greater importance" in the early 2000s because of the need for skilled workers (Jupp, 2007, p198). Over this time, the country of origin of those skilled migrants shifted dramatically from Britain and Europe to Asia, Africa, Latin America and the Pacific (Markus et al., 2009). In parallel, in 1989 there were amendments to other categories of entry such as eligibility for temporary visas and, in 1991, eligibility for humanitarian entry was re-defined in efforts to reduce the number of people arriving via these means (Birrell, 1994).

In the 1990s, skilled migrants became the focus of government programs, at the expense of family reunions, but immigration levels remained high (Pietsch, 2013). This focus has continued although the way in which the program is managed has changed. For example, since 2009 more emphasis has been given to migrants sponsored by employers and, in 2010, the list of occupations in high demand and critical skills lists were withdrawn in favour of a new Skilled Occupations List (Spinks, 2010).

In the wake of terrorist attacks on the World Trade Centre in New York in 2001 and the 2002 bombings in Bali, a popular Australian holiday destination, the Australian Government introduced new approaches to the management of asylum seekers. Those restrictions were particularly aimed at refugees and asylum seekers, notably those arriving by boat from Indonesia, undocumented. The Pacific Solution introduced detention on Pacific Islands. The exclusion of certain islands from Australia's migration zone further isolated asylum seekers from Australian migration processes (Pietsch, 2013). Together these policies slowed the number of asylum seekers in Australia.

According to one author, immigration policy had become entangled with terrorism, in part due to the numbers of Middle Eastern and Afghani people attempting to travel to Australia to escape war in their home countries and, in part, because of the Islamic background of the majority of those people (Hugo, 2002). Jupp agrees that immigration had become a tool for border security leading to "considerable emphasis on further immigration restrictions" (Jupp, 2007, p200).

5.1.2 The Canadian Mosaic

Initial immigration to Canada has been described as "laissez-faire" meaning that people entered Canada according to the principles of supply and demand (Li, 2003, p17). From the late nineteenth century to about 1913 immigration focussed on people who could establish farms, farm workers, and domestic servants from Britain, the USA and Eastern Europe (Green and Green, 2004). The list of preferred and non-preferred countries was somewhat expanded over the following 15 years but remained a discriminatory tool to select migrants based on country of origin (Green and Green, 2004). During the Depression years and World War II immigration was virtually halted. In the post-war years to 1960, migrants' capacity to contribute economically became as important as immigration for population growth. Immigration was still selective based on country of origin, specifically, no Asians were to be allowed and assimilation into a British-based society was expected (Li, 2003; Green and Green, 2004). Triadafilos Triadafilopoulos comments that this particular period was one of tension between Canada's explicit support for international obligations to provide humanitarian relief and its exclusionary and discriminatory immigration policy (Triadafilopoulos, 2010).

As with the Australian experience, racially discriminatory immigration policy was abandoned from the late 1960s when "race-neutral admissions criteria" (Banting and Kymlicka, 2010, p49) focussing on education and occupation were put in place, and assimilation was replaced by the idea of integration with retention of ethnic culture (Li, 2003; Banting and Kymlicka, 2010). This change was enshrined in the Immigration Act 1977 (Can) which included as one of its ten objectives "recognizing the need to enrich the cultural and social fabric of Canada" (Li, 2003, p79). The change resulted in greater focus on individuals, favouring those needed to meet gaps in the labour market (Green and Green, 2004), and removal of overt discrimination against immigrants from non-traditional sources thus satisfying "political and policy requirements" (Triadafilopoulos, 2010, p184). Alan Green and David Green (2004) report that during 1974 to 1985 a new Immigration Act was introduced which, for the first time, included humanitarian immigration along with family reunion and economic growth as goals of the immigration program. At this time defined numbers of refugees were permitted entry, but this number was still counted as part of the overall immigration intake.

The period 1986 to 1993 saw a shift in policy goal to one of population growth. Employment capacity as a pre-requisite for immigration was removed and there were changes in the definition of 'family' in the context of family reunion – this latter as a result of the changes in country of origin of migrants and, therefore, definitions of what constituted an extended family. The early 1990s saw a renewed focus on economic migration and an expectation that migrants would be able to support themselves until employed, or at least not be a burden on the social welfare system. The 1992 amended Immigration Act gave the government greater control of numbers of immigrants (Green and Green, 2004).

From the 1990s, immigration has continued apace although the country of origin has shifted away from European-born to Asian- and Middle Eastern-born immigrants. In 2002 a new Immigration and Refugee Protection Act 2002 (Can) was enacted, combining admissions policy with policy to deny and deport those considered unsuitable or criminal. This was a direct result of a greater focus on national security, especially in response to acts of terrorism such as the attacks on the World Trade Centre in New York (Kelley and Trebilcock, 2010). The new Act shifted the focus on economic migrants towards highly skilled immigrants who met occupational categories most in demand. Family reunion continued to be supported provided certain conditions were met, notably provisions for financial support. It has been argued that the new Act was "the most restrictive" for 25 years (Kelley and Trebilcock, 2010, p461). Nevertheless, despite this tightening, immigration to Canada continues at high levels, balancing economic immigration and refugee intakes (Kelley and Trebilcock, 2010).

As Green and Green (2004) point out, whilst Canada has had various iterations of an Immigration Act since 1869 (amended in 1910, 1952, 1978, and 1992) in fact the Acts have all given the power for determining the detail to the administrative arm of Government through, initially, the Privy Council and later the Minister of the day. This has meant that there has been little parliamentary debate or public exposure for changes in immigration policy. Green and Green (2004) argue that this has given the Canadian government great flexibility to respond to changing economic conditions, for example halting immigration during the Great Depression.

5.2   Multiculturalism – a tool for control, democratic participation or structural equality?

In response to these histories of immigration both Australia and Canada implemented policies of multiculturalism: Canada in the early 1970s and Australia in 1978 are said to be the first countries to use the term "multiculturalism" and to enshrine this in national policy (Levey, 2008b).   However, the literature on multiculturalism has many inconsistencies which mirror the arguments of those who study the topic – those in favour and those against, those who say it coheres society, those who say it divides society – clearly multiculturalism means different things to different people (McGoldrick, 2005; Hage, 2010). George Crowder notes that there is also disagreement about what policy issue multiculturalism is intended to address and how multicultural policy should be expressed (Crowder, 2008).

I want to highlight three particular perspectives of multiculturalism, each of which has implications for health policy officers. The first is multiculturalism as policy providing a means of "managing and controlling diversity" (Gunew, 1999, p18) through a regulatory framework to achieve "meaningful cultural understanding and exchange" (Leung, 2011, p24) and the airing of claims of people from a variety of cultures (Tyrer, 2012).   The second perspective is of multiculturalism as a tool for "democratic participation by minority groups" (Gunew, 1999, p18) encompassing the promotion of "equality, justice and social solidarity based on mutual recognition and respect, intercultural dialogue and fair distribution of resources" (Kivisto, 2012, p4). The third perspective is critical multiculturalism as a way to address structural and power imbalances which entrench disadvantage, in this case disadvantage to people of culturally and linguistically diverse (CALD) backgrounds. This review enables me to propose the approach which provides the best perspective on multiculturalism for citizen engagement in health policy development.

In Chapter 3 I canvassed understandings of culture and cultural competence coming to the conclusion that culture is not fixed but fluid and relational – individuals operate in many groups, each of which has its own culture, and establish relationships with and responses to other people based on membership of those groups. This required a definition of culture that acknowledged not only the changeable nature of culture as a concept but also the way in which culture is mediated through relationships. Thus culture

is "a dynamic process of shared meanings, located in and emerging from interactions between individuals" (Carpenter-Song et al., 2007). I went on to define cultural competence in a way that embraces this definition of culture whilst highlighting the importance of awareness of both self and the way in which institutional structures impose disadvantage on those who are different. Thus, cultural competence in the health policy context is about acknowledging, respecting and valuing difference and diversity, always questioning and challenging assumptions held by individual health policy officers and the health system within which they work, in order to work effectively with people from other cultures and to remove structural barriers to equitable health policy. With this in mind, I now consider the three perspectives on multiculturalism.

5.2.1 Multiculturalism as policy for managing and controlling diversity

Bikhu Parekh and others argue that multiculturalism is a "normative response" to cultural plurality (Parekh, 1999, p27) in response to the realities of demographics (Lopez, 2000; Colic-Peisker, 2011). Writing of Canadian multiculturalism, Peter Li says it is simply an "ideological framework for interpreting cultural diversity" which "reinforced" British and French cultural dominance (Li, 2003, p135). Mitch Berbrier bluntly suggests that multiculturalism is a policy tool to ensure assimilation or integration of the ethnic, in order to defend the dominant culture and ensure anglo-conformity (Berbrier, 2004). Anne Phillips similarly argues that multiculturalism is a response to power imbalances within a society, that is, multicultural policy was invoked by the dominant majority when minority groups sought to exercise their rights to maintain cultural differences (Phillips, 2007). This approach to multiculturalism not only reinforces difference but also applies labels and stereotypes emphasising 'us' and 'them' (Kelly, 2001; Tebble, 2006; Phillips, 2007), thereby "freez[ing]" migrants in their former culture denying them the chance to change (Chan, 2003, p98). According to these authors, policies of multiculturalism are aimed squarely at managing and controlling diversity within a population.

Rather than uniting society by paying attention to what people have in common, this perspective on multiculturalism is divisive, argues Phillips, because of its focus on perceived differences (Phillips, 2007). Guiliana Prato agrees, noting that providing special rights for minorities can fuel resentment in the population at large, as well as between minority groups, essentialising and exoticizing otherness with doubtful value in terms of ending discrimination (Prato, 2009). Alkadry suggests that most liberal

governments take a pluralist integration perspective in which cultural groups are required to relate to the dominant culture, thereby allowing the dominant group opportunities to control cultural practices that it may see as illiberal (Alkadry, 2005). Similarly, he argues, services are provided to citizens in a way that is determined by the dominant group rather than according to the preferences of the individual citizen (Alkadry, 2005). The effect of the implementation of multiculturalism as a policy tool for managing and controlling diversity, according to Sneja Gunew, is maintenance of minorities in a subservient position whilst contributing to a convenient memory loss amongst the dominant majority about "colonial histories" (Gunew, 1999, p19-21). This approach, according to Peter Kurti, diminishes the national culture (Kurti, 2013).

This perspective on multiculturalism falls short of a flexible view of culture as relational and changing and does not recognise culture as anything other than ethnicity identified as comprising certain attributes. The focus on controlling difference that is the feature of this perspective does not meet governments' stated aims of engaging with all citizens in the development of health policy because this perspective is more about protecting the dominant 'us' than hearing from 'them'. Additionally, this perspective does nothing to encourage health policy officers to develop contextual sensitivity, self-awareness or even awareness of institutional structures that might impose disadvantage on CALD citizens. The result is a tendency towards a one-size-fits-all model of policy development.

5.2.2 Multiculturalism as a tool for democratic participation by minority groups

Another way to consider multiculturalism is as a tool for democratic participation by minority groups. There is some agreement that this perspective is about processes which engender and support recognition of diversity with a focus on equality, civil rights, tolerance and social harmony (Racher and Annis, 2007; Levey, 2008b; Prato, 2009). Crowder expresses this as "public recognition of the value of multiple cultural identities within the same society." (Crowder, 2008, p44). Capitman agrees that multiculturalism is "…recognizing, appreciating and respecting dimensions of diversity" (Capitman, 2002, p9). This perspective on multiculturalism should result in policies that "protect and promote" many cultures in one place (Heller, 1996, p37), accommodate "many religious and cultural expressions within a single law, language and polity" (Ata, 2005, p59), and support cultural diversity and toleration of difference (Berbrier, 2004) by focussing on

the richness that diversity brings to a society (Duncan, 1995; Longley, 1999; White, 2003).

According to Charles Taylor, an important caveat is that, in a multicultural state, no single culture should have pre-eminence (Taylor, 2012). However, this perspective continues the language of 'minority' groups which, as Mary Kalantzis argues, has two effects – firstly it implies that minorities have problems, and secondly it implies there is a 'majority' (Kalantzis, 2005). For Kalantzis, traditionally 'majority' is considered to be White, Western but, as she points out, people who appear to be White, Western do not necessarily share the same cultural background (Kalantzis, 2005) – think for instance of the English, Scottish and Welsh.   Kalantzis concludes that the 'culture' in multiculturalism ignores differences even within the White, Western label.

Parekh also argues that multiculturalism should not be about respect for, or toleration of, minorities. Instead, he argues that multiculturalism should be about dismantling the "frozen categories of majority and minority" (Parekh, 2000, piv). Parekh proposes that each culture reflects only one small part of the whole human experience and that each culture must come to know other cultures in order to understand itself. To achieve this understanding requires dialogue, in which each culture views the others as equal partners (Parekh, 2000). Christian Joppke adds to this debate by expressing what he sees as a flaw in multicultural policy, namely that demands for dominant cultures to recognise minorities are not "reciprocal" (Joppke, 2004, p242).

Others also identify the difficulties of a society fractured into majority and minority camps. Some argue that 'food and festivals' (Plaut, 2010, p89-90) or 'celebration' (Kivisto, 2012, p12) multiculturalism does not contribute sustainable knowledge to a community, whilst others note that the tendency to focus on a few "recognised" cultures leaves others sidelined (Hindess, 2008, p84).

On the surface, this perspective on multiculturalism appears to focus on recognition and valuing of diversity, offering a promise of the development of contextually sensitive health policy officers and institutions for engagement and empowerment of all citizens. However, this perspective is also deficient in that the continuing focus on minorities falls back on ethnicity as the defining feature of 'culture'. Thus, this perspective does not draw on flexible and relational definitions of culture, nor does it add any dimension of

challenge to the existing, dominant order. This perspective may appear to meet governments' aims of engaging with all citizens but does not change the rules of the game. In this environment health policy officers are not encouraged to view either themselves or CALD citizens as anything other than 'us' and 'them'.

5.2.3 Critical multiculturalism

The detail given at section 2.4 will not be repeated here. In summary, critical multiculturalism questions the way in which structures in society act to place minorities in subordination to the dominant majority by shining a light on the way meaning is given to social institutions to the advantage of some (the dominant majority) and the disadvantage of others (minorities). The perspective of critical multiculturalism emphasises the relationship between an individual and an institution, drawing attention to the ways in which institutional structures can cause, or cause more, disadvantage. The strength of this perspective is that it makes power visible.

As a policy tool, multiculturalism should seek to include, engage and empower marginalised minorities. However, the generally accepted understanding of culture upon which multicultural policy is based effectively labels difference and places minorities in a subservient position, with unequal access to power and resources and thus less ability to take advantage of the opportunities enjoyed by the dominant majority. Jeffrey Milligan argues that the operation and effect of power on the marginalised is rarely a simple "either/or" situation (Milligan, 2001, p38). Power, he says, is relative – for example white women may have less power than white men but more power than black women – but what he calls the "false generosity" of empowerment as "for their own good" does nothing to enhance equality (Milligan, 2001, p38-39). As Iris Marion Young points out, "group differentiation" is a result of "structural relations" and not because members of that group necessarily share "common attributes" (Young, 1997, p385). Critical multiculturalism provides a response to these criticisms. Critical multiculturalism does not accept that all members of society need to be formed into one common culture, noting instead that there are aspects of all cultures that are worthy of equal respect and support (Turner, 1993). Terence Turner (1993, p425) goes on to argue that political legitimacy can be achieved through a "universal right to cultural self-definition and self-production".

A critical multicultural perspective requires the health policy officer to display greater self-reflection and awareness, to be open minded to the contradictions in society, to engage in conversations with others about those contradictions, and to envision alternative policy responses. Part of the process includes a questioning of institutional processes and procedures in order to identify confining structures and processes which inhibit inclusive health policy development.

Contextual sensitivity within a critical multicultural perspective shifts the emphasis away from the individual as an ethnicity and opens the door to consideration of the individual as a member of many groups concurrently such as female, ageing, vision impaired, non-English speaking. This is a demonstration of a fluid and relational notion of culture, as well as acknowledgement of diversity and the need to challenge traditionally held assumptions. For these reasons, I propose that a critical multicultural perspective is the best perspective for a government and health authority to take. I believe that multiculturalism, when seen from the first and second perspectives, will always struggle to provide benefits to people from CALD backgrounds because of their constant need to convince the dominant majority of their (the minority's) value to society. Taking a critical multicultural approach encourages health policy makers and their institutions to challenge themselves and their assumptions, with a view to engaging with citizens of CALD backgrounds with an open mind.

In the remainder of this chapter I will discuss existing Australian and Canadian government policy at the Federal and State/Provincial levels, and within health authorities, to identify the perspective that each takes and consider the implications of this for citizen engagement for the development of health policy. The policies will be measured against the three perspectives of multiculturalism described above.

5.3 The changing face of Australian multiculturalism

Martina Boese and Melissa Phillips suggest that, in Australia, multiculturalism appeared almost by accident and only as a defensive rather than proactive response to population diversity which emerged as a result of post-War immigration programs (Boese and Phillips, 2011). As formal government policy, multiculturalism was introduced into

Australia in 1978. Initially policy sought assimilation of migrants but, following concerns that assimilation may cause more problems than it solved, policy focus shifted to integration centred on provision of services to assist migrants to settle, whilst encouraging retention of aspects of their home culture (Levey, 2008b). In May 1978, the *Report of the Review of Post-arrival Programs and Services for Migrants* provided recommendations to the Government to "encourage multiculturalism" in an environment where "every person should be able to maintain his or her culture without prejudice or disadvantage and should be encouraged to understand and embrace other cultures" (Galbally, 1978, p4). Recommendations in the report addressed language skills, welfare and employment, child care, and health services and was the precursor to the introduction of a range of migrant-related services including the national Translating and Interpreting Service, English-language classes, migrant resource centres, the multicultural Special Broadcasting Service, and the establishment of the Federation of Ethnic Communities' Councils of Australia (Galbally, 1978; Levey, 2008b).

The 1980s saw a turn away from multiculturalism-as-integration towards a focus on social justice. The Government released a new policy, *National Agenda for a Multicultural Australia*, based on the principles of maintenance of cultural identity, equal opportunity and freedom from discrimination based on culture, economic and national benefits flowing from a diverse society, and respect for "core" Australian values and institutions (Levey, 2008b, p6). Despite this apparent openness, the *National Agenda* made reference to Australia's British heritage as defining the culture of the country (Moran, 2011). The *National Agenda* was supported in part by the 1985 introduction of an Access and Equity Policy, and subsequent Access and Equity Strategy, in order to ensure equitable access to government programs and services by removing potential barriers such as language. The *Strategy* promoted consultation with communities about their needs, as well as enhanced cultural competence amongst government officials (Doyle, 1993). John Wanna and colleagues comment that this was a step forward, as earlier equity policies had only addressed internal public sector staffing issues and not relationships with the community (Wanna et al., 1992). The updated *Multicultural Access and Equity Policy* acknowledges the need for government staff to be "equipped with cultural awareness and competence skills" (Department of Social Services, 2015, p13).

Updated in 1999 (Commonwealth of Australia, 1999) and 2003 (Commonwealth of Australia, 2003) the *National Agenda* shifted emphasis to "…national identity, social cohesion, and community harmony" and acknowledged Australian multiculturalism as a "unique" approach (Levey, 2008b, p7).

Criticisms and concerns in Europe were repeated in Australia, accusing multicultural policy of encouraging separateness and discouraging integration (Kukathas, 2008; Levey, 2008b). In response, in 2006, consistent with a shift in policy emphasis towards social inclusion and citizenship and a return to core Australian values, the government dropped use of the word 'multiculturalism' (Levey, 2008b; Boese and Phillips, 2011).

The theme of social inclusion was subsequently embedded in a Social Inclusion Agenda with a view to providing equal opportunity to participate in society (Carey et al., 2012a), continuing the focus on citizenship based on strong "internal cohesion and unity" (Moran, 2011, p2167). Formal policy released in 2010 entitled *A Stronger, Fairer Australia* called for full participation in society supported by equal and respectful treatment (Silver, 2010), although this aim may not have been achieved as both Hilary Silver (2010) and Gemma Carey and colleagues (2012) note that early successes were largely infrastructure based. Silver went as far as to criticise the Australian "social inclusion rhetoric" for failing to include immigrant and ethnic groups under its umbrella (Silver, 2010, p195). According to Geoffrey Levey this policy failure was because inclusion had not been enshrined as one of the core Australian values (Levey, 2008b).

In 2011, *The People of Australia. Australia's Multicultural Policy* renewed the Government's commitment to multiculturalism and invoked four principles of valuing cultural diversity, committing to social justice and social cohesion, recognising the economic benefits of cultural diversity, and promotion of understanding and acceptance of diversity (Commonwealth of Australia, 2011). More recently, in 2017 the Government released an updated *Multicultural Statement* to "reaffirm and renew" the Government's commitment to multiculturalism (Australian Government, 2017, p15). This 2017 *Statement* articulates shared values based on respect, equality and freedom: shared values which are said to be the "cornerstone" of a "socially cohesive society" (p15). A notable inclusion in this *Statement* is comment about the safety and security of Australian

communities which, the *Statement* says, can be achieved by "focusing on what unites us" (p11).

At the Federal level, Australia does not have any specific legislation referring to multiculturalism, nor does the Australian Constitution address the issue of population diversity. Ellie Vasta is critical of Australian multiculturalism on the grounds that, not being enshrined in law, it is "fragile and open to attack" (Vasta, 2007, p17-18). This is clearly demonstrated by the way in which terminology has changed over time, although successive Australian governments have acknowledged the need to support people from CALD backgrounds, specifically in terms of access to government services. The requirement that government agencies have Multicultural Plans (see for example Department of Health, 2012a) in place is also recognition of the need to focus on CALD citizens.

It appears that throughout Australia's history of multicultural policy and the development of supporting policy tools, multiculturalism continues to be based on a definition of culture represented by a list of attributes and reflective only of ethnicity. This is reflected in statements such as

> "…multicultural policy…allows those who choose to call Australia home the right to practise and share in their cultural traditions and languages… (Commonwealth of Australia, 2011, p2)

and

> "Australian Government programs and services should be accessible…regardless of their cultural and linguistic background" (Department of Social Services, 2015, p9).

Despite changes in language to indicate a desire for justice, social cohesion and respect, there is little to suggest that multiculturalism at the Australian Federal government level is anything other than a preference for melding immigrants into the dominant (British) culture, and toleration of difference. Assimilation, cloaked as integration or social cohesion, does not permit any questioning of the status quo and therefore little opportunity on the part of policy officers to envision alternatives or options for change. Equally, without an understanding of the histories of immigrants, or indeed the history of Australia as part of the British colonial power base, there is no base for questioning institutional structures and assumptions, nor is there any overt requirement for the use of

creative imagination in developing programs to assist citizens of CALD backgrounds. Australian government policy seems to follow a perspective of multiculturalism as a means of managing and controlling diversity in which cultural competence as a required skill hardly appears.

I will now move on to examine how the Federal government commitment to multiculturalism is translated at the State government level. The next section examines multiculturalism in two Australian jurisdictions. Sections 5.4 and 5.5 will look particularly at multiculturalism in the Federal and State health sectors.

5.3.1 Australian Capital Territory (ACT) Government multicultural policy

The *ACT Multicultural Framework 2015-2020* centres on three guiding principles, namely "accessible and responsive services", "citizenship, participation and social cohesion", and "capitalising on the benefits of our cultural diversity" (ACT Community Services Directorate, nd). The *Framework* focusses on inclusion in community life "regardless of ethnicity, gender, sexuality or age" for a cohesive society in which each member "is respected, included and valued" (no pagination in original). Actions to achieve the Government's objectives address issues such as citizen awareness of, and access to, government services, participation on government committees and improved government engagement with the broader multicultural community, use of interpreters, and support for community-based activities such as food festivals. Within the *Framework* there is recognition that ACT Government staff need to understand the cultural diversity of their client groups through data collection, need to be supported to work with interpreters and with clients from CALD backgrounds, and to maintain or enhance their own language skills. Cultural competence is not specifically mentioned.

The ACT Government *Framework* indicates a perspective on multiculturalism as a tool for democratic participation, merged with the need to understand diversity through data collection in order to manage diversity.

5.3.2 Queensland Government multicultural policy

The Preamble to the *Constitution of Queensland 2001* recognises the "many backgrounds" of "our forebears" "whose efforts bequeathed to us…a realistic opportunity to strive for social harmony".

At the time of interviews, the Queensland Government policy *A Multicultural Future for all of us. Multicultural Policy 2011* (Department of Communities, 2011a) and its supporting *Queensland Multicultural Action Plan 2011-2014* (Department of Communities, 2011b) were in place. The *Policy* and *Action Plan* identify cultural competence amongst government staff as one of four core outcomes. The *Action Plan* includes attendance at cross cultural training and cultural competence training as performance indicators (p3-5). The Queensland Government *Language Services Policy*, also in place at that time, mentions the need for staff to have cross-cultural skills and the ability to work with translators (Department of Communities, 2011c, p5) as does the 2014 updated policy (Department of Aboriginal and Torres Strait Islander and Multicultural Affairs, 2014, p5).

Since the time of my interviews, the Queensland Government has reformed its approach to multiculturalism. In 2016 the Queensland Government enacted the *Multicultural Recognition Act 2016* to promote a "united, harmonious and inclusive community" in Queensland; "foster" participation of CALD citizens in all aspects of life; acknowledge the benefits to be gained from a "diverse, dynamic and cohesive society"'; and "recognises…diverse cultural heritage…to ensure government services are responsive to the needs of our multicultural communities". The Act establishes a Queensland Multicultural Charter, a Multicultural Queensland Advisory Council, requires development of a State-wide multicultural policy and action plan, and sets reporting timeframes. Importantly, section 22 of the Act requires Chief Executives to ensure that staff are aware of the Act, Charter, policy and action plan and how these relate to their work.

In 2016, in compliance with the new legislation, the Queensland Government published the *Queensland Multicultural Policy Our Story, Our Future* (Department of Communities Child Safety and Disability Services, 2016a). The policy operationalises the *Multicultural Recognition Act 2016* (Qld) by setting a "framework for achieving an inclusive, harmonious and united Queensland." (p2). The policy is organised around three policy priorities of "culturally responsive government; inclusive, harmonious and united communities; and economic opportunity" (p5). Implementation requires the development of "cultural capability" amongst government staff and service providers (p9). The policy requires government agencies named in the policy to report annually

(this includes Queensland Health and Hospital and Health Services), requires the Minister to report to parliament at least every three years, and notes a review of the *Multicultural Recognition Act 2016* after five years of operations.

The Multicultural Policy is accompanied by a *Queensland Multicultural Action Plan 2016-2017 to 2018-2019* (Department of Communities Child Safety and Disability Services, 2016b). The *Action Plan* is "not intended to reflect core business for departments but rather new and/or extended work to drive improved outcomes for culturally diverse Queenslanders" (p2). The *Action Plan* is organised along the policy and outcome priorities of the *Multicultural Recognition Act 2016* (Qld) and contains specific actions, lead agencies, and deadlines. Actions include data collection to understand cultural diversity in the community and training in cultural awareness – this latter targets Queensland Health although "training to address unconscious bias and other barriers in recruitment and selection" (p9) does not.

A further arm of Queensland multicultural policy is the *Language Services Policy* which recognises that Queenslanders should not be disadvantaged if they have limited English proficiency, and focuses on the appropriate use of interpreters (Department of Communities Child Safety and Disability Services, 2016c). The policy calls for "use of the cultural and linguistic skills of employees" in implementing language services (p5) and ensuring staff are "trained in cross-cultural skills" (p6).

The Queensland State Government has adopted the language of a perspective of multiculturalism that invites democratic participation merged with a need to understand the composition of the community in order to manage diversity.

5.4 Multiculturalism in Australian Federal health policy – Business as usual

Turning to health policy specifically, the Australian Government Department of Health is obliged to implement whole-of-government multicultural policies, and it has done this through its *Agency Multicultural Plan* which acknowledges that vulnerable groups are not limited to those of CALD backgrounds (Department of Health, 2012a). The Department does not have a specific multicultural health policy but does refer to the

culturally and linguistically diverse nature of the health policy audience in a variety of policy documents, the most overarching of which are listed in Table 1 below. Note, however, that none of these policies refer to cultural competence. In addition, specific policies such as the Mental Health Statement of Rights and Responsibilities (Department of Health, 2012b) and the National Women's Health Policy 2010 (Department of Health and Ageing, 2010) mention the need to provide culturally appropriate and sensitive services. The latter also raises the issue of cultural competence training for medical professionals.

At the Federal level, these health policies reflect a business-as-usual attitude, acknowledging that people of CALD backgrounds may need support to access services but, with the exception of the *Australian Safety and Quality Framework for Health Service Standards*, none specifically seek to empower CALD users of health services. None of the policies give any real clue as to how policy officers or service providers may enter into constructive and supportive relationships with CALD people.

Given the overarching Federal policy environment, it is not surprising that the Federal health sector reflects a managing and controlling perspective of multiculturalism which focuses on providing services to individuals who are seen as different by virtue, almost exclusively, of their ethnicity. I have noted above that individual government departments, such as the Australian Government Department of Health, must operationalise national policy for the benefit of their policy audiences. However, whilst the Federal health policies reviewed acknowledge the diversity of health consumers, there is no evidence that cultural competence is seen as a core skill to enable health policy officers to work in a diverse environment and no evidence of contextual awareness.

One telling comment was made by this health policy officer

> "I don't actually think there was actually any hard and fast rules around [CALD engagement]. No, it really was more around "make sure x percent of your budget is spent on CALD groups when you roll this out" which means you have to consider it when you are actually developing and doing your formative research..." (Participant #6, Australia, Federal)

This health policy officer was acknowledging CALD citizens as part of the policy audience but with boundaries around the nature of their involvement. Such an approach

may, albeit unwittingly, control CALD input by putting a dollar figure on the amount of time and effort that should be spent on seeking that input.

Another mentioned

> "...in our day-to-day practice we still don't do enough in relation to making sure that the cultural awareness is built into all the things we do." (Participant #2, Australia, Federal)

This comment shows that the need to address cultural issues in health is recognised but not embedded in the way business is conducted.

Australian Federal health policy officers were somewhat critical of leadership noting that cultural awareness needs to be "across the culture of the organisation" but that "hierarchy is built on seniority where generally the people who are most resistant are at the top and most built on the culture of sometime before" (Participant #2, Australia, Federal). This comment is hinting that some current senior officers are not sufficiently open to the idea of cultural awareness, largely because of their own past history. This is a perceptive insight into the nature of hierarchies in public administration and one that demonstrates a critical multicultural perspective.

Through their comments, Australian Federal health policy officers demonstrated that the existing policy frameworks are not at the forefront of their minds when it comes to considering multicultural issues in health policy development. Despite the personal insights, their everyday approach to multiculturalism is very much one of managing and controlling diversity, in the first instance by putting dollar boundaries around activities and in the second by inaction. Their responses are not greatly surprising in the face of policy frameworks that make little mention of the need to think specifically about communication with citizens of CALD backgrounds.

Table 1: Australian Government Health Department policies relevant to multiculturalism and cultural competence

Title	Date/Author	Key features
Agency Multicultural Plan 2013-2015 (Department of Health, 2012a)	2013 Department of Health	Required by whole-of-government policy. This plan is to ensure that the "needs of culturally and linguistically diverse communities are considered" in the Department's work. Throughout the Plan actions are intended "to maximise access to health services by those that need them", noting that this includes other vulnerable groups as well as people from culturally and linguistically diverse backgrounds.
Australian Charter of Healthcare Rights (Australian Commission on Safety and Quality in Health Care, Endorsed 2008)	2008 Australian Commission on Safety and Quality in Health Care	Includes "respect, dignity and consideration" for "my culture, beliefs, values and personal characteristics".
Australian Safety and Quality Framework for Healthcare (Australian Commission on Safety and Quality in Health Care, 2010)	2010 Australian Commission on Safety and Quality in Health Care	Recognises that healthcare providers should "provide care that respects and is sensitive to different cultures".
National Safety and Quality Health Service Standards, September 2012 (Australian Commission on Safety and Quality in Health Care, 2011)	2011 Australian Commission on Safety and Quality in Health Care	Refers to the *Australian Charter of Healthcare Rights* when discussing patient rights and engagement and includes reference to "governance partnerships which are reflective of the diverse range of backgrounds in the population served by the health service organisation…"

5.5   Australian State multicultural health policy – Democratic participation please

The picture at the State level in Australia is different. My research identified a number of structures that should support consideration of CALD issues in health policy. In this section I will describe these structures in the ACT and Queensland and comment on health policy officers' experiences of working within these structures.

First to the ACT where, in 2013 and following a review of the former Migrant Health Unit, a new Multicultural Health Policy Unit (MCHPU) came into effect with the task of coordinating the ACT Health Directorate's approach to multicultural health "…so that culturally and linguistically appropriate services and information are a focus not only in clinical areas but across the organisation…" (ACT Health Directorate, 2014, p10).

One of its early tasks was to develop *Towards culturally appropriate and inclusive services. A co-ordinating framework for ACT Health 2014-2018* (ACT Health Directorate, 2014) as the Health Directorate's response to the ACT Government multicultural strategy. Built around the characteristics of a culturally competent health service, the *Co-ordinating Framework* addresses understanding the needs of culturally and linguistically diverse people, providing accessible and culturally appropriate services, facilitating participation by people from CALD backgrounds in health service planning and delivery, and maintaining "linguistic and cultural competency" amongst health service staff (p3).

The *Coordinating Framework* commits the Health Directorate to ensuring that its resource allocations "will not raise further barriers to access and equity", and that culturally appropriate services will recognise "diversity within diversity" and treat people as individuals (p16). Seven "key focus areas" detail specific actions under the broad headings of leadership, understanding the health needs of the CALD community, data collection, accessible and culturally appropriate services, participation by CALD people in service planning and improvement, linguistic and cultural competence of the ACT health workforce, and collaboration with other agencies to improve multicultural health. One of the strengths of the *Co-ordinating Framework* is its direct links to the ACT Health Directorate Corporate Plan and annual business plans through the requirement that they include explicit statements relating to implementation of the *Co-ordinating Framework*.

At the time of interviews for this research, the MCHPU was still in its infancy although health policy officers were well aware of its existence and potential role. Whilst the newness of the MCHPU meant there was some uncertainty about the detail of the Unit's work, policy officers spoke highly of the leader of the Unit and the policy intent behind its establishment. At the time of interviews, the *Coordinating Framework* was under development and therefore it is not surprising that it was not mentioned by health policy officers.

The ACT Health Directorate exhibits a perspective on multiculturalism of democratic participation. The new *Coordinating Framework* suggests steps towards a critical multicultural perspective particularly as it refers to the removal of barriers to access. Time will tell whether the promise in the *Coordinating Framework* is realised. Recently Daniel Coase, Senior Manager, Policy and Stakeholder Relations at ACT Health advised by email that the ACT Health Directorate has renamed the MCHPU the Multicultural and Diversity Health Policy Unit "with an additional focus on LGBTI people and people with disabilities, noting that these groups may often overlap" (2017, 15 March).

Turning now to Queensland Health, I note that the Department does not appear to have updated any of its multicultural health policies in light of the *Multicultural Recognition Act 2016* (Qld) and associated Charter and policies. Nor is there any advice on the website to suggest this may be a work-in-progress. My assessment of the Department's multicultural commitments is therefore based on existing policies. The Department's *Strategic Plan for Multicultural Health* (Queensland Health, 2007) appears to be the most current, and aligns Queensland Health activities with the four strategic directions of the previous Queensland Government Multicultural Policy. More recently, detailed implementation assistance has been provided to Queensland Health staff through three key documents set out in Table 2.

Queensland Health disbanded its Multicultural Health Unit a few years ago, resulting in a reported lack of focus for multicultural health activities. Individual Hospital and Health Services, such as the Metro South Hospital and Health Service, must develop their own policies. David Eastgate, Director of the Health Equity and Access Unit at Metro South Health, confirmed by email that Metro South Health is in the process of developing a multicultural health plan which is likely to include actions to improve cultural awareness

(2017, 7 February). In the meantime, Mr Eastgate advised, the role descriptions for all staff state "Ensure patients and other staff are treated fairly and with mutual respect and understanding, regardless of cultural, religious, ethnic and linguistic backgrounds." (2017, 7 February).

Despite the apparent effort by Queensland Health to develop detailed policies and frameworks, none of the Queensland research participants mentioned either the State-wide or Queensland Health policies or frameworks.

Queensland Health identifies the need for cultural competence as a skill staff should attain in order to develop policy appropriate to CALD clients. Despite the publicly available Queensland Health *Cross-Cultural Learning and Development Strategy*, responses from research participants did not indicate any awareness of this *Strategy*, nor any particular support from Queensland Health towards cross-cultural skill development.

At least on paper, Queensland Health articulates a need for multicultural awareness and the development of skills to support working within a multicultural community. That this does not appear to have filtered down to policy officer level could be for any number of reasons ranging from disbanding the Multicultural Health Unit, lack of resources, commitment to other priorities, or even lost in devolution.

Queensland Health policies, including staff learning and development policies, suggest that the Department is keen to continue a perspective of multiculturalism as a tool for democratic participation. However, the lack of centralised guidance means that each Unit of the Department and each Hospital and Health Service will now need to determine their own route to implementation. This is likely to result in different responses and potentially different support for both health policy officers and citizens of CALD backgrounds. Whether the attainment of cultural competence can flourish in this environment remains to be seen.

