Cultural competence in Swedish primary care

Are some providers more prone to be culturally competent than others?

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Abstract
Cultural competence has become an important topic since the society has evolved to be more multicultural, these societies have a big problem with their healthcare systems and it is said that primary care in Sweden must become better adjusted to the needs of minorities. The objective of this study was to investigate the degree of cultural competence in primary care in Sweden and to examine if the degree of cultural competence had a relation to the providers personality, gender, age ethnicity and educational level. Three different county councils were asked to participate but only one agreed. From 13 different primary care wards, 111 participants filled in three different instruments measuring personality, cultural competence and social desirability. The result of Pearson correlations, partial correlations, two-tailed independent t-tests and a $\chi^2$- test show that the degree of cultural competence is relatively low. Also, persons who are more conscientious and open, less neurotic, and educated at a university are more prone to be culturally competent. This investigation shows that there is a need to make individuals who work in primary care more aware of these issues. The focus should not lie on personnel level alone, but on organizational level as well.

Keywords: cultural competence, primary care, personality, culture, multicultural, Sweden
Introduction

Cultural competence, i.e. “a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations” [1, p. 13], has become an important topic since the society has evolved to be more multicultural. It can be difficult to investigate the concept of cultural competence without a clear meaning of culture. Culture is not limited to racial classification and national origin, a definition should also take in account variables as religion, language, gender, sexual orientation, age, socioeconomic status, geographical location etc. [2]. Also, culture should be seen as “a part of identity that emerges in individual interactional moments in specific locales”[3, p. 167].

According to the Amsterdam declaration (2004), multicultural societies have a big problem with their healthcare systems and their delivery of healthcare that demands adjustments and development of quality [4]. Fu and van Ryn (2003) came to the conclusion that health care providers’ behaviours contribute to racial/ethnic disparities in health. This is explained by the process of conscious or unconscious stereotyping, the lack of attention to the problem and the lack of research in the area [5]. Minority groups do not receive the same level of care when it comes to diagnosis, treatments and preventive services as the average population [4]. Furthermore, the interpretation of a disease may depend on a person’s cultural influences [6], and a client would respond more positively to the care that is given if health professionals have knowledge about how to use cultural values and beliefs skilfully in client care [7].

Sundquist (1993) argues that primary care in Sweden must become better adjusted to the needs of minorities since there are differences in how Swedes and foreign-born people use the health care system [8]. Mixed emotions might be evoked when people behave in an unfamiliar way and when observers try to perceive these behaviours [9]. For example, Leval, Widmark, Tishelman and Ahlberg (2004) found in their study about Swedish midwives’ perception of circumcised women that even though cosmetic forms of genital cutting exist in western cultures, circumcision was incomprehensible for them. The encounters with these women were described as stressful and involving strong and mixed emotions. Even though the men that somehow were connected to the women appeared to be sensitive, caring and loving men, the midwives’ had very negative thoughts about them. They did acknowledge their limited
knowledge and inability to ask what the circumcised women felt themselves, but at the same
time they showed curiosity and desire to learn more [10]. Löfvander and Dyhr (2002)
concluded in their review that relatively few studies were found concerning transcultural
issues in primary care in Scandinavia and that the reason for this could be insufficient
research methods, and perhaps because of reluctance to be frank about existing difficulties in
treating immigrant patients. They suggested that research methods should emanate from the

It is also important to understand that the providers too have a culture with specific beliefs
and values that influence the interaction with a client [12]. It could therefore be assumed that
personality has an effect on the degree of cultural competence. Gender has been identified as
a factor that can explain variations in medical encounters, differences in communication styles
can be one explanation [13]. Differences in communication styles have in turn been attributed
to factors like personality, identity, socialization and linguistic skills [14]. These variations in
medical encounters can correlate with many factors besides from gender such as age,
ethnicity, nationality and social and economical standards [13]. The importance of excellent
communication skills and proper interacting styles are mentioned in many studies as
important for cultural competence or in transcultural care situations [11, 13, 15, 16, 17, 18].
Therefore, factors such as personality, age, gender, ethnicity and educational level could have
a relation to the degree of cultural competence.

