

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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