Improving inclusion in rural health services for marginalised community members: Developing a process for change

Christina Malatzky
University of Melbourne

Olivia Mitchell
University of Melbourne

Lisa Bourke
University of Melbourne

Abstract

Australia's mainstream health services located in rural contexts are mandated to provide health care to the entire local population. However, complex power relations embedded and reflected within the cultures of mainstream generalist health services are excluding the most marginalised residents from health care. This paper argues that unless inclusion in rural, generalist mainstream health services is improved, the health experiences of these residents will not substantially change and Australia will continue to report significant health differentials within its population. The concept of culturally inclusive health care is difficult for Australian mainstream generalist health practitioners to engage with because there is limited understanding of what culture is and how it operates within diverse communities. This makes it challenging for many in mainstream health institutions to begin deconstructing how it is that exclusion occurs. Frequently, 'culture' is assigned to 'Others', and there is little recognition that all people, including White, mainstream Australians, are cultural beings, and that health disciplines, services and systems have particular cultures that make assumptions about how to be in the world. Consequently, current approaches to the provision of culturally inclusive health care are not shifting the power relations that (re)produce exclusion. In this paper, we outline a new interdisciplinary methodology that operationalises Foucault's concepts of power, resistance and discourse within a Participatory Action Research (PAR) design and utilises Continuous Quality Improvement (CQI) processes to respond to these power relations and provide health institutions with a process to improve their inclusivity, specifically for Australia's most marginalised residents. It is suggested that employing this new methodology will promote a different way of thinking and acting in health institutions, producing a deconstructed process for health services to adapt to improve their inclusivity.

Keywords: Culturally inclusive health care; power; health institutions; rural mainstream health services: exclusion

In contrast to popularised representations, rural populations are neither homogenously White nor normative. 'Rural' is defined in this paper as geographic places which, while relational, contested and essentially constructed (Carter & Hollinsworth, 2009; Malatzky & Bourke, 2016), are located distinctly outside of major cities and their spatially-immediate districts. In Australia, rural communities are home to a high proportion of people who occupy a range of

Corresponding author: Christina Malatzky (christina.malatzky@unimelb.edu.au)

heterogeneous identities (Malatzky & Bourke 2016), including identities that are systemically marginalised on a socio-structural level, and specifically in the mainstream health care sector (Durey 2010, 2015; Durey, Lin & Thompson 2013; Edwards & Cheers 2007; Fredericks 2010; Levesque & Li 2014; Navarro 2009). The precise makeup of rural communities across Australia does vary. For example, in some rural communities, ninety percent of the population were born in Australia and few residents identify as First Nation Australian (referred elsewhere as Indigenous Australians or Aboriginal and/or Torres Strait Islander Australians/Peoples), while in other rural communities over twenty percent of the population were born overseas and ten percent of residents identify as First Nation Australian (Australian Bureau of Statistics, 2017). When it comes to health however, what is consistently significant for rural populations is that the effects of exclusive health services are substantial. In rural Australia, where there are fewer health services and a lack of specialist services, there is less choice of local services. If the few services that exist are not inclusive of all residents, and their social identities and cultural perspectives, then residents are excluded from accessing health services locally. Evidence has found that when health services are not culturally inclusive, utilisation is lower, particularly amongst vulnerable population groups (Durey et al., 2013). In rural areas, residents may not have any other option without significant travel and cost. Thus, one of the greatest challenges for rural health in Australia today is improving the cultural inclusivity of services to ensure access to health care is equitable.

We argue that unless inclusion is improved, especially in rural, generalist mainstream health services, then the health experiences of Australia's most marginalised residents, who include First Nation Australians, residents from culturally and/or linguistically diverse backgrounds, residents experiencing social and/or economic deprivation, people with disabilities, and lesbian, gay, bisexual, transgender, queer/questioning and intersex people, will not substantially change, and Australia will continue to report significant health differentials within its population. Exclusion generally, and specifically from health care is, from the perspectives of the authors and other scholars (Durey, 2015; Moreton-Robinson, 2014), an effect of power. Thus, this paper seeks to draw attention to some critical effects of power in the field of rural health; the effects of dominant cultural discourses, including Whiteness; and the exclusion of different cultural perspectives in the provision of health care in rural Australia. In doing so, a new interdisciplinary methodology for improving the cultural inclusivity of mainstream rural health services is outlined. This methodology operationalises a Foucauldian lens to move beyond dominant cultural discourses, and a Foucauldian-inspired framework to disrupt, in a practical way, the power relations (re)producing exclusion in mainstream health institutions. We suggest that this methodology will affect a shift in power, and thus a shift in the practices of mainstream health institutions to improve their inclusivity, specifically for Australia's most marginalised residents.

Background

Current approaches to improving inclusion in mainstream Australian health services

Exclusion (for example, the well-documented way in which First Nation Australians have less access to mainstream health services, resulting in significant 'gaps' between First Nation and non-First Nation Australians' health indicators, including life expectancy) represents a major obstacle to national health equity goals (Downing & Kowal 2011). Simultaneously, the provision of inclusive health care represents a critical component to fostering equity. Thus, health services can play an important role in shifting the power relations sustaining wider social inequalities (Downing & Kowal, 2011; Durey 2010; Newman, Persson, Paquette & Kidd, 2013). In essence:

> Mainstream health services need to become safe and enabling environments, offering respectful, quality care that recognises the lived social and cultural experiences of [diverse patients]. (Durey et al., 2013, p. 722)

In order to respond optimally to the health care needs of patients, health services must be able to recognise the unique cultural and social positionalities of their patients/clients and tailor care accordingly, especially for marginalised residents (Levesque & Li, 2014; Torsch & Ma, 2000). To do this, mainstream health services need to develop reflexivity about how dominant cultures and power relations operate within health institutions, inform dominant practices, and exclude patients/clients from a diverse range of cultures and with heterogeneous identities. However, an analysis of current approaches suggests that to date, exclusion/inclusion in mainstream generalist health services in the Australian context has predominantly been dealt with in two ways: firstly through institutional avoidance and obfuscation; and secondly, transference of medicalised 'tick-box' approaches to the socio-cultural, focussed on occasional education at the individual level.

