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Cultural Competence in Health

A Review of the Evidence

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Foreword

Cultural Competence in Health Care: A Review of the Evidence is an exciting and ground-breaking account of the complexities and disparities of knowledge, praxis and process within the quagmire of this slippery beast Cultural Competence. I say slippery beast in that it is a notion that has been very difficult to define and/or collapse into an equitable semantic space. The authors however do just that; they delve into the murky waters of literature and explore the many dimensions of this convoluted term that has remained unattainable to many of us, delivering an inspiring and particularly informing explanation of the many facets of this philosophy of practice. This book examines and brings together what has not been fully known about cultural competence in practice before: the numerous perspectives are synthesised and developed from a far-reaching realm across the broad spectrum of health delivery. The many other "ways of knowing", like cultural competence but known as different for their own special nuances, are also surveyed, bringing a greater clarity of why the difference matters.

Cultural Competence has been viewed as the panacea to build the capacity of health services and those who work for the health service to deliver safe and effective care to those who are marginalised within the broader society. In its many iterations, it has not always been successful in attaining the outcome of providing equitable care to those in need. Cultural Competence has been quibbled about for its shortcomings, and this book demonstrates that its scope has grown considerably beyond its primary promise over the decades. This extension is elucidated clearly and opens up a deeper space of the complexity, of the many levels that require observation, attention, action and measuring. Perhaps the shortcomings have been our own and our health system's lack of appreciation that not one approach only can reduce health disparities.

Evidence explored suggests that there is more to why Cultural Competence has not been a truly triumphant strategy. It is not about the patient's ethnicity, poverty, or linguistic difference or gender. Cultural differences are examined to have a broader reach than race and ethnicity. The social cultural mosaic is also examined, and these determinants impacting on healthcare access and outcomes are extensive. Flipping the equation from patient deficit to where the power is really held, by the

health professionals and health system, is a vital story we must all accept and acknowledge, and it is through this genuine insight that we all may be able to make significant changes in the way we work within a system that has ‘care’ in its schema and praxis.

The authors critically unpack just what a marginalised group of people means and who they are and how they were constructed to be different and less deserving in their society when accessing health care. Can a philosophy of praxis be effective in addressing the historical, politically constructed and social determinants that have fashioned the power differentials that exist in society? Yes, they can, if we all learn to grow our critical reflective gaze and shift our focus to develop the openness Cultural Competence recommends that we do. It is not that Cultural Competence is not working. It is that we in the health sector have not really attempted to take action on this philosophy of practice in its entirety. The depth of evidence provided in this text will assist anyone who may question the authenticity of this way of knowing, being and doing. It will also assist the reader to be able to grasp the essential tenets of Cultural Competence.

What is compelling is the clarity of this book’s purpose of filling in the gaps. This is crafted through the identification of critical yet often ignored points of focus, the drivers of Cultural Competence. Along with models for understanding the conceptual landscape of this messy beast, this book also explores approaches and strategies that are beneficial to the multiple components of the healthcare system. Operationalising Cultural Competence requires a multilevel framework that is beyond the individual health practitioner. It is also about measuring how you are going with your uptake of Cultural Competence. Measuring how you are going is of course a tricky test, and having the right tools backed up by evidence is vital to be confident about achieving best practice.

The exciting outcome of this book is that we are doing the right thing. Cultural Competence is a worthwhile health strategy, and we all need to do more about getting Cultural Competence across more health curriculums and beyond. Operationalising our healthcare systems to embed Cultural Competence into their policies, their evaluations, their practices, their KPIs, their staff training and their appraisals is critical for achieving health equity. Cultural Competence does work and can be a life-saving health practice. If we read and take up some of the strategies explored, we may gain a greater insight. As Cultural Competence is a lifelong journey, both we and our patients gain benefits.

For academics across the spectrum, this is a text that will be invaluable to you. I believe this book will make the difference we have all hoped Cultural Competence could and would achieve. Fortified with and by this text, we will all be in a better place.

By the way I loved this book!!!

Juanita Sherwood
University of Sydney, Sydney, NSW, Australia

Preface

Everyone has the right to accessible healthcare that is safe, responsive, effective and appropriate to their individual needs. That is health equity. Yet, inequalities in healthcare distribution and access are pervasive globally. Concerns about inequalities in healthcare access, service provision and health outcomes for global Indigenous populations and minority groups are prompting regulatory bodies, health services and health professionals to examine how they can better meet the healthcare needs of these groups.

Evidence demonstrates that inequitable access to quality healthcare based on ethnicity contributes to health disparities [1]. Cultural Competence interventions are developing internationally in response to the now considerable research evidence pointing to the need for culturally responsive care for Indigenous populations and minority groups. The argument for developing culturally competent services and workforces is positioned in a human rights framework: the basic human right to life and health [2].

The need for Cultural Competence was first prompted by civil rights movements across Western countries in the 1960s, almost half a century ago. This movement alerted health administrators to the distinct identities and long histories of oppression of Indigenous people, ethnic groups, women, gays and lesbians, people with disabilities and others. A further impetus was the growing number of new immigrants globally, who have brought unique historical, cultural, language, religious and political backgrounds [3].

Yet, inequitable access to quality healthcare still contributes to the health disparities between Indigenous nations and minority groups and benchmark populations. The absence of ethnic concordance in healthcare delivery leads to delayed access to care and contributes to the underutilisation of healthcare services [4]. Healthcare access is an 'intermediate indicator along a pathway linking resources in the social environment to health outcomes' [5]. However, there exist multifactorial causes of inequalities in the distribution of health, healthcare and access, including any number of individual, community and national factors. Perhaps the largest contributors are those related to sociocultural factors that lie outside the healthcare system [6].

Cultural Competency is a key strategy for reducing inequalities in healthcare access and the quality and effectiveness of care received. It works to enhance the capacity and ability of health service systems, organisations and practitioners to provide more responsive healthcare to diverse cultural groups [7]. From a human rights perspective, Cultural Competency is also about how the concept of respect is operationalised to ensure that the cultural diversity, rights, views, values and expectations of diverse populations are respected in the delivery of culturally appropriate health services [7]. In our contemporaneous culturally and linguistically diverse societies, 'this right can only be upheld if cultural issues are core business at every level of the health system—systemic, organisational, professional and individual' [8]. Although substantial evidence suggests that Cultural Competence should work, health systems across all levels have little evidence about how to identify what mix of Cultural Competence strategies work in practice, when and how to implement them properly or how to measure successes.

Achieving health equity for Indigenous populations and other minority group is a challenging task. Current biomedical models of health and illness are limited and do not explain many forms of illness [9]. They are historically embedded in the arrogance of Western sciences and power networks and based on three flawed assumptions: (1) all illness has a single underlying cause; (2) disease (pathology) is always the single cause; and (3) removal or attenuation of the disease will result in a return to health [9]. These models exclude the documented inequalities in the distribution of health and healthcare in terms of culture, ethnicity, social class and gender. Evidence shows that reconsideration of such models is needed 'to explain illnesses without disease and improve the organisation of health care' [9]. However, as Dr. Pat Anderson AO, Aboriginal Australian social justice campaigner, tells us: 'What the evidence tells us is the best approach to solving a particular problem is not always in line with what is the easiest, most popular or most accepted approach—it can indeed be 'an inconvenient truth.''

This book, *Cultural Competence in Health: A Review of the Evidence*, is about the contentious and 'slippery' concept of culturally competent healthcare. It challenges some 'inconvenient truths', but uses the strength of evidence to make a difference in healthcare and its access and health outcomes. It is also about innovation in health delivery, power sharing and equity. This book provides reliable data in the field of culturally competent practice that is necessary for the development of policy, health services, professional development and health education and training through research. It provides policymakers, health practitioners, researchers and students with a much needed summary of what works to improve health systems, services and practice. It provides readers with a clear and systematic overview of the interventions and indicators applied to enable health system agencies and professionals to work effectively in various cross-cultural healthcare situations. The book highlights the importance of Cultural Competence and describes the current situation in the studied countries; identifies effective approaches and strategies for improving the situation; reviews the indicators for measuring progress; assesses the health outcomes associated with Cultural Competence; summarises the quality of the evidence; and presents an evidence-informed conceptual framework for more

Cultural Competence in health service delivery. It develops a new model: a multi-level Cultural Competence intervention implementation and evaluation framework. This innovation unquestionably has weaknesses; it is theoretical and yet untested. However, it strives to provide a fuller understanding of the multitude of factors that influence health at multiple levels.

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Contents

Chapter 1
Introduction

1.1 Cultural Competence Defined

The definition of cultural competence used for the purpose of this book is perhaps the most widely cited and commonly agreed-upon definition of cultural competence, offered by Cross et al. in their seminal monograph *Towards a Culturally Competent System of Care* [1]. They defined cultural competence as 'a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals that enable that system, agency or profession to work effectively in cross-cultural situations' [1]. The definition provided by Cross et al. expands cultural competence beyond individual practitioners to include healthcare institutions and systems, and the policies and structures of these systems, as well as health professionals and staff in all levels of healthcare systems, from providers to managers and administrators [2]. It also does not focus exclusively on cultural factors, but rather more generally on the behaviours, attitudes and policies that enable effective healthcare in cross-cultural situations. The breadth of this definition allows for a fuller, more integrated conceptualisation of cultural competence, which has the scope to include a range of approaches and issues.

However, there is currently no consistent definition of cultural competence across healthcare settings, service delivery systems or countries; the lack of a clear definition is both a product of and contributor to the complexity in cultural competence interventions and evaluations [3]. Cultural competence has been defined in many different ways [4], and significant inconsistencies in its definition across key literature and policy documents are common [5]. Furthermore, many definitions only address certain aspects of cultural competence. For example, they may focus only on one level of healthcare systems in which cultural competence is needed. Alternatively, some definitions include recognition only of factors impacting healthcare which are seen to be 'cultural', not accounting for other social factors which are considered by others to be central to cultural competence.

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Consistent with its roots in cross-cultural education, many definitions of cultural competence describe it in the context of the healthcare provider. Cultural competence has historically been concerned with the capacity of healthcare professionals to provide competent and appropriate care to people who do not share the same ethnic identity, language, cultural markers or racial categorisation [6]. Individual cultural competence has been described as the state of being capable of functioning effectively in the context of cultural differences [7]. However, there is a lack of consensus on what is required to establish this state of effectiveness. It has been persuasively argued that effective healthcare is impossible without a working knowledge and understanding of a person's or group's culture and background [8]. Therefore, many cultural competence approaches aim to increase practitioners' knowledge of patients' cultural backgrounds. Cultural competence is considered to start with the development of individuals' knowledge and skills to allow for effective engagement with people from diverse cultures [9]. Cultural competence approaches also aim to enable practitioners to reflect on their own culture and to identify, respect and act with consideration and humility when relating to people from other cultures [10].

Suh [4] describes various definitions of cultural competence used across medicine, nursing, psychology, social work and education [4]. Each definition reflects similar features considered integral to improved individual cultural competence, including practitioner knowledge, attitudes and values to support cultural competence. Definitions also included aspects such as awareness of diversity and one's own culture, acceptance of and respect for cultural differences, the ability to provide effective and appropriate care and skills such as effective communication and the ability to conduct a cultural assessment [4]. Yet none of these definitions make reference to other social factors beyond culture which are implicated in cultural competence. Beach et al. [11] provides a definition of cultural competence which accounts for social as well as cultural influences which may be implicated in patient health beliefs, behaviours and healthcare and health inequities. Here, cultural competence is defined as 'the ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences by recognising the importance of social and cultural influences on patients, considering how these factors interact, and devising interventions that take these issues into account' (p. 356) [11].

However, it has long been recognised that to meet the needs of culturally, ethnically and racially diverse patient groups, acknowledgement of and responses to sociocultural differences at health system, organisational and individual health practitioner levels are required [1]. Several definitions of cultural competence respond to this need. Addressing the importance of cultural competence in health systems and organisations, cultural competence has been defined as the capacity of a health system to improve population health and wellbeing by integrating cultural practices and concepts into service delivery [12]. Capacity for organisational cultural competence is influenced by values and attitudes; cultural sensitivity; communication; policies and procedures; training and staff development; facility characteristics; infrastructure; intervention and treatment models; family and community participation; and monitoring, evaluation and research [13]. Another

definition describing a culturally competent healthcare system was provided by Betancourt et al. as 'one that acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs' (p. 294) [14].

1.2 Cultural Competence-Related Terms

Contributing to the difficulty of defining cultural competence is the many related terms used in the literature [15]. A lack of consensus on accepted, standard terminology [3, 16] has resulted in the interchangeable use of diverse expressions with similar definitions [17]. Many other terms such as cultural safety, cultural security and cultural awareness are used synonymously with cultural competence [3]. For example, in Canada and New Zealand, models of cultural safety have dominated. In the USA, cultural competence or transcultural or cross-cultural care has been most commonly used. In Australia, a range of terms, including cultural competence, cultural safety and cultural security, are used in descriptions of healthcare [5]. Furthermore, different terms have been put forward to clarify and better articulate the meaning of cultural competence, including cultural responsiveness, cultural sensitivity and cultural humility. However, despite their similarities, each of these terms emphasises particular nuances in the meaning and aims of cultural competence, further revealing the complexity and lack of consensus in defining the approach [14]. Because of the interchangeable use of terms by different authors, for clarity, the meanings of key terms used in this review are defined in the Glossary.

1.3 The Historical Development of Cultural Competence

Cultural competence evolved from early models of cross-cultural education in the late 1970s and early 1980s. The primary focus was on trying to bridge the cultural differences that existed between healthcare providers and migrant populations who did not share the same language or cultural norms. In an attempt to reduce the negative effects of this cultural divide on patient healthcare utilisation and experiences, a range of approaches to increase healthcare provider cultural competence were initiated, such as cross-cultural education and training [18]. However, during the late 1980s and throughout the 1990s, conceptualisations of cultural competence shifted significantly. These changes are thought to have come from challenges to predominant cultural competence models at the time, which argued that cultural competence needed to go beyond cultural awareness and sensitivity to make tangible changes in the healthcare encounter [2]. Increasing evidence of disparities in healthcare treatment and quality experienced by various racial and ethnic minority groups also started to reveal broader injustices in healthcare systems [1].

The concept of cultural competence was thus expanded to encompass a focus on reducing health inequities and improving healthcare and health outcomes [15]. Through this expansion of focus to include issues of healthcare disparities came changes in the population groups and key issues targeted by cultural competence. Cultural competence intervention efforts came to include other racial and ethnic minorities besides migrant groups [18] and other socially marginalised groups such as queer, lesbian, gay, bisexual, transgender and intersex (QLGBTI) communities [19]. Broader sociocultural issues also became implicated in health and healthcare inequities [18]. This new focus on racial and ethnic healthcare and health disparities meant that cultural competence needed to address issues which went beyond culture and cultural differences [20]. Factors such as provider and healthcare system bias and stereotyping, historical and ongoing experiences of racism and discrimination and social determinants of health have all come to be included within the scope of cultural competency [18]. There has also been increasing recognition that it is very difficult to disentangle 'social' factors such as socioeconomic status and social supports or stressors from 'cultural' ones [14]. Hence, the term 'sociocultural' is sometimes used instead of 'cultural' to describe this range of factors. At this time, cultural competence also expanded beyond the level of the patient-practitioner encounter to look at how cultural competence could be integrated across all levels of healthcare systems [1]. So cultural competence has come to include diverse issues and population groups and utilise diverse approaches to implementation. This complexity has meant a lack of consensus across cultural competence definitions, frameworks and interventions.

1.4 What Does Cultural Competence Encompass

In addition to the absence of consensus on a definition of cultural competence, the evolution of the cultural competence field has resulted in a diversity of opinion and lack of clarity around the scope encompassed by cultural competence in healthcare systems. Much of the literature on models and conceptual or theoretical frameworks predominantly examines individual cultural competence at the health provider level [4, 7, 9, 11, 21–27].

Although frequently focused on healthcare providers, there is a substantial amount of literature which examines and accounts for cultural competence at other levels in healthcare [28]. Cross et al. provide a framework that includes intervention strategies for developing cultural competence at policymaking, administrative, practitioner and consumer levels. Central to this framework is the adaptation of services and various service-level processes such as intake, assessment and treatment, to ensure that services are appropriate for patients [1]. Several key cultural competence literature reviews examine intervention strategies in the form of culturally appropriate or sensitive programs and services, as well as training and education for providers [3, 29, 30]. For example, Brach and Fraserirector outline a range of approaches to improving service provision, such as the use of interpreter services,

coordination with traditional healers, use of community health workers and including family/community members in service provision [29]. Providing training on cultural competence to the health workforce was only one of the suggested strategies. The inclusion of such strategies in the repertoire of cultural competence approaches is more consistent with the multilevel approach recognised as core to cultural competence.

1.5 A Multilevel Framework for Cultural Competence in Healthcare

Consistent with the definition provided by Cross et al. [1], we took a systems approach to assessing cultural competence across multiple levels in healthcare. We provide a framework of healthcare levels (see Fig. 1.1) based on the primary targets of the cultural competence interventions reviewed. These include interventions targeting to improve the cultural competence of health profession students during their education and training, interventions to improve the cultural competence of health practitioners, interventions focused on healthcare service delivery through implementing services and programs to improve healthcare cultural competence and interventions targeting whole healthcare organisations and systems. We recognise that any type of division of complex health systems is going to be fraught and incomplete. However, the process of identifying different levels within health systems helps to unpack some of the complexities and more readily enables thorough evaluation through helping to identify appropriate measures of program impact [31].

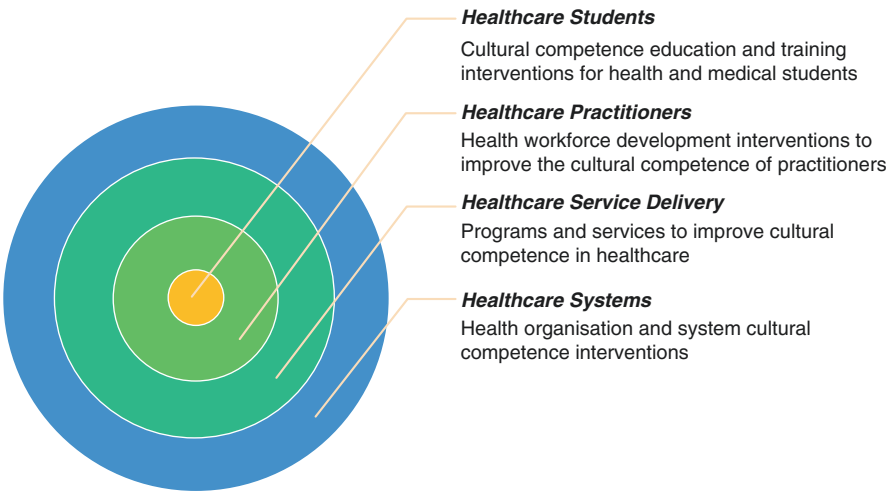

Fig. 1.1 Multilevel framework of cultural competence interventions in healthcare

1.6 The Purpose of This Book

The international cultural competence literature suggests that cultural competence approaches should work for providing healthcare that is responsive to diverse populations and cultural needs and that ameliorates healthcare disparities and health inequity. However, achieving this requires accounting for a range of complex concepts and issues that are frequently not clarified or differentiated. Furthermore, despite the recognition of the need for cultural competence to be integrated across all levels of healthcare systems, there has been a shortage of literature examining cultural competence strategies implemented across different healthcare levels and the outcomes of these.

This book aims to fill these gaps in cultural competence conceptualisation and frameworks by reviewing the available international evidence on cultural competence in healthcare settings in Canada, Australia, New Zealand and the USA (the CANZUS nations) [32]. First, we provide a conceptual model of the justification for the need for cultural competence to help understand the range of concepts and issues central to cultural competence. We then review the intervention literature and identify the scope of strategies that have been implemented across various levels of healthcare systems to improve healthcare cultural competence. We also review the outcomes that have been achieved through these varied interventions. Throughout the review, we examine what indicators have been applied to measure cultural competence and assess the evidence quality of intervention studies. Recommendations on how to improve the evidence base of cultural competence are provided, with a particular focus on how cultural competence interventions can better demonstrate whether they are indeed addressing the identified drivers of cultural competence. Based on these results, we then present an evidence-informed, multilevel framework for the implementation and evaluation of cultural competence interventions. We draw on evidence about what has been done and what has been achieved, along with suggested approaches to measurement, to create a framework to help inform future cultural competence interventions.

1.7 The Objectives of This Book

The objectives of the book are to:

1. Consider the significance of cultural competence, including the use of similar terms.
2. Identify the drivers of cultural competence and suggest an explanatory model for understanding the conceptual landscape of cultural competence.
3. Identify approaches and strategies that are effective in improving cultural competence across multiple levels of healthcare systems.
4. Examine the outcomes of cultural competence strategies and the relationship between cultural competence and patient healthcare and health outcomes.

5. Report on how cultural competence has been measured.
6. Summarise the quality of available evidence.
7. Discuss the implications of these findings for future cultural competence research and practice.
8. Present an evidence-informed framework for cultural competency intervention implementation and evaluation.

1.8 Structure of the Book

1.8.1 Chapter 2: The Drivers of Cultural Competence

Chapter 2 provides an overview and analysis of the key concepts and issues central to cultural competence. Here a model of the drivers of cultural competence is provided. The two main drivers identified are responding to sociocultural difference in healthcare encounters and improving racial and ethnic healthcare disparities. Related concepts and issues which impact on cultural competence and which are addressed in intervention approaches and their evaluations are also described. Some of these concepts and issues as well as the key tensions in the cultural competence literature are discussed in this chapter.

1.8.2 Chapter 3: Methods

The third chapter details the methods used for the systematic search which informed the scoping review reported throughout Chaps. 4–7. This includes the search terms used, the search strategy employed and data extraction and analysis techniques. The limitations of the review are also described.

1.8.3 Cultural Competence: A Multilevel, Systematic Scoping Review

Commitments at multiple levels—systemic/organisational, professional and client care levels—are required to increase cultural competence and create improved healthcare and health outcomes. The following chapters of this book focus on the different types of interventions aimed at improving cultural competency across multiple levels of healthcare. Four main types of cultural competence intervention strategies were identified from evaluation literature: *(1) cultural competence education and training for health and medical students, (2) health workforce development to improve cultural competence, (3) programs and services to improve cultural*

competence in healthcare and (4) health organisations and systems cultural competence interventions. For each of these chapters, we review the measures and measurement issues and assess the study quality of evaluations. We also discuss the implications for interventions on the relevant healthcare level and review the strengths and weaknesses of the evidence base.

1.8.4 Chapter 4: Health Workforce Development Interventions to Improve Cultural Competence

Chapter 4 reviews the documented intervention strategies and outcomes targeting health professionals practising within health systems. The primary interventions identified included cultural competence training and other training and professional development interventions aimed at improving the cultural competence of the health workforce. These health workforce cultural competence interventions reported a range of provider- and patient-related outcomes indicative of improvements in health provider and healthcare cultural competence.

1.8.5 Chapter 5: Cultural Competence Education and Training Interventions for Health and Medical Students

The fifth chapter provides an overview of the documented intervention strategies that have been implemented to improve the cultural competence of health students. Delivered predominantly through universities, the main strategies were the integration of cultural competence into university curriculum, cultural competence training and cultural immersion experiences. The outcomes reported in cultural competence education interventions all related to their impact on student's cultural competence.

1.8.6 Chapter 6: Programs and Services to Improve Cultural Competence in Healthcare

The sixth chapter is focused on reviewing evaluations of health programs and services which aim to improve the cultural competence of healthcare delivery. A range of different programs targeting diverse population groups and health issues across the four countries were identified. The commonalities in intervention strategies were the use of one or more approaches to community, cultural and language adaptations. Most programs and services utilised a combination of various strategies to improve the cultural competence of healthcare delivery. The reviewed interventions reported a range of healthcare outcomes and improvements in certain health measures for participants.

1.8.7 Chapter 7: Health Organisation and System Cultural Competence Interventions

Chapter 7 reviews interventions on the level of healthcare systems and organisations/agencies. The diverse interventions reviewed in this chapter utilised a range of approaches to increasing healthcare cultural competence. The key strategies were audit and quality improvement approaches and organisational-level policies or strategies. Outcomes reported included various organisational system outcomes, as well as outcomes for the patient-provider encounter.

1.8.8 Chapter 8: Cultural Competence Strengths, Weaknesses and Future Directions

In this chapter, we provide an overall discussion outlining the trends in the evidence across the intervention evaluations on the various levels. We examine where the strengths of the evidence lie (what the most promising cultural competence approaches are) and the major evidence gaps (where is further development in the cultural competence evidence base needed). This chapter particularly focuses on analysing the extent to which the interventions reviewed have addressed the primary drivers of cultural competence identified in Chap. 2. Recommendations are provided for the future direction of cultural competence approaches to increase the capacity of health services to provide effective and quality care for social and culturally diverse population groups.

1.8.9 Chapter 9: Multilevel Cultural Competence Intervention Implementation and Evaluation Framework

Based on the results from the previous five chapters, in this chapter we provide an evidence-informed, preliminary framework to inform a multilevel cultural competence approach. The framework addresses strategies for intervention implementation on the various levels. It also details intervention outcomes and measures to guide intervention evaluations to help build the cultural competence evidence base.

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Chapter 2
The Drivers of Cultural Competence

2.1 Introduction: The Conceptual Underpinnings of Cultural Competence

Cultural competence aims to improve service provision and patient-provider encounters through attention to culture- and sociocultural-specific patient needs. In doing so, it also aims to favourably impact on health and healthcare disparities experienced by a diverse range of population groups across multiple countries. These two primary aims of cultural competence are hereafter referenced as the drivers of cultural competence: the primary factors that motivate cultural competence interventions. However, these conceptual drivers are not always made explicit. To increase the effectiveness of cultural competence interventions, it is important to identify clear aims towards addressing the drivers of cultural competence. Figure 2.1 presents a framework for understanding how broader social, political, cultural and historical factors have framed each of these drivers and how the drivers relate to the need for cultural competence in healthcare systems.

2.1.1 Pathway 1: Cultural or Sociocultural Differences

For many individuals and population groups, the healthcare provided by current healthcare systems does not adequately meet patient needs. This can be attributed to a range of cultural or sociocultural differences between patients and providers and healthcare systems, which influence healthcare provision. These differences include diversity in worldviews, sociocultural beliefs and practices, languages, health literacy levels and communication needs among patients and healthcare professionals. These sociocultural differences are in part brought to attention by significant and increasing population diversity. Generated by historical and current global forces and processes such as colonisation, globalisation and war, many societies are made

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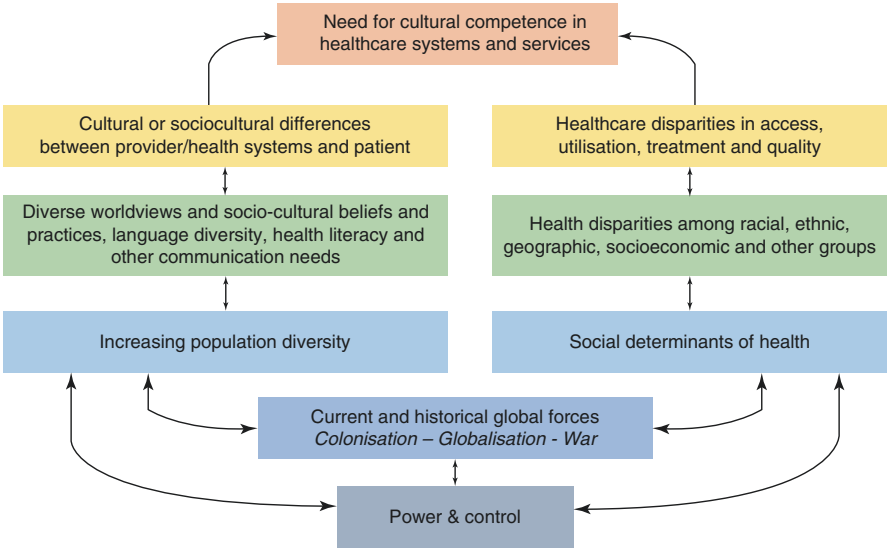

Fig. 2.1 The drivers of cultural competence

up of highly diverse populations. Population diversity has resulted in complex social and interpersonal dynamics in healthcare systems and beyond, which need to be addressed to provide quality healthcare.

2.1.2 Pathway 2: Healthcare Disparities

Efforts to improve the cultural competence of healthcare also stem from disparities in healthcare access, utilisation, treatment and quality. These disparities are a major social justice concern. Of particular concern is the impact of provider and health system racial bias on health disparities. Racial and ethnic disparities in healthcare are connected to wider health disparities seen among racial, ethnic, geographic, socioeconomic and other groups. These health inequities are largely created by factors that sit outside the healthcare system: the broader social, political and economic determinants of health. Determinants extraneous to the healthcare system are also created by the same historical and current global forces such as colonisation and globalisation. These global forces are implicated in creating complex social, economic and political systems, which maintain and continue the unequal distribution of power, resources and opportunities, which privilege certain groups of people over others.

