Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care

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SYNOPSIS

Objectives. Racial/ethnic disparities in health in the U.S. have been well described. The field of "cultural competence" has emerged as one strategy to address these disparities. Based on a review of the relevant literature, the authors develop a definition of cultural competence, identify key components for intervention, and describe a practical framework for implementation of measures to address racial/ethnic disparities in health and health care.

Methods. The authors conducted a literature review of academic, foundation, and government publications focusing on sociocultural barriers to care, the level of the health care system at which a given barrier occurs, and cultural competence efforts that address these barriers.

Results. Sociocultural barriers to care were identified at the organizational (leadership/workforce), structural (processes of care), and clinical (provider-patient encounter) levels. A framework of cultural competence interventions—including minority recruitment into the health professions, development of interpreter services and language-appropriate health educational materials, and provider education on cross-cultural issues—emerged to categorize strategies to address racial/ethnic disparities in health and health care.

Conclusions. Demographic changes anticipated over the next decade magnify the importance of addressing racial/ethnic disparities in health and health care. A framework of organizational, structural, and clinical cultural competence interventions can facilitate the elimination of these disparities and improve care for all Americans.

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Racial/ethnic disparities in health have been well described, with data showing that members of minority groups suffer disproportionately from cardiovascular disease, diabetes, asthma, and cancer, among other conditions.[1] The causes of these disparities are multifactorial, and perhaps the largest contributors are those related to social determinants of health external to the health care delivery system. For example, members of minority communities tend to be more socioeconomically disadvantaged, to have lower levels of education, to work in jobs with higher rates of occupational hazards, and to live in areas with greater environmental hazards (such as air pollution) than members of the majority population.[2–6] Furthermore, minorities are overrepresented among the rolls of the uninsured, with Latinos, for example, representing 13% of the U.S. population but 25% of those Americans without health insurance.[7] Lack of insurance takes a significant toll on these populations, with health effects including less access to preventive care than among people with insurance, high rates of emergency department use and avoidable hospitalizations, later-stage diagnosis of cancer, and the inability to obtain prescription medications.[8,9] Even the prolonged impact of racism has been studied and linked to poor health outcomes among African Americans.[10,11]

Racial/ethnic disparities in quality of care for those *with access* to the health care system are equally concerning. These disparities have been shown to exist in the utilization of cardiac diagnostic and therapeutic procedures,[12–16] prescription of analgesia for pain control,[17–19] surgical treatment of lung cancer,[20] referral to renal transplantation,[21] treatment of pneumonia and congestive heart failure,[22] and the utilization of specific services covered by Medicare (e.g., immunizations and mammograms).[23] The recent Institute of Medicine report *Unequal Treatment: Confronting Racial/Ethnic Disparities in Health Care* identified well over 175 studies documenting racial/ethnic disparities in the diagnosis and treatment of various conditions, even when analyses were controlled for socioeconomic status, insurance status, site of care, stage of disease, comorbidity, and age, among other potential confounders.[24]

Among the many root causes of disparities that have been presented and explored, variations in patients' health beliefs, values, preferences, and behaviors have recently garnered attention.[25–27] These include variations in patient recognition of symptoms; thresholds for seeking care; the ability to communicate symptoms to a provider who understands their meaning; the ability to understand the prescribed management strategy; expectations of care (including preferences for or against diagnostic and therapeutic procedures); and adherence to preventive measures and medications.[28] These factors are thought to influence patient and physician decision-making and the interactions between patients and the health care delivery system, thus contributing to health disparities.[29–32]

As a result of these observations, the field of "cultural competence" in health care has emerged. A "culturally competent" health care system has been defined as one that acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs. A culturally competent system is also built on an awareness of the integration and interaction of health beliefs and behaviors, disease prevalence and incidence, and treatment outcomes for different patient populations.[33] Furthermore, the field of cultural competence has recognized the inherent challenges in attempting to disentangle "social" factors (e.g., socioeconomic status, supports/stressors, environmental hazards) from "cultural" factors vis-à-vis their influence on the individual patient. As a result, understanding and addressing the "social context" has emerged as a critical component of cultural competence.[34] We will therefore refer to *sociocultural barriers* throughout this article to emphasize this connection, and will integrate this idea into our working definition of cultural competence.

