Cultural competence and diversity responsiveness: how to make a difference in healthcare?
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Citation for published version (APA):
Seeleman, M. C. (2014). Cultural competence and diversity responsiveness: how to make a difference in healthcare?
1 Introduction
Introduction

Patient populations in the Netherlands show increasing ethnic diversity. International research has demonstrated the existence of ethnic inequalities in accessibility and quality of healthcare. Similarly, over the years, research in the Netherlands has also shown ethnic inequalities in both health and healthcare.

In the Netherlands, various initiatives have been taken to improve healthcare for ethnic minority patients. However, because these initiatives (usually local) have seldom been evaluated, they have hardly contributed to a systematic development of evidence-based culturally competent healthcare (1). Research does not seem to have kept pace with the need experienced in everyday practice to develop healthcare that effectively responds to the diversity of present-day patient populations.

This thesis aims to contribute to a scientific basis for healthcare that effectively responds to patients’ diversity. For several decades, healthcare that is diversity responsive has been referred to as ‘culturally competent care’. The research presented here focuses on operationalisation of the concept of culturally competent/diversity responsive healthcare and on the application of these concepts in medical practice and education. First of all, this introductory chapter provides some background information about ethnic inequalities in healthcare and about the concept of cultural competence.

Ethnic diversity in the Netherlands

Settlement of migrants from various migration flows to the Netherlands and their children has resulted into an ethnically diverse society. In 2012, 3.5 million people (around 20% of the Dutch population) was from non-Dutch background* (2). In the Netherlands, ethnic groups are broadly divided into Western (mainly from Europe and northern America) and non-Western groups. In the largest Dutch cities, about 33% of the population is from non-Western ethnic background. The largest ‘non-Western’ groups originate from Surinam, Turkey, Morocco and the Dutch Antilles/Aruba. The largest groups classified as ‘Western’ are from Indonesia and Germany.

Based on the reason for migration, various migrant groups can be distinguished. First, there are those from the former Dutch colonies (Indonesia, Surinam, the Dutch Antilles and Aruba). Although the Surinamese and Antillean populations are ethnically highly diverse, most of the migrants from the former Dutch colonies have at least a basic understanding of the Dutch language.

* Non-Dutch background: classified as such by their country of birth and the countries of birth of their parents
Second, labour migrants have immigrated to the Netherlands since the 1960s; the largest groups of such migrants originate from Turkey and Morocco. Turkish and Moroccan men came to the Netherlands as labour migrants in the 1960s and 1970s mainly to perform unschooled jobs; neither group originally spoke Dutch. Nowadays, many labour migrants come from Eastern Europe. For example, Polish migrants are now the largest group of labour migrants in the Netherlands; most of them have not yet mastered the Dutch language (2).

A third migrant group consists of refugees applying for asylum in the Netherlands. The composition of this group is very diverse, and its origin reflects conflict zones around the world. Large groups of refugees that have settled in the Netherlands originated from Iraq, Iran, Afghanistan and Somalia.

A fourth group of migrants results from family reunification, i.e. those who arrive in the Netherlands to get married or to join their partners; for example, the families that followed the Moroccan and Turkish labour migrants in the 1970s. In 2012, family migration was the most frequent motive for people from Turkey, Morocco and Surinam to migrate to the Netherlands (2).

These motives for migration, and the various countries of origin, imply that the composition of the Dutch population is highly ethnically diverse. Also within the ethnic groups themselves, differences exist that might influence healthcare provision; for example, differences in socio-economic status, acculturation, migrant generation (first, second or third-generation migrant), or mastery of the Dutch language. As a consequence, the Dutch healthcare must respond to highly diverse patient populations.

In this thesis we focus on the ethnic diversity of patients. Ethnicity is a complex concept, which can be defined as “the social group a person belongs to and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry, and physical features traditionally associated with race” (3). Different measures are used to operationalise ethnicity. In the United States, ethnicity is referred to as ‘race/ethnicity’ and defined by racial group (e.g. African-American, Caucasian). In the UK, self-identified ethnicity is preferred (e.g. Afro-Caribbean, Pakistani). In the Netherlands, as in other countries in continental Europe, the country of birth of an individual and his/her parents is used as the basis for the classification of ethnic groups (e.g. Turkish, Moroccan, Surinamese) (4).

