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Guidance from a Rapid Realist Review

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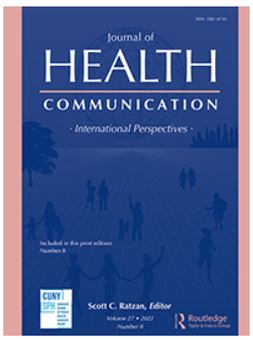

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Implementing Interventions to Improve Health Communication Equity for First Nations People: Guidance from a Rapid Realist Review

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ABSTRACT

Effective communication is critical for engagement between clients and health professionals, transfer of health information and health decision-making. Internationally, there is recognition that if health communication interventions were successfully implemented, then health communication equity would improve. This rapid realist review was undertaken with the aim of providing guidance on the circumstances in which communication interventions were likely to work in regional health service settings accessed by First Nations people from remote and very remote geographic areas of Australia. The realist review involved a process of searching literature on key terms and the identification of relevant studies and policies by a content expert group, including non-Indigenous and First Nations health researchers. Evidence was extracted to inform and synthesize into guiding principles, using a realist perspective. This review identified studies that provided evidence from 37 Australian and international settings where the dominant language and culture of the health sector differs from that of the majority of service users. A number of guiding principles were synthesized: 1) to build trust and respect by inclusion of an individual patient's cultural perspective; 2) to enhance concordant understanding of health information through two-way health literacies and learning; 3) to recognize the entanglement of health communication equity with regional socio-cultural and health determinants. This review generated realist informed guiding principles to suggest how and under what conditions health communication interventions can enable healthcare decision-making at an individual and service level.

Background

Effective health communication is critical for engagement between clients and health professionals, transfer of health information, in decision-making, and in addressing health equity (World Health Organisation, 2022). In Australia, key policy frames effective communication with First Nations consumers as fundamental to the provision of accessible, culturally responsive, and safe health care. For example, the communication domain within the *Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health* (Australian Health Ministers' Advisory Council, 2016) identifies First Nations cultural and linguistic diversity; the link between communication and health literacy; and the broader communication environment inclusive of physical, electronic, and organizational resources. While context-specific issues such as resource levels and skilled workforces are recognized, well-aligned health communication interventions and relevant outcome measures are not detailed. This rapid realist review was undertaken with the aim of producing guidance from existing studies, to support implementation at the local level in regional health services likely to communicate with First Nations clients of diverse linguistic and cultural backgrounds.

Health service performance measures are linked to the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF)* (Australian Institute of Health Welfare, 2017), which in turn includes monitoring through the *National Safety and Quality Health Service Standards* (NSQHS) (Australian Commission on Safety and Quality in Health Care, 2017). 'Communicating for Safety' is Standard 6 of the 8 NSQHSs and intends '*to ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients*' (Australian Commission on Safety and Quality in Health Care, 2017, p. 18). This standard acknowledges the importance of health communication, but it focuses on communication between health professionals rather than between health professionals and other people, excepting for effectively communicating with 'patients, carers, and families during high-risk situations'

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(p. 50). Accordingly, the measure of performance associated with this standard does not cover the three focus areas of the Communication Domain in the national *Cultural Respect Framework 2016–2026*, (Australian Health Ministers' Advisory Council, 2016). However, neither the data generated from these monitoring mechanisms nor the tools themselves provide a level of regional service specificity adequate for remote and very remote health service consumers, nor capture the impact of either successful communication interventions, or of miscommunication.

