

Managing Ethno-cultural Diversity in Health Care Service Delivery: The Irish Experience

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Résumé

L'Europe du 21^{ème} siècle est un continent de diversité ethnique et culturelle. L'élargissement de l'Union Européenne à 27 états, les échanges commerciaux et la migration des peuples ont engendré une forte diversité au sein de l'Europe. Cette diversité croissante se répercute sur les systèmes de santé de l'Union Européenne en les contraignant à s'adapter à la diversité des prestataires de services médicaux et de ses usagers. Le système de santé irlandais est un exemple de système de santé, qui a tenté de planifier et de mettre en œuvre des services de soins et de soutiens tenant compte des besoins spécifiques des minorités ethniques présentes dans une Irlande nouvellement multiculturelle. L'article se concentre sur la mise à disposition de services médicaux appropriés et adaptés aux minorités ethniques en examinant le cas de l'Irlande.

Mots clés : minorité ethnique, la diversité ethno-culturelle, soins de santé, la compétence culturelle et les hôpitaux

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Summary

Europe in the 21st century is a continent of cultural and ethnic diversity. Recent enlargement of the European Union to 27 states, constant flows of free trade and the migration of people have resulted in an increasingly diverse Europe. National health systems face the challenge of accommodating the cultural diversity of health care providers and service users. The Irish health system is an example of a national health system which has attempted to implement adequate planning and delivery of care and support services, encompassing the needs of ethnic minority groups in a new multicultural Ireland. This article focuses on the hands on provision of appropriate health care service delivery to an ethno-culturally diverse population by examining the case of Ireland.

Part one of the article investigates how ethno-diversity impacts hospitals and identifies the priority concerns for Irish hospitals concerning the management of diversity. A review of the literature concerning the challenges of patient diversity, the concept of appropriate culturally sensitive health care delivery and best practices in intercultural training are explored. In addition a comparison of how other international institutions have managed patient diversity is undertaken highlighting different recommendations, standards and guidelines for serving health care to ethno-cultural diverse communities.

Part two focuses on new multiculturalism in Ireland and describes the Irish health sector's process in constructing the Whole Organisation Approach as the framework for Irish hospitals to respond to the management of diversity and the provision of culturally sensitive health care service delivery to members of ethnic minority communities.

Part three describes the empirical results of an exploratory research undertaken in 5 voluntary hospitals in Ireland. The object of the research was to investigate how each hospital has implemented the Whole Organisation Approach as recommended in the Irish Health Services Executive's National Intercultural Health Strategy 2007-2012. Qualitative semi-directed interviews were conducted with high ranking personal in each hospital.

The results of the qualitative exploratory research are analyzed and discussed. Finally conclusions and lessons learnt are drawn from the experience of the 5 Irish hospitals.

Key words: Ethnic minority, ethno-cultural diversity, health care, cultural competency, hospitals.

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Introduction

Political conflicts, regime changes, political and economic unions, globalization, new border arrangements, free trade agreements, the cyclical economic booms and busts of capitalistic societies are just some of the reasons that have resulted in the increase of migration flows across borders worldwide. These migrant flows have led to increased ethnic diversity in societies across the globe. According to the University of Pécs Medical School, host of the 3rd Conference on Migrant and Ethnic Minority Health in Europe, an estimated 200 million people are living outside their native countries. Continents such as the USA and Europe have historically proved to be highly desired destinations and have experienced large inward flows of ethnic populations in recent decades mainly due to favorable economic circumstances. Such inward migration has resulted in more ethnically diverse cities and towns which in turn have posed both positive and negative consequences to the public and private sectors of those host societies. The health sector by its very nature of providing essential health care services to populations is in the front-line of rising to the challenge of adequately managing ethno-cultural diversity and ensuring efficient and effective management of its hospitals and services. According to the Migrant Friendly Hospital Project, migrants are in danger of not having access to the same standards of health care that the majority of the host population receives and that health care needs of minorities are generally not met by national health care systems. Several countries and their respective health ministries have been confronted with the challenges of managing diversity and providing health care services to multi-ethnic populations. Ireland is one of the most recent examples of a country that has experienced a significant increase in the ethnic diversity of its population. Consequently the Irish health sector has had to revise and devise new policies and strategies to ensure the provision of quality health care to ethnic minorities and manage workforce diversity. For the purposes of this research the author has used the definition of ethnic minority proposed by the Commission for Racial Equality in the UK, as a group that regards itself or is regarded by others as a distinct community by virtue of certain characteristics that will help to distinguish the group from the surrounding community.

What conclusions can be drawn from countries such as Ireland, that have attempted to tackle ethnic diversity issues in its health sector by implementing intercultural health strategies which address a new multicultural population? What lessons can be learnt from the Irish experience for future health sectors around the world who may undoubtedly be confronted with the challenges of managing ethno-cultural diversity in the decades to come?

This article identifies the critical issues concerning the management of ethno-cultural diversity in the Irish health care sector and examines to what extent 5 Irish hospitals have been successful in implementing strategies in order to provide quality health care service delivery to members of ethnic minority communities.

1. HOW IS DIVERSITY AFFECTING THE MANAGEMENT OF HOSPITALS?

1.1. WHAT ARE THE KEY CHALLENGES OF MANAGING NEW DIVERSITY IN THE IRISH HEALTH SECTOR?

According to the current National Intercultural Health Strategy (2007-2012), the Irish Health Service Executive (HSE), the body responsible for providing health and social services in Ireland, must overcome the challenges of accommodating the cultural diversity of their service providers and service users. The Irish health system must implement adequate planning and delivery of care and support services in a new multicultural Ireland, encompassing the needs of ethnic minority groups. It is therefore of interest to investigate to what extent Irish health care organizations, i.e. voluntary hospitals, have accommodated patient care diversity and how such hospitals have implemented and managed the provision of quality diverse patient care service delivery? A preliminary exploratory research was undertaken with 9 relevant actors associated with health care to investigate how ethno-cultural diversity has impacted the management of hospitals in Ireland and to establish at what levels of the hospital sector did ethno-cultural diversity impact the most?