Table 2: Queensland Health Department policies relevant to multiculturalism and cultural competence

Title	Date/Author	Key features
Guideline for Multicultural Health Policy Implementation (Queensland Health, 2012b)	2012 Queensland Health	Sets the context, lists the key outcome areas and a glossary of terms, and sets out related legislation and policies.
Guide to Implementing the Queensland Multicultural Health Policy 2011 and Language Services Policy in a health context Attachment A (to the *Guideline*) (Queensland Health, nd)	Not dated Queensland Health	To assist "planning, delivery and evaluation of health services for a culturally and linguistically diverse community." (p3). Mirrors Queensland Health Organisational Cultural Competency Framework and contains action items, strategies and reporting requirements.
Literature Review. Best practice multicultural policy implementation (Queensland Health, 2012a)	2012 Queensland Health	Evidence base for the Department's implementation guide. Published as Attachment B to the *Guideline*.
Cross-Cultural Learning and Development Strategy (Queensland Health, 2010a)	2010 Queensland Health	Defines cultural competence as individual and organisational comprising awareness and behaviours for effective cross-cultural interactions. Establishes five cultural capabilities required by all staff. Focusses on building workforce capacity and integrating training into all programs.

How do ACT and Queensland health policy officers experience working in these democratically hopeful environments? Health policy officers recognised the need for health authorities to develop their own guidance for staff to assist implementation of State-wide multicultural policy

> "…it's envisaged that through that Unit, and the framework that they're developing, that I'm hoping that there will be improved mechanisms for us to connect better with CALD communities with regard to any of our strategies and plans that we go forward with." (Participant #1, Australia, State)

This comment shows that at least one health authority has established a mechanism to provide guidance, even though the possible outcomes were not yet known. Another also acknowledged efforts to improve implementation of multicultural policy

> "I think that this organisation has somehow recognised that responding to women and families of CALD background is more than providing an interpreter." (Participant #3, Australia, State)

Both of these comments illustrate that, at the Australian State level, thought is being given to the way in which multicultural policy is implemented. Nevertheless, I was also informed that the health policy development process lacked prompts to generate consideration of CALD issues as distinct, say, from gender issues which are routinely included "there's not a multicultural section" (Participant #3, Australia, State).

Some health policy officers felt that there was a lack of emphasis on understanding diversity in the policy community and more effort was needed to "…invest in understanding the people [ie the community]…" (Participant #4, Australia, State) in order to be able to deliver appropriate policy, and some cast doubt on the competence of their leadership team

> "…the people upstairs aren't nearly as culturally safe or aware or competent in safety and awareness…so policies or resources…are not developed with consultation with the communities that they're addressing." (Participant #5, Australia, State)

These comments suggest that policy officers are struggling to develop health policy for a diverse community because of a lack of knowledge of that community and a lack of leadership support. This latter criticism was also found at the Australian Federal health level.

Although they did not talk about a policy framework, Australian State health policy officers seem to be expressing a frustration that organisational expectations do not match the support that flows down to them to meet those expectations. Their comments indicate the potential for duplication of effort and lack of cross-fertilisation of ideas, as well as impoverished policy development procedures and, sometimes, leadership practices. There is no focus on skill development in the acknowledged diverse environments, and no encouragement to question structures including processes and procedures that might exclude CALD citizens. The promise that is held out through dedicated policy units, legislation, and State-wide guidance documents does not appear to be met other than by exception at the agency level although I should add a caveat here – the *Multicultural Recognition Act 2016* (Qld) is very new and certainly did not exist at the time I conducted interviews with health policy officers.

In Chapter 6 I will discuss whether and how multicultural policy frameworks enable Australian State health policy officers to engage with CALD citizens.

5.6   Multiculturalism in Canada – A different approach

In summarising the history of multicultural policies in Canada, Leung suggests there have been three distinct phases, namely, the celebration of cultural differences of the 1970s, accommodation of ethnically diverse people by emphasis on equity of the 1980s, followed by the 1990s focus on inclusion through participation and citizenship as nation building (Leung, 2011). Canadian multicultural policy has even earlier foundations beginning in 1963 when the Canadian Government established a Royal Commission on Bilingualism and Biculturalism. The Royal Commission's task was to review the relationship between the two "founding partners" (Yalden, 2011, p6) of Canada – the British and French – in view of the nervousness of French citizens that they would lose their language and unique identity in the face of increasing immigration (Wood and Gilbert, 2005).

At the same time, growing disquiet amongst some ethnic minorities about their relationship to a bi-lingual and bi-cultural Canada forced the Commission to broaden its consideration of societal relationships (Wood and Gilbert, 2005; Dewing, 2013). Book

Four of the Royal Commission addressed the contribution to society made by ethnic groups that were not British, French or Aboriginal (Dewing, 2013). This led directly to the introduction of Canada's first explicit Multiculturalism Policy, in 1971, in an attempt to break the perception that a bi-cultural Canada meant that immigrants from non-traditional countries fell somewhere lower in the social hierarchy.

The 1971 Trudeau Declaration specifically expressed support for the full inclusion of all immigrants in Canadian society, regardless of their country of origin, and scotched the view that two official languages was akin to two official cultures (Wood and Gilbert, 2005; Banting and Kymlicka, 2010; Yalden, 2011). The Policy was supported through the establishment, in 1972, of a Multicultural Directorate, and funding for programs to meet the objectives of the Policy, within the Department of Secretary of State. A Ministry of Multiculturalism was established in 1973 to ensure implementation of initiatives across government and to make connections with the community through formal government bodies such as the Canadian Consultative Council on Multiculturalism (Dewing, 2013).

Multiculturalism policy was given greater strength through enactment of The Constitution Act 1982 (Can) in which section 27 calls for "the preservation and enhancement of the multicultural heritage of Canadians".

A Special Parliamentary Committee on Visible Minorities reported in 1984, leading directly to an updated Multicultural Policy and a Canadian Multiculturalism Act 1988 (Can) (Dewing, 2013). This legislation confirmed Federal government "recognition and accommodation" of immigrants and the removal of barriers to full participation in Canadian society (Banting and Kymlicka, 2010, p50). Notably, the Act sought to create change at the institutional level by expecting all government departments to pay attention to the removal of racism and discrimination, and to recognise the importance of "cultural understanding and awareness" (Dewing, 2013, p4-5). Key Canadian Federal legislation and policies are listed below at Table 3.

In 2008, responsibility for multiculturalism was transferred to the Department of Citizenship and Immigration and the Minister's title was amended to Citizenship, Immigration and Multiculturalism. The multiculturalism program was updated to focus on integration of new Canadians, support for at-risk youth from culturally diverse backgrounds, and promotion of intercultural understanding and Canadian values

(Dewing, 2013). The program was again updated in 2010 to reflect new objectives of building social cohesion, improving institutional responsiveness, and connecting with the international community to discuss multiculturalism and diversity (Dewing, 2013). Federal government focus on the multicultural program was more recently demonstrated through a 2012 review of the program, which acknowledged that it would be difficult to achieve all the desired objectives with the funding available. Michael Dewing reports that greater clarity around objectives and "desired outcomes" is expected with the release of an updated policy (Dewing, 2013, p8). At the time of writing this thesis, the timeline of national policy initiatives has not been updated since 2008 (Government of Canada, 2008), and the web-based description of Canadian multiculturalism has not been updated since 2012 (Government of Canada, 2012a). However, links to individual initiatives such as Black History Month are more up to date (Government of Canada, 2017c). Nevertheless, there does not appear to be a written policy of multiculturalism as such.

My assessment of Canadian multicultural policy is that there has been a shift from a perspective of manage and control to a perspective of democratic participation. This is reflected in the transition from assimilation to social cohesion, as in Australia, and the presence of legislation and Constitutional references to accommodation which indicate a mind-set that has recognised the importance of democratic participation. There is some agreement that "constitutionalised practices of accommodation" and recognition of the "centrality of diversity to Canadian identity" (Kymlicka, 2010, p16-17) has helped not only to enshrine the importance of diversity but also to socialise "the community towards accommodating diversity" (Vasta, 2007, p17). Nevertheless, culture is very much linked to ethnicity although there is recognition that all Canadians have responsibility for social cohesion. On the down-side, none of the legislation or policies mentioned speak of cultural competence explicitly, and the *Values and Ethics Code for the Public Sector* (Treasury Board of Canada, 2011) does not move beyond respectful behaviour.

Although the Canadian Multiculturalism Act 1988 (Can) is Federal legislation, supported by the establishment of a government department and funding programs, the Provinces and Territories, and in some cases municipal councils, established similar policies thus ensuring the spread of the multicultural ideal (Banting and Kymlicka, 2010). Six Provinces have enacted multicultural legislation, two Provinces have formal policies, and the remaining two Provinces have a multicultural advisory structure within government.

The two Territories have neither legislation nor formal policies but do have human rights legislation that prohibits discrimination on the grounds of race and ethnicity amongst other things (Dewing, 2013).

Moving on, I will now review the British Columbia and Ontario Provincial policies of multiculturalism before turning to look at how these are implemented at the health agency level.

Table 3: Canadian Government legislation and policies relevant to multiculturalism and cultural competence

Title	Date/Author	Key Features
Official Languages Act (accessed 17 March 2017)	1969 and updates	Ensures that both English-speaking and French-speaking Canadians have language equality regardless of "their ethnic origins or first language learned" including access to government services in their language of choice.
The Constitution Act 1982	1982 Government of Canada	s27 stipulates support for "the preservation and enhancement of the multicultural heritage of Canadians".
Canadian Multiculturalism Act 1988	1988 Government of Canada	Enshrines "preservation and enhancement" of multiculturalism through recognition and promotion of multiculturalism, freedom of citizens to maintain their cultural heritage, equal participation in society by all citizens, equal freedom and protection under the law, and elimination of barriers to participation (ss3(1)); requires all government institutions to treat all citizens equally, ensure access to programs (ss3(2)), and to "promote policies, programs and practices that enhance the understanding of and respect for the diversity of the members of Canadian society."(ss3(2)(c)).
Annual Report on the Operation of the Canadian Multiculturalism Act - 2014-2015 – Building a diverse and inclusive society Canada (Minister of Immigration Refugees and Citizenship, 2016)	2016 Department of Citizenship and Immigration	The objectives of the program are to fund community groups and outreach programs, support government departments to meet obligations under the Multiculturalism Act and manage international obligations. No detail is provided about how other departments are supported either here or on the responsible department's website.
Values and Ethics Code for the Public Sector (Treasury Board of Canada, 2011)	2011 Treasury Board of Canada Secretariat	Value of "Respect for People" underpinned by behaviour that treats "every person with respect and fairness", values diversity, and encourages "respectful communication" and engagement.

5.6.1 British Columbia (BC) Government multicultural policy

Through a mix of legislation and policy statements, BC Province-wide multicultural policy speaks of anti-racism and diversity awareness, often in language that is more about integration and economic advantage than engagement. None of the statements address cultural competence as a skill set.

Although the BC Government acknowledges that "cultural diversity and increased participation and engagement by all cultures is vitally important" the focus is largely on economic growth in the Province (BC Government, nd-d). Incongruously, responsibility for multicultural policy falls within the purview of the Provincial Minister of International Trade whose second title is that of Minister Responsible for Asia Pacific Strategy and Multiculturalism. The Ministry's most recent Service Plan (Ministry of International Trade and Minister Responsible for Asia Pacific Strategy and Multiculturalism, 2017) has little focus on inclusion, rather giving attention to anti-racism and combatting hatred in the community.

Table 4 sets out key legislation and policies which guide the actions of policy officers in BC.

It is hard to determine what perspective on multiculturalism the BC Government takes. The strong economic focus could be seen as either inclusion in the community for the economic benefit of all, or concentration on managing numbers in order to direct migrants to specific industries. There is no discussion about inclusion of CALD citizens on the Multiculturalism website.   Health policy officers would find little guidance in these policies given the business focus.

Table 4: British Columbia Provincial Government legislation and policies relevant to multiculturalism and cultural competence

Title	Date/Author	Key features
Multiculturalism Act	1993 Government of BC	Makes clear the importance of recognising "diversity…as regards race, cultural heritage…ethnicity, ancestry and place of origin" as "a fundamental characteristic" of British Columbia; and that this "multicultural heritage" should be respected, "cross cultural understanding and respect" should be promoted, and full participation in BC life fostered.
Ministry of International Trade and Minister Responsible for Asia Pacific Strategy and Multiculturalism Ministry Service Plan 2015/16 to 2017/18 (Ministry of International Trade and Minister Responsible for Asia Pacific Strategy and Multiculturalism, 2015)	2015 Ministry of International Trade	Affirms the value of a culturally diverse population in social and economic terms and commits to a "global, multicultural perspective" for the "integration of newcomers" and to "challenge barriers to inclusivity" (p6-7). Strategies to meet the Ministry's goals include capacity building in cultural diversity, anti-racism and inclusivity; sharing best practice across businesses; public education to promote diversity awareness; linking multicultural festivals to trade opportunities; and supporting "locally-led anti-racism and multiculturalism projects" (p12).
Ministry of International Trade and Minister Responsible for Asia Pacific Strategy and Multiculturalism Ministry Service Plan 2017/18 to 2019/20 (Ministry of International Trade and Minister Responsible for Asia Pacific Strategy and Multiculturalism, 2017)	2017 Ministry of International Trade	Part of the strategic context is to "promote diversity and multicultural programs" (p7). Strategies to achieve the Ministry's goals include capacity building in the community to support "multiculturalism, anti-racism and cultural diversity"; implementation of Provincial multiculturalism legislation; supporting the Multicultural Advisory Council in public engagement activities; anti-racism activities; promoting cultural awareness; and managing the Chinese Legacy project (12-13).

5.6.2 Ontario Government multicultural policy

The Province of Ontario does not have an overarching policy on multiculturalism. Deborah Sattler, Team Manager, Implementation Branch, Ministry of Health and Long-Term Care, confirmed by email that the term "multiculturalism" is not used in the public sector where equity, diversity and inclusiveness are the preferred terminology (2015, 16 January). This is demonstrated in the Ministry of Citizenship and Culture Act 1990 (Ont) which includes amongst its objectives the "full, equal and responsible citizenship" and participation of residents of Ontario, and the protection, expression and sharing of the diverse cultural heritage enjoyed by citizens.

Diversity is the responsibility of the Office of Diversity and is captured in a three-year Diversity Plan *Inclusion Now! OPS Inclusion Strategic Plan 2013-2016* which shifts the focus from "the 'why' of diversity to the 'how' of inclusion" (Ontario Public Service Diversity Office, 2013, p8). *Inclusion Now!* commits to embedding inclusion into all "policies, programs and services" ensuring a workforce that not only reflects the diversity of the Ontario population but is able to "respond to the needs" of that diverse population (p22). "Behavioural and cultural transformation" is to be achieved through a mix of diversity training, mentoring, and provision of tools to assist policy development (p15). Diversity in *Inclusion Now!* focusses on providing OPS employees with an inclusive and respectful workplace which, although cultural background is alluded to, limits its reach to access by people with a disability. Although acknowledging diversity amongst its population, and seeking behavioural and cultural transformation, there is no guidance about achieving this objective and no official statement on cultural competence as a skill.

It is hard to categorise the Government's stance on multiculturalism based on this policy framework. On the one hand, reference to cultural transformation suggests a willingness to open government processes to question thereby indicating a step towards a critical multicultural perspective. On the other hand, the limited focus on diversity as disability amongst OPS employees does not acknowledge broader aspects of diversity. It may be that the supporting training, mentoring and tools mentioned in *Inclusion Now!* are more forthcoming in this regard. However, these are not publicly available for review.

Health policy officers at both levels of government in Canada were very familiar with the requirements of the Canadian Constitution and were equally knowledgeable about

mandatory consultation with Aboriginal People. Perhaps because of the lack of Province-wide policy on multiculturalism, health policy officers did not identify multiculturalism as a policy imperative

> "Everybody doesn't have to understand everything about everything…but I think policy has to leave scope for how it gets translated, adapted and applied in different cultural contexts and different circumstances." (Participant #10, Canada, Provincial)

This comment, which was offered in what seemed to me to be a somewhat defensive tone, gives the view that those who *implement* health policy are the people who should be aware of cultural diversity rather than those who *develop* health policy. It is possible that my questioning made this health policy officer a little uncomfortable about her own lack of knowledge. If this was the case, then it was interesting to hear another Canadian health policy officer give an opposing view, showing awareness of the need to consider diversity as well as the potential for bias created by an individual's own history

> "The biggest part of it is just understanding that you apply a lens that may not be the same as the person you're speaking with." (Participant #9, Canada, Provincial)

This health policy officer has internalised the need to consider CALD citizens but, given the nature of existing policy documents, seems to have achieved this without any apparent leadership from the Provincial Government. In the next two sections I look in more detail at multiculturalism in the Canadian health sector.

5.7   Multiculturalism in Canadian Federal health policy – A growing awareness

As in Australia, departments of state are expected to implement Federal policy. However, at the Canadian Federal health level, despite the presence of Constitutional and other statutory requirements for the recognition of diversity, this has not been picked up in the health sector. Health Canada does not have a multicultural health policy. The Public Health Agency of Canada (PHAC) does not have a specific multicultural health policy but does set out core competencies for staff which include the need for skills to support interactions with people from culturally and linguistically diverse backgrounds. For example, the *Core Competencies for Public Health in Canada Release 1.0* (Public

Health Agency of Canada, 2008) includes as values "…a commitment to equity, social justice…respect for diversity…empowerment and community participation" (p3). *Core Competency 5 Diversity and Inclusiveness* relates to interactions with "diverse individuals, groups and communities" (p5) where diversity is defined as "The demographic characteristic of populations attributable to perceptible ethnic, linguistic, cultural, visible or social variation among groups of individuals in the general population" (p10). The competency statements acknowledge the role of culture as a determinant of health, require consideration of diversity in service planning and delivery, and require "culturally relevant and appropriate approaches" when interacting with people from CALD backgrounds (p21).

The Federal health level in Canada presents a mixed picture. The lack of multicultural health policy is made up for by the PHAC in its core competencies. This document presents a perspective of democratic participation based on a definition of diversity that goes beyond ethnicity. Further, it could be inferred from reference to "culturally relevant and appropriate approaches" that health policy officers are encouraged to question how business is done in order to find creative solutions of relevance to CALD citizens. I cannot clearly say this is a critical multicultural approach, but it could be a step in that direction.

Individual Canadian Federal health policy officers interviewed for this research did not mention any of the policy frameworks, or indeed the core competencies, but did demonstrate personal awareness of CALD citizens' growing influence in the community. For example

> "We are now seeing generations of immigrants who are becoming part of the cultural fabric that we need to also try to look at…how does that change the way we communicate or how does that change the way we potentially develop policies or develop programmes? I think it's quite important." (Participant #11, Canada, Federal)

This comment displays a willingness to question internal processes and procedures and consider their impact on CALD citizens. Complementary to this is the need for individual health policy officers to be aware of the broader policy development environment

> "…we also need to ensure that employees…have a heightened awareness and potentially develop more sensitivity to this." (Participant #11, Canada, Federal)

This health policy officer is demonstrating a shift in thinking away from cultural competence to contextual sensitivity. In the next section I will consider the perspective taken by Provincial health authorities and their policy officers.

5.8 Canadian Provincial multicultural health policy – Appreciation of difference

Canadian Provincial government health policies addressing multicultural health vary across jurisdictions. In the absence of a specific BC Ministry of Health multicultural health policy, other policies were reviewed to assess their contribution to multicultural health, and the skills required to engage with CALD communities. The BC *Ministry of Health Service Plan 2015/16 to 2017/18* does not specifically mention people from CALD backgrounds as a priority population, nor does it refer to health inequalities as a result of cultural issues other than in the context of First Nations' health (Ministry of Health, 2015). However, two other policies *A Framework for Core Functions in Public Health. Resource Document* (Ministry of Health Services, 2005) and *Promote, Protect, Prevent: Our Health Begins Here. BC's Guiding Framework for Public Health, a ten-year strategic framework* (Ministry of Health, 2013) acknowledge the role that culture can play as a health determinant, and the need to provide culturally appropriate health services including for "ethno-cultural communities and people of colour" (Ministry of Health Services, 2005, p49). The *Framework for Core Functions in Public Health* notes the need for "Public Health Professionals" to have the skill of "cultural competency" (Ministry of Health Services, 2005, p103).

It is hard to say that the Ministry's perspective on multiculturalism is little more than a policy for managing and controlling diversity. On the surface, it appears that BC health policy officers need to rely on themselves to consider the issues of a diverse policy audience, thereby hampering their ability to question institutional structures, argue for change and develop creative health policy solutions. This is a contrast to my finding that all BC health policy officers interviewed were keenly aware of the cultural diversity within the Province, and expressed strong commitments to meeting the needs of the diverse population. This perspective was unexpected given the Ministry's Service Plan only discusses culture in terms of First Nations' people.

Despite the small amount of policy guidance, the BC Health Ministry organisational culture as described by health policy officers seems to be strongly oriented to multiculturalism as a tool for democratic participation. In part this can be explained by the Ministry's commitment to Indigenous Cultural Competence training which, although focussed on Aboriginal histories, has a broader pay off in terms of a staff member's awareness of her own histories and assumptions (discussed in more detail at Chapter 4). In part the organisational culture can be explained by the leadership given to staff, from the Minister down, which requires citizen engagement in the development of policy solutions (evidence and examples are discussed further at Chapter 6).

To Ontario, where the Ministry of Health and Long-Term Care (MOHLTC) does not have a specific multiculturalism or multicultural health policy. The closest the Ministry comes to acknowledging cultural and linguistic difference is in the Ministry's health equity impact assessment tool that is applied during policy development processes to reduce "avoidable health disparities between population groups" (Ministry of Health and Long-Term Care, 2013). The tool poses questions relating to various population groups, one of which is "ethno-racial communities" (Ministry of Health and Long-Term Care, 2012a) and was raised in interviews

> "The Government of Ontario has a health equity assessment tool
> which is a standard part of our policy process. Each policy is
> screened for how it affects equity in general, and how it affects some
> diverse vulnerable populations specifically. So that's a routine part of
> the government process." (Participant #10, Canada, Provincial).

This response shows health policy officer understanding of government expectations that the potential for unintended consequences of proposed policies must be examined. Ways to mitigate those aspects of policies which may unwittingly cause health inequities are also required. The health equity impact assessment tool suggests a critical multicultural perspective is in play in Ontario, encouraging health policy officers to question processes and policies that may cause disadvantage.

This commitment to CALD issues is continued through the expectation that the fourteen Local Health Integration Networks (LHINs), which report direct to the Health Minister, will pay attention to "inclusion and demographic diversity" (Local Health Integration Network, 2016, p7). The Toronto Central LHIN does not use the term 'multicultural',

the preferred terminology being "ethnocultural". The Toronto Central LHIN's 2013-2016 Integrated Health Services Plan *A Plan to Transform Local Health Care for All* (Toronto Central LHIN, 2013) is a plan to address health priorities for its diverse population, and contains the organisation's guiding principles, goals and priorities which include "equitable access to quality care" and improved "patient experience" (p5). In order to improve patient experience, the LHIN commits to seeking "patient input" making "certain that we include the voices of those in our community with the greatest needs who…are not well served or heard in the health system." (p6). Although the *2013-2016 Integrated Health Services Plan* refers to culturally competent care (p49) and service planning (50), and cultural competence training (p50), these references relate to Aboriginal health specifically.

More recently, and after the date of my interviews, the Toronto Central LHIN updated its Integrated Health Services Plan. The 2016-2019 Integrated Health Services Plan, *The Future of Health Care is Local* (Toronto Central LHIN, 2016), is a plan to address health priorities for its diverse population and contains the organisation's goals and strategic priorities which include improved "patient experience" through "culturally appropriate and culturally competent" care (p29).

The Toronto Central LHIN was reported to have strong leadership at the CEO level. It was reported that the CEO has instilled an organisational culture of respect for, and a desire to include, diversity in the LHIN's work. By way of example, I was advised that the CEO recognised that most staff do not live within the LHIN boundaries and recommended that they get out of the office to appreciate the conditions under which their clients lived. This firsthand view enables staff to appreciate the diversity of the policy audience and is a first step towards a critical multicultural appreciation of the histories and lived experiences of the CALD citizens within the LHIN's boundaries. The importance of this attitude becomes more apparent when citizen engagement is undertaken, as discussed at Chapter 6.

At the Toronto Central LHIN there is a critical multicultural perspective inviting staff to question and consider structures that may entrench disadvantage amongst their CALD clients. It is my view that this is strongly dependent on the specific CEO in place at the

time of my research but which, I was informed, has pervaded the organisation to such an extent that it is now how business is done.

In the environment where there is no multicultural health policy, but yet there is overt recognition of the need to consider cultural issues and policy impacts on diverse populations, Provincial health policy makers seem to be struggling to balance competing priorities and influences

> "Policy makers need...awareness of differences and challenges, but at
> the same time policy makers also have to be focused on the good of
> the population." (Participant #10, Canada, Provincial)

This comment shows an awareness of the importance of diversity considerations but yet a reticence to allow those considerations to take priority or to shape health policy. There is clearly a tension for health policy officers trying to balance many different health policy beneficiaries as was demonstrated by the following comment

> "…policy has to leave scope for how it gets translated, adapted and
> applied in different cultural contexts, and different circumstances.
> From a diversity lens, cultural and racial differences are one area
> that's important but equally important are issues of poverty, gender,
> education and social isolation." (Participant #10, Canada, Provincial)

These two comments show that the many influences on the health policy development process are difficult to balance, leading some health policy makers to distance themselves from the implementation of policy. It may be that the health authority does not encourage detailed consideration of CALD issues even though the policy frameworks suggest the opposite. The comments could also be a defensive response by policy officers who were put on the spot by my questions, an interpretation that was given some weight when one participant quickly informed me that "…we did acknowledge diversity…" (Participant #10, Canada, Provincial).

In summary, the presence of the Constitution and other legislation supporting multiculturalism is only weakly interpreted at the Canadian Provincial level. Although some policies make reference to the consideration of cultural diversity (in lieu of multiculturalism), there does not appear to be structured or consistent follow up. Provincial health policy officers respond as best they can but show mixed responses to multiculturalism as policy. With one notable exception referred to above, there was

minimal evidence that organisational leadership played a role in supporting staff to consider CALD issues. This is an important point that could have ramifications for the way in which health policy officers do, or do not, engage with CALD citizens when developing health policy. This matter will be discussed in Chapter 6.

5.9 The importance of contextual sensitivity for multicultural health policy

Acknowledging that societal concepts of difference are influenced by historical understandings and shaped within the dynamism of everyday interactions, Victoria Plaut describes the nature of multicultural policy as acknowledgement, recognition and valuing of different cultures, and the experiences and traditions they contribute, to a host society; preservation of those different cultures within a host society; and acknowledgement that no single culture should be seen as better or worse than any other (Plaut, 2010). Seen in this light, the end result should be "empowerment" for "social equality and participation" (Vasta, 2007, p7). A contextually sensitive approach to health policy development could meet Vasta's objectives. Contextual sensitivity, focussing on the individual's context rather than ethnicity, would be characterised by acknowledgement and valuing of, and respect for, difference and diversity. When combined with a questioning and challenging of assumptions held by individual health policy officers and the health system within which they work, structures that exclude CALD citizens become more evident. Approaching health policy development this way could support more effective communication with people from diverse backgrounds, highlighting for attention the structural barriers to equitable health policy. I suggest that health policy officers are capable of this approach as evidenced by the comments they made. However, I see little evidence that their own beliefs and those of the health system are challenged. Often this is because their organisations do not provide structural support through policies and guidance or, if they do, such policies and guidance do not seem to be well promulgated or supported.

Multiculturalism as government policy, where it exists, is missing any attempt to understand the history of minority groups especially in relation to the society in which they are wishing to settle. Box foretold the effects of this deficiency as exclusion of

minority voices and a lack of understanding on the part of policy makers of the way in which history has shaped the values of their society, values which have come to dominate and be accepted as givens (Box, 2005). In both countries, State and Province level policy officers described the difficulty in addressing issues of population diversity, finding themselves overwhelmed either because the broader issues of social determinants of health "felt so big that people just stopped paying attention to it." (Participant #9, Canada, Provincial) or because of "conflicting messages" (Participant #3, Australia, State) brought about by the need to consider the many influences on health policy. As one policy officer described the burdens of the current policy system

> "…it's overwhelming sometimes as a policy executive to get it all right. The budget, the gendered lens, the disability lens, the child lens, the carer lens, the multicultural…because often they are conflicting messages…" (Participant #3, Australia, State)

This comment further underscores my earlier discussion about the tensions that arise for health policy officers when trying to balance competing interests and priorities. The opposing view

> "So, for policy makers breaking down the questions to understand that populations are impacted variably is really important." (Participant #9, Canada, Provincial)

was put by one health policy officer who, in this comment, emphasised the need to consider the ways in which health policy may have different impacts on different people. Despite these difficulties, at least one health policy officer thought that health policy could be reinvigorated to take into account "population health and social determinants" because "cultural competency is a way to bring that back in a very practical kind of way" (Participant #9, Canada, Provincial).

In both Australia and Canada, at both levels of government, it appears that multicultural policy and multicultural health policy where it exists, is more about service provision and compartmentalising than a critical questioning of individual and institutional assumptions, skills and structures. It is clear that many Federal and State/Provincial jurisdictions do not break out of the business-as-usual mould, as health policy officers determine priorities and policy responses with little attention to the specific needs of CALD citizens. Despite policy frameworks that espouse multiculturalism as a tool for democratic participation, or even step towards a critical multicultural approach, the reality

is that most jurisdictions operationalise multiculturalism as policy to manage and control diversity.

The value of contextually sensitive health policy lies in its potential for enhanced effectiveness, that is, the ability of health policy to meet the needs of the community in the best way possible. Achieving contextually sensitive health policy is reliant on the actions of skilled health policy officers, enabled by their organisations to develop health policy that is cognisant, not only of the needs of CALD background citizens, but also of the structures and processes that cause bias and thus exclusion and disadvantage. My assessment is that any existing move towards contextually sensitive health policy is largely due to the efforts of individual health policy officers who appear to be more aware in this regard than their organisations. The sporadic efforts to embed what they know as 'cultural competence' in organisational requirements reported in Chapters 3 and 4 are not followed up by obvious actions, and certainly not actions that health policy officers reported as influential in any way.

Conclusion

In this chapter I identified three perspectives on multiculturalism – multiculturalism as policy to manage and control diversity, as a tool for democratic participation, and critical multiculturalism as a way to address disadvantage through structural reform. I concluded that critical multiculturalism is the better path to follow because it supports questioning of structures and processes that cause disadvantage and, more broadly, does not limit disadvantage to that experienced by CALD citizens and does not rely on a focus on ethnicity. I have discussed Australian and Canadian Federal and State/Provincial governments' multicultural and multicultural health policies in the context of definitions of culture as fluid and relational, and cultural competence as acknowledging, respecting and valuing difference and diversity, always questioning and challenging assumptions held by individual health policy officers and the health system within which they work, in order to work effectively with people from other cultures and to remove structural barriers to equitable health policy. Health policy officers recognise cultural diversity within the community, and some acknowledge a broader-than-ethnicity approach to cultural diversity.

Most governments at the Federal and State/Provincial level seem to hold a 'manage and control' perspective of multiculturalism. However, most health authorities at both levels of government at least advocate a perspective of multiculturalism as a 'tool for democratic participation'. Where internal policies exist, they are not referenced by health policy officers and thus provide little if any support to meet this objective.

In this chapter I concluded that health policy officers show a strong commitment to meeting the needs of CALD citizens, largely as a result of their personal strength, commitment and knowledge and despite the lack of support from their organisations.

In the next chapter I will look at contextual sensitivity for deliberative citizen engagement in the development of health policy to gauge the level of organisational commitment to, and support for, this ideal.

Chapter 6 Citizen engagement in Australia and Canada – An overview

"Instead of aiming for a common discussion, democrats might adopt a more fundamental goal: to try to ensure that those who are usually left out of public discussions learn to speak whether their perspectives are common or not, and those who usually dominate learn to hear the perspectives of others" (Sanders, 1997, p372-373).

"Policy makers need to listen to the aspirations of people for whom they make policy" (Dugdale, 2008, p165).

John Dryzek defines "messy" policy issues as characterised by the presence of multiple actors and interests, "conflicting and uncertain values", minimal agreement on the nature of the problem to be addressed, and a deficient policy environment (Dryzek, 1982, p321-322). Following the discussion in Chapter 2, health policy certainly fits within this definition. These characteristics, Dryzek argues, lend themselves to deliberative solutions by exploration of alternatives through an "interchange of frames of reference" of both the policy maker and the policy audience (Dryzek, 1982, p321). Dryzek (1982) highlighted the vital role of the policy maker, not only as facilitator of conversations but as an active participant, contributing assumptions and values, weighing up arguments, participating in the creation of shared values and alternative policy solutions through a process of discussion with all interested parties.

In Chapter 1 I suggested that deliberative citizen engagement offers a promising response to the central research questions. In this chapter I will follow up on this idea, starting with an overview of deliberative democracy and citizen engagement, discussing the advantages and challenges citizen engagement can present. In this thesis I focus on 'deliberative' citizen engagement broadly, by which I mean a two-way conversation between citizens and government to discuss issues and generate solutions: this definition

will become clear in section 6.2 below. My purpose in this thesis is to examine the inclusion of people from culturally and linguistically diverse (CALD) backgrounds in deliberations relating to health policy development and not to comment on the many specific techniques that can be used by governments to deliberate with citizens, for example Citizen Juries, Consensus Conferences, and Deliberative Polling (Abelson et al., 2003).

Following the overviews of deliberative democracy and citizen engagement, I will set out Australian and Canadian Federal, State and Provincial government policy positions on citizen engagement drawing on a review of government documents. I will assess how these policy positions enable contextual sensitivity for the inclusion of CALD background citizens. In the following chapter I will discuss citizen engagement for health policy development specifically.

6.1   Deliberative Democracy – an overview

Deliberative democracy has been described as a "complex ideal" (Bohman, 1998, p401), a "disciplined and structured" way of hearing competing voices (Organisation for Economic Cooperation and Development, 2009, p203). It offers a process, either at the group or individual level, which includes "considering different points of view" and "coming to a reasoned decision" (Abelson et al., 2003, p241) which must be acceptable to all participants (Bohman, 1998; Young, 2001). When deliberating, citizens need to be open-minded, willing to listen respectfully to the different views put by other people (Dryzek, 1994; Gutman and Thompson, 2004), prepared to reach a "reasoned agreement" (O'Neill, 2000, p515) which may mean a change of mind about an issue (Einsiedel, 2002), and to put aside their own interests for the common good (Bohman, 1998). Deliberation is a "cognitive process" (Delli Carpini et al., 2004, p317), a "rational discourse between free and equal citizens" (Shelly, 2001, p37), free from coercion (Young, 2001; Einsiedel, 2002), strategizing and self-deception (Dryzek, 1994).

There is general agreement that deliberative democracy not only allows a government to gauge the views of its citizens (Goodin and Dryzek, 2006; Ankenya and Dodds, 2008), permitting a diversity of views to be heard (Kahane et al., 2013), but also provides

legitimacy for government policy (Goodin and Dryzek, 2006; Ankenya and Dodds, 2008; Dryzek et al., 2009; Kahane et al., 2013) through trust in the government as a result of greater transparency and more equitable outcomes. This trust, in turn, drives acceptance of decisions and behaviour change (Delli Carpini et al., 2004; Hendriks, 2012). Lenihan calls this the "Golden Rule of Public Engagement" – citizens will not take responsibility for implementing a decision unless they are involved in developing the decision and action plan (Lenihan, 2012b, p52). Other benefits include the ability to share knowledge across a greater number of people and potentially identify more alternative solutions to an issue (Hendriks, 2012), and the transformative nature of exposure to differing viewpoints (Chambers, 2003; Delli Carpini et al., 2004; Kahane et al., 2013). Lori Turnbull and Peter Aucoin argue that exposure to a diversity of opinions is both educational and practical in that it helps to resolve conflict and create "shared meaning" (Turnbull and Aucoin, 2006, p5-8). Lenihan proposes a further practical benefit of deliberative democracy in that, during deliberation, citizens act as a "check" on government officials, keeping the officials on track about what can be achieved realistically and how, and demanding plain speaking instead of jargon (Lenihan, 2012a, p7).

It is agreed that anybody who is affected by a government decision should be able to participate in deliberations which help to shape that decision (Dryzek and List, 2003; Goodin, 2003; Brackertz and Meredyth, 2009; Hayward, 2011). In this case 'anybody' includes people from CALD backgrounds (Valadez, 2001). However, deliberative democracy is criticised as being less than inclusive because those citizens who participate in deliberative processes are selected by those in power (Box, 2005) and thus tend to belong to the "exclusive gentlemen's club" (Dryzek, 2001, p659). These chosen citizens tend to be "male, older and more educated, articulate and affluent than the general population" (Brackertz and Meredyth, 2009, p161). Nancy Fraser also argues that "institutionalised patterns of culture" dictate interactions with citizens according to the dominant social norms, thus categorising some citizens as less worthy of inclusion, or their ideas of less value (Fraser, 2001, p24). According to Box, this is not necessarily the fault of policy makers who find themselves squeezed between the opportunity and desire to make change and the system which seeks to maintain authority: that is, they are captured by those who wield power (Box, 2005).

Other stated disadvantages of deliberative democracy lie in the fear of the majority being swayed by a dominant minority of the "well organised and politically active 'usual suspects'" (Brackertz and Meredyth, 2009, p161), bias contained in the information provided, infrequency of deliberations (Delli Carpini et al., 2004), and government lack of capacity to engage in terms of time, resources and know-how (Kahane et al., 2013). Assumptions about citizens' competence to contribute to policy debate, to digest information quickly, and practical matters around meeting arrangements are also forms of exclusion (Bates and Linder-Pelz, 1987; Barnes et al., 2003).