In the case of avoidance and obfuscation, exclusion has been dealt with by supporting the development of specialising services (i.e. services designed to cater to the needs of specific groups of community members). For example, Aboriginal Community Controlled Health Organisations (ACCHOs) were first instigated because of the barriers, including racism, encountered by First Nation Australians to accessing mainstream health services in Australia (Durey, 2010). Today, the creation of specialising services is a common strategy employed to address equitable access to health services for groups of people who do not feel safe in mainstream health services (Armstrong, 2006; Newman et al., 2013; Scott et al., 2012,).

While this response emerged in resistance to dominant normative health care institutions and practices that did not cater to the needs of culturally or socially 'different' patients (Newman et al., 2013), it has simultaneously served the interests of these very same institutions and practices. The development of specialising services has enabled mainstream generalist health services to classify some patients as 'special needs', and to manage them by referral to such specialist services (Newman et al., 2013), often in metropolitan areas or some distance away from patients'/clients' home location. Specialising health services have provided consumers with well-needed choice and access. However, the internal tensions or politics within specialising health services and the impact of these tensions for access must also be acknowledged (Malatzky, Nixon, Bourke & Mitchell, 2016; Newman et al., 2013). Importantly, the strategy of developing specialising services to address inequitable access has meant that the power relations operating within mainstream health services that are (re)producing exclusion have remained relatively unchallenged. The responsibility of mainstream generalist health services for all the population continues to be obfuscated through this approach to exclusion/inclusion (Panaretto, Wenitong, Button & Ring, 2014). Specialist health services remain embedded within, rather than transformative agents of, a broader health care system, and are not often feasible given smaller population size in regional or rural environments.

In the second approach of transference and individual level education, dominant responses include the implementation of cultural competency training in mainstream generalist health services, which again has failed to transform the exclusionary cultures of these services (Downing & Kowal, 2011). Evidence suggests that while seeking to improve the provision of health care to specific groups of patients/clients (Downing & Kowal, 2011), such training is ineffective at changing attitudes and behaviours; and has not generated systemic change to enable mainstream generalist health services to meet their mandate of providing health care to the whole population (Downing & Kowal, 2011). Rather, essentialising discourses and processes of 'Othering' can be reproduced through such interventions (Downing & Kowal, 2011).

Predominately in these training sessions, culture is located in the Other rather than in the learner/White professional (Kumaş-Tan, Beagan, Loppie, MacLeod & Frank, 2007). The focus is on learning about the Other, for example, 'about Aboriginal people', presented as a homogenous group, rather than on the self and the broader workings of culture and power (Downing & Kowal 2011). In such an approach, critical concepts to the delivery of inclusive health care, such as ethnocentrism, heteronormativity, racism and White privilege, are invisible. Learners cannot comprehend the differential and intersectional nature of human positionalities (Kumaş-Tan et al., 2007; Yuval-Davis, 2006). Thus, while health professionals need to be trained to identify when (in)action maintains the status quo (i.e. privileges some and marginalises others) (Kumaş-Tan et al., 2007), this is not achieved through cultural competency training or similar. The development of such skills requires space for open discussion and critical self-reflexivity (Doutrich, Dekker, Spuck & Hoeksel, 2014; Durey, 2010,) over time (Durey, 2010; Pedersen, Walker, Paradies & Guerin, 2011).

More recently, various frameworks and audit tools have been developed for mainstream health services to implement in compliance with government directives to improve the inclusivity of mainstream health services specifically for First Nation Australians (State of Victoria, 2013, 2012; Victorian Department of Health, 2012). However, there are limitations to these existing initiatives. Firstly, these initiatives have been developed for metropolitan rather than rural communities, which is problematic because rural health requires, at its core, an understanding of, and responsiveness to, rural contexts (Bourke, Humphreys, Wakerman & Taylor, 2012; Malatzky & Bourke, 2016). Secondly, there is little evidence that these initiatives have been meaningfully taken up and embedded within mainstream health practice. The body of literature pertaining to these recent initiatives, including details and/or evaluations of their implementation, is often obscurely located or absent (Healthcare Management Advisors Pty. Ltd and Victoria Department of Health, 2011; Victorian Department of Health, 2012). This suggests that such initiatives can be readily pulled back into existing power relations and approached through familiar tick-box tactics that fail to engage meaningfully with diverse consumers. In sum, current approaches to the provision of culturally inclusive health care are failing to shift the complex power relations embedded and reflected within the cultures of mainstream generalist health services that underpin health inequities in Australia.

It is the mandate of all mainstream generalist health services to provide care to everyone living in their local catchment areas (Durey, 2010). However, while some rural health services recognise the need to adapt models of service provision to cater for the diversity within the Australian population, there is little guidance about *how* to go about this in practice (Grant & Luxford, 2011; Kumaş-Tan et al., 2007,). As Newman et al. (2013, p. 93) articulate, an exploration of the "complex dynamics of 'doing' inclusivity" is needed. To improve the health experiences and outcomes of Australia's most marginalised residents, such a process of change requires a long-term commitment from mainstream health institutions rather than simply policy changes or single-session staff education (Downing & Kowal, 2011; Farmer et al., 2012; Pedersen et al., 2011). A genuine shift within mainstream generalist health services requires the deconstruction, critique, and modification of institutional cultures, organisational policies, procedures, education, awareness, practice, how clients are engaged (Downing & Kowal, 2011), and fundamentally, the dominant discourses directing these features. It requires the disruption of current power relations (re)producing exclusion in health institutions.