Furthermore, both pathways are fundamentally based within broader dynamics around struggles for power and control. Power dynamics exist and play out on every

level and in all interactions and decisions in society and healthcare systems. Gross disparities in power and control in various forms across multiple levels of society can be held significantly accountable for why we have healthcare disparities and healthcare systems that do not meet all people's needs. Therefore, an examination of power is arguably key to changing these systems.

This chapter first provides a brief description of the conceptual model of the drivers of cultural competence. Throughout the rest of the chapter, these two drivers of cultural competence and their underpinning influences are described. The authors recognise that it is frequently difficult to determine true lines of cause and effect in complex social worlds and that this is not a perfect or exhaustible model. However, we propose the framework to contribute greater clarity to the complex concepts inherent in cultural competence.

2.2 Pathway 1: Culture and Sociocultural Differences

Several key early cultural competence theorists framed the need for cultural competence responsive to cultural differences [1–6]. Going back to examine the first drivers in more detail, cultural differences between healthcare providers and different population groups have been a common and perhaps the oldest cited driver of cultural competence. As previously outlined, the original concept of cultural competence was formulated in response to the imperative to provide healthcare which was appropriate to the cultural needs of migrant populations. It was recognised that cultural differences between health practitioners of predominantly European descent, and who are trained in the Western biomedical model of health, and migrant populations of culturally distinct backgrounds can negatively impact on patient outcomes [7].

Culture plays a significant role in all aspects of our lives, including healthcare systems [8]; therefore, it is an important consideration in healthcare improvement. However, culture is also a complicated concept which is difficult to define and therefore easily misconstrued. An understanding of the complexities in culture is vital for any approach which attempts to address its impact on healthcare. Cultural factors which are understood to impact on healthcare satisfaction, quality, processes and outcomes include factors such as differences in normative cultural values and language discordance [4]. For example, a recent literature review examining barriers to care for migrants with disabilities identified that patients' needs were not properly addressed because of cultural misunderstandings and disrespect of cultural values, beliefs and traditions [9]. Another study examining the impacts of cultural differences on dementia diagnosis and care access among minority ethnic older adults found that low levels of acculturation and culturally associated beliefs about dementia were barriers to appropriate care [10].

2.2.1 What Is Culture?

The focus on cultural difference as the driver of cultural competence has been based on certain understandings of culture. These understandings have significantly shaped the conceptualisation and implementation of strategies to increase cultural competence. Many definitions of culture make reference to systems of meaning or implicit guidelines shared by a group which shape the way the world is viewed and experienced [11]. In this way, culture is understood to pertain to the factors which provide a common sense of identity among particular groups of people at particular points in time [12]. In the context of cultural competence, culture often references group membership along racial and ethnic lines, with a focus on how shared values, beliefs and experiences impact on patient's behaviour in healthcare encounters [11]. For example, a key focus of cultural competence intervention approaches has been on teaching health professionals ideas about different values, beliefs, norms and experiences held by certain ethnic and racial groups in the hope that this improves patient experiences of the healthcare encounter.

However, such cultural competence approaches have been heavily critiqued for oversimplifying the concept of culture [11, 13, 14]. As demonstrated by its more than 100 varied definitions [15], culture is a very complex, elusive construct. In fact, it has been said that of all words in the English language, culture is one of the two or three most complicated [16]. Additionally, understandings of culture are highly influenced by different belief structures and time-relative perspectives. Therefore, considerations of what culture is and what it encompasses vary considerably among different groups and in different contexts [17].

Cultural competence has also been critiqued for reinforcing group stereotypes [11, 13, 14]. Societies, social groups and related cultures are mostly very complex and heterogeneous, with significant diversity in beliefs, norms, behaviours, practices and expectations among individuals [11]. Within any one ethnic or social group, there are significant variations in cultural processes based on differences in age, gender, class, religion, political affiliation and personality [6]. Culture is dynamic and fluid and in a process of constant change and adaptation. Many individuals belong to multiple distinct cultures, some of which do not exist harmoniously. Moreover, experience of or identification with a culture is something that can change for individuals across a life-span [14]. For example, culture can be modified through exposure to other cultures in different contexts through acculturation [18]. Defined as the internalisation of aspects of a new culture, particularly affecting generations following immigration [19], acculturation has been shown to impact people's engagement with healthcare [20].

Various models have been proposed to clarify the complexities of culture. These models can help to reduce cultural simplification and stereotyping. Chao and Moon offer a meta-theoretical framework using the metaphor of a 'cultural mosaic' to describe the multitude of cultural facets expressed by individuals [21]. The cultural mosaic framework describes culture as a pattern of interlinked cultural 'tiles', with individuals identifying with different patterns or combinations of factors that change

in different circumstances and throughout life. Chao and Moon define three primary categories of cultural features: *demographic features* that include aspects such as age, ethnicity, gender, race, physical characteristics and inherited social identities; *geographical features* that are natural or man-made features that shape group identity, such as country or region of origin, urban or rural and coastal or inland environments and climate; and *associative features* which are the informal and formal groups people identify and associate with, including religion, profession, politics and employment [21]. Erez and Gati also propose a dynamic, multi-level model of culture which conceptualises culture as a system comprising global, national, organisational, group and individual cultural levels [22]. This model demonstrates the dynamic processes through which change in any one cultural level can effect changes on other levels. This influence is conceptualised as multi-directional with higher levels of culture, such as the national level filtering down and shaping individual culture. Similarly, through individual behaviour change shaping group norms and values, individual levels of culture can effect change on higher levels [22]. In this way, culture can be understood as something which is not about difference and 'others', but rather, something that influences everyone. Every individual belongs to and is influenced by multiple cultures and cultural factors across the life-span [5].

There are also macro-level conceptualisations of culture where a whole nation or society is the cultural entity of concern [23, 24]. Furthermore, institutions and organisations are often described as having a 'culture' [25–27]. The Western biomedical model itself, with its participating institutions, various members and values and practices, can be considered a culture [28]. The systems of value and scientific practice of the biomedical model significantly impacts in particular ways on health outcomes. All ideas about health are cultural, including assumptions of objectivity that pervade healthcare conceptions and practices in many healthcare systems [8]. For this reason, many people argue that healthcare improvement requires a much greater focus on the cultures of healthcare systems and institutions, rather than those of service users [8, 28].

2.2.2 *Sociocultural Differences and Healthcare Appropriateness*

Research continues to use vague and overarching categories such as racial categorisation and ethnic identity when trying to identify the impact of culture on healthcare, without exploring the specific factors that influence how care is received. While there is no doubt about the relevance and importance of culture to health and healthcare, the particular role and importance of culture is often not easy to determine. One reason for this is because the construct of culture is frequently not distinguished from other important yet distinct sociocultural characteristics. Research studies have implicated culture in differences in perception of quality of care [29], health service utilisation [30], disparities in mental health treatment [31], access to

infertility care [32], adoption of mammography screening [33] and levels of shared decision-making [34]. However, while these studies talk about cultural differences in these areas, what were actually examined in these studies were differences along lines of racial categorisation, ethnic identity or nationality. This type of categorisation provides no detail about which particular sociocultural factors might or might not have a negative impact on healthcare disparities, just that there are differences.

The lack of differentiation between cultural and other ethnic or racial factors is rife in the cultural competence literature. The early interest in the influence of culture on patient preferences, values, health beliefs and behaviours and healthcare encounters was driven by evidence that patient-provider communication affected patient satisfaction, adherence to care and health outcomes [5]. Differences in expectations of care, thresholds for seeking care, recognition of and ability to communicate symptoms and ability to understand treatment and management strategies have all been understood through the lens of culture. However, there are other factors which would not necessarily be considered cultural that would heavily affect these factors, such as socioeconomic positioning and literacy levels.

2.2.3 Conflating Culture with Ethnicity and Race

Cultural competence approaches have been critiqued for oversimplifying culture and reinforcing stereotypes. They have also been criticised for conflating culture with the importantly distinct constructs of race and ethnicity [11, 13, 14]. As previously discussed, culture is a complex and dynamic construct which exists in multiple forms across societies and individuals. Some argue that definitions of culture need to go beyond race and ethnicity to include constructs such as class or socioeconomic status, religion or faith, gender, age, ability and sexual orientation among others, because these factors also variously influence individual experiences and expressions of culture in a similar way to other cultural factors [13].

Ethnicity or ethnic identification is frequently used to denote culture, yet it is only one aspect of culture. Ethnicity refers to the shared identity or similarity of a group of people on the basis of one or more factors including a long shared history; a cultural tradition, including family and social customs; a common language; a common religion; a common geographic origin; and/or being a minority (often with a sense of being oppressed) [35]. Ethnicity is generally based on self-identification. Similar to culture, ethnic identification is fluid, and identification with multiple ethnicities is becoming increasingly common [35].

Descriptions of ethnicity offer overarching generalisations which mask considerable diversity. For example, Asian ethnicity is defined by Statistics New Zealand to include peoples with origins from Afghanistan in the west to Japan in the east and south to Indonesia [36, 37]. Hispanic or Latino ethnicity is defined by the US Census Bureau as a person of Mexican, Puerto Rican, Central or South American, Cuban or other Spanish culture, heritage, nationality, lineage or country of birth of the person or the person's parents or ancestors [38].

Similarly, categorisation on the basis of race group large numbers of people from diverse ethnic, national and linguistic origins together without accounting for any of the diversity and differences across varied populations [19]. Race is the classification of humans into groups based on physical traits, ancestry, genetics or social relations [39–41]. Racial categorisation in understanding health differences is very limited, considering there are far greater within group differences than between-group [42]. Racial categorisation has been used as a justification for human exploitation the world over [41] and continues to distort perceptions of vastly diverse peoples [43]. Yet despite its limitations, racial categorisation is still frequently used in sociological and health research in preference to other demographic markers [19].

This lack of clarity around what culture is and its entanglement with concepts of race and ethnicity can limit understandings of how culture is specifically implicated in health experiences, behaviours and outcomes [44]. For example, a large population-based cohort study examined the association between patient-provider communication and race-related differences. The researchers found that sociocultural factors, but *not* race, were associated with patient-provider communication. This study suggests that sociocultural differences such as education levels and religious beliefs, as well as greater physician trust and less perceived racism, were associated with better communication in healthcare encounters [45]. Research studies that explore specific sociocultural factors and experiences such as racism, and which differentiate these from broad categories of race and ethnicity to more clearly guide the development of interventions to improve healthcare, are needed to challenge the status quo.

2.2.4 Worldviews, Language and Healthcare Appropriateness

Considering the breadth and complexity inherent in the concept of culture, it might be more useful to take a more nuanced approach to understanding the range of cultural factors which affect healthcare appropriateness. For example, worldviews and language are two distinct aspects of culture that can be useful. Worldviews are defined broadly as structures of beliefs, assumptions, values and principles, often implicit and deeply held, which determine how life at its most basic level is perceived, interpreted and explained [46, 47]. Worldviews provide the foundations which guide other beliefs and resulting behaviours [46, 47] that shape our primary concepts of reality and truth [48]. They are an important aspect of culture. Worldviews affect people's fundamental conceptions of health, wellbeing and sickness [48] and significantly influence the degree of appropriateness of approaches to healthcare.

Biomedical health models and systems hold key assumptions that construct a worldview as the basis from which medicine is practised [49]. Medicine is built on the reductionist approach of scientific paradigms. The key assumption in this paradigm is that complex problems are best solved by separating them into smaller components to distinguish different aspects to be examined separately, and then, using this knowledge about individual parts, try to explain the whole original phenomenon [50]. For

instance, biomedicine has evolved within an understanding of health and wellbeing, where mind and body are assumed to be inherently distinct and separate [51]. However, this approach to health has been critiqued for denying adequate consideration of personal and contextual factors and focusing narrowly on disease [50].

In contrast, many Indigenous worldviews are based on the concept of relatedness. Within a worldview of relatedness, each individual and all core aspects of life, including family, community, land, nature and spirit, are fundamentally understood and defined by their relationship to one another [52–60]. For many Indigenous people, health comprises inseparable physical, mental, emotional, spiritual and social/relational aspects including connection to family, community, ancestors, spirit and the land. These are all central aspects of culture, which need to be held in balance to achieve and maintain health and wellbeing [52–59]. Therefore, healthcare services that do not recognise and work within a holistic framework may be experienced by many Indigenous peoples as culturally incompetent. These fundamental worldview clashes are also relevant to other cultural and ethnic groups [54], which hold holistic views of health, including the importance of spiritual aspects of health [46, 61] and greater collectivist values [62].

The core assumptions in science and medicine play a central role in shaping medical education and professional culture, which in turn influences practitioners' beliefs, behaviours and interactions with health service users [47]. It is possible that as long as healthcare providers and systems continue to operate from the fundamental assumptions underlying medical practice, they will remain inappropriate for certain groups and individuals. This is certainly the case as long as healthcare does not truly hold space for different worldviews and approaches to health and wellbeing. For this reason, some argue that if the medical profession is to truly strive towards cultural competence, then deep reflection on the fundamental worldviews and assumptions of medicine is imperative [47, 49, 63].

There is growing recognition of the relevance of more holistic approaches to health. As a case in point, the connection between mind and body in shaping health has received support through research, especially in regard to how psychosocial factors and the body's nervous, endocrine and immune systems are intimately connected and their mutual functioning [54, 64]. The relationship between spirituality and health has received less attention, yet there is still substantial research evidence to demonstrate the interrelatedness of spirituality and religious factors and health and wellbeing [65]. Research has demonstrated links between religious practices, such as meditation, and beneficial psychological and physical health impact on blood pressure, immune function and neuroendocrine physiological processes [66]. The lesson in incorporating an examination of worldviews is one of humility—recognising that there are different perspectives, respecting these and incorporating them into healthcare and actually recognising their value and understanding that they can hold answers for better understandings about how to create and maintain health and wellbeing.

The role of language in cultural competence becomes even more crucial and also more complicated when language barriers intersect with worldview differences. Language barriers are a significant impediment to accessing appropriate healthcare for many communities and health service users. Being able to access healthcare in

one's primary language is essential for cultural competence [67]. In Australia, for instance, there is a substantial body of research exploring what is needed for effective health communication with remote-dwelling Indigenous people who hold vastly differing worldviews to that of the majority non-Indigenous population and the biomedical health model and also speak English as a second (or third or fourth) language [67–69]. Deep miscommunication has been found between health practitioners and Indigenous patients concerning fundamental issues in diagnosis, treatment and prevention efforts. For example, many basic biomedical concepts that are expressed quantitatively (percentages, weight, volume, dates, hours) are often not understood by people whose spatial and temporal concepts are expressed very differently [70]. Furthermore, there can be vast differences in Indigenous people's fundamental concepts of the body and how bodies function compared to those in medicine. This can result in a lack of understanding about concepts central to medicine, such as circulation and respiration [67–69].

Working with Indigenous people who hold vastly different worldviews, and also do not speak English as their first language, is a unique example of how cultural differences can pose challenges in healthcare encounters. Considering that many key health concepts in the biomedical model do not have translations in Indigenous languages, this type of cross-cultural encounter calls for the in-depth exploration by health professionals of the meaning of words [68] and active incorporation of Indigenous values, worldviews and epistemologies [71–74] into practice. Issues of differences in culture, language and worldviews are likely to be relevant for many population groups for which culturally competent practices can hold benefit. However, their presentation and bearing on the healthcare encounter will be unique for different individuals and populations in different contexts.

2.2.5 Increasing Population Diversity

Increase in population diversity is often cited as a driver of cultural competence [75–77], particularly in relation to sociocultural differences [1–3, 5]. Population diversity is not synonymous with sociocultural differences but rather can be considered an antecedent of sociocultural differences. CANZUS (Canada, Australia, New Zealand, USA) nations [78] are countries which, with the original Indigenous peoples and growing migrant and refugee populations, comprise a milieu of vast cultural, ethnic, religious and national diversity.

Population diversity is seen in a number of ways. For example, although many Indigenous people share common worldviews and cultural practices as well as similar experiences of colonisation and continuing colonial legacies, there is great diversity among Indigenous peoples, even within the same nation or continent [79]. Contemporary Indigenous people in Australia (Aboriginal people and Torres Strait Islanders), Canada (First Nations, Inuit and Métis peoples) and the USA (Native Americans, Alaskan Natives and Native Hawaiians) speak multiple languages and have diverse cultures and political styles [80].

Various subsequent waves of migration have further increased the population diversity of all four countries. The 2011 Australian census reported more than 300 ancestries [81] and the 2011 Canadian National Household Survey (NHS) reported more than 200 ethnic origins [82]. Some waves of forced migration occurred soon after British colonisation. In the USA, the introduction of slavery to provide forced labour for sugar cane plantations started from 1620, just 13 years after first settlement, and led to approximately 600,000 slaves being taken from Africa to the USA. Rapid natural population growth increased the African American population to four million by 1860 [83]. Other migration waves are very recent, for example, Asians have lived in NZ for more than 150 years, but in the past few decades, the population has dramatically spiked. In 2013, 11.8% of the population in New Zealand identified themselves as of Asian ethnicity—a 33% increase since 2006—and Statistics New Zealand (2013) projects this to further increase by 3.4% every year for the next decade [84].

For many countries, this diversity is rapidly increasing due to processes of globalisation including increased migration and forced relocation of refugee populations. Censuses project a continuing diversification of the ethnic/racial population of each of the CANZUS countries. In 2008 in the USA, for instance, approximately 33% residents, or more than 100 million people, identified themselves as belonging to a racial or ethnic minority population. However, the Agency for Healthcare Research and Quality projects that members of underrepresented groups, such as Latino and African Americans, are expected to make up more than 40% of the population by 2035 and 47% by 2050 [3].

For healthcare systems and services in these countries to be relevant and effective in the context of such diversity, adaptability and reflexivity is needed. The increasing racial/ethnic diversity in the four countries means that there are issues of cost, benefits and affordability in responding effectively to the healthcare preferences and needs of increasingly diverse populations [85]. However, as evident from previous discussions, identifying population characteristics using reductive constructs such as race, ethnicity or place of birth is limited. Furthermore, while increasing population diversity does play a major role in the need for cultural competence in healthcare, the dynamics which affect the ability of healthcare systems to meet population needs are more complicated and nuanced.

2.3 Pathway 2: Disparities in Healthcare Treatment and Quality

Moving now to examine the second driver of cultural competence: disparities in healthcare treatment and quality. There is overwhelming evidence to demonstrate that racial and ethnic minorities experience disparate healthcare treatment and quality. The US Institute of Medicine (IOM) (2002) report ‘Unequal Treatment: Confronting Racial/Ethnic Disparities in Health Care’ identified more than 175

studies documenting healthcare disparities [86]. These healthcare disparities were defined as 'racial or ethnic differences in the quality of healthcare that are not due to access related factors or clinical needs, preferences, and appropriateness of intervention' (p. 3–4). The disparities were found even when analyses controlled for socioeconomic status, insurance status, site of care, stage of disease, comorbidity and age [86].

Racial and ethnic healthcare disparities are found across a spectrum of health issues, care settings and treatment processes. These include preventive medicine, immunisations, diagnostic processes, prescription of medication and referral to specialists [5], as well as pain management and treatment [87], and level of information shared by physicians [88]. The IOM report found healthcare disparities in cardiovascular care, cancer diagnostic tests and treatment, HIV treatment and care quality, mental health, diabetes care, maternal and child health and many surgical procedures, among others [86]. More recent evidence from the USA outlines disparities in common healthcare quality measures, including '(a) experience of care, (b) preventive care, (c) chronic disease control, (d) hospitalisations, (e) obstetrics, and (f) behavioural health' [89]. For many health issues, these disparities are associated with poorer health outcomes, including higher mortality rates [86]. The widespread existence of health disparities represents the failure of healthcare systems to respond to the unique needs of patients at multiple, interconnected levels, including healthcare policies, systems, care processes and clinician behaviour [89]. Because of this perceived healthcare system failure, various healthcare system responses have been suggested. Cultural competence is one of these.

Healthcare disparities experienced by ethnic and racial minority groups came to be considered a primary driver of cultural competence for various reasons [90–94]. Recognition of disparities in healthcare access, treatment and quality led to their identification as a central aspect of cultural competence discourses early in its evolution. The seminal monograph by Cross et al. discussed inequalities in treatment and access experienced by several different ethnic and racial minorities in the USA and the need for healthcare systems to respond [95]. The report *Unequal Treatment* also proposed cultural competence training and education as a primary strategy to address healthcare disparities.

The sources of widespread and persistent healthcare disparities experienced by racial and ethnic groups are complex and multifaceted. They are bound to historical and contemporary social disadvantage, but these social inequities then interact with a range of variables on the patient level, provider level and system level that can cause racial and ethnic disparities in healthcare [86]. Patient-level attributes that affect healthcare disparities include patient preferences, poor treatment adherence, delay in seeking care and treatment refusal. Factors such as the appropriateness of care and cultural differences between healthcare providers and recipients, patient mistrust of providers and healthcare systems, miscommunication and misunderstanding in the clinical encounter and previous personal and collective negative healthcare experiences all are recognised as potential contributors to these patient-level variables [86].

Provider- and care process-level variables that contribute to healthcare disparities include provider bias, such as patient stereotypes, and greater levels of clinical uncertainty when interacting with minority patients [96]. *Unequal Treatment* identified a lack of direct evidence to demonstrate the effect of provider bias on healthcare quality and treatment for minority patients [86]. However, over the years, evidence of the presence of bias in healthcare systems and among providers and its impacts on healthcare disparities has grown. System-level factors include availability and the ways in which health systems are financed and organised. System-level contributors include geographical differences in the availability of healthcare services and resources and the impact of language barriers, particularly in the absence of interpretation and translation services [86].

2.3.1 The Role of Bias in Healthcare Disparities

Racial bias at structural, institutional and interpersonal levels [97] produces healthcare disparities through multiple pathways. Racial bias occurs in policies, legislation and the allocation of resources within and between institutions, as well as the individual behaviour of health professionals [89]. Racial bias among health providers, operating explicitly or implicitly without intention or awareness [97, 98], has received the most attention. Through the use of tools such as Implicit Association Tests (IATs), strong evidence has been gathered to demonstrate the existence of implicit racial and skin tone bias among health professionals [99–101]. Not only do healthcare practitioners frequently demonstrate pro-white bias [99, 102], but they also commonly hold stereotypes about non-white patients, such as implicit stereotypes of black Americans as less cooperative with medical procedures [100]. Research into provider trust in patients showed that primary care physicians reported lower levels of trust in patients of non-white race-ethnicity independent of other factors [103]. Research also shows that health provider implicit bias exceeds and is disassociated from self-reported and explicit bias [99, 100], except among African American medical practitioners who do not register as holding implicit racial bias [99].

Provider racial bias affects healthcare interaction and outcomes in various ways. A literature review examining evidence of implicit racial/ethnic bias among healthcare professionals and its influence on healthcare outcomes found that healthcare provider bias affected the nature of patient-provider interactions, treatment decisions, treatment adherence and patient health outcomes [104]. Racial and ethnic bias of health practitioners directly affects individual clinician behaviour [105]. There is particularly strong evidence for the negative influence of provider implicit bias on several indicators of poor provider communication and patient interactions [106]. Research found that physicians provide less information and supportive talk to patients of black and Hispanic backgrounds [86]. Further research shows that white doctors often behave in ways associated with poorer health outcomes when

interacting with minority groups, including non-verbal behaviours such as behaving in a disengaged manner [107]. Greater levels of implicit bias among health professionals are associated with lower levels of information provision [88], shared decision-making [34] and low patient ratings of healthcare [106, 108]. Poor communication dynamics accompanying provider implicit bias also demonstrate adverse impact on subsequent treatment adherence [109]. Provider implicit racial and ethnic bias appears to matter less in routine care. Yet, bias can affect clinician decision-making more in complex clinical decisions involving uncertainty and that are influenced by provider trust in patients [87, 89, 110].

There is very strong evidence to demonstrate that while healthcare providers commonly acknowledge disparities in healthcare treatment, it is rarely considered that these disparities exist within their own practice. Studies show that levels of agreement on the presence of overall racial disparities in healthcare range from 88% to 13% among healthcare providers. Yet, the percentage of providers who agree that these same disparities occurred in their own healthcare settings or among patients in their care is between 40% and 3% [111–114]. Furthermore, health practitioners are most likely to perceive that patient factors are responsible for healthcare disparities and are less likely to name provider factors as contributors.

There are differences in reporting of system-level factors [111–115]. In one study, the majority of respondents even questioned the validity of studies reporting racial healthcare disparities [115]. Likewise, a more recent study demonstrated that white nurses were more likely to believe that genetic factors contribute more to health disparities, compared to black nurses who were more likely to attribute health disparities to external factors such as discrimination in society [116].

Perceptions on the sources of disparities also change as people go through their medical studies and move into the field. A study by Wilson et al. found that, in general, medical students were more likely to perceive unfair treatment of patients than physicians and that first-year students were more likely to see this inequity than fourth-year students [117]. Minority medical students and physicians were more likely than white students and physicians to perceive unfair treatment. This study indicates that a decline in perceptions of healthcare treatment disparities might be the result of the process of acculturation to the medical profession [117]. Another study examined the factors contributing to changes in student implicit bias over the course of their medical degree. This study found that factors which significantly predicted increased implicit racial bias among students included hearing negative comments from attending physicians or residents about African American patients and having unfavourable versus very favourable contact with African American physicians. However, the completion of a black-white Implicit Association Test during medical school was a statistically significant predictor of decreased implicit racial bias among medical students [118].

Provider perceptions of the causes of healthcare and health disparities are of utmost importance because of their potential effects on the behaviour of health practitioners and the role these could play in either sustaining or reducing disparities. If providers believe that health disparities are caused by patient factors rather than

provider- or system-related factors, they can be less willing to look at and change their own beliefs and behaviours or to address the healthcare system itself which contributes to disparities [116]. Few institutional efforts to address healthcare disparities have been documented, and even fewer have reported efforts taken to investigate potential disparities in health provider's personal practice [119]. Greater effort in research and provider education and training is needed to address these issues of provider bias and provider misconceptions of healthcare and health disparities. There is currently greater research on patient-related factors contributing to disparities than provider-related factors [87]. Rather than the dominant focus on patient characteristics, some researchers argue that we need to shift the focus to understanding provider characteristics that contribute to disparities [102] and that this needs to be addressed through education and training of the health workforce [102]. Cultural competence education and training needs to highlight evidence that demonstrates the persistence of healthcare disparities even after controlling for patient factors and the prevalence of implicit bias and its impact on healthcare [115].

To properly examine the impact of racial bias on healthcare inequity necessitates looking beyond individual bias to understand the systemic nature of racism [13] and how racial bias and inequalities occurs within social institutions, including medicine [120]. The reality is that healthcare disparities are likely caused by multiple interacting factors. The relative influence of both provider and patient factors differs depending on the specific disparity measure. Some healthcare measures are more clearly determined by clinicians, whereas others, particularly those involving patient adherence and self-management, are influenced more by patient factors such as social disadvantage and constraints [121]. Moreover, both clinician- and patient-related factors are also heavily influenced by factors on health organisation and broader healthcare and macro environmental levels [89]. Implicit bias among healthcare staff can be reinforced by structural bias, such as differentiated care for private and clinic patients which results in minority patients receiving healthcare by less qualified and experienced staff [89].

2.3.2 The Social Determinants of Health

One thing made clear throughout the literature on racial and ethnic healthcare disparities is the central role that broader social disadvantage plays in healthcare disparities. The seminal report 'Unequal Treatment' identified that it can be difficult to distinguish between socioeconomic status and race/ethnicity when looking at healthcare disparities [122]. In their recent paper on racial and ethnic healthcare disparities in the USA, Fiscella and Sanders identified that although there are large disparities based on race or ethnicity, the most substantial healthcare disparities are based on income differences [89]. The paper identified numerous ways in which broader social disadvantage impacts on healthcare outcomes for minority ethnic and racial groups through structural and geographical barriers such as being uninsured, underinsured, and unable to cover the cost of healthcare [89].

Acknowledgement of the influence of broader social disadvantage on racial and ethnic health disparities calls for the need to encompass factors such as socioeconomic status and social class in cultural competence education [122]. Minority race and ethnicity are frequently conflated with multiple other dimensions of social disadvantage which contribute to poorer health. This is particularly so for groups historically subjected to slavery and forced relocation (e.g. African Americans and Indigenous peoples) [89]. Higher levels of poverty; lower levels of education, employment, health literacy and English proficiency; and ongoing experiences of racism all contribute to social disadvantage. This social disadvantage is then associated with a range of healthcare barriers such as poorer healthcare access, unaffordability and lower care quality [89]. Social disadvantage also impacts negatively on healthcare encounters and clinician and patient decision-making [89].