This study will be built on the personality traits measured by the Big Five, namely:
- Extraversion (includes being sociable and outgoing)
- Agreeableness (includes being warm and sympathetic)
- Conscientiousness (includes being organized and thorough)
- Neuroticism (includes being tense and shy)
- Openness (includes being curious and unconventional) [19]

Also, this study will be built on Campinha-Bacote’s (2003) definition of cultural competence
in health care, which is “the ongoing process in which the healthcare professional
continuously strives to achieve the ability and availability to work effectively within the
cultural context of the client (individual, family or community)” [15, p. 14]. Also, Campinha-
Bacote (2003) has developed a model called “The Process of Cultural Competence in the
Delivery of Healthcare Services” which symbolizes that cultural desire evokes the process of
cultural competence. This desire makes people seek cultural encounters, obtain cultural
knowledge, conduct culturally sensitive assessments and become humble to the process of cultural awareness [15].

The aim of this study was to (a) investigate the degree of cultural competence in primary care in Sweden and (b) to examine if the degree of cultural competence had a relation to the providers personality, gender, age, ethnicity and educational level. Thus, the big question was; are some people more prone to be culturally competent than others?

**Hypotheses**

Since women generally score higher on both agreeableness and neuroticism [20] one could argue that gender will not have an effect on the degree of cultural competence, they should rule out each other. Personality has shown to be relatively stable over time [20] and therefore, neither age should be a predictor for the degree of cultural competence. There is some evidence that the structure of personality traits may be universal [20], and that could suggest that neither ethnicity should predict the degree of cultural competence. These three later factors, and educational level, could of course correlate with the degree of cultural competence independently, but the lack of research on the area makes it difficult to form a hypothesis in a specific direction.

Since there is evidence of disparities in health care in Sweden [4] you could assume that the degree of cultural competence in Swedish primary care would be relatively low. Extraverted people are more outgoing and sociable [19], therefore perhaps more prone to be interested in asking questions and to learn more about different cultures. People that are more open are also seen as more curious and unconventional [19], and could for that reason be more culturally competent, as well as warm, trusting and sympathetic persons who probably will score higher on the scale of agreeableness [19]. Furthermore, individuals that are more neurotic (more tense and shy) [19], could perhaps score lower on the degree of cultural competence. The hypotheses for this study were:

I. The degree of cultural competence in primary care was assumed to be relatively low.
II. The degree of cultural competence was assumed to be higher in people who show a high level of extraversion, openness and agreeableness, and lower in people who scores high on neuroticism.
**Methods**

**Procedure and subjects**

A total of 250 instruments were handed out in 13 different primary care wards in six different communities in one county in the south of Sweden, after permission of a supervisor. Three different county councils were asked to participate but only one agreed to take part in the study. The county that was investigated has approx. 330,000 inhabitants, 9.3 % of those are foreign born (includes Swedish born children with two foreign born parents). The percentage of foreign-born individuals in the different communities ranges from 6.6 % to 11.5 %. In Sweden as a whole, there are approx. 12 % foreign-born inhabitants [25]. The educational level in the area (shown in parentheses) is comparable with the educational level in the country as a whole, which is; compulsory school 24 % (19 %), upper secondary school 46 % (50 %), higher education (less than three years) 13 % (13 %), more than three years 16 % (16 %) [26, 27].

In the investigated county council there were in 2004 approx. 9400 employees (temporary employees are not included). With all employees included, 81 % were women and 19 % were men. The employer offers several different educations on a higher level (college, KY) as well as education in the Swedish language for foreign-born employees. Also, the employer sees diversity and integration as an important topic and encourages foreign-born individuals to choose educations that will lead to an employment in their organization [28].