The importance of effective language use and commensurate understanding building through communication was identified decades ago in relation to First Nation's Australians engagement within national health, justice and education systems. In a report commissioned by the Australian Government of the time, Wangkatja academic, public servant and musician Gloria Brennan (1979) identified the urgent need for interpreting and cultural liaison services for First Nations people in regional inland Australia. She exhaustively argued that when it was enabled, communication would function as a determinant of equity for First Nations as a mechanism of access and inclusion in commensurate systems of health, education, and justice. Morice (1986), an English first language doctor, also working in central Australia throughout the 1970s, observed that intercultural communication specifically underpinned his concordance in treatment of depression or sadness. Morice worked within the framework of Luritja peoples' health beliefs and concepts as well as with his medical knowledge, suggesting the key to his successful health communication and treatment [or not] occurred only with inclusion of his Luritja colleagues' specialist knowledge of illness and society (Morice, 1981, 1986).

It's a Living Thing

Pathways between health communication equity and health benefit outcomes are supported in the logic of the World Health Organization's *Social Determinants of Health* (World Health Organisation, 2022). Taking a contemporary view of communication, it encompasses the bidirectional flow of meaningful information as well as offering contextualizing experience and knowledge (Ireland, Maypilama, Roe, Lowell, & Kildea, 2021; Markham & Smith, 2020; Morice, 1986). Operational definitions of health communication in implementation frameworks (Australian Institute of Health Welfare, 2019a, 2019b) fall short of considering health communication equity (Pollock, Borges, & Cook, 2020; WHO, 2022), which could be measured as a determinant of health outcomes (Fierke & Mackay, 2020; Yadee et al., 2019). Intercultural health delivery studies found that health communication is a multifaceted dynamic process and goes well beyond language interpreting for direct health care and patient information (Ireland et al., 2021). Furthermore, the challenge to health communication equity becomes more apparent in regional Australian health services operating without a First Nations governance structure (Crooks, Casey, & Ward, 2020; Lahn, 2020).

Health literacy in Australia is generally poor (Australian Bureau of Statistics, 2008). Health literacy along with educational achievement and socioeconomic status are given recognition as important social determinants of health outcomes cross-nationally (de Moissac & Bowen, 2018; Pollock et al., 2020; Rheault, Coyer, Jones, & Bonner, 2019; Vass, Mitchell, & Dhurrkay, 2011). Health communication as framed by the concept of health literacy is prominent in the *Australian Government National Cultural Respect Framework for Aboriginal and Torres Strait Islanders* (2016–2026). Interventions to tackle an intercultural health literacy between monolingual English and pre-monolingual First Nations language speakers have historically been approached by embedding First Nations language words against phrases translated from English (Shield et al., 2018). These interventions have overlooked the concordance embraced in an information exchange that seeks to corroborate a shared knowledge and understanding (Einsiedel et al., 2013; Ireland et al., 2021). Language barriers impact on differences in care (appropriateness, continuity, patient-centered services, safety) between those who are proficient in the dominant language (usually English) and those who are not, and on the concordance between patient and provider which is essential for effective communication and quality of care throughout the continuum (de Moissac et al., 2018; Einsiedel et al., 2013; Yashadhana, Fields, Blitner, Stanley, & Zwi, 2020).

Linguistically and culturally diverse, First Nations' people who engage with health services in Australian regional areas share their interpersonal, group and system-level health communication needs with the needs of the health service (Crooks et al., 2020; Trudgen, 2000). Constrained by the lack of resources for, and engagement with, interpreters and liaison staff (Green, Anderson, Griffiths, Garvey, & Cunningham, 2018; Ralph et al., 2017) and by inadequately representative regional governance (Crooks et al., 2020; Lahn, 2020) regional health services lack sources of direct, local First Nations guidance. Not all First Nations speakers read, as written forms of First Nations languages are relatively recent and based on European phonetics and systems of linguistics (Boot & Lowell, 2019) and participation in Governance is usually reliant of written English language literacy. Thus entangled and intracultural, health communication equity requires interventions that are of measurable benefit to health outcomes in regional health service.

Methods

The Rapid Realist Review methodological approach was adopted as it maintains realist logic and constructs but explicitly engages with stakeholders to refine the evidence-synthesis process in order to generate timely evidence-informed guidance for a specific context (Saul, Willis, Bitz, & Best, 2013).