The movement toward cultural competence in health care has gained national attention and is now recognized by health policy makers, managed care administrators, academicians, providers, and consumers as a strategy to eliminate racial/ethnic disparities in health and health care.[35–39] There is, however, an ongoing debate as to how to better define and operationalize this critical yet broad construct. A number of different terms have been proposed to better articulate and encapsulate its meaning. *Cultural sensitivity*, *responsiveness*, *effectiveness*, and *humility* each emphasizes certain aspects and together reveal a lack of consensus, as each has a unique definition. Models for operationalizing cultural competence have emphasized particular aspects of the health care delivery system, especially the provider-patient interaction. No one has yet reviewed the literature and developed a more comprehensive approach to thinking about and implementing cultural competence in health care at multiple levels and from multiple perspectives.

We surveyed the medical and public health literature to seek answers to two questions: (1) What are the major components of cultural competence? and (2)

How do we incorporate culturally competent interventions into the delivery of health care?

METHODS

We set out to practically define cultural competence and develop a framework that links interventions to an overall approach to eliminating racial/ethnic disparities in health and health care. Our goals were to:

- Identify sociocultural barriers to care for various racial/ethnic groups. We focused on specific social and cultural factors that form the basis for individual health beliefs, behaviors, values, and preferences and how they potentially mitigate a patient's ability to obtain quality care. (Limited English proficiency as a barrier is a simple example.) It should be noted that our goal is not to look at sociocultural factors from a deficit model, as there are many cultural factors that have been found to be "protective" for health, and the "healthy immigrant" effect, or "epidemiologic paradox" has been well established. Instead, our goal was to identify situations in which sociocultural factors are not incorporated into the U.S. health care delivery system and how that leads to poorer quality care—as these are points for intervention.
- Explore at what level in the process of obtaining care these barriers occurred (health systems level, clinical encounter level, and so on).
- Identify cultural competence interventions that address these specifically identified sociocultural barriers.
- Link these interventions to a framework that can be applied to the elimination of racial/ethnic disparities in health and health care.

We reviewed:

- Academic literature: We searched the PubMed database (MEDLINE, PreMEDLINE, HealthSTAR) for 1977–2002 using the following keywords: *sociocultural barriers*, *cultural competence*, *cross-cultural care*, *health disparities*, *racial/ethnic disparities*, *minority health*, and *multicultural health*, both alone and in combination. From the original set of articles that we identified, we set up criteria for relevance to our project. We included in our review only those publications that specifically addressed sociocultural barriers to health care (and provided details about the level of the health care system at which they occurred); cultural competence interventions; and/or racial/ethnic disparities in health and health care. We defined a sociocultural barrier to care as a social or cultural quality, characteristic, or experience of a racial/ethnic group or individual that led to differential treatment and varying quality of care.
- Government and foundation publications: We searched major government and foundation reports relevant to our work by reviewing websites of the Commonwealth Fund, the Kaiser Family Foundation, the Kellogg Foundation, the Robert Wood Johnson Foundation, the California Endowment, the Office of Minority Health, the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the National Institutes of Health, the Agency for Healthcare Research and Quality, and other Department of Health and Human Services agencies. We collected data and references, for example, from *Minority Health: A Chartbook*, published by the Commonwealth Fund,[40] the Kaiser Family Foundation's report on *Race, Ethnicity and Medical Care*,[41] the CDC's Diabetes Today project handbook,[42] and the American Medical Association's *Cultural Competence Compendium*.[43]

RESULTS

Sociocultural barriers to health care: a multilevel analysis

We identified three major levels of health care at which sociocultural barriers occur that contribute to racial/ethnic disparities in health and health care. While these are not perfectly distinct categories and there may be some overlap between them, they help to build a framework on which to understand the complex and important issue of cultural competence in health care.