Of the 250 instruments, 119 were returned answered, eight of these were not fully answered and could for that reason not be used. Thus, the study was built on the answers of 111 subjects. It was impossible to control who would be working at a particular time and who would be interested in participating in the study. However, the instruments were handed out to personnel in different workgroups (assistants, nurses, doctors, therapists etc.) These individuals were asked to fill out their gender, age, ethnic background and educational level, as well as three different questionnaires which will be described below. The participants ranged in age from 23 to 62 years with a mean of 47.6 (SD 9.72). Eleven were men and 100 were women, therefore no statistic analysis where made to investigate the relation between gender and cultural competence. Four different educational levels were reported, compulsory school (0.9 %), upper secondary school (9.9 %), higher education (11.7 %), and university education (77.5 %). These four groups were transformed to one group of university educated (77.5 %), and one group of not university educated (22.5 %). Only four of the participants had
a different ethnic background than Swedish, thus the relation between ethnic background and cultural competence was not analyzed.

**Questionnaires**

To measure cultural competence among professionals in primary care, a Swedish version of the *Inventory For Assessing The Process of Cultural Competence Among Healthcare Professionals-Revised* (IAPCC-R) [15] was used. Several investigators have measured reliability, and the Reliability Coefficient Cronbach alpha reaches from 0.75 (n = 218) [21], to 0.90 (n = 50) [22] with a mean of 0.81 [23]. U.S. experts in the field of transcultural health care established the validity of the IAPPC-R. Construct validity has been addressed by linking the IAPCC-R with Campinha-Bacote’s conceptual model of cultural competence [15]. She has divided the degree of cultural competence in four different categories: *culturally proficient* (91-100 points), *culturally competent* (75-90), *culturally aware* (51-74) and *culturally incompetent* (25-50) [15].

To measure the participants’ personality, the *Big Five Inventory* (BFI) [19] was used. In U.S. and Canadian samples Reliability Coefficient Cronbach alpha have typically ranged from 0.75 to 0.90 with an average above 0.80. Validity evidence includes substantial convergent and divergent relations with other Big-Five instruments as well as with peer ratings [19]. The instrument was translated from English to Swedish and back translated to English to control the validity of the translation.

To rule out the possibility that the participants would answer what they thought was the “right” answer on the IAPCC-R, the *social desirability scale of Marlowe-Crowne* was used, which have shown excellent psychometrical qualities in earlier studies [24].

**Statistics**

The statistical analysis’ that were used were means, medians, standard deviations, ranges, Cronbach alphas, Pearson correlations, partial correlations, two-tailed independent *t*-tests, a $\chi^2$- test and a Univariate analysis of variance.

**Results**

Item analyses were made on the instruments that were used in this study. The IAPCC-R [15] had a Reliability Coefficient Cronbach alpha of 0.73. In the BFI [19], the Reliability Coefficient Cronbach alpha ranged from 0.64 (agreeableness) to 0.86 (extraversion) with a
mean of 0.77. The social desirability scale of Marlowe-Crowne [24] had a Reliability Coefficient Cronbach alpha that reached 0.81.

The degree of cultural competence was calculated and the participants had a mean of 67.1, revealing that they in general were culturally aware. The means, medians, standard deviations and ranges for the variables cultural competence, extraversion, agreeableness, conscientiousness, neuroticism and openness are presented in Table 1.

<table>
<thead>
<tr>
<th></th>
<th>Cultural Competence (25-100)*</th>
<th>Extraversion (8-40)*</th>
<th>Agreeableness (9-45)*</th>
<th>Conscientiousness (9-45)*</th>
<th>Neuroticism (8-40)*</th>
<th>Openness (10-50)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>48.0</td>
<td>16.0</td>
<td>24.0</td>
<td>22.0</td>
<td>8.0</td>
<td>15.0</td>
</tr>
<tr>
<td>Max</td>
<td>87.0</td>
<td>39.0</td>
<td>44.0</td>
<td>45.0</td>
<td>31.0</td>
<td>48.0</td>
</tr>
<tr>
<td>Mean</td>
<td>67.1</td>
<td>29.1</td>
<td>36.8</td>
<td>36.0</td>
<td>18.1</td>
<td>35.5</td>
</tr>
<tr>
<td>Median</td>
<td>67.1</td>
<td>29.1</td>
<td>36.8</td>
<td>36.0</td>
<td>18.1</td>
<td>36.0</td>
</tr>
<tr>
<td>SD</td>
<td>7.1</td>
<td>5.7</td>
<td>4.1</td>
<td>5.1</td>
<td>5.0</td>
<td>6.3</td>
</tr>
</tbody>
</table>