Citizens must have confidence that the process of engagement allows for equal participation and an equal opportunity to influence the decision makers (O'Neill, 2000). However, some citizens are described as 'hard to reach' on the grounds of socio-economic disadvantage, age, gender, race or cultural background, health status, language and more (Bishop and Davis, 2001; Von Lieres and Kahane, 2007; Brackertz and Meredyth, 2009; Kahane et al., 2013). For these citizens, the process of deliberation which gives weight to "rational argument" (Dryzek, 2001, p660) is criticised as limiting because it is said to exclude people who prefer to communicate in a different way, such as through story telling or other forms of testimony (Bohman, 1998; Dryzek, 2001). These people may already be "underrepresented in formal political institutions" (Sanders, 1997, p349) and "systematically materially disadvantaged" (Parkinson, 2006, p36). Pessimistically, Lynn Sanders (1997) believes that, even if the usually underrepresented were to be included in deliberations, it is likely that their views would not be accorded the same respect, and thus equal weight, as the views of others. The underrepresented may have been included but their opinions not and this, she argues, is because "status and hierarchy shape patterns of talking and listening" (Sanders, 1997, p370). In a similar vein, it has been argued that inclusion in participation is necessarily on the terms set out by the dominant majority (Hayward, 2011). This places an extra burden on minority participants, who may be forced to conform to the dominant standard or face difficulties in reaching agreement within the forum as a result of too great a focus on difference (Hayward, 2011).

Awad contends that the deliberative norms of discussion, free of coercion, towards a common understanding, provide a mechanism for justice on the basis of inclusive discussions (Awad, 2011). Whilst Melissa Williams agrees about the power of deliberation for justice, she is not so sure that the practice of deliberation has grasped this

nettle, and calls for institutions to pressure privileged groups to cooperate with the marginalised in deliberation (Williams, 2000). Similarly, both Seyla Benhabib and Dryzek fear that communication across difference is difficult to overcome because the norms of deliberative democracy dictate procedures that favour dispassionate, reasoned argument with a demand for consensus through reason giving that, Benhabib says, sets the bar too high (Benhabib, 2002; Dryzek, 2005). Fraser suggests that the remedy for this situation is "participatory parity" (Fraser, 2001, p25), based on institutional procedures enabling participation by all citizens (Martineau, 2012), ensuring that no single group dominates decision making about who should be engaged, thereby reducing the risk that some groups may be excluded (Hayward, 2011).

David Miller speaks of deliberative fairness to the disadvantaged, arguing that deliberation should be about "seeking agreement" in a manner that is respectful of all participants and their views (Miller, 2000, p152). This ensures that each participant can air views honestly and not feel under pressure to restrict reasons to those that might appear to be more acceptable to the majority. Miller (2000, p153) dislikes the argument that suggests that people from disadvantaged groups cannot "marshal rational arguments". This is insulting, he says, and argues that if the interests and views of disadvantaged people are brought into deliberation, that very process will help to cut through any extreme ideas and result in a decision that is both deliberative and appropriate. Finally, Miller suggests a merging of storytelling and reason giving to help identify "practical solutions" that could bring change to "counteract social disadvantage" (Miller, 2000, 156-158).

Other responses to deliberative unfairness provide different solutions based on the way in which a deliberation is defined and on communication within deliberation. Benhabib (2002) addressed the way people from minority groups might be pigeon-holed and therefore denied deliberative fairness. She described three normative conditions for "will and opinion formation" in multicultural society, to ensure that people from minority groups enjoy the same rights as all other citizens, are able to identify themselves as they choose and are not forced into accepting a label, and are able to move within and between groups as they choose and without hindrance (Benhabib, 2002, p106). Wear agrees about the danger of attaching labels to individuals and asks that biases and assumptions be

challenged in order to "look beyond the labels" and reflect on the effect of the dominating relationships in society (Wear, 2003, p554).

James Bohman's "deliberative toleration" which, he argues, is "more than non-interference", characterises his approach to unfairness in deliberation (Bohman, 2003, p775). He says that toleration is necessary to deliberation, especially in diverse societies, but adds that toleration is not about tolerating a person but rather tolerating "structures of communication" (Bohman, 2003, p759). He reasons that if each person is seen as a citizen, then all citizens are entitled to be included in deliberation. Equally all citizens are entitled to have their reasons heard and considered and to be part of decision making so that, even when decisions do not accord with an individual's views, that individual still has the option to accept the decision as the best one that can be made, based on the reasons that have been given and debated. Bohman (2003) notes that ideas of the meaning of diversity do and will change over time, thus necessitating constant review of the structures for communication within deliberations: the means of communication must be open to critique and amendment in order to respond to changes in society. Bohman concludes his discussion arguing that toleration is an attitude that accepts all perspectives in society are "fruitful for deliberation" (Bohman, 2003, p776).

Both McLaren (McLaren, 2001) and Monique Deveaux (Deveaux, 2003) highlight the importance of communication, identifying the need to consider the use of varied forms of communication in deliberative processes in order to ensure participation by people from minority groups. Dryzek (2005) agrees that incorporating a variety of forms of communication enables discussion, but adds that, in order to strengthen deliberation, any form of communication must meet the tests of reflective communication, non-coercion, and expression of lived experience. In keeping with the ideals of deliberative democracy, the end result should be legitimate and just decisions, acceptable to all participants, for reasons that all can understand even though their agreement may be based on different individual reasoning (strategic, ethical or moral grounds) (Benhabib, 2002; Deveaux, 2003).

All of these approaches to deliberative fairness, or deliberative toleration, are useful reminders of the importance of valuing each citizen's contribution in a deliberative forum. However, none of these approaches tackle the thorny issue of contextual sensitivity

amongst deliberators – there is no discussion about how participants can or will be supported to exhibit that openness and toleration, let alone to question the societal and institutional structures that cause disadvantage and exclusion.

Noting that deliberative processes are complex, Jorge Valadez suggests that equality of participation can be undermined, especially in multicultural societies, as a result of individual capacity (Valadez, 2001). He argues that not all citizens have equal means of participation (such as confidence to participate gained through participation in the workforce), nor do they have equal capacity to participate (intellectual or physical). Whilst formal education can serve to "heighten awareness" and teach skills, Valadez cautions that education needs to be combined with a genuine effort to address inequalities in order to motivate participation (Valadez, 2001, p72-81). To this end, he suggests that governments need to provide greater support for community organisations which can then provide education on civic responsibility and participation to improve a citizen's capacity. Valadez (2001, p84) sees the goal of this education as "political efficacy", teaching citizens how they can work with others, such as government departments, in order to achieve the citizens' own goals. The work of both Brenton Holmes (Holmes, 2011) and Brian Head (Head, 2007) supports Valadez' position. Holmes provides a concrete example when he highlights the Australian Centrelink agency initiatives to work with, and empower, citizens in order to engage them in policy and service design (Holmes, 2011).

Valadez' proffered solution of education in civic responsibility and working with others falls short of adding contextual sensitivity into the mix. I have no doubt that there are benefits to CALD background citizens in being more conversant with the political systems and ways in which they could contribute. However, Valadez' preferred approach does not address the need for contextual sensitivity amongst all participants in deliberations.

A possible improvement could be in shifting emphasis from the citizen participant to the subject of discussion. Dryzek, for example, suggests that a focus on the specific needs relevant to the issue under consideration would encourage a shift away from culture as a differentiator (Dryzek, 2005). Both Alexander and Stivers and Nasar Meer and colleagues agree that deliberations should focus on the preferred outcome, that is, how

the goal is achieved (Alexander and Stivers, 2010; Meer et al., 2012). Marina Falbo also advocates shifting emphasis from the individual to the subject. She argues for the creation of temporary identities to enable the inclusion of "unconstrained actors for unconstrained content", allowing individuals and groups to come together based on interest in the subject rather than allowing the subject to be used as a discriminator about who may be included in deliberations (Falbo, 2006, p257). Again, contextual sensitivity is missing from the discussion.

Apart from exclusion as a result of the actions (unwitting or otherwise) of government officials, citizens may choose not to participate in deliberations for other reasons including lack of interest or time and lack of trust in the process and outcomes (Brackertz and Meredyth, 2009). In addition, those who wish to engage may consciously or unconsciously marginalise other members of the public because of their own views about who constitutes an appropriate audience for the issue at hand and who can represent that audience (whether as individuals or group representatives) (Barnes et al., 2003). Who is invited, the process chosen, and how input, including dissenting input, is managed are all crucial to the success or otherwise of deliberative democracy.

Debate in the field of deliberative democracy has so far paid little attention to the critical issue of contextual sensitivity. Discussions of the advantages and disadvantages of deliberation stop short of the vital issue of how the people participating in deliberations are enabled to acknowledge, respect and value difference and diversity, to question and challenge individual and systemic assumptions, and to work effectively with others including people from CALD backgrounds. Thus, there seems to be an assumption that, having brought together a diverse group of people for a specific deliberative purpose, despite their acknowledged differences they will intuitively be able to communicate with, and understand, one another. While it is important that deliberative democrats continue to call for greater inclusion and intercultural understanding, of sharing values, ideals and goals, it will be difficult to achieve these objectives if deliberative participants do not have the necessary skills or awareness to interact effectively. This is a gap in current deliberative democracy debates that my research aims to address with specific reference to health policy officers.

In the next section I look more closely at citizen engagement, its benefits and limitations, and examine whether contextual sensitivity is more apparent within that field.

6.2   Citizen engagement for inclusion

As mentioned in Chapter 1, there is agreement that deliberative democracy provides a framework for citizen engagement, especially in culturally diverse societies (Deveaux, 2003; Ercan, 2011; Ercan, 2017). However, before considering citizen engagement in more detail, some discussion about terminology is necessary.

There are several terms which seem to be used interchangeably and which appear to be intended to mean the same thing – citizen engagement, citizen participation, public participation, public deliberation, consumer engagement, community consultation (Arnstein, 1969; Delli Carpini et al., 2004; Rowe and Frewer, 2005; Brackertz and Meredyth, 2009). This profusion seems to derive from different notions of what engagement actually means. Sherry Arnstein's (1969) much cited eight rung Ladder of Citizen Participation, the OECD's three strand participation model (Gramberger, 2001) and Gene Rowe and Lynn Frewer's (2005) three tier typology of public involvement all describe a continuum of activity ranging from basic education and information giving to active participation through dialogue and exchange of views. These can be summarised as shown in Table 5 (adapted from Rowe and Frewer, 2005, p254-255) below:

Table 5: Typology of public involvement

Type of involvement	Flow of information
Public communication	One way – from the organiser to the public, no chance for discussion, no public influence possible.
Public consultation	One way – information provided by the public to the organiser, no chance for discussion, amount of public influence unknown.
Public participation	Two way – information exchanged between the public and the organiser, discussion encouraged, influence possible and visible.

The OECD acknowledges that it can be hard to separate the multiple terms and proposes that *active engagement* implies greater citizen input in setting priorities and agendas as well as in discussions, whereas *consultation* is a government-led process with limited opportunities for citizens to exert influence (Ham, 2001). Further discriminators can be added if the focus is placed on the individual who is to be engaged. For example, in earlier policy advice Health Canada distinguished between "citizens" and "the public", where the "citizens" are defined as all Canadians but "the public" is usually "represented by associations, health professionals, lobbyists and interest groups" (Health Canada, 2000, p14). In the most recent Health Canada policy (Health Canada, 2016b) this distinction has been slightly re-cast to separate "citizens, patients, consumers and consumer groups" (p4) from "stakeholders", where only the latter is defined as individuals or groups who may have "a specific interest in, influence on, or be affected by" a policy decision (p32). Nevertheless, the distinction between the public or stakeholders and citizens is important for two reasons. Firstly, consumer lobby groups, which may be included in the 'public', are not necessarily well recognised, organised and resourced to meet their objectives (Palmer and Short, 2000; O'Reilly, 2001) and may thus not be in a position to make the most of opportunities to engage with governments. Secondly, and on the positive side of the ledger, both Palmer and Short and Patricia O'Reilly argue that a focus on citizens can help to balance the competing interests of the medical profession, providers of medical equipment and pharmaceuticals, lobbyists, interest groups and the government itself (O'Reilly, 2001; Palmer and Short, 2014).

In Chapter 1 I referred to, and accepted, the complementary understandings of 'citizen engagement' proposed by Phillips and Orsini (2002) and Lukensmeyer and Torres (2006). Their arguments are based on an understanding of engagement as a two-way, iterative process between individuals, exercising their rights as citizens, and government officials. As noted in Chapter 1, for the purposes of this thesis I will use the term 'citizen engagement'.

Along with the advantages of deliberative democracy described above, benefits that flow from the engagement of citizens in the development of government policy and programs include identifying stakeholders and their expectations, defining the agenda and setting boundaries, encouraging debate, improving information gained by both citizens and government (Bishop and Davis, 2001), the opportunity for citizens to influence decision

making (Bolitho, 2013), and the production of better policy as a result of citizen input (Phillips and Orsini, 2002; Palmer and Short, 2014). As Paul Dugdale puts it, "policy makers need to listen to the aspirations of the people for whom they are making policy" (Dugdale, 2008, p165). He argues that public servants cannot "intuitively" determine the "concerns of the disadvantaged groups" that are the beneficiaries of health policy (Dugdale, 2008, p197). Further, both Dugdale (2008) considering the health sector, and Box (2005) considering public administration more generally, recognise a role for policy officers as insiders who can facilitate discussions between the community and the bureaucracy, helping align community needs, policy making and government processes and effecting change.

Whilst the premise of this thesis is that citizen engagement is beneficial to policy making, I noted, at Section 1.4 above, that citizen engagement is an imperfect science. There are many reasons why governments choose to engage with citizens, for some this is an exercise in politics, in ticking boxes, and in raising personal profiles (Cawston and Barbour, 2003). A limited focus on certain methods of citizen engagement to the exclusion of others, or being driven by specific ideologies, can limit the range of solutions identified (Cawston and Barbour, 2003; Tritter and McCallum, 2006). This limited focus may be driven by a reliance on "the classical literature" which can hamper the development of "productive and realistic participation policies" (Contandriopoulos, 2004, p322). Thus, the advantages of citizen engagement must be balanced by the difficulties surrounding citizen engagement.

Some of the difficulties are particular to the nature of public administration. Mary Hamilton argues that public administrators have become so expert at their jobs that they forget what the citizen can bring to the table in terms of knowledge and skills that could assist decision making (Hamilton, 2007). Equally troubling is Cheryl King's view that, generally speaking, policy makers have been neither trained nor "socialized" to undertake public participation (King, 2007, p71). Whilst she acknowledges the good intentions of policy makers, King believes that there is an inherent tension between the principles of citizen engagement (such as openness and honesty), and bureaucratic processes and structures which focus on efficiency (time limited public hearings with no debate) at the expense of genuine input (King, 2007). This view is supported by Alfred Ho who suggests that policy makers tend to choose engagement mechanisms that are fast and cost

effective, rather than mechanisms that would allow time and space to build relationships, demonstrate sincerity, and ensure equality (Ho, 2007). These views were shared by some Canadian Provincial health policy officers

> "We are asking in ways that are the least cost or the least disruptive to maybe us and to the citizens" (Participant #8, Canada, Provincial)

> "Typically, a policy review process would involve examining options and setting direction for the most part internally with some limited stakeholder engagement for the purposes of information gathering and for validation and confirmation of the internal decisions." (Participant #10, Canada, Provincial).

These two comments say, firstly, that citizen engagement is limited by the health authority's resources of money and time and, secondly, that citizen engagement is a one-way process that does not really give the citizen an opportunity to influence health policy development. These comments illustrate the truth in what Hamilton (2007), King (2007) and Ho (2007) have observed – that the health authority sets the rules of engagement according to its own convenience.

Julia Abelson and John Eyles raise two additional concerns: that citizens will be too focused on local issues rather than the bigger picture, and that citizens participating may not be representative of the community at large (Abelson and Eyles, 2002). Box adds that citizens frequently hesitate to comment on the underlying systems or structures of disadvantage or oppression, preferring instead to limit their comments to specific issues such as "air pollution" (Box, 2005, p7). On the issue of representation, Walt distinguishes between insider groups and outsider groups (Walt, 1994). Insider groups are accepted by government as respectable and therefore legitimate and thus consulted and often invited to join committees. Outsider groups are not seen as legitimate and are excluded from formal government processes. For this reason, many community organisations do not have bargaining power (Butler et al., 1999) and many are rendered toothless because they are only invited to the table in so far as their input can be controlled by government and used to confirm, or protect, dominant interests (Löfgren et al., 2011). On the other side of the ledger, Patrick Bishop and Glyn Davis suggest that citizens have become somewhat cynical and distrusting of their political representatives, viewing citizen engagement as a means to achieving policy legitimacy rather than any higher ideal about democracy (Bishop and Davis, 2001). To counteract this, the OECD pointedly states that government

officials must take citizen engagement seriously, starting from the citizen's perspective (Gramberger, 2001), and argues that commitment, leadership and capacity are essential for success (Ham, 2001).

Drawing on personal experience, Box (2005) expresses the view that citizen engagement is dominated by those people with wealth and power who can dictate both the terms of participation and the relative merits of individual contributions. Similarly, Cheryl King and Lisa Zanetti rather bleakly conclude that "money talks and citizens don't" (King and Zanetti, 2005, p16). Indeed, government agencies may have difficulty identifying those who should be invited to participate (Brackertz and Meredyth, 2009). Goodin warns that the very act of ensuring inclusion "entails exclusion" because there will always be a limit to who can participate: eligibility to participate does not necessarily equate to "active participation" (Goodin, 2003, p198-199). Phillips also sounds a note of caution – although she advocates inclusion of people and groups who are normally excluded, she suggests that procedures to ensure this need to be carefully considered or the objective will not be achieved (Phillips, 1993). This view is supported by Falbo, who goes on to add that inclusion is not just about being seen to be present but about effective participation (Falbo, 2006).

In the specific context of health policy, John Church and colleagues (2002) express concern that the complex and technical nature of health policy means that decision-making power is held by administrators and technical experts. If citizens are to participate in decision making those citizens would need to have a "strong personality", an "ability to mobilize" other citizens, and be "knowledgeable about the issues" (Church et al., 2002, p21).

These perspectives hint at the difficulties government health agencies face when trying to balance fairness and inclusion with institutional structures that dictate the way business should be conducted, inevitably showing up power differentials between government agencies and individual citizens. Addressing power imbalances is crucial in any attempt to empower citizens (Aronson, 1993) as is the need to understand the power bases of various influences in the policy process in order to understand the extent to which "participation is tolerated" (Walt, 1994, p6), rather than welcomed.

Young argues that "systematic institutional processes…inhibit people's ability to play and communicate with others" and "institutional conditions…inhibit or prevent people from participating in determining their actions" (Young, 1990, p38). Martineau agrees that the dominant majority establishes culture, ideas and institutions in its own image and everybody is expected to fit in: anybody who does not fit in is considered different or deviant (Martineau, 2012). The result, she says, is that minority groups are denied the opportunity to participate in society because the dominant power structures do not accommodate participation by people who are different, a view with which Fraser has some sympathy (Fraser, 2001).

Whilst it is true that public administration is supposed to serve the government of the day, there is agreement about the need for debate and argument to expose and explore institutional assumptions and structures, comparing them with the lived experience of a diversity of citizens in order to address tensions in society (Jun, 1997; Zanetti and Carr, 1997; Box, 2005). Institutional and structural discrimination follow when the norms and values of the dominant group in society become, de facto, the unquestioned norms of that society, resulting in the exclusion of people of CALD backgrounds and production of policy that does not meet their needs. Young suggests that, under these circumstances, minority groups may feel a sense of futility, an inability to influence decision making, in the face of such "deep rooted norms and systems" (Young, 2001, p685). The awareness of context suggested by Jong Jun (1997), Zanetti and Carr (1997) and Box (2005) above is a step towards a contextually sensitive approach to citizen engagement.

In keeping with a critical multicultural approach, the preceding discussion has shown support for the importance not only of inclusion but of enabling citizens of diverse backgrounds to explain their lived experiences to citizens with different life experiences. This is a scenario that we could imagine could cause consternation and disagreement amongst those of the dominant majority. In such a situation, both Marcuse and Box argue that structures only allow for dissenting discussion if that dissent can be managed and interpreted within the norms of the institution (Marcuse, 1965; Box, 2011). In other words, dissent is not allowed to upset the apple cart. To address this, Box and colleagues demand collaborative public administration to ensure shared knowledge and decision making, with the added benefit of educating the community about an issue and therefore facilitating engagement and deliberation between government and citizens (Box et al.,

2001). Such collaborative public administration, they say, requires an amount of "courage" in order to effect change to policy development processes (Box et al., 2001, p616).

Assuming that institutional processes can be optimised, there are further criticisms levelled at citizen engagement in so far as people of CALD backgrounds are concerned. Several authors argue that the deliberative process is flawed, primarily, because of a reliance on Western ideals to determine deliberative norms, which both excludes people of CALD backgrounds and does nothing to create shared understandings around different lived experiences (Williams, 2000; Deveaux, 2003; Min, 2014). When the rules of engagement are stipulated by the dominant society they become "exclusionary" and "assimilationist" (Marchettoni, 2014) which Alexander and Stivers say pigeon-holes citizens in a "safe" place, that is, safe in terms of the government officials involved (Alexander and Stivers, 2010, p589). This situation has been described as the "systematic marginalization" of people who are unable to express ideas in the same way, and with the same language, as the dominant society (Olson, 2011, p542). Trying to find a solution to this situation, Valadez argues for "intercultural conversations" based on a commitment to the common good, respect for all individual participants and a drive for mutual understanding (Valadez, 2001, p30). These intercultural conversations can lead to the development of solutions that take into account the needs and interests of all parties in a multicultural society which, in keeping with the norms of deliberative democracy, will also educate citizens, hold them accountable for their views, and open a path for a change of mind as a result of receiving further information.

Jayne Beilke argues that dialogue through engagement creates a "mutually beneficial partnership", beneficial in terms of awareness of social and institutional structures that create inequity and discrimination, reflection for problem solving, and opening opportunities for change (Beilke, 2005, p6). However, Valadez (2001) is concerned that greater participation in deliberations by minority groups will only occur if those minority groups are empowered to participate. Valadez argues, similarly to Beilke, that mutual understanding, which may mitigate inequality but not eliminate it, must be underpinned by an understanding of the history of minority groups, especially social, political and economic factors that led to their current position in a society, how this contributes to prejudice and discrimination, and thus to the formation of a minority group's view of

society, to "see the world from their perspective" (Valadez, 2001, p91). This view is supported by Plaut who notes that history shapes and is used to justify the decisions and actions of people in "racially diverse situations" and, importantly, that "stereotyping and prejudice is animated by cultural meanings and status relations" (Plaut, 2010, p82-83). Ultimately, Valadez (2001) says, mutual understanding can serve a purpose beyond mutual respect, transforming and enlarging the knowledge of the dominant group, reducing fear of Others and opening discussions to the potential for compromise and moderation of demands. Beilke (2005), Valadez (2001) and Plaut (2010) are all advocating for a contextual sensitivity in citizen engagement.

This is a good place to pause before moving on to look more closely at Australian and Canadian policy frameworks for citizen engagement. The literature in deliberative citizen engagement clearly recognises that people from different cultural backgrounds may have trouble understanding each other or coming to an agreement about the best way to tackle an issue under discussion. As noted earlier, there is agreement that anybody affected by a decision should be involved in making that decision and that the "expression and criticism of diverse opinions" (Young, 2002, p6) and acknowledging difference will enhance any process directed to changing views (Phillips, 1993). In addition, scholars such as Young (2002) and Dryzek (2005) have argued for the use of multiple forms of communication to open channels of communication between people from different cultural perspectives. Nevertheless, others like Valadez argue that "minority policy alternatives" will always be given short shrift because of the gap between cultural understandings (Valadez, 2001, p65).

As this review of relevant literature has shown, with the very few exceptions noted above, citizen engagement as a field of academic endeavour recognises, but gives little useful attention to, contextual sensitivity within deliberations. Given that governments are relying on key supporters of citizen engagement to build their own processes, how does government policy reflect a need for contextual sensitivity in processes and amongst personnel? The following sections will examine and assess the policy frameworks for citizen engagement in Australia and Canada both generally and in the health sector.

6.3 "If we must" – Australian Federal government commitment to citizen engagement

In Australia, terminology around the inclusion of citizens in policy development has varied from consumer participation to citizen engagement to social inclusion. According to Catherine Butler and her colleagues, community activism in Australia grew in strength during the 1970s and 1980s as a result of public opposition to government policy in fields as diverse as defence, employment and the environment (Butler et al., 1999). This period saw the rise of "consumer associations and the women's movement" (Butler et al., 1999, p257). Gwendolyn Gray Jamieson reports that the publication of the first National Women's Health Policy, in 1989, was a direct result of this activism, and notes that one of the underpinning principles in the policy was "participation by women in decision making as consumers and providers" (Gray Jamieson, 2012, p14). Butler et al (1999) report that the launch of the Federal Community Health Program, in 1973, heralded the start of community participation in the health system in Australia, and was marked by the establishment of local advisory boards and management committees which included community representatives. Although this particular initiative did not last into the 1980s, the establishment of the Consumers' Health Forum as a peak body representing all health consumers marked a turning point in the relationship between health consumers and the Federal government. The Consumers' Health Forum arose as a result of pressure on the Minister for Health to build "public participation…into the national health administration." (Consumers' Health Forum of Australia, nd). Following a review by the Department of Health, the Consumers' Health Forum was established, through funding in the 1986-1987 Federal Budget, with the objective of providing advice to "the government on health issues affecting consumers" (Consumers' Health Forum of Australia, nd).

Despite this background, there is no whole-of-government legislative backing for citizen engagement in Australia, although successive Australian governments have attempted to instil a culture of citizen engagement in public administration through a variety of reform activities. The 1976 Royal Commission on Australian Government Administration (the Coombs Inquiry), set in train a series of reforms which came to be grouped under the banner of New Public Management (NPM), and included the need to connect citizens with government (Holmes, 2011). Under NPM, citizens were seen as customers of

government services but this terminology changed in the mid-1990s with the emergence of civic engagement and a shift to the notion of citizens as individuals rather than consumers of services (Denhardt and Denhardt, 2000; Holmes, 2011).   This shift has been described as a "thickening" of democracy, which brought with it promises of greater accountability and government responsiveness (Podger et al., 2012, p103). This, in turn, required public servants to create space for public deliberation (Denhardt and Denhardt, 2000).

Continued reforms focussing on the way in which government conducted its business further strengthened the idea of engaging with citizens (Head, 2011). Examples of this attitude change can be found in *Connecting Government: Whole of Government Responses to Australia's Priority Challenges* (2004) and *Changing behaviour: a public policy perspective* (2007) (cited in Holmes, 2011, p10), both of which identified the need for government and Federal public servants to focus more on the inclusion of citizens in policy discussions to assist the government to solve difficult issues (Australian Public Service Commission, 2007). This was followed, in 2010, by further explicit support in the Australian Government's Advisory Group on Reform of Australian Government Administration report *Ahead of the Game. Blueprint for the Reform of Australian Government Administration* (Advisory Group on Reform of Australian Government Administration, 2010). The *Blueprint* proposed nine reform areas to strengthen the public sector, one of which is particularly relevant to this research – create more open government. This reform area called for greater consultation and collaboration with citizens in policy development and service design, in conjunction with a citizen survey intended to discover citizen satisfaction with government services in order to "inform government business" (Advisory Group on Reform of Australian Government Administration, 2010, p39-40), and was explicitly supported by the Prime Minister of the day (Holmes, 2011).

At the Australian Federal level, citizen engagement for policy development generally seems to be largely undirected. The expectation has been set, but there is a lack of follow up support in the form of a specific citizen engagement policy or toolkits to assist policy officers. None of the health policy officers interviewed referred to any of these attempts at reform or their impact on citizen engagement.

The next section looks at the situation in Australian State jurisdictions to see if they are any better organised in policy terms.

6.4   "We get it" – Approaches to citizen engagement in Australian State government policy

Looking first at the Australian Capital Territory (ACT) government, citizen engagement was given Chief Minister support in mid-2011 with the announcement of "Open Government" – a range of initiatives to make government more accountable and transparent to the ACT community (Legislative Assembly for the ACT, 2011). Activities include an Open Government website as a portal for access to information (ACT Government, 2015), weekly Chief Minister reports on key issues discussed in Cabinet, Virtual Cabinet meetings via Twitter, and a "Your Say" website to facilitate access to projects that are open for comment (ACT Government, 2017). *Engaging Canberrans. A guide to community engagement* acknowledges cultural issues as potential barriers to participation by people who are marginalised, and provides advice on engaging people from CALD backgrounds, specifically drawing attention to the need to understand the cultural background of those being consulted (ACT Government, 2011). This policy has some of the features of a contextually sensitive approach to citizen engagement.

Taken together, the ACT *Multicultural Framework 2015-2020*, referred to in Chapter 5, and the Open Government initiatives ensure that all ACT Government Directorates have a commitment to engage with all ACT citizens. The work of each Directorate is accountable through their annual reports.

In Queensland, at the time of my initial review of government documents conducted in 2014 and 2015, I identified the "Engaging Queenslanders" series of booklets. One of these specifically addressed engaging with CALD communities, and another provided advice to help agencies meet their commitments to Queensland Multicultural Policy, as it was at the time, and to community engagement. The guide *Engaging Queenslanders: An introduction to working with culturally and linguistically diverse (CALD) communities* was published in 2007, noting in the introduction that the booklet is not a "how to" guide but "a starting point" which "raises key issues" to be taken into account when "engaging with diverse communities" (Department of Communities, 2007, p1).

The booklet reiterated the benefits of community engagement, set out the policy framework supporting engagement with diverse communities, explained the barriers to CALD participation and how to overcome them, and provided advice on managing engagement processes in CALD communities as well as good practice examples. Importantly, the guide acknowledged the potential for bias based on individually held values and beliefs, and specifically noted that policy is always written from within the dominant paradigm. In doing this, the guide exhibited a critical multicultural awareness of the potential discrimination inherent in government structures.

More recently, and after the time of my interviews with health policy officers, the Queensland Government updated its citizen engagement advice. According to its website, the Queensland Government supports "community engagement as an integral part of developing and evaluating policies, programs and services" (Queensland Government, 2017). This publicly available website appears to be intended for government employees, containing only limited information relevant to online engagement activities. For the community, the Queensland Government website "Get Involved" (Queensland Government, 2014) contains details of current consultations and links to other ways in which Queenslanders can engage with government. The awareness that was explicit in the earlier advice is now missing from Queensland Government policy as a result of the removal of the "Engaging Queenslanders" series of booklets from the Government website (see also section 3.5.1).

None of the Australian State health policy officers interviewed referred to any overarching policies. It is reasonable that health policy officers may be more familiar with their Agency specific advice, but it is noteworthy that such strong work within the ACT government, particularly, does not appear to be obvious at the health policy officer level.

6.5   "Yes we must and we will" – the Canadian Federal government approach to citizen engagement

Abelson and her colleagues put the view that the Canadian government has been increasing its efforts in public participation as a result of a decrease in public confidence in the health care system (Abelson et al., 2007). Today, the Constitution Act 1982 (Can)

forms the basis of Canadian policy on citizen engagement, making it clear that citizens of all backgrounds should be involved in government business. Canada's formal commitment to accountable and transparent government dates back to the mid-1970s, initially focussing on issues such as protection of personal information (Government of Canada, 2012b). Canada was also part of the NPM reforms of the 1980s and early 1990s, modelling the public sector on the private sector and increasingly contracting-out activities with a resultant loss of expertise within the public service (Phillips and Orsini, 2002).

During the 1990s, the Canadian Privy Council required that any Memoranda proceeding to Cabinet for discussion include a section outlining how the community had been consulted and what was made of the information received (Health Canada, 2000). Later, in parallel with the development of the Social Union Framework Agreement which required Federal, Provincial and Territory governments to include citizens in policy deliberations (Phillips and Orsini, 2002), the Canadian Privy Council Office developed a policy for whole-of-government consultation with citizens. The *Policy Statement and Guidelines on Consulting and Engaging Canadians* published in May 2000 (Smith, 2003) "…affirms the government commitment to involve Canadians in public policy-making, establishes guiding principles and responsibilities for directing this work, and provides practical guidelines for its application." (Ham, 2001, p39). I have been unable to access a copy of this policy and its associated guidelines – they appear to have been removed from circulation as a result of more recent initiatives which are set out below.

During 2009-2010 the Canadian government undertook national consultations on the idea of Open Government. This culminated in the March 2011 launch of the Open Government Action Plan which identifies three areas for action: Open Information, Open Data, and Open Dialogue (Government of Canada, 2012b). The most recent *Third Biennial Plan to the Open Government Partnership* for the period 2016-2018 is organised around four goals, one of which is "Engaging Canadians and the World" (Government of Canada, 2017b). Under this goal, the Canadian Government recognises the importance of involving the community in policy development, specifically naming "First Nations, Inuit and Metis" and the need to develop meaningful engagement processes to support inclusion of these citizens, and undertakes to "identify necessary supports eg skills development" to assist engagement (Government of Canada, 2017b). Progress reports

against this, and earlier, Action Plans are available through the Open Government portal which also provides a single point of access to government data, information and consultation opportunities (Government of Canada, 2017a).

An additional means of accessing consultations is via a direct Consulting with Canadians website (Government of Canada, 2014) which links to all Federal government consultations and is searchable by title, subject or department, and includes completed consultations.

These national initiatives are clear but do not appear to have any tone of contextual sensitivity.

6.6 "We get it too" – Canadian Provincial government policy on citizen engagement

British Columbia (BC) and Ontario offer contrasts at the Provincial government level with BC seemingly well ahead of Ontario in the citizen engagement stakes in both policies and actions. Public servants in BC are provided guidance through the *Citizens at the Centre BC Gov 2.0* strategy (BC Public Service, nd). One of the three central themes of the *Strategy* is "Citizen Participation: engaging British Columbians more directly with their government, particularly through improved access to government data and sharing of information." (p13). The *Strategy* articulates three "defining principles", the first of which is "Empower citizens to create value from open government data" (p13) and centres on the use of information technology to ease citizen access to information of and about government, as well as providing a means for citizen input.

BC policy on citizen engagement is managed through the central agency, Government Communications and Public Engagement (GCPE). This agency is responsible for providing advice across all BC Ministries, as well as managing the interface with the community. For example, the agency manages the govTogether BC website which supports "the government in its objective to become more transparent and accessible" (BC Government, nd-c). The website provides a one-stop shop for BC citizens interested in active participation in the BC community. Health policy officers advised me that the GCPE provides a single point of guidance for BC policy officers through resources,

training and advice on citizen engagement activities (see section 7.6 below). This comment is supported by the presence of a *Citizen Engagement Handbook* which makes clear the role of the GCPE which, it says, will do "much of the heavy lifting" (BC Government, nd-a, p8). The *Handbook* gives practical advice on designing and conducting citizen engagement but does not mention any particular skill sets and does not draw attention to CALD citizens (BC Government, nd-a). The *Handbook* lists a series of additional resources such as "Getting Participation" and "Building Your Community" but these are not publicly available and so no assessment could be made of the content (BC Government, nd-a, p20). Although the BC Provincial government is very active in engaging with the community, there is nothing on the websites managed by GCPE to suggest a commitment to contextual sensitivity in citizen engagement (BC Government, nd-b).

In Ontario, overt support for citizen engagement appeared in October 2013 when the Premier of Ontario wrote an open letter to Ontario citizens setting out the Premier's vision for a more engaged Province, wherein citizens can participate in decision making in a variety of ways as well as access a range of government information online. The Premier foreshadowed engagement plans to be developed by all Ministries, supported by a newly established expert team to lead "Province-wide discussion" (Wynne, 2016).

In March 2016 a Province-wide *Public Engagement Framework* was launched comprising four approaches to engagement: "share, consult, deliberate, collaborate" (Government of Ontario, 2016). There is no further detail about the *Framework* other than the case studies used to test different approaches to engagement, thus it is not possible to judge whether contextual sensitivity is a key question in the *Framework*. This *Framework* was not in place at the time of interviews.

Conclusion

In this Chapter I have addressed the second research question, considering how cultural competence is applied to citizen engagement for health policy development. The conclusions in this chapter draw on a review of government policy documents. This Chapter started by introducing the concepts of deliberative democracy and citizen

engagement. I then focussed on the benefits of, and challenges presented by, citizen engagement for health policy development.

By assessing Federal and State/Provincial government policies in both countries, I observe a mixed picture. Australian Federal governments, over time, have acknowledged the need to support people from CALD backgrounds specifically in terms of access to government services. The current requirement that agencies have Agency Multicultural Plans in place acknowledges the need to focus on CALD citizens. Despite this, Australia does not have Federal legislation establishing citizen engagement as a requirement of all government agencies. Nevertheless, some agencies such as Australia's NHMRC have their own establishing legislation which does require public consultation. There is little, if any, policy support at the Federal level to drive citizen engagement. Public sector reform initiatives such as the *APS Blueprint for Reform* (Advisory Group on Reform of Australian Government Administration, 2010) mention citizen engagement but do not appear to be central to health policy officers' thinking.

Canada's Federal government provides a contrast. The Constitution Act 1982 (Can) recognises the multicultural nature of Canada, affirms the equality of all citizens, and calls for involvement of all citizens in government business.

In Australia, only the ACT has a clear framework for citizen engagement at the whole-of-government level. Although Queensland has a stated policy of citizen engagement this is no longer as explicitly supportive as it was a decade ago. In the Canadian Provinces, BC offers whole-of-Province policy support for citizen engagement thus ensuring some consistency across departments of state, although CALD citizens are not mentioned as deserving of special or different attention. Ontario has only recently introduced government policy on citizen engagement. In neither country is there any sense that Federal governments provide leadership, which means that the States and Provinces must develop their own interpretation of, and guidance about, Federal government requirements.

Whilst the Canadian Federal government is ahead of its Australian counterpart, thanks to the Canadian Constitution and more recent Open Government initiatives, Australian State governments and Canadian Provincial Governments appear to be similarly active in policy terms. Despite this, as far as engagement of citizens of CALD backgrounds goes,

no single jurisdiction shows clear leadership. Although BC Provincial Government demonstrates a whole-of-government approach to supporting Ministries to engage with citizens, there is no sense that the inclusion of citizens of CALD backgrounds is highlighted in any way. In Australia, the ACT provides policy guidance on the inclusion of CALD citizens, but this does not appear to be followed up in a systematic way. Only BC offers training in citizen engagement.

In the next Chapter I will examine citizen engagement policy at the health authority level and will report on the experiences of health policy officers who must implement those policies.

