An investigation of culturally competent terminology in healthcare policy finds ambiguity and lack of definition

Abstract

Objective: This research explored how the concept of cultural competence was represented and expressed through health policies that were intended to improve the quality and efficacy of healthcare provided to families from culturally marginalised communities, particularly women and children with refugee backgrounds.

Method: A critical document analysis was conducted of policies that inform healthcare for families from culturally marginalised communities in two local government areas in South Australia.

Results: The analysis identified two major themes: lack of, or inconsistent, definitions of 'culture' and 'cultural competency' and related terms; and the paradoxical use of language to determine care.

Conclusions: Cultural competence within health services has been identified as an important factor that can improve the health outcomes for families from marginalised communities. However, inconsistency in definitions, understanding and implementation of cultural competence in health practice makes it difficult to implement care using these frameworks.

Implications: Clearly defined pathways are necessary from health policy to inform culturally competent service delivery. The capacity for policy directives to effectively circumvent the potential deleterious outcomes of culturally incompetent services is only possible when that policy provides clear definitions and instructions. Consultation and partnership are necessary to develop effective definitions and processes relating to cultural competence.

Key words: immigration, child health, child welfare, culture, health services

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While there is a growing literature related to the conceptual importance of culturally competent healthcare, there is little evidence demonstrating its effectiveness in improving healthcare outcomes.[1-3] Studies also often lack methodological rigour.[4] There is some evidence that training health professionals in the provision of culturally competent care results in improved service delivery,[3-5] but contrary evidence also exists.[6]

Internationally, terminology around the provision of culturally competent healthcare is varied. For example, cultural competence, or cross-cultural or transcultural care, has been mainly used in the United States (US). The cultural safety model has taken precedence in New Zealand (NZ) and in Canada. However, in Australia, there is a wide variety of terms including cultural security,[7] cultural safety,[7,8] and cultural competence.[9] From a strictly theoretical perspective, cultural competence has been critiqued[2,10-12] but, despite limitations, the relatively stronger body of evidence perpetuates its use as a preferred concept. Other more recent concepts, such as cultural safety, have been described as being theoretically more appropriate, but lack research evidence to support their adoption.[13,14]

Despite years spent developing policies and strategies for culturally competent healthcare, culturally marginalised clients continue to experience culturally incompetent healthcare.[15-17] Despite best intentions, health professionals use unexamined approaches of white Western practices when working with families who are culturally different to themselves.[18,19] This can have unintended effects of paternalism and assimilation into Western cultural practices.[18,19]

Discriminatory healthcare experiences are particularly significant for children from culturally marginalised communities because early experiences greatly affect long-term health outcomes and ability to achieve educationally and economically.[20,21] Exposure to racial discrimination is described as a chronic stressor and risk factor for poor health outcomes.[22] Studies that have explored the relationship between discrimination and child health are limited and primarily relate to older children from African American groups.[23] Existing studies show strong relationships between perceived racism and mental health problems, as well as behavioural issues, particularly in adolescent risk taking behaviours and indicators of metabolic and cardiovascular disease.[23,24] This is consistent with an Australian study of children from Middle Eastern and Asian backgrounds that found perceived discrimination in childhood linked to withdrawn social behaviours, greater emotional problems and indirect aggression.[25]

Children with parents from refugee backgrounds are particularly vulnerable, and have an increased risk of developing physical or psychological problems.[17,25,26] More specifically, refugee children who have also experienced traumas such as physical and mental deprivation, violence and displacement at critical developmental stages are likely to have a higher burden of mental health problems.[27] More research is required to understand the relationship between the timing of racial discrimination and negative health impacts.[24]

A child's experience is explicitly shaped by their parents' socio-emotional, physical and economic situation. Indeed, disadvantage that begins before birth and follows into infancy and early childhood is known to accumulate throughout life.[28] While we know that vicarious racism, through parents or caregivers, is associated with poor health outcomes among Indigenous child populations in Australia,[29] what is not clear is how the vicarious experiences of racial discrimination affects health outcomes for children.[24] Links have been identified to reduced maternal support and involvement with children, reduced quality of the maternal-child relationship and reduced capacity to provide a warm, caring environment.[22,23] Where parents seeking care for their children encounter – at best – culturally unsafe services and – at worst – discriminatory or racist experiences, their children will be further disadvantaged.