Search terms identified for use were 'Patient Experience' 'Remote (Regional, Remoteness, Very Remote) 'Health Service (Intercultural, Culture, Language, Interpreter, Liaison Officer) AND Indigenous (Australian, First Nations, Aboriginal, Torres Strait Islander). Search data bases included PubMed, Informit, and SCOPUS. Snowball searching from database records and source bibliographies and expert input extended the search terms to include Health Communication (and iteratively Effective Health Communication; Health Literacy) and Cultural Respect (Framework, Policy, Implementation).

Established health researchers, content and practice experts, whose expertise is focused in Aboriginal and Torres Strait Islander health in remote regions in Australia, were consulted as to the scope and for identification of relevant articles and documents (published and gray) to review.

152 sources were identified and screened for evidence of health communication interventions or strategies; health settings with linguistic, cultural and intercultural diversity; or health communication determinants evident in intervention or implementation. Thirty-seven papers were selected for inclusion in the review, including four international studies selected for the significance of their cross-national comparability to the Australian context. Twenty-four of the papers were published between 2016 and 2021. Of the others, six were published between 2001 and 2015 and seven were published before 2001. In terms of policy content that guides health communication with Aboriginal and Torres Strait Islander people, ten Australian Government policy position papers, three Australian Bureau of Statistics reports, one Northern Territory Government, and two health communication intervention commentary papers were reviewed.

The majority of studies were qualitative and reported on discreet language cohorts of First Nations language speakers; and/or were conducted within discreet health districts; and or with a focus on a regional Australian health service setting; or multiple regional settings, but for a limited range of health concerns. The methodological challenge of these constraints includes the degree to which any such synthesis might inform cross-national comparison.

The design of this review followed the parameters and methods undertaken by Saul et al. (2013). Identification of mechanisms and contextual factors that link to the outcome sought for complex social interventions were extracted as statements of context mechanism outcome (CMOCs) as is consistent with methods described by Pawson and Tilley (Pawson & Tilley, 1997) and RAMESES publication standards for realist synthesis (Wong, Greenhalgh, Westhorp, Buckingham, & Pawson, 2013). The process of forming guidance for interventions using realist methods began with modest strands of initial rough proposition (IRP) (Dalkin, Greenhalgh, Jones, Cunningham, & Lhussier, 2015), from extraction taken from the selected literature which serve to elucidate from initial retroduction toward points of guidance. The result produced a short narrative of approaches to communication that consider determinants of health communication equity and raise the question of outcomes measures. The review is challenged by the scope of context-relevant available data coverage, and by limitations to the degree of generalization that can be attained from ad-hoc, location specific case-study literature.

Results

Commensurate Communication

Well-being for consumers of health services is enhanced where services influence the initiation and response to conversation or question through integrating local language use and cultural beliefs, because that deepens experiences of cultural security (Northern Territory Government, 2016). Acknowledging that communication relationships are between people and not categories of person and care giver (Einsiedel et al., 2013; Ryan, 2020) and that person, not illness-centered communication facilitates the experience of cultural respect also underpins quality of care (de Moissac & Bowen, 2018; Green et al., 2018; Lowell et al., 2012).

Quality of care has been defined as the degree to which health outcome meets professional knowledge (de Moissac & Bowen, 2018). At an organizational level health communication styles and patterns reflect the depth [or not] of practice of cultural competence and demonstration of cultural safety (Amery, 2017; Northern Territory Government, 2016; Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation, 2016; Yashadhana et al., 2020). Appropriate health communications should facilitate the flow of information that can improve quality of care (Green et al., 2018; Lowell et al., 2012). The prevalence of monolingualism evident in systems designed to operate in contexts with cultural continuance of a high proportion of First Nations language speakers (Australian Bureau of Statistics, 2016; Brennan, 1979) enforces the pattern of evidence of 'broken' communication flow (Fierke & Mackay, 2020).