Part Three: A New Attitude

Chapter 7 Contextual sensitivity for citizen engagement in health policy development

> "We're such a small team trying to address such a massive problem,
> it's kind of like throwing a water balloon at a burning building"
> (Participant #5, Australia, State)

In the previous chapter I provided an overview of deliberative democracy and citizen engagement, followed by a review of government policies in Australia and Canada, at both the Federal and State and Provincial levels of government. Based on that review, I observed that the States and Provinces seem to be better equipped with policy frameworks for citizen engagement than their Federal government peers, although none paid specific attention to the inclusion of citizens of culturally and linguistically diverse (CALD) backgrounds.

In this chapter I will look in more detail at the way in which Federal and State or Provincial government policies are translated into action by health authorities for the inclusion of citizens from CALD backgrounds in health policy making. I start by identifying the promise and challenges of the inclusion of CALD citizens and then use my review of government documents to outline and assess health authority policies. A number of themes emerged from my discussions with health policy officers such as the split of responsibilities between Federal and State/Provincial governments, and organisational leadership. Drawing on interviews with health policy officers, I will discuss these themes and illustrate health policy officers' experiences of citizen engagement, and particularly the engagement of CALD background citizens. The chapter concludes with some observations about current practices and how they relate to contextually sensitive citizen engagement for health policy development.

7.1 Deliberative citizen engagement in health policy development and the inclusion of people of CALD backgrounds

In Chapter 6 I canvassed some of the advantages and disadvantages of deliberative citizen engagement more generally. I turn now to look at the health sector in particular. A review of the literature on health policy, discussed in Chapter 2, found that the health sector is complicated, not least because of the many interest groups which seek to influence policy processes. Lenihan argues that public policy has become more complex and policy issues more interconnected than ever before, thus health policy has links to education, employment, housing and so on (Lenihan, 2009). For this reason, complex policy issues need complex solutions and these, he believes, can only be teased out through collaboration, allowing governments to tap into the richness of community experiences in order to identify a full range of solutions. Although arguments are often marshalled for excluding citizen input because of this complexity – such as the specialised nature of health debates – the benefits of citizen engagement can accrue to health policy processes (Tenbensel, 2010). Engagement is to be encouraged because of the unique perspective citizens bring to the table offering balance amongst competing points of view (Kushner and Rachlis, 1998). In fact, longstanding World Health Organization Charters, such as those of Alma Ata of 1978 and Ottawa of 1986, explicitly include citizen participation (Butler et al., 1999). According to Andrew Oxman and colleagues, the benefits of including citizens in the development of health policy are three-fold – citizens' concerns can be addressed and their ideas included, health services are better targeted and improved, and as a result better health outcomes can be achieved (Oxman et al., 2009). Additional benefits include community capacity building (Putland et al., 1997) through heightened levels of awareness and understanding of health issues in the community, ownership of the health policy and processes, and stronger potential for input to the design of services for the disadvantaged (Kushner and Rachlis, 1998; Palmer and Short, 2014).

From the health policy officer's point of view, citizen engagement widens the scope of the information gained enabling identification of needs as well as the ability to test policy ideas, both of which add to the legitimacy of health policy and greater compliance by citizens (Dwyer, 1989; Putland et al., 1997). This view is supported by the remarks of one health policy officer that "when you're co-creating a health policy with patient

partners at the table…you actually have a better policy, a more effective policy." (Participant #12, Canada, Provincial).

One of the difficulties faced by health policy officers is that policy development processes often operate to a short, political timetable and may not be linear in nature (Church et al., 2002). In this environment policy officers need supportive structures, including strong relationships with the communities they serve, in order to ensure successful citizen engagement (Putland et al., 1997). Enablers include official support; skills; consistent procedures combined with stability in structures, functions and staffing; and a means of balancing budget constraints and the desire for just outcomes (Putland et al., 1997).

To ensure that people from CALD backgrounds have an equal opportunity to participate and influence the health policy agenda, internal processes and procedures must be accommodating. Without this accommodation those very processes and procedures, when combined, entrench disadvantage (Hindess, 2008). Demonstrating this tension, health policy officers in both countries, and at both levels of government, reported resource constraints which dictated how much they could engage with the community

> "…making that consultation happen is seen as useful but when budgets are tight …it may be useful but not as important as something else, so in the current climate…it's not seen as the core job." (Participant #2, Australia, Federal)

> "I think you've got to be very careful not to be tokenistic, so doing it genuinely takes time and resources and skill and not everything in this [organisation] allows that luxury." (Participant #3, Australia, State)

> "…we have to be mindful…it's not about leaving [particular communities] out, it's about making sure our dollars and our resources are focussed on…the largest percentage of the population." (Participant #8, Canada, Provincial)

> "As soon as it looks like more resources, as soon as…it is shifting resources, people won't do it." (Participant #9, Canada, Provincial)

These comments show the dilemma facing health policy officers. Their desire to engage with citizens is tempered by resource constraints and the necessity for them and their colleagues to prioritise activities. Too often, that prioritising means that health policy officers are denied the chance to engage with citizens, or engage with a broader group of citizens, thereby stunting options to draw on a greater breadth of input. Inevitably this

means that citizen engagement follows a business-as-usual approach, limiting input to health policy. The result is a lack of input from CALD citizens and, importantly, lost opportunity for people with differing views to hear from each other and potentially learn from opposing or different views on the subject. This outcome is contrary to the view that "Governments need to promote voice as well as choice" (Keating and Weller, 2001, p78) and Dugdale's demand that policy makers listen to their audience (Dugdale, 2008).

There are other challenges for health policy officers intending to engage citizens in the health policy debate, not the least of which is to ensure that the many and varied, and often competing, views can be heard and balanced. Health policy officers need to be able to bring together and facilitate respectful discussions based on mutual trust, understanding, and a willingness to debate and compromise (Dugdale, 2008). They must get over their own prejudice that Joe Public will not be able to understand, let alone contribute to, a "complex policy issue" (Sheedy et al., 2008, p25). To achieve these goals, health policy officers need to supplement their skill as technical experts (Denhardt and Denhardt, 2000; Stewart, 2009) with expertise in communication and relationship building (Gramberger, 2001; Dugdale, 2008; Organisation for Economic Cooperation and Development, 2009; Podger et al., 2012; Nabatchi, 2014), and "cultural sensitivity", in order to demonstrate fairness, equality and equity (Hamilton, 2007, p13).

In summary, including people of CALD backgrounds is a task that requires extra effort such as paying particular attention to the population that is to be drawn on (Smith and Wales, 2000), explicit "outreach" (Silver, 2010, p200), and improved institutional structures to facilitate engagement (Young, 2002). Deliberative citizen engagement can provide a vehicle for managing differences by inclusion in government decision making of a diversity of voices and opinions (Stanisevski and Miller, 2009; Olson, 2011; Marchettoni, 2014). To achieve this requires a vigorous public sphere in order to challenge institutions which, by their greater weight of size, wealth and power, dominate and exclude some citizens (Bronner, 2002).

As set out in Chapter 2, critical multiculturalism argues that economic and social structures in society discriminate against people of CALD backgrounds, thus making it difficult for them to engage with governments and achieve policy justice. The result is a continuation of the status quo – health policy that perpetuates one-size-fits-all and a lack

of awareness amongst health policy officers about the effects of this on people of CALD backgrounds. Conversely, institutional processes that are open will ensure that all voices have the opportunity to contribute to the best possible health policy to meet the needs of all citizens (Fuller, 1997). The promise of deliberative citizen engagement in multicultural societies will not be realised if less dominant voices are not heard and dominant groups do not understand how their norms serve to oppress minorities, see these practices as unreasonable, and therefore make changes to modes of operating (Williams, 2000).

I turn now to identify the health policy frameworks relevant to citizen engagement to assess whether, and how, they enable contextually sensitive citizen engagement.

7.2 Australian Federal health authority approaches to citizen engagement

The Federal government of Australia has expressed explicit support for multiculturalism and citizen engagement. How does this translate to action at the health policy officer level? The Federal Health Department does not have an explicit policy mandating citizen engagement. Nevertheless, some individual national health policies call for engagement with citizens, and acknowledge people from CALD backgrounds. In brief, these policies are the

- *Australian Safety and Quality Framework for Health Care* which identifies "consumer centred" health care requiring a partnership with consumers to ensure shared decision making, and acknowledges the need to "provide care that respects and is sensitive to different cultures" (Australian Commission on Safety and Quality in Health Care, 2010);

- *Australian Charter on Healthcare Rights* which identifies the right to *respect* which means "The care provided shows respect to me and my culture, beliefs, values and personal characteristics", and the right to *participation* which means "I may join in making decisions and choices about my care and about health service planning". (Australian Commission on Safety and Quality in Health Care, Endorsed 2008); and

- *Australian Safety and Quality Goals for Healthcare* Goal 3 which requires "partnering with consumers" not only about their own health care but also in the "governance of healthcare organisations" (Australian Commission on Safety and Quality in Health Care, nd).

Some individual agencies within the health portfolio have specific legislation requiring them to engage with the community, for example the National Health and Medical Research Council (NHMRC). The NHMRC has developed advice to support citizen engagement, such as the *2016 Standards for Guidelines* which note that guidelines must be "informed by public consultation" in order to be "relevant and useful for decision making", although guidance on what this means is still under development (National Health and Medical Research Council, 2016a). Advice on engaging consumers and the community in health and medical research acknowledged the need to consider culture as an influence (National Health and Medical Research Council and Consumers' Health Forum of Australia, 2002). The 2002 document has been replaced by an updated version entitled *Statement on Consumer and Community Involvement in Health and Medical Research* (National Health and Medical Research Council and Consumers' Health Forum of Australia, 2016b). This updated *Statement* lists "implementation issues that may need to be considered" including "reach out to an appropriately diverse range of consumers and community members" and "be inclusive" (p12). Both of these statements focus on the process of engagement, the former to help identify the "most effective involvement strategies" and the latter so that "more consumer and community members will be able to contribute" (National Health and Medical Research Council and Consumers' Health Forum of Australia, 2016b, p13). There is no mention of citizens of CALD backgrounds or of cultural competence.

Despite these shortcomings, the *Statement* has aspects of contextual sensitivity embedded within its advice to research organisations. Barriers to citizen engagement are identified and include "feeling of isolation…strong organisational cultures" and "power imbalances between researchers and consumer and community members" (National Health and Medical Research Council and Consumers' Health Forum of Australia, 2016b, p13). The *Statement* acknowledged that organisational structures, and the location of power, can affect the way in which citizens engage with health and medical research processes. By

identifying the need to use inclusive engagement strategies, the *Statement* hints at the need to consider the best ways of engaging with citizens who may not normally be included.

It is possible that the lack of leadership from the Federal health portfolio, illustrated by the absence of overarching policies in Australia, could explain the poor attention to citizen engagement in health policy development. There is no policy imperative driving health policy officers to pay specific attention to citizen engagement, nor to the deeper issue of inclusion of CALD citizens. Conversely, the NHMRC examples suggest that the presence of agency-specific legislation has influenced actions within that agency. The result is advice to NHMRC's stakeholders about the importance of, and ways in which to engage with, citizens. Nevertheless, the NHMRC examples do not address explicitly the issue of cultural diversity. First impressions suggest that compliance with legislation is a driver of citizen engagement at the Federal level in Australia, and the absence of legislative frameworks more broadly leads to poor attention to citizen engagement.

In the next section I address Australian State health authorities' approaches to citizen engagement.

7.3   ACT and Queensland health authorities' actions to engage with citizens

At section 6.4 I set out the overarching State government approaches to citizen engagement, noting that both the ACT and Queensland had explicit policies. None of the Australian State health policy officers interviewed referred to any of the States' overarching policies which led me to wonder whether they were more familiar with their agency specific advice. This did not appear to be the case because none of the following policies were mentioned by Australian health policy officers.

Starting with the ACT, the Health Directorate's *Consumer and Carer Participation Framework* makes clear the Directorate's commitment to citizen engagement. It states that successful consumer participation rests on, amongst other things, an awareness of or openness to cultural diversity amongst health professionals, and culturally sensitive health services offering cultural awareness training to their staff (ACT Health Directorate,

2011). People from CALD backgrounds are not otherwise specifically recognised in this *Framework.*

In addition, some individual ACT Health Directorate policies address the inclusion of CALD citizens such as:

- *Towards Culturally Appropriate and Inclusive Services: ACT Coordinating Framework 2014-2018,* the Directorate's multicultural health policy, which requires action to facilitate participation in "feedback, service planning and improvement" by people from CALD backgrounds (ACT Health Directorate, 2014, p28). A number of actions are specified to meet this objective, including feedback mechanisms, inclusion of CALD people on a variety of fora within the Directorate, development of a communication strategy and targeted consultation with CALD people, and funding of a CALD liaison position within the ACT Healthcare Consumers organisation. (To be fair to the health policy officers I interviewed, this Framework was a work-in-progress at the time of my interviews although the Unit developing the Framework was mentioned);

- *Listening & Learning ACT Health Consumer Feedback Standards* which provide guidance for people working in health services about establishing a consumer feedback system, a system that must be accessible to all people, including those from CALD backgrounds, taking into consideration "language, social and cultural beliefs, practices and values" (ACT Health Directorate, 2003, p7). The feedback system is to be supported by training in receiving feedback, including "cross cultural issues" (p14).

All of these policies rely on awareness to precipitate action, but none really exhibit a contextual sensitivity. It may be that there is too little detail in the actual policies but, having said that, upon questioning health policy officers I was not made aware of any toolkits or other internal guides that would assist with implementation. As further evidence of a lack of contextual sensitivity, despite this policy framework one health policy officer advised that the focus on citizen engagement too frequently emphasised the process, such as whether community members appointed to policy committees should receive payment and how they would be recruited, rather than the quality of the engagement.

In Queensland, Queensland Health provides overarching policies as well as guidance to the State's Hospital and Health Services (HHS). Since the establishment of the HHSs, earlier Queensland Health policies relating to citizen engagement have been removed from view. Prior to this, the 2010 *Community Engagement Policy* endorsed the State Government's six guiding principles of inclusiveness, reaching out, mutual respect, integrity, affirming diversity and adding value (Queensland Health, 2010c). Importantly the policy recognised that citizens may share "common goals" or "interests" regardless of "cultural characteristics" (Queensland Health, 2010c, p3). As with earlier State Government policy on citizen engagement – also removed from circulation as noted at section 6.4 – the Queensland Health reference to citizens as not bounded by cultural group showed a contextually sensitive approach to health policy development. In order to assess the current status of citizen engagement within Queensland Health, I repeated my search of the Queensland Health website in February 2017, looking particularly for 'consumer' or 'citizen engagement' or 'participation'. The only resources discovered belonged to the various HHS, there were no publicly available, updated, policies belonging to Queensland Health itself. In addition, as noted in Chapter 5, none of the Queensland Health multicultural health policies appear to have been updated to take into account the introduction of multicultural legislation in 2016. Neither is there any advice on the Department's Multicultural Health website to indicate that updates are in progress. However, because these multicultural health policies are relevant to citizen engagement I rely on the currently available documents for the following analysis.

The Queensland Health *Strategic Plan for Multicultural Health 2007-2012* contains actions for "partnerships and engagement with multicultural communities" and calls for ongoing engagement supported by relationship building and internal resource documents (Queensland Health, 2007, p6). Further, the *Guide to implementing the Queensland Multicultural Policy 2011 and Language Services Policy in a health context* which represents *Attachment A* to the *Guideline for multicultural health policy implementation* includes community engagement as a specific action area (Queensland Health, nd). Actions include development of district CALD profiles, use of existing resources to guide engagement planning and processes, provision for regular community engagement both for information provision and to receive input into service planning, building of relationships to facilitate community input, and annual reporting.

Legislation establishing the HHSs required development of "consumer and community engagement strategies" within six months of their establishment. To assist this process the Minister for Health asked Health Consumers' Queensland, a not-for-profit organisation, to "work with…HHSs to support the development" of these strategies, resulting in the *Consumer and Community Engagement Framework 2012* (Health Consumers Queensland, 2012, p8). The *Framework* contains nine principles of community engagement, sets out the benefits of engagement and provides a model to guide HHSs in developing their own engagement strategies. Whilst the *Framework* comments on the added value gained by including input from people of CALD backgrounds, it does not mention cultural competence, for example, as a required skill.

The Metro South Health *Consumer, Carer and Community Engagement Strategy 2016-2019* is an example of the frameworks required under HHS legislation referred to above (Metro South Health, 2015). This *Strategy* is based on several principles of engagement, one of which is "respectful, culturally appropriate and meaningful" engagement with consumers (p24). The *Strategy* acknowledges the importance of community engagement to assist with service planning, design, monitoring and evaluation and identifies action to deliver "multicultural and diversity training" to staff (p16). One performance measure is to identify both the "number and diversity" of consumers engaging with the HHS (p22). This *Strategy* differs from the 2012-2015 community engagement strategy (Metro South Health, 2012) in that there is no mention of cultural competence, and no specific acknowledgement of the cultural context of the HHSs consumers, meaning that previous contextual sensitivity has been lost.

Although reference to cultural diversity is included in their policies, neither the ACT nor Queensland health authorities show a contextually sensitive approach to citizen engagement. By not mentioning any specific policy documents, Australian State health policy officers show a lack of awareness that may be a result of poor organisational focus on citizen engagement and the inclusion of CALD citizens.

7.4 Canadian Federal health authority approaches to citizen engagement

The Canadian Constitution enshrines multiculturalism and citizen engagement which suggests that Canadian Federal health agencies should be well placed to engage with CALD citizens. There is a long history in Canada of engaging with the community around health issues. For example, in the health sector the Health Forum (established in 1994) was tasked with seeking citizen input into the suitability of Canada's health system and ways in which resources could be used more effectively. The Forum was reportedly a catalyst for greater public involvement in Canadian health policy (Ham, 2001). As well, the 2001 Royal Commission on the Future of Health Care in Canada recommended greater citizen involvement in government decision making (Tritter and McCallum, 2006). Although the Royal Commission has been criticised as not fulfilling the full promise of deliberative democracy (Von Lieres and Kahane, 2007), it should be recognised as a major commitment and attempt by the Canadian government to engage its citizens in discussion around substantial health issues.

Following the Health Forum, and in parallel with national initiatives to improve citizen engagement, in 2000 Health Canada developed a policy on public involvement (Health Canada, 2000). The policy was underpinned by five principles which acknowledged the integral nature of public involvement in policy making; committed to improving levels of knowledge of health issues in the community; welcomed the views of citizens and committed to providing feedback on public involvement outcomes; sought to reflect the diversity of Canadian citizenry whilst being transparent, accessible and coordinated; and supported departmental staff to engage with the community and to acquire and maintain appropriate policy-related skills. Health Canada also established the Office of Consumer and Public Involvement (OCAPI) to act as a focal point for citizen engagement within Health Canada (McGregor, 2003). OCAPI was disbanded in 2012 and the policy on public involvement is no longer available as a result of initiatives described below.

More recently, Health Canada has established a Division of Consultation, Public Engagement and Public Marketing to provide support to both Health Canada and the Public Health Agency of Canada (PHAC). One of the results of this new focus is the publication of *Health Canada and the Public Health Agency of Canada Guidelines on Public Engagement* (Health Canada, 2016b). The *Guidelines* are intended "to strengthen

public engagement" at both agencies through advice on effective and best practice, whilst allowing for "flexibility to address varying needs for conducting engagement." (p2). The *Guidelines* are also intended to "foster a culture of public engagement" across both agencies (p2). Although not mentioning culture, cultural competence or CALD citizens specifically, the *Guidelines* promulgate three guiding principles of "open and inclusive", "timely and transparent", "responsive and relevant" public engagement (p7). Rosa Venuta, Manager, Public Engagement Unit, Communications and Public Affairs Branch, at Health Canada confirmed by email that the *Guidelines*

> "are generally broad and not specifically targeted to people from culturally or linguistically diverse backgrounds, however the guidance does encourage employees conducting public engagement activities to use Guiding Principles to ensure that the consultations are open and inclusive. For example, potential barriers to participation should be noted and addressed (e.g., disabilities, and cultural, socio-economic, language, geographic or other factors)." (2017, 22 February).

These *Guidelines*, along with coordinated support through the new Division, have superseded initiatives that were once particular to each agency. However, it is worth noting that, at the time of writing, the PHAC *Core Competencies for Public Health in Canada Release 1.0* are still available (Public Health Agency of Canada, 2008). The *Core Competencies* were developed within a framework of accepted values and attitudes which include "…a commitment to equity, social justice…respect for diversity…empowerment and community participation" (p3) where community participation is defined as "Procedures whereby members of a community participate directly in decision-making about developments that affect the community." (p9). There is no specific core competency to address community participation but this activity can be inferred from reading *Core Competency 4 Partnerships, Collaboration and Advocacy* and *Core Competency 6 Communication*, which both have oblique references to engagement with the community such as "Identify and collaborate with partners", "build partnerships", "mediate between differing interests" (p20) "communicate effectively with…groups", "interpret information for…community audiences" and "mobilize individuals and communities" (p22). As noted above, Health Canada now provides public engagement support to PHAC.

The new Health Canada Division of Consultation, Public Engagement and Public Marketing and *Guidelines* on public involvement (Health Canada, 2016b) indicate a

renewed focus on citizen engagement in Health Canada. The reference in the comment above to "potential barriers to participation" is an indication that Health Canada is alert to the need to question context surrounding citizens and their ability to engage with government. This is an implied step towards contextual sensitivity in citizen engagement.

In addition, information about consultations underway is provided at the Health Canada Public Involvement webpage (Health Canada, 2016a). This page provides links to related sites including the Federal Government's Consulting with Canadians website.

Similar in function to Australia's NHMRC, the Canadian Institutes of Health Research (CIHR) has developed a *Strategy for Patient Oriented Research* based on the belief that patient engagement in medical research will enhance research outcomes, thus providing a stronger evidence base upon which to build health policy to achieve better health outcomes for Canadians (Canadian Institutes of Health Research, 2011). Because "patient and public engagement is integral to the Strategy as a whole" (p20) there is considerable emphasis on suggested strategies to achieve this engagement. Unlike the NHMRC, there is no agency-specific legislation requiring CIHR to engage with the community.

7.5 British Columbia and Ontario health authority actions to engage with citizens

I now turn to Canadian Provincial health authorities' policy frameworks. In British Columbia (BC), in the late 1980s and early 1990s, a series of reforms saw the devolution of greater responsibility for health care management from the Provincial level to the regional level. The reason for this devolution, with its key feature of greater public involvement in the health care system, was said to be the need for greater efficiency and responsiveness and accountability to the community (Chessie, 2009). However, the BC Health Ministry does not have a policy on citizen engagement, although this absence could be explained by the presence of a Central Agency responsible for whole-of-government citizen engagement (described at section 6.6).

Ontario, in the 1970s, was reportedly the first Province to initiate public participation in the health system, initially through participation on local health boards and later

regulatory boards, followed in the late 1990s by mandatory mechanisms for public participation in health (Abelson and Eyles, 2002). These early initiatives do not seem to have survived. Despite the recent introduction of a Province-wide public engagement framework (see section 6.6), the Ontario Ministry for Health and Long-Term Care does not have a publicly expressed policy on citizen engagement although there are some activities which indicate the Ministry's commitment to citizen engagement. An example can be found in the Ministry's *Guidance Document for Declaration of Values ECFAA Requirement* to assist hospitals to work through public consultation mandated in the Excellent Care for All Act (ECFAA) (Ont) (Ministry of Health and Long-Term Care, 2010). The *Guidance Document* includes "respect for cultural diversity" as a core value (p5), and directs hospitals which need procedural help to access community engagement resources provided by the Ontario Hospital Association. On the face of it, it appears the Ministry is not intending to develop detailed advice since it is referring hospitals to external organisations for community engagement assistance. This *Guidance* has not been updated in the intervening years.

In addition, the Ministry has established a Citizens' Council, a group of 25 Ontarians "from all walks of life" that meet to provide "values and opinions that reflect the needs, culture and attitudes of Ontario citizens" relevant to Provincial drug policy (Ministry of Health and Long-Term Care, 2012c). The reports of each of these meetings are freely available on the Ministry website.

Similar to Queensland, Ontario has also devolved certain health policy activities through the establishment of a number of Local Health Integration Networks (LHIN). The Local Health System Integration Act 2006 (Ont), establishing the LHINs, requires community engagement in the development of priorities and integrated health service plans. The Toronto Central LHIN *The Future of Healthcare is Local. Integrated Health Services Plan 2016-2019*, required by legislation, acknowledges that culture is just one of many factors that influence health and notes the need to "engage marginalized populations" as part of a population health approach (Toronto Central LHIN, 2016, p33-34). The *Integrated Health Services Plan* references Ontario's Health Equity Impact Assessment toolkit and the LHIN's own citizen engagement guidelines.

The Toronto Central LHIN is assisted in its community engagement activities in three ways. Firstly, a collaboration of the 14 LHINs and the Ministry of Health and Long-Term Care developed advice to all LHIN's in the form of the *LHIN Community Engagement Guidelines and Toolkit* (Local Health Integration Network, 2011). The *Guidelines,* revised in 2016, comprise eight principles for "meaningful engagement" which includes "attention to inclusion and demographic diversity" (Local Health Integration Network, 2016, p7). The revised *Guidelines* also acknowledge that "access to information" is complex and is "mediated" by a range of influences including the cultural background of the community member (Local Health Integration Network, 2016, p6).

Secondly, in-house support is provided through a *Community Engagement Toolkit for Health Service Providers and the Toronto Central LHIN* (Toronto Central LHIN, 2011b). This short *Toolkit* places community engagement in all activities including "defining issues and needs, considering solutions, establishing priorities and implementing a program, project or service change" and emphasises the value to be gained by "incorporating the knowledge, experience, values and perspectives of individuals and communities" in terms of "better decisions, policies and services" which will "ultimately create healthier individuals, organizations and communities." (p3). The *Toolkit* identifies "inclusion and demographic diversity" as a guiding principle to "equitably incorporate diverse people, voices, ideas and information to lay the groundwork for quality outcomes and democratic legitimacy" (p4), and articulates the expectations the Toronto Central LHIN has of itself and its health service providers in terms of which activities must be built on community engagement. The *Toolkit* includes a checklist of actions and a list of "engagement tactics" (pii-iv). Details of skills needed, including cultural competence, are not mentioned.

Lastly, the *2011-2012 Toronto Central LHIN Community Engagement Plan* was developed to guide engagement activities (Toronto Central LHIN, 2011a). The *Plan* sets out priority populations (eg the public, health service providers, government, priority communities such as Aboriginal people) and the processes that will be used to engage with them. The *Plan* also contains the goals of engagement, namely to develop a new strategic plan, support implementation of the 2010-2013 Integrated Health Services Plan, and to "enable and ensure" health service providers involve the community in decisions relating to "health service changes and programs" (p15). Each goal identifies actions to

achieve the goal for each priority population. There does not appear to be an updated *Community Engagement Plan* to complement the 2016-2019 *Integrated Health Services Plan* referred to above.

The Toronto Central LHIN is the only Provincial health authority of those examined that has policy frameworks which articulate a contextually sensitive approach to citizen engagement.

7.6 Common themes in citizen engagement for health policy development

In Chapter 1 I posed the question *How is cultural competence applied to citizen engagement for health policy development?* In this and the next section I will explore this question by looking at health policy officer experiences of working within policy frameworks for citizen engagement in multicultural societies. In parallel with this review, I will assess whether contextual sensitivity is demonstrated at any level of government in either country.

Health policy officers across Australia and Canada and at both levels of government are aware of the need to engage with citizens. Structural support to facilitate fully inclusive citizen engagement for health policy development, described above, is patchy with the most obvious policies existing in health authorities in the ACT, Health Canada and the Toronto Central LHIN.

In discussing their experiences, I note that no Australian health policy officer referred to the policy frameworks. On the contrary, they expressed a view that the policy development process was insufficient to ensure that "…the multicultural community out there" (Participant #1, Australia, State) is not forgotten. This was less so in Canada where the requirements of the Constitution were mentioned at both the Federal and Provincial level. The reality of citizen engagement differs for health policy officers in Australia and Canada despite the presence – notably in Australia – of policy frameworks. A number of themes emerged from our discussions.

7.6.1 The split of responsibilities in a Federation

A consistent theme arising from interviews, crossing countries and levels of government, was the way in which government responsibilities in a Federation are split between the Federal and the State or Provincial levels of government. On occasions, this split of responsibilities was used to explain why the jurisdiction in question had not specifically targeted people from CALD backgrounds for inclusion in policy development activities

> "In the policy development process there's…the feeling that…you need to deal with the majority and then focus on particular groups, but it does often depend on the purpose of the policy…" (Participant #2, Australia, Federal)

> "In Canada there is a relationship with the Federal government and a division of responsibilities for healthcare and immigrant policy…it's not that it's not relevant to us but we wouldn't set up to address migrant issues as our initial focus because the lead responsibility rests with the Federal government." (Participant #10, Canada, Provincial)

These responses illustrate the need for clarity about the nature and place of citizen engagement as a fully inclusive activity, regardless of the level of government. The presence of policy frameworks does not seem to have translated into the everyday work of health policy officers, and the defensive tone of the remarks could suggest that policy officers know there is a gap in citizen engagement coverage and are trying to explain it away.

7.6.2 Legislation and policy frameworks as drivers of citizen engagement

At the Federal level, in both Australia and Canada, health policy officers are aware of the legal requirements relating to citizen engagement which apply to their health authority

> "…it was explicitly written into our Act that we would consult on everything we do…" (Participant #2, Australian, Federal)

For Australian State health policy officers who have policies rather than legislation to rely on, these policies did not figure in their discussions with me. Canadian Provincial health policy officers have the same legal framework as their Federal counterparts and this was mentioned in discussions, sometimes along with other policy frameworks

> "There's a standard to adhere to. Our biggest standard is the Constitution… There could be other agreements… like codes of conduct or standards of practice or ethical guidelines that we would

> have documented, and professional practice standards...” (Participant #7, Canadian, Provincial)

Legal requirements around citizen engagement form part of a health authority's accountability framework and so I am not surprised that the law is high in policy officer's consciousness. I would expect that health authorities would be held to account for implementation of whole-of-government policies and guidelines in the same way as they must account for compliance with legislation. However, this does not seem to be the case. Existing policy frameworks do not have the same presence, either in the minds or work programs of the majority of health policy officers.

In my experience as a career public servant, policies that are an administrative burden are more likely to be consigned to the back burner and only brought out when reporting is required – forgotten under the weight of everyday priorities and pressures. Given the relative seniority of the health policy officers who participated in this research, this is not an adequate explanation for the lack of reference to existing policy frameworks, something that was particularly noticeable in Australia at both levels of government.

When policies are strongly supported by health authority leadership they are more likely to become embedded in policy officer activities as a matter of course. This conclusion is borne out by the actions of the majority of Canadian health policy officers, at both levels of government, who not only mentioned the Constitution and its requirements but also reported strong government and health authority commitments to citizen engagement. The same was not true in Australia where it appears that existing policy structures, especially at the State level, are not being used to the full advantage of health policy officers, nor even seemingly explicitly supported by health authority leadership teams in such a way that would make the presence and content of policy structures part of doing business.

Looking more closely at the policies that do exist, very few exhibit any signs of contextual sensitivity in citizen engagement. For example

> “As far as do I feel that we communicated effectively, or even reasonably well with the CALD community, I think the answer would be no.” (Participant #1, Australia, State)

This holds true even for the ACT, where State-wide policies of citizen engagement include a contextually sensitive approach to CALD citizens. At the Australian Federal level, one health policy officer advised that

> "…in our day-to-day practice we still don't do enough in relation to making sure that the cultural awareness is built in to all the things we do." (Participant #2, Australia, Federal)

This comment illustrates that the structures within which health policy officers operate do not encourage them to question the status quo, thus perpetuating business-as-usual approaches with consequent exclusion of CALD citizens. This comment is also an indication that the lack of procedures to engage with CALD citizens results in a check list approach to citizen engagement, rather than critical consideration of appropriate and inclusive deliberative processes.

It appears that, regardless of the level of government, the presence (in Canada and in some Australian health authorities) or absence (in Australia generally) of legislation is a strong driver of knowledge, but there is a contradiction between the presence of policy frameworks and policy officer actions. Having said that, I will leave this section with the comments of one particular health policy officer who said that citizen engagement was important because of a

> "…moral impetus around ensuring that for democratic principles, that those who are affected by research are engaged in research."
> (Participant #11, Canada, Federal)

At least in one health authority, citizen engagement is seen as an issue of values rather than simply compliance, thus balancing legal requirements with humanity.

7.6.3 Positive leadership and organisational culture as an enabler

Regardless of the status of policy frameworks, what seems to be lacking in some health authorities is clear and active leadership reflected in the culture of the organisation as one which values the inclusion of CALD citizens in health policy development. This issue arose, especially, in Australia where policy officers commented that organisational culture depended on the leadership team modelling appropriate behaviours

> "The culture of cultural awareness may not be present unless, of course, the people in leadership positions are aware themselves…hierarchy is built on seniority where generally the

people who are most resistant are at the top…" (Participant #2, Australia, Federal)

"…the people upstairs aren't nearly as culturally safe or aware or competent in safety and awareness as people like us working directly with the communities…so policies or resources…are not developed with consultation with the communities that they're addressing." (Participant #5, Australia, State)

Demonstrating through their comments a lack of organisational focus on citizen engagement and participation by CALD citizens, some health policy officers translated this situation into a perceived lack of support from the leadership team "…what I would be asking for is…encouragement…" (Participant #1, Australia, State) although one policy officer did see some progress

"I think that this organisation has somehow recognised that responding to women and families of CALD background is more than providing an interpreter." (Participant #3, Australia, State)

Many Canadian health policy officers were both aware and complimentary of assistance provided by their own health authority

"…what I've seen from our Ministry folks is pretty solid work around preparing the background for that. …it's pretty rich, it's not just verbiage..." (Participant #7, Canada, Provincial)

"Now that seems to be part of our culture, how we work." (Participant #12, Canada, Provincial)

These comments illustrate the presence of a positive organisational culture, of leadership, and widespread interest in citizen engagement. However, there is no emphasis on the inclusion of CALD citizens.

Policy officers in both countries, and across both levels of government, made strong statements about the value of leadership for the conduct of citizen engagement

"It is very much a leadership driven thing." (Participant #9, Canada, Provincial)

As several health policy officers noted

"I think it's interesting when leadership sets the tone and direction. ...when our organisation is clear about the objectives and mandates, it

makes it easier for us to have permission to do that work." (Participant #7, Canada, Provincial)

"I don't think it would garner traction if we didn't have top support…and there is very clearly support from the Minister, Deputy Minister and Associate Deputy Minister right down the line." (Participant #12, Canada, Provincial)

"I do think a top down approach to make sure that it happens and make sure that every Division gets it at a priority level." (Participant #3, Australia, State)

These comments reflect the value of strong leadership as an enabler of citizen engagement. Contrasting leadership styles were identified in Australia and Canada, at the State and Provincial level of government

"…[we need] more, stronger leadership in raising the importance." (Participant #3, Australia, State)

"Part of it is she just talked about it [engaging the community] as a value." (Participant #9, Canada, Provincial)

In Australia, the lack of strong leadership was noted. Conversely, in Canada the personal commitment of an Agency head was a major factor in the success of engagement activities.

There was some sympathy for the pressures under which a leadership team works, and the impact that might have on matters relating to cultural competence, citizen engagement and the inclusion of people from CALD backgrounds

"I think there's individual understanding, but not concerted pulling together effort and it's because we're all so busy…being a Health Care Manager is very reactive withstanding staffing shortages…budget blow outs…broken equipment…the time to be strategic is swamped by the operational needs and…I'm not saying that's an excuse, that's just the reality…" (Participant #3, Australia, State)

"…it's overwhelming sometimes as a policy executive to get it all right. The budget, the gendered lens, the disability lens, the child lens, the carer lens, the multicultural…because often they are conflicting messages…" (Participant #3, Australia, State)

These comments could be interpreted two ways. Firstly, they show a loyalty to managers recognising the many influences on their time and capacity to engage with the

community. Secondly, they could be interpreted as defensive of the current situation, excusing poor attention to CALD citizen engagement by highlighting the difficult policy environment.

In terms of personal leadership, one Canadian health policy officer referred to a personal commitment to citizen engagement

> "My goal…that every staff person in the [Agency] understands what the engagement imperative is… My imperative here is to establish a framework and then train everybody in the [Agency] about how to use that framework." (Participant #9, Canada, Provincial)

It is interesting to note that these comments come from an environment with strong citizen engagement principles embedded in the way work is conducted. On the opposite side of the ledger, when health policy officers showed some leadership themselves this did not necessarily lead to organisational change

> "Well there was a lot of interest. Certainly we communicated a lot about the power of this model and the potential that it offers. But it's not the normal way of how people do business. Unless people are inclined to work this way already, or unless they've been part of a process and experienced it and then have converted to the model, just offering information isn't enough to inspire people to change." (Participant #10, Canada, Provincial)

This Canadian response illustrates a personal commitment to citizen engagement but one that was not embraced by the health authority as a whole. The telling part of this comment was the acceptance that citizen engagement is not the normal way of doing business and that staff need to be "converted", which suggests that this particular health authority has not signed on to whole-of-government commitments to involve the community in government business.

Strong leadership at the Provincial government level in BC, described in section 6.6, is a demonstration of transformative public service (King and Zanetti, 2005) which ensures that specific procedures are seen as a normal part of doing business. Building on this Provincial policy, the BC Health Ministry not only makes a commitment to citizen engagement but demonstrates its commitment through action.