Cultural competence has been internationally recognised as a safety and quality strategy that can reduce harm and ultimately save lives.[30-32] However, there is a lack of research around strategies for working with cultural diversity in children's health in an Australian context.[33] While there is a growing body of evidence around the health impacts of discrimination on children at an individual level, there is a significant lack of research around how institutional and structural racism affects the health and well-being of children.[24] For this reason, it is essential to explore how health policies aimed at supporting children and their families represent diversity and cultural competency for practice.

In South Australia, both new arrivals and individuals in the early childhood years are identified as at-risk populations requiring specific effort for equity strategies within health.[34] Further, women and children are identified in the *Framework for Early Childhood Services in South Australia* as particularly susceptible to inequalities in health and welfare, mainly during the antenatal period and throughout the early childhood years.[35] Women and children from marginalised communities, such as those with refugee backgrounds, face even greater challenges in having their healthcare needs met due to the host culture lacking the language skills, resources, cultural knowledge and understanding for adequate communication. Both of these reports were intended to guide organisational policies in the ensuing years.

Despite the subsequent implementation of policy there is little research evidence as to how related policies are understood and implemented for services for families from refugee backgrounds. Newman, Baum and Harris[36] reviewed national policy responses to health inequities and highlight the omission of refugee health to close the vulnerability gap. They also report that terms such as 'disadvantage' and 'health inequities' are not defined clearly, nor are they noticeably addressed in government targets.[36]

To address health inequities, the Australian Institute of Health and Welfare (AIHW)[37] suggests that "access to affordable socially and culturally appropriate services and support systems that strengthen families and community capacity to look after children is important for improving outcomes for children". In 2012, "culturally appropriate" care remains ill-defined. Sims et al.[17] identified cultural competency and partnership as important factors in the provision of culturally appropriate care. In 2005, AIHW[37] said that as a nation we "lack specific indicators to monitor the performance of systems and services that are available to children and families". The 2009 AIHW report argues that many indicators are available on a range of performance measures around health and well-being, however there remain no measures to indicate whether service provision is culturally safe.[38] Performance of systems and services aimed at supporting families becomes more imperative when they have experienced the multiple traumas of forced migration and are at risk of experiencing continued trauma through institutional racism.[39] Unless we comprehensively define effective strategies such as cultural competence we cannot develop indicators to monitor systems and services used by marginalised families, such as refugees.

In the public health domain, policies define goals and strategies to promote, protect and maintain the health of the population. Public policies have been enacted in a variety of sectors, including education, water and sanitation,[40] transport and finance, as well as in the healthcare sector. Further, policy and government ideologies play a pivotal role in health funding and outcomes. However, although policies are necessary to ensure universal, competent, professional practice, they are not sufficient on their own. The process of creating policies to reduce structural forms of racial discrimination and thus reduce health inequities requires an understanding of the interplay between policy, service provision and the effectiveness of the outcomes on the population in question. This study explicitly explores this interface by critiquing how cultural competence is represented in public and health services policies.

Policy and procedural directives represent structural determinants of health. As a determinant of health, this focus on policy highlights the upstream, government-based influences on health outcomes for the population of refugee infants and children. Policy occurs through three processes of change: "convincing policy makers that a problem exists; proposing feasible, politically attractive proposals to solve the problem; and negotiating the politics that influence whether a proposal succeeds in the political arena".[41] The focus here is to explore the concept of cultural competence in policy. Overall, training and information about cultural competence will ultimately only be as effective as the policy that drives practice. This study will contribute this much needed perspective to the literature.

We performed a policy document analysis of mainstream healthcare organisations that provide health and parenting services to families who gained entry to Australia through humanitarian programs (i.e. as refugees or asylum seekers). Our analysis sought to identify how cultural competence was represented and expressed

in policy. Thus, the critique examined the structural foundations that influence practice in these organisations. Significantly, this study addresses two of the seven strategic directions of Australia's *National Preventative Health Strategy*: to "act early and throughout life" and "reduce inequality" through targeting disadvantage.[42] Given that disadvantage that begins early continues throughout life,[28] this research is important not only for this generation of newly arrived Australian children, but also for the future of all families negotiating the challenges of parenting alongside the challenges of being racially and culturally marginalised.