1.1.1. Exploratory research, Ireland

The exploratory research consisted of 9 semi-directed interviews with 9 separate organizations related to the hospital sector in Ireland in May, 2009. The 9 organizations included 2 universities (nursing schools), 4 voluntary hospitals, 2 employers' advisory agencies and 1 diversity trainer / cross-cultural consultant who had extensive experience in the sector. Exploratory interviews were conducted with hospital human resource managers, directors of nursing, training and development managers, university lecturers, researchers and consultants.

1.1.2. Conclusions of exploratory research

The conclusion of the exploratory research revealed that the main issue of concern for Irish hospital management is the delivery of appropriate quality health care to ethno-culturally diverse patients. It emerged from the research that hospital management are less concerned

with the organisational behaviours concerning ethno-cultural diversity in the workforce. The assumption that if the patient diversity issues could be successfully managed, then workforce diversity issues would be easier to solve. A sample of the patient care diversity challenges emerging from exploratory research interviews included problems related to different behaviours, languages, beliefs, interpretations, attitudes to building trust, relationships, communication styles, cultural sensitivity, cultural birth rituals, death and mourning rituals, special medical needs, food and diet requirements, religious diversity, gender issues and patient safety.

1.2. EXAMINATION OF THE KEY FACTORS ASSOCIATED WITH THE PROVISION OF APPROPRIATE HEALTH CARE SERVICE DELIVERY TO ETHNO-CULTURALLY DIVERSE PATIENTS.

A review of the literature was undertaken to establish what constitutes appropriate culturally sensitive health care service delivery to members of ethnic minorities and to overview the related challenges, theoretical concepts and international best practices.

1.2.1. What is appropriate culturally sensitive health care service provision?

To understand the elements of quality health care service delivery to ethno-culturally diverse patients it is important to first comprehend the challenges of providing appropriate culturally responsive health care and support services to ethnic minorities.

1.2.2. Overview of challenges in provision of health care service delivery to non national ethnic minorities.

The American Nurses Association define cultural diversity as “the differences between people based on a shared ideology and valued set of beliefs, norms, customs and meanings evidenced in a way of life”, Wells (2000). Appropriate culturally sensitive health care service delivery or “culturally congruent care” as described by Douglas (2003) requires the service provider to have the ability to “integrate the patient’s belief system” and “using knowledge regarding cultural beliefs” of the patient in delivering health care. Douglas continues by suggesting that service providers should have the necessary “cross-cultural communication skills and a sensitivity to values and beliefs about life, death and the world around us that may be different from the ones we hold to be true and inviolate”. According to Gardenswartz and Rowe (1993), cross-cultural communication skills allow service providers to understand different direct and indirect communication styles and administer feedback to patients in a culturally appropriate manner. Furthermore language skills, assumptions and non verbal communication, are all

culturally relevant. Issues around building relations and trust which are essential in health care are culturally relevant. In addition different cultures have different beliefs and norms which affect attitudes towards health care. Therefore a significant challenge of providing appropriate culturally sensitive health care service delivery is the ability of service providers to be culturally savvy and competent. Various authors such as Kelly, Kleiman, Macdonald, Darr, Craig, McCabe, Lyons, O’Keefe, Clarke, Staines, Campinha-Bacote, Hawthorne, Singer, Blackhall all have recently contributed to research regarding service delivery and patient diversity challenges. Many of the patient diversity issues they discuss correspond to a list of patient diversity challenges as outlined in the HSE’s Intercultural Health Strategy. A sample of these challenges is compiled in a non exhaustive list in Table 1.

Table 1: Sample challenges of patient diversity issues in Irish health care

<ul style="list-style-type: none"> • Specific intercultural health issues not familiar with the native host culture. (E.g. hematological, diabetes and renal disease, more prevalent to ethnic minorities.) • Women’s health and specific care needs for ethnic minority women (family responsibilities, cultural restrictions specific to women e.g. financial independent, permission from spouse to move, drive, education, employment; Gender roles different to Irish women’s roles.) • Maternity services and maternal care and support services for women from diverse ethnic backgrounds (higher rates of still birth, infant mortality, female genital mutilation , birth weight is culturally relevant and risks of low birth weight is culturally relevant (Fabian Society (2007) Born Unequal) • Specific cultural and religious observations (Muslim faith special prayers recited in baby’s ear,) Circumcision can be an expected cultural and religious duty of infant males. • Nutritional needs of children, breastfeeding mothers • Mental Health services should be delivered in a culturally sensitive manner. Incidence of stress, depression and mental illness higher in minority ethnic groups than native population • Children address care and support needs of children from diverse cultural and ethnic backgrounds (child protection and harsh disciplinary actions in conflict with legislation and local population norms) Children from ethnic minorities have a tendency to have lower levels of well-being in health, education and access to family and community resources. • Aging and ethnicity (cultural and language barriers cause anxiety and distress) • Disability (taboo attitudes in certain cultures with stigmatization) • Sexual health (contraception, family planning and adolescents, HIV stigmatization) • Attitudes to Health Screening (TB, Hepatitis)

Extracted from National Intercultural Health Strategy (2007)

1.2.3. Providing appropriate culturally sensitive health care

Having reviewed some of the challenges relating to service provision to diverse patient populations, we shall now focus on some of the responses drawn from the academic literature. The two emerging principle solutions involve cultural competency skills obtainment and intercultural training.

