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Cultural Competence: New Conceptual Insights into its Limits and Potential for Addressing Health Disparities

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ABSTRACT

The increasing interest in the role of racism and racialization in health disparities, calls for exploring new paradigms in addressing and eliminating health disparities related to race/ethnicity. Cultural competence is conceptualized as one of the keys ways to address racial/ethnic disparities in public health and healthcare. However, for cultural competence to fulfill this role, it requires a critical understanding of the underlying socio-political and economic processes of power, privilege and institutional racism that create, support and maintain existing health disparities. This paper outlines how the concept of cultural competence can be made more robust, by incorporating concepts such as Public Health Critical Race praxis (PHCR) and cultural humility, to more fully tackle the impact of structural inequities on health disparities.

Keywords: Cultural Competence, Health Disparities, Health Equity

INTRODUCTION

The growing racial/ethnic diversity, both nationally and globally, and the increasing interest in the role of racism and racialization in health disparities, calls for exploring new paradigms in addressing and eliminating health disparities related to race/ethnicity (Almutairi & Rondney, 2013; Ford & Airhihenbuwa, 2010a). Cultural competence is conceptualized as one of the keys ways to address racial/ethnic disparities in public health and healthcare (Brach & Fraser, 2000; Office of Minority Health, 2013). The U.S. Office of Minority Health describes cultural competence within healthcare as "...healthcare services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients [that] can help bring about positive health outcomes"(Office of Minority Health, 2013). However, for cultural competence to fulfill this role, it requires a critical understanding of the underlying socio-political and economic processes of power, privilege and institutional racism that create, support

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and maintain existing health disparities (Bhui, Ascoli, & Nuamh, 2012; Griffith, Johnson, Ellis, & Schulz, 2010). This paper outlines how the concept of cultural competence can be made more robust, by incorporating concepts such as Public Health Critical Race praxis (PHCR) (Ford & Airhihenbuwa, 2010a) and cultural humility (Tervalon & Murray-Garcia, 1998), to more fully tackle the impact of structural inequities on health disparities.

PHCR put forth by Ford and Airhihenbuwa (Ford & Airhihenbuwa, 2010a; Ford & Airhihenbuwa, 2010b) provides a praxis framework – theory informed action – to conceptualize and address racial inequities that are the root causes of health disparities. Tervalon and Murray-Garcias' concept of cultural humility (Tervalon & Murray-Garcia, 1998), advocates for self-reflection of one's own multidimensional and multiethnic identities, backgrounds, and an examination of biases and patterns of intentional and unintentional racism, classism and homophobia. It allows for integration of self-critique and reflective inquiry of ones' own social location in systems of privilege and oppression. We argue that both PHCR and cultural humility help to extend cultural competence beyond knowledge and communication skills, in a way that considers the structural inequities that undergird much of health disparities.

Cultural Competence and Cultural Humility

Cultural competence is a tool to address culturally and racially linked disparities, through increased cultural awareness and racial sensitivity among public health practitioners, researchers, healthcare providers, and institutions (Betancourt, Green, & Carrillo, 2002; Brach & Fraser, 2000; Purnell, 2005). A report by the Expert Panel on Cultural Competence Education for Students in Medicine and Public Health (Association of American Medical Colleges and Association of Schools of Public Health, 2012) went further, and defined cultural competence within a broader context of diversity and inclusion as deliberate activities geared towards increasing ones awareness and emphatic understanding of individuals and systems.

While cultural competence does, indeed, provide many useful insights into the complexity of interacting with diverse populations (Betancourt et al., 2002; Purnell, 2005), and addressing disparities (Brach & Fraser, 2000), there are several limitations to its effectiveness in reducing health disparities.

For example, cultural competence primarily focuses, on the ability of individuals and institutions, to describe and interact within, but not investigate or challenge, existing racial and cultural structures. "White" is often explicitly or implicitly understood as the norm and being culturally neutral (Jensen, 2005), and culture is something that belongs to the Other -- other racial/ethnic groups (Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007). To be competent requires the acquisition of a finite amount of knowledge rather than an ongoing process of self-examination and reflection on issues relating to structural power, privilege and inequities, including racism, and its effect on health disparities (Kumagai & Lypson, 2009).

Cultural competence is traditionally treated as a series of dos and don't's, a checklist of cultural practices or "a-typical" behavior that needs to be mastered by those outside the Other, yet in a position of structural power. This approach can further reinforce existing stereotypes (Kumagai & Lypson, 2009; Tervalon, 2003), and cultural essentialism (Powell Sears, 2012). Competence that is framed within the notion of knowledge of the Other runs the risk of "objectifying individuals" who are different from the dominant group and results in oversimplification of culture and cultural competence (Jenks, 2011; Kumagai & Lypson, 2009). Also, it often conflates culture with race and ethnicity and fails to capture the diversity within groups (Thackrah & Thompson, 2013). More recent notions of cultural competence attempt to

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steer away from the mastery of a checklist to a more nuanced understanding of culture. These newer conceptualizations still do not address the underlying social determinants of health and power inequities that underlie health disparities (Jenks, 2011). Bhui and colleagues (Bhui et al., 2012) argue that cultural competence is more than an educational intervention. They posit, "…tackling inequities requires personal development and the emergence and containment of primitive anxieties, hostilities, and fears"(Bhui et al., 2012, p.185).