Method

Policy data were gathered from freely available online national and state policy directives, as well as organisational policy and procedures from mainstream healthcare organisations providing services to parents and children from refugee backgrounds in two Local Government Areas (LGAs) in South Australia. LGAs selections were based on settlement data that indicated areas of greatest refugee settlement in the Adelaide metropolitan area. Funding was obtained from a grant from the Flinders University Faculty of Health Sciences in 2009. Ethical approval was gained from the Social and Behavioural Research Ethics Committee (SBREC) of Flinders University (number 4663). Key informants, such as chief executive officers (three), public health service managers (four), and local government health and welfare service managers (four), were contacted to identify which health organisations to approach. Organisations that were approached were asked to "provide copies of any current policy and practice documents that pertain to cultural competency, partnership or general policies that make reference to these aspects of care". The following list of terms was circulated with the invitation to participate: "cultural competency and related terms such as cultural awareness, cultural sensitivity, cultural safety, partnership, engaging consumers, working with diversity". Chief executive officers, managers or directors of participating organisations were directly invited to participate. To indicate acceptance, they were asked to sign a letter of permission for a nominated person to liaise with the researchers to provide the requested documentation. Participant organisations were assured anonymity of their organisation and their policy documents. All organisations that were invited to participate did so. The research design did not include an offer to discuss findings or recommendations with participating organisations.

Policy documents were provided on consumer participation, partnership, information sharing, cultural and linguistic diversity, child protection and Aboriginal health. Additionally, many services provided examples of procedural documents that enabled critique of how and if policy recommendations were represented at a procedural level. In total, 79 documents were provided and analysed. They comprised frameworks, policy directives, policies, policy guidelines, clinical standards, practice guidelines and procedures. Many health services also referred us to Commonwealth of Australia Frameworks, South Australian Government and SA Health

Frameworks and Policy Directives, which were incorporated as part of the analysis. The analysis that follows excludes data from clinical standards, practice guidelines and procedures as these did not routinely make any reference to culturally competent or safe care. The discussion in this paper is limited to the results as they specifically related to the use of 'cultural competence' and related terms. The term 'policy documents' is used to refer to all remaining documents analysed in this paper.

All documents were loaded onto *Nvivo* software to support both inductive and deductive analysis. Inductive analysis enabled initial coding in an open manner. All documents were read and reread to identify content, context and concepts for initial coding.[43] This enabled the data to be read, described and interpreted without the encumbrance of a preconceived set of questions.[44] All documents were deductively coded using an analysis framework by Newman, Baum and Harris[36] that was adapted with permission to specifically critique cultural competency. The framework provided an eight-point analytical grid to question the data:

1. What was the focus of the document? How does it link to other documents?
2. How was it developed and by whom? Were stakeholders involved in the development?
3. Were the terms explicitly mentioned and defined? How? Who is responsible for implementation?
4. What are the aims of the policies?
5. What specific strategies for implementation were identified?
6. Were there any strategies involving intersectorial collaboration?
7. Is there any evidence that the policies have been implemented?
8. Are there clear, measurable targets and deadlines with processes for monitoring and evaluating progress?

All data were clustered into themes. Following Braun and Clarke,[45] this involved "searching across the data set…to find repeated patterns of meaning". The themes were critiqued using discourse analytical techniques through a lens of critical social theory. For this study, discourse refers to language in social use.[46,47] The construction of discourse is marked by a history of domination, subordination and resistance shaped by the social conditions of those who use it.[47] Discourse can also refer to how knowledge is structured and enacted through social practice.[46] In this context, we refer to the discourse of healthcare policy and explore how policy affects relations of power between healthcare providers and vulnerable consumers.

Critical theory offers a reflexive approach that "respects the complexity of the social world".[48] It enables an examination of the "competing power interests between groups and individuals within society".[48] Of particular importance for this study, it accounts for a range of areas of privilege such as race, gender, class and sexuality, and does not lay the responsibility for improved health on the individual. Rather, it sees any form of active social justice as a relational activity.