Disparities in healthcare quality and treatment are intermingled and crossed over with broader health and social inequalities. The disproportionate burden of disease and health disparities experienced by many ethnic and cultural minority groups is often identified as a driver of cultural competence alongside healthcare disparities [3, 76, 90, 94]. However, while important, disparities in healthcare treatment only account for a small percentage of the overall racial and ethnic disparities in health outcomes. Studies have found that the relative contribution of healthcare is between 10% [123, 124] and 20% [125] with social determinants of health accounting significantly more for health outcomes [126].

The term commonly employed to describe this web of non-medical political, economic, social and cultural factors which impact health and wellbeing is the social determinants of health [127]. Social and health inequalities are structural, primarily resulting from differential life circumstances caused by unequal access to power and resources [128], both between [129] and within nations [130]. The manifold and complex social determinants are conceptualised as operating on multiple levels. *Proximal determinants* are those most visible, such as access to employment, income and education, food security, health behaviours and physical and social environments. *Intermediate determinants* create proximal determinants and include social institutions and policies; education, healthcare and labour systems; community capacity, resources and infrastructure; and capacity for cultural continuity and environmental stewardship. Lastly, *distal determinants* are the economic, social and political contexts within which proximal and intermediate determinants are situated, such as colonialism, racism, social exclusion and a lack of self-determination [131]. They are the underlying 'causes of causes' for unequal and unjust life circumstances for particular groups of people compared to others [132].

Because of their breadth and complexity, it is beyond the scope of this book to explore the social determinants of health in detail. However, in the next section, we include a brief discussion of two important determinants of health, which are particularly pertinent to cultural competence: racism and colonisation. These are particularly relevant not only because of their impact on key population groups concerned but because, as distal determinants, they can be considered as fundamental factors underlying a wide range of other determinants.

2.3.3 *Racism as a Social Determinant of Health*

Racism is a significant aspect of social inequality [133] and is one social determinant of health that is very relevant in the context of cultural competence. Numerous studies have reported on perceived racial discrimination experienced by varied minority groups in healthcare settings [12, 134–139]. Racism, in its many guises, potentially has a greater impact on health and healthcare disparities than culture [140, 141]. It operates at individual, cultural and institutional levels. On each level, racism can exhibit overtly or covertly and intentional or unintentional. In fact, research evidence from around the world demonstrates that over the past half century 'racism has progressively become less blatant and overt, and more subtle and covert' (p. 16) [59].

Racism manifests in various forms. Institutional racism refers to the way that societies' educational, economic, justice and healthcare institutions or organisations disadvantage certain groups and result in racist consequences [59]. Institutional racism plays out in various forms in healthcare including funding inequity, differing performance criteria and differences in treatment regimens [142]. Many authors argue for the need to examine racism within the culture of biomedicine [11], which is seen as central to the maintenance and propagation of stigma in medical institutions and among health professionals [6]. Cultural racism on the other hand refers to widespread beliefs about essential racial differences that favour a dominant group over minorities, accumulating in a common racist worldview [59]. Individual racism is distinguished by the belief in the inferiority of a group based on physical traits, which are further believed to be indicative of behaviour or intrinsic qualities. While individual racism is very often indirect and concealed behind a veil of acceptance and tolerance [143], research evidence demonstrates the prevalence of interpersonal racism and its impacts on health and healthcare. One systematic review found statistically significant evidence of racist beliefs, emotions or practices among healthcare providers concerning minority groups [144]. In healthcare settings, greater perceived racism, as well as higher medical mistrust, correlates with lower satisfaction with healthcare among participants [145].

On an individual level, experiences of racism have been associated with poorer self-reported health [141] and higher psychological stress [137]. In a systematic review of self-reported racism and ill-health, a consistent link was found between racism and negative mental health outcomes and other health-related behaviours [146]. In a later meta-analysis of 293 studies examining the health impacts of reported racism, racism was associated with poorer mental health and general health outcomes [147]. Additionally, factors such as sex, age, education level and place of birth did not appear to change the effects of racism on health [147]. Interestingly, research exploring the relationship between ethnic identity and experiences of racial oppression on self-reported health for ethnic minority people found that only experiences of racism, perceived racial discrimination and class demonstrated a strong independent relationship with health, not ethnic identity [148]. Karslen and Nazroo found that people reporting experiences of racial harassment and those who

perceived the persistence of racist attitudes among employers have significantly increased risk of reporting fair to poor health [148]. This points to the need for more research exploring the impacts of racism on health and healthcare in its various manifestations. Indeed, if cultural competence does truly aim to address disparities in health and healthcare, racism and racial bias in healthcare systems and among healthcare professionals, as well as in other social institutions and broader society, might be one of the most important considerations to address.

2.3.4 Colonisation as a Social Determinant of Health

Colonialism is widely considered to be a principal determinant of health disparities for Indigenous people [132, 143, 149, 150]. Colonisation has had devastating impacts on aspects of Indigenous culture which are core to Indigenous health and wellbeing. When working to address health and healthcare disparities among Indigenous peoples, it is important to understand that there are key distinctions between mainstream and Indigenous understanding of the social determinants of health [43, 151]. In particular, the many varied and interconnected determinants of health affecting Indigenous communities can only be understood in the context of colonisation, its associated dispossession, assimilation attempts, systemic racism and denial of citizenship rights which resulted in continuing unequal power relations, intergenerational trauma in all its forms and other colonial legacies [127]. For example, by prohibiting the practice and sharing of core cultural practices such as language, ceremony, songs and dances, which connected people to their traditional lands, ancestors and kin, assimilation attempts have had a devastating impact on the social and cultural fabric that wove Indigenous peoples' identity together [152, 153]. The forced acquisition and widespread destruction of Indigenous peoples' lands is another aspect of colonisation with significant harmful health impacts [143]. For Indigenous people, the physical environment is inseparable from concepts of culture, health and wellbeing. Some argue that the environmental disposition experienced by Indigenous people around the world is at the core of the health and social inequities experienced by many Indigenous communities today [153]. Indeed, the loss of and severance of Indigenous peoples' connection to land are seen by some to be the largest contributing factors impacting cultural stress within Indigenous communities [154].

Colonialism remains a foremost determinant underlying health disparities experienced by many cultural and ethnic minorities. While most often associated with Indigenous peoples, much of the historical and contemporary experiences of other populations are closely related to similar colonial practices. For instance, the Atlantic slave trade displaced large populations of African descent across the Americas who suffer from cultural and language suppression and land insecurity and experience social and health inequalities [143]. While often seen as historical, these colonial processes are embedded in continuing social realities, policies and practices [155]. Various socio-political factors resulting from colonisation create

barriers to healthcare and directly have damaging effects on the health status of Indigenous people [156] and other minority groups. Colonisation is also a fundamental factor underlying interactions between Indigenous people and health practitioners, services and systems which have been created within and shaped by colonial systems of governance [12]. Such experiences underlie both primary drivers of cultural competence.

2.4 The Centrality of Power, Voice and Control

At the root of the framework, systemic power differences underlie both sociocultural differences and healthcare disparities. These power differences are reflected throughout cultural competence discourses in a variety of ways. Cultural competence, like all concepts, has been constructed in the context of relationships of power [48]. Cultural competency models were largely created within frameworks based on dominant group norms and founded on assumptions and ideas about individuals who differ from the majority group [157]. Power dynamics are evident in cultural competence discourses where the focus is on patients' culture, and those different to the dominant group, instead of a self-reflective approach. The prevailing attitude among healthcare providers that disparities in healthcare treatment are primarily caused by patient, rather than provider factors, mirrors and further contributes to unequal power dynamics. This is further reflected in the literature which frames racial healthcare disparities according to patient race rather than factors such as the racial stereotypes and biases of health professionals [102]. Issues related to power and control are seen in healthcare encounters through medical staff having control over the topics, timing, structure, language and style of discourse, as well as the dominance of Western biomedical knowledge and discourses [70].

Cultural competence interventions ought to focus on challenging and changing unequal power dynamics in healthcare in their manifestations at different levels of the healthcare system. Power differentials are seen in the core discourses and fundamental assumptions about what constitutes health and wellbeing and how this can be measured. For instance, there is a debate in the field of Indigenous health and wellbeing in Australia as to whether statistical equality should be prioritised as a primary goal towards Indigenous development. This debate highlights an ongoing tension between a focus on achieving statistical equality and the prioritisation of maintaining culturally informed differences in aspirations and life choices [158]. Healthcare systems, healthcare encounters and cultural competence approaches are all embedded in processes and discourses of power and struggles for control and representation of marginalised groups. Because of their centrality, issues of power and control should be considered at the centre of all efforts to improve cultural competence.

2.5 Summary: Complexity in the Cultural Competence Conceptual Landscape

Within the literature on cultural competence in healthcare and medical education, the two main drivers of cultural competence are frequently intermingled without proper explanation or expressed consideration of the complexities and contentions. It is not uncommon for cultural competence literature to utilise various conceptual drivers concurrently when explaining the relevance of cultural competence [3, 76, 90, 159]. In the introductions of many published papers on cultural competence, the authors discuss in varying order the significance of population diversity, cultural differences and the unacceptable healthcare disparities and health inequities experienced by many racial and ethnic minority populations. While these issues are certainly relevant to healthcare quality and appropriateness, it is problematic that they are frequently linked together without adequate evidence or conceptual explanation. This can cause confusion because there is no clear conceptual or theoretical framework which is consistently used to explain how these drivers relate to each other. For example, Betancourt et al. stated that cultural competence has been identified as a key strategy for eliminating racial/ethnic disparities in healthcare and thereby improving health outcomes. However, this is said to be achieved through acknowledging and responding to differences in patients' values, preferences and behaviours and by adapting services to meet culturally unique needs [94].

Early theorists in cultural competence hypothesised that by increasing practitioner awareness of cultural factors affecting patients' engagement with health services, the relationship between health professionals and patients could be improved and, through this, positive changes in ethnic and racial healthcare disparities effected [5]. Brach and Fraserirector developed a conceptual model of how cultural competence 'techniques could theoretically improve the ability of health systems and their clinicians to deliver appropriate services to diverse populations, thereby improving outcomes and reducing disparities' [3]. The conceptual model theorised how the cultural competence techniques outlined might be able to impact both provider and patient behaviours. It was hypothesised that improvement in communication and increased trust, as well as improved provider understanding of patients' cultural behaviours and environment, would help to create positive behaviour changes. It was further proposed that these changes in provider and patient behaviours would lead to the delivery of more appropriate and quality services, such as culturally relevant treatment options, better informed diagnoses and culturally tailored health education and treatment regimens to increase treatment adherence. The provision of more appropriate services was then thought to improve other healthcare and health outcomes [3]. By this logic, cultural competence came to be seen as a strategy for reducing healthcare disparities and, by extension, health inequities experienced by racial and ethnic minorities [85]. However, the assertion that cultural competence is an effective strategy for reducing racial and ethnic health and healthcare disparities

has been criticised as misguided, under-theorised and lacking a sufficient evidence base [157]. Brach and Fraserirector's conceptual model was developed more than 15 years ago. However, there is still no coherent evidence base to determine the effectiveness of cultural competence strategies on healthcare disparities and health outcomes. Some cultural competence interventions have been associated with positive healthcare outcomes [159]. However, there is limited research exploring the impacts of cultural competence interventions on specific disparities in healthcare treatment good or otherwise [86, 89].

Another key problem associated with conflating the issues of healthcare disparities and health inequity with cultural factors in cultural competence is that these issues bring in a whole range of other factors related to social disadvantage and discrimination which go much beyond culture [7]. Discussing the failure of mental healthcare systems to provide adequate and appropriate care to young people experiencing mental health problems, Cross et al. say:

> If you are an adolescent and Black and you are seriously emotionally disturbed, chances are you will end up in the juvenile justice system rather than in the treatment setting to which your Caucasian counterpart would be referred… If you are a Native American child and seriously emotionally disturbed, you will likely go without treatment or be removed legally and geographically from your family and tribe… If you are a child who is Hispanic and seriously emotionally disturbed, you will likely be assessed in a language not your own… And if you are an Asian child and seriously emotionally disturbed, you will likely never come to the attention of the mental health system… In short, if you are a racial minority of colour, you will probably not get your needs met in the present system. Yet, you are more likely to be diagnosed seriously emotionally disturbed than your Caucasian counterpart. When you do make it into the system, you will experience more restrictive interventions. Cultural traits, behaviors, and beliefs will likely be interpreted as dysfunctions to be overcome. The data are clear: the system of care provides differential treatment to minority children in various service systems. [95]

Here Cross et al. makes reference to a range of healthcare disparities as well and broader systematic discrimination [95]. Yet, cultural competence is the proposed strategy to respond to these complex issues. Factors such as provider and healthcare system bias and stereotyping, historical and ongoing experiences of racism and discrimination and social determinants of health do not necessarily concern culture. Some believe that to diminish the multifaceted and complex nature of racial and ethnic disparities in health and healthcare treatment under the banner of culture is dangerous because it obscures structural disadvantage and interpersonal and institutional racism [14]. This is especially evident in healthcare workforce training and education approaches where understanding the impacts of factors such as provider bias and racism has been replaced by a focus on culture to explain racial and ethnic inequality, an approach which is considered to be fundamentally flawed [160]. Limitations in cultural competence constructs, frameworks and approaches, such as not directly addressing race-based discrimination and bias and perpetuating limited notions of culture and disparities, call into question whether cultural competence is an appropriate framework for healthcare that is inherently focused on social justice [16].

2.6 Conclusion

There is a need to more explicitly acknowledge that culture is just one part of the puzzle of cultural competence. There are range of other important factors to be considered which also deserve attention. Different influences that contribute to the structural determinants of health include ethnicity, class and socioeconomic positioning, gender, social location and historical oppression. Some have argued that cultural competence takes valuable attention, which would be better spent addressing the social determinants of health [157]. Other approaches to reducing healthcare and health disparities which more directly target key issues that create them could be given greater consideration. For example, public health interventions to counter racism have shown promise in improving certain health outcomes for minority groups [161].

Cultural competence might be an appropriate approach for addressing healthcare and health disparities if these complexities and contentions can be made explicit and addressed in cultural competence interventions. The concept of intersectionality could be used to analyse how these multiple different influences interact to influence health, health behaviours and healthcare system encounters. Intersectionality encourages a focus on the interrelatedness of different social categories, which are associated with poorer health outcomes, and acknowledges the role of power dynamics across social institutions in experiences of advantages and disadvantages [162]. This is one approach to counter the propensity of health inequities research to focus on different aspect of inequality in isolation and instead move to a greater focus on the structural drivers of inequality.

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Chapter 3
Methods

3.1 Introduction

This book is based on the results of a rapid systematic review of the literature to identify publications on cultural competency interventions in healthcare for Indigenous peoples and other minority ethnic groups in the CANZUS nations [1]. The review aimed to determine the intervention strategies and indicators that have been applied to increase cultural competency in healthcare and identify the outcomes of those interventions. These four countries were chosen because they have similar colonial settler histories and legacies of English common law, political governance, language, settlement and culture and healthcare systems [2].

3.2 Inclusion/Exclusion Criteria

Studies in this review included peer-reviewed and grey literature published in English from January 1, 2006, to December 31, 2015, inclusive. Publications were included if the following criteria were met:

1. The study was from Australia, Canada, New Zealand or the USA.
2. The study was focused on cultural competence as it pertains to Indigenous or other minority ethnic groups.
3. The study evaluated an intervention designed to improve cultural competence in healthcare (i.e. hospitals, primary healthcare settings, specialist healthcare, private practice and community health settings).

C. Jongen et al., *Cultural Competence in Health*, SpringerBriefs in Public Health,
https://doi.org/10.1007/978-981-10-5293-4_3

3.3 Search Strategy

The search strategy employed for the review comprised seven steps. Our first search was conducted in 2012, for the period 2002–July 2012, and a search update in 2016 was conducted for the period 2012–2015. We decided to revise the start date of the review to 2006 following the US comprehensive review of cultural and linguistic competence in healthcare by Goode, Dunne and Bronheim [3]. Figure 3.1 reports summaries of search 1 and search 2.

Step 1: In 2012, an expert librarian (MK) searched 17 relevant electronic databases. 1135 references excluding duplicates were identified for screening.

Step 2: Relevant grey literature in clearinghouses and websites of relevant organisations in each of the four countries were searched for additional literature (including government and agency reports). Thirty further publications were identified.

Step 3: The reference lists of seven reviews were examined manually. At this step, an additional six studies were identified for inclusion.

Step 4: The 1171 references identified were imported into EndNote and their abstracts manually examined for first screening, with 51 intervention studies meeting the inclusion criteria.

Step 5: Steps 1–4 were repeated again in June 2016 in a search update. The search terms used were modified slightly to capture further relevant literature. Some websites previously searched were no longer operational, so other websites and clearinghouses were identified (see Fig. 3.1, search 2). The updated search identified 1511 references from the electronic database search and an additional 16 from the grey literature. All of the 1527 references identified were imported into EndNote and their abstracts examined manually. Twenty-six intervention studies met the inclusion criteria. The reference lists of an additional four literature reviews revealed further 16 studies for inclusion.

Step 6: Following the updated search, a decision was made to include only studies published between the years 2006 and 2016. The timeframes were selected because of the availability of the review by Goode et al. for the US National Centre for Cultural Competence [3]. The Goode et al. review was based on a structured search of the literature (1995–2006) and identified the evidence base for the impact of cultural and linguistic competence in health and mental healthcare on health outcomes and wellbeing and the costs and benefits to the system. Our exclusion of studies covered by the Goode et al. review period pre-2006 resulted in 29 studies being excluded, leaving a total of 64 studies for final inclusion. See Fig. 3.2 for search strategy flow chart.

Step 7: The 29 studies had a natural fit with four intervention types. They were categorised as (1) *health workforce development interventions to improve*

cultural competence (n = 16), (2) *cultural competence education and training interventions for health and medical students* (n = 16), (3) *programs and services to improve cultural competence in healthcare* (n = 22) and (4) *health organisation and system cultural competence interventions* (n = 10).

SEARCH 1

A) Electronic Database search: Indigenous Australia; Indigenous Studies Bibliography: AIATSIS; ATSIHealth; APAIS-ATSIS; FAMILY-ATSIS; Informit Indigenous Collection; Campbell Library; EBM Reviews/Cochrane DSR/ACP Journal club/DARE; PsycINFO; PsycEXTRA; Medline; Embase; CINAHL; Global Health; PAIS; Sociological Abstracts.

Separate searches for each database for the time period, 2002- 2012 (July) using database specific subject headings and keywords:

Search strategy: Search of databases using the appropriate subject headings in each database as well as keywords for the following search groups:

1. Health professionals OR health care providers OR health workers OR health administrators OR health workforce OR nurses OR doctors OR allied health workers OR medical practitioners OR health services OR primary care OR private practice OR community health OR hospitals
2. Aborigin* OR indigenous OR native OR inuit OR maori OR torres OR first nation* OR ethnic OR immigrant OR migrant OR "culturally and linguistically diverse populations" OR "vulnerable populations" OR "diverse"
3. Cultural competenc* OR cultural sensitivity OR cultural safety OR cultural security OR cultural awareness OR cultural literacy OR cultural respect OR cultural framework OR cross-cultural OR inter-cultural OR cultural difference OR inter-racial OR racism OR discrimina* OR competence
4. Indicators OR measures OR intervention OR policy OR policies OR program* OR evaluation OR training OR assessment OR strategy OR strategies OR "indicators of cultural competence"
5. Health service outcomes OR population health outcomes OR equitable access OR health disparities OR patient satisfaction OR quality of health care OR delivery of health care OR clinical competence OR outcome assessment OR health indicators
6. Australia OR Canada OR USA OR New Zealand
7. 1 AND 2 AND 3 AND 4 AND 5 AND 6

B) Websites manually searched

- Australia: Indigenous HealthInfoNet; Closing the Gap Clearinghouse; NSW Ministry of Health. Aboriginal health.
- Canada: The National Collaborating Centre for Aboriginal Health; National Aboriginal Health Organization.
- New Zealand: Maori Health
- USA: American Indian Health.

Web search strategy

Using keywords and/or the appropriate topic headings in each website, I searched:

- Cultural competency OR cultural
- Health
- 1 AND 2
- Web search engine MedNar to locate grey literature using the search terms "cultural competency" AND (indigenous or aborigin* or native) AND health.

Search 1 = 1171 publications (after electronic removal of duplicates)

Fig. 3.1 Search strategy 1 and 2

SEARCH 2

A) Electronic Database search: Indigenous Australia; Indigenous Studies Bibliography: AIATSIS; ATSIHealth; APAIS-ATSIS; FAMILY-ATSIS; Informit Indigenous Collection; Campbell Library; EBM Reviews/Cochrane DSR/ACP Journal club/DARE; PsycINFO; PsycEXTRA; Medline; Embase; CINAHL; Global Health; PAIS; Sociological Abstracts).

Separate searches for each database for the time period, 2012 – 2015 (December) each database using database specific subject headings and keywords:

Search strategy: Search of databases using the appropriate subject headings in each database as well as keywords for the following search groups:

1. health professionals OR health care providers OR health workers OR health administrators OR health workforce OR nurses OR doctors OR allied health workers OR medical practitioners OR health services OR primary care OR private practice OR community health OR hospitals
2. indigenous OR aborigin* OR Torres Strait Islander OR Native Americans OR native OR inuit OR maori OR torres OR first nation* OR ethnic OR immigrant OR migrant OR "culturally and linguistically diverse populations" OR "vulnerable populations" OR "diverse" OR african american OR black american OR latin* american OR marginalis*
3. cultural competenc* OR cultural sensitivity OR cultural safety OR cultural security OR cultural awareness OR cultural literacy OR cultural respect OR cultural framework OR cross-cultural OR inter-cultural OR inter-racial OR racism OR discrimin* OR competence
4. indicators OR measures OR intervention OR policy OR policies OR program* OR evaluation OR training OR assessment OR strategy OR strategies OR "indicators of cultural competence"
5. health service outcome OR population health outcome OR equitable access OR health disparities OR patient satisfaction OR client satisfaction OR customer satisfaction OR consumer satisfaction OR quality of health care OR delivery of health care OR clinical competence OR outcome assessment OR health indicators
6. Australia OR Canada OR USA OR New Zealand
7. 1 AND 2 AND 3 AND 4 AND 5 AND 6

B) Websites manually searched

- Australia: Indigenous HealthInfoNet; Closing the Gap Clearinghouse; NSW Ministry of Health.
- Canada: The National Collaborating Centre for Aboriginal Health; Health Council Canada
- New Zealand: Maori Health; Whakauae: Research for Maori Health and Development
- USA: Centres for American Indian and Alaska Native Health; Think Cultural Health Clearinghouse; US National Centre for Cultural competency

Web search strategy the same as search 1

Search 2 = 1527 publications (after electronic removal of duplicates and references identified in step 1)

Fig. 3.1 (continued)

3.3.1 Identification, Screening and Inclusion of Publications

The combined results for both searches were imported into the bibliographic citation management software, EndNote X7 with duplicates removed. Titles and abstracts of the remaining publication titles and abstracts in the first search were screened by one author. A second author retrieved and screened titles and abstracts of the remaining publications from the second search; those which did not meet inclusion criteria were excluded. The full texts of the remaining publications were

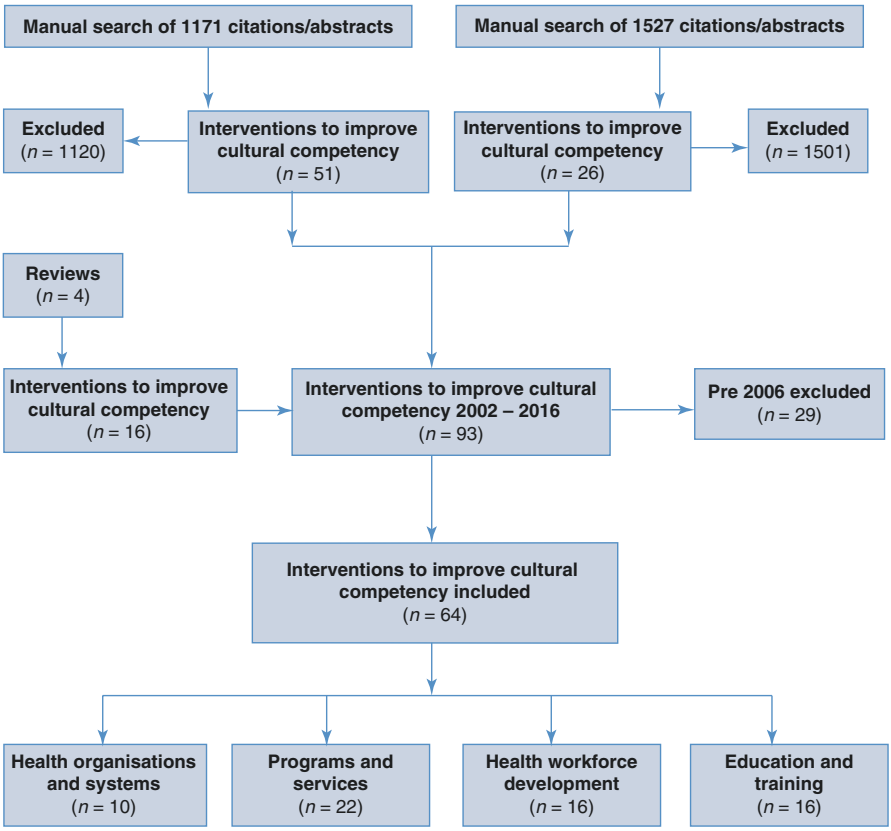

Fig. 3.2 Flowchart of search strategies

retrieved and screened by blinded reviewers. Inconsistencies in reviewer assessments were resolved by consensus.

3.3.2 Data Extraction and Analysis

Data were extracted from the full texts of studies including publication authorship, year and type, country, population and sample size, intervention setting, intervention type and strategies, study design, outcome measures and outcomes reported. Thematic analysis methods [4] were used to identify key themes in interventions strategies, outcomes and measures across evaluations. These analyses are reported in the following four chapters. The quality of included quantitative studies was assessed using the Effective Public Health Practice Project quality assessment tool [5]. Qualitative studies were assessed using the Critical Appraisal Skills Programme

quality assessment tool [6]. The chapters in this book reporting the results of this systematic review are drawn from journal articles previously published in peer-reviewed journals by the authors [7–10]. Data extraction tables for each publication are summarised and available in these published papers.

3.3.3 Limitations of the Review

The methods used to review this literature and establish the findings have limitations. The publications in this review were identified with a non-exhaustive search strategy designed to produce the bulk of peer- and non-peer-reviewed health studies that described or evaluated cultural competence interventions (2006–2016). It is possible that some relevant publications were missed, particularly those published in the grey literature and book chapters which are more difficult to systematically search than the peer-reviewed journal articles. However, given the two-step strategy of searching electronic databases and reference lists of reviews, it is highly likely that the studies represented in this review are representative of published cultural competence research from the CANZUS nations. Relevant intervention evaluations may have been misclassified; however, a high level of agreement between blinded coders suggests not. Evaluations with statistically significant findings are more likely to be published; hence it is possible that the published evaluations reviewed overestimate the true intervention effectiveness [11].

Finally, Greenhalgh critiqued systematic reviews in relation to today's complex and multifaceted health challenges because they leave many broad questions unanswered [12]. She claimed that 'The technical process of stripping away all but the bare bones of a focused experimental question removes what practitioners and policymakers most need to engage with: the messy context in which people get ill, seek health care (or not), receive and take treatment (or not), and change their behaviour (or not)' (p. 571). Greenhalgh's argument suggests that any application of the strategies outlined in this book should be carefully tailored to the discrete (messy) contexts in which they might be implemented.

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Chapter 4
Health Workforce Development Interventions to Improve Cultural Competence

4.1 Background

Health professionals and the knowledge, attitudes, skills and behaviours they bring to the healthcare encounter have a major impact on patients' healthcare experiences. Research studies demonstrated how cultural and linguistic differences between health professionals and health service users can influence healthcare and patient experiences. Differences can result in issues such as miscommunication [1], loss of trust [2], decreased sense of satisfaction and feelings of disempowerment [3] among service users. Perhaps because of the central role of health practitioners in shaping patient healthcare experiences, improving health professionals' cultural competency is one of the oldest and most predominant cultural competency strategies [4, 5]. Intervention efforts to improve the cultural competence of the health workforce generally focused on providing education and training in the knowledge, attitudes and skills needed to work effectively in cross-cultural clinical encounters [5]. Key in these efforts are developing understandings of the role culture plays in shaping behaviour and increasing respect and acceptance of cultural differences. Education and training efforts also focused on increasing practitioner capacity to work effectively within cross-cultural contexts by teaching adapted and culturally specific approaches to providing healthcare. An ongoing process of developing awareness of one's own cultural influences, personal prejudices or biases, thoughts and sensations was also central to the types of cultural competence strategies in the health workforce [6–9].

