

## Chapter 2

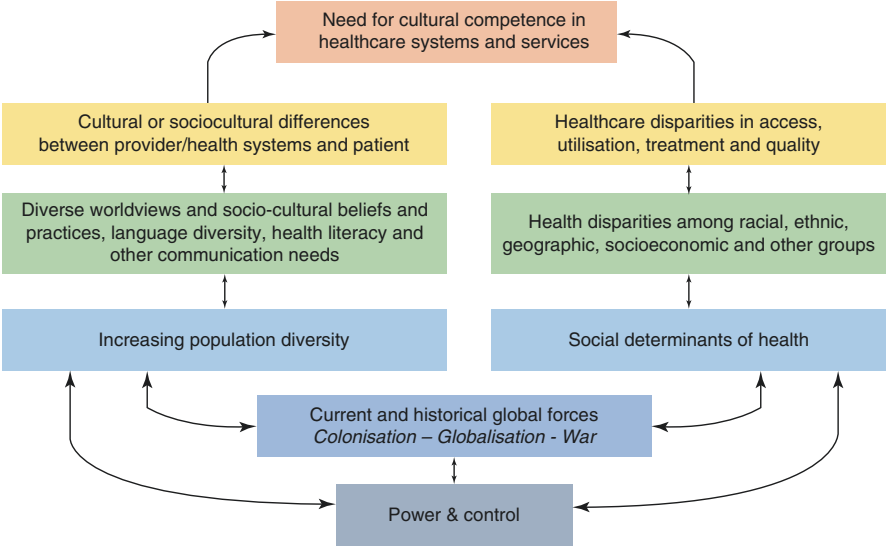
# The Drivers of Cultural Competence

### 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



**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, socio-economic 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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