* The scale of possible points

Pearson correlations with the above mentioned variables as well as educational level, age and the results of the Marlowe-Crowne social desirability scale was executed. The variables that correlated with the degree of cultural competence were, extraverted \( r = 0.24, p < .05 \), agreeableness \( r = 0.22, p < .05 \), conscientiousness \( r = 0.27, p < .01 \), openness \( r = 0.47, p < .001 \), and educational level \( r = 0.41, p < .001 \). A partial correlation showed that agreeableness no longer correlate with the degree of cultural competence when educational level was controlled for \( r = 016, p = .103 \).

After splitting the cultural competence variable at the median and divided it in to a high group and a low group, \( t \)-tests were made to see if there were any significant differences between these groups in any of the personality variables (see Table 2).
The relation between educational level (low and high group) and the degree of cultural competence (median split) was calculated with an $\chi^2$-test. Pearson Chi-Square was 6.32 ($p<.05$).

Table 2.

<table>
<thead>
<tr>
<th>Personality</th>
<th>Low group</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extraversion</td>
<td></td>
<td>28.29</td>
<td>5.93</td>
<td>-1.32</td>
<td>0.19</td>
</tr>
<tr>
<td></td>
<td>High group</td>
<td>29.72</td>
<td>5.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agreeableness</td>
<td></td>
<td>36.22</td>
<td>3.75</td>
<td>-1.39</td>
<td>0.17</td>
</tr>
<tr>
<td></td>
<td>High group</td>
<td>37.30</td>
<td>4.38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>Low group</td>
<td>34.55</td>
<td>5.26</td>
<td>-2.95</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>High group</td>
<td>37.30</td>
<td>4.57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuroticism</td>
<td>Low group</td>
<td>19.20</td>
<td>5.33</td>
<td>2.17</td>
<td>0.03</td>
</tr>
<tr>
<td></td>
<td>High group</td>
<td>17.18</td>
<td>4.46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Openness</td>
<td>Low group</td>
<td>32.82</td>
<td>6.19</td>
<td>-4.45</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>High group</td>
<td>37.78</td>
<td>5.56</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

After splitting the personality variables at the median as well, a Univariate analysis of variance was conducted to see if there were any combinations of personality traits that were significant for the degree of cultural competence. The result revealed that besides from a high educational level ($F_{1.81} = 17.99, p<.001$, partial $\eta^2=0.182$), a high level of openness ($F_{1.81} = 4.83, p<.05$, partial $\eta^2=0.056$) and a high level of conscientiousness ($F_{1.81} = 4.54, p<.05$, partial $\eta^2=0.053$), the combination of a high level of extraversion, a high level of agreeableness, and a high level of openness ($F_{1.81} = 7.78, p<.01$, partial $\eta^2=0.088$), as well as the combination of a high level of extraversion, a high level of conscientiousness, and a low level of neuroticism ($F_{1.81} = 5.39, p<.05$, partial $\eta^2=0.062$), was significant for a high degree of cultural competence when educational level was controlled for.
Discussion

The aim of this study was to investigate the degree of cultural competence in primary care in Sweden and to examine if the degree of cultural competence had a relation to the providers personality, gender, age, ethnicity and educational level.