7.6.4 Lack of support for CALD citizen engagement in health authorities

The policy structures surrounding health policy officers are not providing adequate support when it comes to engaging with CALD background citizens. Across countries and levels of government, the lack of guidance was lamented. To bridge the gap, health policy officers commented on the importance of tapping into community networks to support engagement of CALD citizens

> "There is not a road map that we can use, and often it comes through the various [community] groups." (Participant #2, Australia, Federal)

> "But we did…really hear strongly from the different representatives that we needed to ensure that there was a diversity of voices and that patients who are engaged in a number of different organisations are really the conduit to help us identify other patients, those whose voices are not typically heard…" (Participant #11, Canada, Federal)

These health policy officers' comments show that organisational support to identify and approach CALD citizens is lacking, causing them to fall back on sources of guidance within the community. As a result of the lack of guidance, CALD citizens are rarely targeted as potential participants in citizen engagement exercises, a point that was acknowledged by one Canadian health policy officer

> "We didn't try to address some of the cultural issues or cultural kind of challenges that would occur in terms of how to make the engagement more equitable across different groups within Canada." (Participant #11, Canada, Federal)

In Australian State jurisdictions change for the better was anticipated following the establishment of specific units to support multicultural health and citizen engagement. These units were seen as a promise for the future as they were already raising awareness, helping to build internal relationships and address issues of potential duplication of effort

> "It certainly has been brought more to our attention and our consciousness with the development of the new [name of] Unit, and so it's envisaged that through that unit, and the framework that they're developing, that I'm hoping that there will be improved mechanisms for us to actually connect better with CALD communities with regard to any of our strategies and plans that we go forward with." (Participant #1, Australia, State)

> "There is currently a lot of talk between [name of person]'s team and our team with regards to how do the roles differ and what does each

unit do and how do we work together." (Participant #4, Australia, State)

As well as hoping for in-house support as above, Australian health policy officers also expressed a desire for specific assistance from the Federal health department, suggesting that existing national standards such as the *Australian Safety and Quality Framework for Healthcare* should

> "…incorporate some multicultural work, standards, …because…everyone works towards those Standards so if there was one included on multicultural engagement, that would be really powerful." (Participant #3, Australia, State)

These Australian responses show a desire for greater support, but this was not the case in Canada where health policy officers overwhelmingly reported support from their organisations. BC furnishes an example of explicit organisational support for citizen engagement through a specialist, whole-of-Provincial government, Central Agency established to support Ministries in their citizen engagement activities

> "So from a training perspective…across government of British Columbia there is a group…part of their portfolio is that dedication to developing toolkits and training for citizen engagement and really just ensuring that BC public servants have the knowledge on how to do it…" (Participant #8, Canada, Provincial)

This training for citizen engagement "focussed on generalities" (Participant #8, Canada, Provincial) and did not include any emphasis on engaging with citizens of CALD backgrounds. The tailoring to "make sure that it accounts for those cultural pieces" (Participant #8, Canada, Provincial) was left to each program area to manage although not necessarily unassisted

> "but of course with Ministry support where they may know something more about that particular community than we do or have already engaged them more." (Participant #8, Canada, Provincial).

Despite the Provincial government's willingness to support policy officers to engage with citizens, there appears to be little emphasis on the inclusion of CALD citizens.

Across countries and levels of government, policy and practical support to health policy officers to engage with CALD citizens is mixed. Whilst the BC Government's initiatives to support all portfolios in citizen engagement is strong there is still no focus on the

inclusion of CALD citizens. This is addressed to a small extent in one Canadian Federal agency which has initiated activities to improve broader cultural awareness amongst staff. That these activities are both in Canada suggests, once again, that the Constitution and related legislation is a driver of citizen engagement activity. BC Health Ministry efforts in providing Indigenous Cultural Competency training are not mirrored in terms of CALD cultural competence. In summary, whilst Canada in general and BC in particular, appear to be the strongest jurisdictions in terms of citizen engagement practices, and the ACT acknowledges the need to consider cultural diversity in citizen engagement, this knowledge must be moderated by the realisation that attention to inclusion of CALD citizens is missing across the board.

7.6.5 Reliance on external bodies and individual staff for procedural advice

In Canada, where organisational support is generally reported as quite good, health policy officers nevertheless turn to external sources for advice and guidance about approaching CALD citizens, using community organisations as either an entrée to a community or as a single point of consultation. For example, Canadian health policy officers utilise external organisations as facilitators

> "…because they already have pre-established relationships. They have connections in the community. They have that trust there." (Participant #9, Canada, Provincial)

> "I think if we had an issue come up there's lots of folks to connect to who are happy to…engage. I don't know if BC is the same as everywhere else…but every time I've worked with the groups like S.U.C.C.E.S.S.[3] or MOSAIC[4]…they are thrilled that we are interested in getting to know what is going on." (Participant #7, Canada, Provincial)

These comments are positive statements about the value of external organisations to government citizen engagement activities, reflecting a sense of the relationship as

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[3] S.U.C.C.E.S.S. is a social services organisation established in 1973 as a "new immigrant settlement service" now a multi-service multicultural agency providing "culturally sensitive" services. The acronym does not appear to stand for anything today but may relate to its initial establishment. S.U.C.C.E.S.S. 2014. *About Us* [Online]. Available: http://www.successbc.ca/eng/company/about-us [Accessed 19 April 2017].

[4] Multilingual Orientation Service Association for Immigrant Communities (MOSAIC) is a "multilingual, non-profit organisation, dedicated to addressing issues that affect immigrants and refugees in the course of their settlement and integration into Canadian society." MOSAIC. nd. *MOSAIC* [Online]. Available: https://www.mosaicbc.org/ [Accessed 19 April 2017].

advantageous and sought after. Indeed, Provincial health policy officers seem highly attuned to the value of networks as evidenced by the comments of another policy officer who spoke of the health-based Patient Voices Network as a source of citizen input

> "And part of that was to push a survey out…through Patient Voices Network, so part of Patients as Partners, and we do still engage with them and some of our public representatives are from that group." (Participant #7, Canada, Provincial).

Similarly, in Australia it was reported that external organisations are approached for support and advice

> "…we have specifically engaged migrant groups on particular topics…" (Participant #2, Australia, Federal).
>
> "…to be able to engage with people from multicultural CALD backgrounds, what we did is we went to [name of person], who is the head of the multicultural group, because that's basically the peak group that I am aware of that can actually help us to engage with them…and [name of person] was able to come." (Participant #1, Australia, State)

although it should be noted that the multicultural group referred to in this comment represented just one country of origin and not CALD citizens more generally.

After reflecting about a specific instance of engaging with a CALD community, one policy officer noted that engagement with people from CALD backgrounds was sometimes serendipitous. I was advised that a peak body through which the agency had worked on a specific project funded a "CALD group…and that was a really good interaction…but that was a surprise." (Participant #2, Australia, Federal).

Health policy officers in both countries, and at both levels of government, recognise the value of reaching out to community organisations for advice on appropriate engagement procedures. However, these actions cannot be interpreted as a contextually sensitive approach to citizen engagement – health policy officers are looking further afield for guidance because they are not finding any, or enough, help in-house. Their comments, though, reflect an approach to CALD citizens very much focused on culture as an identifier, something that contextual sensitivity seeks to put aside. It should be noted here that, in the context of this research, I was interested in in-house help in the form of

policies. In-house help excludes reliance on staff from CALD backgrounds which, as discussed in Chapters 3 and 4, carries its own difficulties.

There is another dimension to external assistance which came to the fore in Australia. External consultants are used

> "to actually do our recruiting for us…they did the protocols for ensuring that we had a nice distribution of people…with a variety of backgrounds" (Participant #6, Australia, Federal)

This comment shows that responsibility for inclusion has been passed to a body outside the health authority. There are two problems with this approach: firstly, how can a health policy officer approve a recruitment plan if unaware about what constitutes inclusive citizen engagement? Secondly, how are the many competing groups and individuals balanced and how is the decision made to draw the line when, as reported, resources dictate the size and shape of any engagement? Inevitably, judgements will be made based on resources of time and personnel, project boundaries, and possibly personal biases about who in the community could be useful to a particular engagement activity.

Despite the reliance on external bodies, not all health policy officers were satisfied with these approaches. The following criticism was made of a disease-specific community group used to obtain citizen input

> "…the groups themselves don't seem to be culturally aware."
> (Participant #2, Australia, Federal).

Whilst this comment is critical of external groups it does not seem to impact on willingness to approach them in the first place. I wonder how this policy officer is judging whether a community group is culturally aware or not – according to what criteria? In the reported absence of training for cultural awareness, the only yardsticks available are those imposed by the organisation and the individual's own opinions. As the literature on critical multiculturalism makes clear (see section 2.3), the dominant group in society, including organisations embedded within that society, make up the rules in order to maintain their dominant position. Expecting health policy officers to display a contextually sensitive approach under these circumstances imposes a pressure on individuals to act contrary to the organisational culture surrounding them. Whilst some may choose to do this (see for example King and Zanetti, 2005) many are not so willing

or well equipped. The general impression given by health policy officers at both levels of government in both countries is that groups external to the bureaucracy, including CALD communities, were more likely to be aware of the issues affecting CALD communities and therefore able to advise policy officers on engagement strategies or provide community input. Relying on external sources, such as disease-specific groups or consultants, for advice means that information is mediated through another body. This seems to suggest that health authorities accept those sources as reliable in terms of providing information relative to CALD citizens. That health authorities seem content to allow health policy officers to rely on external sources for advice, rather than engaging with CALD citizens to get their input direct, seems to be a denial of responsibility.

As I reported in Chapter 4, health authorities in Australia (Federal) and Canada (Federal and Provincial) also look internally to departmental staff from CALD backgrounds in the expectation that they will be able to provide culture-specific information. When combined with a reliance on external bodies, the impact of these actions is profound. Firstly, agency processes are driven by external groups who may have their own vested interests – how can such a process be guaranteed to be fair and inclusive? How can the agency be sure that the external group speaks for many CALD citizens and not just a few? Secondly, reliance on staff as the holders of cultural information could result in less citizen engagement because the information is thought to be held in-house. Lastly, staff are considered to be the holders of all information about a particular cultural group which is contrary to the literature (see Chapter 3) that culture is a constantly evolving concept and therefore no one person could be said to be the repository of all knowledge about a particular group of people.

7.6.6 Dissatisfaction with citizen engagement processes

As a result of the overall lack of guidance, health policy officers in both countries and at both levels of government report dissatisfaction with the way in which citizen engagement is undertaken in terms of CALD participation

> "I know that we have specifically engaged migrant groups on
> particular topics, but I don't think we do as good a job as we should in
> that area. I think that the first point of call is always to produce work
> in English…it's only if we get feedback that there are particular
> migrant groups affected or particular people that would like to have

input that we would then go down that road. It's often not the first choice." (Participant #2, Australia, Federal)

"As far as do I feel that we communicated effectively, or even reasonably well with the CALD community, I think the answer would be no." (Participant #1, Australia, State)

"No, I don't think we're very good at that…it's a missed opportunity" (Participant #3, Australia, State)

"I think we will continue to get better at that. I don't think we're doing a brilliant job of it right now… We do have public representatives, but I would say it's still pretty weak" (Participant #7, Canada, Provincial)

The energy amongst almost all Canadian Provincial health policy officers was obvious, and there was a strong sense of citizen engagement as the way business was done and pride in that focus. Nevertheless, these policy officers were no different to their peers in other jurisdictions in wishing they could do better in terms of engaging with CALD citizens: this even though, for example, the BC Provincial government has engagement structures and benchmarks that are explicitly supported. This contrasts with the Australian situation where policy officers intuitively understand the importance of engaging with CALD citizens but are not supported to pursue this.

When organisational culture supports an activity, in this case citizen engagement, that activity becomes a normal part of conducting business. In Canada this has led to both acceptance of citizen engagement and an eagerness to do the very best with the available resources. General feelings of goodwill amongst Canadian health policy officers towards their health authorities were also in evidence, even though health policy officers felt that more could be achieved. Contrarily, this conclusion is supported by the absence of those attributes amongst Australian health authorities and health policy officers. Australian health policy officers exhibited feelings of uncertainty and frustration as they were expected to engage with the community but with little if any organisational support. The lack of reference to such policy frameworks as do exist indicates that they are not embedded in an organisational culture of citizen engagement. The exception to this is where legislation directs activities.

7.6.7 Information sharing and collegiality a strength in Canada

Sharing information was a strong feature of citizen engagement practice in Canada, at both levels of government. A number of comments were made about the value of informing, and learning from, other health policy officers such as the following

> "At each of the forums what I try and do is ensure that there are other Ministry people coming to the forum…they get a sense of the impact and the understanding of some of the issues…" (Participant #12, Canada, Provincial)

> "…[we use] our internal intranet…for citizen engagement so we can learn from each other what worked." (Participant #8, Canada, Provincial)

Others referred to the importance of identifying lessons learned, not only from their own experiences but also from partner organisations, in order to inform future citizen engagement

> "…we're developing a community of practice within [Agency]…to look at some of these implications…how we can help develop our recruitment efforts and supports…what are some of the organisations out there who can provide us with some of their lessons learnt around how they've tried to broaden the scope of who they involve" (Participant #11, Canada, Federal)

> "…any engagement should include that opportunity, for lack of another word, about lessons learned. ..if you're not constantly learning how to engage people then you're probably not learning from what you engaged in well." (Participant #8, Canada, Provincial)

All of the above comments demonstrate willingness to share information and to learn from others. This was not the case in Australia, where sharing information or learning from others was only mentioned in one health authority, where I was told that policy officers were documenting their actions so that their experiences could be used as a teaching aid for other staff

> "What I see to be part of our role in this project…is working with other staff members to develop their cultural competence." (Participant #5, Australia, State)

Sharing information means that policy officers do not have to make all the same mistakes, trial and discard the same procedures, endure criticism for missing certain steps, groups or individuals. Sharing information enhances both work efficiency and effective use of

resources to achieve policy outcomes. It appears that the organisational culture in Canada, which is more embracing of citizen engagement, is empowering Canadian health policy officers to seek advice, share information, and learn from the experiences of colleagues. That Australian health policy officers are lacking in support may mean that they are not enabled to share information, even within their own organisation.

7.6.8 Importance of adequate resources

Another common theme across all jurisdictions was the need for adequate resourcing, both human and financial, not only for citizen engagement but to achieve cultural awareness and inclusive practices. Policy officers in Canada, at both levels of government, commented on resources that their organisations already contributed to citizen engagement

> "So the support has been ongoing. …probably the last three or four years more of a designated staff resource devoted to this area within the organisation…" (Participant #11, Canada, Federal)

> "…the Federal government is giving us targeted funding in our budgets…" (Participant #11, Canada, Federal)

> "We have a budget that is approved to do the work…" (Participant #12, Canada, Provincial)

These comments illustrate recognition of the resources provided for citizen engagement and included items such as training for staff and patient partners. There was no sense that resources were being provided to extend business-as-usual citizen engagement practices to include CALD background citizens.

The call for additional resources was a stronger message in Australia than in Canada. One health policy officer articulated what many alluded to, that the size of the task they were being asked to tackle was not in proportion to the resources available and a key message for the leadership team would be "…highlighting the importance of how we do our work and the fact that what we're expected to do…" does not match "our capacity" (Participant #5, Australia, State). Other health policy officers, in both countries and at both levels of government, emphasised the need for agencies not only to invest in their own staff and programs, but also in "understanding" the roles of health policy officers who engage with the community

> "We need to invest in understanding the people [ie the
> community]…" (Participant #4, Australia, State)

> "…it's important to invest resources around this [cultural competence
> and citizen engagement]…it's important to invest resources in
> ensuring that we get it right". (Participant #11, Canada, Federal)

As the literature discussed in Chapter 6 shows, including citizens of CALD backgrounds in health policy development demands more time and effort. Resources of time, money and people to undertake citizen engagement is the strongest commitment an organisation can make, sending the message that citizen engagement is a priority and essential to business. Without adequate resourcing, citizen engagement becomes a hit-and-miss affair, falling back on the usual contacts and the simplest ways of receiving input in order to meet deadlines that do not take into account the amount of time and effort that citizen engagement requires. Although Canadian health authorities are better placed than their Australian counterparts in terms of resources provided for citizen engagement, there is still a lack of focus on CALD citizens. As noted at section 6.2, health policy officers commented that taking the least costly or quickest route to citizen input was generally the norm, thus not recognising the barriers to inclusion that these processes can present.

7.6.9 Empowering citizens to engage with government

Considering ways in which citizen engagement can be enhanced, policy officers in Canada spoke of a commitment to ensuring that citizens and healthcare provider partners could be empowered to participate in health policy development, such as the provision of International Association of Public Participation (IAP2) certification for staff and health consumers. One health policy officer highlighted the role of citizens in the development of training priorities

> "…they had opportunity to pick or identify some skills and we picked
> the top six or eight." (Participant #12, Canada, Provincial)

This participant went on to note that the health authority then provided "…opportunities for training…providing skill building workshops." and "…people can go online, be trained and taught…" (Participant #12, Canada, Provincial). This health authority's commitment to citizen engagement extended to ensuring that citizens were equipped to participate. The citizens within this program are self-selected, they have volunteered to be involved, and there was no discussion about extending this initiative specifically to CALD citizens.

At the Canadian Federal level there is a future plan

> "…we're going to be developing a training…curriculum for patients
> to be involved…" (Participant #11, Canada, Federal)

These comments reflect a commitment to providing citizens with the skills to interact with government. Whilst the definition of 'citizen' for inclusion in these training activities was not specified, neither did my research participants indicate that they were particularly targeting (or not targeting) CALD citizens for these programs. The danger of a non-specific approach to the community is that marginalised voices will continue to be left out as I noted in my discussion of the literature in Chapter 6.

Providing opportunities to empower citizens and healthcare provider partners is not always successful as one health policy officer reported

> "We've funded a project, an online series of modules around cultural
> competency. The online content actually hasn't been taken up very
> well. So we've funded a project to try and translate it into a
> curriculum that can be delivered with some of our…agencies."
> (Participant #9, Canada, Provincial)

Despite the poor uptake of the online course, this health authority is not giving up but is looking for another way to achieve its objective.

In summary, considering citizen engagement for health policy development, there are some clear differences and similarities between Australia and Canada. Looking at differences first, Canadian health policy officers at both levels of government were aware of the Canadian Constitution and other standards for citizen engagement. This was not obvious in Australia, where mention of policy frameworks was limited to agency specific legislation at the Federal level. It seems that the presence of legal requirements as the rationale for citizen engagement improves awareness amongst Canadian health policy officers.

A notable difference between the two countries is the organisational commitment to citizen engagement, which is very obvious in Canada at both levels of government, supported by resources and leadership to meet government expectations. In Australia, this is not the case, with both Federal and State health policy officers referring to what they considered poor leadership practices, poor resources, and minimal or sometimes

non-existent commitment to citizen engagement. Some Australian health policy officers tried to excuse their leadership teams by commenting on the difficult environment within which health policy is developed, especially the many competing interests. It is fair to say that the presence of laws such as the Constitution Act 1982 (Can) is a significant driver of citizen engagement behaviour in Canada. Australian State health policy officers indicated a hope that support would be forthcoming in the future after the establishment of specific units focussing, variously, on multicultural health and citizen engagement.

Canadian health policy officers at both levels of government are active in sharing information across their own, and other, agencies and have an expressed commitment to learning from each other. This was not evident in Australia, with the exception of one State example where procedures were being documented as a teaching aid for other team members. Canadian health policy officers at both the Federal and Provincial levels of government spoke of ways in which they were empowering citizens to engage with government, although it should be noted that CALD citizens were not specifically mentioned. This subject was not raised in Australia.

Looking at similarities between countries and jurisdictions, Australian Federal and most State and Provincial health policy officers in both countries were attuned to the division of responsibilities in a Federation. Some offered this division of responsibilities as the reason for their own health authority's failure to target CALD citizens for participation in decision making. Although in Australian States and Canadian Provinces the need to develop health policy for larger populations rather than specific groups was raised, the tone of these comments was defensive, rather than explanatory, of a citizen engagement policy. All health policy officers expressed a dissatisfaction with the way in which CALD citizens are engaged and all acknowledged that they could do better. Despite the differences in commitment to citizen engagement, there is no focus on engagement with CALD citizens at any level of government in either country including a lack of practical support at the Canadian Provincial level where citizen engagement programs are well established. Across countries and levels of government, health policy officers sought advice and assistance from external organisations, particularly CALD community groups and sometimes consultants. In Canada this was described as a positive relationship, whereas in Australia some groups that were consulted were criticised as being culturally unaware.

None of the Federal or State and Provincial health policy officers in either country displayed a well formed contextually sensitive approach to citizen engagement, instead falling back on culture as an identifier of individuals or groups and the focus of attention. Nevertheless, there are some hints at progress towards contextually sensitive thinking evidenced, for example, in comments about the need to consider the life experience of CALD citizens, and recognition that CALD citizens need to be approached in ways that might differ from those used to approach the dominant majority. This is true of both countries and both levels of government.

In the next section I consider contextually sensitive citizen engagement using an example from Provincial Canada to illustrate what is achievable.

7.7   Contextually sensitive citizen engagement in the health sector

Box has argued that, in public administration, decisions are made within an "historical, political and economic context" and individuals need to be empowered to debate issues and identify potential solutions through communication that is not influenced by differentials in power (Box, 2005, p21-23). In making this claim, he is alluding to a contextually sensitive approach to citizen engagement. The outcomes of citizen engagement exercises can only be as good as the engagement process allows it to be (Delli Carpini et al., 2004). There are some people or groups who are habitually left out of the engagement process, largely through no fault of their own. Acknowledging that policy making usually reflects the dominant power and systems at the expense of minority, disadvantaged or otherwise marginalised groups (Asumah, 2004; Fowers and Davidov, 2006; Stewart, 2009), places the onus on policy makers to take explicit steps to counteract the disadvantage processes impose (Asumah, 2004).

Nera Komaric and colleagues argue that, using their term, culturally competent health sector citizen engagement not only leads to shared responsibility for issue definition and problem solving, but has the added advantage of improving awareness of CALD citizens' health issues at both the individual health policy officer and institutional levels (Komaric et al., 2012). Linda DeLeon and Robert Denhardt (deLeon and Denhardt, 2000, p94) go further arguing that engaging with others in a "democratic discourse" not only helps to

educate and inform but also to instil cultural competence. As discussed in Chapter 3, not only is culture a changing concept but an individual can move in and out of cultural groups depending on the situation. For these reasons, health policy officers who are intending to engage with citizens from CALD backgrounds need to bear in mind this complexity, and pay greater attention to how they are defining and considering diversity in order to maximise citizen engagement outcomes (Petriwskyj et al., 2012).

The discussion in preceding sections shows that health policy officers struggle to engage with citizens of CALD backgrounds. The result of this struggle is lose-lose-lose: health policy officers feel bad about not doing a better job, health policy is the poorer for lack of input, and CALD citizens miss out on an opportunity to influence health policy development. The added loss is the damage this does to government-citizen relations when health policy does not take into account the needs of people from CALD backgrounds. The lack of appropriate skills amongst government officials has been described not only as a barrier to citizen participation, particularly when accompanied by attitudes of prejudice, ethnocentrism, stereotyping and racism (Racher and Annis, 2007), but also as a "lack of respect" for the citizens being engaged (Petriwskyj et al., 2012, p187).

In considering the third research question, it seems likely that the lack of attention to cultural competence as a skill has affected the way in which CALD citizens are considered for inclusion in citizen engagement for health policy development. Health policy officers have demonstrated, through their discussions with me, that there was no attention to cultural competence and consequently no attention to the inclusion of CALD citizens. It does not necessarily follow that paying attention to cultural competence would enhance CALD citizen inclusion in health policy development. In Chapter 4 I argued that language should be changed from cultural competence to contextual sensitivity so that greater emphasis could be placed on identifying discriminatory structures which serve to exclude. My research has highlighted several aspects of exclusion, fuelled by poor commitment to citizen engagement. Exclusion occurs through one-size-fits-all engagement processes, lack of support and training for health policy officers, poor resource allocations and, importantly, little or no attention to cultural diversity amongst the policy audience. Even in jurisdictions where the commitment to citizen engagement is clear, no thought has been given to cultural competence in terms of CALD background

citizens. Again, a shift in focus to contextual sensitivity can lay the groundwork for the inclusion of more citizens regardless of their country of birth.

I understand that health policy cannot be tailored to individual needs, but I see that there are successful examples of contextual sensitivity in involving people of CALD backgrounds in decision making around health policy and health care. An example is the interCultural Online Health Network (iCON) in BC.

> "iCON is a community-driven health promotion initiative that
> supports multicultural communities, patients and caregivers across BC
> to optimize chronic disease prevention and self-management."
> (Faculty of Medicine, 2017a).

iCON works in partnership with, amongst others, community members, health care providers and government, to provide "culturally competent care" (Faculty of Medicine, 2017a). This is achieved through the use of community languages, teaching community members about the healthcare system, and integrating information technology into programs for wider outreach (Faculty of Medicine, 2017a). One of iCON's missions is to "foster culturally sensitive healthcare" and has as a value, amongst others, "Embracing cultural diversity in health care. Fostering cultural sensitivity and open dialogue in health care" (Faculty of Medicine, 2017b).

iCON focusses on ethnicity as an identifier and therefore targets two specific population groups. However, what makes this an interesting example is the awareness that a new approach was needed to address a long-term, and well defined, problem, the focus on means of communication as an enabler, and the openness of health policy officers to new ways of doing things in order to engage with CALD citizens.

As one health policy officer said "The iCON forums are specifically for the Punjabi…and also the Cantonese and Mandarin population in the lower mainland" (Participant #12, Canada, Provincial). The forums are attended by "500 to 1000 people...as well as video satellite throughout the Province… so triple or quadruple that number around the Province are beaming in…" (Participant #12, Canada, Provincial). The success of the iCON forums is seen in significant reductions of hospital presentations. Members of these language groups routinely return to their country of origin and, in the past, did not know how to manage their health issues whilst overseas. The result of this was that

> "Generally they would come back very sick and so they would take a taxi right from the airport to either the Emergency Department or their walk-in clinic and we can track these because the out-migration and in-migration is at the same time every year. So we saw really huge spikes in surgeries and emergency departments on the in-migration time and now we're seeing that decrease" (Participant #12, Canada, Provincial).

iCON focusses on individual health care but, in so doing, highlights ways in which citizens of CALD backgrounds can be drawn into discussion with health professionals and policy officers about health needs and health promotion opportunities. The contextual sensitivity embedded in the iCON program shows that providing a means of participation, in the way most suitable for the Punjabi and Chinese citizens, encourages participation as can be seen from the numbers of people involved. The use, for example, of language-specific fora combined with technology demonstrates that paying attention to the nature of communication can bring dividends in terms of participation as well as health gains.

Some scholars have argued that deliberation for policy making needs to occur in concert with a greater awareness of other ways of "doing, being, having" and a greater understanding of other perspectives (see for example Goodin, 2003, p230). At the very least, teaching and encouraging health policy officers to understand the importance of engaging with CALD citizens and their views, and ways in which to approach CALD citizens, could enhance health policy deliberations. In Chapter 4 I discussed the issue of training to acquire a level of cultural competence relating to the breadth of CALD backgrounds in Australia and Canada, concluding that, despite the presence of policy frameworks in some jurisdictions, no jurisdiction at either level of government provided such training to health policy officers. The situation is little different when it comes to training for CALD citizen engagement. Common across countries and levels of government, almost all health policy officers reported that they did not receive any training, support or guidance from their organisations about how to identify CALD communities, engage with people from CALD backgrounds, or even acquire a level of what they know of as 'cultural competence'.

This lack of training results in an overall lack of focus on CALD citizens as deserving of special attention when health authorities seek to engage with citizens. Consequently,

health policy officers rarely seek out people of CALD backgrounds to participate in policy development.

Conclusion

In this chapter I have completed my consideration of the second research question and explored the third research question, discussing especially the value of contextual sensitivity to citizen engagement for health policy development.

I started by reviewing health authority policies of citizen engagement in Australia and Canada, at both the Federal and State and Provincial levels of government. There is variability in the guidance provided to health policy officers. Apart from the ACT Health Directorate and the Toronto Central LHIN which display a contextually sensitive approach in their guidance on citizen engagement, there is no focus on CALD background citizens. The lack of consistent and clear policy structures disempowers health policy officers who must interpret jurisdictional government statements the best they can, potentially re-inventing the wheel as they go. The resulting inequality of attention to citizen engagement in multicultural societies means that some citizens of CALD backgrounds fare better than others.

Through the words of health policy officers, in both Australia and Canada, I have shown that Canadian jurisdictions are, by and large, ahead of their Australian counterparts in terms of citizen engagement, especially when judged by knowledge of policy frameworks, organisational culture including leadership, and resource allocations. Health policy officers believe that inclusive deliberative citizen engagement is very much dependent on the leadership teams in their agencies – without resources and explicit support individual health policy officers can make little progress towards the goal of including all citizens in health policy deliberations. This is an expression of structural flaws which hinder inclusive deliberative health policy development. Nevertheless, as far as engagement of citizens of CALD backgrounds goes, no single jurisdiction demonstrates clear leadership.

In the last chapter I will draw together the threads of this thesis to highlight key findings. I will also comment on the implications of my research for public administration generally, reflect on the research project, and note potential for further research.

Chapter 8 Contextual sensitivity for deliberative health policy development

This thesis examined the concept of cultural competence and its role in citizen engagement processes in health policy development in multicultural societies. It examined whether, and to what extent, the skill of cultural competence enables a better engagement with culturally and linguistically diverse (CALD) background citizens in two multicultural societies, Australia and Canada. Existing theories on citizen engagement, and most notably deliberative democracy theory, suggest that all citizens should be given the opportunity to engage with governments in an open, equal, non-coercive, non-judgemental environment. However, scant attention has been given to the skill of cultural competence as a means of ensuring more effective and inclusive citizen engagement in the face of cultural diversity. My thesis has drawn attention to this issue.

Against this background, the following three questions form the core of this thesis and informed the research design and methodology: (1) how do governments, health authorities and health policy officers understand and practice cultural competence; (2) how is cultural competence applied to citizen engagement for health policy development; ultimately asking (3) could paying greater attention to cultural competence enhance citizen engagement in health policy development.

This thesis sought to explore these questions, from the perspective of the health policy officer, through an in depth and comparative analysis of the way in which CALD citizens are included in health policy development in two multicultural countries – Australia and Canada – and two levels of government – Federal and State or Provincial. By choosing a methodology which included examination of government and health authority policies, complemented by interviews with health policy officers, I was able to explore some of the issues that influenced health policy officer actions. Adopting a conceptual framework of critical multiculturalism (described in Chapter 2) guided my consideration of government policies and health policy officer actions, particularly focusing on the ways in which these could cause or exacerbate disadvantage of CALD citizens.

In Chapters 3 and 4 I considered the first research question, discussing the theory of 'culture' and 'cultural competence' and using a review of government documents and interviews with health policy officers to compare understandings across governments and health sectors and amongst health policy officers. This examination led me to conclude that generally understood meanings of both culture and cultural competence are not particularly helpful in facilitating a more inclusive health policy development in the face of cultural diversity. In response to this, in Chapter 4 I suggested that a shift in focus from 'cultural competence' to 'contextual sensitivity' may be a more effective way of enabling the inclusion of CALD citizens in health policy development. Contextual sensitivity is relevant to my three research questions concerning the understanding, application and impact of cultural competence on citizen engagement in health policy making.

In Chapter 5, I summarised three perspectives on multiculturalism and gave a brief history of multiculturalism in Australia and Canada. By examining government policy, I identified the perspective held by each government, as well as the ways in which Federal government commitments are operationalised at the State and Provincial levels of government and within health authorities. This is the environment within which health policy officers are required to engage with citizens. Clear legislative frameworks in Canada drive sensitivity to cultural diversity as it relates to Aboriginal people, but the same sensitivity to the multicultural community is less apparent. These legislative frameworks are not mirrored in Australia, where weaker policy frameworks exist but appear largely unknown. It may be that this weakness was part of the motivation for introduction of the *Multicultural Recognition Act 2016* (Qld), legislation which was not part of the policy landscape when I spoke with Queensland based health policy officers.

In Chapter 6, I explored the second research question in part, focussing on Federal and State and Provincial government policies of citizen engagement generally. My review looked for the presence of cultural competence in those policies. In Chapter 7, I concluded my consideration of the second research question, focussing on the inclusion of cultural competence in health authority policies of citizen engagement. I then addressed the third research question, using fieldwork data to consider the helpfulness or otherwise of cultural competence in citizen engagement. In both chapters I was also able

to comment on the degree of contextual sensitivity demonstrated by health policy officers and their health authorities.

Whatever understandings of 'cultural competence' exist amongst health policy officers, these did not appear to be taken into account in either country, or at either level of government, when engaging with citizens in health policy development. Despite this, there is progress towards contextually sensitive thinking in both countries and at both levels of government.

In the remainder of this concluding chapter I will highlight key findings and then discuss the implications of my findings for citizen engagement within public administration generally. I end with some reflections on the research project and suggestions for potential future research.

8.1   The relevance of critical multiculturalism

Key finding: A critical multicultural perspective draws attention to systemic and individual assumptions which serve to stereotype CALD citizens and entrench exclusion and disadvantage. Application of a critical multicultural approach to health policy development supports questioning of institutional processes and procedures, as well as health policy officer assumptions and biases, for equitable health policy development.

In Chapter 1, I noted that this research would be considered within a critical multicultural framework. After consideration of the literature, the perspectives taken by governments and health authorities included in this research, and discussion with health policy officers, I concluded that the language of 'cultural competence' was not helpful in the context of CALD citizen engagement in health policy development. Further comment on this is included at section 8.3 below. However, a change in language is linked to ideas of equity and inclusion, key points in a critical multicultural approach. Thus, a critical multicultural perspective also presents an opportunity for a new perspective on citizen engagement, thus shifting from an analytic framework to a practical model.

To recap, multicultural policy is a government's response to the need to manage increasing population diversity. In this thesis I drew attention to three perspectives on

multiculturalism: (1) as a tool for managing and controlling diversity; (2) as a tool for democratic participation by minority groups; and (3) critical multiculturalism as a tool to address structural inequity. For the reasons discussed in Chapter 5, the first two perspectives fail to improve the lives of, and access to services by, people from CALD backgrounds in any real sense because these perspectives are based on the constant need for minority populations to prove their worth to the dominant society.

Application of a critical multicultural perspective facilitates questioning of institutional and societal structures and assumptions that label some people as 'Other' and distinct from 'us', examining the history that led to this labelling in order to understand how current modes of operating and thinking impact on CALD citizens. Recognising these assumptions, labels, and histories helps to acknowledge the inequities built into society and its institutions. By applying this perspective to citizen engagement for health policy development, attention is drawn to systemic and individual assumptions which serve to stereotype CALD citizens and entrench exclusion and disadvantage. This attention to systems and institutions puts the focus on the structures with which a citizen interacts, drawing attention away from the individual citizen. This approach removes the need or opportunity to think of citizens as defined by ethnicity. Further, a critical multicultural perspective incorporates a fluid and relational understanding of culture, recognising that 'culture' could encompass issues as diverse as age, health status, country of birth, or even sporting club membership. Critical multiculturalism recognises that a citizen's responses to culture will vary with the context within which she is responding.

A critical multicultural perspective to health policy development also offers opportunities for health policy makers in terms of personal development (such as improved contextual sensitivity), more productive engagement with a diversity of citizens, and an enriched policy development process reflecting ideas that could probably not have been imagined without a diversity of minds around the policy table.

The reality is that, in both Australia and Canada, most governments subscribe to a 'manage and control' perspective of multiculturalism but, interestingly, most health authorities lean more towards multiculturalism as a tool for democratic participation. Nevertheless, only one health authority (the ACT) has a specific multicultural health policy which also recognises the importance of including CALD background citizens in

health policy development. Some health policy officers at the Federal, State and Provincial levels of government, do not appear to see a need for multicultural health policy in their agency because they believe this should be managed by another layer of government. That other layer was variously identified as local government, Federal government, or another agency within the same level of government. This confusion adds complexity to considerations around citizen engagement.

8.2 Understandings of culture and cultural competence are outdated and restrictive

Key finding: Everyday understandings of culture as an unchanging catalogue of attributes, which is somehow knowable, are out of step with current anthropological thinking of culture as relational and meaning centred and thus constantly changing. To suggest that a health policy maker could become competent in culture is therefore misleading.

As discussed in Chapter 3, the literature shows that anthropological understandings of culture have evolved from ideas of culture as a list of attributes characterising a person, or group of people, to ideas of culture as changeable and constantly changing. Following these considerations, this thesis is based on an up to date understanding of culture as unbounded, relational and meaning centred, "a dynamic process of shared meanings, located in and emerging from interactions between individuals" (Carpenter-Song et al, 2007, p1364). Across the jurisdictions examined, only one Canadian Provincial government and one Canadian Federal health authority expresses a view of culture as broader than ethnicity, demonstrating that governments and health authorities across countries and levels of government maintain outdated understandings of culture. Further evidence of this is found in the reliance a number of health authorities, at both levels of government, place on their own CALD background staff to be experts in a particular ethnicity, thereby sustaining the idea of culture as unchanging and knowable.

Although the concept of 'cultural competence' is well known within the public health sector, its application is limited to Aboriginal (Australia and Canada) and Torres Strait Islander (Australia) cultures. In neither Australia nor Canada, at any level of government, is there any explicit consideration given to the diversity of cultures present in both

countries despite the fact that some health authorities have, or have recently had, policies acknowledging that CALD citizens must be involved in policy deliberations. Although some jurisdictions provide Indigenous cultural competence training of various types and durations, this has not led to parallel thinking about citizens from other CALD backgrounds.

In Chapters 4 and 7, I analysed understandings of culture and cultural competence and their application by health policy officers to health policy deliberations. Through their responses, health policy officers reported that culture is rarely taken into account in planning for or undertaking citizen engagement. Despite some comprehensive understandings of cultural competence, some of which included the notion of context, this was not influential in citizen engagement planning and conduct. The inclusion of CALD citizens in health policy deliberations was acknowledged to be poor.