A commensurate understanding can carry the ethic of care throughout the continuum of health service (Morice, 1986; Ryan, 2020) and may contribute to culturally safe experiences of health service (Northern Territory Government, 2016). Oral language and its interpretation best inform shared understanding, and failing a shared practical experience, conversations were the most effective means through which people developed a flow of health knowledge across language and cultural differences (Aitken, Stulz, & Clark, 2017; Brennan, 1979; de Moissac & Bowen, 2018; Lowell et al., 2012; Ralph et al., 2017).

If cultural security afforded that heterodoxic orientation (Koechlin, 2021) to quality of care, then health outcomes may become disentangled from reliance on [only] a professional knowledge. In this respect health communication could be considered as more open system oriented than discreet categoric biomedical data can portray (Shield et al., 2018; Yashadhana et al., 2020). Working against this notion of heterodoxy are the conceptually 'closed' categorizations that determine criteria such as role, status, or belief through which people interact, and which may delimit the aim of achieving shared understanding between professionals and others.

Initial Rough Proposition 1: Health communication equity operates by inclusion of cultural, intercultural and interpreter expertise which informs health literacies, builds trust, and demonstrates respect for an individual's cultural perspective. When these practices can carry the ethic of care then the flow of information between people and the work of communication of health knowledge can be shared, mobilized and effective. Communication flows, and the communication environment becomes less entangled.

Health Literacy

Multiple and new chronic diseases are relatively recent to First Nations peoples. Initially introduced in Australia with European

colonization (Cooke, 2009), unsurprisingly some have felt there is an obligation on the people of the cultures who brought them to fully share their knowledge of how to combat these sicknesses (Lowell, 2013; Lowell et al., 2012).

Health literacies are as essential as bio-medical advances to increase regional health benefit and prevention and improve health outcomes. If health literacy functions well, then First Nations people can share their expert knowledge of their cultural and health beliefs and practices, which are particular to each regional health context (Byers, Kulitja, Lowell, & Kruske, 2012; Haynes et al., 2019; Shield et al., 2018). This function of commensurate information flow is essential for informed consent (Shield et al., 2018) and, when embedded linguistically and culturally, can become knowledge which is effectively communicated by the whole community (Amery, 2017; Finlay & Armstrong, 2019).

Health literacy is one part of wider sets of cultural and linguistic literacies essential to the flow of information in health service. It may be best achieved through discovery education in local language that can conceptually frame and connect the information to cultural knowledge and community transmission (Morice, 1981; Shield et al., 2018). This process can provide the mechanism through which people discuss and inform each other, which can support more individual understanding and the wider societal uptake of the knowledge (Boot & Lowell, 2019).

Health literacy can bring the knowledge and language of the people involved as the central tenet of the frameworks, knowledge and practices that support their biomedical health, social capital, and care (Finlay & Armstrong, 2019; Ireland et al., 2021; Pollock et al., 2020). For example, co-constructive co-interpretive processes of communicating health literacy operated effectively in midwife engagement in a child-birthing program (Ireland et al., 2021). In chronic disease prevention, co-constructed health messages directly increased the health knowledge of a local community and of participating health staff and there was a higher uptake of vaccination in the location involved. Evidence of ongoing community wide health literacy and cultural embedding of the health knowledge was confirmed seven years post that collective community level intervention (Rheault et al., 2019).

A health service's engagement with the health literacy of their region implies that improved health communication is being mobilized. Where evident over time, this may contribute to more effective health service and to the management of long-term chronic illness as well as to preventative health strategies (Ireland et al., 2021; Rheault et al., 2019; Shield et al., 2018).

Initial Rough Proposition 2: When co-constructive co-interpretive processes are the central tenet in health literacy, then the flow of knowledge and information amongst the people involved is effective. When shared knowledge is embedded in cultures of practice then the uptake of the health practice among the wider community can contribute as a measure of health communication equity.