Results and Discussion

The two major findings in relation to cultural competence are: 1) a lack of definition, consistency, and application of the terms 'culture', 'cultural competency' and related concepts; and 2) the paradoxical use of language to determine care.

Defining culture

A major finding was an inconsistent use of the term 'culture' and lack of clear definition. This is not a new problem, nor is culture a term that can be defined singularly. Raymond Williams, a prominent theorist and researcher of culture, states that "culture is one of the two or three most complicated words in the English language".[49] However, the indiscriminate use of the word without an attendant definition within policy documents adds to confusion regarding interpretation of it for application. It also reduces the inherent significance of working with culture and diversity proposed within the documents.

The National Health and Medical Research Council of Australia guide to culturally competent care,[50] like many policy documents we analysed, does not define what is meant by culture. Culture is assumed, and continually appears only to be held by those who are ethnically different to those from Anglo backgrounds. The majority of documents analysed did not offer definitions. Only two documents from one health service offered the following inclusive definition of culture as an:

> "integrated pattern of human behaviour which includes, but is not limited to: communications languages, beliefs, values, practices, customs, rituals, roles, relationships and expected behaviours of a racial, ethnic, religious, social or political group".

This definition can be applied to individuals and groups, and it does not, like the majority of policy documents, conflate culture with ethnicity. From a mainstream policy perspective, this enables the policy to include a range of marginalised groups and individuals such as same-sex attracted peoples, those with disabilities and those from refugee backgrounds and, as such, is conceptually an ideal definition.

In Australia, nationhood is represented through concepts of 'multiculture' and 'multiculturalism', where culture is often understood to represent 'different' ethnic groups and associated ways of life. Indeed, the current Australian policy *Multicultural Australia: United in Diversity* incorporates a strategic direction for access and equity, highlighting the need for greater investment for vulnerable individuals and groups, including refugees living as permanent or temporary residents in Australia.[51] While multiculturalism has been useful to value the range of cultural identities within the nation, it is problematic, as it does not account for the fluid and hybrid nature of disparate cultural groups or individuals.

Most of the policies reviewed either defined or inferred culture as identification with a group with shared or collective meaning. One policy, for example, stated that culture was "a property of a group". In common 20th century usage, culture generally refers to different cultural groups, where culture in the anthropological sense represents a particular way of life, as in – for example – an ethnic group. In the delivery of healthcare, this anthropological understanding can have adverse effects. Where care is informed by a belief that by understanding groups or cultures that are distinguished by common customs and ways of being in the world, informed by a national or common "spirit",[52] one can learn the group customs and thus have the knowledge to care for them. This anthropological approach has been adopted widely throughout Western nations, through "transcultural nursing practice".[53] The problem is that this has led to many health professionals feeling unable to competently work with clients culturally different to themselves without first having an armoury of knowledge about 'them' rather than an armoury of self-critique, cultural respect and professional inquiry.[18]

This approach leaves unattended the construct that assembling cultural meanings is a fluid and changing process, often conflicting within particular cultural groups.[48] Culture is not static but always negotiated within relations of power.

Cultural competency and other related terms

While 'cultural competency' was used in a prominent manner in all documents analysed, only two documents from one service provider explicitly defined 'culturally competent care'. In these documents, it was defined as a "set of behaviours, attitudes and policies within a system that enables effective interactions in a cross-cultural framework". This definition helpfully included behaviours and attitudes and also positioned this requirement within the context of both the individual and the organisation's responsibility.

This definition clearly follows the NHMRC guide, where cultural competence is defined as "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".[50] Core to this model is valuing diversity, cultural self-assessment, awareness of intercultural dynamics, and institutionalisation of cultural knowledge. Providing definitions means that all people working within the organisation potentially know explicitly what to aim for in relation to the care of peoples from diverse cultural backgrounds. Where definitions have not been made explicit, beliefs and practices about culturally competent care are left to the individual and their specific beliefs and values.

It was disconcerting that even though two policy documents detailed a framework for what 'should' happen in the delivery of culturally competent care, such as, "to value diversity and incorporate this into all aspects of the organisation" and to "self-assess in relation to these", no further documents, procedures, or practice guidelines offered how this might be enacted at the individual level. The only related items were procedures relating to the use of interpreters in practice. While important, it is not the whole of care for people from diverse cultural backgrounds. No policy explicitly mentioned the need to attend to race-based discrimination, other than to say all peoples should be treated 'regardless' of difference.