1.2.4. Cultural competency

An exploration of the literature surrounding the methods and approaches to successfully accommodate diverse patient care service delivery was undertaken. Research was focused on cultural competencies with the view of constructing a best practice or ideal approach for hospitals to deal with patient diversity. There are many definitions of cultural competence in health care settings throughout the literature. Leininger (1999), Brach and Fraser (2000), Alexander (2002), Burchum (2002), Frusti, Niesen and Campion (2003) and Fox (2005), have all put forward definitions of cultural competence in health care settings. According to Walsh (2004) a widely accepted definition of cultural competence is put forward by Cross, Basron, Dennis & Issacs (1989) as: “Culture and linguistic competence is a set of congruent behaviours, knowledge, attitudes, and policies that come together in a system, organisation or among professionals that enables effective work in cross-cultural situations. Culture refers to integrated patterns of human behaviour that include the language, thoughts, actions, customs, beliefs and institutions of racial, ethnic, social or religious groups. Competence implies having the capacity to function effectively as an individual or an organisation within the context of the cultural beliefs, practices and needs presented by patients and their communities.” Hunt (2007) cites Svehla (1994) who states in research entitled “Diversity Management: Key to Future Success” that “while Cultural Competence is the goal, diversity management is the process leading to culturally competent organisations. Diversity management is a strategically driven process whose emphasis is on building skills and creating policies that will address the changing demographics of the workforce and patient populations”.

There are many frameworks and models that assist in evaluating and developing cultural competences in varying discipline areas of patient care delivery. These include: “the Transcultural Assessment Model offered by Giger and Davidhizar (1995), the Continuum of Intercultural Sensitivity offered by Louie (1996), the Cultural Sophistication Framework offered by Orlandi (1992) and the Cultural Model of Care offered by Campinha-Bacote, Yahle and Langenkamp (1996). The literature suggests that meeting the challenges of health

care diversity necessitates both individual and institutional changes. There seemingly is a need for both culturally competent individuals and organisations.

1.2.5. Intercultural training

Intercultural training has a critical role in the obtainment of cultural competence skills in healthcare. The HSE in 2005 proposed a 6 level tiered approach to intercultural training. The 6 levels of training include, level 1 induction and orientation training, level 2 understanding cultural diversity, level 3 specialist training for professional groups, level 4 intercultural dialogue training, level 5 managing multicultural teams and level 6 training for managers in legislative and ethical responsibilities of diversity management.

A tiered or incremental approach to training allows for trainees to progress in knowledge, skills and attitudes based on the needs of the discipline. Lister's (1999) Taxonomy of Cultural Competence as illustrated in Table 2, acts as theoretical justification for the tiered approach allowing the trainee to progress from one level of competence to the next.

Table 2: Lister's Taxonomy of Cultural Competence

<p><u>Cultural Awareness</u>: the staff member is able to describe how beliefs and values are shaped by culture, and those different cultures, subcultures and ethnicities may validate different beliefs and values.</p> <p><u>Cultural Knowledge</u>: The staff member begins to show familiarity with the broad differences similarities and inequalities in experience, beliefs, values and practices within many groupings in society.</p> <p><u>Cultural Understanding</u>: The staff member recognises the problems and issues faced by individuals and groups when their values beliefs and practices are compromised by a dominant culture.</p> <p><u>Cultural Sensitivity</u>: The staff members show regard for an individual client's beliefs, values and practices within a cultural context and show awareness of how their own cultural background may be influencing professional practice.</p> <p><u>Cultural Competence</u>: The staff member provides or facilitates care which respects the values, beliefs and practices of the client, and which addresses disadvantages arising from the client's position in relations to networks of power.</p>
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Adapted from Lister (1999), A Taxonomy for Developing Cultural Competence

“Lister's Taxonomy of Cultural Competence model highlights the fact that depending on the amount of contact a staff member has with minority ethnic communities the staff members need for cultural competence will vary. Lister's model serves by illustrating that a tiered approach to training is necessary to respond to the different needs of staff depending on their contact/exposure to ethnic minority communities.” (Learning, Training and Development

needs of Health services staff in delivering services to members of minority ethnic communities. Thrive Consulting for the HSE. 2005). This comprehensive 6 level tiered approach recommended by the HSE and theoretically supported by Lister’s cultural competence model serves as a suitable framework for intercultural training.

Comprehensive intercultural training is the main driver for service providers to obtain the cross-cultural skills required to meet the needs of providing appropriate health care service delivery to diverse patient populations. However, the academic literature suggests that training and skills building are insufficient if the results are not complemented by hospital wide development initiatives and broader system changes.

1.3. THEORETICAL AND CONCEPTUAL FRAMEWORKS FOR INDIVIDUAL AND ORGANISATIONAL CULTURAL COMPETENCY OBTAINMENT

Authors such as Papadopoulos, Tilki, and Taylor (1998) proposed a model for developing culturally competent health care practitioners containing the four constructs cultural awareness, cultural knowledge, cultural sensitivity and cultural competence. A review of literature concerning diversity and cultural competencies suggest that success in meeting the challenges of cultural diversity in health care settings requires for organisational and/or individual progression along a continuum framework consisting of various stages of development. The Cultural Competence Continuum and the Cultural Development Model are two examples of such frameworks.

1.3.1. Cultural Competence Continuum

Cross (1989) proposes a Cultural Competence Continuum (see Table 3) which examines cultural competency as a continual process and serves organisations by allowing them to better position themselves along a continuum regarding cultural competence.