**Ethnic diversity in healthcare**

Internationally, the body of evidence concerning ethnic inequalities in healthcare is growing (5,6). Also in the Netherlands, insight into the process and outcomes of healthcare among ethnic minority patients has broadened.
Ethnic diversity among patients affects healthcare provision in various ways and care providers do not always respond adequately (7). An obvious issue of importance is language. Although the added value of using professional interpreters in the medical setting has been documented (8), professional interpreters are underused by Dutch healthcare providers (7,9). Inadequate response to a language barrier will hamper adequate information exchange. For example, Fransen et al. revealed ethnic inequalities in informed decision-making about participation in prenatal screening, due to underuse of interpretation services and translated information materials (10). Additionally, various Dutch studies showed ethnic differences in other aspects of medical communication. Compared with Dutch patients, for example, they found shorter consultations with ethnic minority patients, less patient participation, and a lower level of empathy shown by general practitioners (11-13).

Furthermore, difficulties might arise from differences in illness perceptions or expectations between patients and care providers. Ethnic differences in illness perceptions were found for both hypertension (14) and asthma (15), which may influence patients’ decisions regarding their treatment. Differences in patient expectations may also result in misunderstandings. If care providers behave in ways that are different from patients’ expectations this might result in lack of trust (9), as has been reported in oncology care (16). Finally, providers’ (unconscious) bias regarding ethnically diverse patients may play a role. For example, Begeer et al. showed an ethnic bias among paediatricians that led to ethnic differences in the diagnosis of autism in children (17).

If, when and how these difficulties in the patient-care provider interaction influence the outcomes of healthcare for ethnic minority patients is not completely clear due to a lack of studies in this area. However, it is known that various healthcare outcomes are worse for ethnic minority patients. For example, studies show a higher risk for adverse perinatal and maternal outcomes in ethnic minority groups (18-20); less asthma therapy adherence among ethnic minority children (21) as well as worse outcomes for paediatric asthma care (22); and higher drop-out rates from rehabilitations programs among ethnic minority patients (23). These studies, however, do not provide insight into how underlying variables that account for inequalities in outcomes influence the care process.

Taking all this evidence into account, barriers in the healthcare process provided to ethnic minority patients, that could negatively influence healthcare outcomes, have been demonstrated. Cultural competence is a strategy that has the potential to improve the healthcare process provided to patients from ethnically diverse backgrounds.
Cultural competence

Culturally competent care is considered an important strategy to decrease inequities in healthcare outcomes for ethnic minority patients (5,24,25). The term ‘cultural competence’ derives from the United States and started to appear in the literature during the 1990s. Originally, cultural competence programs stemmed from an urge to overcome cultural and linguistic barriers experienced between immigrant patients and their care providers. These programs focused on teaching about beliefs and characteristics of specific cultural and ethnic groups. Over the years, the concept of cultural competence has expanded beyond culture, and now addresses a broad array of topics relevant to (ethnic) inequalities in healthcare quality. Additionally, cultural competence has extended from focus on the patient-provider interaction to encompassing the level of healthcare organisations and health systems (25-27).

Cultural competence at the level of individual care providers

Cultural competence at the level of individual care providers is generally defined as the knowledge, attitudes and skills necessary to provide good quality of care for ethnic minority patients. With the proper knowledge, attitudes and skills (i.e. cultural competence), individual healthcare providers should be able to more effectively manage and solve barriers in the patient-provider interaction. Although there are reports describing what ‘cultural competence’ is comprised of, a practical and concrete translation of the often abstract terms (e.g. for the purpose of developing training), is still lacking.

Meanwhile, in the Netherlands as well as elsewhere, many initiatives have been launched to improve cultural competence of care providers, mostly by providing training. However, evaluation of cultural competence training programs on students’ and physicians’ behaviour is lacking, and the effect of healthcare provider’s level of cultural competence on healthcare outcomes of diverse patients has not been well investigated (28,29). This is partly due to the lack of thoroughly evaluated instruments to measure providers’ cultural competence (29,30).