One approach advocated in the early days of cultural competence was categorical approaches towards improving practitioner cultural competence. Categorical approaches involved providing information specific to particular cultural, ethnic or racial groups. This included things such as descriptions of common health beliefs, values, attitudes and behaviours among ethnic groups and suggested *do's*

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and *don'ts* for the clinical encounter [5]. However, this approach was soon recognised as inadequate and problematic for several important reasons. First, the expectation that health practitioners could be familiar with all cultural perspectives that they might encounter especially given the extent of cultural, ethnic, religious and national diversity present in many countries was not feasible [5, 10, 11]. Second, categorical approaches are critiqued for oversimplifying and misrepresenting culture as a fixed and static phenomenon [12] without regard for its fluid and dynamic nature [11, 13, 14]. Evidence suggests that this approach can increase stereotyping and cultural misunderstanding [5, 10, 12] giving little attention to intra-group variability [14]. Lastly, categorical approaches are critiqued for failing to account for the impact of factors such as acculturation (see Chap. 2, p. 4) and socioeconomic status on individual experiences and expressions of culture [5].

The other key strategy used in cultural competency education and training is the cross-cultural approach. This approach addresses some of the key concerns associated with categorical approaches. It teaches generic knowledge, attitudes and skills that can be applied to any cross-cultural situation [5, 11]. The types of knowledge, attitudes and skills central to cross-cultural training and education strategies are outlined in the models created by pioneers in cross-cultural medicine such as Berlin and Fowkes [15], Kleinman [16] and Leininger [17]. These include developing an understanding of health and illness in its biopsychosocial context, skills for eliciting patients' explanatory models of health issues and their causes and teaching strategies for negotiating shared understanding and facilitating participatory decision-making in creating treatment plans [10, 11]. A significant amount of cultural competence training focuses on the development of awareness, sensitivity, attitudes and knowledge. However, these cross-cultural models share a focus on skills for health practice. The importance of going beyond knowledge and awareness to focus on practice-specific skills and their translation into informed, concrete behaviour applied in the practice setting is widely recognised as key to effective cultural competence training [4, 9, 13, 18].

In the US Government's report, *Unequal Treatment* revealed the pervasive and persistent disparities in healthcare quality and treatment received by ethnic and racial minorities [19]. Cultural competency training for healthcare professionals was established as a core strategy for addressing these critical disparities [11, 20]. As discussed in Chap. 2, factors such as patient mistrust of health practitioners and systems, discrimination and provider bias were integrated in the discourse and scope of cultural competency training [10, 11]. The training incorporated acknowledgement and critical reflection on practitioner perspectives brought to the clinical encounter, such as the 'medico-centric' perspective passed on through medical education and professional training, and reflection on issues of power and privilege in professional status [10].

This chapter extrapolates the key themes in intervention strategies, reported outcomes and measures used to assess outcomes. It is based on a journal article, which

was in press at the time of writing this book. The article was written by the authors reviewing 16 studies [21–36] that were published between 2006 and 2016 and that aimed to increase cultural competence in the health workforce [37].

4.2 Characteristics of Workforce Development Interventions

We found 16/64 (25%) papers that met the inclusion criteria as intervention studies that evaluated health workforce development and training interventions to increase cultural competence. Of these 16 evaluation studies, seven were from Australia [21, 22, 24, 25, 29, 33, 38]; all focused on improving cultural competence for the benefit of Indigenous Australians. Eight papers were published in the USA, with three of these aimed at improving cultural competence for Latino or Spanish-speaking patients [31, 32, 36] and a further five studies addressing general cultural competence rather than for a specified cultural or ethnic group [27, 28, 30, 34, 35]. A single study from Canada also addressed general cultural competence for working with ethnically diverse patient groups [23]. The included studies targeted a range of different health professionals. Six targeted various health professionals [21, 24, 25, 27, 31, 32], five targeted general practitioners/physicians and medical residents/registrars [22, 28, 29, 35, 36], and two targeted training for nurses [23, 34]. There were three other studies, each targeting pharmacists and Aboriginal health workers [33], alcohol and other drug workforce [38] and ethnic minority faculty [30], respectively. Interventions were delivered in diverse practice settings including hospitals [24, 34, 36], area health services (including hospitals and community health clinics) [21, 31], a general practice [29] and various other health settings such as for diabetes care, mental health, alcohol and other drugs and e-health [23, 25, 27, 28, 33, 35, 38].

A detailed overview of intervention strategies and outcomes is provided in Table 4.1. The symbol ✓ denotes evidence that the author(s) explicitly advanced adoption or support of the element of cultural competence; ~ denotes an implicit or inferred reference consistent with the intent of that element; and x denotes no evidence for that element.

4.3 Cultural Competence Workforce Development Intervention Strategies

The 16 studies reviewed reveal two primary intervention strategies which can be used to improve the cultural competency of the health workforce. The two primary strategies seen across cultural competence workforce development intervention studies were discrete cultural competency training courses and professional development interventions aimed at improving the cultural competency of practitioners.

Table. 4.1 Characteristics of health workforce interventions to improve cultural competence

Publication	Aim	Intervention Strategies							Intervention Outcomes										
		Cultural Competence training			Professional Development		Delivery mode		Practitioner cultural competence outcomes					Healthcare/health outcomes				Other outcomes		
First Author year	Increased cultural competency	Cross-cultural approach	Categorical approach	Minimal detail	Other training	Mentoring/Supervision	Multiple sites	Single sites	Knowledge	Attitudes/Beliefs	Skills	Behaviour	Confidence	Patient satisfaction	Patient trust	Practitioner satisfaction	Health outcomes	Research productivity	Training completion rates	Improved readiness to provide cc care
Aboriginal Workforce (2015)	✓	x	✓	✓	x	x	✓	x	x	x	x	x	x	x	x	x	x	x	✓	x
Abbott (2014)	~	x	x	x	x	✓	~	x	~	x	✓	✓	✓	x	x	x	x	x	x	x
Brathwaite (2006)	✓	✓	x	x	x	x	x	✓	✓	x	~	x	x	x	x	✓	x	x	x	x
Chapman (2014)	✓	x	✓	✓	x	x	x	✓	✓	✓	x	x	x	x	x	x	x	x	x	x
Dingwall (2015)	~	x	x	x	✓	x	✓	x	✓	x	✓	x	✓	x	x	x	x	x	x	x
Hinton (2012)	~	x	x	x	✓	x	x	✓	✓	x	~	x	✓	x	x	✓	x	x	x	x
Khanna (2009)	✓	✓	x	x	x	x	✓	x	✓	x	✓	x	x	x	x	x	x	x	x	x
Kutob (2009)	✓	✓	~	x	x	x	✓	x	✓	x	✓	x	x	x	x	x	x	x	x	x
Liaw (2015)	✓	x	~	~	✓	✓	✓	x	~	✓	✓	✓	x	x	x	✓	x	x	x	✓
Lopez-viets (2009)	~	x	x	x	x	✓	x	✓	x	x	x	✓	x	x	x	x	x	✓	x	x
McElmurry (2009)	✓	x	✓	~	✓	x	✓	x	✓	✓	✓	~	x	x	x	~	✓	x	x	x
McGuire (2012)	✓	x	✓	x	x	x	✓	x	✓	x	x	x	x	x	x	x	x	x	x	x
McRae (2008)	✓	x	✓	✓	✓	x	✓	x	✓	✓	✓	x	✓	x	x	✓	x	x	x	x
Salman (2007)	✓	✓	x	✓	✓	x	✓	x	~	✓	x	x	✓	x	x	~	x	x	x	x
Thom (2006)	✓	✓	x	x	x	x	✓	x	x	x	~	✓	x	✓	✓	~	✓	x	x	x
Wu (2006)	✓	x	✓	~	x	~	x	✓	x	x	x	x	x	✓	x	~	x	x	x	x

4.3.1 Cultural Competence Training

Of the studies reviewed, 11 (69%) provided discrete cultural competency training courses to the health workforce as the primary intervention. There was significant variation in training approaches, frequency and duration which makes comparisons of intervention effects difficult (see the paper by Jongen et al. 2017, for further details on intervention characteristics). There were, however, also important commonalities and themes across studies, which provide insight into the strengths and limitations of current cultural competency training approaches.

For well over a decade, the cultural competency literature presented research documenting the limitations of categorical approaches to cultural competence training. Yet despite this, six [21, 24, 31–33, 36] cultural competence training studies still used a categorical approach focused on teaching about characteristics, beliefs and behaviours of particular population groups [21, 24, 31–33, 36]. For example, McGuire et al. evaluated a training program focused on factors which might affect patient-practitioner communication and care process for Latino patients [32]. The training covered factors such as barriers in accessing healthcare in the USA, differences in healthcare systems in Latin America and the USA, expectations of Latino patients seeking care, social and cultural constructs of health and illness in Latino cultures and common health beliefs and practices such as the use of complementary medicine [32]. Two instances where a categorical approach to cultural competency training can be appropriate and effective have been identified [11]. One instance is when the focus of training is on learning about the cultures of local-level populations facilitated by the involvement of community members [11, 13]. In the six studies using categorical approaches, only two involved community members to help teach about local-level populations [21, 32]. The other instance is when knowledge taught has a specific, evidence-based effect on healthcare delivery or patient outcomes. It was difficult to determine whether any of the included studies taught this type of knowledge. Aside from these two cases, it is recommended that practitioners focus on learning directly from patients about their own sociocultural perspective and avoid generalisations about cultural beliefs or practices [11].

Five cultural competence training intervention studies used a cross-cultural approach focusing on general knowledge, skills and characteristics of culturally competent practice [23, 27, 28, 34, 35]. For example, the cultural competency training intervention reported by Brathwaite and Majumdar for health professionals in Canada [23] taught general knowledge and processes for providing culturally competent care, including (a) acknowledging intracultural diversity and the breadth and complexity of culture as something possessed by all, (b) conducting cultural assessments of service users, (c) learning from patients about their culture, (d) recognising the processes of acculturation and cultural diversity within individuals, (e) developing agreed-upon treatment plans and (f) accommodating non-harmful health beliefs and practices which can differ from practitioners personal and professional culture.

Case Study 1: Cultural Competence Training
Thom et al. [35] reported on a randomised control trial (RCT) assessing the impact of cultural competency training for primary care physicians providing diabetes care. The training was delivered to 53 primary care physicians across 4 diverse healthcare practice settings. The three training modules, which could be delivered as one half-day training or three separate sessions of 1–1.5 h addressed several core competencies. These included knowledge (such as knowledge of cultural identification and levels of agreement with respect to mainstream health beliefs), communication skills (including listening, explaining, acknowledging, providing recommendations and working effectively with interpreters) and cultural brokering (including negotiating a treatment plan with patient and family, understanding community resources available to patients and working with the healthcare system to meet the needs of culturally diverse patients). A RCT was employed to assess the impacts of training on Patient-Reported Physician Cultural Competence (PRPCC) score, patient satisfaction with and trust in physician and patient health outcomes of weight, blood pressure and glycosylated haemoglobin. While this study was rated strong in the study quality assessment, it was found that physician cultural competence training was not associated with any significant improvement on any outcome measure found for the intervention groups.

Despite the availability of established theoretical models that can be used to inform cultural competence training for health professionals [39], there was minimal use of these in the studies included in this review. The advantages of using such theoretical models are that they more readily allow for comparisons between studies using the same model and comparisons between studies using different models. This would help to determine whether certain models or approaches impact the effectiveness of interventions. One framework for cultural competency used in two studies [28, 35] was the LEARN model developed by Berlin and Fowkes [15]. This model focuses on teaching generic communication and negotiation skills applicable across all patient-practitioner encounters involving the negotiation of difference (cultural or otherwise). These same two studies drew upon Kleinman's explanatory model of disease [16] and involved experts in the development of the training method or framework. Further two studies [23, 34] evaluated training based on Campinha-Bacote's model of cultural competence [6]. All four studies that utilised pre-existing models evaluated training based on cross-cultural approaches.

Tools are needed to enable the comparison of cultural competency training interventions and help develop greater consistency in intervention approaches based on the evidence of what works. Such a tool was described by Dolhun et al. to assess the themes, concepts, methods and learning objectives of cultural competence education interventions [40]. In addition to the diversity and inconsistency in training approaches, the review of intervention strategies was made more difficult because of lacking detail in the training content and focus in several studies [21, 24, 33, 34, 36].

Additionally, many studies made no reference to the evidence base informing their cultural competency training approaches.

These issues, coupled with the widespread use of outdated cultural competence training approaches, demonstrate a lack of rigour and in-depth engagement with this complex field. This deficit was particularly evident in categorical-based interventions that focused on teaching about specific cultural or ethnic minority groups. The studies that adopted a cross-cultural training approach generally provided greater detail on the content of interventions; this assists with intervention assessment and comparisons. These cross-cultural interventions also demonstrated a more thorough grounding in theoretical frameworks and the evidence base than did interventions which took a more categorical approach.

An approach which prioritises self-understanding and critical reflection on one's own cultural backgrounds, beliefs, values, life experiences, behaviours and ways of communicating is considered crucial to cultural competence training and education [8]. Yet there is minimal research available that integrates this kind of self-awareness with cultural competence. In a review of reviews by Truong et al., only 4 out of 19 cultural competency literature reviews discussed the concepts of self-awareness and self-reflection on one's personal and professional culture [41]. In the studies included for this review, only one cultural competence training intervention for the health workforce assessed participants' cultural self-awareness [28].

Some suggest that cultural humility may be a better approach to embarking on the in-depth self-exploration and critical reflection needed to change practitioner attitudes, beliefs and behaviours which negatively impact patients [13, 46, 47]. Cultural humility training 'incorporates a life-long commitment to… redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships' (p. 117) [42]. Cultural humility addresses both the presence of cultural diversity in the broadest sense and the interconnected issues of power imbalances, represented in different forms of injustice and inequality [43]. Cultural humility might also be more aligned with the ongoing and developmental approach to cultural competency knowledge and skill building recommended in the literature [13]. The developmental, self-reflective approach of cultural humility can potentially help healthcare systems to avoid the trap of perceiving cultural competence as an easily demonstrable mastery of a finite body of knowledge [42] as opposed to an ongoing process of quality improvement.

4.3.2 Professional Development Interventions

To be effective, recommendations for the integration of cultural competence into all professional development endeavours across all levels of an organisation have been made [44]. This endorsement was reflected in the remaining workforce development interventions that utilised training and/or mentoring and/or supervision to increase the capacity and cultural competence of the health workforce.

These professional development strategies differ from more commonly utilised cultural competency training interventions. To the authors' knowledge, they have not previously been explored in the context of cultural competence.

The aforementioned strategies provide some insight into the range of approaches that can be employed to increase the cultural competence of health professionals. In some studies, training was concentrated on particular health issues or fields or on teaching certain skills sets for particular service-level interventions designed to improve the cultural competence of health practitioners [25, 26, 29, 31, 33, 34, 36]. For example, Dingwall et al. [25] evaluated the effects of training in a culturally adapted Indigenous e-mental health application on Indigenous and non-Indigenous service providers' awareness, perceived knowledge and confidence in using the app with Indigenous clients.

Case Study 2: Other Training to Improve Cultural Competence
Hinton and Nagel evaluated the effects of a culturally adapted 'Yarning about Mental Health' training for the Australian alcohol and other drug (AOD) workforce. Fifty-nine participants, including AOD workers and counsellors and mental health and allied health workers from two AOD workforce network agencies, attended four 1-day training workshops held over a period of 2 years. Pre-post questionnaires were administered to measure participant knowledge and skills in providing culturally appropriate strategies and tools for understanding mental health, promoting wellbeing and delivering brief, evidence-based interventions for Aboriginal and Torres Strait Islander service users. The qualitative evaluation found significant self-reported improvement in confidence and knowledge related to Indigenous mental health and wellbeing. This included improved knowledge of the warning signs and treatment of mental illness and increased confidence to assess, treat and communicate with Indigenous mental health clients. This study was rated as moderate in the study quality assessment [26].

Mentoring and supervision were identified as another common cultural competence workforce development strategy [22, 29, 30, 36]. Mentoring approaches were used to support the development of individual practitioners, whole health practices and minority research faculty and students with the aim of increasing cultural competence in the healthcare workforce. For example, Abbott et al. [22] evaluated an intervention to explore GP supervisors' and medical educators' attention to cultural competence when providing supervision to medical registrars. Participants viewed a simulated consultation between an Aboriginal patient and GP Registrar that highlighted inadequacies in communication and cultural awareness and documented teaching points to prioritise and use in supervision as a response to the video consultation.

Case Study 3: Mentoring to Improve Cultural Competence
Wu et al. [36] evaluated the reported satisfaction and healthcare experiences of 250 parents receiving care for children from a Paediatric Department of a large teaching hospital [40]. The intervention consisted of cultural education added to the role of Spanish interpreters in the hospital. Interpreters provided brief cultural competency training where residents were introduced to Latino cultural values and home remedies important to medical history taking. Residents were also taught Spanish expressions to help establish rapport with Spanish-speaking patients, and the training addressed techniques for optimising the use of interpreters in improving communication. In addition to this training, Spanish interpreters also worked as cultural mentors and provided individual cultural education sessions to residents where language or cultural issues that emerged during specific clinical encounters were reviewed.

Medical residents delivering care to Spanish-speaking parents in one large teaching hospital participated in the study. Each participant attended one 30-min group cultural workshop and two individual cultural mentoring sessions. The evaluation, which was given a strong study quality rating, used a comparative study design with historical control measuring parent reported satisfaction with interpreter service and healthcare experience. Parents' self-reported satisfaction with an in-person interpreter service compared to a telephone interpreter service and the impact of the additional cultural and language education on parent's satisfaction were assessed. The use of an in-person interpreter significantly increased Latino parents' satisfaction ($p < 0.001$) versus phone interpreter, but a program using an interpreter to educate residents in cultural and language issues increased parents' satisfaction even more [36].

Mentoring is an important and widely used tool for personal and career development in the workplace [45]. The inherently developmental and reflective focus of mentoring relationships [45, 46] places mentoring as a potentially powerful strategy for the development of health professional cultural competence. However, research on cultural competence mentoring and supervision has primarily examined supervision for minority practitioners by Caucasian supervisors [46–48]. It has focused on the provision of culturally appropriate supervision to health professionals of different backgrounds or identities to supervisors [49, 50] or as a strategy for the recruitment and retention of minority students [51]. Unfortunately, there is a scarcity of research exploring the role of mentoring and supervision in increasing the cultural competence of general health professionals. This is one intervention approach which could be further explored for its potential benefits on health provider cultural competence.

4.3.3 Delivery Mode

Interesting distinctions between reviewed studies in the delivery mode of interventions were evident. The majority of studies (69%) evaluated interventions specifically targeting a broad spectrum of health professionals across practice sites. Five interventions were delivered to health professionals across multiple sites in one geographical area [27, 29, 31, 34, 35]; three delivered cultural competency-focused interventions to professionals from diverse, unspecified practice settings [22, 25, 33]; and a further three delivered cultural competence training on a state or nationwide basis [21, 28, 32]. One example of a large-scale cultural competence workforce development initiative is described in the report by the Aboriginal Workforce [21]. This intervention aimed to provide cultural competence training to all staff of an Australian state government health service that employs approximately 100,000 people. In another study, McGuire et al. [32] evaluated a cultural competence training intervention in the USA utilising an education DVD delivered to healthcare professionals statewide through conferences, community meetings and clinic training. A live nationwide webcast and satellite conference were also offered, and the training was accessible online. Twenty-six American states were represented in the webcast. These large-scale interventions provide an example of the potential reach of cultural competency training and demonstrate the widespread recognition of cultural competence as a core component of quality healthcare.

Considering the key role that language plays in culture and the impact of language discordance on patient healthcare experiences as discussed in previous chapters, addressing linguistic competence should be commonplace in cultural competence workforce training and development interventions. Research evidence demonstrates the negative impact of language discordance on patient satisfaction and quality of care measures [52, 53]. While this review did not specifically search for studies on linguistic competence interventions for the health workforce, the lack of attention in the literature to issues of language in cultural competence training and professional development is discouraging. One study provided Spanish language courses and an integrated language immersion program alongside cultural competence training for health practitioners [31]. Another evaluated the impact of interpreter services as well as cultural education of medical residents on patient satisfaction [36]. The lack of attention to linguistic competence is consistent with previous research evidence, which showed that medical schools rarely teach about responding to language differences in healthcare practice, such as teaching about the use of interpreters in cultural competency course content [40].

4.4 Intervention Outcomes

Research studies on cultural competency interventions targeting the health workforce have demonstrated various positive practitioner and patient-related outcomes. Beach et al. found excellent evidence of improved knowledge and good evidence of

improved attitudes and skills among healthcare providers in response to cultural competence education. However, the evidence for the impact of cultural competence training and education on patient-related outcomes was less clear [54]. Several studies have found increased levels of practitioners' cultural competence to be positively associated with increases in patient satisfaction [55, 56], self-reported treatment adherence [57] and patient information seeking and sharing [56]. However, while Beach et al. found some evidence for effects of cultural competence education on patient satisfaction, poor evidence was found for patient adherence, and no evidence was found for improved health outcomes [54]. In a more recent review of cultural competence training interventions, including measures of health outcomes, Lie et al. found limited evidence of a positive relationship between cultural competency training initiatives and improved health outcomes [58].

In this review, we found significant heterogeneity in the outcomes reported across the intervention studies. The outcomes most commonly measured and reported across the reviewed cultural competency training and professional development interventions were related to health practitioner cultural competence. These included knowledge (9/16) [23–28, 31–33], attitudes/beliefs (5/16) [24, 29, 31, 33, 34], skills (7/16) [22, 25, 27–29, 31, 33], behaviour (4/16) [22, 29, 30, 35] and confidence (5/16) [22, 25, 26, 33, 34]. While these outcomes indicate some positive effects of workforce development initiatives on health practitioner cultural competence, there are some critical issues which need to be explored before assuming these results do in fact demonstrate improved practitioner cultural competence.

There is widespread recognition that assessments of knowledge and attitude are insufficient to demonstrate practitioner cultural competence. Firstly, knowledge- or fact-based evaluations can be problematic in cultural competency training given the complex, dynamic nature of culture and the diversity within all ethnic, racial and cultural groups [11]. Assessments focused solely on practitioners' knowledge of group characteristics run the risk of actually encouraging practitioners to stereotype people [11, 59]. Likewise, improved knowledge and attitudes, while arguably important in their own right, are not representative of subsequent changes in practitioner behaviour which is critical to cultural competence. Instead, a focus on teaching specific practice skills and assessing how these skills translate into demonstrable practitioner behaviour is needed [6, 13, 39]. The absence of reported behavioural outcomes, particularly in cultural competence training interventions, makes it difficult to comment. The studies reviewed did not generally provide any indication of the effects of cultural competency training on practitioner's behaviour. Only one training study assessed Patient-Reported Physician Cultural Competence behaviours but found that cultural competence training had no impact [35]. Two mentoring and supervision interventions assessed behavioural outcomes reporting increased research productivity [30] and changes in the practice settings to increase cultural appropriateness [29].

Other research studies found that cultural competency training that used didactic approaches and courses of shorter duration did not achieve behaviour change in practitioners [4]. A recent study found significantly improved knowledge, attitudes and comfort following cultural competence training. However, there were smaller

than anticipated improvements in practitioners' levels of comfort in using cultural competency strategies. The findings suggest that practitioners needed additional support to implement learned knowledge and skills in daily practice [60]. This concentration on knowledge, attitudes and skills, without assessment of their application in practice, is recognised as a core challenge in cultural competency workforce training interventions [41, 61].

The general heterogeneity across all factors in intervention content, duration and outcomes and measures makes comparisons of study effects very difficult. Similar to the findings of Beach et al., most of the reviewed training interventions reported positive outcomes independent of course duration and content [54]. Despite this, there was such variance between interventions in content and duration that a comparison of intervention impacts on outcomes was not possible. Furthermore, no studies compared the effects of training of longer or shorter duration on the same training curriculum and outcome measures. Likewise, there were no studies which compared the effects of different training approaches and content on the same practitioner cultural competence measures.

The lack of evidence for the impacts of cultural competence workforce training and development interventions on patient health outcomes [58] remains an ongoing limitation. Only a small number of studies evaluated healthcare outcomes, including practitioner satisfaction (4/16) [23, 26, 29, 33], patient satisfaction (2/16) [35, 36] and patient trust (1/16) [35]. Of the two studies which measured patient satisfaction, only one reported improvements in patient satisfaction following the intervention [36]. Considering that a major aim of cultural competence is to improve healthcare treatment and quality, patient experiences, as indicated by measures such as patient satisfaction, trust and healthcare access, deserve far greater attention in intervention evaluations. Health outcomes were assessed in only two studies [31, 35] with neither demonstrating significant changes as a result of intervention effects.

4.5 Measurement and Study Quality

The overall quality of studies evaluating interventions to improve the cultural competence of the health workforce was moderate to poor. Only two studies received a strong study quality rating [35, 36], and four were assessed as moderate (25%) [21, 24, 26, 28]. Ten of the sixteen studies (63%) were assessed as being weak in study quality. Study quality issues regarding the measurement of cultural competency training and workforce development intervention outcomes were common. For example, of the seven studies which measured practitioner cultural competency using some form of measurement tool, only four used existing validated measurement tools [23, 24, 29, 34], and one used a tool developed from existing validated instruments [28]. Similar to Beach et al., we found that no two studies used the same measurement tool [54]. A systematic review of 54 instruments to measure health professional's cultural competency by Kumas-Tan et al. also found that measures were rarely cited more than once [61].

A significant lack of uniformity was found in the outcome measures of practitioner cultural competence even within the same outcome categories. This finding was also identified by Beach et al. [21]. For instance, while many studies assessed knowledge outcomes, none assessed the same type of knowledge using the same method of assessment. Furthermore, studies rarely accounted for practitioner variables such as gender, age, race and prior training or cultural competency levels. Another issue with many practitioner cultural competence measurement tools is that they have been developed without patient input and are normed on predominantly white, middle-class, English-speaking populations [61]. These measures are therefore of questionable reliability and validity when used with people who are not represented in this normative group [61, 62].

The over-reliance on practitioner self-report measures of cultural competence is an ongoing limitation and concern [8, 41, 61]. This is demonstrated in the 16 reviewed studies, 69% of which relied on self-report to measure intervention outcomes. Because of the subjective nature of self-report, these measures are susceptible to a range of biases. For instance, higher levels of self-assessed confidence may be indicative of poorer insight and awareness on behalf of health practitioners [61]. The inherent issue of social desirability bias can also lead to participants selecting socially appropriate responses, which may not reflect their true beliefs [11, 61, 62]. Such responses are not predictive of resulting behaviour in clinical encounters [11]. The over-reliance on self-assessment is accompanied by a general lack in evaluations of patient perspectives. In this review, only one study evaluated patient perspectives by assessing the relationship between patient-reported physician behaviour and patient satisfaction and trust [35]. To develop a stronger evidence base for the effectiveness of interventions in improving the cultural competence of health professionals, more objective measures of intervention success beyond self-assessment are necessary [41]. There is also a great need to measure intervention effects over time. Only one study addressed the sustainability of intervention effects by completing a follow-up assessment at 3 months; it found that intervention impacts were sustained in this timeframe [23]. This is something which ought to be commonly measured in any workforce development interventions to improve healthcare cultural competence.

4.6 Conclusion

Interventions to increase the cultural competence of health professionals are common. Research studies demonstrate great diversity in approaches to address health practitioner cultural competency with some positive outcomes. However, it is apparent that there are some core issues which need attention to advance this intervention approach and build the evidence base for its effectiveness. Of particular concern is the lack of assessment of the impact of specific practitioner knowledge, attitudes, skills and behaviours on healthcare and health outcomes. This review, similar to others, demonstrates the strong need for studies of greater theoretical and

methodological rigour if we are to elucidate the true potential benefits of health workforce development interventions to improve cultural competence. Finally, consistent measures of practitioner, patient, healthcare and health outcomes are required.

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Chapter 5
Cultural Competence Education and Training for Health and Medical Students

5.1 Introduction

Over the last 10 years or so, the term 'cultural competence' [1] has become prominent in the health and medical education literature. According to Betancourt [2], 'physicians need a practical set of tools and skills that will enable them to provide quality care to patients everywhere, from anywhere, with whatever differences in background that may exist…' (p. 501). Consistent with this imprimatur, most medical and nursing schools must provide some level of training in this area to meet accreditation requirements and therefore now include some level of cultural competence education and training [2–4]. For example, in Australia, competency is endorsed by the Australian Medical Council (AMC) [4], and medical courses must provide cultural competency training in their curricula [5]. Although these requirements ensure that cultural competence is included in health and medical curricula, there is variation between health and medical schools in the content and delivery of this training [2, 5].