Table 3: Cross’s Cultural Competence Continuum

Continuum	1-----2-----3-----4-----5-----6
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1. Organisations that are culturally destructive, i.e. attitudes, policies and practices, do cultural integrity of individuals who work there or interact with them.
2. Organisations are culturally incapacitated when the functioning of such organisations is fundamentally biased, believes in the superiority of the dominant group and assumes a paternal posture lesser groups.
3. Organisations that persist in believing that the system works the same for everyone and ignore the relevance of cultural diversity are identified as being culturally blind.
4. Cultural pre-competence is evident in organisations that recognise that they have weaknesses in the services they deliver to some communities and make attempts to improve.
5. Organisations that respect differences, continually improve and adapt their diversity policies and training, seek feedback from their diverse client base and ensure that employees from the communities they serve are represented throughout all staffing levels are culturally competent.
6. Cultural proficiency is embedded in expansive organisations that embrace culturally based research and therapeutic approaches, recruit staff that is specialists in culturally competent practices and advocate for cultural diversity throughout the health care system.

Adapted from Cross et al (1989), Towards a Culturally Competent System of care.

1. 3.2. Cultural Development Model

Wells (2000) proposes a continuum whereby change occurs as health care professionals and their institutions progress from cognitive through affective phase. (See Table 4)

Table 4: The Cultural Development Model

A 6-stage continuum for individuals and institutions							
Cognitive phase	→	→	→	→	→	→	Affective phase
<u>Cognitive Phase:</u> Consists of 3 stages, cultural incompetence, cultural knowledge and cultural awareness. During this phase the emphasis is on learning and acquiring knowledge about culture and its manifestations.							
<u>Affective Stage:</u> Consists of 3 stages. Cultural sensitivity, cultural competence, and cultural proficiency during this phase the goal is attitudinal and behavioural change through the application of the knowledge acquired in the cognitive phase. This requires actual experience working with members of diverse groups. Progression through these stages requires more of an investment and commitment to cultural diversity by health professionals and institutions.							

Adapted from Wells (2000), Beyond Cultural Competence: A Model for Individual and Institutional Cultural Development.

These two models provide theoretical frameworks by which service providers at both an organisational and individual level can position themselves along continuums of cultural competency. These frameworks serve to indicate if the service provider, either organisational or individual is addressing the challenges of providing appropriate health care service delivery to ethnic minorities.

1.4. INTERNATIONAL INSTITUTIONAL PERSPECTIVES AND BEST PRACTICES

A comparison of the different recommendations, standards and guidelines for delivering health care to ethno-cultural diverse communities offered by selected international institutions and organisations from North America and Europe were analysed.

1.4.1. Europe, Migrant Friendly Hospital Project: The Amsterdam Declaration towards Migrant Friendly Hospitals in an Ethno-culturally Diverse Europe

The Amsterdam Declaration resulted from the European Union funded Migrant Friendly Hospital Project involving 12 European partner hospitals in different European countries and coordinated by the Ludwig Boltzman Institute for Sociology of Health and Medicine, Vienna. The project was developed to respond to the care needs of culturally diverse patients in hospital settings. The declaration offered 26 recommendations for European hospitals and health settings regarding implementation of migrant friendly health policies. These recommendations are supervised by the Task Force on Migrant-Friendly Hospitals which was established in the framework of the World Health Organisation's Network on Health Promoting Hospitals. The 26 recommendations cover general and specific advice for the health care service settings on how to manage diversity. Recommendations are offered to staff and health professions, hospital owners, management and quality management initiatives, service users and representatives of community groups, health policy formulation and health administrators and even offer advice on the importance of health sciences and need for ethnic diversity to be put on the health research agenda.

1.4.2. USA, Culturally and Linguistically Appropriate Standards

The Office of Minority Health in the USA (Department of Health 2001) established 14 Culturally and Linguistically Appropriate Standards (CLAS), in order to measure the cultural competency of organisations. These standards set out to ensure that service users of ethnic minority communities receive quality appropriate culturally sensitive health care service delivery. In summary the CLAS recommendations suggest 4 standards that deal with language access services, 3 standards which focus on culturally competent care and 7 standards regarding organisational support for cultural competence.

1.4.3. Canadian Council of Refugees

The Canadian publication Best Settlement Practices published by the (Canadian Council for Refugees 1998) suggests that health care services should follow the following 9 guidelines for newcomers to the health system as illustrated in Table 5.

Table 5: Guidelines for newcomers to the health system in Canada

<ol style="list-style-type: none"> 1) Be accessible to all who need them. 2) Be offered in an inclusive manner, respectful of, and sensitive to diversity. 3) Empower clients. 4) Respond to needs as defined by users. 5) Take account of the complex, multifaceted, interrelated dimensions of settlement and integration. 6) Be delivered in a manner that fully respects the rights and dignity of the individual. 7) Be delivered in a manner that is culturally sensitive. 8) Promote the development of newcomer communities and newcomer participation in the wider community, and develop communities that are welcoming of newcomers. 9) Be delivered in a spirit of collaboration.
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Extracted from Bischoff (2003), Report on Caring for Migrant and minority patients in European Hospitals, A review of effective interventions.

The American, European and Canadian approaches offer valuable principles for policy development and for planning and provision of quality health care service delivery to diverse patient populations.

2. THE IRISH EXPERIENCE

Having broadly examined international perspectives it remains to explore how the Irish health sector has responded to the challenges of providing culturally sensitive health care to ethnic minority communities.

2.1. IRELAND AND NEW MULTICULTURALISM

Ireland during the last decade has experienced strong economic prosperity. Three widely accepted critical reasons for this economic growth were Ireland's success in attracting US foreign direct investment, membership in the European Union and the internationalization of the Irish economy. This period of economic success led to fundamental changes in Irish society catapulting the Irish economy from a once stagnant inward economy to a modern open multicultural economy. Following this success, Ireland once considered a country plagued with high unemployment and centuries of high emigration became during the early 2000s a country with almost full employment and rampant immigration. Barrett et al (2006) and Fanning (2007), (2002) have written extensively on subjects relating to the impact of

immigration on social change, racism and the labour market in Ireland. Currently over 10 percent of the Irish population are first generation immigrants. This indeed represents a serious challenge for a country that was more or less heterogeneous throughout its long history.