Methods

First, literature, across multiple areas (including sociology/social science, medical anthropology, critical theory, health and rural health, organisational studies, community development, Aboriginal health, and transformative education) was reviewed over a three year period (2014-2017) by the authors who were, at that time, establishing a new stream of research in the discipline of rural health focussed around culture and inclusion (see Malatzky

& Bourke, 2017). To begin, the authors read widely across a number of key domains related to culture in rural health, including the cultures and/or cultural practices of: health professions, rural communities, mainstream health institutions, Western health systems, biomedicine, rural health as a discipline, and marginalised, rurally-living health care users. This involved an iterative process of searching in and re-searching across the identified domains for content related or relevant to the concepts of culture and cultural inclusion in rural health (Arksey & O'Malley, 2005; Barnett-Page & Thomas, 2009). A variety of methods were employed in undertaking this review. These methods included: searching in electronic databases, including the platforms CINAHL Complete, Informit, ProQuest, Ovid, Ebsco and Gale; tracing related research, including conceptual and theoretical research cited or in some way used in sourced literature; searching in specific journals, including *Social Science & Medicine*, *Health & Place*, *Health*, *Health Sociology Review*, *Health & Social Care in the Community*, *Journal of Rural Studies* and *Social Theory in Health*; and seeking advice from senior colleagues, specifically those in rural health and health sociology regarding bodies of related or relevant research (Arksey & O'Malley, 2005). The authors then identified several core bodies of literature that were relevant, either conceptually, theoretically and/or topically, to the concept of cultural inclusion in rural health. The most substantive of these were: understandings of 'culture' and processes of culture in health; Whiteness and (White) privilege; processes of exclusion/inclusion; cultural competency/similar models in health; power in health; structural explanations for health disparities; politics of 'access' to health care; racism and discrimination in health care/delivery; social models of health; and biomedical/dominant health practices. The authors then synthesised these bodies of literature into working documents (Barnett-Page & Thomas, 2009).

Second, the authors conducted two small studies with two rural health services, which were granted ethics approval from The University of Melbourne. In one study, 20 interviews were conducted with staff, executive and board members about cultural safety and cultural inclusion. This study found that there was great variation in the talk of staff and how they viewed cultural inclusion and not all staff understood why inclusion was important (Malatzky, Nixon, Mitchell & Bourke, 2018). In a second study, four focus groups were conducted with staff of a different rural health service. In this service, staff were adamant that they should treat everyone the same and that their local population was not culturally diverse (Malatzky, Mitchell & Bourke, 2017), despite seeing the second highest number of First Nation Australian patients compared to any other service of its size in the state (Department of Health and Human Services, 2017; Vaughan, 2017).

The findings of these initial research projects with rural health services and the synthesises of related literature were used to advance the authors analytical insights into how these sets of data could be used to structure and guide a new study (Antaki, Billig, Edwards & Potter, 2002; Eisenhart & Jurow, 2011): the design of a new interdisciplinary methodology for improving the cultural inclusivity of mainstream rural, generalist health services. A Foucauldian understanding of power, resistance and discourse was applied to both the analyses of research project data and literature review data to interrogate what, through such a lens, is contributing to the maintenance of exclusion in mainstream rural, generalist health services, and what this means for how, practically, these conditions could be effectively disrupted and change stimulated. Taking this Foucauldian-inspired framework as a method for undertaking the research, participatory and organisational change principles and methodologies were built into the study's design to strengthen its practical application.

In the next section we detail the rationale for the design of the new proposed methodology by reviewing the dominant ways in which culture and Whiteness are constructed in mainstream Australian health institutions. This analysis contextualises the enduring invisibility of power relations in mainstream health institutions and the limitations of current approaches to inclusion. Within this context, discussion shifts to the proposed new methodology for improving the inclusivity of rural generalist mainstream health institutions. The operationalisation of

Foucault's toolkit in this methodology, and its importance for responding to exclusion and improving inclusivity in such institutions, is detailed. The final section sets forth the new methodology itself, describing a plan of action to deconstruct the process of exclusion and construct a process of inclusion in mainstream health institutions.

The meaning of culture and Whiteness in rural communities

One of the central reasons underlying why mainstream generalist health services in Australia have struggled to engage with the concept of culturally inclusive health care is a lack of understanding about what culture is and how it operates within diverse communities. Foundational anthropological understandings of culture have not informed conceptions in the medical or health service domains (Kleinman & Benson, 2006), nor are they widely embedded within mainstream consciousness. Most White Australians do not see or understand themselves as having a culture or being cultural (Grant & Luxford, 2011). Thus, culturally inclusive health care is not considered relevant to the majority; such concepts are applied to 'the Other' (Grant & Luxford, 2011), disguising how power operates through dominant discourse to privilege some and marginalise others (Kumaş-Tan et al., 2007).

In Australia, Whiteness is constructed as the norm (Grant & Luxford, 2011; Kumaş-Tan et al., 2007), and those who occupy this position are thereby "excluded from the concept of cultural diversity" (Kumaş-Tan et al., 2007, p. 551). This is particularly the case in rural communities, which have historically been imagined as White geographies (Panelli, Hubbard, Coombes & Suchet-Pearson, 2009). Yet Australian ruralities have never been exclusively White spaces (Panelli et al., 2009). In Australia, Others, such as First Nation Australians, are marginalised and excluded from spaces such as rural generalist mainstream health services through non-First Nation Australians' marking of territory (Fredericks, 2010). Because White Australians do not understand themselves as cultural beings, key concepts for the exploration of Whiteness and power, and their implications in health care settings, are difficult to engage. The focus remains on 'the Other as the problem', and the operation of ethnocentrism and racism within health services remains obscured and unarticulated by internal actors (Kumaş-Tan et al., 2007, p. 552).