Several reviews examined the effects of cultural competence interventions on trained health professionals [6–8]. The findings of these reviews demonstrate that cultural competence training can be effective for improving health professionals' knowledge, attitudes and skills, as well as patient satisfaction [6–9]. Despite the promise of cultural competency training, there has been limited examination of its potential impact when included in the university-based professional training of health and medical students.

Sixteen out of the sixty-four studies (25%) included for review evaluated cultural competence training and/or education interventions included in university-based training of health and medical students. This chapter describes the characteristics of cultural competence education and training interventions evaluated, describes their key components and reviews the quality of evaluations measuring their impact on improving the cultural competency of health professionals undertaking university-based training.

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5.2 Characteristics of Education and Training Interventions

Sixteen studies evaluating the impact of cultural competence training/education in the university-based training of health and medical students were identified. This relatively small number of evaluations is consistent with reviews of other types of cultural competence interventions, which also found a limited number of intervention evaluations published in the peer review literature. Of the 16 studies, 8 were conducted in Australia and 8 in the United States. No studies were from Canada or New Zealand, despite these countries having accredited cultural competence training programs [10, 11].

Fourteen studies targeted undergraduate and two postgraduate health professional students undertaking university-based training. Medical students were the most common health professional student group targeted, with five studies targeting this group. Four studies targeted nursing students, three health science students and two each psychology and pharmacy students. The number of health professional students targeted by cultural competence training/education interventions ranged from 31 to 1974 students.

Three main types of education/training intervention strategies designed to improve the cultural competency of health professional students undertaking university-based training were identified: (1) integration of cultural competency into core or elective curriculum, (2) cultural immersion experience and (3) cultural awareness education/training. The details of the interventions are reported in the recent open access paper [12] upon which this paper is based.

5.3 Education/Training Intervention Strategies and Their Components

5.3.1 Integration of Cultural Competency into Curriculum

Nine of the 16 studies integrated cultural competency education/training into university curriculum for delivery to medical, nursing, health science, pharmacy and/or psychology students [13–21]. This is encouraging given calls for cultural competence training of health professionals as part of a broad strategy to tackle health inequities and ensure quality healthcare for increasingly culturally diverse populations [2, 22, 23].

Cultural competency curriculum was integrated into core [14–21] or elective units of study [13]. Two studies evaluated the impact of integrating cultural competence education across the health and medical curricula within a program of study [14, 21]. The remaining seven studies evaluated the impact of integrating cultural competence education as discrete core or elective unit of study [13, 15–20]. A review

of Indigenous health curricula in health science courses found that in 17 out of the 35 studies identified, Indigenous health was integrated within the broader curriculum and not as a stand-alone element [5]. That only two of the studies in this review integrated cultural competency training within the broader curriculum suggests that the outcomes of this approach are not being evaluated or published in the peer review literature.

Although the content of cultural competency education varied considerably across integration strategies, content areas most commonly reported related to cultural differences, culturally competent healthcare and health disparities [13–21]. Content was primarily delivered using a mix of didactic (e.g. lectures) [13, 14, 16, 21], interactive (e.g. tutorials) [14, 16, 19, 20] and experiential (e.g. case scenarios) teaching methods [14, 16, 20, 21]. The duration of delivery varied from 6 h of didactic and interactive sessions over 5 weeks [15] to a 1-year program of didactic lectures, monthly meetings, mentoring and personal reflection [13].

In terms of student assessment, only the two studies integrating cultural competence training within the broader curriculum formally assessed students' knowledge and skills in areas of cultural competence [14, 21]. This suggests that one indicator of the level of integration of cultural competency training is the level and type of student assessment. The integration of cultural competency training within the broader health and medical curriculum and formalised student assessment of learning outcomes is consistent with a framework by the Medical Council of New Zealand for implementing cultural competency training in the medical curricula [22]. The three components of this framework include (1) creation of early classroom experiences to teach students the basic principles of culture and cultural diversity, (2) opportunities for students to engage in continued training of these early concepts throughout the preclinical years and (3) the assessment and evaluation of knowledge and skills throughout the course [23]. Among the seven studies integrating cultural competence education as a discrete unit of study, the second and third of these components were absent, reinforcing the importance and value of integrating cultural competence education and training within a program of study.

The outcomes measured to assess the impact of cultural integration interventions focused on participants' knowledge of [15–21] and attitudes to [16, 17, 19, 20] factors related to cultural competence and their perceptions and experiences of receiving cultural competency education/training [18–20]. Knowledge-related outcomes focused on participants' knowledge of cultural factors and specific Indigenous health problems, while attitude-related outcomes focused on changes in participants' perceptions of different cultural groups and their readiness to work in cross-cultural situations. Confidence outcomes most commonly measured participants' confidence to interact with clients from different cultural groups. Six out of the nine integration studies assessed pre-post changes in outcomes measured [14–17, 20, 21], with improvements related to knowledge of cultural competence, attitudes towards working with Indigenous people and awareness of cultural differences most commonly reported.

Case Study 1: Integration of Cultural Competency into the Curriculum
Paul et al. [14] evaluated the effect of an integrated Aboriginal health curriculum in the medical degree at the University of Western Australia (UWA), Australia on students' perceptions of their knowledge and ability in Aboriginal health. The core Aboriginal health curriculum provided students with a minimum of 37 h of direct teaching in Aboriginal health over the course of the program with the option for students to undertake electives that provided them with over 150 h of direct teaching in this area. The Aboriginal health curriculum was delivered using lectures, problem-based learning and self-directed learning tasks. The effectiveness of the integrated Aboriginal curriculum was evaluated using a cohort study design with an historical control group. Final year medical students in 2003 (cohort one: control group) and 2004 (cohort two: intervention group) administered a survey to assess their perceptions of Aboriginal health as a social priority; Aboriginal health issues, service provision, student preparedness and ability; and future commitment towards Aboriginal health. There was a significantly higher level of agreement among respondents in the second cohort for items relating to ability to work with and care for Aboriginal and Torres Strait Islander people, communicate with Aboriginal people and provide culturally secure healthcare. Students in the second cohort were also more likely to agree they had a responsibility to work for change in Aboriginal health and that they would work for change as a social priority. The study was rated moderate to strong on five out of six key methodological criteria and demonstrated that integrating a relatively small amount of targeted and structured teaching and learning in Aboriginal health throughout a program of study can achieve significant positive shifts in university-based training health professionals' self-perceived levels of knowledge, skills and attitudes.

5.3.2 Cultural Immersion

Many of the challenges to improving health outcomes for Indigenous and ethnic minority populations relate to a lack of understanding among healthcare professionals of the contexts in which these populations live and the impacts of these contexts on healthcare outcomes [22]. Cultural immersion is one strategy which can help professionals better understand peoples' social contexts. Four studies employed cultural immersion as the main intervention strategy [24–27].

Cultural immersion strategies included two or more of the following components: education sessions, clinical placements and/or a community experience. The duration of cultural immersion programs ranged from one and a half to five days. The content commonly delivered by the educational component of cultural immersion programs targeted participants' cultural knowledge and awareness. Clinical placement and community experience components of immersion strategies targeted

students' attitudes to Indigenous peoples, confidence to interact with Indigenous people and their perceptions of the cultural immersion experience.

Consistent with the experiential focus of cultural immersion, evaluations of this strategy primarily assessed participants' experiences and perceptions using qualitative methods. Two out of the four cultural immersion studies assessed pre-post changes in measured outcomes [24, 26]. Improvements in measures related to students' attitudes towards Indigenous people [24] interacting with Indigenous people and providing culturally competent healthcare [26] were reported. The other two studies conducted a post-test of students' perceptions of and/or satisfaction with the cultural immersion experience [25, 27]. Future evaluations could be strengthened by including outcome measures more closely linked to the primary rationales for implementing cultural immersion programs in health and medical curricula. These include increasing the number of health professionals who are culturally competent and/or willing to work with Indigenous and other ethnic minority populations and the ensuing impact of these increases on healthcare and health outcomes of Indigenous and other ethnic minority populations [21, 25].

Case Study 2: Cultural Immersion

Bennett et al. [26] evaluated the effect of a 4–8-week structured and educational clinical placement program on undergraduate nursing students' confidence in areas of primary healthcare delivery and culturally knowledgeable practice. The program included a 5-day orientation to develop nurses' skills, knowledge and attitudes relating to Indigenous health and primary healthcare followed by an extended clinical placement to consolidate learnings and establish Indigenous and non-Indigenous relationships and networks. The study was evaluated using a pre-post single-group design. Nursing students' confidence to communicate effectively with Indigenous clients, provide culturally appropriate care, understand the needs of Indigenous clients and ask Indigenous clients questions about their healthcare needs was assessed using confidence logs self-completed before and after their placement and at a 3-month post-placement phone interview. Focus groups were also conducted as a debriefing session. All 31 undergraduate nursing students' completed the evaluation. All confidence domains increased at post assessment, with the greatest increase observed for nurses' confidence in understanding the needs of Indigenous clients, followed by asking Indigenous people questions about their healthcare. Focus groups identified salient themes related to nursing students' increased confidence to relate to Indigenous people, understanding of the complexity of Indigenous healthcare and how to effectively work in the Indigenous community. The most significant finding from the 3-month post-placement interview was that 68% of nursing students indicated their intention to work in a rural/remote location, of whom 36% did so post-graduation. The study was rated weak in three out of five key methodological criteria but provides some evidence for the effectiveness of cultural immersion strategies combining structured education with real-world experience.

5.3.3 Cultural Education and Training

Three studies delivered cultural education to students in nursing, health science and counselling fields [10, 28, 29]. Education sessions were delivered using didactic [10, 28, 29] and/or interactive sessions [10] of 45 min [28], 60 min [29] and 3 h duration [10]. The outcomes measured included knowledge of cultural concepts [29], attitudes to and awareness of racial stereotypes [28] and cultural sensitivity [10]. All three studies assessed pre-post changes in the outcomes they measured, with statistically significant improvements in students' cultural knowledge [10, 28, 29] and attitudes towards racially offensive behaviour [28] and cultural diversity [10] reported.

Although cultural awareness education is an important component of an overall framework for cultural competence, it is generally insufficient to significantly change attitudes and in turn behaviour [5]. Improving these types of outcomes is likely to require structural changes at the level of the organisation, to reinforce and sustain behaviour change in health professionals [2]. Some strategies proposed for achieving this include embedding cultural competence in organisational policy, protocols and related key performance indicators [30]. Although there is some evidence that organisations that have integrated cultural competency standards into policies and practices influence health professionals to develop more culturally competent behaviours, more rigorous research is needed in this area [31–33].

Case Study 3: Cultural Awareness Education and Training
Sanner et al. [10] evaluated the impact of a 3-h cultural diversity forum on nursing students' cultural sensitivity as measured by their openness to cultural diversity. The forum included a 45 min keynote address by a nurse educator with expertise on diversity issues. After the forum the speaker and students shared a meal. The meal was followed by interactive group activities in which students got to apply the concepts presented in the keynote address. Changes in students' levels of cultural sensitivity were measured using the Openness to Diversity/Challenge Scale (ODCS) which was administered to nursing students before and after the forum. A convenience sample of 47 nursing students completed the pre-post survey. The forum had a statistically significant impact on promoting students openness to diversity/challenge. The study was moderate to strong on two out of four relevant methodological criteria. Notwithstanding the study's key methodological limitations related to participant selection bias and dropout, the authors contend that its findings suggest that educational strategies to promote openness to diversity are more effective with women, students who are older and students who represent minority groups.

5.4 Intervention Outcomes

The outcomes measured to assess the impact of cultural integration interventions focused on participants' knowledge of [15–21] and attitudes to [16, 17, 19, 20] factors related to cultural competence and their perceptions and experiences of receiving cultural competency education/training [18–20]. Knowledge-related outcomes focused on participants' knowledge of cultural factors and specific Indigenous health problems, while attitude-related outcomes focused on changes in participants' perceptions of different cultural groups and their readiness to work in cross-cultural situations. Confidence outcomes most commonly measured participants' confidence to interact with clients from different cultural groups. Six out of the nine integration studies assessed pre-post changes in outcomes measured [14–17, 20, 21], with improvements related to knowledge of cultural competence, attitudes towards working with Indigenous people and awareness of cultural differences most commonly reported.

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5.5 Methodological Quality of Evaluations

Eleven studies conducted a quantitative [14–17, 19, 21, 24, 26, 27] and five studies a qualitative evaluation [13, 18–20, 25]. The methodological quality of quantitative evaluations varied. For example, while nine out of the ten studies conducting a quantitative evaluation utilised a pre-post study design [10, 13, 15–17, 21, 24, 26, 28, 29], only five employed a control group and one randomisation [13, 15, 17, 21, 28]. Two of the five studies employing a control group were rated strong for confounding; one reported no important differences between groups prior to the intervention [15] and the other controlled for differences in the analysis [17]. The other four studies were rated weak because differences between groups were not reported or not controlled for in the analysis [13, 17, 21, 28].

Six out of the ten quantitative studies collected outcome data using a previously tested or validated instrument [10, 15–17, 21, 28]. For the other four studies, the

measurement instrument was not validated or adequately reported [18, 26, 27, 29]. Almost two-thirds of studies rated weak for selection bias on the basis that the percentage of individuals consenting to participant was unclear or less than 60% [16, 17, 21, 26, 27, 29]. Similarly, almost two-thirds of studies rated weak for withdrawal and dropouts on the basis that less than 60% of participants completed the study [15–17, 21, 24, 27, 29]. Two studies provided a citation to justify their method of statistical analysis [20, 27]. No study reported economic costs.

All five qualitative studies were rated adequate for their aims, methodology and recruitment strategy [13, 18–20, 25]. The majority of qualitative studies were rated adequate for criterion related to the collection [13, 18–20] and analysis [13, 18, 19, 25] of data and the presentation and discussion of research findings [13, 18–20]. Ethical issues and the relationship between the researcher and the participants were rated adequate in less than 50% of studies [20, 25].

Overall, the evidence base for the effectiveness of cultural competency interventions targeting health and medicine and students would be strengthened by quantitative evaluations that employ study designs with a control group, retain a higher percentage of study participants, control for confounding variables and conduct high-quality economic evaluations. The methodological quality of the five qualitative studies included in this review was generally adequate but could be improved with better reporting of ethical and methodological issues related to the role of the researcher.

5.6 Conclusion

The quality of evidence derived from the studies reviewed is insufficient to provide a strong basis for recommending the inclusion of specific cultural competence education and training strategies in the professional training of university-based health and medical students. Notwithstanding, three clear recommendations for improving future evaluations can be posited. First, evaluations could be improved by more explicitly linking specific learner outcomes (e.g. knowledge and confidence to deliver culturally competent healthcare) to patient outcomes of interest (e.g. satisfaction, quality of healthcare and health outcomes), to determine the extent to which undertaking university-based professional training translates to culturally competent healthcare delivery for patients. Studies comparing improvements in patient healthcare outcomes in disciplinary areas of health and medicine where cultural competence is integrated in the health and medical curricula with areas that do not might also be useful. Second, given the heterogeneity of cultural competence education/training strategies included in the training of university-based health and medical students, it would be helpful if future evaluations compared similar types of strategies (e.g. cultural competence education integrated into the curriculum as discrete versus related units of study). Third, evaluations of greater methodological quality are required to accurately assess the impact of cultural competence education/training intervention strategies when included in the university-based professional

training of health and medical students. Fourth, researchers undertaking such evaluations should provide data on the resources and costs required for their implementation to enable economic analysis of the level of investment required to achieve a given outcome.

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Chapter 6
Services and Programs to Improve Cultural Competency

6.1 The Role of Programs and Services in Culturally Competent Healthcare Systems

Health programs and services are unequivocally an integral component of any healthcare system. Within an integrated healthcare system, culturally appropriate health programs and services reflect both culturally competent professionals and culturally competent healthcare organisations and systems. In fact, the adaptation of services to meet peoples' culturally unique needs is identified as a core component of culturally competent systems of care in the seminal framework provided by Cross et al. [1].

There is a substantial body of research indicating that health services may not be appropriate for different cultural and ethnic minority groups when there is a lack of cultural fit [2–5]. The absence of cultural fit occurs particularly when there is an incongruence between the health frameworks used in services and programs with beliefs that characterise the health perspectives of Indigenous and other ethnic minority groups [6, 7]. In many instances, health programs and the overarching systems and frameworks in which they were created have been developed in a cultural context highly variant to that of the communities in which the same services and programs are delivered [6]. The goal of improving the cultural competency of health promotion services and programs is premised on the recognition that no single approach to providing healthcare fits all people and populations [8]. If health programs and services are to be meaningful for a particular community, it is necessary to understand the extent to which these services make sense within the structures, practices and meanings of that community [6]. To this end, culturally competent health programs and services focus on improving health and wellbeing through the integration of cultural understanding and responsiveness into health services delivery [9].

Culturally appropriate health services and programs are commonly included in reviews of the cultural competence literature [8, 10, 11]. However, similar to broader

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concepts of cultural competence (see introduction), one of the key difficulties in understanding the role of programs and services in a whole-system cultural competency framework lies in the varied terminology that is used across the literature to describe such interventions. This lack of cultural fit between programs and services and patient/community groups, along with what is needed to remedy it, is described in different ways, with varied approaches put forward about how to make programs and services more appropriate.

6.1.1 Diversity of Terminology in the Cultural Competence Literature

Cultural sensitivity is one concept that has been well developed in the literature and is used to talk about programs and services meeting peoples' cultural needs. Culturally sensitive services are focused on equity of care and equality of outcomes through recognising that to achieve similar outcomes for different people, some people might need services targeted to their unique needs [12]. In a concept analysis of cultural sensitivity by Foronda, the tailoring of services and programs to meet peoples' unique cultural needs was one of the five primary attributes, along with knowledge, understanding, consideration and respect [13]. Tailoring is about creating, altering or adapting services or approaches for a particular individual or group. It is something that needs to take place in order to meet people's needs and demonstrate cultural sensitivity [13]. Resnicow et al. differentiate cultural competency from akin terms, by saying that cultural competency refers to practitioners' capacity to exercise interpersonal cultural sensitivity [14]. They define cultural sensitivity as 'the extent to which ethnic/cultural characteristics, experiences, norms, values, behavioural patterns, and beliefs of a target population as well as relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs' [14]. Other key literatures on programs and services talk about cultural relevance. Castro et al. defined cultural relevance as the characteristics of being understandable, interesting and important and relevant to peoples' everyday lives [15].

The diversity in terminology continues when delving into the literature on programs and services. Some common terms used to describe different types of interventions in the form of services and programs include culturally adapted, culturally tailored, culturally targeted, culturally responsive and culturally appropriate. The differences between these terms can be very minor with significant overlap in their meanings. For example, cultural tailoring is described as 'the process of creating culturally sensitive interventions, often involving the adaptation of existing materials and programs for racial/ethnic subpopulations' [14]. Adaptation is defined as 'the process of altering a program to reduce mismatches between its characteristics and those of the new context in which it is implemented or used' [16].

The lack of consensus over terms aside, it is clear that programs and services aimed at increasing the cultural competence of healthcare are recognised as an important component of healthcare systems and are gaining momentum. The year 2016 alone saw a multitude of research articles published evaluating and reviewing culturally adapted [17–19], culturally tailored [20–24] and culturally responsive [25–27] health interventions for a range of health issues and targeting various Indigenous peoples and other ethnic minority groups in several countries. Of these approaches to improving the cultural competence of programs and services, culturally adapted evidence-based treatment (EBT) or evidence-based interventions (EBIs) are the most developed. Although culturally adapted programs apply to the specific circumstances of adapting already established EBTs or EBIs, the literature base on such approaches can also offer important insights into other approaches towards increasing the cultural appropriateness and effectiveness of programs and services.

6.1.2 Cultural Adaptation of Health Programs and Services

Approaches to culturally adapting programs arose largely out of community participation in program planning, implementation and development. Under these circumstances, it was recognised that interventions that do not reflect the cultural needs and realities of different groups might not succeed in garnering community support and participation and will therefore be ineffective. On the other hand, culturally focused interventions can be appropriate and acceptable to communities, yet might not be effective in creating changes in the targeted outcomes [15]. Additionally, when there are significant differences between an intervention program's validation group and the intervention group or community where implemented, there are many sources of potential mismatch which can impact the effectiveness of EBI. Sources of program mismatch include language, socio-economic status, ethnicity, urban-rural-remote context, type of staff and staff cultural competence, community readiness, community consultation processes and number and/or severity of risk factors in target group [15]. Cultural adaptations of EBIs evolved to respond to the tension that exists between wanting to maintain the scientific integrity of EBI while reducing the impact of program mismatch and making them more responsive to unique cultural needs of different target communities [15].

Various models are proposed for the adaptation of evidence-based health interventions [16, 28–32]. Castro et al. classify forms of program adaptation into two basic categories: (1) adaptation involving the modification of program content and (2) adaptations to the form of program delivery such as the delivery person, channel of delivery or location of delivery [15]. Castro et al. further identify two primary dimensions to guide adaptations: (1) cognitive-information processing characteristics related to language and translation, including ensuring cultural equivalence in translation and addressing other circumstances where language is not clear or appropriate and (2) affective-motivational adaptation related to program components

or activities which create cultural conflict or behavioural resistance as a result of conflict with groups of values or traditions [15]. Other specific components of adapted programs include an explicit incorporation of clients cultural values and worldviews into sessions, matching clients and therapists who share a language and/or ethnic background, using clients' preferred language, locating programs which are accessible and delivered in peoples communities and cooperation with supportive community members, extended family and spiritual leaders [33, 34].

The models outlined are reflected in the intervention strategies described across reviews of cultural competence interventions that included evaluations of programs and services. In a 2000 literature review, Brach and Fraser identified a range of intervention strategies commonly applied to improve the cultural competency of services and programs including coordinating with traditional healers, the inclusion of family and community members, the involvement of community health workers and the use of interpreter services [8]. Later, Goode et al. found that while there was no consistent model used for developing cultural competency services and programs, strategies utilised included community input, health information delivered by community members, adapting intervention delivery modes, ensuring language access through bilingual or bicultural staff and materials in preferred languages and alignment of interventions with cultural beliefs, values and practices [11].

6.1.3 A Continuum of Adaptation Strategies

Adaptations differ vastly in the extent of the adaptation, involving anything from minor changes in the language or terminology used to more significant changes such as the removal of whole program components [35]. Resnicow et al. defined the cultural sensitivity of programs and services along two dimensions, adaptations to surface structure and deep structure. *Surface structure* adaptations occur where the outward characteristics of target populations, such as language, food, locations and music, are reflected in programs and services. This adaptation type focuses on increasing the acceptance of health interventions and can help to establish feasibility. On the other hand, *deep structure* adaptations include the social, cultural, environmental, psychological and historical factors which impact health in target communities. Such adaptations convey greater significance and focus on factors which influence certain health predictors and risk factors. *Surface structure* adaptations are likened to face validity, whereas *deep structure* adaptations determine program impact [14]. The literature on cultural adaptations suggests that programs move beyond surface structure adaptation to deep structure adaptations which address core norms, values and beliefs and important aspects of worldviews and behaviours [15].

Okamoto et al. took the concept of differing levels of cultural adaptations further, describing a conceptual model of different methods which can be used to develop culturally focused interventions [36]. They offered a continuum of adaptation approaches from surface structure adaptations to culturally grounded programs.

Culturally grounded programs are interventions that are designed from the 'ground up', based on the worldviews, values, norms and behaviours of the population they hope to serve. Okamoto et al. recommend that culturally grounded interventions might be more necessary for Indigenous populations, especially when current evidence-based approaches cannot effectively respond to the unique contexts and cultural constructs which relate to the health disparities of Indigenous populations. They argue for culturally grounded interventions to be used to establish a foundation on which an Indigenous prevention science could be built and then to establish culturally congruent adaptations for Indigenous populations [36].

6.1.4 Research Evidence on the Effectiveness of Programs and Services

A recent large meta-analytic review compared internationally adopted programs with no adaptation to international programs with contextual adaptations and novel programs, those designed for the particular community and context in which they are implemented [35]. Both adapted and novel programs were found to be more effective than adopted programs with no adaptation [35]. Some of the strongest evidence for the effectiveness of culturally adapted EBIs comes from the mental health field. Griner and Smith completed a meta-analytic review of culturally adapted mental health interventions and found that 'culturally adapted interventions resulted in significant client improvements across a variety of conditions and outcome measures' [34] (p. 541). Specifically, the meta-analysis revealed that interventions which were targeted to a specific cultural group were four times as effective as culturally adapted interventions targeting mixed cultural groups. However, these broadly adapted interventions were still more effective than non-adapted interventions. Additionally, interventions in clients' language were twice as efficacious as those conducted in English [34]. In a more recent meta-analysis of studies on culturally adapted psychotherapy interventions, Benish et al. found that according to primary measures of psychological functioning, culturally adapted psychotherapy is more effective than unadapted psychotherapy for ethnic minority groups [33].

In the cultural competency review literature, research shows promising evidence of the success of health programs and services to improve cultural competence on certain healthcare and health outcomes [10, 11]. Truong et al. completed a systematic review of literature reviews on interventions to improve cultural competency in healthcare [10]. Patient/client outcomes reported across reviews included improvements in patient knowledge, lifestyle and dietary behaviours and certain clinical outcomes, such as glycaemic control for diabetes patients [10]. However, there were study quality and measurement issues that limited confidence in the evidence that cultural competency improves health outcomes [10].

Of the 64 cultural competence intervention evaluations found, 22 (34.4%) were studies of healthcare programs and services. This chapter is based on a recent

systematic review of these 22 studies written by the authors [37]. In this review, we examined the strategies implemented to increase the cultural appropriateness of health programs and services and their resulting outcomes for health service users.

6.2 Characteristics of Programs and Services to Improve Cultural Competence

Similar to the findings of previous literature reviews [10, 11] and as seen in other chapters in this book, there was significant variation between studies on a range of factors. Across the 22 studies of cultural competency services and programs found in our literature search, intervention evaluations from the USA ($n = 13$) were most common. It was also in studies from the USA that the greatest diversity in population groups being targeted by interventions was evidenced. US populations included Native American [38–41], African American [42–44], Latino [45, 46] and Mexican American [47], Native Hawaiian [48], Haitian American [49] and Chinese American [50]. The second largest number of studies came from Australia ($n = 6$) where all interventions targeted Australian Indigenous peoples [51–56]. An additional two studies from Canada were found, targeting Indigenous Canadians [57] and South Asian Canadians [58], as well as one study from New Zealand targeting Asian New Zealanders [59]. The most common health issues addressed across studies were mental health, diabetes, cancer and cardiovascular disease (see *Jongen et al. 2017* for further details [37]).

The level of diversity across studies in terms of target population, health issues and settings, intervention strategies and outcomes makes comparisons between studies difficult. This variation reflects the complexity of cultural competency services and programs and their implementation in practice and research [10]. Yet despite this heterogeneity, there are clear patterns across the included literature, in both intervention strategies and outcomes. A detailed overview of intervention strategies and outcomes is provided in Table 6.1. The symbol ✓ denotes evidence that the author(s) explicitly advanced adoption or support of the element of cultural competence, ~ denotes an implicit or inferred reference consistent with the intent of that element and x denotes no evidence for that element.

6.3 Intervention Strategies to Improve the Cultural Competency of Programs and Services

The interventions in the included studies utilised various approaches to increase cultural competence in promoting health services and programs for the targeted population groups. Thematic analysis of the intervention strategies utilised in services and programs studies revealed three distinct categories: (1) community-oriented strategies, (2) culture-oriented strategies and (3) language-oriented strategies.