Organizational barriers. Health care systems and structural processes of care are shaped by the leadership that designs them and the workforce that carries them out. From this *organizational* standpoint, one factor that impinges on both the availability and acceptability of health care for members of minority racial/ethnic groups is the degree to which the nation's health care *leadership and workforce* reflect the racial/ethnic composition of the general population.

Institutional leadership. Despite representing almost 28% of this nation's population,[44] African Americans, Latinos, and Native Americans make up only 3% of medical school faculty, fewer than 16% of public health school faculty, and only 17% of all city and county health officers.[40] Furthermore, fewer than 2% of indi-

viduals with senior leadership roles in health care management are non-white.[45]

In the absence of strong quantitative data, a plethora of anecdotal evidence suggests that lack of diversity in the leadership and workforce of health care organizations results in structural policies, procedures, and delivery systems inappropriately designed or poorly suited to serve diverse patient populations.[45–47] Given their social and cultural understanding of the communities they serve, minority professionals are more likely than their white counterparts to organize health care delivery systems to meet the needs of minority populations.[47] Examples of barriers to care in the way systems are currently organized include: limited clinical hours of service that don't account for community work patterns, bureaucratic intake processes that create fear of deportation among the undocumented, and long waiting times to make appointments and/or at the time of visit.[48] In addition, under-representation of minorities on faculty at medical schools and schools of public health prevents a nuanced understanding of community needs from being shared through the critical avenues of role modeling and teaching. Ultimately, inadequate minority representation in governance, administrative, and clinical leadership roles causes health care systems to be disconnected from the minority communities they serve.[45]

Health care workforce. Racial/ethnic diversity in the health care workforce has been well correlated with the delivery of quality care to diverse patient populations. For example, research has shown that, for minority patients, racial concordance between patient and physician is associated with greater patient satisfaction and higher self-rated quality of care.[49] Other work has established the preference of minority patients for minority physicians, independent of practice location or other geographic issues.[50–52] Spanish-speaking patients, for example, report more satisfaction with care from Spanish-speaking providers than from non–Spanish-speaking providers,[53] and African American patients report more satisfaction with care when their physician employs a participatory and inclusive style of decision making.[54] Although there are no head-to-head quality of care comparisons between patients of minority and non-minority physicians, in general, self-rated quality of care and patient satisfaction have been closely linked to certain health outcomes, such as blood pressure control.[55–57] Given this logical link, it is feasible to hypothesize that there are quality of care differences for minority patients dependent on the race/ethnicity or culture of their providers.

Other practical issues that link service delivery to diversity arise. Komaromy et al. showed that approximately 45% of African American physicians and 24% of Hispanic physicians in office-based practices in California care for patients with Medicaid as the primary insurer, compared with 18% of white physicians.[51] Furthermore, in a national consumer survey, Saha et al. found that 25% of African American respondents and 23% of Hispanic respondents were cared for by either African American or Hispanic physicians, despite African American physicians making up 4% and Hispanic physicians 5% of the nation's physician pool.[52]

These studies demonstrate that minority physicians are more likely than their white counterparts to provide care to poor and minority patients and may provide more effective care to patients of their own ethnicity. However, African Americans, Hispanics, and Native Americans are drastically underrepresented in the health professions.[58] The prognosis for the future is not much brighter. From 1996 to 1997, Mexican American medical school enrollment dropped by 8.7% (451 to 412) and enrollment of mainland Puerto Ricans dropped by 31% (141 to 97), while the enrollment of African Americans dropped by 3.7% (1,189 to 1,134), compared to a 1% drop in whites—from 10,556 to 10,450. In that same year, only 11% of all graduates were from underrepresented minority groups.[59] It is both impossible and inappropriate to try to match minority patients to concordant minority providers. Still, these data suggest that there is justification for bolstering the ranks of minorities in the health care professions.