Culture plays a defining role in human perception and experience (Kleinman & Benson, 2006; Levesque & Li, 2014). An essential component of providing culturally inclusive health care is thus the recognition within health institutions and by health professions that all humans are cultural beings, and that power situates individuals differently depending on the intersection of various socially constructed categories to which individuals are assigned in their particular historical and cultural contexts (Maynard, 2001; Munro, 2003). Relatedly, teaching and learning about culture and power in health services needs to focus on the *processes* of culture and power, including those of Whiteness, in order to firstly make it visible (Downing & Kowal, 2011), and secondly to enable health service providers to be reflexive about their actions and challenge rather than reinforce inequities (Kumaş-Tan et al., 2007). If such changes do not occur, then current health inequities within Australian society will continue; rural generalist mainstream health services will remain inaccessible for those who need health care the most (Durey et al., 2013).

Operationalising Foucault's toolkit in the analysis and response to exclusion in Australian mainstream health services

In Australia, exclusion from the institutions that provide health care is, we argue, an effect of the power relations operating within a diverse, multicultural society. According to Foucault (2002, p. 340), power "acts upon actions"; it manifests through actions and the consequences of these actions. Thus, "power appears in people's actions" (Ohman, 2010, p. 396). People's under-utilisation of health services, including seeking care only in emergency situations, and

the consequences generated (poor health), are reflective of the dominant discourses informing the delivery of health care in mainstream health institutions (Daley & MacDonnell, 2015; Ohman, 2010).

From a Foucauldian perspective, power is a productive, ever-present force that is constituted through knowledge, discourse and 'regimes of truth' within societies, producing particular constructions of the real. Foucault (1991, p. 131) explains that 'truth' is:

> produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth, its "general politics" of truth: that is, *the types of discourses which it accepts and makes function as true*; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth, the status of those who are charged with saying what counts as true. [emphasis added]

Power through this lens is woven into everyday social life where it "reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives" (Foucault & Gordon, 1980, p. 39).

Current approaches that aim to address exclusion from health services are inadequate because they fail to address exclusion as an effect of power; they fail to recognise and challenge the relations of power that (re)produce exclusion. Instead, the need for mainstream health institutions to address and, ultimately, shift these power relations is circumvented or ignored. However, in order to facilitate such a shift, it is necessary to understand how the practices of, and (inter)actions within, mainstream health institutions are excluding certain ways of 'being in the world' (Grant & Luxford, 2011) – that is, being in the world as other than a White, middleclass, heterosexual, and other normalised subject positions.

Health institutions are constituted through the relations of power operating in their particular contexts (Foucault, 2002; Skeggs, 1997). Through dominant discourses, such as sameness and clinical neutrality, power normalises certain actions and certain health practices as acceptable and guides people to act accordingly (Amigot & Pujal, 2009; Foucault, 1991, 1995; Foucault & Gordon, 1980). However, normalised health service practices ignore individual needs (Foucault, 2004; Levesque & Li, 2014) and can negatively shape patient experience (Foucault & Gordon, 1980; Scott, 1991).

Health service providers are also influenced by broader dominant societal discourses. White privilege and class blindness (Downing & Kowal, 2011; Levesque & Li, 2014; Navarro, 2009), as well as health service and biomedical discourses of sameness and clinical neutrality (Baum, Laris, Fisher, Newman & MacDougall, 2013; Foucault, 2004; Grant & Luxford, 2011), shapes these actors. Together, these discourses produce certain perceptions of reality and normalise certain actions, which, we suggest, are critical to deconstructing the mechanisms through which exclusion occurs within mainstream health services.

Importantly, identifying how such dominant discourses manifest in the actions of health service actors, and how the practices of mainstream health institutions exclude people who are culturally and/or socially Other, also involves identifying possibilities for transformation (Golob & Giles, 2013). As Foucault (1990, p. 100-101) described:

> Discourses are not once and for all subservient to power or raised up against it…We must make allowances for the complex and unstable processes whereby a discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling point of resistance and a starting point for an opposing strategy. Discourse transmits

and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart.

Resistance for Foucault is embedded within the workings of power itself as a productive force – "where there is power, there is resistance" (Foucault, 1990, p. 95). The exercise of power is thus a 'necessary condition' to produce possibilities for change (Golob & Giles, 2013). In this paper, we harness this conceptualisation in setting forth a new approach to addressing exclusion in mainstream health institutions. Envisioned as tools in the process, Foucault's theorisations of power, resistance and discourse are used to deconstruct the dominant discourses reinforcing exclusion and reproducing alternative discourses that undermine them, expose them, render them fragile, and ultimately thwart them (Foucault, 1990).

A new methodology for improving the cultural inclusivity of mainstream health institutions

This new methodology to improve the cultural inclusivity of mainstream health institutions outlined here operationalises Foucault's concepts of power, resistance and discourse in a Participatory Action Research (PAR) design. PAR methodologies share a concern with involving members of a targeted group in the research process and positioning these participants as equal partners in related decision-making (Golob & Giles, 2013). In this paradigm, participants/co-researchers are encouraged to develop "their own meanings and understandings of a particular issue" (Golob & Giles, 2013, p. 357).