If it is assumed that Campinha-Bacote’s definition of cultural competence is just and useful, this study show that the primary care in the investigated county council does have some difficulties with these issues (m = 67.1). A high degree of openness and conscientiousness, a low level of neuroticism, and a university education could be seen as the four variables that are the strongest predictors for a high degree of cultural competence in this study. That persons who are more curious and unconventional are more prone to be cultural competent is not an astonishing result. What was more surprising was that individuals that are more conscientious also seems to be more cultural competent. Perhaps persons that are more organized and thorough are less prone to falling into the trap of stereotyping behaviours. Fu and van Ryn explained racial/ethnic disparities in health with, among other things, the process of conscious or unconscious stereotyping. They mean that humans universally apply stereotypes when they make sense of other people. It makes the world more manageable when we use categorizing and generalizing techniques to simplify the massive amount of complex information and stimuli we are exposed to. The authors conclude that public health providers’ acceptance and awareness of these natural automatic processes, and a motivation to detect and inhibit them are important. Also, they point out that it is essential to give providers’ time, and to have settings and systems that allow them to have sufficient cognitive resources to overcome and replace automatic cognitive processes [5]. So perhaps it is easier for persons that are naturally conscientious to have the ability to overcome these processes than for persons that are not. These individuals will perhaps need more support from the organization. If this is the case, it could be an interesting angle to do further research on. If the primary care providers were given the time and structure by the organizations to work more organized and thorough, would they work in a more cultural competent way? To be less neurotic was assumed to increase the degree of cultural competence, and the result show that this also was the case. Persons that are less neurotic are perhaps also less suspicious over things that are different, for example other cultures. That a university education appeared to be such a strong predictor for a high degree of cultural competence was a surprise as well. This variable explained more than 18 % of the variance in cultural competence alone. Maybe knowledge in general widens people’s perspectives and helps us to see the bigger picture. Another
surprising result was that the degree of extraversion and agreeableness were not stronger predictors of the degree of cultural competence. Of course, if a person is sociable and outgoing does not necessarily have to mean that the person likes to interact with people that are different from him or her self. If persons that are agreeable are not aware of the disparities that are said taking place in Swedish health care, why should they then be sympathetic to minorities in particular? The big issue here could perhaps be awareness of the problem and the consequences of it. As it was argued for above, age didn’t have a relation to the degree of cultural competence. Löfvander and Dyhr concluded in their review that relatively few studies were found concerning transcultural issues in primary care in Scandinavia [11]. This suggests that these issues are relatively new to the most of us, and it is therefore nothing strange that both older and younger persons are unfamiliar with it. A higher degree of extraversion seemed to have a relation to a higher degree of cultural competence if a person was high on conscientiousness and low on neuroticism as well. The combination of being more extraverted and more agreeable had a relation to a higher degree of cultural competence if a person was high on openness as well. Many different combinations could correlate with the degree of cultural competence but several of the possible combinations weren’t measured due to the small sample. The result of the Univariate analysis of variance should for that reason be interpreted cautiously.

It became quite clear that the questionnaires used in this study arouse many different feelings and reactions. Some found the questions to be hard, and explained that cultural competence was not something they had reflected over before. Fu and van Ryn came to the conclusion that the lack of attention to the problem of these issues was one of the reasons for disparities in health care [5]. This idea could be strengthened by the reaction to this investigation. Some found the questions to be funny, the reason for this was never really explained. Some found them to be an ethical problem for the organization and did not want to participate for that reason. Overall, this study seemed to make the subjects feel offended and in some way accused. Lövander and Dyhr saw the reluctance to be frank about existing difficulties in treating immigrant patients as one of the reasons for the lack of research on the area [11]. It was many obstacles to overcome before the data was collected and it is not hard to understand why researchers keep away from such sensitive issues. More than 52 % of the questionnaires were not answered, and an additional 3 % were not fully answered. That gives an idea of the reluctance to participate in the study. Of course there are several reasons for the decline, such as lack of time. It was also mentioned that persons who work with health care get to answer
many questionnaires and they are therefore quite fed up with it. However, to get less than 50% returned answered indicates that there was some reluctance to participate in this particular study.

The findings of this study should be interpreted cautiously since the Reliability Cronbach Alpha was, for some variables, quite low. The reason for this could be the Swedish translations of both the IAPCC-R and the BFI. The Swedish version of the IAPCC-R has, according to the author, never been used before, and the BFI was translated only for this study. Furthermore, the result of this study should not be generalized to the Swedish primary care, only to the county council that was investigated. The demographical facts presented in the method show that the amount of foreign-born individuals in the investigated region was lesser than in the country as a whole. Also, the participants in this study had a much higher education in general than the Swedish population. There could of course be different results if the investigation would take place in an other area of Sweden.

This investigation shows that there is a need to make individuals who work in health care more aware of these issues. Future research should therefore investigate what the specific consequences are if they do not acknowledge the existing problems and what they can do to minimize them. The focus should not lie on personnel level alone, but on organizational level as well.
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