Structural barriers. In a complicated health care system in which the rules are many and economic forces drive both structure and function, the needs of vulnerable populations inevitably suffer. *Structural* barriers arise when patients are faced with the challenge of obtaining health care from systems that are complex, underfunded, bureaucratic, or archaic in design. Whereas many structural barriers to care may equally impact people of low socioeconomic status, regardless of race/ethnicity, several barriers are especially pertinent to minority populations:

- Lack of interpreter services or culturally/linguistically appropriate health education materials is associated with patient dissatisfaction, poor comprehension and compliance, and ineffective or lower quality care.[60–68] Doctor-patient communication without an interpreter when there is even a minimal language barrier is recognized as a major challenge to effective health care delivery.[60–62] Research in this area has shown that:
  - ✦ Spanish-speaking patients discharged from emergency rooms are less likely than their

English-speaking counterparts to understand their diagnosis, prescribed medications, special instructions, and plans for follow-up care[63]; less likely to be satisfied with their care or willing to return if they have a problem; more likely to report problems with their care[64]; and less satisfied with the patient-provider relationship.[64]

- ✦ Physicians who have access to trained interpreters report a significantly higher quality of patient-physician communication than physicians who use other methods, such as untrained staff or family members.[65,66]
- ✦ Hispanic patients with language-discordant physicians are more likely to omit medication, miss office appointments, and visit the emergency room for care than those with Spanish-speaking physicians.[67]

- Bureaucratic intake processes and long waiting times for appointments have both been cited disproportionately by minority patients as major barriers to access to health care.[46,48,69] When patients have insurance but must undergo difficult intake processes to see a provider or when patients must wait exceedingly long to receive medical care, quality of care is compromised.[70,71]
- Members of minority groups also face structural barriers with regard to referral to specialists and continuity of care. A large survey by the Commonwealth Fund found that 22% of Hispanics and 16% of African Americans, as compared to 8% of whites, reported a "major" problem accessing specialty care.[40] Another study revealed that 46% of Hispanic and 39% of African American adults, compared with 26% of white adults, do not have a regular doctor.[40]

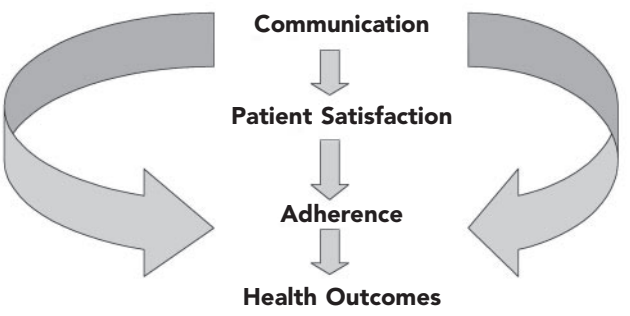
Clinical barriers. Clinical barriers have to do with the interaction between the health care provider and the patient or family. They occur when sociocultural differences between patient and provider are not fully accepted, appreciated, explored, or understood. Patients may have very different socioculturally based health beliefs; medical practices, including use of home remedies; attitudes toward medical care; and levels of trust in doctors and the health care system.[72] As the country becomes more culturally diverse, health care providers of all ethnic backgrounds are dealing with a greater proportion of patients whose perspectives are different from those taught in the mainstream health care system. Research has shown that provider-patient communication is directly linked to patient satisfaction, adherence, and subsequently, health outcomes[55–57,73,74] (see Figure). Thus, when cultural and linguistic barriers in the clinical encounter negatively affect communication and trust, this leads to patient dissatisfaction, poor adherence (to both medications and health promotion/disease prevention interventions), and poorer health outcomes.[38,53,63,67,69,75,76] Moreover, when providers fail to take social and cultural factors into account, they may resort to stereotyping, which affects their behavior and decision-making.[32] In the worst cases, this may lead to biased or discriminatory treatment of patients based on their race/ethnicity, culture, language proficiency, or social status.[15,32]

Defining cultural competence: a practical framework

"Cultural competence" in health care entails: understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations. Given the evidence of sociocultural barriers to care and the levels of health care delivery in which they occur, a new framework for cultural competence would include organizational, structural, and clinical interventions:

- *Organizational cultural competence interventions* are efforts to ensure that the leadership and workforce of a health care delivery system is diverse and representative of its patient population—e.g., leadership and workforce diversity initiatives.[77–79]
- *Structural cultural competence interventions* are initiatives to ensure that the structural processes of care within a health care delivery system guarantee full access to quality health care for all of

Figure. Linking communication to health outcomes



its patients—e.g., interpreter services, culturally and linguistically appropriate health education materials.[33]

- *Clinical cultural competence interventions* are efforts to enhance provider knowledge of the relationship between sociocultural factors and health beliefs and behaviors and to equip providers with the tools and skills to manage these factors appropriately with quality health care delivery as the gold standard—e.g., cross-cultural training.[31,80–82]

To date, there have been various cultural competence interventions at the organizational, structural, and clinical levels:

Organizational cultural competence interventions. Organizational cultural competence interventions include "diversity" and "minority recruitment" initiatives within the Department of Health and Human Services, academic health centers, hospitals, and medical schools. As a result of minority under-representation in medicine, the Physician-Population Parity Model of the Association of American Medical Colleges (AAMC) was set forth in 1970. Its goal was that the percentage of minorities in our physician workforce would approximate the percentage of minorities within the general population of the U.S. Although progress was made, efforts fell short. In the 1990s, the AAMC initiated Project 3000 by 2000 with the stated goal of having 3,000 minority students enrolled in the entering medical school class by 2000. Despite strategies to achieve these goals, the AAMC fell quite short of its target, perhaps as a result of anti–affirmative action legislation in states such as California and Texas in the mid-1990s.[52] Given our growing diversity, minority recruitment efforts in health care have been seen as critical to meeting the needs of our population.[52,83] There are successful models at many levels of the health care delivery system, including those sponsored by foundations (the Commonwealth Fund, the Robert Wood Johnson Foundation), professional organizations (including the AAMC), and government (HRSA). Describing these in more detail is outside the scope of this article. Ultimately, it is obvious that the organizational component of cultural competence is an important part of efforts to improve quality of care for all Americans.

Structural cultural competence interventions. These initiatives have been the most studied, with research focusing, for example, on the impact of reducing language barriers on quality of care.[84] Some studies have also been done on culturally appropriate health education materials and their impact on patient knowledge and understanding of certain medical interventions.[85] There is an obvious and direct link between these structural barriers and quality of care, and this remains a fertile area for intervention. The federal government and managed care organizations, through various initiatives, have attempted to develop policy and regulatory efforts to ameliorate these barriers.[33,86] Structural barriers, however, encompass more than simply language discordance between patients and providers. As has been highlighted, the design and functioning of health care delivery systems—including intake processes, waiting times for appointments, referral mechanisms, and continuity of care—pose clear structural barriers to the quality of care provided to diverse patient populations. These key aspects of health care system design, when developed in the absence of an appropriate sociocultural assessment of the population, can limit access to care. Structural cultural competence interventions would address many of these factors by implementing racial/ethnic data collection; developing specific quality measures for diverse patient populations; improving medical referral processes; and ensuring culturally and linguistically appropriate health education materials, signage, and health promotion and disease prevention interventions.

Clinical cultural competence interventions. Given that sociocultural factors are critical to the clinical encounter, "cross-cultural" (often called "cultural competence") curricula for providers have been developed.[80] The overarching goal of these educational and training interventions is to equip health care providers with knowledge, tools, and skills to better understand and manage sociocultural issues in the clinical encounter. The methods for cross-cultural education have varied, and range from the "categorical" or "multicultural" approach,[87] in which specific information about certain cultures is taught to providers, to a more "cross-cultural" approach, which focuses on the key process issues of caring for patients from diverse backgrounds (e.g., communication issues).[29,88] Traditionally, training in cross-cultural medicine has focused on a categorical approach, describing the relevant attitudes, values, beliefs, and behaviors of certain cultural groups. For example, training in methods of caring for the "Asian" patient or the "Hispanic" patient would present a list of common health beliefs, behaviors, and key "do's and don't's" for providers. With the huge array of cultures in the U.S. and the many powerful influences such as acculturation and socioeconomic status leading to intra-group variability, it is difficult to learn a set of "facts" about any particular group and hope to be effective in caring for them. Furthermore, these approaches may contribute to stereotyping. Still, there