Operational Health Communication

Health services are entangled with the cultures, beliefs, and languages of their consumers. This entangled health communication environment is acknowledged in Australian and international settings (Amery, 2017; Penn & Watermeyer, 2018; Pollock et al., 2020; 2018; Ryan, 2020). Knowing that varied cultural world views exist, and that entanglement with a dominant cultural system can silence those of different cultural and linguistic background, has not been enough to operationalize equitable health communication in Australia (Brennan, 1979; Green et al., 2018; Morice, 1986; Rheault et al., 2019; Trudgen, 2000), or internationally (de Moissac & Bowen, 2018; Finlay & Armstrong, 2019; Pollock et al., 2020; Schick-Makaroff et al., 2019). For impact, an intervention should be scalable, address inequality and be relatable (Pollock et al., 2020).

Health communication equity currently relies upon the technologies through which the health service functions, in conjunction with the ethics of care that underpins cultural security (Australian Commission on Safety and Quality in Health Care, 2019b; McKivett, Paul, & Hudson, 2019). The inclusion of First Nations governance and leadership in regional health service is rare and yet essential to redistribute the burden of ineffective health communication (Bond & Singh, 2020; Crooks et al., 2020; Ryan, 2020). Respect for cultural and linguistic difference is vital to an ethic of care so that health services afford an openness to questioning for all involved (Penn & Watermeyer, 2018).

Collecting health information with consumers produces data, but that data is not yet appropriate or adequate to provide a measure of outcomes of health communication equity. As yet, the means for collecting data to inform key health service frameworks about the use and impact of these health communication interventions do not extend throughout regional health service. Health communication-related elements that do appear as measures in policy frameworks are not sustained by publicly reported and regionally comprehensive data collection processes, tools or instruments (Australian Bureau of Statistics, 2019; Australian Commission on Safety and Quality in Health Care, 2017, 2019a; Lahn, 2020; Markham & Smith, 2020).

Initial Rough Proposition 3: If the ethic of care underpins the objective of data collection and data collection informs design of interventions that are scalable, then all people will better understand the risk of miscommunication, and the value of evidence gleaned from localized health communication interventions. Awareness of the practice of health communication expertise as a contributor to health communication equity will increase.

Locally Inclusive Workforce

Engaging health staff who share the language and cultural background of consumers assists health professionals or organizations in learning how people think or live and what they feel, need, or want; and then health providers can take notice of what they say (Brennan, 1979; Ireland et al., 2021; Ralph et al., 2017). When interpreters and liaison staff are not included in health communication the difference that they may make is unknown; and the need for them can remain unapparent (Brennan, 1979; Ralph et al., 2017).

Employment and training pathways for health interpreters and cultural liaison staff is equally as important for improved

health outcomes as training for First Nations and all other health professionals (de Moissac & Bowen, 2018; Lahn, 2020; Ralph et al., 2017). However, Interpreting and liaison may not necessarily work well as one role for all health service employees owing to the fact that the cultural and linguistic literacies required for each are exacting and discreet (de Moissac & Bowen, 2018; Einsiedel et al., 2013; Green et al., 2018; Loomis, Epstein, Dauria, & Dolce, 2019)

For health personnel to take the time to establish relationships prior to and during the health communication encounter is particularly important when consumers are in unfamiliar and intercultural settings and need to grasp and exchange concepts in their everyday language, and which are sometimes outside their generational or cultural use (Amery, 2017; Brennan, 1979; Green et al., 2018; Perales, Baffour, & Mitrou, 2015). Individual health provider commitment to a culturally respectful health service experience is necessary, alongside organizational commitment and appropriate organizational implementation and resourcing solutions (Aitken et al., 2017; Bond & Singh, 2020; Boot & Lowell, 2019; Cass, Cunningham, Paul, Wang, & Hoy, 2003; Cass et al., 2002; Lowell, 2013; Lowell, Kildea, Liddle, Cox, & Paterson, 2015; Lowell, Schmitt, Ah Chin, & Connors, 2014; McKivett et al., 2019; Penn & Watermeyer, 2018; Ralph et al., 2017; Ryan, 2020).