One of the substantial failings we identify in the translation of policies and/or existing strategies for improving inclusivity into practice is that, while leadership and/or management may engage with members of a specific community, for example, a local First Nation community, to inform their goals and strategies as an institution related to inclusivity, often, on-the-ground staff are not engaged in this process nor prepared for the change required (Healthcare Management Advisors Pty. Ltd and Victoria Department of Health, 2011; Sollecito & Johnson, 2013). Participatory work with staff to engage them with the concept of inclusivity, what it means, why it is important and, crucially, how culture and power operate in the social world and in health institutions, does not occur. Staff are not given the tools to practise reflexivity, and are therefore not prepared for thinking about and engaging in the translation of policy initiatives into genuine, embedded practice change. Thus, this methodology uses a PAR design to actively involve staff as well as marginalised members of a community in the process, and specifically works with staff as the central implementers of change to ensure they develop an understanding of the processes of exclusion that are a key feature of this methodology.

By cultivating particular knowledges and practices, people can "gain the capacity to pursue, through their own means, practices of (self)transformation" (Golob & Giles, 2013, p. 363). This methodology develops a critical awareness among staff participants of how dominant discourses exclude particular groups of people from mainstream health services, and then uses this awareness to work with staff to inform their future action/s and the broader practices of the organisation in which they work. This approach recognises that all subjects are always situated within power relations, and thus, possibilities of domination co-exist with "an ever-present capacity to modify power relations through action upon action" (Golob & Giles, 2013, p. 368).

This methodology prepares health service staff for change prior to community engagement. PAR has been married with Continuous Quality Improvement (CQI) processes, since these are frequently used in Australian health institutions and are familiar processes of change among health service providers (Sollecito & Johnson, 2013). Similar to PAR strategies, CQI follows a practical Plan, Do, Study/Check, Act (PDSA) cycle (McLaughlin & Kaluzny, 2006; Sollecito & Johnson, 2013), which has been embedded into this methodology to give staff

participants a guide to how the approach can be tailored to specific contexts and employed to deconstruct and challenge the existing power relations (re)producing exclusion within mainstream health institutions.

By employing this new, interdisciplinary methodology, a different way of thinking and acting is promoted, one that engages and equips health service staff and uses the experiences of the marginalised to inform change within mainstream health institutions. Utilising Foucauldian tools and the processes inherent in PAR and CQI, this methodology deconstructs the (re)production of dominant discourses in health institutions and fosters critical awareness and reflection (Doutrich et al., 2014; Durey, 2010; Pedersen et al., 2011) amongst health service providers. This critique then informs proceeding cycles of action (through which power is manifest), rendering resistance to, and the transformation of, existing power relations possible (Golob & Giles, 2013). The aim is to produce a deconstructed process for other health services to adapt and use to improve their inclusivity. It is our contention that undergoing the resulting process is nowhere more important than in regional, rural and remote Australian communities, given that these communities are home to many people occupying diverse cultural and social identities, who simultaneously experience a lack of choice of services and providers. This new methodology is therefore of particular relevance to rurally-based generalist mainstream health services whose mandate to provide health care to their entire local population is both imperative and a substantive challenge.

The approach begins with assessing services' readiness for change in relation to cultural/social inclusion. The dominant ideas about culture and 'being in the world' (Grant & Luxford, 2011) that inform staff thinking and practice need to be identified to provide key stakeholders with a clear, documented understanding of how and to what extent staff from different levels and areas within an organisation are influenced by the dominant discourses reinforcing exclusion. This stage in the approach recognises that individuals working within health services are actors in the health care system and wider social field, influenced by broader social discourses as well as those specific to their professional training (Beagan, 2003; Levesqu & Li, 2014). Thus, as illustrated by the permeable boundaries between the wider social field, the health care system and individual health services, a service's readiness for change needs to be contextualised within the broader power relations operating within the health care system and the wider social field.
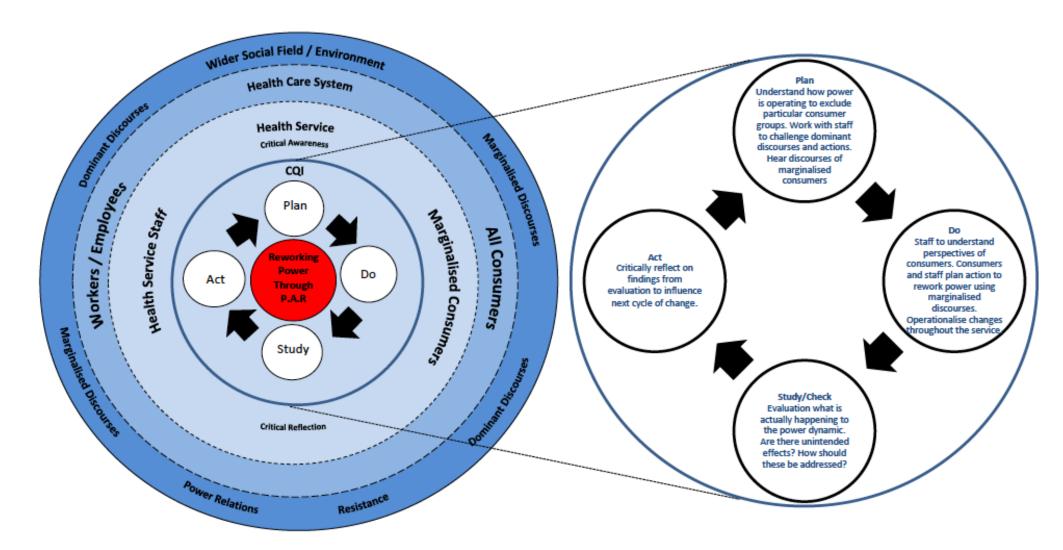
The dominant discourses reinforcing exclusion identified and explored in the initial phases of the approach need to be deconstructed and critiqued for and with staff across a health service over a period of time. Staff need to acquire alternative knowledge and develop an ability to critically reflect on the workings of culture and power through action in the health service (Doutrich et al., 2014; Durey, 2010; Pedersen et al., 2011). This stage of the approach focuses on making the processes of culture and power visible to on-the-ground staff so that they can be reflexive about how their (in)actions and the service's practices contribute to the exclusion of some community members from the service (Doutrich et al., 2014; Durey, 2010; Pedersen et al., 2011). It is critical at this time that staff are engaged, through discussion, workshops and being challenged, in a process of change and develop a fundamental understanding of *why* change is important. Staff across the organisation must be equipped through learnings in this phase to recognise that improving the service's inclusivity for culturally/socially 'different' people involves a long-term commitment to a change process; a service cannot be transformed into a culturally inclusive organisation by simply putting staff through a single training session (Doutrich et al., 2014; Downing & Kowal, 2011; Durey, 2010; Fredericks, 2010; Kumaş-Tan et al., 2007; Pedersen et al., 2011,).