2.1.1. Profiles of non nationals

According to the Central Statistics Office of Ireland's Census of 2006 there are 420,000 foreign nationals living in Ireland. Demographic trends estimate further increases from 10.4 percent to 18 percent in non nationals living in Ireland by 2030. (National Intercultural Health Strategy 2007). This would suggest that ethno-cultural diversity is foreseeable for the long term in Irish society. The profile of minority ethnic groups in Ireland are comprised of refugees, asylum seekers, family reunification, migrants and migrant workers, undocumented migrant workers, travelers and foreign students. Irish community development organizations such as Cairde have been working to address health inequalities and access to health services among ethnic minority communities, while the New Communities Partnership launched in 2005 aims at empowering and representing ethnic minorities to fully participate in economic social, political and cultural life in Ireland. Thus workforce and patient diversity has increased due to a new multicultural Ireland. The question of how the Irish health sector has coped with such diversity in the management of hospitals and the provision of health care services merits investigation.

2.1.2. Description of the health care sector

The (HSE) is the government body responsible to provide health and social services to all those living within the Republic of Ireland. It is the largest employer in the country employing 65,000 staff in direct employment and a further 35,000 in voluntary hospitals and bodies funded by the state. The HSE was established in 2005 with the aim of delivering health and social services throughout the Republic of Ireland. There are three different types of hospitals in Ireland namely, hospitals owned and funded by the HSE, then Voluntary public hospitals which are funded by the state but can be owned by private bodies, such as religious orders or are incorporated by charter or statute and are run by boards often appointed by the Minister for Health and Children and finally private hospitals, which receive no state funding.

2.2. HOW THE IRISH HEALTH SECTOR HAS REACTED TO CULTURAL DIVERSITY IN SERVICE DELIVERY (THE WHOLE ORGANISATION APPROACH)

The HSE published a report entitled “Learning, Training, and Development needs of Health Services Staff in Delivering Services to Members of Minority Ethnic Communities” in 2005. The purpose of the report was to set out frameworks of learning and development initiatives for health sector staff in provision of services to ethnic minority populations. The HSE undertook an extensive research and scoping exercise identifying, best practices, training and educational needs of service providers and gaps in the health sector regarding the provision of appropriate health care to ethnic minority community members. The HSE adapted the framework of the Whole Organisation Approach (WOA) which was proposed by the National Consultative Committee for Racism and Interculturalism. This was a government funded organisation that addressed racism and promoted interculturalism in government agencies and ministries. The HSE took this framework which promoted three key strands, Organisational Ethos, Workplace Environment and Support to Training and used it as the model to address workforce diversity and provision of appropriate service health care delivery to members of ethnic communities. Studies of relevant guidelines and policies from England, Scotland, Wales, Northern Ireland, and Australia, Canada and the United States and the work of the Migrant Friendly Hospital Project were compared and the HSE visited Bradford teaching hospitals (part of the NHS Foundation Trust), which had long established intercultural health policies in place. In addition consultations between the HSE and health related organisations which had experience in intercultural training to staff and service providers in New York, USA and Queensland, Australia were conducted.

2.3. THE WHOLE ORGANISATION APPROACH (WOA)

As stated in the National Intercultural Healthcare Strategy published in 2007, the HSE constructed the WOA in order to deliver culturally appropriate services and develop a culture that supports interculturalism. The WOA focuses on developing three main strands of an organisation namely, Organisational Ethos, Workplace Environment and Service Elements necessary to Support Intercultural Training. Table 6 illustrates the key elements of the WOA.

Table 6: Key elements of the Whole Organisation Approach proposed by the HSE

<p>Strand 1: Organisational Ethos</p> <p>Leadership and commitment from senior management in championing a culture that promotes equality and values diversity. Developed informed policies and ensuring they are applied consistently.</p> <ul style="list-style-type: none"> • Specific initiatives that demonstrate the commitment and support of managers • Up to date Intercultural policy for the health services

<ul style="list-style-type: none"> • Equality Framework including culture proofing of documentation and a template for Equality proofing service planning and delivery • Ethnic monitoring system including an agreed framework for data collection and data usage
<p>Strand 2: Workplace environment</p> <p>Proactively promoting diversity in the profile of the workforce through attraction and retention initiatives.</p> <p>Educating and embracing the involvement of all staff through learning, training and development initiatives.</p> <ul style="list-style-type: none"> • A tiered approach to intercultural training • Workplace support structures to support staff to manage issues relating to cultural diversity • Development of initiatives to integrate and manage multicultural teams • Training methodology to include co-facilitation by members of minority ethnic communities
<p>Strand 3: Service elements necessary to support intercultural training</p> <p>Embracing openness to partnership between health services agencies and representative groups</p> <p>Developing services that are appropriate to the needs of a diverse and multi-ethnic society.</p> <ul style="list-style-type: none"> • Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system. • Signage, particularly in reception and public areas in the key languages of service users • Literature in the key languages of service users • A comprehensive interpretation service

Adapted from Learning, Training and Development needs of Health services staff in delivering services to members of minority ethnic communities. Thrive Consulting for the HSE (2005).

It is broadly recognised throughout the literature that training is only effective when supplemented with other training initiatives. “Education, awareness raising and training are without doubt key ingredients in developing a culturally appropriate health service. However research clearly indicates that training will only be useful and effective when supplemented by other learning and development issues as well as relevant systems changes. International best practices confirm this view and demonstrate that a Whole Organisation Approach is essential in developing culturally appropriate health services.”(Learning, Training and Development needs of Health services staff in delivering services to members of minority ethnic communities. Thrive Consulting for the HSE 2005).

