Inclusive Practices in Healthcare Services[1]

Policy Position Statement

Key messages:

Priority and under-served populations[2] have poorer health than the general population. More inclusive health services are needed to reduce inequities. Inclusive practice aims to acknowledge, respect, and accommodate the unique needs of diverse groups to improve healthcare services delivery and outcomes.

The PHAA is committed to understand the perspectives of people with lived experience, and work with representative organisations and key non-government organisations. We advocate for a national, collaborative, and comprehensive approach to improving inclusive practices in healthcare services.

Key policy positions:

1. More inclusive practices in healthcare services are needed which acknowledge, respect, and address the unique needs of diverse groups to reduce health inequities, raise awareness of diversity and intersectionality, reduce discrimination, and provide person-centred care.
2. The inputs from those with lived experience of diversity must be central to identifying, developing, implementing, and monitoring inclusive practices and supportive policies.
3. Diversity, Equity, and Inclusion curriculum content must be embedded within all health professional education courses and continuing education.
4. Healthcare service research must include data from diverse participant groups to provide evidence from a range of lived experiences and intersectionality.

Audience: Federal, State and Territory Governments, policymakers and program managers, PHAA members, media, people with lived experience.

Responsibility: PHAA Diversity, Equity and Inclusion Special Interest Group

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[1] healthcare services are defined as all services that provide care across the health, aged and disability sectors

[2] Australian Institute of Health and Welfare determines vulnerable or 'priority' populations as people who: experience homelessness, are Aboriginal and/or Torres Strait Islander, are from culturally and linguistically diverse backgrounds, are in contact with criminal justice systems, identify as LGBTIQ, experience mental health conditions, inject drugs, are older or younger.

Inclusive Practices in Healthcare Services

Policy position statement

This position statement should be read in conjunction with the following background paper, which provides further supporting arguments and evidence: Marjadi B, Flavel J, Baker K, Glenister K, Morns M, Triantafyllou M, Strauss P, Wolff B, Procter AM, Mengesha Z, Walsberger S, Qiao X, Gardiner PA. Twelve Tips for Inclusive Practice in Healthcare Settings [Internet]. International Journal of Environmental Research and Public Health. 2023; 20(5):4657. Available from https://www.mdpi.com/1660-4601/20/5/4657

PHAA affirms the following principles:

1. Health is a fundamental human right. All people have a right to expect the highest attainable standard of health without discrimination on the basis of race, age, disability, gender, sexuality, economic or social condition, religion, or political belief. [1, 2]
2. Inclusive practices are those which acknowledge, respect, and address the unique needs of diverse groups in the community. Inclusive practices require strengths-based approaches[3] rather than a deficit lens, and awareness of the negative impacts of social determinants of health inequities which are often outside the control of the individual. [4, 5]
3. Diversity aspects include but are not limited to age, ethnicity, Indigeneity, socio-economic status, education level, health literacy, sexuality, gender identity, sex characteristics, disability, mental health, refugee or migrant background or religion/spirituality. [6] These aspects often intersect and are influenced by powers which come from privileges and historical context, [7] where layers of advantage and disadvantage can compound inequalities experienced. [8, 9]
4. Inclusive practices are a pre-requisite for patient-/person-centred care, an approach where patient/persons are holistically served and their diverse unique individual contexts are catered for. [10, 11] Patient-/person-centred care is embedded throughout all Australian Commission on Safety and Quality in Health Care standards to improve safety and quality of care and patient and staff satisfaction. [12]
5. Inclusive practices need to value lived experiences and co-creation principles. The 'nothing about us without us' principle should always apply; changes in practices or policies on inclusive practices should not be decided without full and direct participation at all stages of the groups affected by these decisions. [13]

PHAA notes the following evidence:

6. Priority and under-served groups experience worse health status than the general population[14-16] which is correlated with social determinants of health, i.e., the conditions in which people live.[17] Social determinants of health are unequally distributed in the population and also interact to create health inequities.[5] Lack of inclusive practices in healthcare service further contribute to these health inequities.[18]

7. Inclusive practices are often overlooked in healthcare services due to the following factors[19]:
    a. Lack of awareness of the full range of diversity among service users;
    b. Lack of awareness of the intersectionality of diversity aspects;
    c. Lack of knowledge of what could be done to improve inclusivity;
    d. Lack of skills and resources to deliver inclusive person-centred care; and
    e. Lack of institutional commitment, support, and policy framework for inclusive practices.