Building on more recent approaches to improving the inclusivity of mainstream health services (Durey et al., 2012), CQI PDSA cycles are employed to guide services through a process of change that recognises power as central to exclusion *and* inclusion (Foucault, 1990; Golob & Giles, 2013). In our approach, staff are prepared for and engaged in the need for change

(Bloor, 1999; Kotter, 1995), and at this point the knowledge, discourses and alternative perspectives of targeted marginalised community members can be sought and acted upon by staff within the service. The engagement of community members in the process is vital. Consultation cannot be tokenistic; community members may be paid to lead new directions and practices; and the service needs to recognise that the knowledge possessed by community members makes them powerful actors in the change process. In collaboration, marginalised community members and staff design alternative practices, policies and structures to be trialled, evaluated and modified within the service to effect a rupture in the existing power relations (re)producing exclusion (Foucault, 1991). Focussing on different levels and different actions, including from entering the service, to clinical practices, food services and administrative processes, a (continuous) series of responsive PDSA cycles increases the capacity of stakeholders to pursue new possibilities for change and transformation (Golob & Giles, 2013). These cycles have a built-in mechanism (study/evaluate) to assess whether unintended consequences have been generated from the change (for example, the reproduction rather than rupture of existing power relations) and to address such consequences in proceeding cycles of action (plan) (Sollecito & Johnson, 2013).

At the heart of this new methodology is the re-working of power relations within mainstream health institutions. Producing change at this fundamental level requires health service staff to be engaged and prepared to think and act differently – deconstruction, critique and learning occurs within the organisation to enable the experiences and perspectives of marginalised community members to have an impact on health service practice and culture. This methodology explicitly documents these steps and provides health services with a plan of incremental, continuous action to affect meaningful change over time (see Figure 1).

Figure 1: Conceptualising the Change Process

Conclusion

It is planned that this new methodology will achieve long-lasting, genuine change by disrupting usual practices and the assumptions that underpin them. Both health consumers and health professionals are cultural beings who engage in power relations through the process of health care. Recognising power relations at the heart of cultural practices brings to the surface many of the cultural assumptions of all actors involved in health care (Horsfall, Blignault, Perry & Antonopoulos, 2016). To first deconstruct the dominant practices within a health service that work to exclude reveals opportunities to build more open, flexible and culturally appropriate practices. Engaging excluded consumers in the re-development of such practices empowers the marginalised. Through small cycles of change (PSDA), small changes are achieved and acknowledged over time in a manner consistent with changes to practice in health settings. Thus, this methodology transforms complex thinking around cultural exclusion into a practical model for services to adopt. It is only when health care is targeted to the most marginalised residents that health outcomes will improve.

References

Amigot, P. & Pujal, M. (2009). 'On power, freedom, and gender: A fruitful tension between Foucault and feminism'. *Theory and Psychology*, 19(5), 646-669.

Antaki, C., Billig, M., Edwards, D. & Potter, J. (2002). 'Discourse analysis means doing analysis: A critique of six analytic shortcomings'. *DAOL Discourse Analysis Online* 1.

Arksey, H. & O'Malley, L. (2005). 'Scoping studies: Towards a methodological framework'. *International Journal of Social Research Methodology*, 8(1), 19-32.

Armstrong, R. M. (2006). 'Perspectives on Aboriginal community controlled health services'. *The Medical Journal Of Australia*, 184(10), 526-526.

Australian Bureau of Statistics. Commonwealth of Australia (2017). Available from http://www.abs.gov.au/.

Barnett-Page, E. & Thomas, J. (2009). 'Methods for the synthesis of qualitative research: A critical review'. *BMC Medical Research Methodology*, 9, 59-59.

Baum, F. E., Laris, P., Fisher, M., Newman, L. & MacDougall, C. (2013). '"Never mind the logic, give me the numbers": Former Australian health ministers' perspectives on the social determinants of health'. *Social Science & Medicine*, 87, 138-146.

Beagan, B. L. (2003). 'Teaching social and cultural awareness to medical students: 'It's all very nice to talk about it in theory, but ultimately it makes no difference'.' *Academic Medicine*, 78(6), 605-614.

Bloor, G. (1999). 'Organisational culture, organisational learning and total quality management: A literature review and synthesis'. *Australian Health Review: A Publication Of The Australian Hospital Association*, 22(3), 162-179.

Bourke, L., Humphreys, J. S., Wakerman, J. & Taylor, J. (2012). 'Understanding rural and remote health: A framework for analysis in Australia'. *Health & Place*, 18(3), 496-503.