Cultural competence in medical education

Preparing all physicians to respond to the ethnic diversity present in modern societies should start during medical education. In various countries, licensing bodies and curricular objectives require medical curricula to address cultural competence (31-33). In spite of this, teaching of cultural competence has remained mostly unsystematic, non-uniform and fragmented (34); moreover, cultural competence training programs are not yet structurally implemented in medical schools (31,35,36).
Also in the Netherlands, the document that describes the objectives of medical curricula, the so-called ‘Raamplan’ (General Plan) (33) addresses issues related to cultural competence. It clearly states, for example, that students must be able to "take into account ethnic backgrounds and contextual characteristics that might influence the provision of healthcare to individuals in society" (Raamplan, p.37 (33)); or: "to signal when an interpreter is necessary and be able to call in an interpreter" (Raamplan, p.29 (33)). Despite these objectives, also in the Netherlands, teaching in cultural competence is not a structural part of the medical curricula (35,37). Internationally, several barriers for implementing cultural competence teaching in medical education have been identified, such as the lack of clarity about what the concept of cultural competence means, how it should be framed, how it should be assessed, and how it should be implemented throughout the curriculum. Other identified barriers were a lack of faculty support, a lack of expertise of staff, and students who do not experience a need for cultural competence training (34). In the Netherlands, implementation of cultural competence teaching has not yet been investigated; however, it is likely that some of these barriers will play a role here as well. For example, although the ‘Raamplan’ includes objectives related to cultural competence, these objectives are not clearly specified.

Cultural competence at organizational level

Some barriers experienced in healthcare by ethnic minority patients have their origin in the way various organisations are structured (e.g. unavailability of interpreter services). By putting into place certain key elements in service policies and management, organisations can improve accessibility and create conditions for individual healthcare providers to provide culturally competent health care (25,38,39).

Various institutions have developed guidelines and standards that provide insight into their views on organisational cultural competence. Probably the best known approach is the CLAS standards: ‘National Standards for Culturally and Linguistically Appropriate Services in Health Care’ developed by the U.S. Department of Health and Human Services Office of Minority Health (40,41). These standards were launched in 2001 and have served as the foundation for a large number of initiatives to improve quality of care for ethnic minority patients (42,43). Within and outside the United States other approaches have been developed to guide healthcare organisations in becoming responsive to patients’ ethnic diversity, such as the ‘interculturalisation approach’ in the Netherlands in the early 2000s (43,44). It has remained unclear, however, to what extent various approaches relate to each other: is there consensus between them in the aspects that healthcare organisations should implement, or do they all differ in their views on organisational diversity responsiveness?
Aim and research questions

The main aim of the research in this thesis is to operationalise the concept of cultural competence and to provide insight into the application of this concept in medical practice and medical education. The studies presented here address cultural competence at two levels: the level of individual healthcare providers and the level of healthcare organisations. At both levels we focus on the operationalisation of the cultural competence concept and, second, on the application of these concepts in everyday medical practice, in medical education and in healthcare organisations. The studies are arranged according to three themes:

I. Cultural competence at the level of individual health care providers

Within this first theme of the thesis we aim to operationalise the concept of cultural competence at the level of the individual healthcare provider. With qualitative studies based on experiences of care providers and patients in medical practice in various healthcare settings, we explore care for ethnically diverse patients and cultural competence from a broad perspective. The aim of the first three studies presented here is to specify the broad concept of cultural competence into specific competencies to develop the general idea into a useful concept for medical practice and medical education, in different settings and for different types of patients.