A review of the literature suggests that the Irish government’s development of the WOA to dealing with cultural diversity in the health sector is well researched and represents a suitable approach. This approach encompasses the recommendations of improving health care delivery to diverse patient groups as outlined in the Amsterdam Declaration. Also the WOA

encompasses the 14 Culturally and linguistically Appropriate Standards established by the Office of Minority Health in the USA (2001), (Department of Health) and complies with the Canadian Council of Refugees guidelines for newcomers in the health system.

The idea of a WOA to meeting the needs of patient care diversity is further supported by an examination of the literature by various authors such as LaVeist et al (2008) who refers to the research of Anderson et al. (2003), Betancourt et al. (2005), Hayes-Bautista (2003) in stating that “some have argued that while training individuals and assessing their progress in the principles of cross-cultural communication and interaction is beneficial, it may be more efficient and effective to foster an organisation-wide culture that is accepting of, supportive of, and prepared to adjust to the changing demands of the increasingly diverse patient population.” In addition a study of 60 health care organisations in the USA which explored best practices for addressing patient diversity issues focused on key areas, such as leadership, quality improvement and data use, workforce implications, patient safety and provision of care, language services and community engagement (Wilson-Stronks and Galvez 2007). All these principals are encompassed in the WOA adopted by the Irish government.

3. TO WHAT EXTENT HAS THE WHOLE ORGANISATION APPROACH BEEN IMPLEMENTED IN IRISH HOSPITALS?

The objective of the research was to explore to what extent the WOA has been implemented in Irish voluntary hospitals. This involved an investigation into how 5 Irish hospitals were managing service delivery regarding diversity in patient care and to what extent each institution had implemented the three strands of the WOA as recommended in the National Intercultural Health Strategy 2007-2012 and in the Learning, Training and Development Needs of Health Services Staff in Delivering services to members of Minority Ethnic Communities guideline 2005 as published by the HSE. It is important to note that both the strategy and guideline are not specific to the hospital sector alone and cater to primary care and other sectors such as asylum seekers health, community nursing, therapeutic services, general practitioners or graduate education. This research is limited to a sample of 5 voluntary hospitals from the acute hospital sector.

The research methodology involved semi-directed personal interviews with employees in a sample of 5 voluntary hospitals of varying sizes and functions located in Ireland. Semi-directed interviews were deemed suitable as they allow for focused, conversational, two-way

communication, which provide ample opportunity for the interviewer and the interviewee to exercise flexibility and probe for details and discuss in depth related issues.

Each hospital had its own range of specialization care ranging broadly from elderly care, to general care, to maternity care and children's care (see Table 7). Choosing five different hospitals, each with its own organizational culture and specialization allowed for a more comprehensive comparative investigation. Table 7 illustrates the profile of the interviewee and a broad description of the type of care offered by each hospital.

Table 7: Hospital type and profile of interviewee

Hospitals	Interviewee Profile	Hospital Status
1	HR Manager	Elderly and disabled adults care
2	HR Manager	General - multi specialized
3	HR Manager	General – multi specialized
4	Training and Diversity Officer	Maternity Care
5	HR Manager and Diversity Representative	Children's care

3.1. Profile of respondents and interview protocol

The qualitative semi-directed interviews were conducted with four Human Resource managers, a Diversity representative and a Training and Development manager. It was envisaged that these high ranking interviewees would be appropriately positioned and knowledgeable to answer questions regarding diversity policies and the WOA. Interviews took place in October 2009 on site in the 5 hospitals. The interview process involved interviews which lasted on average 2 hours and questions were guided by a pre-prepared matrix involving the implementation of the WOA and questions referred to the three strands and sub-elements of the WOA as outlined in HSE documentation.

3.2. RESULTS AND ANALYSIS OF EXPLORATORY RESEARCH

The analysis focuses on the three strands of the WOA followed by an individual analysis of each of the hospitals.

3.2.1. Description of Table 8: Coded numerical results demonstrating implementation of WOA

Table 8 entitled “coded numerical results demonstrating implementation of WOA”, highlights the three strands of the WOA and illustrates the four main sub-elements of each strand. The right side of the table contains a separate column for each of the five sample hospitals. Table 8 demonstrates numerically to what extent the three strands of the WOA have been implemented in each hospital. For each of the four sub-elements of each strand, there is a corresponding score for each of the 5 hospitals. Scores range from 0 to 2. A 0 score signifying that the sub-element is not installed, a 1 score signifying that the sub-element is partially implemented and a 2 score identifying a comprehensively implemented sub-element of the WOA. Each strand has a sub-total indicating the combined score of each sub-element scored out of a maximum of 8 for each hospital. Also each hospital has a cumulative total score combining the total of each of the three strands scored out of a maximum of 24.

Table 8: Coded numerical results demonstrating implementation of WOA

Strand 1 : Organisation Ethos	Hosp 1	Hosp 2	Hosp 3	Hosp 4	Hosp 5
Specific initiatives that demonstrate the commitment and support of managers	0	1	2	2	2
Up to date intercultural policy for the health services	1	2	2	1	2
Equality Framework including culture proofing of documentation and a template for equality proofing service planning and delivery	1	1	1	2	2
Ethnic monitoring system including an agreed framework for data collection and data usage	0	2	2	2	2
Sub-total	2/8	6/8	7/8	7/8	8/8
Strand 2 : Workplace Environment					
A tiered approach to intercultural training	1	1	1	1	1
Workplace support structures to support staff to manage issues relating to cultural diversity	1	1	2	2	2
Development of initiatives to integrate and manage multicultural teams	1	1	2	2	2
Training methodology to include co-facilitation by members of minority ethnic communities	0	0	2	2	2
Sub-total	3/8	3/8	7/8	7/8	7/8
Strand 3 : Support to Training					
Information and awareness for minority ethnic service users on the processes and practices of the Irish health care system	0	0	1	2	2
Signage , particularly in reception and public areas in the key languages of service users	0	0	0	1	2
Literature in the key languages of service users	0	0	0	0	1

A comprehensive interpretation service	0	2	2	2	2
Sub-total	0/8	2/8	3/8	5/8	7/8
Total	5/24	10/24	17/24	19/24	22/24

Codage: 0 = not installed / 1 = partially installed / 2 = comprehensively installed

3.2.2. Analysis of implementation of each strand of the Whole Organisation Approach

Strand 1: Organisation Ethos

The Organisational Strand of the WOA has the highest scores with four of the five hospitals scoring 6 or higher. These results signify a strong commitment to the ethos by the majority of the hospitals to diversity issues and leadership. The results may reflect strong compliance with national equality legislation and anti racism initiatives put in place in Irish society by the Irish government in the late 1990s, early 2000s.