Initial Rough Proposition 4: Health providers recognize that in a culturally secure experience an interpreter and or cultural liaison expert is needed to access health literacy and effect an adequate information exchange. Improved information exchange contributes to more commensurate understanding of health practices, and to a more mobilized health communication environment.

System-level Guidance

First Nations involvement is essential to the flow of information at all levels of regional health service including governance, monitoring and evaluation (Finlay & Armstrong, 2019; Haynes et al., 2019; Rheault et al., 2019; Shield et al., 2018). It has been suggested that effective communication can only truly be present when culturally and linguistically diverse First Nations Australians are leading their engagement with a health service (Bond & Singh, 2020; Brennan, 1979). Governance that is inclusive of First Nations people must be mobilized in order to redistribute the burden of socioeconomic, historic and cultural marginalization (Markham & Smith, 2020). The health services that are most in need of linguistic and cultural health communication interventions to overcome barriers to health communication equity are those whose governance and ways of working are not currently influenced by First Nations peoples (Lahn, 2020; Markham & Smith, 2020).

There is potential for regional health services to link communication compliance activities with other standards for a broader range of evidence (Australian Commission on Safety and Quality in Health Care, 2017, p. 42). At present none of these standards is explicitly linked to cultural or linguistic responsiveness in respect to health communication between health providers and First Nations people. Nor is there any publicly available information about cultural security performance beyond a health service achieving or not achieving accredited status under the NSQHS standards. Information about health service implementation of the communication standard, its impact on service-level change, or inclusion or exclusion of remote constituents in data collection remains available only within the health service itself.

Initial Rough Proposition 5: Outcomes measures are developed for interventions that improve health communication and health communication interventions are evaluated, monitored, and implemented for ethic of care and as measurable outcomes of health communication equity.

Methodological Challenges or Limitations

This rapid realist review has established that there are gaps and silences in data and in the omission of health communication interventions in relevant national and cross-national frameworks. The available literature describes the tip of an iceberg. We were unable to locate available and comprehensive studies of health communication interventions that were implemented and measured in any way as determinants of health communication equity effecting First Nations individuals and societies. The studies available tended to report on bespoke parts of health communication systems, or on jurisdictional frameworks that were not tested for operational outcome at multiple, or even at very many, regional levels, or at cross-national ones. Further, the data collected by regional health services, to test a measure of cultural security and patient experience as indicators of health communication equity were only available for internal health service purposes.

Discussion

As Fierke and Mackay (2020) describe, communication can break entanglement through speech, bringing the unseen into negotiation and currency. That flow of information that mobilizes effective health communication in regional health services has a transformative role to play in dismantling inequities recognized as social determinants of health (World Health Organisation, 2022). By using language, concepts, and culture to co-construct a shared understanding which can then be mobilized, monitored and exchanged (Australian Health Ministers' Advisory Council, 2016; Brennan, 1979) we can hypothesize that an information flow that is dynamic and interactive between levels of health service and people, and a service which reflects the socio-cultural determinants of the region, can better support health communication equity, which supports health outcomes (Aitken et al., 2017; World Health Organisation, 2022).

Pollock et al. (2020) have argued that community structure theory moves the focus of analysis successfully from the individual to community or group level and may even allow for cross-national comparisons to be developed. Cross-national comparison might assist in realizing outcomes measures which are relatable (Pollock et al., 2020) and which operate region by region (McKivett et al., 2019) to achieve better and more appropriate outcome measures of health communication equity, however in regional Australia, the data required for any

regional outcomes measures is either inadequate and or unavailable.