Carter, J., & Hollinsworth, D. (2009). 'Segregation and protectionism: Institutionalised views of Aboriginal rurality'. *Journal of Rural Studies*, 25(4), 414-424.

Daley, A., & MacDonnell, J. A. (2015). ''That would have been beneficial': LGBTQ education for home-care service providers'. *Health and Social Care in the Community*, 23(3), 282-291.

Department of Health and Human Services. (2017). Program report for integrated service monitoring: Kyabram and District Health Services. Victoria State Government.

Doutrich, D., Dekker, L., Spuck, J. & Hoeksel, R. (2014). 'Identity, ethics and cultural safety: Strategies for change'. *Whitireia Nursing and Health Journal*, 21, 15-21.

Downing, R., & Kowal, E. (2011). 'A postcolonial analysis of Indigenous cultural awareness training for health workers'. *Health Sociology Review*, 20(1), 5-15.

Durey, A. (2010). 'Reducing racism in Aboriginal health care in Australia: Where does cultural education fit?' *Australian and New Zealand Journal of Public Health*, 34 Suppl 1, S87-S92.

Durey, A. (2015). 'Antonio Gramsci and Pierre Bourdieu: 'Whiteness' and Indigneous healthcare'. In F. Collyer (ed) *The palgrave handbook of social theory in health, illness and medicine*, 191-204. New York: Palgrave Macmillan.

Durey, A., Lin, I. & Thompson, D. (2013). ''It's a different world out there': Improving how academics prepare health science students for rural and Indigenous practice in Australia'. *Higher Education Research and Development*, 32(5), 722-733.

Durey, A., Wynaden, D., Thompson, S. C., Davidson, P. M., Bessarab, D. & Katzenellenbogen, J. M. (2012). 'Owning solutions: a collaborative model to improve quality in hospital care for Aboriginal Australians'. *Nursing Inquiry* , 19(2), 144-152.

Edwards, J., & Cheers, B. (2007). 'Is social capital good for everyone? The case of same-sex attracted women in rural South Australian communities'. *Health Sociology Review*, 16 (3/4), 226-236.

Eisenhart, M., & Jurow, A. S. (2011). 'Teaching qualitative research'. In N. Denzin & Y. Lincoln (eds) *The sage handbook of qualitative research*, 699-714. Thousand Oaks: Sage Publications.

Farmer, J., Bourke, L., Taylor, J., Marley, J. V., Reid, J., Bracksley, S. & Johnson, N. (2012). 'Culture and rural health'. *Australian Journal of Rural Health*, 20(5), 243-247.

Foucault, M. (1990). *The history of sexuality, Penguin history*. London: Penguin.

Foucault, M. (1991). *The Foucault reader*. in P. Rabinow (ed), *Penguin social sciences*. London: Penguin.

Foucault, M. (1995). *Discipline and punish: The birth of the prison*. Translated by Alan Sheridan. 2nd ed. New York: Vintage Books.

Foucault, M. (2002). 'The subject and power'. In J. D. Faubion (ed) *Essential works of Foucault 1954-1984. volume 3, power*, 326-348. London: Penguin Books.

Foucault, M. (2004). 'The crisis of medicine or the crisis of antimedicine?'. *Foucault Studies* (1), 5-19.

Foucault, M., & Gordon, C. (1980). *Power/knowledge: Selected interviews and other writings, 1972-1977*. Brighton, Sussex: Harvester Press.

Fredericks, B. (2010). 'What health services within rural communities tell us about Aboriginal people and Aboriginal health'. *Rural Society*, 20(1), 10-205.

Golob, M. I., & Giles, A. R. (2013). 'Challenging and transforming power relations within community-based participatory research: The promise of a Foucauldian analysis'. *Qualitative Research in Sport, Exercise & Health*, 5(3), 356-372.

Grant, J., & Luxford, Y. (2011). ''Culture it's a big term isn't it'? An analysis of child and family health nurses' understandings of culture and intercultural communication'. *Health Sociology Review*, 20(1), 16-27.

Healthcare Management Advisors Pty. Ltd, and Victoria Department of Health. (2011). *Department of Health ICAP and KMHLO developmental review: Final report*. Melbourne, Victoria: Healthcare Management Advisors Pty. Ltd and Department of Health.

Horsfall, D., Blignault, I., Perry, A. & Antonopoulos, P. (2016). 'Love stories: Understanding the caring journeys of aged Greek-Australian carers'. *Health & Social Care in the Community*, 24(2), 194-202.

Kleinman, A., & Benson, P. (2006). 'Culture, moral experience and medicine'. *Mount Sinai Journal of Medicine*, 73(6), 834-839.

Kotter, J.P. (1995). 'Leading change: Why transformation efforts fail'. *Harvard Business Review*, 73(2), 59-67.

Kumaş-Tan, Z., Beagan, B., Loppie, C., MacLeod, A. & Frank, B. (2007). 'Measures of cultural competence: Examining hidden assumptions'. *Academic Medicine: Journal of the Association of American Medical Colleges*, 82(6), 548-557.

Levesque, A., & Li, H. Z. (2014). 'The relationship between culture, health conceptions, and health practices: A qualitative-quantitative approach'. *Journal of Cross-Cultural Psychology*, 45(4), 628-645.

Malatzky, C., & Bourke, L. (2016). 'Re-producing rural health: Challenging dominant discourses and the manifestation of power'. *Journal of Rural Studies*, 45, 157-164.

Malatzky, C., & Bourke, L. (2017). 'When the social meets health in rural Australia: Confronting the disconnect'. *Health Sociology Review*, 26(2), 190-203.