Table 6.1 Characteristics of programs and services to improve cultural competence

Publication		Aim	Intervention Strategies											Intervention Outcomes						
			Community Strategies				Culture Strategies				Language Strategies			Intermediate Outcomes						Health Outcomes
First Author	Year	Increases Cultural Competency	Community participation	Community partnerships	Community spaces	Community networks	Values/beliefs/ practices	Activities	Religion/ spirituality	Interactive/visual resources	Full language adaptation	Partial language adaptation	Written/ audiovisual	Patient perceived satisfaction	Health worker acceptability	Service access utilization	Retention/ adherence	Health knowledge	Behavioral outcomes	Improved health status outcomes
Arora	(2013)	✓	✓	~	✓	x	✓	✓	✓	x	✓	x	x	✓	~	✓	x	~	x	x
Browne	(2014)	✓	x	x	x	x	x	x	x	✓	x	x	x	x	✓	x	x	~	x	x
Chavez-Korell	(2012)	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	x	✓	✓	x	x	✓	~	✓	✓
Davies	(2015)	✓	✓	✓	x	x	x	x	x	✓	x	x	✓	✓	x	x	x	✓	x	x
Dingwall	(2015)	✓	✓	~	x	x	✓	x	~	✓	x	x	x	x	✓	x	x	x	x	x
D'Silva	(2011)	✓	✓	~	✓	x	✓	✓	✓	x	x	✓	x	x	x	~	~	x	✓	x
Guadagnolo	(2011)	✓	✓	~	x	x	✓	x	x	x	x	x	✓	✓	x	x	x	x	x	x
Houston	(2011)	~	✓	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	✓
Jandorf	(2013)	✓	✓	x	x	x	✓	x	x	x	x	✓	x	✓	x	~	✓	x	x	x
Jones	(2013)	✓	✓	✓	✓	✓	x	x	✓	x	✓	x	x	✓	x	✓	x	x	~	✓
Ka'opua	(2011)	✓	✓	✓	✓	x	✓	x	✓	x	x	✓	✓	✓	x	x	✓	x	x	x
Knoche	(2012)	✓	✓	✓	x	x	x	x	x	x	x	x	x	✓	✓	✓	x	x	x	x
LoGiudice	(2012)	~	✓	✓	x	x	~	✓	x	x	x	x	x	x	x	✓	x	x	x	x
McElmurry	(2009)	~	✓	x	x	x	~	x	x	x	✓	x	✓	x	✓	~	✓	x	~	✓
McEwen	(2010)	~	~	x	✓	x	✓	✓	x	x	✓	x	✓	x	x	x	x	x	✓	x
Nicolas	(2009)	✓	✓	✓	x	x	✓	x	~	x	x	~	x	-	-	-	-	-	-	-
Oser	(2013)	~	✓	✓	x	✓	x	x	x	x	x	x	x	x	x	x	x	✓	x	x
Sanderson	(2010)	~	✓	x	x	x	x	x	x	x	x	x	✓	✓	✓	x	x	✓	x	x
Taylor	(2012)	✓	✓	~	x	x	x	x	x	x	x	x	✓	✓	✓	x	x	✓	✓	x
Ward	(2015)	✓	~	x	x	x	✓	✓	✓	x	x	✓	x	✓	x	x	✓	x	x	✓
Wong	(2010)	✓	✓	✓	✓	✓	✓	x	x	x	✓	x	✓	✓	x	~	✓	x	✓	x
Yeung	(2010)	~	x	x	✓	x	✓	x	x	x	✓	x	✓	x	x	✓	✓	~	x	x

The specific intervention approaches taken within these categories differed depending on the study focus and the unique cultural context and needs of the target group. The majority of studies incorporated multiple intervention strategies from two or more of these overarching community-, culture- and language-focused approaches.

6.3.1 Community-Oriented Strategies

Community-oriented strategies had the greatest diversity of approaches. These included strategies which incorporated community participation and partnership, the use of community spaces, and community networks and media to make programs and services more culturally appropriate for the target population.

The most common community-oriented strategy utilised in 18 (18/22, 82%) of the interventions was the participation of various community members in aspects of the development and implementation of services and programs. The types of community members involved in studies were members of the community health workforce [46, 52, 53, 56, 57], general community members [40, 43, 56, 59] and community or church leaders [48, 58]. Other community members involved in these interventions were cancer survivors and family members of survivors [41, 48], heart attack and stroke survivors [40], community volunteers [58], community seniors/elders [57], community representatives [39] and clinicians from the target population [44]. A case demonstrating the role of community participation in a culturally tailored intervention is provided by Ka'opua et al. [48]. Ka'opua et al. evaluated a culturally tailored breast cancer screening educational intervention for Native Hawaiian women delivered through local churches. The local minister, church congregant liaisons and church volunteers were involved in the delivery of the sessions, and breast cancer survivors and family members of survivors from the local community delivered testimonials [48]. This strategy of various community members participating in interventions is similar to that identified in the cultural competency literature over the past 15 years [8, 11].

Although the utilisation of community participation in the reviewed studies cannot be clearly correlated to specific outcomes, Bath and Wakerman's comprehensive literature review found a positive impact of community participation on health outcomes in primary healthcare. This review found a small but significant body of evidence linking community participation with improved health outcomes and some evidence demonstrating an impact of community participation on intermediate health outcomes such as service access, utilisation, responsiveness and quality [60].

While the role of community participation in increasing the cultural appropriateness of interventions cannot be underestimated, it needs to be distinguished from the kind of community-based partnerships which have been recognised as key to addressing health disparities at the local level [61]. Lacking patient and community involvement throughout all stages of research, from determining study issues through to the dissemination of results, is recognised as a major limitation in cultural competency research [11]. There were several studies that included the creation

of community partnerships through the research process. However, this strategy was utilised less than community participation. Two studies identified a community-based participatory research (CBPR) approach [48, 52]; another identified using a community participation framework to guide the research [59]; and a further two discussed the involvement of a community steering committee [55] or advisory board [49]. Other studies discussed community involvement such as being initiated by community leaders and maintaining a strong community engagement focus [58], establishing partnerships with key community groups and stakeholders [49] and collaborating with community health departments [40]. For example, Nicolas et al. reported on the process of culturally adapting an evidence-based cognitive behavioural therapy (CBT) group treatment for Haitian American adolescents diagnosed with depression. The community participation approach included creating an advisory board with representatives from various stakeholder groups and establishing collaborative partnerships with community mental health centres and schools. The community partners participated in all stages of the project playing a key role in its design, implementation and evaluation [49].

The studies that included community participation and partnership strategies showed significant variation in the specific ways these strategies were implemented in practice. Community participation is a complex, wide-ranging and context-specific process that is affected by economic, social and contextual factors which impact on participation processes [62]. The degree of community participation in public health interventions and research depends on the model of community engagement which is being drawn upon [63]. There are several typologies of community engagement discussed in the literature [62, 64, 65], many of which are presented along a continuum of power sharing. The level of community participation is often reflective of the level of control and power community members have over the planning, development, implementation and evaluation of interventions [62]. The results of this review indicate some progression towards stronger community partnerships throughout the whole research process.

Another community-focused strategy identified in the included studies was the use of non-clinical, community spaces to increase the acceptability and accessibility of health interventions for the target groups. As previously discussed in the overview of adoption models, the use of alternative intervention settings is a very common adaptation strategy. Community spaces utilised in studies included local churches [47, 48] or other religious facilities [58], a community centre [45], a community health centre [50] and tribal clinic [38] (see case study 1 for an example of the use of community spaces). Health interventions conducted in non-clinical or community settings have received global research attention [66–71]. In the reviewed evaluations, this approach was shown to be an effective strategy for reaching different population groups that typically do not access health services.

The final community-oriented strategy was the use of community networks and local media in the promotion and recruitment aspects of programs. This comprised the use of local, language-appropriate radio and television and print media [40, 45, 58, 59] announcements at local religious facilities [45, 58] and community meetings and events [45, 59]. One study evaluating a heart attack and stroke symptom public

awareness campaign for two Native American reservation communities utilised community media and networks as the primary intervention strategy. The campaign was delivered through local print and radio media channels and theatre advertisements. Additionally, campaign material was included in local press releases, print inserts and direct mailers, and materials were featured on road signs at one community [40]. The use of community networks in health service recruitment and promotion was a strategy not previously identified by the authors in the literature on cultural competence and related concepts. This strategy was shown to be effective in engaging the target population and building community support for interventions in the studies which utilised this strategy.

Case Study 1: Community-Oriented Strategy

Chavez-Korell et al. reported on a culturally adapted depression treatment for Latino older adults and elders (aged 60 years and older) in the USA called *Un Nuevo Amanecer* (A New Dawn) [45]. This intervention utilised a range of community-, culture- and language-oriented cultural competence strategies to make it appropriate for the target population. The community-oriented strategies included the use of community spaces and community networks and media to make the program more accessible and to specifically promote it among the target population. The treatment was delivered through a non-mental health community centre setting with which the local Spanish-speaking, low-acculturated, first-generation immigrant older adult Latino target population has a strong sense of trust and identification and already attend regularly for other activities. Information about the intervention was disseminated in the Latino community through announcements at area churches, on local Spanish radio shows, coverage on local Spanish public television and informational sessions at community festivals, health fairs and social gatherings. Information was also disseminated by hosting Latino-style bingo games at older adult public housing buildings and at older adult day programs serving Latino elders.

Cultural sensitivity and cultural humility were used in all recruitment efforts, screenings, treatment planning, interventions and interactions with participants and their families. All staff involved were also bicultural and culturally competent. Latino cultural values of *familismo* (family orientation and connectedness), *personalismo* (recognition of the individual within a larger social and familial context), *respeto*, *dignidad* and *espiritualidad* (strong sense of spirituality and/or religiosity) and the gender roles of *machismo* (male gender role) and *marianismo* (female gender role) were carefully considered in treatment conceptualisation, planning and intervention. Culturally sensitive and appropriate activities were used in the behavioural activation (BA) and problem-solving treatment (PST) exercises. Many of the behavioural activation pleasant activities involved activities with family and community members. When using PST, clinicians were careful not to impose their

own value systems in the problem-solving exercises and honoured the client's solutions. *Un Nuevo Amanecer* also ensured a high level of language accessibility, with all staff involved in the intervention and research being bilingual. All forms and documents were translated to Spanish, and all treatment and communications were delivered in participants' preferred language.

The evaluation was conducted using a multiple time-series design, assessing depressive symptoms, physical functioning and quality of life at baseline, 6 months and 12 months. One hundred thirty Latino older adults participated in the program from baseline to 6 months and 87 participants from baseline to 12 months. Overall, 56.15% (73 of 130) of participants showed a 50% or greater reduction in depressive symptoms from baseline to 6 months, and 63.22% (55 of 87) of participants have shown a 50% or greater reduction in depression symptoms from baseline to 12 months. Preliminary data also indicated statistically significant improvements in the physical functioning (from 36.26 to 38.49, p _ 0.01) and overall quality of life (QOL) (from 6.12 to 7.36, p _ 0.001) for UNA participants from baseline to 6 months. The measurement instruments used to assess intervention effects on identified outcomes have established validity and reliability with older adults, Latinos and Spanish speakers [45]. This study was rated as being moderate quality, with a lack of reporting on confounders affecting the overall rating.

6.3.2 Culture-Oriented Strategies

The tailoring or adaptation of health interventions to be more congruent with the cultural beliefs, values and practices of target groups is one of the most recognised and utilised strategies in cultural competence services and programs. The evaluated interventions implemented various culturally oriented adaptations and strategies with most studies including several different cultural aspects. The cultural adaptation most commonly reported was the inclusion of some aspect of the target group's cultural values, beliefs and practices/traditions [38, 39, 43–45, 47–49, 53, 57, 59], including things such as recognising the role of extended family [39, 48], the involvement of family [45, 59] and the use of culturally relevant metaphors [48, 49]. Several studies also integrated aspects of the target community's religion/spirituality and culture [38, 44, 45, 48, 57, 58]. For example, the Ka'opua et al.'s study of a culturally tailored breast cancer screening educational intervention integrated Native Hawaiian cultural strengths, including those related to spirituality and the extended family system [48].

The interconnection of spirituality and culture is a potentially powerful resource for culturally appropriate healthcare. It has been utilised as a resource for the positive engagement of different populations with health services [72]. Research studies show a link between spiritually based resources, which contain values, beliefs and practices based on a connection to a higher or sacred power with the long-term

survival of those with breast and other treatable cancers [72]. The integration of spiritual and/or religious components is also consistent with the worldviews of many Indigenous peoples and other cultural groups where health is understood holistically—in all of its mind, body and emotional and spiritual dimensions [73] (see Chap. 2 on the drivers of cultural competence for a discussion on the role of worldviews in healthcare).

Another culturally oriented strategy employed in several interventions was the utilisation of culturally relevant activities congruent with the unique lifestyle preference of the targeted culture [44, 45, 47, 55]. LoGiudice et al. reported on the evaluation of a pilot model of care for older and disabled people in a remote Aboriginal community in Australia. This model of care utilised culturally appropriate respite activities such as hunting, fishing, camping and art [55]. Lastly, three Australian studies reported the development of interactive and visual intervention resources [51–53] as a strategy for increasing the cultural appropriateness of health promotion for Aboriginal people. One study published by Davies et al. reported on the development and evaluation of a highly visual and interactive, culturally appropriate bilingual app about hepatitis B for Indigenous Australians in Arnhem Land [52].

Culturally focused strategies have the potential to go beyond merely attempting to make healthcare more appropriate for communities to providing health benefits of cultural engagement. This is particularly pertinent for groups such as Indigenous peoples who hold worldviews of health and wellbeing that link engagement in cultural activities with health benefits [74, 75]. There is a significant amount of literature identifying and exploring culture as a protective factor for the health and wellbeing of various Indigenous populations and its significance in health interventions [76–78]. McIvor et al. reported a literature review and analysis exploring the role that Indigenous language and culture plays in mediating health risk factors and in maintaining and improving health for Indigenous people. This review found evidence for the positive effects of Indigenous languages and culture on health and wellbeing [79]. There is research evidence to link engagement in practices of caring for country to better health outcomes for Aboriginal peoples in Australia [80] and engagement in traditional cultural and spiritual activities with increased alcohol cessation with Native American peoples [81].

Case Study 2: Culture-Oriented Example

Arora et al. evaluated a culturally sensitive diabetic retinopathy tele-ophthalmology screening program for Aboriginal Canadians delivered in a community-based tribal clinic [57]. The intervention strategies used to improve the cultural competence of the program were community-, culture- and language-oriented strategies. This intervention is a good example of the ways in which cultural practices can be integrated into health services and programs to improve their cultural competence. In the program reported by Arora et al., religious/cultural artefacts were included in the clinic screening protocols. Before and after every clinic, ‘smudge’ ceremonies were held

under the guidance of an invited spiritual leader from the community to purify the body and invite health into participants. Open circles were held for participants to discuss physical, mental, spiritual and emotional health issues and goals, and a tepee was set up outside the clinic for attendees to gather to socialise and participate in more cultural activities. The intervention also implemented community- and language-oriented strategies. The clinic was set up at the community level in a remote clinic serving a predominantly Cree community. Several community members were involved in the delivery of the program, including staff and community elders and leaders. Nurses fluent in Cree were also hired from local communities to ensure participants could access the program in their native language.

The program was evaluated retrospectively, 2 years after initial implementation. To assess program outcomes, interviews were held with five patients and other key stakeholders including two program administrators, one hospital nurse, one community nurse and one spiritual liaison. Clinic attendance rates were also assessed using program data. The main outcome measures were clinic attendance rates and self-reported patient satisfaction. The evaluation found an increase in appointment attendance from 25% to 85% over the 2 years from program commencement to evaluation. Qualitative accounts of increased patient satisfaction, trust towards the healthcare team and increased communication among participants were also reported [57]. This study was rated as of moderate quality.

6.3.3 Language-Oriented Strategies

Clear and effective communication between health service providers and users is critical to accessible, quality and safe healthcare provision. Language discordance between patients and health professionals can affect patients' experiences and satisfaction with care, increasing the risk of lower quality care [82–84], with research evidence demonstrating negative impacts on health outcomes [85]. An evaluation of 1590 Spanish-speaking Latino adults' experiences of care found that patients who needed and always used interpreters had better ratings of doctor communication, staff helpfulness and satisfaction with care compared to those who needed interpreters but did not use them [86]. Among less-established ethnic groups, research show slower availability or access to interpreters and subsequent increased communication problems [87]. Despite this need, research studies reported the underuse of interpreters by physicians when communicating with patients with limited English proficiency (LEP) [88].

In CANZUS nations [89], for people who do not speak English as their first language, effective communication requires access to health information and services in one's primary language. However, even for populations that are proficient in

English, language is still an important consideration in ensuring communication is appropriate for the target audience. Delivering health interventions using language which is appropriate for the targeted audience is a strategy that is referenced in models for the cultural adaptation and tailoring of health programs and services [90]. Language adaptations can consist of translation, interpretation, use of appropriate vocabulary and concepts and consideration of people's reading literacy levels [90]. In the reviewed interventions, there were three primary forms in which interventions were made linguistically appropriate for target groups: (1) full language adaptation, (2) partial language adaptation and (3) the creation or translation of written and audio-visual resources.

There were seven studies in which participants could choose to have the entire intervention delivered in a language other than English: three US programs were delivered in Spanish by bilingual health professionals [45–47]; one Canadian program was offered to Southeast Asian participants in English, Gujarati, Punjabi, Hindi or Dari [58]; two studies delivered the intervention for Chinese and Korean New Zealander [59] and Chinese American [50] participants in their chosen language; and one study that hired nurses fluent in Cree [57]. Employment of native-speaking health workers/educators/promoters is one important strategy [91] which was reported across the reviewed interventions. Interestingly, even when programs were made linguistically accessible, participants did not necessarily use them. A case in point is demonstrated in Jones et al. [58]. While Jones et al. reported on a cardiovascular disease risk factor screening program offered in multiple languages based on the target population, 71% of participants chose to have the intervention delivered in English [58]. What this highlights is that language accessibility is about having the *choice* to have interventions delivered in participants' preferred language.

In other studies, partial language adaptations appropriate for the population were implemented. For example, two studies with African American people discussed utilising colloquial language and limiting medical jargon [43] and the incorporation of relevant and meaningful language, such as naming a program 'Oh Happy Day' after the popular gospel song [44]. A further two studies included minimal language adaptations, through the use of some native words in spoken and written aspects of the programs [38, 48]. This kind of adaptation is reflective of surface structure adaptation approaches [15] which aim to increase the acceptability of programs and services by mirroring the use of language of target groups.

In some studies, the creation or translation of written materials, such as forms and documents, or educational materials for program participants, was only one aspect of a broader program [39, 45, 46, 59]. However, three studies reported a primary intervention as an audio-visual or multimedia resource developed or translated in the language/s of the target population. These interventions included an e-mental health application which was translated from English to Yolngu Matha for Aboriginal Australians of the Yolngu language group [52], a breast cancer education video in Navajo language with English subtitles for Native American women [41] and a dementia education resource in Australia translated from English into three Aboriginal languages [56]. Taylor et al. reported on the evaluation of a culturally

and linguistically targeted dementia awareness pilot resource in three Aboriginal languages (Warlpiri, Kriol and Djambarrpuyngu) as well as English [56]. The video was pilot tested and evaluated with aged care workers and service users and community members to assess the effectiveness of the resource and evaluate the difference that culturally safe communication can make towards dementia education [56]. Similar to Jones et al. [58], Taylor et al. found that while participants thought it useful to have a dementia education resources in local languages and this helped to build participant engagement, they also appreciated having the resource in English and considered it to be more important to be able to have discussions in participants language after viewing the resource [56].

When working with people who not only share a different language but also have a radically different worldview, language accessibility needs to go beyond translation and the use of interpreters [92]. When working in cross-cultural spaces, an extensive exploration of the meaning of health-related words and specific health topics is needed [93]. For instance, miscommunication was extensively documented in interactions between healthcare providers and Aboriginal Australian people accessing healthcare, related to a lack of shared understanding around basic health concepts [91–94]. In these contexts, health interventions and information which incorporate and build on both traditional and contemporary Indigenous health frameworks need to be developed [93]. Some of the included studies addressed such issues of intercultural communication in the context of worldview differences. In situations where translation is required and/or utilised, the effectiveness of translations depends greatly on how representative and accurate they are for people [95]. Some studies tested the appropriateness of translated program resources for the target population, while others did not. When reported, different levels of detail around the process and quality of the translation were provided. As noted by Vass et al. 'while words and worldview concepts vary between Indigenous nations, the principles of working in-depth in language and through the Indigenous worldview are likely to have relevance to any Indigenous groups who do not speak English as a first language and who do not have a biomedical or Western worldview' (p. 37) [93]. This issue of differences in fundamental concepts of health and comprehension of health information is relevant to many cultural minority groups and is one area which deserves further attention to the design and implementation of programs and services to increase cultural competence.

Case Study 3: Language-Oriented Example

Jones et al. [58] conducted a feasibility study of a community-based, culturally adapted cardiovascular disease (CVD) risk factor screening program for South Asian (SA) Canadians. The program implemented a range of community-, culture- and language-focused intervention strategies to ensure its cultural appropriateness. The program was initiated by SA community leaders who approached researchers requesting the implementation of the program. These same community leaders chose six local religious facilities as

screening locations to improve the accessibility and cultural relevance of the program. Participation was invited by community leaders through announcements at the facilities and notices in local community newsletters, radio and television. The screening program was also delivered by lay trained, community volunteers identified by community leaders. To improve cultural appropriateness, the intervention was conducted at local culturally relevant religious facilities attended by the SA community. The program also ensured language accessibility by conducting the initial screening, assessment and all other program activities in participants' language of choice. The languages included in the program were English, Punjabi, Hindi or the Dari dialect.

Two hundred thirty-eight participants with elevated blood pressure (BP) or 1 or more CVD risk factors participated in the initial screen, and 99 participants presented for rescreening. The evaluation sought to assess changes in risk factor measures from baseline, as well as program satisfaction and health system follow-up from baseline screening to follow-up screening. Blood pressure (BP) and a measure of total cholesterol/high-density lipoprotein (TC/HDL) were taken at baselines and follow-up. The study found modest and significant improvements in cholesterol measures; however, no changes in BP were found. Also, 80% of participants reported being very satisfied with program, and the other 20% reported being satisfied. Eighty-two percent of participants reported having visited their family physician to discuss results. This evaluation received a strong rating for study quality.

6.4 Cultural Competence Intervention Outcomes

The intervention strategies employed across the literature demonstrate the range and diversity of approaches which can be utilised to improve the cultural competence of health programs and services. Unfortunately, because of the mix of strategies used across many interventions, it is impossible to determine whether certain intervention components have a greater impact on program outcomes than others. Additionally, the level of difference between studies on many dimensions makes comparisons difficult. This being said, many of the included evaluations assessed for similar outcomes. By reviewing these, we can determine the impact of program and services on outcomes of importance.

According to Lau, two key aspects of intervention success are engagement (the ability to successfully reach and involve participants in interventions) and outcomes (the ability of interventions to positively impact on the variables being targeted) [33]. This was seen in the two main types of outcomes assessed across studies, although various indicators were used to measure these outcomes. The primary outcomes assessed across studies were intermediate healthcare outcomes (including patient and staff satisfaction, service utilisation/access and retention/adherence/

treatment rates and improvements in health-related knowledge and behaviours) and health outcomes. In Lau's model, engagement refers to the social validity of interventions, their perceived acceptability and usefulness [33]. Indicators which can measure successful engagement include levels of recruitment, program attendance, enrolment and retention rates and participant/patient satisfaction [32, 96].

The most common outcome reported in 12 of the 22 included studies (55%) was patient-perceived acceptability of interventions. Positive appraisal of interventions was reported in all studies which addressed this indicator. However, only five studies reported directly on patient satisfaction [39, 43, 44, 57, 58], while the remaining seven reported a range of other outcomes related to program acceptability [41, 45, 48, 52, 54, 56, 59]. Furthermore, only one study used a validated satisfaction measurement tool [44], and only two reported an increase in satisfaction following interventions [39, 57]. An additional two studies included measures of patient/participant trust along with satisfaction [5, 43]. One intervention reported by Guadagnolo et al. utilised a scale developed by the authors to measure satisfaction with care and medical mistrust. The study reported a significant improvement in scores for satisfaction with healthcare following a patient navigation (PN) service but found no change in scores for medical mistrust [39]. A further six studies evaluated the acceptability and usefulness of health interventions from the perspectives of health professionals [41, 46, 51–54, 56].

Four studies reported health access/utilisation outcomes (see case study 2 for an example). However, only two studies provided comparisons to pre-intervention service utilisation rates [55, 57]. Other studies measured program engagement success through results on retention, treatment and adherence rates with high retention rates reported across three studies [44, 45, 48]. For example, Yeung et al. demonstrated an increase in treatment rates of Asian American patients diagnosed with major depressive disorder from 6.5% pre-intervention to 45% during the intervention [50].

Four studies reported outcomes related to health knowledge and awareness with three of these noting improvements from pre-intervention levels [40, 52, 56]. Davies et al. reported some improvements in hepatitis B-related knowledge for one group evaluated [52]. Oser et al. found significant improvements in knowledge of heart attack and stroke warning signs and symptoms across two American Indian reservations following a culturally relevant health education campaign [40]. Many studies discussed some behaviour change outcomes resulting from interventions. However, a lack of information on measurement tools and outcomes meant that these results were not generally significant except for in one study which found some improvements in physical functioning of participants in a depression treatment program [45] (see case study 1).

Finally, there is a significant focus in the cultural competency literature on improving specific health-related outcomes. The review found some evidence of improved health outcomes across five studies. It found strong evidence for improvements in depression severity resulting from culturally adapted mental health interventions. Ward and Brown reported a decrease from moderate to mild depression and improvements in quality of life (QOL) measures of physical health and mental

health in their first pilot and a decrease from moderate depression to no depression in their second pilot, utilising measures which have been validated with African American people [44] (see also case study 1).

We also found positive outcomes for cardiovascular disease [42, 58] and one study reporting on improved diabetes risk indicators [46]. For example, in their study, Houston et al. found substantial and significant improvements in blood pressure for patients with baseline uncontrolled hypertension when compared to the control participants [42] (see also case study 3). Finally, McElmurry reported improvements in blood glucose control measured by a statistically significant drop in levels of haemoglobin A_{1c} (HbA_{1c}) <0.001 [46].

6.5 Study Quality

To determine whether and to what extent culturally competent service provision enhances outcomes of services and treatment, it is essential that cultural competency is accurately assessed [97]. However, a lack of systematic tools and approaches for measuring the presence, level and contribution of cultural competency interventions to quality healthcare continues to weaken the growing evidence base [97, 98]. Only 3 of the 22 papers (13%) were rated to be of strong study quality [42, 53, 58]. A further eight (37%) papers were rated at moderate [39, 40, 43, 45, 48, 49, 56, 57], and 11/22 (50%) were rated weak [38, 41, 44, 46, 47, 50–52, 54, 55, 59].

The included studies reported many positive outcomes indicating the potential positive impact of programs and services to improve cultural competence on improving patient healthcare and health outcomes. However, there were various measurement and study quality issues that limit the interpretability and generalisability of results. There was a shortage of properly controlled studies which demonstrated attribution of outcomes to particular strategies. Because of the multi-strategic nature of most interventions, it is impossible to link outcomes directly with particular strategies. Comparisons between studies were also made difficult because of the multiplicity of outcomes reported across studies and the lack of consistency in outcome measures. Even studies that evaluated the same indicator type frequently measured and reported this in different ways. Across many studies assessing various outcomes, there was a lack of properly validated measurement tools for assessing outcomes. To improve the evaluation quality of cultural competency services and programs, greater attention on the use of appropriate and, where available, validated measurement tools is needed.

The included studies provide useful evidence on intermediate outcomes such as satisfaction levels and service utilisation rates. Nevertheless, the presence of key methodological flaws, such as a lack of pre-intervention comparisons, diminishes the strength of outcome data on intermediate health outcomes. In contrast, the studies demonstrating improved health outcomes generally used fairly rigorous study designs with appropriate measurement tools. This kind of attention to study quality is needed to measure intermediate healthcare and health outcomes, both of which

are important indicators of intervention success. The preponderance of intermediate and short-term health outcome reported was a further limitation seen across studies. Further research is needed into longitudinal, population-based studies to determine the overall impact of cultural competence interventions on population health and health disparities among groups. Between the countries included, the strongest evidence came from US-based and Canadian studies with Australian and New Zealand lagging behind in terms of study quality.

6.6 Conclusion

The included studies demonstrate a growing evidence base for the impact of health promotion services and programs to improve cultural competency on intermediate and health outcomes. Nonetheless, because of methodological issues related to appropriate indicators and study design, it cannot be definitively concluded what types of interventions produce what types of outcomes with particular populations. Interventions need to be based on the evidence available for what works with different populations and health issues as well as the desires of the community/target population. The primary lesson from reviewing the strategies and approaches to culturally tailoring or developing culturally grounded health interventions for minority population groups is that each needs to be consistent with the unique cultural needs and characteristics of target populations and needs to be embedded in context and community.

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Chapter 7
Health Organisation and System Cultural Competence Interventions

7.1 Introduction

The mandate for systems-level cultural and linguistic competence to reduce disparities in healthcare has strengthened in the decades since the first definition of cultural competence. In the introductory chapter, cultural competence was defined by Cross et al. in the late 1980s as a 'set of congruent behaviors, attitudes and policies that come together in a healthcare system, agency or among professionals that enable that system, agency or professions to work effectively in cross-cultural situations' [1:p. iv/7]. The responsibility for cultural competence was concentrated in individual healthcare services while simultaneously recognising the need for broader system-wide policies [2]. Systems approaches to cultural competence were posited because: 'The bottom line is that clinicians and caregivers cannot on their own drive and follow practices that lead to culturally and linguistically appropriate care' [3].