Strand 2: Workplace Environment

Three hospitals scored 7 while two scored 3 in the Workplace Environment Strand. Scores for implementation of the sub-element tiered approach to intercultural training are the weakest. Upon closer analysis this bears testimony to the fact that data emerging from the interviews indicates that all five hospitals failed to implement the 6 training levels of the tiered approach to intercultural training.

Table 9: Implementation of 6 levels of Tiered Approach to Intercultural Training

Training level	Hospital 1	Hospital 2	Hospital 3	Hospital 4	Hospital 5
Level 1	√	√	√	√	√
Level 2				√	√
Level 3					
Level 4					
Level 5			√		√
Level 6	√	√	√	√	√

Table 9 demonstrates that level 1 (induction/orientation training) and level 6 (training for senior personnel) are the only two levels that have been implemented by all five hospitals. Two hospitals have implemented level 5 (managing multicultural teams) and level 2 (understanding cultural diversity). However level 3 (specialist training for professional groups) and level 4 (intercultural dialogue training) have not been implemented by any of the five hospitals. Considering the importance of intercultural training and cultural competence capacity building in providing culturally appropriate health care, the fact that only an average of 46% of the training levels were implemented in the five hospitals is indeed an alarming observation. This may reflect budget restrictions for training or perhaps time restrictions for employees such as nurses to take time off work to participate in sometimes lengthy training sessions. It is encouraging that level 6 training designed for senior personnel is implemented in all hospitals however the intercultural training needs of lower and middle ranking staff who represent the majority that deliver health care within the hospitals does not seem to be satisfactory.

In relation to recruitment and retention, all the hospitals had policies in place promoting diversity in the profile of the workforce through attraction and retention initiatives. During the economic boom period, all five hospitals had actively recruited health sector professionals from around the world to fill the gap from the lack of Irish recruits due to a highly competitive labor market. Thus each hospital had experience and tradition for recruitment of non nationals and each hospital abides by and complies with subsequent national equality legislation with regard to recruitment. Hospital managers did cite difficulty in succession planning and promotion of non national nurses as a result of peer pressures and loss of earnings due to withdrawal of overtime earning opportunities when promoted. It must be noted that at the time of research the HSE had issued a moratorium on recruitment throughout the health services as a direct result of an unprecedented national economic crisis.

Strand 3: Support to Training

Support to Training has the weakest scores in the majority of hospitals, with the weakest sub-element for four of the five hospitals being a lack of literature in key languages of service users and signage in reception and public areas in the key languages of service users. This may be the result of budget constraints and may be seen by management as a lesser priority. There is however strong evidence that comprehensive interpretation services are accessible in

four hospitals. Hospital 1 does not offer such services because its service user profiles are elderly people who do not reflect significant ethnic diversity.

3.3. INDIVIDUAL HOSPITAL ANALYSIS

In analysing the results for each hospital the following observations can be drawn.

3.3.1. Hospital 1: “Awakening to the issues of diversity”

Scores are low in all three strands and consequently this hospital has the lowest total score among the five hospitals. This would indicate that the WOA is at the beginning stages of implementation as far as Organisational Ethos and Workplace Environment are concerned but Support to Training elements have not been considered at all. These low scores reflect the fact that the service user profile of this hospital is elderly populations with limited ethnic diversity. It could be construed that the hospital is only awakening to the need to focus on intercultural issues that have been led not by patient diversity issues but rather by workforce diversity as a result of significant recruiting of non-Irish national nurses due to tight labour markets during the economic boom period. This is supported by the fact that the highest scores are in the Work Place Environment strand. However it is evident that there has been no multicultural team training (level 5 of the tiered approach) despite the workforce diversity in areas such as nursing. Management did cite their plans to begin level 5 training in the near future which indicates an awakening to the cross-cultural training needs of multicultural nursing teams currently in place.

3.3.2. Hospital 2: “Head in the sand” minimizing, compliance oriented

Hospital 2 is a large hospital. The low total results from hospital 2 in Workplace Environment and Support to Training may represent that the respondent was not entirely knowledgeable or had recall difficulties regarding the details and extent that the hospital has implemented intercultural health care policies as per the WOA. The respondent indicated that the hospital was very compliance and quality based which is reflected in the relatively high scores in the Organisation Ethos strand. Equally it was mentioned that there have been no equality or discrimination grievance cases based on ethnic diversity issues despite strong patient and workforce diversity in the hospital. This may explain the poor scoring in Workplace Environment and the lack of adequate intercultural training. Alternatively it may be construed that the hospital management is minimising the need for training in addition to citing budget, time and a recruiting moratorium as factors influencing implementation progress. The

hospital's head in the sand approach to the need of implementing elements such as the 6 levels of intercultural training may change as diversity increases in time and inevitable challenges present themselves.