8. Care must be taken so the first encounter with health services is free from prejudice, untested assumptions, and stereotyping.[20]

9. Thoughtful and sensitive choices in language, terminology, labels, signage, and symbols could greatly improve users' comfort and ease in accessing healthcare services. [21-24]

10. While physical arrangements are required to ensure safe physical access for all service users in part due to building codes, this is not always the case in practice.[25] Physical arrangements should include choices in furniture,[26] colours,[27] and gown sizes,[28] and having equipment that caters for diverse groups.

11. Asking about and adhering to service users' preferences in communication is key to successful rapport building and delivery of patient-/person-centred care.[29-31] Language barriers may distress patients/clients.[32] Professional health interpreter services, not family and friends, should be engaged by healthcare providers to ensure translation accuracy.[33]

12. No language and communication guidelines should be assumed as correct all the time and apply to all peoples[29] because there is always *diversity within diversity*. Language and communication acceptability evolves over time, meaning that health services need to regularly update guidelines and training.

13. Service providers using a deficit lens when serving patients/persons often leads to seeing the patients'/clients' context as mainly troublesome or even hopeless and may give rise to a 'saviour complex'.[34] The preferred strength-based approaches include service providers working together with the clients/patients to build on what they and their community have,[3] which is more likely to engage individuals and communities in managing their health challenges.[35]

14. Some priority and under-served groups are left out in healthcare service research due to language and communication barriers, inability to attend interviews and group discussions, and other social determinants of health.[28, 36-38] Health care research needs to employ a wider

strategy for recruitment and participation and engaging in equity-oriented health research priority-setting. [39]

15. Inclusivity is a dynamic process and not a static outcome. Models of service need to be routinely evaluated and improved for inclusivity as part of a continuous service improvement cycle. [40, 41]

16. Basic and continuing education on Diversity, Equity, and Inclusion for all healthcare professionals is paramount,[42] and may help students and staff identify where practices are not inclusive and change is needed.[43] Experts by lived experience must be involved in the curriculum design, delivery, assessment, and evaluation.[44]

17. Diversity among healthcare workers is important as it will reflect the diversity of the community.[45] The more diverse the staff are who provide healthcare services, the better they can identify, acknowledge, respect, and address unique needs of diverse groups.[46]

18. Practices and corresponding infrastructure are often directed by standard operating procedures, professional standards, and accreditation requirement. These standards should be developed with inclusivity in mind. A periodic audit of service-level inclusive strategies can identify areas for improvement and increase healthcare services' ability to address racial and ethnic health disparities by responding to clients'/patients' cultural, social, and communication needs.[47]

19. Inequity in Australian research funding for public health leads to limited data on health of under-served population groups and drivers of health inequities.[48, 49] Of NHMRC funding, only 18% of 2022 Investigator Grants awarded were in public health and 3% to Health Services Research compared with 41% clinical and 38% basic science.[50]

PHAA seeks the following actions:

The Australian Government should:

20. Develop a policy framework for inclusive practices in healthcare services and requirement for proven institutional commitment.

21. Improve education and training programs on Diversity, Equity, and Inclusion in healthcare courses by university and other education providers to ensure these principles are embraced before students join the healthcare workforce. Education and training programs from professional bodies are also needed for those already in the workforce.

The Australian Government, community organisations, healthcare providers, and other stakeholders should:

22. Raise awareness of the full range of diversity among healthcare service users and intersectionality of diversity aspects.

23. Raise awareness of, and provide support for, what can be done to improve inclusivity and eliminate discrimination and inequality in healthcare services.

24. Develop educational and training programs to improve skills to deliver patient-/person-centred care with rigorous assessment and evaluation.

Governments at all levels should:

25. Improve collection of data on priority, under-served and under-reported populations including their experiences of healthcare and the health system as highlighted by research on health inequities[48, 49] and as acknowledged by the National Preventive Health Strategy.[51] This data should inform evidence-based policies and avoid inadvertently widening health inequities.

Healthcare providers should:

26. Create a roadmap to continuously improve health equity among their service users. These roadmaps must be co-created with under-served populations who should also be involved in monitoring progress.

PHAA resolves to:

27. Advocate for the above steps to be taken based on the principles in this position statement.
28. Assume a national leadership role in implementing, promoting, and supporting evidence-based inclusive practices in the public health sector, starting from within the PHAA itself.
29. Proactively collaborate with other healthcare professional peak bodies and networks in pursuing a continuous improvement of inclusive practices.
30. Centre lived experiences of diverse groups in its advocacy and policy work.

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