may be certain helpful, culturally specific information that can be effectively taught while avoiding stereotypes. This includes particular folk illnesses among certain populations; ethnopharmacology; disease incidence, prevalence, and outcomes among distinct populations; the impact of the Tuskegee Syphilis Study and segregation as the cause of mistrust among African Americans; the effect of war and torture on certain refugee populations and how this shapes their interaction with the health care system; and the common cultural and spiritual practices that might interfere with prescribed therapies, to name a few.

A newer approach focuses on the process of communication and trains providers to be aware of certain cross-cutting cultural and social issues and health beliefs that are present in all cultures.[30,80,81] The focus is on the individual patient as teacher and on developing important attitudes and skills for providers. For example, curricula of this type have focused on identifying and negotiating different styles of communication, decision-making preferences, roles of family, sexual and gender issues, and issues of mistrust, prejudice, and racism, among others.[30] Ultimately, some balance of cross-cultural knowledge and communication skills seems to be the best approach to cultural competence education and training.

Interest in clinical cultural competence has gained momentum as a result of several studies that have raised awareness of provider bias and discrimination in medical decision-making.[14,31] Despite this growing attention, a look at undergraduate medical education, for example, shows that this type of training has only been marginally integrated into mainstream curricula.[89,90] Although minimal evaluation has been done to date on these interventions, with a focus primarily on process issues and self-report,[83] cultural competence education and training is moving forward in the policy arena, including as a requirement for medical school accreditation.[36] Given the literature highlighting the importance of sociocultural factors in the clinical encounter and their impact on medical decision-making and outcomes, targeting providers and their attitudes and practices will be a crucial aspect of an overall framework for cultural competence.

Linking a cultural competence framework to the elimination of racial/ethnic disparities in health and health care

Given a practical framework that focuses on three umbrella categories of interventions—organizational, structural, and clinical—it becomes clearer how cultural competence initiatives could assist in the elimination of racial/ethnic disparities in medical care. Research has established the important role minority health care professionals play in the delivery of quality care to minority patients. "Organizational cultural competence" efforts—*increasing the numbers of underrepresented minorities in the health professions and health care leadership*—are important ways to improve both clinical outcomes and the health status of the nation's vulnerable populations. Similarly, given that the structure of a health care delivery system, and subsequent structural barriers, impact minorities in distinct ways, it is clear that only through the development of "structural cultural competence" interventions—*innovations in health care system and structure design*—that racial/ethnic minorities will be able to truly obtain quality health care. Finally, understanding and managing socioculturally based variations in health beliefs, values, and behaviors is paramount to the care of racially/ethnically diverse patient populations. "Clinical cultural competence" interventions—*educational initiatives that aim to teach providers the key tools and skills to delivery quality care to diverse populations*—is the final piece of an emerging field that will directly address racial/ethnic disparities in health and health care.

CONCLUSION

The demographic changes that are anticipated over the next decade magnify the importance of addressing racial/ethnic disparities in health and health care, as groups currently experiencing poorer health status are expected to grow as a proportion of the total U.S. population. In fact, quality improvement of our health care system in these critical areas will improve care not only for minority patients but for all Americans. It remains true today, however, that minority patients with access to the health care system face organizational, structural, and clinical barriers that preclude them from fully capitalizing on the advances in health promotion and disease prevention that have benefited the majority of Americans. While it is unclear what proportion of the disparities seen is due to these barriers, this is where the health care system has the most power to intervene.

Greater attention is now being placed by government and the private health care industry on cultural competence in light of the overwhelming literature on racial/ethnic disparities in health and health care. A basic framework and conceptual model that is simple, practical, and based on a review of the literature in the field, such as the one presented here, can facilitate targeted interventions. Given the strong evidence for sociocultural barriers to care at multiple levels of the health care system, culturally competent care is a key

cornerstone in efforts to eliminate racial/ethnic disparities in health and health care.

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