According to Kumas-Tan and colleagues (Kumas-Tan et al., 2007), the problem of cultural competency is that it is framed as the "disadvantages borne by minority groups – not in the advantages of dominant group membership" (Jensen, 2005, p.551). Cultural competency does not explicitly consider or address the structural origins of inequities and the antecedent assumptions of power and privilege that contribute to health disparities (Kumagai & Lypson, 2009).

Cultural humility signifies an ongoing process of learning, self-critique and self-reflection. Although it was initially developed to address power inequities between patients and physicians, it has been adopted in the health promotion and public health practice field (Minkler, 2004; Rock, Brugge, Slagowski, Manning, & Lewis, 2007; Wallerstein & Duran, 2006).

Because of cultural humility's focus on process and self-reflection over knowledge and mastery, it presents a useful lens through which to view oneself and "Others" within a larger system. Competence implies it is possible to know something fully, but humility stresses that it is impossible to do so (Levi, 2009), and allows for analyzing and redressing structural power imbalances and White privilege.

Cultural humility requires the ability to reflect on and address the roles of individuals and of systems in unequal power relationships (Tervalon & Murray-Garcia, 1998; Tervalon, 2003). This is in keeping with critical race theory (Ford & Airhihenbuwa, 2010a; Ford & Airhihenbuwa, 2010b) with an emphasis on a level of race consciousness -- an understanding of the contemporary and historical process by which racism and inequities result in persistent health disparities.

Race, Racialization, and Health Disparities

In the U.S., race, racism, racialization, and the social construction of race persist as key components of an inequitable system that manifests itself as health disparities. Race is a socio-political construct. Systems of racial classification in the U.S. and across the world lack a scientific basis, are arbitrary and are embedded in systems of politics, power, stratification, and ideology (Krieger, 2008; Williams & Rucker, 2000; Williams & Mohammed, 2009). However, the health consequences of racial classifications are very real. Over a century ago, the seminal work of W.E.B. Du Bois underscored the primacy of social factors in explaining the stark disparities between blacks and Whites (DuBois, 2003).

Racism includes individual beliefs, action, and a set of dominant ideologies and frameworks that guide action. It reflects both the social process and the underlying inequities in the institutional structures of society (including education, health, housing, banking, criminal justice, etc.). Racism influences a person's life opportunities and access to valued resources in society that are critical to one's health, social well-being and the ability to live one's life with dignity and grace (Williams & Rucker, 2000).

In a racialized society such as the U.S., race is, in effect, a "master status" and dominates, overrides or supersedes all the other statuses of a person (Goffman, 2002; Hughes, 1945). The process of racialization involves social, political, economic, and cultural processes that

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transforms groups of people into socially constructed racial categories, assigning them meaning, values and attributes (generally negative). This leads to their stereotyping, marginalization, dehumanization and oppression. It is through culture that these attributions, value judgments and notions of "virtue" and "purity" become entrenched in, and define for society what is normatively expected for different socially constructed groups (Griffith et al., 2010; Omi, 1994). Griffin and colleagues (Griffith et al., 2010), argue that both institutionalized racism, as well as the cultural process by which such structures are created, maintained, perpetuated and resist change within a race conscious ideological system, need to be addressed in order to impact the fundamental determinants of racial/ethnic disparities in health.

Given the primacy of race and racialization in the social determinants of health, an understanding of the underlying socio-political process of racialization and racism is essential in notions of cultural competence. These racial inequities are embedded in social institutions, and social determinant of health, and cause systematic differences between groups that ultimately lead to health disparities at the population-level (Griffith et al., 2010; Krieger, 2008).

Public Health Critical Race

The public health critical race (PHCR) praxis, based upon Critical Race Theory (CRT), and described by Ford and Airhihenbuwa (Ford & Airhihenbuwa, 2010a; Ford & Airhihenbuwa, 2010b) joins a growing body of public health scholarship, that draws from the research of various disciplines (such as jurisprudence and sociology) and theoretical orientations to understand and illustrate how multiple structural inequities related to racism, racialization, and social location, all contribute to health disparities.

Addressing the system-level causes of racism and challenging and transforming the existing structure of stratification are key elements in PHCR. This approach highlights the central role of race in the social stratification that undergirds health disparities -- including the access to and use of healthcare -- and calls for an activist orientation in research that "…connotes explicit attention to racial dynamics"(Ford & Airhihenbuwa, 2010b, p.1393).