3.3.3. Hospital 3: “Action oriented” enthusiastic believers

High scores in Organisational Ethos and Workplace Environment indicate a hospital that is progressing in the management of diversity. The hospital is fully conscientious of the needs of providing quality patient care to ethnic minorities and demonstrated a proactive approach to implementing the WOA and at the time of research, hospital management were in the process of expanding their intercultural training to level 5 multicultural team training. However the hospital does need to continue to develop its tiered approach to intercultural training by offering level 2, level 3 and level 4 to employees. Also the hospital will need to address weak scores in literature and signage in the key languages of signage users. Indications emerging from the interview data indicated a management fully awake to the needs of culturally appropriate health care service delivery and determined to put in place the remaining policies and procedures in the future.

3.3.4. Hospital 4: “Diligent implementer” good progress

Hospital 4 has strong scores in Organisational Ethos and Workplace Environment. One of the few areas that have been overlooked in this hospital is the literature in key languages of service users in the Support to Training strand. Concerning the Workplace Environment strand, the hospital provides 50% of levels of training and cited intention to further develop the tiered approach to training. The overall results illustrate a hospital that is fully aware of the multifaceted issues of managing diversity in hospitals. Such positive results may be linked to the strong links that the hospital has with the HSE and the hospital acts as a demonstration site for implementing intercultural health strategies.

3.3.5. Hospital 5: Children's hospital: “Star implementer” almost culturally competent

This hospital has the highest scores of the 5 hospitals in all three strands. It scores a perfect 8 in organisational ethos and is advanced in all areas of implementing the WOA approach to managing diversity in Irish hospitals. The hospital has won awards for its work in diversity management in the Irish hospital sector and has strong links with the HSE and has piloted various HSE initiatives regarding service provision to multi-ethnic groups. This hospital has successfully used the WOA in ensuring inclusive, culturally sensitive strategies are the norm

in the hospital for meeting the needs of serving ethnic minority community members. The hospital needs to continue to further develop two training levels in order to encompass all 6 levels of the incremental approach to intercultural training.

3.3.6. Synthesis

From an analysis of the primary data a number of conclusions can be drawn regarding the implementation of the WOA in Irish hospitals.

Strand 1 (Organizational Ethos): Four out of five of the hospitals were relatively advanced in all aspects which may reflect compliance to national equality legislation and anti racism guidelines.

Strand 2 (Workplace Environment): from the 6 levels of training recommended as best practices all hospitals conducted level 1 induction and orientation (Introduce the individual to the organisation approach to interculturalism and anti-racism and increase individual's awareness of diversity) and level 6 (Training to enable senior personnel to effectively discharge their responsibilities for Equality and Diversity in the health sector). Two hospitals had implemented level 5 (multicultural teams training), and only one hospital had implemented four levels of training. Considering the importance of intercultural training and cultural competency in the delivery of quality health care services to ethnic minorities the results clearly indicate that the five hospitals are not undertaking adequate intercultural training. All hospitals had however recruitment and retention policies accommodating non nationals.

Strand 3 (Service Elements Necessary to Support Intercultural training): Evidence indicates awareness of the importance of interpretation services in hospitals which is a critical element for providing culturally appropriate health care. However there is improvement needed in the provision of information and awareness for minority ethnic service users of the processes and practices of the Irish health care system. The most striking need is the provision of signage in public areas and the distribution of literature in the key languages of service users.

3.4. DISCUSSION

As a consequence of rapid inward migration and a new multicultural Ireland, it is clear that the provision of quality health care service provision to minority ethnic community members is the priority issue on the diversity agenda for the Irish health sector. In addressing the challenges of diversity, the HSE having undertaken extensive international research and internal scoping exercises assessing the needs and gaps in the Irish health system, proposed an organisation wide approach namely the WOA. Irish hospital and health settings were advised by the HSE to implement the three strands of the approach in order to provide appropriate culturally sensitive health care service delivery to members of ethnic minority communities. In randomly selecting 5 voluntary hospitals this research has served as a simple indication to what extent the WOA has been implemented on the ground in Irish hospitals. The research further indicates that four out of five of the hospitals who have experienced increasingly ethnic diversity in their service user profiles have advanced in implementing the WOA. The research illustrates that while advancement has been made, there are considerable efforts remaining to be made in areas of intercultural training, cultural competency skills obtainment, and initiatives to support training. Different hospitals are implementing the WOA at different speeds based on the needs of the hospital and levels of patient diversity. With reference to Cross's Cultural Competence Continuum, it can be argued that the majority of the hospitals sampled could be ranked at point 4 (Cultural pre-competence) or above on the continuum and reflect hospitals that are succeeding in creating a culture of interculturalism that meets the needs of patient diversity care. Equally it is noteworthy that the two hospitals with the highest scores for implementing the WOA were a maternity and a children's hospital which may suggest that the need for providing appropriate culturally sensitive health care is greater in these types of hospitals.

Conclusion

It would appear that the Irish health sector reacted rapidly to the challenges of immigration, and put in place best practice plans to manage ethno-cultural diversity as a matter of priority. This strategy was planned at a time of unprecedented economic prosperity in Ireland when the Ministry of Health had the necessary financial resources to react appropriately by producing the WOA in 2005 and incorporating it into its five year National Intercultural Health Strategy 2007 – 2012. As of 2008, Ireland has experienced an unprecedented economic crisis, leading to a return to high unemployment, rapidly growing emigration, public spending cutbacks, and a moratorium on recruitment in public services. This has undoubtedly had adverse consequences on the implementation of the WOA in relation to critical areas such as training,

support to training and recruitment. These elements are crucial to the long term success of providing appropriate cultural sensitive health care to ethnic minorities in Irish society. The National Intercultural Health Strategy in Ireland runs from 2007 to 2012. Evidence would suggest that if the Irish health sector is to succeed in providing comprehensive culturally sensitive health care provision to members of ethnic minority communities it will need to provide the necessary financial resources to ensure that all strands of the WOA can be fully implemented.

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