Health policy officers have shown me that they are deeply interested in the outcomes of their work and, in many cases, are passionate about engaging with citizens. These public servants are doing the best they can, with the resources they have, within the policy framework that has been set for them. What becomes clear from my research is that engagement with CALD background citizens is, except for serendipity, missing from citizen engagement activities across both countries and both levels of government. In Australia this can be explained in part by the structural barriers which impede health policy officers' ability to engage with citizens in the development of health policy. These barriers include the absence of both clear policy frameworks and support and training for citizen engagement, and the lack of leadership and resources. This is true despite government commitments to citizen engagement. In Canada where legal frameworks, strong policy structures and positive organisational cultures of citizen engagement exist, the same explanation cannot be applied.

My research suggests that poor attention to CALD citizen engagement can be explained largely by the outdated and limited understandings of culture and cultural competence which shape organisational and individual approaches to citizen engagement. Although culture as ethnicity appears to be the accepted tenet, it is apparent that in everyday activities culture is reduced even further to mean only Indigenous cultures. This reduction is influenced and reinforced by organisational understandings of 'cultural competence'

focussing only on Indigenous culture. This is true of both Australia and Canada, and both levels of government.

It may therefore be more helpful to move away from culture as a means of thinking about, and organising, citizen engagement activities. A critical multicultural approach to citizen engagement offers an alternative because it does not rely on culture as a defining attribute. As noted above, critical multiculturalism emphasises the context which directs and shapes the life of a citizen. This context includes institutional structures, including structures of power, which influence interactions with government. Greater consideration of context may facilitate more effective communication with CALD citizens by addressing structural barriers to equitable health policy.

8.3   The language of 'cultural competence' can be a barrier to inclusion

Key finding: The language of 'cultural competence' is unhelpful because it focusses on culture as ethnicity. It is timely to shift language to 'contextual sensitivity' for heightened awareness of citizens as individuals shaped by their histories, life experiences and current institutional structures. Awareness of the context surrounding CALD citizens removes the need to consider an individual as an ethnicity.

The term 'cultural competence', with its connotations of relevance to Indigenous cultures alone, has not been challenged within health authorities. Only one Provincial health authority showed a focus on improving cultural competence as a system-wide priority although this was also limited to Indigenous cultural competence. The inference that can be drawn from this is that cultural competence of any sort is a low priority for the vast majority of health authorities in both countries and at both levels of government. This is a weak base from which to build inclusive citizen engagement activities, a point borne out by the fact that health policy officers are not encouraged to take cultural considerations into account when developing policy or designing citizen engagement processes.

In Chapters 3 and 4 I examined the first research question – reviewing understandings of cultural competence amongst governments, health authorities and health policy officers.

In Chapter 4, I argued that the term 'cultural competence' was not helpful in the health policy sector and suggested that it should be replaced by the term 'contextual sensitivity'. The main reason for this proposal is that, in practice, 'cultural competence' is understood to encompass Indigenous cultures only, thus excluding consideration of the many other citizens of diverse backgrounds. Contextual sensitivity, on the other hand, brings a critical multicultural approach into sharp focus relying, as it does, on considerations of context rather than any individual attributes or characteristics such as ethnicity. The inclusion of 'sensitivity' directs attention away from the assumption that a health policy officer can be competent in or know everything about a subject, instead emphasising the need to be attuned to a variety of factors influencing a citizen's health or capacity to engage with governments.

Perhaps the reverse might be argued, that the meaning of 'cultural competence' should be expanded to ensure it encompasses all cultural diversity. However, my research suggests that this will still be insufficient in practice, at least in the countries that have been the focus of this thesis. Multiculturalism has been a fact of life in Australia and Canada for many decades, but this has not been reflected in citizen engagement processes for health policy development nor in training for cultural competence. The fact that health policy officers are equivocal about which level of government should pay attention to cultural issues, and are neither resourced nor encouraged to engage with CALD citizens, demonstrates that matters of cultural and linguistic diversity are low on the priority list. This is further demonstrated by the complete absence of cultural competence training relevant to CALD communities.

The benefit of a contextually sensitive approach to citizen engagement for health policy development is that it will remove the need to consider culture as an identifier thereby removing a factor of discrimination, opening up consideration of the many other factors that shape the life of a CALD citizen.

8.4   The many influences on citizen engagement processes

Key finding: Resource constraints, multiple interests and competing priorities influence citizen engagement practices. Despite the presence of guidance and support in some

jurisdictions, the current one-size-fits-all processes exclude CALD background citizens. A critical multicultural perspective applied to citizen engagement supports questioning of processes and procedures with a view to adoption of inclusive practices.

In Chapter 2 I discussed what was special about health policy. In particular, I highlighted the many competing interests, the influence of the medical profession, and the nature of health as an activity shared between Federal and State or Provincial governments. The links between health policy and other policy domains, such as housing, and the very personal nature of health as an issue, add to the complexity of the health policy domain.

Internal influences also play a crucial role in helping to balance competing interests and priorities. The overriding internal influence on citizen engagement is the culture within the health authority. It is this culture that dictates how much or how little attention will be given to citizen engagement. In discussions, health policy officers identified an enabling organisational culture, supported by positive leadership, as important to inclusive citizen engagement. Health policy officers made the point that when an organisation takes the lead by setting the tone for interactions or policy development processes, it is easier for employees to follow. There was little evidence that this was happening with the only exception being one Canadian Provincial health authority. The internal culture of an organisation is an important support for the implementation of a critical multicultural approach. When enabled by positive leadership, this approach confers permission on policy officers to question institutional structures, especially policies and procedures, which may cause disadvantage to CALD background citizens.

As discussed in Chapter 7, there is a positive attitude towards citizen engagement in Canada linked to the presence of Constitutional and other legislative requirements enshrining inclusion, respect for diversity, and citizen engagement. In part, this environment drives concrete resource allocation. There is no similar legislation in Australia, which creates a tension between government expectations to engage with the community and the lack of resources dedicated to this task. Canada's policy framework welcoming citizen engagement flows through that country's health authorities, and is reflected in leadership styles, collegiality and information sharing. This was not a feature of Australian jurisdictions.

In Chapter 7 I reported that, across both countries and both levels of government, health policy officers identified the need for extra resources, time and effort in order to engage with citizens of CALD backgrounds. Resource constraints of time, money and personnel, and competing policy priorities influence how citizen engagement will be conducted. All too frequently, as my research participants told me, there are insufficient resources to meet all priorities, resulting in a squeezing of citizen engagement into an already fully committed budget. Australian health policy officers were overwhelmed by the need to make choices between competing priorities, with the result that CALD citizens were excluded from decision making. This exclusion was not malicious but rather the outcome of poor attention to citizen engagement processes. Notwithstanding the specific budgets granted to Canadian health policy officers, business-as-usual approaches to citizen engagement within constrained resources disempowers citizens of CALD backgrounds in procedural terms (ie how engagement is conceived and conducted) and also in policy terms (ie how diversity is acknowledged and managed).

The words of Brenton Holmes (2011) were prophetic – it is clear that one size does indeed fit few and yet it is largely one size that is being implemented by health policy officers. If there is a failure here it can found in both the approach to cultural competence, discussed above, and in the organisational culture within health authorities. The poor attention to the inclusion of CALD citizens in citizen engagement means that there is little recognition of the value of the input those citizens could contribute, and the complementary recognition that obtaining that input is worth the extra effort required to obtain it. This translates into poor support for health policy officers in terms of resources and authority to engage with CALD citizens. Taken to its logical conclusion, this means a failure to develop the very best, most efficient and effective health policy and thus make the best use of taxpayer dollars.

Contextual sensitivity within a critical multicultural approach to citizen engagement allows for a more thoughtful consideration of the ways in which more citizens can be included. Contextual sensitivity pays attention to the structures in the health system which cause exclusion: structures such as one-size-fits-all engagement methods, insufficient time and resources, assumptions about who is capable of contributing to a debate and will therefore be approached and, conversely, those who will be left out. The benefit of a more thoughtful process is a balancing of competing interests and the

inclusion of many voices, each with an opportunity to learn from others and to influence government policy.

8.5   Implications for public administration

Contextual sensitivity within a critical multicultural approach challenges an organisation to scrutinise its own history of establishment, its long-held beliefs about the superiority of the policy officer over the policy beneficiary, and demands a questioning of everything that has gone before. Power structures are thrown open to scrutiny and critique, and the usual way of doing business is questioned and picked apart. Leaders in this questioning organisation need to model new behaviours to support and guide policy officers to do the same. There must be no sacred cows, everything is open to scrutiny.

As already argued, internal organisational culture influences the behaviour of policy officers. A move to a contextually sensitive approach to citizen engagement for policy development will require a change in attitude, especially at the organisational level. This is likely to be a challenging process, which can be smoothed by strong leadership supporting real questioning and challenging of long-held assumptions and organisational beliefs. Policy officers take their cues from the leadership team, and never more so than when respected executives stand up and demonstrate a new organisational attitude. Executive champions could be helpful to remind the agency and its staff of the reasons for adopting a new style.

Organisational change requires education and support to ensure that a contextually sensitive approach is embedded in the ethos of the organisation and thus in all leadership and support structures. Whether contextual sensitivity training is mandatory or not, the profile it is given will set the tone for policy officers in their dealings with the CALD community. As health policy officers told me, being given permission to be absent from their desks for as long as the training takes is a powerful message of leadership support. Only when staff see the importance the agency places on contextual sensitivity will they be able to appreciate its fundamental importance to their work.

For this research I chose to focus on the health sector. However, I believe the findings and suggestions are relevant to all policy domains. I invite those interested in public

administration to read this thesis and mentally strike out the word "health" as they do. Insert your own domain and I have no doubt that there will be many similarities amongst us – our efforts to meet government expectations within constrained resources; our desire to be inclusive and fair to all policy beneficiaries; and our frustration at not being able to do better for more citizens.

A contextually sensitive approach to citizen engagement, managed by contextually sensitive policy officers supported by a contextually sensitive agency, offers an opportunity to improve the richness of input to the policy process. The results, in terms of process and policy, can be beneficial for all involved. This might sound like a scenario for the ideal world, but could it be applied to today's pressure situation of competing priorities, competing influences, and budget constraint? My answer is an optimistic "yes". Public sector agencies need to take the first steps towards changing attitudes to citizens of CALD backgrounds and the way in which they are included in policy development. By taking this action, agencies will be able to reduce the risk of missing significant numbers of citizens whose status in society is compromised by misunderstandings and lack of information on both sides, and the continuation of structural inequities that entrench disadvantage.

It is my contention that national, sub-national, and local governments can all benefit from additional attention to contextual sensitivity in policy development as described in this thesis.

8.6   Further reflections on this research project

This research comprised a comparative case study, comparing two countries, two levels of government, and using the health sector as the case study. Information was gathered from three sources: theoretical understandings came from a literature review of the key domains relevant to the topic; a review of government and health authority documents identified policies about multiculturalism, citizen engagement, and cultural competence; and fieldwork consisted of interviews with a number of health policy officers in two countries and at two levels of government.

Undertaking as comprehensive a literature review as time would permit was a helpful starting point, introducing me to key concepts such as deliberative democracy and multiculturalism, and providing much food for thought. The literature influenced my thinking, helping me to shape discussions with health policy officers and think through some of the important issues.

The review of government documents helped me to come to grips with government policy, allowing me to assess where the policies stood in terms of perspectives on multiculturalism and the application of cultural competence and contextual sensitivity. What was less helpful was the discovery that some of the policies reviewed disappeared from public view over the course of my research, many not replaced! Apart from precipitating rewriting, some of these changes left me wondering what happened – a crucial example is the disappearance of the *Engaging Queenslanders* series of booklets which not only demonstrated a contextually sensitive approach to engaging CALD citizens, but also provided solid guidance for the engagement of CALD citizens. The replacement website is disappointingly sparse.

I approached interviews with health policy officers in a semi-structured manner, having questions as conversation starters and prompts but also leaving flexibility to explore issues raised. I am indebted to my research participants for their honesty and forthright comments which not only provided solid grist for my mill but also, as some told me, made them think about cultural competence too. I see this thoughtfulness as an early impact arising from my research.

A cross country comparative methodology was useful for this research project because it enabled me to look, in some detail, at the policies and processes in place in two countries that have similarly multicultural populations, federal structures of government, and similar systems of healthcare. Any similarities or differences could be considered with reference to what was similar or different between the two countries – for example healthcare as a responsibility shared between levels of government is a shared feature whilst the presence of enabling legislation is peculiar to Canada. Taking a case study format permitted deeper reflection on one area of government, the health sector, strengthening the comparison across countries and levels of government. There may be similarities between other government sectors and the health sector (for instance

education and health), but the benefit of concentrating on one sector is that it supports explanation of findings in the context of levels of government, and by country, without introducing confounders that may be peculiar to other government sectors. I raise this again as a potential future research project, below.

The importance of speaking with health policy officers should not be underestimated. Their views reflect what is happening on the ground, enabling comparison with the text of policies and frameworks describing what *should* happen. Further, comparing actions across countries enabled identification of similarities and differences, with a view to explaining why they may exist. An unintended outcome of this research project was the level of thoughtfulness our discussions sparked amongst health policy officers. More than one remarked to me that our time together had made them think harder, and sometimes for the first time, about the subject under discussion.

In Chapter 2, I remarked that I chose senior level health policy officers because I thought they would be less hesitant to discuss their actions and opinions than might be a more junior officer. Whilst our discussions were, I believe, frank and friendly, the seeming lack of awareness of policy frameworks amongst some health policy officers could indicate a cause for concern. Given their seniority, are not these the people who should be driving policy development, including the development of contextually sensitive policy processes? That they do not appear to raises, for me, questions about organisational culture which demands inclusive policy development processes but does not seem to have internal structures and capacity to make that happen. Questions for another day may be "who is responsible for determining internal processes?", "how are senior policy officers involved?", and "how are internal processes approved and supported to become integral to policy development?"

This latter train of thought also focusses attention on the interview design. Health policy officers responded freely to questions I asked and contributed further information without prompts. I have noted at different points throughout this thesis that health policy officers did not refer to existing policy frameworks. Perhaps this was because I did not ask a sufficiently specific question to prompt such a response. As with any research project, a shared understanding of concepts is important to the collection of comprehensive information. As a researcher, I must reflect on the questions I asked, the language I used,

and the direction of the discussion to consider whether there was anything in that process that may have led interviewees to forget to mention policy frameworks, or not consider that this was what I might have been interested in. I raise this matter even though several Canadian interviewees did speak explicitly about Constitutional requirements, suggesting that at least some of their policy framework had a sufficiently high profile to be part of everyday conversation.

One other issue relating to the research design should be raised here and that is the matter of the government documents reviewed and discussed in this thesis. As noted above, reviewing existing policies gave me a sense of the frameworks within which health policy officers work. The relative presence or absence of policy frameworks was a starting point from which to consider organisational attitudes and commitments, especially when married with empirical data. I have commented in different places that some policies I reviewed were superseded, updated, or simply disappeared from public view. This does not explain why the policies in place at the time of interviews were not referred to, but it does explain why particularly useful policies, such as the ACT Multicultural Health policy, were not mentioned. Quite simply, it did not exist when ACT health policy officers were interviewed. Perhaps it is a limitation of the research design that I did not return to the health policy officers, in jurisdictions where policies were updated, to seek an update of their views.

On the conceptual front, a critical multicultural approach was attractive to me because it presented the CALD citizen as a person, acting differently in different contexts and not defined simply by ethnicity, and encouraged me to question the health system that not only attaches labels but continually repeats the same processes without a thought for the impact on citizens. Although critical multiculturalism arose in the field of education, particularly in the USA and initially focussing on African-American students, I believe this conceptual framework can be applied to any bureaucratic system, however large or small.

My research specifically excluded people of Aboriginal (Australia and Canada) and Torres Strait Islander (Australia) backgrounds because I felt that there would be too many aspects of citizen engagement than could be encompassed within one thesis. I also chose to restrict my perspective to that of the health policy maker. I did this because of the

paucity of information about policy officer experiences with citizen engagement, reflected in my own experience in the field.

A further limitation of my research was the number of research participants in the jurisdictions chosen for study. This limitation was imposed by the need to contain fieldwork within an acceptable timeframe and manageable logistics. Nevertheless, given the seniority of the participants and the expectation that they would be conversant with organisational directions, I am inclined to think that more participants would not necessarily have given me more or different perspectives and responses.

8.7   Areas for further research

This thesis has offered insights into the way health authorities, in two multicultural societies, understand cultural competence and engage with CALD citizens. Taking into account my research findings and the limitations of this thesis, some areas for further research suggest themselves.

Conversations about culture

I have expressed the view that all government policy domains have similarities that would enable a contextually sensitive approach to citizen engagement to be applied. However, it would be useful to test whether there is anything special about the health sector in this regard that is not evident in, say, education or transport policy. Testing this empirically would open for comparison understandings of 'culture' outside the health sector, and the ways in which these understandings are shared within an organisation. Reviewing how other public sector policy domains address skill acquisition may provide some useful models that can be shared across public administration. Addressing a wider set of jurisdictions would shed light on whether Federal and State or Provincial governments are homogenous in their understandings and actions, and would bring to light the basis for beliefs about culture and the opportunities for a contextually sensitive approach to citizen engagement.

Balancing policy officer and citizen views

This thesis has considered only one point of view, that of health policy officers. This is a reflection of my own background and interest and not because I think citizens views are less worthy of research. Citizens' experiences of engaging with government have been documented but it would be useful to question whether CALD background citizens, specifically, feel that they are included or excluded, on what grounds and with what frequency? Pursuing this line of inquiry would identify whether CALD citizens are as familiar with government policy and requirements for engaging with the community as non-CALD citizens. It would also discover how CALD citizens experience interactions with government in terms of the skills and willingness of government officials and their agencies. These questions could be explored either as comparative across policy domains and jurisdictions or by concentrating on a detailed case study in one policy domain and jurisdiction.

Policy officers as agents of change

I have written of the need for leadership in health authorities to uphold policy directions and to effect change. King and Zanetti reported a number of US cases of policy officers as agents of change, focussing specifically on citizen engagement in policy development (King and Zanetti, 2005). It could be helpful to undertake a similar study of Australian or Canadian government agencies to identify programs of citizen engagement where CALD citizen input is specifically sought, to determine the characteristics of those programs, how they were developed and implemented, and the role of the policy officer. The lessons learned from case studies will provide valuable information to public administration in the chosen countries, and possibly beyond.

8.8 Looking ahead

This thesis has addressed the issue of the inclusion of CALD background citizens in the development of health policy. It has been both disappointing and heartening to gather and consider the views of health policy officers in Australia and Canada. The disappointment lies in current restricted understandings of and approaches to cultural competence. These understandings have reduced cultural competence to encompass

relevance only to the Indigenous people of Australia and Canada. Broader population diversity is poorly considered, if at all.

It was also disheartening to listen to the enthusiasm and goodwill amongst health policy officers only to find this balanced by the difficulties they face in attempting to engage with CALD background citizens. These difficulties lie in organisational cultures that do not recognise the value of citizen engagement or of CALD citizen input, and lack of support illustrated by the absence of training and minimal resource allocations. The extent of these difficulties varied across countries and levels of government.

However, I feel an optimism for the future. Health policy officers did express contextually sensitive views about the inclusion of CALD citizens at least in some tentative ways. Their views demonstrate their understanding that current organisational practices may act as barriers to the inclusion of CALD citizens. Their advocacy within their own organisations, although not always successful up to now, can act as an influence to transform organisational thinking and subsequently actions. This transformation will take time but there is some momentum towards this goal.

References

Canadian Multiculturalism Act 1988 (Can).

The Constitution Act 1982 (Can).

Constitution of Queensland 2001 (Qld).

Ministry of Citizenship and Culture Act 1990 (Ont).

Multicultural Recognition Act 2016 (Qld).

Multiculturalism Act (BC).

Official Languages Act 1985 (Can).

ABELSON, J. & EYLES, J. 2002. Public Participation and Citizen Governance in the Canadian Health System. *Discussion Paper No. 7.* Commission on the Future of Health Care in Canada.

ABELSON, J., FOREST, P.-G., EYLES, J., SMITH, P., MARTIN, E. & GAUVIN, F.-P. 2003. Deliberations about deliberative methods: issues in the design and evaluation of public participation processes. *Social Science & Medicine,* 57**,** 239-251.

ABELSON, J., GIACOMINI, M., LEHOUX, P. & GAUVIN, F.-P. 2007. Bringing 'the public'into health technology assessment and coverage policy decisions: from principles to practice. *Health Policy,* 82**,** 37-50.

ACT COMMUNITY SERVICES DIRECTORATE nd. ACT Multicultural Framework 2015-2020. Canberra: ACT Government.

ACT GOVERNMENT 2011. Engaging Canberrans. A Guide to Community Engagement. Canberra: ACT Government.

ACT GOVERNMENT. 2015. *Open Government* [Online]. ACT Government. Available: http://www.cmd.act.gov.au/open_government [Accessed 23 March 2017].

ACT GOVERNMENT. 2017. *Your Say* [Online]. ACT Government. Available: https://www.yoursay.act.gov.au/ [Accessed 10 March 2017].

ACT HEALTH DIRECTORATE 2003. Listening and Learning. ACT Health Consumer Feedback Standards. Canberra, ACT: ACT Health Directorate.

ACT HEALTH DIRECTORATE 2011. Consumer and Carer Participation Framework. Canberra: ACT Government.

ACT HEALTH DIRECTORATE 2014. Towards Culturally Appropriate and Inclusive Services. A Co-ordinating Framework for ACT Health 2014-2018. Canberra: ACT Government.

ACT HEALTH DIRECTORATE 2016. *Annual Report 2015-2016,* Canberra, ACT Health Directorate.

ADVISORY GROUP ON REFORM OF AUSTRALIAN GOVERNMENT ADMINISTRATION 2010. *Ahead of the Game. Blueprint for the Reform of Australian Government Administration,* Canberra, Commonwealth of Australia.

ALEXANDER, J. & STIVERS, C. 2010. An ethic of race for public administration. *Administrative Theory & Praxis,* 32**,** 578-597.

ALKADRY, M. G. 2005. Democratic administration in a multicultural environment. *In:* BOX, R. C. (ed.) *Democracy and Public Administration.* Armonk, New York: M E Sharpe.

ANDERSON, J. M., TANG, S. & BLUE, C. 2007. Health care reform and the paradox of efficiency: "Writing in" culture. *International Journal of Health Services,* 37**,** 291-320.

ANDERSON, L. M., SCRIMSHAW, S. C., FULLILOVE, M. T., FIELDING, J. E. & NORMAND, J. 2003. Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine,* 24**,** 68-79.

ANKENYA, R. A. & DODDS, S. 2008. Hearing community voices: public engagement in Australian human embryo research policy, 2005-2007. *New Genetics and Society,* 27**,** 217-232.

APPLEWHITE, S. L. 1998. Culturally competent practice with elderly Latinos. *Journal of Gerontological Social Work,* 30**,** 1-15.

ARNSTEIN, S. R. 1969. A ladder of citizen participation. *Journal of the American Institute of Planners,* 35**,** 216-224.

ARONSON, J. 1993. Giving consumers a say in policy development: Influencing policy or just being heard? *Canadian Public Policy/Analyse de Politiques,* 19**,** 367-378.

ASUMAH, S. N. 2004. Racial identity and policy making: Redefining Whiteness. *Western Journal of Black Studies,* 28**,** 501-510.

ATA, A. W. 2005. Beyond the stereotypes. *Quadrant,* 49**,** 1-2.

AUSTRALIAN BUREAU OF STATISTICS. 2012. *Cultural Diversity in Australia. Reflecting a Nation: stories from the 2011 Census* [Online]. Available: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2071.0main+features902012-2013 [Accessed 6 May 2017].

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE 2010. Australian Safety and Quality Framework for Health Care. Sydney, NSW: ACSQH.

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE 2011. *National Safety and Quality Health Service Standards,* Sydney, NSW, ACSQH.

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE Endorsed 2008. Australian Charter of Healthcare Rights. Sydney, NSW: ACSQH.

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE nd. Australian Safety and Quality Goals for Health Care. Sydney, NSW: ACSQH.

AUSTRALIAN GOVERNMENT 2017. Multicultural Australia. United, Strong, Successful. Australia's Multicultural Statement. Canberra: Australian Government.

AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE 2016. *Health Expenditure Australia 2014-15,* Canberra, AIHW.

AUSTRALIAN PUBLIC SERVICE COMMISSION 2007. *Tackling Wicked Problems: A Public Policy Perspective,* Canberra, APSC.

AUSTRALIAN PUBLIC SERVICE COMMISSION. 2016. *APS Values* [Online]. Australian Public Service Commission. Available: http://www.apsc.gov.au/working-in-the-aps/your-rights-and-responsibilities-as-an-aps-employee/aps-values [Accessed 3 May 2017].

AWAD, I. 2011. Critical multiculturalism and deliberative democracy: Opening spaces for more inclusive communication. *Javnost-The Public,* 18**,** 39-54.

BABBIE, E. 1992. *The Practice of Social Research, 6th ed.,* Belmont, California, Wadsworth Publishing Co.

BAILEY, M. L. 2005. Cultural competency and the practice of public administration. *In:* RICE, M. F. (ed.) *Diversity and Public Administration. Theory, Issues and Perspectives.* New York: M E Sharpe Inc.

BANTING, K. & KYMLICKA, W. 2010. Canadian multiculturalism: Global anxieties and local debates. *British Journal of Canadian Studies,* 23**,** 43-72.

BARNARD, A. & SPENCER, J. (eds.) 1996. *Encyclopedia of Social and Cultural Anthropology,* London: Routledge.

BARNES, M., NEWMAN, J., KNOPS, A. & SULLIVAN, H. 2003. Constituting 'the public' in public participation. *Public Administration,* 81**,** 379-399.

BATES, E. M. & LINDER-PELZ, S. 1987. *Health Care Issues,* Sydney, Allen & Unwin Australia.

BAUMANN, G. 1999. *The Multicultural Riddle,* New York, Routledge.

BC GOVERNMENT. nd-a. *Citizen Engagement Handbook* [Online]. BC Government. Available: http://www2.gov.bc.ca/gov/content/governments/services-for-government/service-experience-digital-delivery/citizen-engagement/ce-handbook [Accessed 4 May 2017].

BC GOVERNMENT. nd-b. *Government Communications & Public Engagement (GCPE)* [Online]. BC Government. Available: http://www2.gov.bc.ca/gov/content/governments/organizational-structure/ministries-organizations/central-government-agencies/government-communications [Accessed 4 May 2017].

BC GOVERNMENT. nd-c. *govTogether BC/Get involved* [Online]. BC Government. Available: https://engage.gov.bc.ca/govtogetherbc/ [Accessed 3 March 2017].

BC GOVERNMENT. nd-d. *Multiculturalism* [Online]. Government of British Columbia. Available: http://www2.gov.bc.ca/gov/content/governments/multiculturalism-anti-racism/multiculturalism [Accessed 17 March 2017].

BC PUBLIC SERVICE 2012. Reflecting our Communities: Building a Diverse BC Public Service 2012. Victoria, BC: BC Government.

BC PUBLIC SERVICE 2014. Being the Best. 2014 Corporate HR Plan. Victoria, BC: BC Government.

BC PUBLIC SERVICE nd. Citizens @ The Centre: BC Government 2.0. A Transformation and Technology Strategy for the BC Public Service. Victoria, BC: BC Government.

BC STATS. nd. *Open Data From the Census - Health Geographies (HAs, HSDAs, LHAs)* [Online]. BC Stats. Available: http://www.bcstats.gov.bc.ca/StatisticsBySubject/Census/OpenData.aspx [Accessed 11 April 2017].

BEILKE, J. R. 2005. Whose world is this? *Multicultural Education,* 12**,** 2-7.

BEN-ARI, A. & STRIER, R. 2010. Rethinking cultural competence: What can we learn from Levinas? *British Journal of Social Work,* 40**,** 2155-2167.

BENHABIB, S. 2002. *The Claims of Culture: Equality and Diversity in the Global Era,* Princeton, Princeton University Press.

BENNETT, M. J. 2004. Becoming interculturally competent. *In:* WURZEL, J. S. (ed.) *Toward Multiculturalism: A Reader in Multicultural Education.* Newton, MA: Intercultural Resource Corporation.

BERBRIER, M. 2004. Assimilationism and pluralism as cultural tools. *Sociological Forum,* 19**,** 29-61.

BERRY-JAMES, R. M. 2012. Cultural competency in health care: Standards, practices and measures. *In:* NORMAN-MAJOR, K. A. & GOODEN, S. T. (eds.) *Cultural Competency for Public Administrators.* New York: ME Sharpe.

BETANCOURT, J. R., GREEN, A. R. & CARRILLO, J. E. 2002. *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*, Commonwealth Fund, Quality of Care for Underserved Populations.

BETANCOURT, J. R., GREEN, A. R., CARRILLO, J. E. & ANANEH-FIREMPONG, O. 2003. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports,* 118**,** 293.

BHAGAT, R., JOHNSON, J., GREWAL, S., PANDHER, P., QUONG, E. & TRIOLET, K. 2002. Mobilizing the community to address the prenatal health needs of immigrant Punjabi women. *Public Health Nursing,* 19**,** 209-214.

BHOPAL, R. 2004. Glossary of terms relating to ethnicity and race: for reflection and debate. *Journal of Epidemiology and Community Health,* 58**,** 441-445.

BIRRELL, R. 1994. Immigration control in Australia. *The Annals of the American Academy of Political and Social Science,* 534**,** 106-117.

BISHOP, P. J. & DAVIS, G. C. 2001. Developing consent: consultation, participation and governance. *In:* DAVIS, G. C. & WELLER, P. (eds.) *Are You Being Served? State, Citizens and Governance.* Crows Nest, NSW: Allen & Unwin.

BLATTER, J. & HAVERLAND, M. 2012. *Designing Case Studies: Explanatory Approaches in Small-N Research,* UK, Palgrave Macmillan.

BOESE, M. & PHILLIPS, M. 2011. Multiculturalism and social inclusion in Australia. *Journal of Intercultural Studies,* 32**,** 189-197.

BOHMAN, J. 1998. Survey article: The coming of age of deliberative democracy. *Journal of Political Philosophy,* 6**,** 400-425.

BOHMAN, J. 2003. Deliberative toleration. *Political Theory,* 31**,** 757-779.

BOLITHO, A. 2013. *The Role and Future of Citizen Committees in Australian Local Government,* Sydney, Australian Centre of Excellence for Local Government, University of Technology.

BONILLA, J., LINDEMAN, L. & TAYLOR, N. 2012. Educating for and assessing cultural competence. *In:* NORMAN-MAJOR, K. A. & GOODEN, S. T. (eds.) *Cultural Competency for Public Administrators.* Armonk: ME Sharpe.

BOURQUE BEARSKIN, R. L. 2011. A critical lens on culture in nursing practice. *Nursing Ethics,* 18**,** 548-59.

BOX, R. C. 2005. *Critical Social Theory in Public Administration,* Armonk, New York, M E Sharpe.

BOX, R. C. 2011. Marcuse was right: One-dimensional society in the twenty-first century. *Administrative Theory & Praxis,* 33**,** 169-191.

BOX, R. C., MARSHALL, G. S., REED, B. & REED, C. M. 2001. New public management and substantive democracy. *Public Administration Review,* 61**,** 608-619.

BRACKERTZ, N. & MEREDYTH, D. 2009. Community consultation in Victorian local government: A case of mixing metaphors? *Australian Journal of Public Administration,* 68**,** 152-166.

BRONNER, S. E. 2002. *Of Critical Theory and Its Theorists, 2nd ed.,* New York, Routledge.

BRONNER, S. E. & KELLNER, D. M. 1989. Introduction. *In:* BRONNER, S. E. & KELLNER, D. M. (eds.) *Critical Theory and Society: A Reader.* New York: Routledge.

BROWN, L. D. 2010. Pedestrian paths: Why path-dependence theory leaves health policy analysis lost in space. *Journal of Health Politics, Policy and Law,* 35**,** 643-661.

BURRIDGE, K. & STEBBINS, T. N. 2016. *For the Love of Language: An Introduction to Linguistics*, Cambridge University Press.

BURTON, D. 2002. Towards a critical multicultural marketing theory. *Marketing Theory,* 2**,** 207-236.

BURTON, O., JR & TRYMAN, M. D. 2005. Public service in America's urban areas: Why the bar in perception and practice remains higher for African-American public managers. *In:* RICE, M. F. (ed.) *Diversity and Public Administration. Theory, Issues and Perspectives.* New York: M E Sharpe Inc.

BUSE, K., MAYS, N. & WALT, G. 2012. *Making Health Policy, 2nd ed.,* Berkshire UK, McGraw-Hill Education.

BUTLER, C., RISSEL, C. & KHAVARPOUR, F. 1999. The context for community participation in health action in Australia. *Australian Journal of Social Issues,* 34**,** 253-265.

CAMPINHA-BACOTE, J. 1999. A model and instrument for addressing cultural competence in health care. *The Journal of Nursing Education,* 38**,** 203.

CANADIAN INSTITUTES OF HEALTH RESEARCH 2011. Canada's Strategy for Patient-Oriented Research. Improving health outcomes through evidence-informed care. Ottawa, Canada: Canadian Institutes of Health Research.

CANADIAN INSTITUTES OF HEALTH RESEARCH 2014. Strategy for Patient-Oriented Research. Patient Engagement Framework. Ottawa, Canada: Canadian Institutes of Health Research.

CANADIAN INSTITUTES OF HEALTH RESEARCH. 2017a. *About Us* [Online]. Available: http://www.cihr-irsc.gc.ca/e/37792.html [Accessed 7 April 2017].

CANADIAN INSTITUTES OF HEALTH RESEARCH. 2017b. *CIHR in numbers 2015-16* [Online]. CIHR. Available: http://www.cihr-irsc.gc.ca/e/50218.html [Accessed 10 April 2017].

CAPERCHIONE, C. M., KOLT, G. S. & MUMMERY, W. K. 2013. Examining physical activity service provision to culturally and linguistically diverse (CALD) communities in Australia: A qualitative evaluation. *PloS one,* 8**,** e62777.

CAPERCHIONE, C. M., KOLT, G. S., TENNENT, R. & MUMMERY, W. K. 2011. Physical activity behaviours of culturally and linguistically diverse (CALD) women living in Australia: a qualitative study of socio-cultural influences. *BMC Public Health,* 11**,** 26.

CAPITMAN, J. 2002. Defining diversity: A primer and a review. *Generations,* 26**,** 8-14.

CAREY, G., RILEY, T. & CRAMMOND, B. 2012a. The Australian Government's 'Social Inclusion Agenda': the intersection between public health and social policy. *Critical Public Health,* 22**,** 47-59.

CARPENTER-SONG, E., NORDQUEST SCHWALLIE, M. & LONGHOFER, J. 2007. Cultural competence reexamined: Critique and directions for the future. *Psychiatric Services,,* 58**,** 1362-1365.

CAWSTON, P. G. & BARBOUR, R. S. 2003. Clients or citizens? Some considerations for primary care organisations. *Br J Gen Pract,* 53**,** 716-722.

CHAMBERS, S. 2003. Deliberative democratic theory. *Annual Review of Political Science,* 6**,** 307-326.

CHAN, K.-B. 2003. Inner hybridity in the city: Toward a critique of multiculturalism. *Global Economic Review,* 32**,** 91-105.

CHANDRA, P. 2012. Marxism, Homi Bhabha and the omissions of postcolonial theory. *Critique,* 40**,** 199-214.

CHECKOWAY, B. 2009. Community change for diverse democracy. *Community Development Journal,* 44**,** 5-21.

CHESSIE, K. 2009. Health system regionalization in Canada's provincial and territorial health systems: do citizen governance boards represent, engage, and empower? *International Journal of Health Services,* 39**,** 705-724.

CHIEF MINISTER AND CABINET 2012a. The overseas born population of the ACT. *2011 Census Fact Sheets, Issue #5 September 2012.* Canberra: ACT Government.

CHIEF MINISTER AND CABINET 2012b. Aboriginal and Torres Strait Islander peoples in the ACT. *2011 Census Fact Sheets, Issue #4 August 2012.* Canberra: ACT Government.

CHIEF MINISTER AND TREASURY 2013. Population and age structure. How does Canberra compare? *2011 Census Fact Sheets Issue #12 April 2013.* Canberra: ACT Government.

CHIN, J. L. 2000. Culturally competent health care. *Public Health Reports,* 115**,** 25.

CHU, C. 1998. Cross-cultural health issues in contemporary Australia. *Ethnicity & Health,* 3**,** 125-134.

CHU, C. 2005. Postnatal experience and health needs of Chinese migrant women in Brisbane, Australia. *Ethnicity & Health,* 10**,** 33-56.

CHURCH, J., SAUNDERS, D., WANKE, M., PONG, R., SPOONER, C. & DORGAN, M. 2002. Citizen participation in health decision-making: past experience and future prospects. *Journal of Public Health Policy***,** 12-32.

COLIC-PEISKER, V. 2011. A new era in Australian multiculturalism? From working-class "ethnics" to a "multicultural middle-class". *International Migration Review,* 45**,** 562-587.

COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA 2002. Building on Values: The Future of Health Care in Canada - Final Report. Ottawa.

COMMONWEALTH OF AUSTRALIA 1999. A New Agenda for Multicultural Australia. Canberra: Australian Government Publishing Service.

COMMONWEALTH OF AUSTRALIA 2003. Multicultural Australia: United in Diversity. Updating the 1999 New Agenda for Multicultural Australia. Canberra: Commonwealth of Australia.

COMMONWEALTH OF AUSTRALIA 2011. The People of Australia. Australia's Multicultural Policy. Canberra: Commonwealth of Australia.

CONKLIN, A., SLOTE MORRIS, Z. & NOLTE, E. 2010. Involving The Public in Healthcare Policy. An update of the research evidence and proposed evaluation framework. *Technical Report.* Santa Monica: RAND Corporation.

CONSUMERS' HEALTH FORUM OF AUSTRALIA. nd. *About Us* [Online]. Consumers' Health Forum of Australia. Available: https://chf.org.au/about-chf [Accessed 10 March 2017].