Malatzky, C., Mitchell, O. & Bourke, L. (2017). Project report: Determinants of inclusive rural health care. Shepparton: The University of Melbourne.

Malatzky, C., Nixon, R., Bourke, L. & Mitchell, O. (2016). Project Report: The process of organisational change on the journey towards a culturally inclusive community health service. Shepparton: The Department of Rural Health, The University of Melbourne.

Malatzky, C., Nixon, R., Mitchell, O. & Bourke, L. (2018). 'Prioritising the cultural inclusivity of a rural mainstream health service for First Nation Australians: an analysis of discourse and power'. *Health Sociology Review*.

Maynard, M. (2001). 'Beyond the "big three": The development of feminist theory into the 1990s'. In M. Juschka (ed) *Feminism in the study of religion: a reader*, 292-313. London: Continuum.

McLaughlin, C. P., & Kaluzny, A. D. (2006). *Continuous quality improvement in health care: Theory, implementations, and applications*. 3rd edition ed. Sudbury, Mass.: Jones and Bartlett.

Moreton-Robinson, A. (2014). 'The house that Jack built: Britishness and white possession'. *Critical Race & Whiteness Studies*, 10(1), 1-12.

Munro, V. E. (2003). 'On power and domination: Feminism and the final Foucault'. *European Journal of Political Theory*, 2(1), 79-99.

Navarro, V. (2009). 'What we mean by social determinants of health'. *International Journal of Health Services*, 39(3), 423-441.

Newman, C. E., Persson, A., Paquette, D. M. & Kidd, M. R. (2013). 'The new cultural politics of the waiting room: Straight men, gay-friendly clinics and 'inclusive' HIV care'. *Sexuality Research and Social Policy*, 10(2), 87-96.

Ohman, M. (2010). 'Analysing the direction of socialisation from a power perspective'. *Sport, Education & Society*, 15(4), 393-409.

Panaretto, K. S., Wenitong, M., Button, S. & Ring, I. T. (2014). 'Aboriginal community controlled health services: leading the way in primary care'. *The Medical Journal Of Australia*, 200(11), 649-652.

Panelli, R., Hubbard, P., Coombes, B. & Suchet-Pearson, S. (2009). 'De-centring White ruralities: Ethnic diversity, racialisation and Indigenous countrysides'. *Journal of Rural Studies*, 25(4), 355-364.

Pedersen, A., Walker, I., Paradies, Y. & Guerin, B. (2011). 'How to cook rice: A review of ingredients for teaching anti-prejudice'. *Australian Psychologist*, 46, 55-63.

Scott, E., Hermens, D. F., Glozier, N., Naismith, S. L., Guastella, A. J. & Hickie, I. B. (2012). 'Targeted primary care-based mental health services for young Australians'. *The Medical Journal of Australia*, 196, 136-140.

Scott, J. (1991). 'The evidence of experience'. *Critical Inquiry*, 17(4), 773-797.

Skeggs, B. (1997). *Formations of class and gender: becoming respectable, Theory, culture & society*. London and Thousand Oaks, California: Sage publications.

Sollecito, W. A., & Johnson, J. K. (2013). *McLaughlin and Kaluzny's continuous quality improvement in health care*. 4th edition. Burlington, MA: Jones & Bartlett Learning.

State of Victoria. (2012). Koolin balit: Victorian government strategic directions for Aboriginal health 2012–2022. edited by Department of Health. Melbourne, Victoria: Finsbury Green.

State of Victoria. (2013). Improving Care for Aboriginal Patients: Guidelines for Victorian hospitals and area mental health services. edited by Department of Health. Melbourne Victoria.

Torsch, V. L., & Ma, G. X. (2000). 'Cross-cultural comparison of health perceptions, concerns, and coping strategies among Asian and Pacific Islander American elders'. *Qualitative Health Research*, 10(4), 471-489.

Vaughan, N. (2017). Campaspe primary care partnership population health and wellbeing profile: Community, health and wellbeing. Rochester: Campaspe primary care partnership.

Victorian Department of Health. (2012). Continuous quality improvement tool: Aboriginal health in acute health services and area mental health services. edited by Victorian Department of Health. Melbourne, Victoria: The Victorian Government.

Yuval-Davis, N. (2006). 'Intersectionality and feminist politics'. *European Journal of Women's Studies*, 13(3), 193-209.

Biographical Notes

Dr Christina Malatzky is a Research Fellow in Culture and Rural Health at The University of Melbourne. Christina has served on the Executive Committee of Australia's national peak association for sociologists, The Australian Sociological Association and is convenor of the Rural Issues thematic group. As a feminist sociologist, Christina's background is in gender relations and discourses of contemporary femininities and maternities. Her current research interests include discourses of rural health, power relations in rural health, the cultures of rural health services, inclusive health care practices and gender relations in rural medicine, the broader rural health workforce and health care systems.

Dr Olivia Mitchell holds a Bachelor of Science degree with Honours and a PhD in Pharmacology from The University of Melbourne. Olivia has extensive experience working in the health care industry where she developed knowledge and expertise in dominant health care practices. In 2015, she accepted a research-focused position in the culturally inclusive rural health care stream of research at the Department of Rural Health to assist rural health services to improve their processes and policies to become responsive to and inclusive of all groups within the communities they serve.

Professor Lisa Bourke is Director of the University Department of Rural Health at The University of Melbourne. Lisa holds a Masters from Utah State University and a PhD from Penn State University in Rural Sociology. She has researched rural communities in Australia and the U.S. for almost 25 years and draws on multiple research paradigms and methods to undertake rural research in sociological, public health and multidisciplinary ways. Since joining The University of Melbourne in 2000, her research interests have included social inclusion, the development of rural health as a discipline and power relations in rural communities.