In PHCR, researchers and practitioners start by framing their inquiry from a race-conscious perspective (Ford & Airhihenbuwa, 2010a). This could include, for example, understanding the ubiquity of contemporary racism and taking into account the effects of everyday racism on health seeking behavior of a member of a racial/ethnic minority group. As reflected in principles of cultural humility, PHRC also recommends critical consciousness and inquiry, calling for self-refection of one's social location along the multiple axes of power and privilege. It draws attention to how social location and power inform knowledge production and problem definitions. In addition to self-critiques, PHRC also calls for researchers and practitioners to critique their disciplines -- a questioning of the ontological understandings of scientific knowledge and the underlying dynamics of power and process that shape knowledge production, research questions, funding priorities and the acknowledgement of the lack of "objectivity" of research (Airhihenbuwa, 2007; Ford & Airhihenbuwa, 2010a; Ford & Airhihenbuwa, 2010b). Questions that are deemed to be relevant in cultural competence practice and research methodology will require a self-examination, given that they arise within a system that is inherently racialized from a structural standpoint.

Embedded in the PHRC race consciousness approach, is the understanding that the social experience of people of color is different from whites'. Hence beyond traditional perspectives that see race as a biological construct or an epidemiological explanatory variable, this perspective advocates for "centering in the margins" which is to develop understandings of the

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lived experience of minorities within a racialized society, giving them voice and prioritizing their perspectives. Ford and Airhihenbuwa (Ford & Airhihenbuwa, 2010a; Ford & Airhihenbuwa, 2010b) argue that valuing experiential knowledge can lead to innovative interventions and solutions that will foster the creation of a more egalitarian society (Ford & Airhihenbuwa, 2010b). Through strong community engagement and critical self-enquiry researchers and practitioners can ensure that the perspectives, strengths and concerns of marginalized groups are a critical element in cultural competency discussions. Indeed, by incorporating experiential knowledge and the lived experience of marginalized groups, cultural competence constructs can be made more effective to make an impact on health disparities among minorities.

While acknowledging the primacy of race and racializaiton in society, PHCR notes the ordinariness, ubiquity and structural nature of contemporary racism, as opposed to more overt, egregious acts of racism that marked the pre-civil rights era (Bonilla-Silva, 2006; Ford & Airhihenbuwa, 2010a). While historical factors and structural racism undergird the inequities in society, it is these contemporary, subtle, yet repetitive, seemingly innocuous acts of everyday micro-aggression (example, being followed while shopping (Ford & Airhihenbuwa, 2010a), or being ignored by a waiter at a restaurant) that often create a non-inclusive environment for the Other. Understanding the ordinariness of present day racism can help inform cultural competence training and interventions to ensure equitable practice in public health.

Cultural humility and PHCR both endorse critical consciousness and reflection of one's social location. The intersectionality of one's social location along axes of social class, race/ethnicity, gender, etcetera, are critical in PHCR. The concept of praxis in PHCR involves the iterative process by which knowledge gained through personal experience, practice, research and theory inform one another. Effectively addressing health disparities will require integrating the knowledge, skills and attitudes approach of cultural competence with PHCR's critical consciousness and understanding of, and active stance against, racism. Through race consciousness, or the explicit acknowledgment of the workings of race and racism in everyday society, cultural competence can move toward developing strategies to transform and dismantle existing systems of privilege which is an important and necessary step in eliminating health disparities and achieving equity.

Key Questions

Using the PHCR and cultural humility framework, cultural competence can broaden the discourse and better address health disparities by incorporating the following critical questions:

- ✓ How do we better understand the primacy of race and racial stratification and its impact on social problems including that of health?
- ✓ What are the aspects of contemporary everyday racism that might undergird a persons' experience and their health?
- ✓ What are the interlocking, multiple axes of power/privilege and subordination that are present, and how do they manifest within a practice or research environment?
- ✓ While these perceived imbalances are often embedded within an intractable structural context, are there ways by which it can be minimized or redressed within a practice or research context through critical consciousness and social action?
- ✓ How do both the structural and socio-cultural process of racialization and possible disciplinary biases influence the definition of "culture" and the "other"?

How do we "center in the margins" and prioritize the perspectives of disenfranchised communities? What methodologies can we use to ensure that the marginalized are heard?

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CONCLUSION

Within a cultural competence framework, public health must challenge itself and others who enjoy the privilege of power and knowledge production to question the origins and effects of structural inequities and its relationship to health disparities. Failure to do so implicates cultural competence in the perpetuation of disparities, even as we engage in research and interventions intended to eliminate them.

As long as the concept of cultural competence continues to be dominated by acquiring finite level of knowledge of the "Other" without critical inquiry into how cultural and structural inequities, including racism, work to position people of color in relation to the dominant White paradigm, the opportunity will be limited to move beyond improving the quality of individual interactions in public health to naming and addressing the structural underpinnings of health disparities.

We posit that within the broad framework of cultural competence (Kumagai & Lypson, 2009), both cultural humility (Tervalon, 2003) and PHCR (Ford & Airhihenbuwa, 2010a) provide mechanisms to deconstruct the underlying structural inequities, through inquiry into power, race, and assumptions of culture, race, and ethnicity. Using a PHCR lens can help cultural competence remain attentive to issues of racism and inequities in tailoring programs and interventions to meet the needs of diverse populations (Ford & Airhihenbuwa, 2010a). PHCR may prove useful to current and future practitioners and researchers. Identifying and considering historical factors and structural racism that underlie the inequities in health and healthcare may be extremely useful to understanding health disparities in the U.S.

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