What Needs to Change

In a regional health service health communication requires localization through inclusion of strong, local language and culture, and the representation of these authorities in local health service governance. The traditions of medical scientific knowledge have thus far been most influential in health communication but have not provided effective outcome measures, or consistently identified the determinants of health communication equity. Health communication equity could be better framed through co-creation with the cultures whose diverse origins, reasoning, and identified ways or means of attaining wellness originate prior to monolingual biomedical health communication (Koechlin, 2021). If health communication prompts a disentanglement from the brokenness of current systems (Barad, 2007; Fierke & Mackay, 2020) and diverse and vibrant culture and language intermingle, then a strong and contributory health knowledge and literacy emerges and mobilizes the flow of information (Ireland et al., 2021). Outcome measures provoke us to see what is otherwise silent or what else contributes to inequity.

Guiding Principles for Health Communication Equity

Consistent with the original intent of this Rapid Realist Review, we propose a set of guiding principles and propositions, paying attention to the nature of health communication [in]equity as visible and silent, in regional contexts.

1. *Demonstrated trust and respect for individuals and inclusion of their cultural perspectives are drivers of effective communication. Intercultural practice can support health outcomes that require using First Nations language, worldview, and social and cultural rules for effective communication to occur*. If health providers with appropriate health literacy and commensurate biomedical knowledge share the same language and cultural background as the health service consumer, then a concordant understanding is more likely communicated. Communication is more readily accessible and is increasingly effective because shared cultural and language attributes are used in common understanding. Trust is more likely fostered and maintained. If health providers and consumers are competent in intercultural health communication, then they are more likely to include interpreters and liaison staff and be able to listen to ensure that their communication can incorporate peoples' health beliefs and understandings. Through health information being accessible and appropriately communicated the risks of miscommunication are lessened, trust is maintained, social determinants are understood, and likely health benefits increased.
2. *Effective two-way health literacy and education shape intercultural communication and promote concordant understandings of health information. The regional health communication environment decolonizes as intercultural health literacy practice is undertaken between consumers and staff in regional health services*. If two-way learning occurs in a culturally and linguistically responsive and intra-active environment then health, cultural and linguistic literacies entangle to decolonize and strengthen regional health communication. Health literacy is mobilized because accessible and appropriate resources and knowledge are co-constructed and co-interpreted within communication that is effective at the regional level. If regional health service communication is effective and appropriate, a range of existing policies and frameworks will contribute to implement and monitor communication interventions. The intercultural communication that is fundamental to the consumers' experience of care and treatment will contribute to their sense of cultural respect and to the organization's provision of culturally safe health care.
3. *Social determinants include regional cultural, demographic and historic characteristics and are entangled with health. Social determinants characterize important facets of the environment in which consumers and health providers communicate, and services are provisioned*. If health service organizations, systems and staff can respond to and continue to improve communication policy, then policy will frame the best practice of effective health communication. Health services will invest in local relationships, develop regional cultural competence, and co-create adequate resources to carry intercultural communication into matters of policy and governance, to influence health service provision. Effective health communication can better inform health service governance. If performance criteria are developed, regular monitoring occurs, and positive change is enacted on an evidence base that includes regionally accurate and meaningful data then strategic improvement of communication is likely to occur across all levels of health system.

Conclusion

Effective health communication has a transformative role to play in Regional Health Services. In dismantling the language and cultural barriers that perpetuate the health burden of First Nations peoples, and particularly those in remote and very remote Australia, health communication equity should be acknowledged as a significant determinant of health outcomes.

By situating health communication equity as a determinant of health, this paper has generated guidance for the potential design, implementation, and evaluation of health communication interventions in Australia and which have a potential contribution to make to cross-national comparison. Further work to hypothesize and test measurable outcomes is required. In order to progress, it is critical to consider outcomes measures for health communication equity. Cross-national comparisons should be considered in determining indicators for measuring health communication equity.

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