CONTANDRIOPOULOS, D. 2004. A sociological perspective on public participation in health care. *Social Science & Medicine,* 58**,** 321-330.

COVENEY, J. 2010. Analyzing public health policy: three approaches. *Health Promotion Practice,* 11**,** 515-521.

CROSS, T. L., BAZRON, B., DENNIS, K. & ISAACS, M. 1989. Towards a Culturally Competent System of Care. A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. Washington, DC: Georgetown University Child Development Center.

CROSS, T. L., EARLE, K., SOLIE, H. E.-H. & MANNESS, K. 2000. Cultural strengths and challenges in implementing a system of care model in American Indian communities. *Systems of care: Promising practices in children's mental health, 2000 series*.

CROWDER, G. 2008. Multiculturalism. A value-pluralist approach. *In:* LEVEY, G. B. (ed.) *Political Theory and Australian Multiculturalism.* New York: Berghahn Books.

CSDH 2008. *Closing the Gap in a Generation. Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health.,* Geneva, World Health Organization.

DANIEL, C. L. 2008. From liberal pluralism to critical multiculturalism: The need for a paradigm shift in multicultural education for social work practice in the United States. *Journal of Progressive Human Services,* 19**,** 19-38.

DAUVERGNE, C. 1999. Confronting chaos: Migration law responds to images of disorder. *Res Publica,* 5**,** 21-43.

DAVIS, G., WANNA, J., WARHURST, J. & WELLER, P. 1993. *Public Policy in Australia,* Sydney, Allen and Unwin.

DEAN, R. G. 2001. The myth of cross-cultural competence. *Families in Society: The Journal of Contemporary Human Services,* 82**,** 623-630.

DELANTY, G. 2011. Cultural diversity, democracy and the prospects of cosmopolitanism: a theory of cultural encounters. *The British Journal of Sociology,* 62**,** 633-656.

DELBRIDGE, A. 2001. *The Macquarie Dictionary*, Macquarie Library.

DELEON, L. & DENHARDT, R. B. 2000. The political theory of reinvention. *Public Administration Review,* 60**,** 89-97.

DELLI CARPINI, M. X., COOK, F. L. & JACOBS, L. R. 2004. Public deliberation, discursive participation, and citizen engagement: A review of the empirical literature. *Annual Review of Political Science,* 7**,** 315-344.

DENHARDT, R. B. & DENHARDT, J. V. 2000. The new public service: Serving rather than steering. *Public Administration Review,* 60**,** 549-559.

DEPARTMENT OF ABORIGINAL AND TORRES STRAIT ISLANDER AND MULTICULTURAL AFFAIRS 2014. Language Services Policy. Brisbane, Queensland: Queensland Government.

DEPARTMENT OF COMMUNITIES 2007. Engaging Queenslanders. An Introduction to Working with Culturally and Linguistically Diverse Communities. Queensland: Queensland Government.

DEPARTMENT OF COMMUNITIES 2011a. A Multicultural Future For All of Us. Queensland Multicultural Policy 2011. Queensland: Queensland Government.

DEPARTMENT OF COMMUNITIES 2011b. Multicultural Action Plan 2011-2014. Queensland: Queensland Government.

DEPARTMENT OF COMMUNITIES 2011c. Language Services Policy. A Multicultural Future for All of Us. Queensland: Queensland Government.

DEPARTMENT OF COMMUNITIES CHILD SAFETY AND DISABILITY SERVICES 2016a. Queensland Multicultural Policy. Our Story, Our Future. Queensland: Queensland Government.

DEPARTMENT OF COMMUNITIES CHILD SAFETY AND DISABILITY SERVICES 2016b. Queensland Multicultural Action Plan 2016-2017 to 2018-2019. Queensland: Queensland Government.

DEPARTMENT OF COMMUNITIES CHILD SAFETY AND DISABILITY SERVICES 2016c. Queensland Language Services Policy. Queensland: Queensland Government.

DEPARTMENT OF FINANCE CANADA. 2017. *Federal Support to Provinces and Territories* [Online]. Department of Finance. Available: https://www.fin.gc.ca/fedprov/mtp-eng.asp#BritishColumbia [Accessed 11 April 2017].

DEPARTMENT OF HEALTH 2012a. Agency Multicultural Plan 2013-2015. Canberra: Department of Health.

DEPARTMENT OF HEALTH. 2012b. *Mental Health Statement of Rights and Responsibilities* [Online]. Commonwealth of Australia. Available: http://www.health.gov.au/internet/publications/publishing.nsf/Content/pub-sqps-rights-toc [Accessed 10 March 2017].

DEPARTMENT OF HEALTH 2016. *Annual Report 2015-2016,* Canberra, Department of Health.

DEPARTMENT OF HEALTH AND AGEING 2010. *National Women's Health Policy 2010,* Canberra, Commonwealth of Australia.

DEPARTMENT OF SOCIAL SERVICES 2015. The Multicultural Access and Equity Policy Guide for Australian Government Departments and Agencies. Canberra: Australian Government.

DEPARTMENT OF SOCIAL SERVICES 2016. *Beginning a Life in Australia. Welcome to Australia,* Canberra, Department of Social Services.

DEVEAUX, M. 2003. A deliberative approach to conflicts of culture. *Political Theory,* 31**,** 780-807.

DEWING, M. 2013. Canadian Multiculturalism. *Background Paper*. Ottawa, Canada: Library of Parliament, Parliamentary Information and Research Services.

DOWNING, R., KOWAL, E. & PARADIES, Y. 2011. Indigenous cultural training for health workers in Australia. *International Journal for Quality in Health Care,* 23**,** 247-257.

DOYLE, R. 1993. An evaluation of the Australian government's policy of access and equity strategy in selected localities. *Journal of Health & Social Policy,* 5**,** 15-34.

DRYZEK, J. 1982. Policy analysis as a hermeneutic activity. *Policy Sciences,* 14**,** 309-329.

DRYZEK, J. S. 1994. *Discursive Democracy: Politics, Policy, and Political Science,* Cambridge, Cambridge University Press.

DRYZEK, J. S. 2001. Legitimacy and economy in deliberative democracy. *Political Theory,* 29**,** 651-669.

DRYZEK, J. S. 2005. Deliberative democracy in divided societies. Alternatives to agonism and analgesia. *Political Theory,* 33**,** 218-242.

DRYZEK, J. S., GOODIN, R. E., TUCKER, A. & REBER, B. 2009. Promethean elites encounter precautionary publics: The case of GM foods. *Science, Technology & Human Values,* 34**,** 263.

DRYZEK, J. S. & LIST, C. 2003. Social choice theory and deliberative democracy: a reconciliation. *British Journal of Political Science,* 33**,** 1-28.

DUDAS, K. I. 2012. Cultural competence: An evolutionary concept analysis. *Nursing Education Perspectives,* 33**,** 317-321.

DUGDALE, P. 2008. *Doing Health Policy in Australia,* Crows Nest, Allen & Unwin.

DUNCAN, G. 1995. Multiculturalism and democracy. *Southern Review,* 28**,** 189.

DWYER, J. 1989. The politics of participation. *Community Health Studies,* 13**,** 59-65.

EINSIEDEL, E. 2002. Assessing a controversial medical technology: Canadian public consultations on xenotransplantation. *Public Understanding of Science,* 11**,** 315-331.

ERCAN, S. A. 2011. The deliberative politics of cultural diversity: Beyond interest and identity politics? *In:* MONSOURI, F. & LOBO, M. (eds.) *Migration, Citizenship and Intercultural Relations. Looking Through the Lens of Social Inclusion.* Surrey: Ashgate.

ERCAN, S. A. 2017. From polarisation to pluralisation: A deliberative approach to illiberal cultures. *International Political Science Review,* 38**,** 114-127.

FACULTY OF MEDICINE. 2017a. *What is iCON?* [Online]. University of British Columbia. Available: https://about.iconproject.org/About-Us/What-is-iCON [Accessed 8 May 2017].

FACULTY OF MEDICINE. 2017b. *Our Mission & Values* [Online]. University of British Columbia. Available: https://about.iconproject.org/About-Us/Our-Mission-Values [Accessed 8 May 2017].

FALBO, M. 2006. Reinventing inclusion: from a politics of presence to inessential coalitions. *Contemporary Politics,* 12**,** 247-260.

FERGUSON, S. L. & CAMPINHA-BACOTE, J. 1997. Cultural competence: A critical factor in child health policy. *Journal of Pediatric Nursing,* 12**,** 260-262.

FLERAS, A. 2002. Multiculturalism as critical discourse: Contesting modernity. *Canadian Issues,* 10**,** 9-11.

FONTEFRANCESCO, M. F. 2012. Thirty years of multiculturalism and anthropology. *Anthropological Notebooks,* 18**,** 59-62.

FORD, M. E. & KELLY, P. A. 2005. Conceptualizing and categorizing race and ethnicity in health services research. *Health Services Research,* 40**,** 1658-1675.

FOSTER, S. G. & VARGHESE, M. M. 2009. The Making of the Australian National University 1946–1996. Canberra: ANU e-Press.

FOWERS, B. J. & DAVIDOV, B. J. 2006. The virtue of multiculturalism: Personal transformation, character, and openness to the Other. *The American Psychologist,* 61**,** 581-594.

FRASER, N. 2001. Recognition without ethics? *Theory, Culture & Society,* 18**,** 21-42.

FREIRE, P. 1972. *Cultural Action for Freedom,* Middlesex, Penguin Education.

FULLER, J. 1997. Multicultural health care: reconciling universalism and particularism. *Nursing Inquiry,* 4**,** 153-159.

GADAMER, H.-G. 1989. *Truth and Method, Second revised edition, translation by Joel Weinsheimer and Donald G Marshall,* New York, Crossroad.

GALBALLY, F. 1978. *Review of Post-Arrival Programs and Services for Migrants. Migrant Services and Programs,* Canberra, AGPS.

GALEOTTI, A. E. 2009. Identity, difference, toleration. *In:* DRYZEK, J. S., HONIG, B. & PHILLIPS, A. (eds.) *The Oxford Handbook of Political Theory.* Oxford Handbooks Online: Oxford University Press.

GILL, G. K. & BABACAN, H. 2012. Developing a cultural responsiveness framework in healthcare systems: an Australian example. *Diversity and Equality in Health and Care,* 9**,** 45-55.

GIROUX, H. A. 1988. *Schooling and the Struggle for Public Life: Critical Pedagogy in the Modern Age* Minneapolis, University of Minnesota Press.

GIROUX, H. A. 1995. The politics of insurgent multiculturalism in the era of the Los Angeles uprising. *In:* KANPOL, B. & MCLAREN, P. (eds.) *Critical Multiculturalism: Uncommon Voices in a Common Struggle.* London: Bergin & Garvey.

GIROUX, H. A. 2000. Insurgent multiculturalism and the promise of pedagogy. *In:* GOLDBERG, D. T. (ed.) *Multiculturalism: A Critical Reader.* Oxford: Blackwell Publishers.

GOLDBERG, D. T. 1994. Introduction: multicultural conditions. *In:* GOLDBERG, D. T. (ed.) *Multiculturalism: A Critical Reader.* Oxford: Blackwell Publishers.

GOODEN, S. T. & NORMAN-MAJOR, K. A. 2012. An assessment of the state of cultural competency in public administration. *In:* NORMAN-MAJOR, K. A. & GOODEN, S. T. (eds.) *Cultural Competency for Public Administrators.* Armonk, New York: M E Sharpe.

GOODIN, R. & DRYZEK, J. 2006. Deliberative impacts: The macro-political uptake of mini-publics. *Politics & Society,* 34**,** 219-244.

GOODIN, R. E. 2003. *Reflective Democracy,* Oxford, Oxford University Press.

GOODKIND, J. R., ROSS-TOLEDO, K., JOHN, S., HALL, J. L., ROSS, L., FREELAND, L., COLETTA, E., BECENTI-FUNDARK, T., POOLA, C., BEGAY-ROANHORSE, R. & LEE, C. 2010. Promoting healing and restoring trust: Policy recommendations for improving behavioral health care for American Indian/Alaska Native adolescents. *American Journal of Community Psychology,* 46**,** 386-94.

GOVERNMENT OF CANADA. 2008. *Policy and legislation concerning multiculturalism* [Online]. Government of Canada. Available: http://www.cic.gc.ca/english/department/laws-policy/multi-policy.asp [Accessed 12 April 2017].

GOVERNMENT OF CANADA 2011. *Aboriginal Consultation and Accommodation. Updated Guidelines for Federal Officials to Fulfill the Duty to Consult*, Government of Canada.

GOVERNMENT OF CANADA. 2012a. *Canadian Multiculturalism: An Inclusive Citizenship* [Online]. Government of Canada. Available: http://www.cic.gc.ca/english/multiculturalism/citizenship.asp [Accessed 6 May 2017].

GOVERNMENT OF CANADA 2012b. *Canada's Action Plan on Open Government,* Ottawa, Government of Canada.

GOVERNMENT OF CANADA. 2014. *Consulting with Canadians* [Online]. Government of Canada. Available: https://www1.canada.ca/consultingcanadians/ [Accessed 10 March 2017].

GOVERNMENT OF CANADA. 2017a. *Open Government* [Online]. Government of Canada. Available: http://open.canada.ca/en?_ga=1.203682896.1991233656.1489119730 [Accessed 10 March 2017].

GOVERNMENT OF CANADA. 2017b. *Third Biennial Plan to the Open Government Partnership* [Online]. Government of Canada. Available: http://open.canada.ca/en/content/third-biennial-plan-open-government-partnership#toc5 [Accessed 23 March 2017].

GOVERNMENT OF CANADA. 2017c. *Multiculturalism* [Online]. Government of Canada. Available: http://canada.pch.gc.ca/eng/1489666040971 [Accessed 12 April 2017].

GOVERNMENT OF ONTARIO. 2016. *Public Engagement* [Online]. Government of Ontario. Available: https://www.ontario.ca/page/public-engagement [Accessed 23 March 2017].

GRAMBERGER, M. R. 2001. Citizens as Partners: OECD Handbook on Information, Consultation and Public Participation in Policy-Making. Paris: OECD Publications.

GRAY JAMIESON, G. 2012. *Reaching for Health. The Australian Women's Health Movement and Public Policy,* Canberra, ANU e-Press.

GREEN, A. G. & GREEN, D. 2004. The goals of Canada's immigration policy: A historical perspective. *Canadian Journal of Urban Research,* 13**,** 102-139.

GUBA, E. & LINCOLN, Y. 1994. Competing paradigms in qualitative research. *In:* DENZIN, N. K. & LINCOLN, Y. S. (eds.) *Handbook of Qualitative Research.* Thousand Oaks: Sage.

GUNEW, S. 1999. Colonial hauntings: The (post)colonialism of multiculturalism in Australia and Canada. *Australian Canadian Studies,* 17**,** 11-32.

GUTMAN, A. & THOMPSON, D. 2004. *Why Deliberative Democracy?,* Princeton, Princeton University Press.

HAGE, G. 2010. Intercultural relations at the limits of multicultural governmentality. *In:* IVISON, D. (ed.) *Ashgate Research Companion to Multiculturalism.* Ashgate Publishing.

HAM, L. 2001. Consulting on health policy in Canada. *In:* CADDY, J. & VERGEZ, C. (eds.) *Citizens as Partners: Information, Consultation and Public Participation in Policy-making.* Paris: OECD Online Bookshop.

HAMILTON, M. R. 2007. Democracy and public service. *In:* BOX, R. C. (ed.) *Democracy and Public Administration.* Armonk: M E Sharpe.

HAYWARD, C. R. 2011. What can political freedom mean in a multicultural democracy? On deliberation, difference, and democratic governance. *Political Theory,* 39**,** 468-497.

HEAD, B. W. 2007. Community engagement: participation on whose terms? *Australian Journal of Political Science,* 42**,** 441-454.

HEAD, B. W. 2011. Australian experience: Civic engagement as symbol and substance. *Public Administration and Development,* 31**,** 102-112.

HEALTH CANADA 2000. *Health Canada Policy Toolkit for Public Involvement in Decision Making,* Ottawa, Health Canada.

HEALTH CANADA. 2013. *First Nations and Inuit Health Branch* [Online]. Available: http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/index-eng.php [Accessed 10 April 2017].

HEALTH CANADA. 2014a. *About Health Canada* [Online]. online. Available: http://www.hc-sc.gc.ca/ahc-asc/index-eng.php [Accessed 10 April 2017].

HEALTH CANADA. 2015. *Health Canada 2015-2016 Report on Plans and Priorities* [Online]. Health Canada. Available: http://www.hc-sc.gc.ca/ahc-asc/performance/estim-previs/plans-prior/2015-2016/report-rapport-eng.php [Accessed 10 April 2017].

HEALTH CANADA. 2016a. *About Health Canada/Public Engagement* [Online]. Health Canada. Available: http://www.hc-sc.gc.ca/ahc-asc/public-consult/index-eng.php [Accessed 3 March 2017].

HEALTH CANADA 2016b. *Health Canada and the Public Health Agency of Canada Guidelines on Public Engagement,* Ottawa, Health Canada.

HEALTH CONSUMERS QUEENSLAND 2012. Consumer and Community Engagement Framework. Brisbane, Queensland: Queensland Health.

HELLER, A. 1996. The many faces of multiculturalism. *In:* BAUBOCK, R., HELLER, A. & ZOLBERG, A. R. (eds.) *The Challenge of Diversity. Integration and Pluralism in Societies of Immigration.* Aldershot: Avebury/Ashgate Publishing Ltd.

HENDRIKS, C. M. 2012. Policy evaluation and public participation. *In:* ARARAL, E., SCOTT, F. & HOWLETT, M. (eds.) *Routledge Handbook of Public Policy.* Routledge.

HESS, P. M. & BILLINGSLEY, A. 2007. Cultural competence at the heart of capacity building. *In:* MOTES, P. S. & HESS, P. M. (eds.) *Collaborating with Community-based Organizations Through Consultation and Technical Assistance.* New York: Columbia University Press.

HESTER, R. J. 2012. The promise and paradox of cultural competence. *HEC forum,* 24**,** 279-291.

HINDESS, B. 2008. "Something that deserves our admiration and respect". *In:* LEVEY, G. B. (ed.) *Political Theory and Australian Multiculturalism.* New York: Berghahn Books.

HO, A. T. 2007. Citizen participation in performance measurement. *In:* BOX, R. C. (ed.) *Democracy and Public Administration.* Armonk: M E Sharpe.

HOLMES, B. 2011. Citizens' Engagement in Policymaking and the Design of Public Services. *Research Paper No 1, 2011-2012*. Canberra: Parliament of Australia.

HOWLETT, M. & CASHORE, B. 2014. Conceptualizing public policy. *In:* ENGELI, I. & ALLISON, C. R. (eds.) *Comparative Policy Studies: Conceptual and Methodological Challenges.* Houndmills, UK: Palgrave Macmillan.

HUGO, G. 2002. Australian immigration policy: The significance of the events of September 11. *The International Migration Review,* 36**,** 37-40.

HUNT, L. M. 2001. Beyond cultural competence: Applying humility to clinical settings. *Park Ridge Center Bulletin,* 24.

HUSBAND, C. 2000. Recognising diversity and developing skills: the proper role of transcultural communication. *European Journal of Social Work,* 3**,** 225-234.

INDIGENOUS AND NORTHERN AFFAIRS CANADA. 2016. *Government of Canada and the Duty to Consult* [Online]. Government of Canada. Available: http://www.aadnc-aandc.gc.ca/eng/1331832510888/1331832636303#sec1 [Accessed 10 March 2017].

INGLIS, C., BIRCH, A. & SHERINGTON, G. 1994. An overview of Australian and Canadian migration patterns and policies. *In:* ADELMAN, H., BOROWSKI, A., BURSTEIN, M. & FOSTER, L. (eds.) *Immigration and Refugee Policy. Australia and Canada Compared.* Carlton, Victoria: Melbourne University Press.

JENKS, A. C. 2010. What's the use of culture?: Health disparities and the development of culturally competent health care. *In:* WHITMARSH, I. & JONES, D. S. (eds.) *What's the Use of Race? Modern Governance and the Biology of Difference.* Cambridge, Massachusetts: MIT Press.

JIRWE, M., GERRISH, K. & EMAMI, A. 2006. The theoretical framework of cultural competence. *Journal of Multicultural Nursing and Health,* 12**,** 6.

JOPPKE, C. 2004. The retreat of multiculturalism in the liberal state: theory and policy. *British Journal of Sociology,* 55**,** 237-257.

JUN, J. S. 1997. Interpretive and critical perspectives: An introduction. *Public Administration Theory Network,* 19**,** 146-153.

JUPP, J. 2007. *From White Australia to Woomera. The Story of Australian Immigration,* Cambridge, Cambridge University Press.

KAHANE, D. 2003. Dispute resolution and the politics of cultural generalization. *Negotiation Journal,* 19**,** 5-27.

KAHANE, D., LOPTSON, K., HERRIMAN, J. & HARDY, M. 2013. Stakeholder and citizen roles in public deliberation. *Journal of Public Deliberation,* 9**,** 2.

KALANTZIS, M. 2005. Conceptualising diversity - defining the scope of multicultural policy, education and research. *Australian Mosaic,* 10**,** 6-9.

KANPOL, B. & MCLAREN, P. 1995. Introduction: resistance multiculturalism and the politics of difference. *In:* KANPOL, B. & MCLAREN, P. (eds.) *Critical Multiculturalism: Uncommon Voices in a Common Struggle.* London: Bergin & Garvey.

KEATING, M. & WELLER, P. M. 2001. Rethinking government's roles and operations. *In:* DAVIS, G. C. & WELLER, P. M. (eds.) *Are You Being Served? State, Citizens and Governance.* Crows Nest, NSW: Allen & Unwin.

KELLEY, N. & TREBILCOCK, M. 2010. *The Making of the Mosaic. A History of Canadian Immigration Policy. 2nd ed.,* Toronto, University of Toronto Press.

KELLY, J. 2001. Troubled Canadian gazing: Aboriginal women's lifestorytelling, multicultural nationalism and the Australian-Canadian comparative model. *Balayi,* 2**,** 137-167.

KINCHELOE, J. L. & STEINBERG, S. R. 1997. *Changing Multiculturalism,* Philadelphia, Open University Press.

KING, C. S. 2007. Citizens, citizenship and democratic governance. *In:* BOX, R. C. (ed.) *Democracy and Public Administration.* Armonk: M E Sharpe.

KING, C. S. & ZANETTI, L. A. 2005. *Transformational Public Service: Portraits of Theory in Practice,* Armonk, M.E. Sharpe.

KING, N. & HORROCKS, C. 2010. *Interviews in Qualitative Research,* Los Angeles, SAGE.

KIVISTO, P. 2012. We really are all multiculturalists now. *The Sociological Quarterly,* 53**,** 1-24.

KOLETH, E. 2010. *Multiculturalism: A Review of Australian Policy Statements and Recent Debates in Australia and Overseas* [Online]. Canberra: Parliament of Australia. Available: http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1011/11rp06 [Accessed 11 April 2017].

KOMARIC, N., BEDFORD, S. & VAN DRIEL, M. L. 2012. Two sides of the coin: patient and provider perceptions of health care delivery to patients from culturally and linguistically diverse backgrounds. *BMC Health Services Research,* 12**,** 322.

KUKATHAS, C. 2008. Anarcho-multiculturalism: The pure theory of liberalism. *In:* LEVEY, G. B. (ed.) *Political Theory and Australian Multiculturalism.* New York: Berghahn Books.

KURTI, P. 2013. Multiculturalism and the Fetish of Diversity. *CIS Policy Monographs.* Australia: Centre for Independent Studies.

KUSHNER, C. & RACHLIS, M. 1998. Civic lessons: Strategies for increasing consumer involvement in health policy development. *Canada Health Action: Building on the legacy making decisions: evidence and information.* Sainte-Foy, Quebec.

KYMLICKA, W. 1995. *Multicultural Citizenship: A Liberal Theory of Minority Rights,* Oxford, Clarendon Press.

KYMLICKA, W. 2010. Ethnic, linguistic and multicultural diversity of Canada. *In:* COURTNEY, J. C. & SMITH, D. E. (eds.) *Oxford Handbook of Canadian Politics.* Oxford Handbooks Online.

LAIRD, J. 2000. Theorizing culture. *Journal of Feminist Family Therapy,,* 11**,** 99-114.

LEGISLATIVE ASSEMBLY FOR THE ACT 2011. Debates. Weekly Hansard. Seventh Assembly. 23 June 2011. Canberra: ACT Government.

LENIHAN, D. 2009. Rethinking the Public Policy Process. A Public Engagement Framework. Ottawa: Public Policy Forum.

LENIHAN, D. 2012a. Building a Strategic Design Capacity with Community. A Report on the DHS Co-design Community Engagement Prototype. Ottawa: Public Policy Forum.

LENIHAN, D. G. 2012b. *Rescuing Policy: The Case for Public Engagement,* Ottawa, Public Policy Forum.

LEUNG, H. H. 2011. Canadian multiculturalism in the 21st century: Emerging challenges and debates. *Canadian Ethnic Studies,* 43/44**,** 19-33.

LEVEY, G. B. (ed.) 2008a. *Political Theory & Australian Multiculturalism,* New York: Berghahn Books.

LEVEY, G. B. 2008b. Multicultural political thought in Australian perspective. *In:* LEVEY, G. B. (ed.) *Political Theory and Australian Multiculturalism.* New York: Berghahn Books.

LI, P. S. 2003. *Destination Canada: Immigration Debates and Issues,* Don Mills, Ont, Oxford University Press.

LINDBLOM, C. E. 1959. The science of "Muddling Through". *Public Administration Review,* 19**,** 79-88.

LOCAL HEALTH INTEGRATION NETWORK 2011. LHIN Community Engagement Guidelines and Toolkit. Toronto, ON: Local Health Integration Network.

LOCAL HEALTH INTEGRATION NETWORK 2016. LHIN Community Engagement Guidelines - Revised. Ontario: Pan LHIN Communications.

LÖFGREN, H., LEAHY, M. & DE LEEUW, E. 2011. From activism to state inclusion: health consumer groups in Australia. *In:* LOFGREN, H. & DE LEEUW, E. (eds.) *Democratizing Health: Consumer Groups in the Policy Process.* Cheltenham, UK: Edward Elgar Publishing.

LONGLEY, K. O. 1999. Beyond multiculturalism: Australia and Canada. *Australian Canadian Studies,* 17**,** 75-83.

LOPEZ, M. 2000. The politics of the origins of multiculturalism: lobbying and the power of influence. *People and Place,* 8**,** 22-28.

LUKENSMEYER, C. J. & TORRES, L. H. 2006. Public Deliberation: A Manager's Guide to Citizen Engagement. *Collaboration Series.* Washington, DC: IBM Center for the Business of Government.

LYSHAUG, B. 2004. Authenticity and the Politics of Identity: A Critique of Charles Taylor's Politics of Recognition. *Contemporary Political Theory,* 3**,** 300-320.

MANDERSON, L. & REID, J. C. 1994. What's culture got to do with it? *In:* WADDELL, C. & PETERSEN, A. R. (eds.) *Just Health.* Melbourne: Churchill Livingstone.

MANN, J. 2012. The introduction of multiculturalism in Canada and Australia, 1960s-1970s. *Nations and Nationalism,* 18**,** 483-503.

MARCHETTONI, L. 2014. Inferentialism, culture and public deliberation. *Philosophy & Social Criticism,* 40**,** 25-42.

MARCUSE, H. 1965. Repressive tolerance.

MARCUSE, H. 1969. *An Essay on Liberation,* Boston, Beacon Press.

MARKUS, A., JUPP, J. & MCDONALD, P. 2009. *Australia's Immigration Revolution,* Crows Nest, Allen & Unwin.

MARMOR, T., FREEMAN, R. & OKMA, K. 2005. Comparative perspectives and policy learning in the world of health care. *Journal of Comparative Policy Analysis: Research and Practice,* 7**,** 331-348.

MARTINEAU, W. 2012. Misrecognition and cross-cultural understanding: Shaping the space for a 'fusion of horizons'. *Ethnicities,* 12**,** 161-177.

MARTIS, T. 2012. Framework for Action. Cultural Proficiency and Diversity. Winnipeg, Saskatchewan: Winnipeg Regional Health Authority.

MATUSTIK, M. B. 2002. Contribution to a new critical theory of multiculturalism: A response to 'anti-racism, multiculturalism and the ethics of identification'. *Philosophy & Social Criticism,* 28**,** 472-482.

MAY, S. 2009. Critical multiculturalism and education. *In:* BANKS, J. A. (ed.) *The Routledge International Companion to Multicultural Education.* New York: Routledge.

MAY, S. & SLEETER, C. E. 2010. Introduction. Critical multiculturalism: theory and praxis. *In:* MAY, S. & SLEETER, C. E. (eds.) *Critical Multiculturalism: Theory and Praxis.* New York: Routledge.

MCGOLDRICK, D. 2005. Multiculturalism and its discontents. *Human Rights Law Review,* 5**,** 27-56.

MCGREGOR, S. 2003. Government transparency: the citizen perspective and experience with food and health products policy. *International Journal of Consumer Studies,* 27**,** 168-175.

MCLAREN, P. 1994. White terror and oppositional agency: Towards a critical multiculturalism. *In:* GOLDBERG, D. T. (ed.) *Multiculturalism: A Critical Reader.* Oxford: Blackwell Publishers.

MCLAREN, P. 2001. Wayward multiculturalists. A reply to Gregor McLennan. *Ethnicities,* 1**,** 408-419.

MCPHATTER, A. R. & GANAWAY, T. L. 2003. Beyond the rhetoric: Strategies for implementing culturally effective practice with children, families, and communities. *Child Welfare-New York,* 82**,** 103-124.

MEER, N., MARTINEAU, W. & THOMPSON, S. 2012. Misrecognition and ethno-religious diversity. *Ethnicities,* 12**,** 131-141.

METRO SOUTH HEALTH 2012. Metro South Health Consumer and Community Engagement Strategy 2012-2015. Queensland: Metro South Hospital and Health Service.

METRO SOUTH HEALTH 2015. Improving Healthcare Together. A Consumer, Carer and Community Engagement Strategy 2016-2019. Queensland: Metro South Hospital and Health Service.

METRO SOUTH HEALTH. 2017. *About Us* [Online]. Queensland Government. Available: https://metrosouth.health.qld.gov.au/about-us [Accessed 10 March 2017].

METRO SOUTH HOSPITAL AND HEALTH SERVICE 2016. *Annual Report 2015-2016,* Queensland, Metro South Hospital and Health Service.

MILLER, D. 2000. *Citizenship and National Identity,* Cambridge, Polity Press.

MILLIGAN, J. A. 2001. Multiculturalism and the idolatry of inclusion. *In:* STEINBERG, S. R. (ed.) *Multi/Intercultural Conversations: A Reader.* New York: Peter Lang Publishing.

MIN, S.-J. 2014. On the Westerness of deliberation research. *Journal of Public Deliberation,* 10**,** 5.

MINISTER OF IMMIGRATION REFUGEES AND CITIZENSHIP. 2016. *Annual Report on the Operation of the Canadian Multiculturalism Act - 2014-2015 - Building a diverse and inclusive society Canada* [Online]. Government of Canada. Available: http://www.cic.gc.ca/english/resources/publications/multi-report2015/index.asp [Accessed 17 March 2017].

MINISTRY OF FINANCE. 2012. *2011 Census Highlights: Factsheet 6 Mother Tongue and Language* [Online]. Ministry of Finance. Available: http://www.fin.gov.on.ca/en/economy/demographics/census/cenhi11-6.html [Accessed 11 April 2017].

MINISTRY OF FINANCE. 2013. *2011 National Household Survey Highlights: Factsheet 1 Immigration* [Online]. Ministry of Finance. Available: http://www.fin.gov.on.ca/en/economy/demographics/census/nhshi11-1.html [Accessed 11 April 2017].

MINISTRY OF HEALTH 2013. *Promote, Protect, Prevent: Our Health Starts Here. BC's Guiding Framework for Public Health* BC, Ministry of Health.

MINISTRY OF HEALTH 2015. 2015/16 - 2017/18 Service Plan. Victoria, BC: Ministry of Health.

MINISTRY OF HEALTH. nd. *2015/16 Annual Service Plan Report* [Online]. Victoria, BC: BC Ministry of Health. Available: http://www.bcbudget.gov.bc.ca/Annual_Reports/2015_2016/pdf/ministry/hlth.pdf [Accessed 11 April 2017].

MINISTRY OF HEALTH AND LONG-TERM CARE 2010. Guidance Document for Declaration of Values ECFAA Requirement. Ontario: Ministry of Health and Long-Term Care.

MINISTRY OF HEALTH AND LONG-TERM CARE 2012a. Health Equity Impact Assessment (HEIA) Workbook. Ontario: Ministry of Health and Long-Term Care.

MINISTRY OF HEALTH AND LONG-TERM CARE 2012b. Health Equity Impact Assessment: Public Health Unit Supplement in Collaboration with Public Health Ontario. Ontario: Ministry of Health and Long-Term Care.

MINISTRY OF HEALTH AND LONG-TERM CARE. 2012c. *Citizens' Council* [Online]. Ontario: Queen's Printer for Ontario. Available: http://www.health.gov.on.ca/en/public/programs/drugs/councils/about.aspx [Accessed 3 March 2017].

MINISTRY OF HEALTH AND LONG-TERM CARE. 2013. *HEIA Health Equity Impact Assessment* [Online]. Queen's Printer for Ontario. Available: http://www.health.gov.on.ca/en/pro/programs/heia/ [Accessed 10 March 2017].

MINISTRY OF HEALTH AND LONG-TERM CARE. 2015. *2015-16 Published Plans and 2014-2015 Annual Reports* [Online]. Ministry of Health and Long-Term Care. Available: http://www.health.gov.on.ca/en/common/ministry/publications/plans/ppar15/#top [Accessed 4 May 2017].

MINISTRY OF HEALTH AND LONG-TERM CARE. 2016. *Ministry Plans: 2016-17 Published Plans and 2015-2016 Annual Reports* [Online]. Ministry of Health and Long-Term Care. Available: http://www.health.gov.on.ca/en/common/ministry/publications/plans/ppar16/#3.1 [Accessed 11 April 2017].

MINISTRY OF HEALTH AND LONG-TERM CARE. 2017. *About the Ministry* [Online]. Ministry of Health and Long-Term Care. Available: http://www.health.gov.on.ca/en/common/ministry/default.aspx [Accessed 11 April 2017].

MINISTRY OF HEALTH SERVICES 2005. A Framework for Core Functions in Public Health. Resource Document. BC: Ministry of Health Services.

MINISTRY OF INTERNATIONAL TRADE AND MINISTER RESPONSIBLE FOR ASIA PACIFIC STRATEGY AND MULTICULTURALISM 2015. 2015/16 - 2017/18 Service Plan. Victoria, BC: Ministry of International Trade and Minister Responsible for Asia Pacific Strategy and Multiculturalism,.

MINISTRY OF INTERNATIONAL TRADE AND MINISTER RESPONSIBLE FOR ASIA PACIFIC STRATEGY AND MULTICULTURALISM 2017. 2017/18 - 2019/20 Service Plan. Victoria, BC: Ministry of International Trade and Minister Responsible for Asia Pacific Strategy and Multiculturalism.

MORAN, A. 2011. Multiculturalism as nation-building in Australia: Inclusive national identity and the embrace of diversity. *Ethnic and Racial Studies,* 34**,** 2153-2172.

MORROW, R. A. & BROWN, D. D. 1994. *Critical Theory and Methodology,* Thousand Oaks, Sage Publications.

MOSAIC. nd. *MOSAIC* [Online]. Available: https://www.mosaicbc.org/ [Accessed 19 April 2017].

MOTT, W. J., JR. 2003. Developing a culturally competent workforce: A diversity program in progress. *Journal of Healthcare Management,* 48**,** 337-42.

MOXHAM, L. & PEGG, S. 1998. Delivering health services for ethnic minorities in regional Australia. *Australian Journal of Primary Health,* 4**,** 72-77.

MURRAY, S. B. & SKULL, S. A. 2005. Hurdles to health: immigrant and refugee health care in Australia. *Australian Health Review,* 29**,** 25-9.

NABATCHI, T. 2014. Deliberative civic engagement in public administration and policy. *Journal of Public Deliberation,* 10(1)**,** Article 21.

NAPIER, A. D., ANCARNO, C., BUTLER, B., CALABRESE, J., CHATER, A., CHATTERJEE, H., GUESNET, F., HORNE, R., JACYNA, S. & JADHAV, S. 2014. Culture and health. *The Lancet,* 384**,** 1607-1639.

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL 2006. *Cultural Competency in Health: A Guide for Policy, Partnerships and Participation,* Canberra, Commonwealth of Australia.

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL. 2016a. *Resources for Guideline Developers* [Online]. Available: https://www.nhmrc.gov.au/guidelines-publications/information-guideline-developers/resources-guideline-developers [Accessed 6 March 2017].

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL & CONSUMERS' HEALTH FORUM OF AUSTRALIA 2002. *Statement on Consumer and Community Participation in Health and Medical Research,* Canberra, Commonwealth of Australia.

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL & CONSUMERS' HEALTH FORUM OF AUSTRALIA 2016b. *Statement on Consumer and Community Involvement in Health and Medical Research,* Canberra, National Health and Medical Research Council.

NYLUND, D. 2006. Critical multiculturalism, whiteness, and social work: Towards a more radical view of cultural competence. *Journal of Progessive Human Services,* 17**,** 27-42.

O'NEILL, S. 2000. The politics of inclusive agreements: Towards a critical discourse theory of democracy. *Political Studies,* 48**,** 503-521.

O'REILLY, P. 2001. The Canadian health system landscape. *In:* ADAMS, D. (ed.) *Federalism, Democracy and Health Policy in Canada.* Kingston, Ontario: McGill-Queen's University Press.

OELKE, N. D., THURSTON, W. E. & ARTHUR, N. 2013. Intersections between interprofessional practice, cultural competency and primary healthcare. *Journal of Interprofessional Care,* 27**,** 367-372.