A further challenge was that two of the documents referred to cultural competency only as required in the care of people from Aboriginal and Torres Strait islander groups. We know that

Indigenous health outcomes in Australia have long been unattended and there is urgent need to redress this situation.[54,55] While it is important for the position of Indigenous Australians to be upheld as unique and necessarily privileged, doing so does not need to be at the exclusion of people from other marginalised groups. Implications for practice from this policy expression are demonstrated through recent Australian research into supporting diversity and preventing race-based discrimination in workplaces. Trennery et al.[3] found that while many tools exist for individual assessment of culturally competent practices, those from an Australian context were aimed primarily at working exclusively with Indigenous peoples. There were no programs for culturally competent care with other cultural groups in the Australian context documented or evaluated in the academic literature. The lack of explicit mention of the requirement to attend to behaviours and attitudes in definitions of culturally competent care in all but two documents is also consistent with the findings of Trennery et al.[3] The majority of programs reviewed by Trennery et al.[3] focused on improving knowledge rather than attending to attitudes or behaviours, which does not equate to a subsequent change in practice.

Policies need to lead an organisation and its practice.[56] Unless policies identify the need to address issues of behaviour and attitudes, and name race-based discrimination, practice will not change and peoples from diverse cultural and linguistic backgrounds will continue to receive care that is inequitable at best, and racist at worst, resulting in poorer outcomes.[57] In the majority of documents, the term 'cultural competency' is used uncritically, without explicit consideration of the nature of culture, keeping practice embedded in and reinforcing notions of anthropologically-based disparity. This raises the question: is cultural competency an appropriate framework from which to deliver care within a framework of social justice?

Models of cultural competence based on multiculturalism have been criticised for increasing distances between cultures,[58] thwarting cultural acceptance and integration,[59] marginalising cultural concerns to those outside the dominant white majority,[60] reinforcing middle-class normative positions,[61] and racial superiority.[62] In framing cultural competence, the NHMRC clearly stated that "achieving culturally competent healthcare is everybody's responsibility" and that cultural competence can only be achieved through partnership and participation.[50] This position of social inclusion and reciprocity is further reinforced by the repeated use of the term 'cultural diversity' rather than multiculturalism.

The term 'diversity' was present and defined in only one document. Terms that also appeared but were not defined in other documents included 'cultural inclusivity', 'cultural responsiveness' and 'culturally sensitivity'. A noticeable absence was the term 'cultural safety', which was used in only one document that specifically referred to service provision for Aboriginal and Torres Strait Islander people. This is concerning, because a culturally safe approach takes social justice as its starting point[63,64] and is showing promise as an approach in healthcare policy in NZ and Canada. Combined with critical approaches to culture, it is constructed as much more than cultural practice.

Originating in the bicultural context of NZ, cultural safety is an approach primarily adopted for use between non-Indigenous and Indigenous peoples.[64] Documents from this study indicate that cultural safety has primarily related to care for Aboriginal and Torres Strait Islander peoples. Cultural safety is the provision of healthcare by clinicians who recognise the self as a cultural being, the rights of others and the legitimacy of diversity and difference .[63] It does not attempt to learn about other cultural groups as a separate activity from this self-awareness. This is based on the premise that a health professional "who can understand his or her own culture and the theory of power relations can be culturally safe in any context".[63] This is reflected in the policy analysis of this research.

The paradox of liberal humanism

A major finding was that the majority of documents included language that suggested that services and care should be provided 'irrespective of difference'. Other similar statements include, 'regardless of sex, race, disability or religion', or 'regardless of individual circumstances, characteristics, differing abilities, language, culture or background'. This raises the question of how healthcare professionals can logically provide care in a culturally and linguistically appropriate manner where the policy is that care is to be provided 'without regard' to a person's cultural characteristics.

This language arguably stems from the political philosophy of liberalism, which developed in Europe during the 18th and 19th centuries following calls for recognition of individual freedoms. While the freedom of the individual was regarded as supreme, how this individuality was constructed remained the domain of democratic institutions such as contemporary health institutions. People were attributed individual freedom when they were able to demonstrate acceptance of the rational, scientific truths or universal knowledge of the particular culture or institution. This truth was based on the rationality of the mind and disregarded the emotive, non-scientific responses of the body or culture. Importantly, this separation, or Cartesian duality, marked the beginning of the separation of the universal from the specific, and culture from nature.