Systems approaches are increasingly being applied in the delivery and management of various aspects of healthcare [4]. The systems focus of Cross et al.'s broad definition of cultural competence was reiterated in 2008 by the US National Quality Forum [5]. They framed cultural competence as the 'ongoing capacity of healthcare systems, organisations and professions to provide for diverse client populations' high quality care that is safe, client and family-centred, evidence-based and equitable'. Racial and ethnic diversity has increased in Canada, Australia, New Zealand (NZ), and the USA (the CANZUS nations [6]), with census projections predicting continuing diversification [3]. In these nations, Indigenous and other ethnic and minority peoples, particularly those with limited English proficiency, share poorer health and life expectancies than the majority populations [7–11].

A systems perspective views healthcare organisations as systems comprised of interrelated and interdependent components: client care, ancillary services, professional staff, and financial, informational, physical and administrative subsystems [12, 13]. Systems thinking focusses attention on how components are connected to each other within a whole entity, how components work together to achieve an

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intended outcome and thereby how systems can be changed to produce better outcomes [4]. A systems approach to cultural competence integrates practices throughout the organisation's management and clinical subsystems, thus requiring an amalgamation of attitudes, practices, policies and structures to enable healthcare organisations and professionals to work effectively in culturally diverse situations [1]. An organisation becomes more culturally competent by adapting these systems and subsystems to the needs of its diverse workforce and client population [13].

Multilevelled and multi-strategic systemic responses have been enacted in the CANZUS nations to improve cultural competence. At national levels, the governments of NZ and the USA have enacted legislation (NZ Health and Disability Act and US National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and healthcare which have been legislatively mandated by at least six states) to improve culturally competent care, language access services and organisational supports for cultural competence [14–16]. The US National Quality Framework reiterated its commitment by identifying six domains for cultural competency: (1) leadership, (2) integration into management systems and operations, (3) workforce diversity and training, (4) community engagement, (5) client-provider communication and (6) care delivery and support mechanisms [5]. Australia recently renewed its national framework for cultural respect [17], and in Canada, the broad *Multiculturalism Act* aims to provide all citizens with equal access and opportunities to ensure that needs associated with culture are considered in decision-making processes [18]. National professional associations in CANZUS nations have also developed healthcare practitioner competency standards. At regional and local levels, healthcare organisations, including hospitals and primary healthcare services, are increasingly recognising cultural competence as an organisational strategy to address the needs of diverse client populations [6]. Healthcare organisations have developed policies; workforce education and training programs; audit, monitoring and quality improvement practices; and culturally tailored programs and services [10, 19–26]. Despite some healthcare organisations being responsive to the cultural and linguistic needs of their client populations, the necessary financial investments and failure to recognise the potential benefits mean that some organisations do not implement cultural competence interventions [13].

Despite efforts to enact systems-level approaches to cultural competence, few studies described or assessed the extent or effects of systems approaches to cultural competence [13]. This chapter aims to bridge the gap in available evidence about systems approaches to cultural competence by systematically searching, selecting and synthesising classified publications to identify systems-level interventions that have been evaluated in the literature and report the effects of these interventions in improving cultural competence [27]. The significance of this aim was reported by Dijkers [28] who proffered that the reporting of how cultural competence at a systems level has been measured and assessments of the quality of studies are necessary to provide confidence that the implications of the review for policy, practice or clients are based on high-quality research.

7.2 Results

We found 10/64 (15.6%) papers that met the inclusion criteria as intervention studies that evaluated systems approaches to cultural competence. Four studies were conducted in Australia, three in the USA, one in New Zealand and two were cross-national comparison studies (USA and Australia and NZ and Australia). Seven studies targeted systems approaches for Indigenous health improvement, three for the health improvement of ethnic minority groups in general. Four studies evaluated systems-level intervention strategies in hospitals, two in primary healthcare settings and four in care for specific health needs (veteran services, mental health, antenatal and disability care). There was a significant variation in content, mode of delivery and duration of interventions. There was also heterogeneity in the outcomes reported across the studies.

Although expressed using diverse terms (e.g., cultural sensitivity, cultural respect, diversity management), the aim of all ten papers was to increase cultural competency through systems-level approaches. A detailed overview of intervention components is provided in Table 7.1. The symbol ✓ denotes evidence that the author(s) explicitly advanced adoption or support of the element of cultural competence, ~denotes an implicit or inferred reference consistent with the intent of that element, and X denotes no evidence for that element.

7.3 Principles for Implementation

All of the ten intervention studies explicitly iterated some core principles for implementing cultural competence across healthcare systems. There was variation across studies in the explication of important implementation principles. The three principles highlighted in this review were user engagement in the development and/or implementation of strategies (n = 7), organisational readiness or commitment (n = 7) and delivery across multiple sites (n = 10). Other principles reported in publications included being grounded in a social view of health, employing minority group staff, creating a welcoming service, supporting access, integrating cultural protocols, self-rating of services' processes of change against the end goal of cultural security and using multilevel strategies and careful coordination.

7.3.1 User Engagement

Other reviews of the cultural competence literature reported the value of user engagement to ensure congruence of strategies with the cultural beliefs, values and practices of the affected population groups [6, 22, 25, 26]. In this review, we found

Table 7.1 Characteristics of the systems-level interventions to improve cultural competence

Publication	Aim	Implementation Principles			Intervention Strategies							Intervention Outcomes									
					Audit and Quality Improvement		Organisational Systems				Client/Practitioner Encounter	Healthcare Outcomes								National Outcomes	
First Author Year	Increased cultural competence	User engagement	Organisational readiness/commitment	Multiple sites of delivery	Development of resources, tools and guidelines	Implementation of audit and monitoring	Cultural protocol or policy	Workforce diversity/communication	Workforce cultural competence training	Tailored services/programs	Organisational environment: support, access, resource	Advocacy for cultural, economic and social	Promoted implementation of national cultural competence standards	Increase quality/access/participation	Improved resources/tools for providing cultural competence	Identification of needs for improvement	Healthcare outcomes	Cultural respect/communication	Client/family satisfaction	Practitioner satisfaction	Health outcomes or reduced disparity	Informed national standards
Chong (2011)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	x	✓	✓	x	✓	x	✓	x	✓
Freeman (2014)	✓	✓	✓	✓	x	x	✓	✓	x	✓	✓	✓	x	x	x	✓	x	✓	✓	✓	x	x
Liaw (2015)	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	x	x	x	✓	✓	✓	✓	x	x	x	x
Noe (2014)	✓	x	✓	✓	x	x	x	x	~	✓	~	x	x	~	✓	✓	x	✓	x	~	x	x
O'Brien (2007)	✓	✓	✓	✓	✓	✓	✓	~	~	✓	~	~	✓	✓	✓	✓	✓	✓	✓	✓	x	✓
Reibel (2010)	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	x	x	✓	✓	✓	✓	✓	✓	x	x	x
Weech-Maldonado (2012)	✓	x	✓	✓	x	x	~	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	x	x	x
Whelan (2008)	✓	x	✓	✓	x	x	✓	✓	x	x	✓	x	x	x	✓	✓	x	x	x	x	x	x
Whitman (2008)	✓	x	✓	✓	x	x	✓	✓	✓	x	✓	x	✓	✓	x	✓	x	✓	x	x	x	x
Wiley (2009)	✓	✓		✓	x	x	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	x	✓	✓	✓	x	✓

that seven of the ten papers described innovative systematic ways to embed user engagement and collaboration into the development and/or implementation of systems-level cultural competence [15, 16, 29–35]. Ways of embedding user engagement included providing services that are based on the worldviews/paradigms and control by the user group [e.g. 15, 30]; audit indicators for user's consent, choice, mutual goal setting and review; assessment by cultural advisors; specific cultural preferences and access to these; and support for access to traditional medicine/remedies [e.g. 16]. The frequency with which publications reported engagement with users in the development and delivery of effective cultural competence interventions indicates the importance of user involvement in identifying appropriate interventions. The consequence of not involving users was described by Wiley [15] whose evaluation of NZ's national disability strategy found that Maori disability clients deemed the strategy to be less than optimally effective because it was adapted from mainstream to the Maori context rather than user developed. The finding that some mainstream systems-level interventions were less effective when users were not engaged throughout [e.g. 15] suggests that, similar to other cultural competence strategies, achieving improvements in systems-level cultural competence approaches is dependent on early collaboration with affected user groups and networks with user-controlled health services. Given the importance of user engagement, there is also a strong case for incorporation of patient perspectives in evaluating the cultural competence of healthcare interventions.

Case Study 1: User Engagement
Chong et al. [29] described a quality improvement framework designed collaboratively with Aboriginal Australians to improve the cultural sensitivity and environmental culture at five Australian hospitals. The main objective was to produce tools and processes that could assist hospitals to engage with local Aboriginal Australian communities in a collaborative exercise of cultural reform. They noted that hospitals with improved cultural sensitivity were those who engaged and had relationships with local Aboriginal Australian communities and commitment to supporting their Aboriginal workforce. This required senior management to prioritise and support this work and ensure that Aboriginal staff were trained to facilitate the process.

7.3.2 Organisational Readiness and Commitment

The issue of organisational readiness/commitment was also identified in other reviews. It makes sense that organisational commitment is required for systems approaches, given the complexity required to coordinate organisational subsystems to work together in a coordinated way to achieve culturally competent healthcare provision [35]. Organisational commitment is also required because cultural competence is just one of the many investment priorities facing healthcare

organisations. Additionally, as Weech-Maldonado et al. [36] argued, the available financial incentives for cultural competence remain 'not always clear or consistent'. Seven studies considered the commitment of managers, organisational readiness and capacity to supporting cultural competence as one key enabler of implementation [29, 30, 36–40, 42].

Case Study 2: Organisational Readiness and Commitment
From the USA, an exploratory study by Noe [40] focused on the issue of the organisational readiness and capacity of 27 healthcare services of the Department of Veterans Affairs to adopt and implement native-specific services for American Indian and Alaska Native (AI/AN) veterans. They profiled the availability of AI/AN veteran programs and measured interest in and resources for such programs using an adapted Organisational Readiness to Change Assessment survey. They found that only 15% services reported that their facilities provided traditional healing services. Perceptions by Veterans Affairs staff of whether their facilities were meeting the needs of AI/AN veterans were predicted by the survey subscales for program needs, leader's practices and communication. However, no subscale predicted greater implementation of native-specific services.

7.3.3 Multiple Sites of Delivery

An interesting review finding was that all intervention studies of systems approaches were implemented across multiple sites, rather than single healthcare sites. The number of sites ranged from two primary healthcare services [30] to 66 hospitals [35]. This may be a result of efforts to scale up interventions for maximum reach and outcomes or simply due to a quest for stronger research outcomes. Further research is needed within singular health organisation and across multiple organisations.

7.4 Health System Cultural Competence Intervention Strategies

The two key types of intervention strategies to embed cultural competence within health systems identified were audit and quality improvement approaches and service-level policies or strategies for cultural competence.

7.4.1 Audit and Quality Improvement Approaches Conducted Across or Within Health Services

Audit and quality improvement approaches were implemented across diverse healthcare settings. Relevant to improving healthcare practice against national benchmark standards, we found four intervention publications that reported on the

trialling and/or implementation of audit and quality improvement approaches through targeted strategies [29, 31–33]. All four specifically focused on Indigenous clients from Australia (3) and NZ (1) and were implemented within hospitals, primary healthcare services and mental health and antenatal services.

In these diverse healthcare settings, each study documented the development or tailoring of audit tools for the setting. In some studies, audit processes were used simply to identify the need for quality improvement. For example, persistent and significantly poorer Aboriginal perinatal outcomes motivated Reibel and Walker [34] to audit the usage frequency and characteristics of cultural responsiveness of maternal and child health antenatal services used by Aboriginal women in Western Australia. The utility of such studies lays in their identification of the extent of need for quality improvement. Other studies developed audit tools and tested them in trial sites. A pre-post mixed methods study by Liaw [31] documented the full audit and quality improvement cycle with ten general practices. The study assessed the identification of Aboriginal clients, completion of health checks and management of chronic disease risk factors and training and mentorship of staff to embed cultural respect in practice [31]. Monitoring of the frequency and characteristics of expected healthcare and client usage was then conducted [31]. The audit and quality improvement studies resulted in improved relationships with local communities, increased health service access and frequency of visits, and the increased involvement of clients and their families in their own healthcare and ultimately improved recovery following mental illness [31, 33, 34].

Case Study 3: Audit and Quality Improvement Approaches

Targeting mental health services across NZ and Australia, one study compared cultural competence in mental health services [33]. O'Brien et al. [32, 33, 41] described the development and validation of culturally and clinically reliable bicultural audit tools to measure the achievement of mental health nursing practice standards in NZ. The Consumer Notes Clinical Indicators (CNCI) audit tool was based on identification of 'critical events' from nursing notes in consumer's case notes. Critical events were non-sentinel rate-based clinical indicators considered crucial to achievement of practice standards which, if not achieved, identifies a need for immediate rectification [33, 41]. Of 100 clinical indicator statements, 25 valid and reliable indicators were considered crucial to the achievement of the NZ standards. The measures were also considered to be relevant to mental health nursing internationally by providing a framework for improving practice against standards of expected healthcare. O'Brien and Boddy [33] found that the bicultural nature of the mental health indicators enabled mental health staff in NZ and Australia to involve patients in their own care and also engaged their kin and community. The culturally sensitive indicators also provided a quality mechanism for identifying areas of clinical nursing care where improvements could be made. The study reported significant variations in health practitioners' and clients/patients expectations of cross-cultural healthcare for Maori and Aboriginal clients in NZ and Australia and in the actual culturally competent care provided.

7.4.2 *Evaluations of Service-Level Policies and/or Strategies for Cultural Competence*

Evaluations of service-level policies and strategies for cultural competence included cultural protocols or policies such as for interpreter services and translation of materials; workforce diversity and training; the tailoring of services or programs; providing a conducive organisational environment; advocacy; promoting national standards; and increasing access, participation and quality. We found seven evaluations within or across service-level policies or strategies for cultural competence [15, 29, 30, 32–34, 38, 39, 42]. Three were from Australia, two were from NZ, one was from the USA, and one compared US and Australian hospitals. The evaluations considered very diverse populations and healthcare settings.

Two studies evaluated the effect of cultural competence policies on clients' experiences of care. Weech-Maldonado et al. [35] explored whether greater cultural competence in hospitals improved client experiences, particularly for ethnic/racial minority clients, by correlating scores from the US National Consumer Assessment of Healthcare Providers and Systems Hospital Survey with those from the Cultural Competence Assessment Tool for Hospitals. Freeman et al. [30] identified cultural respect strategies in two primary healthcare case studies. The strategies were being grounded in a social view of health, including advocacy and addressing social determinants; employing Aboriginal staff; creating a welcoming service; supporting access through transport, outreach and walk-in centres; and integrating cultural protocol. They also identified client experiences and barriers to cultural respect (communication difficulties, racism and discrimination and externally developed programs).

Three studies evaluated the extent to which (or how well) organisational or national cultural competence policies/strategies had been implemented. Whitman and Davis [42] considered whether the policies and practices used by Alabama hospitals met the national US National CLAS standards. Whelan et al. [39] compared diversity management strategies by senior hospital managers in Pennsylvania with those of Sydney hospitals to determine how well they implemented best practice diversity management. The diversity management activities evaluated included planning, stakeholder satisfaction, diversity training, human resources, healthcare delivery, organisational change, diversity performance and external and internal influences on racial/ethnic diversity initiatives. From NZ, Wiley [15] suggested a need for improved coordination, collaboration, workforce development, information and resources and community engagement in the implementation of the NZ Disability Strategy. Studies found that compliance with service-level policies resulted in improved client and family satisfaction [15, 30, 32, 33, 36, 38] and health outcomes such as improved compliance with medication [38]. These findings were extended by a promising recent paper, published post-search, which found that a systemic, multifaceted and organisational-level cultural competency initiative in two hospitals led to overall performance improvement.

Case Study 4: Service-Level Policies and/or Strategies
A US study by Weech-Maldonado et al. [35] aimed to assess whether greater cultural competence in hospitals improved client experiences of care, particularly for ethnic/racial minority clients. Working across 66 hospitals, client experiences of care were measured in terms of their satisfaction with communication with doctors and nurses, staff responsiveness, pain control, communication about medications, discharge information, cleanliness of the hospital, quietness of the hospital, likelihood of recommendations of the hospital to friends and family and an overall rating. These attributes were correlated with measures of hospital cultural competence and self-reported client race, ethnicity and language. The study found that hospitals with greater cultural competency had better client scores for doctor communication, hospital rating and hospital recommendation. Minority ethnic group clients also scored hospitals with greater cultural competency higher on four other dimensions: nurse communication, staff responsiveness, quiet room and pain control. The authors concluded that greater hospital cultural competency may not only improve overall patient experiences but also may particularly benefit minorities in their interactions with nurses and hospital staff. Hence, cultural competence may reduce racial/ethnic disparities in inpatient experience as well as contributing to general quality improvement. As an exploratory, single time point design, the study was rated of moderate quality.

7.5 Health System Interventions Outcomes

Systems approaches focus attention on how things work together to achieve an intended outcome and on understanding of the 'whole' system [4]. By understanding how things are connected to each other within a whole entity, systems can be changed to produce better outcomes [4]. Four types of outcomes of systems-level cultural competence were identified. These were (1) organisational systems outcomes including improved resources/tools for providing cultural competence and identification of needs for improvement; (2) outcomes related to the client/practitioner encounter including identification of cultural respect/communication, client/family satisfaction and practitioner outcomes/satisfaction; (3) healthcare outcomes; and (4) broader outcomes such as informing national standards for cultural competence.

However, we could not determine the overall effectiveness of systems-level interventions to reform health systems because interventions were context specific to the country, setting and population and to the type of healthcare services concerned. As well, there were either too few comparative studies or studies did not examine the same outcome measures. The preponderance of the literature about systems-level cultural competence interventions focused on qualitative process

evaluations, which explore the concepts and issues and described the interventions and formative or intermediate outcomes. It is likely that this is because the field is still in the relatively early stages of development; therefore, there has not been enough elapsed time for follow-up studies, and thus we do not know the full impact of systems-level cultural competence interventions on healthcare services or their clients.

7.5.1 Organisational Healthcare Systems Outcomes

Six of the ten intervention papers described outcomes of improved resources/tools for providing cultural competence, and all ten papers identified needs for systems improvements in promoting cultural competence. The publications that reported audit and quality improvement approaches [29–33] considered these approaches to be relevant for establishing benchmarks for health service utilisation and quality and to driving system-wide healthcare action against national standards and reported improved healthcare outcomes. Audits provided a quality mechanism for identifying aspects of healthcare where improvements in cultural competence were needed [33] and a commitment by healthcare administrators to achieving culturally competent policy, health service delivery and environments [29]. Liaw et al. [31] found encouraging improvements in primary healthcare staff members' scores on cultural competency scales and that audits, training and mentoring led to increases in Aboriginal health checks and improved management of clinical risk factors.

All ten publications identified areas of further need for improved implementation of systems approaches to cultural competence. For example, Reibel and Walker [34] identified that only 9 of the 42 Western Australian antenatal services which reported use by Aboriginal women had provided both culturally secure and consistent antenatal care. Few services incorporated Aboriginal-specific antenatal protocols/program, employed Aboriginal Health Workers or were accessed regularly by Aboriginal women. The authors suggested that the cultural responsiveness indicators used in the audit established benchmarks as a starting point for future service delivery improvement [34]. Freeman et al. [30] concluded that service-level strategies were necessary to achieving cultural respect and had the potential to improve Aboriginal and Torres Strait Islander health and wellbeing.

Similarly, studies based on surveys of healthcare system administrators also identified needs for systems improvements in promoting cultural competence. For example, Noe et al. [40] determined that program needs, leaders' practices and communication predicted the provision of care that staff considered met the needs of AI/AN veterans, but not implementation of native-specific services. Assessment of organisational readiness could assist in developing strategies for adopting and implementing native-specific programs and services. At a broader scale, Whelan et al. [39]'s comparison of Australian and US hospitals found that both systems can do much more to implement best practices in diversity management. Australian hospitals scored higher on organisational change indicators, US hospitals on human

resource indicators, but there was more similarity than difference. They concluded that despite 30–40 years of 'multicultural health', hospitals in neither country have achieved best practice. Similarly, the study by Whitman and Davis [42] of Alabama hospitals found that although these hospitals were taking initial steps to prepare for a diversifying client population, only 13% hospitals met all four of the linguistic CLAS standards, and 19% met none. That is, enforcement of national legislation was inconsistent, and legislation in itself does not necessarily guarantee health service implementation. Studies have suggested that the business potential provided by quality culturally competent care should be recognised in national cultural competence policies or strategies by linking these with quality care incentive payments [13, 36]. However, this systematic search found no intervention studies of the impact of financial incentives or the cost-effectiveness of systems-level approaches; hence, it remains unclear whether systems-level cultural competence is a cost-effective strategy.

7.5.2 Client/Practitioner Encounter Outcomes

Study outcomes included the increased involvement of clients and their families in their own healthcare, improved relationships in the client/practitioner encounter and consequently increased health service access and frequency of visits. For example, Weech-Maldonado et al. [35] found that greater cultural competence was positively associated with some measures of clients' experiences with care (doctor communication, overall hospital rating and hospital recommendation). There were greater relative benefits for non-English-speaking non-Hispanic whites. Freeman [30] found that 22 staff and 21 clients reported positive appraisals of the achievement of cultural respect. While not significant, Reibel and Walker [34] found that Aboriginal women increased utilisation to the nine culturally responsive antenatal services from three to five visits. No study reported health outcomes. Identified gaps in the literature included a need for cost-effectiveness studies of systems approaches to improve cultural competence, further explication of the effects of cultural competence on client experience and studies to further explore the ultimate effect of cultural competence on improving health outcomes and reducing ethnic- and racially based healthcare disparities. Doing so will require a concerted commitment to adequately funding the implementation and monitoring of such initiatives [36, 43].

7.5.3 National Outcomes

There were national policy outcomes from cultural competence interventions. For example, elements of the quality improvement toolkit developed for hospitals by Chong et al. [29] were included in the Australian Council of Healthcare Standards; this provided a further driver for change. Wiley [15] demonstrated that there was

commitment to achieving a culturally competent NZ national disability strategy, health service delivery and workplace environment to benefit Maori people with disabilities. The implementation of the strategy required collaboration across sectors, accountability structures and effective evaluation tools, as well as collaboration between Maori people with disabilities and their families and the disability sector. As stated by Wiley [15], these 'provide cautionary lessons that Indigenous [and other ethnic and racial] peoples and governments in other countries can use in the development of culturally comprehensive… policy'.

7.6 The Quality of Available Evidence

None of the ten intervention studies was rated of strong quality. Three studies were rated of moderate quality and seven of weak quality, with lack of consistently strong methodology across the majority of assessed criteria. There were no randomised controlled studies. Five provided evidence from controlled single time point audits or measures of cultural competence across multiple healthcare services [29, 31, 36, 38, 39]. The remaining studies used an exploratory qualitative case study design [15, 29, 30].

Also, we found a significant lack of uniformity in the outcome measures of systems-level cultural competence interventions, even within the same outcome categories. Almost every included study utilised a different measure, suggesting that measures of cultural competence at systems level require further elucidation. Measurement studies have found that the domains of the mental health performance measures for administrative and service entities [16] and more recent Cultural Competence Assessment Tool for Hospitals (CCATH) for application in hospitals [35] suggest that important outcome measures are the cultural competence of clinical/healthcare (including consumer representation and care delivery), human resource management (including workforce diversity and training), translation and interpretation services and organisational commitment, leadership and data management and quality improvement systems. The findings of this review suggested that also useful are measures of broader research translation to effect national or jurisdictional policies related to cultural competence in healthcare. While tailoring across healthcare setting is necessary, as suggested by Brach and Fraser [43], the consistent use and reporting of systems-level cultural competence measures within each setting type would provide an important tool for comparable quality improvement efforts to build a strong evidence base.

7.7 Conclusion

Few studies previously examined the impact of systems-level approaches to cultural competence [20, 23, 35]. While substantial evidence suggests that systems-level cultural competence should work, our finding of only ten intervention studies means

that we cannot confidently determine the extent to which systematic approaches to cultural competence are useful for improving clients' experiences of healthcare and their health outcomes. Rather, there is little guidance for healthcare organisations about how to identify what mix of cultural competence strategies works in practice: when and how to implement them properly [19] or whether their investment in cultural competence interventions will have the intended effects on client experiences or health outcomes.

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Chapter 8
Cultural Competence Strengths, Weaknesses and Future Directions

8.1 Addressing the Drivers of Cultural Competence

To strengthen the conceptual foundations of cultural competence and to improve the evidence base of its impacts, cultural competence interventions need to evaluate their success against the drivers that they aim to address. An analysis of the cultural competence literature revealed two primary drivers of cultural competence: sociocultural factors and their impacts on the healthcare encounter and healthcare and health disparities. Given that these are the issues driving cultural competence, they ought to be the issues that cultural competence aims to change. Yet, despite being central to cultural competence, these drivers are not consistently addressed in cultural competence intervention approaches and evaluations.

8.1.1 Evidence Supporting the Positive Impact of Cultural Competence Interventions on the Effects of Sociocultural Differences in Healthcare

The first driver of cultural competence is the differential impact of different sociocultural factors on healthcare encounters. Some of the key sociocultural factors include culture and cultural norms; values, beliefs and behaviours; ethnic identity and racial categorisation; and worldviews, language and health literacy (see Chap. 2, 'The Drivers of Cultural Competence', for a more detailed discussion of the effects of sociocultural differences on healthcare). The push to improve cultural competence in healthcare was driven by the recognition of the impacts that cultural and sociocultural differences can have on important healthcare processes. These include healthcare processes such as patients' level of understanding of treatment and management strategies, communication dynamics and decision-making processes [1]. Of particular concern is evidence that showed an impact of patient-provider communication on

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improving patient satisfaction, healthcare adherence and health outcomes [1]. The intention of cultural competence interventions is to help ameliorate the effect of these sociocultural factors by increasing patient trust in healthcare, improving communication between providers and patients and improving patient satisfaction [2]. Although this is what cultural competence interventions set out to achieve, many interventions do not explicitly measure outcomes to assess these goals.

In the studies reviewed, there was some evidence of positive impacts of cultural competence interventions on healthcare processes and outcomes affected by sociocultural differences. The strongest evidence was for the impacts of cultural competence on patient/participant satisfaction. Satisfaction was reported by nine studies (five evaluations of programs and services to improve cultural competence [3–7], two evaluations of healthcare system interventions [8, 9] and two health workforce development studies [10, 11]). But only three studies reported an increase in patient satisfaction following the intervention [3, 4, 11]. Only one study used a validated satisfaction measurement tool [7]. An additional three studies (two programs and services studies [3, 5] and one health workforce development study [10]) included measures of patient trust along with patient satisfaction. However, only one of these studies found that the cultural competence intervention was associated with high levels of trust [5].

In healthcare systems-level interventions, there were some reports of improvements in the provider/patient relationship and increased involvement of patients in their healthcare. One study found that greater cultural competence was positively associated with measures of clients' care experiences, including doctor communication, overall hospital rating and hospital recommendation [12]. However, assessment of the impacts of cultural competence interventions on communication dynamics and decision-making processes was lacking.

These findings suggest that there is a need to better develop and utilise approaches to assess the impact of cultural competence interventions on specific sociocultural-related factors known to have bearing on healthcare. This means specifically measuring the impacts of cultural competence approaches on interpersonal and communication dynamics, such as patient healthcare provider and system trust, and levels of shared decision-making. But, to truly determine the impact of cultural competence on healthcare processes and outcomes, measures of impact on interpersonal dynamics in healthcare encounters should be assessed for their association with other healthcare and health outcomes. Here, the driver of sociocultural differences overlaps with the other primary driver of cultural competence, healthcare and health disparities.

8.1.2 Evidence Supporting the Positive Impacts of Cultural Competence Interventions on Healthcare and Health Disparities

Perhaps the most compelling and commonly used justifications for the need to improve cultural competence in healthcare are the disparities in healthcare and health outcomes experienced by Indigenous peoples and various racial and ethnic minority groups across the CANZUS nations [13]. Healthcare disparities are

evidenced across a range of specific measures related to various aspects of healthcare processes and outcomes [14–17] (see Chap. 2). Inequities in a range of markers of health status and outcomes are also seen for different population groups across these countries [18–21]. Considering there are so many different factors that contribute to healthcare and health disparities [15, 17], to determine the relative impacts of cultural competence interventions on broader population level disparities is difficult. Nevertheless, a step in the right direction towards assessing the impact of cultural competence on this key driver is to measure healthcare and health outcomes alongside other measures of improved cultural competence.