OLIVER, T. R. 2006. The politics of public health policy. *Annual Review of Public Health,* 27**,** 195-233.

OLSON, K. 2011. Legitimate speech and hegemonic idiom: The limits of deliberative democracy in the diversity of its voices. *Political Studies,* 59**,** 527-546.

ONTARIO PUBLIC SERVICE DIVERSITY OFFICE 2009. Driving Change From a Solid Foundation. OPS Diversity Three-year Strategic Plan & Annual Progress Report. Ontario: Ministry of Government Services.

ONTARIO PUBLIC SERVICE DIVERSITY OFFICE 2013. *Inclusion Now! OPS Inclusion Strategic Plan 2013-2016,* Ontario, Ministry of Government Services.

ORGANISATION FOR ECONOMIC COOPERATION AND DEVELOPMENT 2009. *Focus on Citizens. Public Engagement for Better Policy and Services*, OECD.

ORTIZ, L. & JANI, J. 2010. Critical race theory: A transformational model for teaching diversity. *Journal of Social Work Education,* 46**,** 175-193.

OXFORD DICTIONARY. 2017a. *Competence* [Online]. Oxford University Press. Available: http://www.oxforddictionaries.com/definition/english/competence [Accessed 16 March 2017].

OXFORD DICTIONARY. 2017b. *Dictionary: Competence* [Online]. Oxford University Press. Available: https://en.oxforddictionaries.com/definition/competence [Accessed 10 March 2017].

OXMAN, A., LEWIN, S., LAVIS, J. & FRETHEIM, A. 2009. SUPPORT Tools for evidence-informed health. Policymaking (STP) 15: Engaging the public in evidence-informed policymaking. *Health Research Policy and Systems,* [Online], 7.

PALMER, G. R. & SHORT, S. D. 2000. *Health Care and Public Policy. An Australian Analysis. 3rd ed.,* South Yarra, MacMillan Publishers Australia Pty Ltd.

PALMER, G. R. & SHORT, S. D. 2014. *Health Care and Public Policy: An Australian Analysis. 5th ed.,* South Yarra, Palgrave Macmillan.

PAREKH, B. 1999. Political theory and the multicultural society. *Radical Philosophy***,** 27-32.

PAREKH, B. 2000. Towards multiculturalism. *New Statesman,* 13**,** iii-iv, 16 October.

PARKER-TOULSON, S. & HARRISON, A. 2010. Anti-Racism & Diversity Trainers: Core Competencies and Leading Training Practices. A Literature and Scoping Review. British Columbia: Ministry of Citizens' Services.

PARKINSON, J. 2006. *Deliberating in the Real World: Problems of Legitimacy in Deliberative democracy,* Oxford, Oxford University Press.

PEPPER, F. 2017. *Pipis: The Unassuming Shellfish at the Heart of a Racially Fuelled Debate at Venus Bay* [Online]. ABC News. Available: http://www.abc.net.au/news/2017-03-28/pipi-shellfish-at-heart-of-racially-fuelled-debate-at-venus-bay/8368990 [Accessed 28 March2017].

PERRY, L. B. & SOUTHWELL, L. 2011. Developing intercultural understanding and skills: models and approaches. *Intercultural Education,* 22**,** 453-466.

PETRIWSKYJ, A., WARBURTON, J., EVERINGHAM, J.-A. & CUTHILL, M. 2012. Diversity and inclusion in local governance: An Australian study of seniors' participation. *Journal of Aging Studies,* 26**,** 182-191.

PHILLIPS, A. 1993. *Democracy and Difference,* Pennsylvania, Pennsylvania State University.

PHILLIPS, A. 2007. *Multiculturalism Without Culture,* Princeton, Princeton University Press.

PHILLIPS, S. D. & ORSINI, M. 2002. Mapping the Links: Citizen Involvement in Policy Processes. *CPRN Discussion Paper.* Ottawa: Canadian Policy Research Networks.

PIETSCH, J. 2013. Immigration and refugees: Punctuations in the Commonwealth policy agenda. *Australian Journal of Public Administration,* 72**,** 143-155.

PLATT, J. 2011. Case study. *In:* OUTHWAITE, W. & TURNER, S. P. (eds.) *The SAGE Handbook of Social Science Methodology.* : SAGE Publications Ltd, http://dx.doi.org/10.4135/9781848607958.

PLAUT, V. C. 2010. Diversity science: Why and how difference makes a difference. *Psychological Inquiry,* 21**,** 77-99.

PLESS, N. & MAAK, T. 2004. Building an inclusive diversity culture: Principles, processes and practice. *Journal of Business Ethics,* 54**,** 129-147.

PODGER, A., WANNA, J., CHAN, H., MA, J. & SU, T. T. 2012. Putting the citizens at the centre: Making government more responsive. *Australian Journal of Public Administration,* 71**,** 101-110.

PRATO, G. B. 2009. Introduction - Beyond multiculturalism: Anthropology at the intersections between the local, the national and the global. *In:* PRATO, G. B. (ed.) *Beyond Multiculturalism: Views from Anthropology.* Surrey, England: Ashgate Publishing, Ltd.

PRINS, B. & SAHARSO, S. 2013. Multiculturalism and identity. *In:* WAYLEN, G., CELIS, K., KANTOLA, J. & WELDON, S. L. (eds.) *The Oxford Handbook of Gender and Politics.* Oxford: Oxford University Press.

PUBLIC HEALTH AGENCY OF CANADA 2008. *Core Competencies for Public Health in Canada, Release 1.0,* Ottawa, Canada, Public Health Agency of Canada.

PUBLIC HEALTH AGENCY OF CANADA. 2016. *Public Health Agency of Canada 2015-2016 Department Performance Report* [Online]. Available: https://www.canada.ca/en/public-health/corporate/transparency/corporate-management-reporting/departmental-performance-reports/2015-2016-departmental-performance-report.html [Accessed 10 April 2017].

PUBLIC HEALTH AGENCY OF CANADA. 2017. *About Us* [Online]. Available: http://www.phac-aspc.gc.ca/about_apropos/index-eng.php [Accessed 10 April 2017].

PURNELL, L. 2000. A description of the Purnell model for cultural competence. *Journal of Transcultural Nursing,* 11**,** 40-46.

PURNELL, L. 2002. The Purnell model for cultural competence. *Journal of Transcultural Nursing,* 13**,** 193-196.

PUTLAND, C., BAUM, F. & MACDOUGALL, C. 1997. How can health bureaucracies consult effectively about their policies and practices?: some lessons from an Australian study. *Health Promotion International,* 12**,** 299-309.

QUEENSLAND GOVERNMENT. 2014. *Get Involved* [Online]. Queensland Government. Available: https://www.getinvolved.qld.gov.au/ [Accessed 10 March 2017].

QUEENSLAND GOVERNMENT. 2017. *Community Engagement* [Online]. Queensland Government. Available: https://www.qld.gov.au/gov/community-engagement [Accessed 10 March 2017].

QUEENSLAND HEALTH 2007. Strategic Plan for Multicultural Health 2007-2012. Queensland: Queensland Government.

QUEENSLAND HEALTH 2010a. Cross Cultural Learning and Development Strategy 2009-2012. Queensland: Queensland Government.

QUEENSLAND HEALTH 2010b. Cross Cultural Learning and Development Strategy 2009-2012. Background Paper. Queensland: Queensland Government.

QUEENSLAND HEALTH 2010c. Community Engagement Policy. Queensland: Queensland Health.

QUEENSLAND HEALTH 2012a. Literature Review. Best Practice Multicultural Policy Implementation. Queensland: Queensland Health.

QUEENSLAND HEALTH 2012b. Guideline for Multicultural Health Policy Implementation. Queensland: Queensland Health.

QUEENSLAND HEALTH 2016a. *Annual Report 2015-2016,* Queensland, Queensland Health.

QUEENSLAND HEALTH. 2016b. *Service agreements and deeds of amendment* [Online]. Queensland Health. Available: https://www.health.qld.gov.au/system-governance/health-system/managing/agreements-deeds [Accessed 10 April 2017].

QUEENSLAND HEALTH nd. Guide to Implementing the Queensland Multicultural Policy 2011 and Language Services Policy in a Health Context. Queensland: Queensland Health.

QUEENSLAND TREASURY AND TRADE. 2012a. *Census 2011: Queensland's Population Compared* [Online]. Queensland: Queensland Treasury and Trade. Available: http://www.oesr.qld.gov.au/products/bulletins/qld-pop-compared-c11/qld-pop-compared-c11.pdf [Accessed 4 May 2017].

QUEENSLAND TREASURY AND TRADE. 2012b. *Census 2011: Diversity in Queensland* [Online]. Queensland: Queensland Treasury and Trade. Available: http://www.qgso.qld.gov.au/products/reports/diversity-qld-c11/diversity-qld-c11.pdf [Accessed 4 May 2017].

RACHER, F. & ANNIS, R. C. 2007. Respecting culture and honoring diversity in community practice. *Research and Theory for Nursing Practice,* 21**,** 255-70.

RICE, M. F. 2005. Teaching public administration education in the postmodern era: Connecting organizational culture to diversity to social equity. *In:* RICE, M. F.

(ed.) *Diversity and Public Administration. Theory, Issues and Perspectives.* New York: M E Sharpe Inc.

RICE, M. F. 2007. A post-modern cultural competency framework for public administration and public service delivery. *International Journal of Public Sector Management,* 20**,** 622-637.

RICE, M. F. & MATHEWS, A. L. 2012. A new kind of public service professional. Possessing cultural competency awareness, knowledge and skills. *In:* NORMAN-MAJOR, K. A. & GOODEN, S. T. (eds.) *Cultural Competency for Public Administrators.* New York: ME Sharpe.

RONELLENFITSCH, U. & RAZUM, O. 2004. Deteriorating health satisfaction among immigrants from Eastern Europe to Germany. *International Journal for Equity in Health* [Online]. Available: https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-3-4 [Accessed 19 April 2017].

ROSEBERRY, W. 1992. Multiculturalism and the challenge of anthropology. *Social Research***,** 841-858.

ROWE, G. & FREWER, L. J. 2005. A typology of public engagement mechanisms. *Science, Technology & Human Values,* 30**,** 251-290.

S.U.C.C.E.S.S. 2014. *About Us* [Online]. Available: http://www.successbc.ca/eng/company/about-us [Accessed 19 April 2017].

SAKAMOTO, I. 2007. An anti-oppressive approach to cultural competence. *Canadian Social Work Review/Revue Canadienne de Service Social***,** 105-114.

SANDERS, L. M. 1997. Against deliberation. *Political Theory,* 25**,** 347-376.

SCHEFFLER, S. 2007. Immigration and the significance of culture. *Philosophy & Public Affairs,* 35**,** 93-125.

SCHMITZ, C. L., STAKEMAN, C. & SISNEROS, J. 2001. Educating professionals for practice in a multicultural society: Understanding oppression and valuing diversity. *Families in Society: The Journal of Contemporary Human Services,* 82**,** 612-622.

SEHA, E. & MULLER-ROMMEL, F. 2016. Case study analysis. *In:* KEMAN, H. & WOLDENDORP, J. J. (eds.) *Handbook of Research Methods and Applications in Political Science.* Cheltenham, UK: Edward Elgar Publishing.

SENGUPTA, S., HOPSON, R. & THOMPSON-ROBINSON, M. 2004. Cultural competence in evaluation: An overview. *New Directions for Evaluation***,** 5-19.

SHEEDY, A., MACKINNON, M. P., PITRE, S. & WATLING, J. 2008. Handbook on Citizen Engagement: Beyond Consultation. Ottawa: Canadian Policy Research Networks.

SHELLY, R. 2001. Institutionalising deliberative democracy. *Alternative Law Journal,* 26**,** 36-40.

SHOOKNER, M. 2002. An Inclusion Lens: Workbook for Looking at Social and Economic Exclusion and Inclusion. Halifax, NS: Health Canada.

SHORE, C. & WRIGHT, S. 1997. Policy. A new field of anthropology. *In:* SHORE, C. & WRIGHT, S. (eds.) *Anthropology of Policy: Critical Perspectives of Governance and Power.* London: Routledge.

SIGMOND, R. M. 1978. The linkage between health policy making and planning. *Bulletin of the New York Academy of Medicine,* 54**,** 59.

SILVER, H. 2010. Understanding social inclusion and its meaning for Australia. *Australian Journal of Social Issues,* 45**,** 183-211.

SIME, D. 2016. Migrant children and young people's 'voice' in healthcare. *In:* THOMAS, F. (ed.) *Handbook of Migration and Health.* Cheltenham, UK: Edward Elgar Publishing.

SMITH, B. L. 2003. Public Policy and Public Participation. Engaging Citizens and Community in the Development of Public Policy. Halifax, NS: Health Canada.

SMITH, G. & WALES, C. 2000. Citizens' juries and deliberative democracy. *Political Studies,* 48**,** 51-65.

SPINKS, H. 2010. Australia's Migration Program. *Background Note.* Canberra: Department of Parliamentary Services.

STANISEVSKI, D. M. & MILLER, H. T. 2009. The role of government in managing intercultural relations: Multicultural discourse and the politics of culture recognition in Macedonia. *Administration & Society* 41**,** 551-575.

STATISTICS CANADA. 2011. *Immigrant Languages in Canada* [Online]. Ottawa. Available: http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-314-x/98-314-x2011003_2-eng.cfm [Accessed 26 April 2017].

STATISTICS CANADA. 2015. *NHS Profile, Canada, 2011* [Online]. Statistics Canada. Available: http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=PR&Code1=01&Data=Count&SearchText=canada&SearchType=Begins&SearchPR=01&A1=All&B1=All&Custom=&TABID=1 [Accessed 4 May 2017].

STATISTICS CANADA. 2016. *Immigration and Ethnocultural Diversity in Canada* [Online]. Statistics Canada. Available: http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.cfm [Accessed 26 April 2017].

STEINBERG, S. R. & KINCHELOE, J. L. 2001. Setting the context for critical multi/interculturalism: The power blocs of class elitism, white supremacy, and patriarchy. *In:* STEINBERG, S. R. (ed.) *Multi/Intercultural Conversations: A Reader.* New York: Peter Lang Publishing.

STEWART, J. 2009. *Dilemmas of Engagement. The role of consultation in governance,* Canberra, ANU e-Press.

STREET, B. 1993. Culture is a verb: Anthropological aspects of language and cultural process. *In:* GRADDOL, D., THOMPSON, L. & BYRAM, M. (eds.) *Language and culture: Papers from the Annual Meeting of the British Association of Applied Linguistics.* Clevedon: British Association for Applied Linguistics.

STREET, J. 2014. The use of Citizens' Juries in health policy decision making. *Social Science & Medicine,* 109.

TAYLOR, C. 2012. Interculturalism or multiculturalism? *Philosophy & Social Criticism,* 38**,** 413-423.

TEBBLE, A. J. 2006. Exclusion for democracy. *Political Theory,* 34**,** 463-487.

TENBENSEL, T. 2010. Virtual special issue introduction: Public participation in health policy in high income countries–A review of why, who, what, which, and where? *Social Science & Medicine,* 71**,** 1537-1540.

TERVALON, M. & MURRAY-GARCIA, J. 1998. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved,* 9**,** 117-125.

TORONTO CENTRAL LHIN 2011a. 2011-2012 Toronto Central LHIN Community Engagement Plan. Ontario: Toronto Central LHIN.

TORONTO CENTRAL LHIN 2011b. Community Engagement Toolkit for Health Service Providers and the Toronto Central LHIN. Ontario: Toronto Central LHIN.

TORONTO CENTRAL LHIN 2013. A Plan to Transform Local Health Care for All. Integrated Health Service Plan 2013-2016. Ontario: Local Health Integration Network.

TORONTO CENTRAL LHIN 2016. The Future of Healthcare is Local. Integrated Health Services Plan 2016-2019. Ontario: Local Health Integration Network.

TORONTO CENTRAL LHIN nd. Annual Report 2015-2016. Ontario: Local Health Integration Network.

TREASURY BOARD OF CANADA 2011. *Values and Ethics Code for the Public Sector,* Ottawa, Government of Canada.

TRIADAFILOPOULOS, T. 2010. Global norms, domestic institutions and the transformation of immigration policy in Canada and the US. *Review of International Studies,* 36**,** 169-193.

TRITTER, J. Q. & MCCALLUM, A. 2006. The snakes and ladders of user involvement: moving beyond Arnstein. *Health Policy,* 76**,** 156-168.

TURNBULL, L. & AUCOIN, P. 2006. Fostering Canadians' Role in Public Policy: A Strategy for Institutionalizing Public Involvement in Policy. *Research Report P/07 Public Involvement Network.* Ottawa: Canadian Policy Research Networks.

TURNER, T. 1993. Anthropology and multiculturalism: What is anthropology that multiculturalists should be mindful of it? *Cultural Anthropology,* 8**,** 411-429.

TUTTON, M. 2017. *Bassam Al-Rawi, Halifax Cabbie Acquitted in Sex Assault, is Victim of Racism: Lawyer* [Online]. The Huffington Post. Available: http://www.huffingtonpost.ca/2017/03/06/halifax-taxi-driver-an-innocent-man-being-pilloried-in-public-his-lawyer-says_n_15196068.html [Accessed 28 March 2017].

TYRER, D. 2012. Race, offence and democracy. *Working Paper #8.* Institute for Muslim and non-Muslim Understanding, University of South Australia.

VALADEZ, J. 2001. *Deliberative Democracy, Political Legitimacy and Self-Determination in Multicultural Societies,* Colorado, Westview Press.

VASTA, E. 2006. Migration and migration research in Australia. *In:* VASTA, E. & VUDDAMALAY, V. (eds.) *International Migration and the Social Sciences. Confronting National Experiences in Australia, France and Germany.* Hampshire: Palgrave Macmillan.

VASTA, E. 2007. *Accommodating Diversity: Why Current Critiques of Multiculturalism Miss the Point*, Centre on Migration, Policy and Society, University of Oxford.

VENNESSON, P. 2008. Case studies and process tracing: theories and practices. *In:* DELLA PORTA, D. & KEATING, M. (eds.) *Approaches and Methodologies in the Social Sciences. A Pluralist Perspective.* Cambridge, UK: Cambridge University Press.

VON LIERES, B. & KAHANE, D. 2007. Inclusion and representation in democratic deliberations: Lessons from Canada's Romanow Commission. *In:* CORNWALL, A. & SCHATTAN COELHO, V. (eds.) *Spaces for Change?* London: Zed Books.

WALT, G. 1994. *Health Policy: An Introduction to Process and Power,* London, UK, Zed Books.

WANNA, J., O'FAIRCHEALLAIGH, C. & WELLER, P. M. 1992. *Public Sector Management in Australia,* Melbourne, Macmillan.

WEAR, D. 2003. Insurgent multiculturalism: rethinking how and why we teach culture in medical education. *Academic Medicine,* 78**,** 549-554.

WHITE, H. & RICE, M. F. 2005. The multiple dimensions of diversity and culture. *In:* RICE, M. F. (ed.) *Diversity and Public Administration. Theory, Issues and Perspectives.* New York: ME Sharpe Inc.

WHITE, R. 2003. Liberalism and multiculturalism: The case of Mill. *Journal of Value Inquiry,* 37**,** 205-216.

WILLIAMS, C. C. 2006. The epistemology of cultural competence. *Families in Society-the Journal of Contemporary Social Services,* 87**,** 209-220.

WILLIAMS, M. 2000. The uneasy alliance of group representation and deliberative democracy. *In:* KYMLICKA, W. & NORMAN, W. (eds.) *Citizenship in Diverse Societies.* Oxford: Oxford University Press.

WONG, L. 2010. Postcolonial interventions and disruptions: Contesting cultural practices. *International Journal of Cross Cultural Management,* 10**,** 345-362.

WOOD, P. K. & GILBERT, L. 2005. Multiculturalism in Canada: Accidental discourse, alternative vision, urban practice. *International Journal of Urban and Regional Research,* 29**,** 679-691.

WU, E. & MARTINEZ, M. 2006. Taking Cultural Competency from Theory to Action. The Commonwealth Fund.

WYNNE, P. K. 2016. *Let's Open up Government to New Possibilities* [Online]. Available: https://www.ontario.ca/page/lets-open-government-new-possibilities [Accessed 10 March 2017].

YALDEN, M. 2011. Multiculturalism - an anniversary celebration. *Canadian Ethnic Studies,* 43**,** 5-15.

YIN, R. K. 2003. *Applications of Case Study Research, 2nd ed.,* Thousand Oaks, Sage Publications.

YOUNG, I. M. 1990. *Justice and the Politics of Difference*, Princeton University Press.

YOUNG, I. M. 1997. Difference as a resource for democratic communication. *In:* BOHMAN, J. (ed.) *Deliberative Democracy: Essays on Reason and Politics.* Cambridge, Mass,: MIT Press.

YOUNG, I. M. 2001. Activist challenges to deliberative democracy. *Political Theory,* 29**,** 670-690.

YOUNG, I. M. 2002. *Inclusion and Democracy,* Oxford, Oxford University Press.

YOUNG, J. 2010. Migration, ethnicity and privilege. *Systemic Practice and Action Research,* 23**,** 101-113.

YOUNG, R. J. 2012. Postcolonial remains. *New Literary History,* 43**,** 19-42.

ZANETTI, L. A. & CARR, A. 1997. Putting critical theory to work: Giving the public administrator the critical edge. *Administrative Theory & Praxis,* 19**,** 208-224.

Appendixes

Appendix 1 – Literature Review Search Terms

Domain: Multiculturalism
Search terms:
Multicultural AND theory
Migration AND political theory
Migration AND Canada AND policy
Migration AND Australia AND policy
Postcolonial theory
Multicultural AND policy development
Multiculturalism AND policy development

Domain: Deliberative Democracy
Deliberative Democracy
Politics of identity AND theory
Politics of difference AND theory
Communicative democracy
Deliberative Democracy AND publics

Domain: Cultural Competence
Cultural Competence
Cultural Competence AND public policy
Cultural Competence AND policy making
Cultural Competence AND public administration
Cultural Competence AND health AND Canada
Cultural Competence AND health AND Australia
Cultural Competence AND health policy making AND Canada with or without participation
AND/OR civic engagement
Cultural Competence AND health policy making AND Australia with or without
participation AND/OR civic engagement

Domain: Health Related Public Policy
Health policy AND policy making
Health policy AND policy making AND citizen participation OR citizen engagement

Domain: Citizen Engagement
Citizen Engagement
Citizen engagement AND public policy
Citizen Engagement AND public policy AND health
Citizen Engagement AND Canada AND health
Citizen Engagement AND Australia AND health
Social Inclusion AND public policy
Social Inclusion and public administration
Social Inclusion AND Canada
Social Inclusion AND Australia

Appendix 2 – List of Participants (alphabetical order)

AUSTRALIA:

Anonymous
Australian Government Department of
Health, Australian Capital Territory (ACT)

Ms Elizabeth Chatham
Executive Director
Division of Women, Youth and Children
Health Directorate, ACT

Ms Andrea Cruikshank
Health Access and Equity Unit
Metro South Health, Queensland

Mr Thomas Lilley
Health Access and Equity Unit
Metro South Health, Queensland

Dr Clive Morris
Head
Strategic Policy Unit
National Health and Medical Research
Council, ACT

Ms Joan Scott
Senior Manager
Policy and Government Relations Branch
Health Directorate, ACT

CANADA:

Ms Caryl Harper
Director
Patients as Partners
Ministry of Health, British Columbia (BC)

Ms Sophia Ikura
Senior Director
Community Engagement and Corporate
Affairs
Toronto Central Local Health Integration
Network, Ontario

Ms Barbara Leslie
Director
Dietitian Services, HealthLink BC
Ministry of Health, BC

Ms Deborah Sattler
Team Manager
Home and Community Care
Implementation Branch
Ministry of Health and Long-Term Care,
Ontario

Ms Brande Strachan
HealthLink BC
Ministry of Health, BC

Ms Rosa Venuta
Senior Adviser
Platforms and Major Initiatives
Canadian Institutes of Health Research,
Ontario

Appendix 3 – Interview questions

Could you give me a brief overview of the nature of the engagement(s) you were involved in – what was the policy about (generally), why did you decide to engage with the community, what process of engagement was used (eg World Café) etc.

How did you decide which groups or individuals should be invited to the engagement activity? Did you target migrants either individually or by groups? Why, why not?

During the engagement activity, did you or your staff experience any particular issues in understanding a point of view that was being expressed? How did you manage that situation? What did it feel like at the time?

Did you feel that the migrant voice was heard during the engagement? And how was that voice transmitted in the post-engagement reporting and follow up? Please explain your response.

Did the engagement activity achieve the outcomes that you wanted? Please explain your response.

Were there any cultural issues raised on the day that could have affected – either negatively or positively – the outcome of the engagement?

What support does or did your organisation give you in engaging with citizens from culturally and linguistically diverse backgrounds?

What does the word "competence" mean to you?

How do you understand cultural competence within the policy process? And as an aspect of citizen engagement?

Do you think it is possible to be culturally "competent"? Why do you think that? What is the implication of this for citizen engagement and policy making?

It seems to me that there is a range of behaviour that could be called a continuum of competence ranging from not knowing anything about another culture and not being aware of this lack of knowledge, to being aware of the lack of knowledge and ignoring it,

to being aware and trying to take difference into account, to paying lots of attention to cultural difference, learning about difference, and trying to apply that knowledge. Where do you think policy makers stand on this continuum?

How can citizen engagement be made more fully inclusive (of CALD communities) and the outcomes more effective?

When I have finished my research, if I were to present the results to the head of your Department, what messages would you like me to convey?

Are there any other issues you would like to raise relevant to this topic?

Appendix 4 – Snapshots of jurisdictions

Australian Federal Health

The Australian Government Department of Health is primarily located in Canberra, the national capital. According to the 2015-2016 Annual Report, staff number 5,037 of which just under 1000 are located in offices in the States and Territories. The role of the Department is reflected in its Vision Statement namely "Better health and wellbeing for all Australians, now and for future generations" (Department of Health, 2016, p26). This vision is achieved through eleven outcome areas addressing issues such as pharmaceutical and medical services, health infrastructure, population health, the health workforce, and biosecurity and emergency responses. The Department administered a budget of AUD55.8 billion in the 2015-2016 year covering medical and pharmaceutical benefits and private health insurance rebates, aged care, and grants for health related activities (Department of Health, 2016).

The National Health and Medical Research Council (NHMRC) is an independent agency within the Health portfolio. Its role is to improve health and medical knowledge through funding research and translating research into evidence-based clinical practice, "administering legislation governing research", providing advice on ethics in health, and promoting public health (National Health and Medical Research Council, 2016a, p6). At 30 June 2016 NHMRC staff numbered 219 of whom 92% worked in Canberra, ACT with the remainder based in Melbourne, Victoria. Funding for health and medical research in 2015-2016 amounted to AUD845.5 million (National Health and Medical Research Council, 2016a).

Australian Capital Territory (ACT)

Drawing on the 2011 Australian Census, the most recent national Census data available, the ACT recorded a population of 360,550 being 1.7% of the total Australian population. This was a 15.6% population growth over the previous decade (Chief Minister and Treasury, 2013). Of this population, 5,183 or 1.5% identified as of Aboriginal or Torres Strait Islander origin (Chief Minister and Cabinet, 2012b) and 86,324 or 24.2% were born overseas – more than 58% of these people had lived in Australia for more than 15 years (Chief Minister and Cabinet, 2012a). Of these longer term residents 54.4% were born in

Europe and 25.8% were born in Asia (Chief Minister and Cabinet, 2012a). Since 2005, the number of Asian-born arrivals has continued to increase amounting to more than half of the overseas-born ACT population each year since 2005 (Chief Minister and Cabinet, 2012a). The 2011 Census demonstrates the diversity of the ACT population. Increased numbers of migrants settled in the ACT from China, India, The Philippines, South Korea, Sri Lanka, Vietnam, South Africa, the USA and Malaysia. At the same time there was a decline in the number of residents born in the United Kingdom (Chief Minister and Cabinet, 2012a).

Of the ACT population at the 2011 Census, 64,673 spoke a language other than English at home and 11.9% of these residents claimed that they did not speak English "well" or "at all". Of these latter residents, the main languages spoken were Mandarin, Vietnamese and Cantonese. Looking at the overall picture of ACT residents who spoke a language other than English at home, the main languages spoken were Mandarin and Cantonese (accounting for nearly 11,000 people in total), followed by Vietnamese, Italian, Spanish, Greek, Arabic, Croatian and Hindi (Chief Minister and Cabinet, 2012a).

Health care

According to the 2015-16 Annual Report the ACT Health Directorate's Vision is "Your Health – Our Priority" and its role is to deliver services to the community "on behalf of our government" and to the government "to meet the needs of our community" (ACT Health Directorate, 2016, p4). In the same reporting period Directorate staffing comprised 7,195 people made up of clinical and other health professionals and legal and administrative staff. Services delivered by the Health Directorate include dental, hospital, immunisation, food services and health infrastructure. In the 2014-15 year, total recurrent health expenditure in the ACT was AUD2,818 million (Australian Institute of Health and Welfare, 2016, p23).

Queensland

According to the 2011 Census, Queensland recorded a population of 4,332,739 people, or 20.1% of the total Australian population. This is a growth of 11% over the previous five years and makes Queensland the third most populous State in the country. Of this population, 3.6% or 155,824 people identified as being of Aboriginal or Torres Strait Islander origin, and nearly 21% or 888,636 people were born overseas, an increase of

almost 3% over the previous five years (Queensland Treasury and Trade, 2012a). The United Kingdom and New Zealand were the countries of origin for 45.7% of overseas-born Queenslanders, with South Africa third. Increasing numbers of immigrants are arriving from India and The Philippines (Queensland Treasury and Trade, 2012b).

At the 2011 Census, 9.8% of Queenslanders did not speak English at home. For these people, Mandarin (0.9%), Cantonese (0.5%) and Vietnamese (0.5%) were the most widely spoken languages. Just over 1% of Queenslanders born overseas who did not speak English at home said they did not speak English "at all" or "very well" (Queensland Treasury and Trade, 2012b).

Health care

The 2015-2016 Annual Report records the Department's Vision Statement as "Healthcare that Queenslanders value" (Queensland Health, 2016a, p9). The Department is responsible for the "overall management of the Queensland public health system" (p9) which includes providing support services to the 16 Hospital and Health Services (HHSs) which manage health service delivery throughout the State. In 2015-16 the Department employed over 80,000 staff of which just under 11,000 were "employed by and worked in" the Department (Queensland Health, 2016a, p88). This number included staff in the Queensland Ambulance Service, Health Support Queensland and eHealth Queensland. The remaining staff are employed by the HHSs direct or by the Department and contracted to the HHSs. In the 2014-15 year, total recurrent health expenditure in Queensland was AUD30,848 million (Australian Institute of Health and Welfare, 2016, p23).

Each of the 16 HHSs have entered into a service agreement with Queensland Health to specify the services that will be provided and performance expectations. The HHS's offer a variety of public health services as well as teaching and research activities (Queensland Health, 2016b).

Metro South Hospital and Health Service

Metro South Health provides public health services to over 1 million people over a diverse geographic area covering metropolitan and rural districts in the south east of Queensland. This region comprises 23% of the Queensland population. The HHS's vision is "To be

renowned worldwide for excellence in healthcare, teaching and research" (Metro South Hospital and Health Service, 2016). Metro South Health has more than 14,000 staff comprising doctors, nurses, health practitioners, associated technical officers, administrative and clerical staff. In the 2015-2016 reporting year, the HHS had an annual operating budget of more than AUD2.1 billion expended on a range of services including inpatient care, aged care, home and community care, screening programs, and other public health initiatives including oral health and sexual health (Metro South Hospital and Health Service, 2016).

Canadian Federal Health

Information in this section was drawn from a variety of sources. The reader will notice that references do not rely on an annual report in the same way as descriptions above about Australian health authorities do. This is because the Health Canada annual report focuses on implementation of the Canada Health Act 1984 (Can) and therefore is a very different type of report.

The Canadian Federal health department, Health Canada, is primarily located in Ottawa, the nation's capital, with some staff in regional offices. According to the 2015-2016 Report on Plans and Priorities staff number approximately 9,000 (Health Canada, 2015) most of whom are located in Ottawa. The First Nations and Inuit Health Branch has offices in most provinces (Health Canada, 2013).

The role of Health Canada is to ensure Canadians are amongst the healthiest people in the world (Health Canada, 2014a). This goal is achieved through 3 strategic outcomes addressing the health system, regulation of food, pharmaceuticals and environmental health hazards, and Indigenous health. The Department estimated a total budget of over CAD3.6 billion in the 2015-2016 year, a figure which includes staffing and resources across all programs (Health Canada, 2015).

The Canadian Institutes of Health Research (CIHR) and the Public Health Agency of Canada (PHAC) are separate agencies within the Health portfolio. CIHR's role is to "create new scientific knowledge and to enable its translation into improved health, more effective health services and products, and a strengthened Canadian health care system" (Canadian Institutes of Health Research, 2017a) which it does through an independent budget of over CAD970 million in 2015-2016 (Canadian Institutes of Health Research,

2017b). The role of the PHAC is to promote health, prevent chronic and infectious diseases and manage public health emergencies; to draw on international research for the benefit of Canadian health and to share Canadian knowledge internationally; and to work towards intergovernmental responses to "public health policy and planning" (Public Health Agency of Canada, 2017). In 2015-2016 the PHAC expended over CAD573 million and was supported by 2,143 staff (Public Health Agency of Canada, 2016).

British Columbia

At the 2011 Census the British Columbia population sat at 4,400,057 people. Language is an important indicator of diversity and Canada has two official languages, English and French. Of the BC population at the time of the 2011 Census, 3,912,950 people knew only English, 2,045 knew French only, and 296,645 knew both English and French. In terms of language spoken most often at home, 3,506,600 people spoke English and 16,685 spoke French. A further 144,555 people knew neither English nor French. Of other languages spoken at home Asian languages predominate with Chinese (Cantonese, Mandarin and other not-specified Chinese languages) being the most common, followed by Punjabi, Korean and Tagalog (BC Stats, nd).

Health Care

The Ministry of Health's role is to ensure the "…quality, appropriate, cost-effective and timely" delivery of health services in BC (Ministry of Health, nd, p5). It does this through a mix of direct service provision, such as the Medical Services Plan and Pharma Care, and through a number of Provincial health authorities. The Ministry also works in partnership with the First Nations' Health Authority to "improve the health status of First Nations in BC" (Ministry of Health, nd, p5). Through this network, services provided to the BC population cover the full range of health promotion, illness prevention, medical and hospital services. In 2015-16 the Ministry's budget totalled CAD17.444 billion plus almost CAD6 million for capital works (Ministry of Health, nd, p16-17). The Ministry's budget includes Federal government funds through the Canadian Health Transfer totalling almost CAD4.5 million (Department of Finance Canada, 2017).

Ontario

According to the 2011 National Household Survey, Ontario is the Province with the highest number of overseas born residents numbering over 3.6 million, or 28.5% of a population of 12.85 million people. Significantly, this figure represents 53.3% of the total Canadian overseas born population. At the time of the Census, most immigrants to Ontario came from Asia (63.1%) with the next largest group – at 12%, considerably fewer – from Europe. The greatest number of Asian immigrants came from India, China and The Philippines (Ministry of Finance, 2013).

As in British Columbia, English is overwhelmingly reported as the mother tongue of 69% of the population, with French at just over 4%. The remaining 26.6% of Ontarians report a mother tongue other than one of the two official languages. The language spoken most at home is overwhelmingly English (81.1%), 2.4% spoke French and 16.4% spoke other languages. Bengali, Hindi, Persian, Tagalog, Arabic and Punjabi represent the fastest growing language groups outside of the official languages (Ministry of Finance, 2012).

Health care

The Ministry of Health and Long-Term Care has what it calls a stewardship role in health meaning that the Ministry provides "overall direction and leadership" for health care in Ontario. Activities include the development of legislation, regulations and standards for health care, monitoring health system performance, establishing funding models and providing overall strategic direction (Ministry of Health and Long-Term Care, 2017). Health care in Ontario is provided both by the Ministry and through Ministry funding of 14 Local Health Integration Networks (LHINs) established through their own enabling legislation. The Ministry is responsible for managing Ontario's health insurance program as well as public health and emergency management (Ministry of Health and Long-Term Care, 2015).

In 2015-2016 the Ministry expended over CAD50 billion including CAD1.3 billion on capital items. In the same reporting year the Ministry reported staffing of 3,483 (Ministry of Health and Long-Term Care, 2016). In addition to Provincial funds, Ontario receives Canada Health Transfer funds from the Federal government which totalled over CAD13 million in 2015-16 (Department of Finance Canada, 2017).

Toronto Central Local Health Integration Network

Toronto Central LHIN is one of 14 LHINs established to provide health services throughout Ontario and, whilst geographically small measuring a number of city blocks, it is the most diverse LHIN in the Province. The population of 1.2 million residents live in a high density completely urban setting which contains the highest percentage of immigrants anywhere in Canada: 140 languages and dialects are spoken and 5% of the population do not speak either official language; 59,000 residents are Francophone; 25% are low income households; and more than 5000 people are homeless (Toronto Central LHIN, 2016, p9-10).

The Toronto Central LHIN's mission is to "Transform the health care system to achieve better health outcomes for people now and in the future" which it directs towards three goals of "A healthier Toronto, positive patient experiences, [and] system sustainability" (Toronto Central LHIN, 2016, p28). Activities to meet these goals include integration of care, taking a population health approach and giving attention to health equity, and building greater capacity within the LHIN for health equity impact assessment and community engagement (Toronto Central LHIN, 2016, p30-40).

In the 2015-16 financial year the Toronto Central LHIN budget amounted to over CAD4.8 billion. The majority of funding was dedicated to health service provision, CAD5.8 million was expended on operating expenses including administrative staff salaries, and the remainder was expended on grants to approved activities within the LHIN area (Toronto Central LHIN, nd, p29).