This separation or way of thinking is particularly endemic in healthcare.[65] In the policy analysed in this study, there is an attempt to balance the scientific rationality of physiological sameness within a population with the cultural or non-scientific requirements of individuals. This results in the normative scientific position, or mainstream care, taking precedence.

Historically, this rationality has been enacted as a logic of domination and oppression.[66] Scientific rationalism has eliminated competing ways of thinking by claiming itself as the sole basis for truth.[67] In the reviewed policies, dominance of the mainstream population, while paradoxically purported to be underpinned by universal human rights, was maintained through directives that care should explicitly be 'regardless of' or should not take into consideration the non-scientific or cultural complexities of life.

Enforcing humanism, where humans are viewed as physiologically the same, means that the democracy and its institutions operate through a rational and sanctioned system.[48] While this makes sense, it loses traction when the needs of those who might be culturally

different require alternate and specific care. This is when we see, as in the majority of the policies examined, dominant or mainstream discourses claimed as truth being hegemonically authorised, defining and controlling all other systems.[68] The systems that are controlled in healthcare become the systems of care enacted by healthcare professionals who have no choice but to adhere to policy.

In seeking to engender equity in healthcare policy, we found a language of humanism, such as that from the International Declaration of Human Rights. Unfortunately this seems to have led to a paradoxical loss of 'equity'. The United Nations' declaration of equity for all without distinction of any kind[69] is vastly different to the provision of services that are 'regardless of' individual distinctions promulgated by the healthcare policy documents. Equity requires recognition that those who require services are not equal. By disregarding individual distinctions, services may be equal even though recipients of care may not be, resulting in services that are not equitable. From a critical cultural studies perspective this is an example of the liberal humanist paradox.[48] As "the protector of individual rights and freedoms",[48] our healthcare policy makers forfeit individual rights for the greater interests of the state.

Universalising assumptions inherent within the liberal humanist paradigm presents major challenges for those living in the margins of normative culture and, in particular from this study, for health professionals seeking to provide care. To interpret and enact this framework is confusing for healthcare professionals who desire to provide equitable care and respect diversity.

Conclusions

Cultural competency within health services has been identified as an important factor that can improve the health outcomes for families from marginalised communities. However, there is an inconsistency in how cultural competency is defined, understood and implemented in health practice, making it difficult for health workers to implement care using this concept.

Within these policy documents the language is constitutive of the culture of healthcare service provision in South Australia. This culture shapes the discourses used by health professionals as they support those within their care. At the individual level, the discourses of liberal humanism within the policies continue to influence policy users to maintain a relationship of power whereby mainstream thinking overrides the needs of those from marginal groups. Therefore, it recognises "how people use discourse and how discourse uses people".[70] Policies provided to staff need to clearly define pathways for the delivery of services that address the current deficits in culturally competent care. Policy directives represent the interface between the goals of the organisation or government and the care provided by healthcare professionals. Therefore, the capacity of a policy directive to effectively circumvent the potential deleterious outcomes of culturally unsafe services is only possible when that policy provides clear definitions and instructions on what constitutes cultural competency. If practice is to change, policy needs to lead the way. Policy has the capacity to shape how healthcare organisations enact care.

Implications

People from marginalised communities are entitled to receive care that is tailored to their cultural needs and individual past histories through greater clarity in policies and processes. This is important, especially given the numbers of children who are potentially exposed to unsafe and inappropriate healthcare.

We recommend that policies incorporating notions of culturally competent care define their understanding and usage of the term. A multiplicity of definitions is not problematic if intentions around concepts and usage of terminology are clear. Ideally, descriptions of usage would be determined through consultation with stakeholders, particularly those who will be impacted by the policy directives. The language of liberal humanism needs to be removed from policy documents intended to improve care of societies' most marginalised individuals. Families from culturally marginalised communities will never receive care that is respectful of their particular cultural histories if policy continues to insist that care be undertaken 'irrespective' of diversity.

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