Across the 63 studies reviewed, a total of 22 interventions (20 programs/services and 2 workforce development interventions) included some assessment of the impact of cultural competence interventions on healthcare outcomes. The most promising evidence was demonstrated by the programs and services interventions. Health programs and services interventions, which included direct health services as well as health promotion and education programs, reported a range of healthcare outcomes, including patient/staff satisfaction, service access/utilisation and retention, treatment and adherence rates. Healthcare programs and services to improve cultural competence showed very strong evidence for program acceptability, with 12/20 (55%) studies reporting some indicator of patient reported acceptability [3–7, 22–28]. Although several health programs and services studies addressed service utilisation or treatment rates, improvements were only reported in three evaluations [3, 29, 30], with a further three programs and services studies reporting high program retention rates [7, 23, 25]. Other healthcare outcomes included improvements in health knowledge and awareness [26, 28, 31] and improved health-related behaviour [23].

Health outcomes were also assessed in six evaluations of interventions to improve healthcare cultural competence—four programs/services and one workforce development intervention, as well as one study including a health program and workforce development strategies. Once again, studies evaluating the effects of programs and services presented the strongest evidence of cultural competence impact on health outcomes. These interventions targeted specific health issues relevant to discrete population groups; this allowed easier measurement of health outcomes. Improvements were found for mental health [7, 23] and cardiovascular disease measures [6, 32]. One multilevel intervention which implemented a culturally appropriate diabetes education program and provided cultural competence training and other workforce development strategies found some improvements in diabetes risk indicators [33]. However, these improvements were assessed more in relation to the health program rather than the workforce development strategies. The one workforce development study that assessed health outcomes found no significant impact [10].

While these outcomes are promising, a lack of properly controlled studies means that outcomes could not be categorically linked to specific cultural competence strategies. Also, there were few properly validated measurement tools used to assess outcomes, a lack of objective evidence of intervention effectiveness with an over-reliance on self-report measures and an absence of pre-intervention comparisons. While there are study quality issues associated with these interventions, they do show real promise for cultural competence strategies to affect positive changes on the drivers of cultural competence.

8.1.3 What Are the Major Gaps in the Evidence in Cultural Competence Literature?

The most significant gaps in the evidence of intervention outcomes were in training and education interventions. There was strong evidence for the impacts of cultural competence education, training and other culturally targeted training on improvements in knowledge, attitudes, confidence and skills among health profession students and practitioners. While these outcomes can be considered positive in their own right, they provide no information on whether these improvements translate into positive effects in the healthcare encounter.

The merits of cultural competence training and education interventions include their intended impacts on practitioner capacity and their subsequent interactions with patients in healthcare encounters [1]. There is moderately strong evidence to suggest that greater levels of practitioner cultural competence are associated with several positive healthcare outcomes including higher levels of patient satisfaction, improved provider-patient communication and greater treatment adherence [34–36]. In particular, patient-assessed practitioner cultural competence was associated with improved healthcare and health outcomes [37, 38]. Unfortunately, the studies rarely linked cultural competence education and training to patient-perceived cultural competence or improvements in patient-provider interactions and healthcare outcomes [34–38]. One study assessed the impact of cultural competence training on patient-perceived provider cultural competence and healthcare outcomes including patient satisfaction and trust in providers, as well as health outcomes. However, this study found that cultural competence training had no impact on any of the assessed outcomes [10].

There was minimal evidence that cultural competence interventions had any impact on practitioner behaviour. Only one cultural competence training intervention for healthcare workforce development reported patient assessment of physician cultural competence behaviours. It used the Patient-Reported Physician Cultural Competence (PRPCC) scale [10], but no significant changes were reported. In addition, two mentoring and supervision interventions assessed behavioural outcomes. These studies reported increased research productivity [39] and changes in the practice settings to increase cultural appropriateness [40].

8.2 Improved Measures to Assess the Impacts of Cultural Competence Interventions

Improved measures to assess the extent to which cultural competence interventions produce positive outcomes towards the identified drivers of cultural competence is a priority. These measures are particularly needed for cultural competence training and education interventions, where the reliance on self-report measures to assess intervention impact is an ongoing limitation. Measures for assessing cultural competence

education and training outcomes have been critiqued for reproducing problematic assumptions about what constitutes cultural competence [41]. Considering that cultural competence can itself be considered a culturally bound construct, assessments of patient perspectives/experiences and healthcare and health outcomes are arguably more valid ways of assessing the impact of cultural competence [42].

There are various indicators for measuring patient perspectives and experiences, which could be used to better assess the impacts of cultural competence interventions on healthcare. Patient assessment of practitioner cultural competence is one useful measure that could be better utilised. There are various validated instruments that can be used to measure patient-perceived provider cultural competence [34, 43, 44]. Greater effort could be taken to evaluate the correlation between provider self-reported cultural competence and patient assessment of provider cultural competence. Assessing the correlations between particular providers' self-assessed cultural competence attributes and different aspects of patient perspectives and experiences in healthcare encounters would also be beneficial. For example, one study found that physician-reported motivation to learn about other cultures was associated with greater perceived helpfulness and greater patient information seeking and sharing. Also, a greater reported frequency of culturally competent behaviours was associated with greater patient information seeking and sharing [36]. Studies that assess the different facets of cultural competence in healthcare providers and their connection to specific healthcare outcomes would add to the evidence base.

The most frequently used indicator for assessing patient experience was satisfaction with healthcare or health promotion programs. Satisfaction with care is an important healthcare outcome which ought to be consistently assessed to better determine the impact of cultural competence on healthcare. However, there are other options for measuring the effects of cultural competence interventions on patient perceptions and experiences, which would help to create a more in-depth picture of the impacts of cultural competence. These include measures of patient trust, fear of physicians, the behaviour of health providers in practice and on healthcare and health outcomes.

Patient trust in providers and/or healthcare systems is another important indicator for assessing the effectiveness of healthcare systems to deliver quality and appropriate care. Patient trust is a central component of the patient-provider relationship [45] and is predictive of healthcare access and adherence [46]. Higher medical mistrust was associated with lower patient satisfaction with care [47] and poorer communication with healthcare providers [48]. Patient trust is considered more relevant as a measure for predicting the quality of ongoing healthcare relationships than satisfaction with care [46]. For example, one study included in this review evaluated the impact of a culturally tailored patient navigation service on Native American cancer patients' satisfaction with care and medical mistrust [49]. Although there were positive reports of improved patient satisfaction following the intervention, there were no improvements in patient medical mistrust. This study concluded that medical mistrust among Native American people is impacted by larger historical and cultural concerns that are unlikely to be addressed through brief, time-limited interventions [49].

A third potential indicator for assessing patient perspectives and experiences of healthcare is patient fear of physicians. Fear of physicians affects patients' likelihood to ask for care-related information, therefore impacting on the effective management of illness. It is associated with lower levels of confidence in healthcare quality, lower levels of patient autonomy, avoidance of physicians and aversion of participation in clinical trials [50]. However, research evidence shows that patient perceptions of physician cultural competence are associated with reduced fear of physicians [50]. This relationship deserves greater attention in the cultural competence literature. Similarly, other potential measures which have been positively correlated with provider cultural competence and healthcare outcomes such as patient-perceived provider fairness also warrant further consideration [51].

Assessments of the impacts of cultural competence training and education on the behaviour of healthcare providers in practice are also warranted. Approaches to evaluating the behavioural outcomes resulting from cultural competence training could include: qualitative physician and patient interviews to see if there is agreement on the implementation of cultural competence skills and behaviours in the clinical encounter; medical record review to check for documentation of the use of cultural competence skills and how these have impacted healthcare processes and outcomes; and, video-/audiotaped clinical encounters conducted randomly to assess whether cultural competence skills are being implemented [1].

Better assessment of the impacts of cultural competence interventions also requires more consistent measurement of healthcare and health outcomes. Studies on programs and services to improve cultural competence provide good examples of the kinds of healthcare outcomes that can be assessed. These include a range of healthcare access and utilisation indicators, as well as treatment rates, and impacts on health knowledge and behaviour. Considering that the healthcare disparities experienced by many racial and ethnic minority groups are a key driver of cultural competence, intervention evaluations need to focus more on assessing their impact on healthcare outcomes. However, improvements in study quality are needed to meet these evaluation standards. These include greater use of validated measurement tools and stronger study designs which allow for randomisation or comparisons across multiple time periods. Wherever possible, cultural competence interventions should also be assessed for their impact on patient health outcomes.

We recognise that assessing the impacts of cultural competence training and education on healthcare and health outcomes poses challenges that are not encountered in evaluating other types of interventions. However, it is possible to assess training and education impacts on these outcomes. A potential approach to evaluating the impacts of cultural competence training on healthcare and health outcomes was outlined by Betancourt [1]. To link cultural competence training to healthcare and health outcomes, Betancourt suggested that cultural competence training needs to (a) target a particular population group, (b) focus on a particular clinical condition and (c) teach a specified set of targeted skills related to an outcome measure, alongside general cultural competence training. Demonstrating that health practitioners first learn the core knowledge, attitudes and skills and then consistently apply these in patient encounters is critical. An example of its workability is as follows: a review

of medical records could be used to evaluate the application of specific skills (such as asking for patients' explanatory model) and whether this impacts on access to health promotion and prevention interventions (such as screening tests) and/or is associated with increased adherence to medication regimes or improved measures (such as blood pressure control) [1]. Such a research methodology would go a long way towards testing the potential impacts of cultural competence training and education on patient healthcare and health outcomes and contribute significantly to the strength of the evidence base on cultural competence.

8.3 Attention to Issues of Power

There is a tension in the assumption that cultural competence training is an effective strategy for addressing racial and ethnic health disparities. In cultural competence training, issues around cultural differences are confused with issues related to larger structural disadvantage such as racism and discrimination or poverty [52]. There is particular concern that by focusing on culture and cultural differences, issues of unequal power, exhibited through institutional racism and racial discrimination or bias in healthcare, are overlooked or ignored [52, 53]. As discussed in Chap. 2, for healthcare to address the disparities experienced by racial and ethnic minority populations, healthcare provider and system racial bias are key considerations. Despite the impact of racial bias on healthcare disparities, there is minimal evidence of this being addressed in cultural competence training [54, 55]; rather, it focuses on patients' culture and characteristics [56].

Greater attention to racial bias among health professionals and in healthcare systems at large is needed. This includes measuring the impact of cultural competence education and training on practitioner bias. To assess practitioner racial bias, measures beyond self-assessment, which only tests for explicit bias, are needed. Response time measures such as those used in Implicit Association Tests (IATs) can assess implicit bias by testing people's 'spontaneous and uncensored reactions' [57]. IATs are one approach that could be used to more accurately measure the effects of cultural competence and other training on practitioner bias. However, approaches such as these should include opportunities for self-affirmation to increase willingness to acknowledge racism and white privilege and to decrease negative responses which have been associated with IATs [56, 58]. Reflexive anti-racism is another approach which encourages reflection on one's own experience of race, self-reflection on racial identity and white privilege while addressing counter-productive emotional responses [59].

In general, the issues of racial bias among health providers and systems, as well as racism in society and across institutions, deserve far greater attention in the cultural competence literature. There is ample evidence to demonstrate the central role played by practitioner racial bias in healthcare disparities through its effects on practitioner behaviour in the clinical encounter [16, 17, 60–65]. Research studies also show that experiences of racism are clearly linked to health outcomes [66–70].

However, our understanding of exactly how racial bias and racism affect healthcare and health disparities is limited by current research methods. While there is a substantial body of research on interpersonal and institutional racism, particularly looking at patient-perceived discrimination and provider bias, it has been found that measures do not allow for a closer examination of the impact of racism on disparities in healthcare [71]. More sophisticated approaches to assessing healthcare provider racism are needed to better inform intervention approaches to address this issue [72].

8.4 Conclusion

The studies included in this review provide some evidence that cultural competence interventions are successful in addressing the purported issues driving cultural competence. However, in general, the reviewed studies reported limited impacts of interventions on sociocultural factors implicated in healthcare and health outcomes. Better assessments of the degree to which cultural competence interventions address the identified drivers require greater focus on assessing patient experiences, as well as healthcare and health outcomes. Cultural competence education and training intervention and evaluation approaches need improvement with issues of unequal power, as exhibited through racial bias and discrimination, given greater attention. The lessons learned from examining the strengths and weaknesses of the evidence in these evaluations can help to develop a more robust evidence base on the impact of interventions on the drivers of cultural competence.

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Chapter 9
Multilevel Cultural Competence Intervention Implementation and Evaluation Framework

9.1 A Multilevel Framework for Cultural Competence in Healthcare

The seminal definition of cultural competence proposed by Cross et al. describes the need for cultural competence to be coherently integrated across the different key components of health systems to achieve maximum benefit [1]. Indeed, one of the primary factors which distinguishes cultural competence from the earlier concepts, such as cultural awareness, cultural security and cultural safety, is that it goes beyond any one dimension of healthcare systems to focus on facilitating changes in all levels of healthcare practice, including the practitioner, services, organisation and system levels [2]. This type of whole of organisation approach is reflected in the systems cultural competence interventions reviewed by the authors [3] and reported in Chap. 7 of this book. However, cultural competence interventions are most commonly delivered using a siloed approach, where interventions target one aspect of healthcare systems without explicit consideration of effects on or integration across other levels.

Achieving the kind of congruent cultural competence discussed by Cross et al., in the complex health systems that exist today, necessitates integrated, multilevel intervention approaches, approaches which affect change on individual, team, organisational and larger systems levels of healthcare systems to enable deeper more sustained changes [4]. To encourage and help develop such integrated intervention approaches, we present a multilevel framework for the design and evaluation of cultural competence interventions (see Table 9.1). This framework demonstrates how cultural competence is addressed at various levels or components of health systems through interventions targeting healthcare education, workforce development, programs and services and organisations and systems. Drawing on the results of the literature review presented in previous chapters, the framework includes the key intervention strategies, measurement tools and indicators and

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Table 9.1 Multilevel cultural competence intervention implementation and evaluation framework

	Workforce development	Education and training	Services and programs	Systems and organisations
Intervention strategies	**Delivery mode:** • **Professional development interventions to improve cultural competence** – Health issue/field or practice specific training – Supervision and mentoring • **Cultural competence training** – Categorical training approaches – Cross-cultural training approaches • **Delivery mode** – Single-site – Multiple-site	**Delivery mode:** • **Integration of cultural competence into core or elective curriculum** – Didactic (e.g. Lectures) – Interactive (e.g. Tutorials) – Experiential (e.g. Case scenarios) • **Cultural immersion** – Education sessions – Clinical placements – Community experience • **Cultural education and training** – Didactic – Interactive	**Delivery mode:** • **Community focused strategies** – Community Participation – Community Partnerships – Community Spaces – Community Networks • **Culture focused strategies** – Values/beliefs/ practices – Cultural Activities – Religion/spirituality – Interactive/visual resources • **Language focused strategies** – Full Language Adaptation – Partial Language Adaptation – Written/Audio-visual Resources	**Delivery mode:** • **Audit and quality improvement** – Develop resources, tools and guidelines – Implementation of audit and monitoring • **Organisation-level policies or strategies** – Cultural protocol or policy – Workforce diversity/communication – Workforce cultural competence training – Tailored services/programs – Org. environment: support, access, resource – Advocacy for cultural, economic and social determinants – Promoted national cultural competence standards implementation – Increase quality/access/participation

Measures and indicators	• **Measurement tools** – Practitioner self-report pre-post questionnaire – Interview – Focus group – Practice site audit – Measures of research productivity • **Measurement instruments** – Patient-Reported Physician Cultural Competence (PRPCC) – Cultural Knowledge Scale (CKS) – Cultural Competency Assessment (CCA) tool – Cultural Competence Assessment Tool (CCAT) – Cultural Quotient (CQ) questionnaire • **Indicators** – Provider knowledge, attitudes, skills, behaviour and confidence – Patient satisfaction and trust	• **Measurement tools** – Student learning outcomes – Reflective journal – Assignments – Exams/tests • **Measurement instruments** – Modern Racism Scale (MRS) – Attitudes Towards Indigenous Australians (ATIA) scale – Colour blind and racial attitudes scale – Transcultural self-efficacy (TSE) – Inventory for Assessing the Process of Cultural Competence – Revised (IAPCC-R) • **Indicators** – Knowledge – Attitudes – Confidence – Openness to diversity – Self-perceived cultural competence and skills	• **Measurement tools** – Survey/questionnaire – Interview – Focus group – Clinical/program records • **Measurement instruments** – Client Satisfaction Inventory (CSI) – Medical Mistrust Index – Patient Hospital Satisfaction Index • **Indicators** – Medical mistrust and patient satisfaction – Program/service access/utilisation – Treatment/retention rates – Health knowledge – Health outcomes	• **Measurement tools** – Audit – Interview – Focus group/client workshop – Survey/questionnaire • **Measurement instruments** – Cultural Competence Assessment Tool for Hospitals (CCATH) – Consumer Assessment of Healthcare Providers and Systems (CAHPS) – Consumer Notes Clinical Indicators (CNCI) – Adapted Organisational Readiness to Change Assessment (ORCA) • **Indicators** – Cultural sensitivity/respect/competence/responsiveness – Staff perspectives – Patient experiences and perceived barriers – Service self-report of cultural competence practices – Healthcare quality, delivery and access – Stakeholder knowledge and attitudes – Organisational readiness to change

(continued)

Table 9.1 (continued)

	Workforce development	Education and training	Services and programs	Systems and organisations
Intervention outcomes	• **Provider related outcomes** – Provider knowledge, attitudes, confidence and awareness – Provider cultural competence skills for the clinical encounter – Provider behaviour in clinical encounter • **Patient-related outcomes** – Patient satisfaction and trust – Patient assessed practitioner cultural competence – Service access, utilisation, retention and treatment adherence rates – Health outcomes	• **Student outcomes** – Student knowledge, attitudes, awareness – Student perceptions and experiences – Student satisfaction – Student confidence	• **Intermediate healthcare outcomes** – Patient and staff satisfaction – Service utilisation/ access – Retention/adherence/ treatment rates – Improved health knowledge and awareness – Improved health behaviours • **Health outcomes** – Reduction in depression severity – Improvements in quality of life – Improvements in physiological measures for cardiovascular disease and diabetes risk factors	• **Organisational systems** – Improved resources/tools for providing cultural competence – Identification of needs for improvement – Healthcare outcomes • **Patient/practitioner encounter** – Cultural respect/communication – Patient/family satisfaction – Practitioner outcomes/satisfaction • **National outcome** – Informed national standards

outcomes to inform intervention planning, implementation and evaluation for each of these healthcare levels.

This framework offers a coherent set of strategies with related measures and outcomes. It can be used to inform cultural competence interventions for respective levels or multilevel interventions which incorporate strategies from across different levels to achieve maximum benefit towards cultural competence goals. The framework has universal application for healthcare delivery by explicating the factors important in quality healthcare for all. This is particularly the case given the current population diversity in the four CANZUS nations and continuing global migration.

We present the framework for discussion and comment on its relevance and usefulness in healthcare system contexts. To assess its utility, this framework requires testing and evaluation in practice. Application of the framework could also be improved by addressing study quality issues identified in previous chapters. This includes the assessment of behavioural outcomes in healthcare providers resulting from cultural competence education and training interventions and the evaluation of intervention impacts on healthcare and health outcomes.

9.2 Evaluating Multilevel Interventions

In complex multilevel cultural competence interventions, determining what works in what contexts and which specific intervention components have the greatest impact can be very difficult [5]. Systemic evaluation approaches can help to better understand the relationship between intervention strategies and outcomes. Different approaches to multilevel intervention evaluations were suggested [5–8], and while they exhibit some distinctions, they also share significant commonalities. All suggested evaluation approaches for multilevel interventions require mixed-method design [5–8]. Longitudinal case study approaches that explore contextual- and site-specific variables across an intervention's lifetime are also frequently recommended [5–7]. For example, in their study, Harris et al. used a mixed-method, longitudinal case study approach including interviews, focus groups, observation of program meetings and report design questionnaires to explore synergies and catalytic interactions between a public health campaign and other levels of an intervention program, many of which were not anticipated or hypothesised in advance [5]. Nastasi and Hitchcock additionally recommend going beyond notions of program success when measuring outcomes. They suggest including aspects such as program acceptability and integrity, cultural or social validity, program sustainability and institutionalisation, along with program impact outcomes [8]. The summary table can assist program and evaluation developers to consider the types of strategies, measures and indicators that can be included to facilitate the achievement of desired outcomes.

Frequently, evaluations focus solely on intervention impacts without exploring the processes occurring in between which explain the 'how' of cultural competence intervention outcomes [9]. These types of 'black box' evaluations, where we know

the intervention strategies and outcomes [9] but cannot explain the reasons for program outcomes, affect program validity and replicability [7]. To determine causal relationships between cultural competence intervention strategies and outcomes in a way that accounts for complex community and organisational factors, we need to go beyond impact evaluations [7]. Systemic analysis helps to provide a more explicit understanding of cultural competence programs [9] by identifying the different components within a system and explicitly analysing their relationships, both to each component and the whole system [10].

One of the major benefits of multilevel cultural competence interventions is that they can increase program effectiveness through unpredictable interactions between intervention components [11]. When evaluating multilevel interventions, it is important that these dynamics are captured. Therefore, it is imperative to explore how different intervention components in complex interventions interact over time [5, 12, 13]. In particular, to understand the operation of synergistic effects 'where the combined effect of two (or more) intervention components is greater than the sum of the two parts provided in isolation' [5]. This requires novel approaches to intervention evaluation.

One issue in the evaluation of complex multilevel cultural competence programs is the continued reliance on linear models for mapping program relationships. These models explain relationships between program components using 'predictable, sequential and unidirectional' models [14]. To better capture the complex relationship between cultural competence program components and outcomes in multilevel interventions, models that depict complex system properties and relationships are crucial [14]. Causal loop diagrams, a system thinking tool for mapping complex relationships in multifaceted programs, provide a more detailed and nuanced picture of the relationships and interactions between and within different cultural competence program components [9]. Causal loop diagrams have been shown to enhance the interpretation of qualitative and quantitative data and allow for reframing of program problems and the emergence of more effective solutions than those offered by linear models [9]. Mapping the patterns and relationships between program components has the potential to more accurately reveal the different factors leading to cultural competence program outcomes. This mapping can help to avoid drawing incorrect conclusions about program cause and effect when there are many factors at play [9].

9.3 Conclusion

We drew on the trends in intervention strategies, measures and outcomes across the reviewed studies to form a preliminary framework for multilevel cultural competence interventions in healthcare. The framework presented here is designed to help guide those designing, implementing and evaluating cultural competence interventions. The framework provides a template of intervention strategies, measurement tools, indicators and outcomes which can inform interventions to improve the

capacity of healthcare systems to provide care that is responsive to differing cultural needs and contexts. This framework has the potential to increase consistency across interventions and, in doing so, can help build a stronger evidence base for the effectiveness of interventions aimed at improving the cultural competence of health systems.

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Glossary

Acculturation The degree to which an individual accepts and adheres to the majorly dominant cultural values and their own cultural values [1].

Clinical indicators Statements describing pivotal healthcare behaviours that provide a practical and simple method of auditing important aspects of healthcare and have been used as a means of improving healthcare quality [2].

Culturalism The process of viewing people through the lens of culture defined narrowly as shared values, beliefs and practices and often conflated with ethnicity. In this process, 'culture' thus defined operates as the primary explanation for why certain people or groups experience various health, social or economic problems such as poverty, substance abuse or low birth weight [3].

Cross-cultural Relating to different cultures or comparison between them [4].

Cultural adaptation The process of altering a program to reduce mismatches between its characteristics and those of the new context in which it is implemented or used [5].

Cultural awareness An understanding of a relevant cultural issue, not necessarily accompanied by a common or accepted practice or action [6].

Cultural competence A set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations [7]. Cultural Competence is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services [8]. It involves understanding and integrating differences and incorporating them into daily care and working effectively in cross-cultural situations [9].

Cultural distance The degree of difference between the home culture and the host culture [10].

Cultural framework Traditions, value systems, myths and symbols that are common in a given society [11].

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Cultural humility The ability to maintain an interpersonal stance that is open to the other in relation to aspects of cultural identity that are most important to the person [12].

Cultural literacy The ability to understand and participate fluently in a given culture [13].

Cultural respect The recognition, protection and continued advancement of the inherent rights, cultures and traditions of a particular culture [14].

Cultural responsiveness The ability to learn from and relate respectfully with people of your own culture as well as those from other cultures [15].

Cultural safety Involves health providers working with individuals, organisations and the community to counter tendencies in healthcare that create cultural risk (or unsafety) through small actions and gestures, not usually standardised as policy and procedure. Cultural risk occurs when people from one ethnocultural group believe they are demeaned, diminished or disempowered by the actions and the delivery systems of people from another culture [3, 6].

Cultural security Links understandings and actions through policies and procedures which create processes that are automatically applied in healthcare [6].

Cultural sensitivity Is based on views of culturally diverse patients rather than views of healthcare professionals. Patient-centred, culturally sensitive healthcare (a) emphasises healthcare provision and policies that culturally diverse patients identify as indicators of respect for their culture and that enable these patients to feel comfortable with, trusted and respected by their healthcare providers and office staff; (b) conceptualises the patient-provider relationship as a partnership that emerges from patient centeredness; and (c) is patient empowerment oriented [16].

Cultural tailoring The process of creating culturally sensitive interventions, often involving the adaptation of existing materials and programs for racial/ethnic subpopulations [17].

Culture A system of beliefs, values and customs that are learned, shared and transmitted through symbols [18]. Three primary cultural features are *demographic features*, such as age, ethnicity, gender, race, physical characteristics and inherited social identities; *geographical features* and climate; and associative *features* including religion, profession, politics and employment [19].

Culture shock The stress, anxiety or discomfort a person feels when they are placed in an unfamiliar cultural environment, due to the loss of familiar meanings and cues relating to communication and behaviour [8].

Discrimination The unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age or sex [20].

Diversity The variety of differences that exist among people who comprise humanity [21].

Enculturation The process by which an individual learns about and identifies his or her own cultural roots [1].

Ethnicity Shared group identity based on history, tradition, social customs, common language, religion, geographic origin and/or being a minority. Generally based on self-identification [22].

Healthcare disparities Differences in health care quality, access, and outcomes adversely affecting members of racial and ethnic minority groups and other socially disadvantaged populations [23, 24].

Health inequities Differences in the health status and the distribution of health determinants between different population groups [25].

Indigeneity (Australian) Involves a three-part definition: being of Aboriginal and/or Torres Strait Islander descent, being Aboriginal or Torres Strait Islander and being recognised by the community as being an Aboriginal or Torres Strait Islander [26]. However, Yin Paradies makes the point that Indigeneity does not require 'particular phenotypical traits, certain forms of cultural alterity, specific ethico-moral beliefs/actions or a certain level of social disadvantage … [instead] … the poor and the rich Indigene, the cultural reviver and the quintessential cosmopolitan, the fair, dark, good and bad and disinterested may have little in common, they are nonetheless all equally but variously Indigenous' [27].

Indigenous peoples globally The heterogeneity of Indigenous peoples globally is reflected in differing definitions across different countries. International forums have abandoned attempts to define Indigenous groups in favour of self-definition, due to the risk of excluding peoples because they do not fit in the definition [28]. The Draft Declaration on the Rights of Indigenous Peoples states that 'Indigenous peoples have a collective and individual right to maintain and develop their distinct identities and characteristics, including the right to identify themselves as indigenous and to be recognized as such' [28].

Institutionalised racism The way that societies' educational, economic, justice and healthcare institutions or organisations disadvantage certain groups, resulting in racist consequences [29, 30].

Intercultural Taking place between cultures or derived from different cultures [31].

Interracial Existing between or involving different races [32].

Multiculturalism Emphasises the need to respect and be sensitive to the cultures of different groups [3].

Race Classification of humans into groups based on physical traits, ancestry, genetics or social relations [33, 34].

Racial bias Inclination or prejudice for or against one person or group based on their race [35].

Racialisation The social process by which people are labelled according to particular physical characteristics or arbitrary ethnic or racial categories and then dealt with in accordance with beliefs related to those labels [3].

Racism Prejudice, discrimination or antagonism directed against someone of a different race based on the belief that one's own race is superior [36, 37].

Social determinants of health A range of casual factors, which sit outside of the health domain, corresponding with political, economic, social and cultural inequities [38–40].

Sociocultural A range of factors including both cultural and social economic status, support or stressors [41].

Traditionality An adherence to cultural values and behaviours that define a traditional perspective or way of life [1].

Transcultural (cross-cultural) care Working in cross-cultural situations [7].

Worldviews Structures of beliefs, assumptions, values and principles, often implicit and deeply held, which determine how life at its most basic level is perceived, interpreted and explained [42, 43].

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