The following research questions were addressed:

1) What cultural competencies are necessary for healthcare professionals to provide good quality care to ethnic minority patients? (Chapter 2)
2) What mechanisms characterise the care process for ethnic minority patients, and what competencies for the care provider can be derived from these mechanisms? (Chapter 3)
3) According to care providers working with asylum seekers, what cultural competencies are required specifically for medical contact with asylum seekers? (Chapter 4)

II. Cultural competence in medical education

Within this theme we explore the application of the concept of cultural competence at the level of individual healthcare providers to medical education. The aim is to find concrete entry points for cultural competence curriculum development by exploring the level of cultural competence of students and physicians and by consulting experts in the field of teaching about ethnic diversity in medical education. We addressed the following research questions:

4) What are the outcomes of a cultural competence assessment among students and physicians? How are the assessed cultural competence domains
(knowledge, reflection ability and consultation behaviour) associated with subjective (self-perceived) cultural competence? And to what extent can the results of this assessment be applied in developing a cultural competence training program? (Chapter 5)

5) According to experts in diversity in medical education, what recommendations can be made for the development of training for medical students in communication with ethnically diverse patients? (Chapter 6)

III. Cultural competence at the level of healthcare organisations

The third theme of this thesis aims to operationalise the concept of cultural competence at the level of healthcare organisations. We chose to analyse existing approaches that provide recommendations or guidance for healthcare organisations to increase their organisational responsiveness to ethnic diversity.

The research question we addressed was:

6) According to the various approaches, what are the essential elements in providing care that is responsive to the needs of diverse patient groups, and how much consensus is there between these various approaches? (Chapter 7)

Overview of this thesis

Table 1.1 presents an overview of the studies presented in this thesis.

Chapters 2-4 discuss the operationalisation of cultural competence at the level of individual healthcare providers. We chose to use qualitative studies within medical practice in various healthcare settings to explore care for ethnic minority patients and cultural competence from various perspectives.

Chapter 2 describes a conceptual framework that outlines the specific knowledge, attitudes and skills that are necessary for care providers to deliver high-quality care to ethnic minority patients. The framework is based on personal interviews with patients and physicians, which were held as part of the development of educational material for medical students: i.e. the case study book entitled ‘Een arts van de wereld’ (Physician of the world) (45), and key literature on cultural competence.

In Chapter 3 we explore the healthcare process for ethnic minority patients in a specific context: specialist paediatric asthma care. For this qualitative study, paediatricians and nurses were interviewed to explore mechanisms which lead to deficiencies in culturally competent care. The interviews were analysed according to the cultural competence framework presented in Chapter 2, and findings were compared with literature.
Chapter 4 focuses on the provision of health care to asylum seekers living under specific conditions in a host country while awaiting the decision about their request for asylum. Based on questionnaires and group interviews, we explored those particular cultural competencies that nurse practitioners working with asylum seekers consider important. The findings are placed in the perspective of the conceptual cultural competence framework (Chapter 2).

In Chapters 5 and 6 we explore the application of the concept of cultural competence at the level of individual healthcare providers to medical education. We used both a quantitative assessment method and a qualitative survey.

Chapter 5 describes the assessment of cultural competence of medical students and physicians to identify gaps in the curriculum regarding cultural competence training. We developed an assessment instrument based on our conceptual cultural competence framework (Chapter 2) which we distributed among medical students and physicians.

Chapter 6 presents ten recommendations for the development of training in communication skills for consultation with ethnic minority patients in medical curricula. The recommendations emerged from a questionnaire sent to the members of a Dutch special interest group on diversity in medical education, and represent the views and experiences of these respondents.

The final theme of this thesis aims to operationalise the concept of cultural competence at the level of healthcare organisations; document analysis was used for this part. In Chapter 7 we developed an over-arching analytic framework within which different approaches for organisational responsiveness to patients’ diversity are compared and contrasted. To develop the framework, we selected six approaches from the USA, Australia and Europe, and used qualitative analysis to categorise the content of each approach into domains (conceptually distinct topic areas) and, within each domain, into dimensions (operationalisations). The resulting classification framework was used for comparative analysis of the content of the six approaches.

Chapter 8 (General discussion) deals with answers to the research questions, discusses aspects of the methodology of the various studies, presents an interpretation of the findings in the light of current literature, and closes with implications for further research and practice.
**Table 1.1 Overview of the studies presented in this thesis**

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