The effectiveness of cultural competence programs in ethnic minority patient-centered health care—a systematic review of the literature

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Abstract

Purpose. To examine the effectiveness of patient-centered care (PCC) models, which incorporate a cultural competence (CC) perspective, in improving health outcomes among culturally and linguistically diverse patients.

Data sources. The search included seven EBSCO-host databases: Academic Search Complete, Academic Search Premier, CINAHL with Full Text, Global Health, MEDLINE with Full Text, PsycINFO PsycARTICLES, PsycEXTRA, Psychology and Behavioural Sciences Collection and Pubmed, Web of Knowledge and Google Scholar.

Study selection. The review was undertaken following the preferred reporting items for systematic reviews and meta-analyses, and the critical appraisals skill program guidelines, covering the period from January 2000 to July 2011.

Data extraction. Data were extracted from the studies using a piloted form, including fields for study research design, population under study, setting, sample size, study results and limitations.

Results of data synthesis. The initial search identified 1450 potentially relevant studies. Only 13 met the inclusion criteria. Of these, 11 were quantitative studies and 2 were qualitative. The conclusions drawn from the retained studies indicated that CC PCC programs increased practitioners’ knowledge, awareness and cultural sensitivity. No significant findings were identified in terms of improved patient health outcomes.

Conclusion. PCC models that incorporate a CC component are increased practitioners’ knowledge about and awareness of dealing with culturally diverse patients. However, there is a considerable lack of research looking into whether this increase in practitioner knowledge translates into better practice, and in turn improved patient-related outcomes. More research examining this specific relationship is, thus, needed.

Keywords: patient-centered care, cultural competence, intercultural health care, health-care interventions

Introduction

Worldwide immigration has increased throughout the past century and considerably so in the past decade from 150 million migrants in 2000 to 214 million in 2010 [1]. Such change is reflected in various developed countries and specifically in public sectors such as health care, where the workforce and client base are becoming increasingly multifarious in terms of ethnicity and culture [2]. This demographic transformation is not without its problems, however, as massive disparities in the health status of the population are evident, negatively affecting primarily ethnic and cultural minority groups [3–6].

The successful delivery of health care in a multicultural setting is often hampered by a host of factors, including chiefly language and non-verbal communication barriers between carer and patient [7, 8], lack of respect and/or awareness of cultural traditions and beliefs in the practitioner–client
relationship [9–11] and interpersonal as well as institutional stereotyping and prejudice [12–14]. Accordingly, several health-care models have been proposed to shift from a somewhat paternalistic health-care model to an approach that engages the patient in decision making and self-care. Such models include cultural competence (CC) and patient-centered care (PCC) models [15, 16].

CC has been conceptualized as a ‘set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations’ [17–19]. It has been hypothesized that lack of awareness about cultural differences, together with culturally and linguistically diverse (CALD) patients’ lack of knowledge about the health system, can lead to two possible unwanted outcomes [16, 20]: (i) compromised patient–provider relationships, making it difficult for both providers and patients to achieve the most appropriate care and (ii) effects on patients’ health beliefs, practices and behaviors. As a result, the National Center for Cultural Competence in the USA has suggested a framework for CC [21] emphasizing the need of health-care systems to
• have a defined set of values and principles, policies and structures that enable them to work effectively and cross-culturally;
• have the capacity to value diversity, conduct self-assessment, manage the difference and institutionalization of cultural knowledge and adapt to diversity and the cultural contexts of the communities they serve;
• incorporate the requirements above in all aspects of policy development, administration and practice/service delivery.

The health-care models

PCC relies on the recognition that each patient represents a distinctive case with unique requirements and treatment needs and, thus, focuses on holistic care provided through open carer–patient communication and collaboration [22]. Patient empowerment and support also feature prominently in this method. As such, PCC principally signifies a move away from a ‘one-size-fits-all’ approach in health care to a more tailored treatment plan [22, 23].

Several studies attest the relevance of PCC in a range of health-care settings and the association between the form of patient care and health outcomes. For example, Stewart et al. [24] found significant positive correlations between patient-centered communication and patient perception of finding common ground \( (P = 0.01) \) and in turn linked such positive perceptions with better recovery \( (P = 0.0001) \), better emotional health \( (P = 0.05) \) and fewer diagnostic checks and referrals \( (up \ to \ 2 \ months \ later) \). These results were supported by Wanzer et al. [25] who linked patient satisfaction with communication and physician and nurse practice of PCC \( (r = 0.73, P = 0.001; \ r = 0.61, P = 0.001, \) respectively). Patient satisfaction with care received was also correlated with perceived physician PCC practice \( (r = 0.67, P = 0.001) \) and perceived nurse PCC practice \( (r = 0.68, P = 0.001) \) [25].

Similar findings highlight the value of PCC in other settings, including general preventive health care [26], diabetes management [27], cancer management [28–30], post-cancer follow-up treatment [31, 32], palliative care [33, 34], mental health [35] and HIV management and treatment [36]. Thus, there is considerable research providing relatively clear support for beneficial relationships between the practice of PCC and patient health, treatment and satisfaction.

PCC and CC

As PCC is designed to take into account the specific circumstances relevant to each patient—including ethnic and cultural variables. The successful delivery of this type of collaborative care relies on the ‘CC’ of the health-care provider. That is, for effective PCC, the practitioner must be able to communicate effectively verbally and non-verbally and respect the traditional practices and beliefs of the patient [37]. The significance of CC in health care is exemplified in several studies on issues such as physician language ability, cultural knowledge and patient satisfaction. Fernandez et al. [38], for example, found significant positive associations between physician self-rated language ability and successful elicitation of and responsiveness to patient concerns and problems \( (OR \ 4.3; 95\% \ CI, 1.75–10.56) \). Physician self-rated understanding of patients’ health-related cultural beliefs was also significantly linked with patient clarity \( (OR \ 3.98; 95\% \ CI, 1.43–11.45) \), responsiveness \( (OR \ 4.56; 95\% \ CI, 1.67–12.46) \) and understanding of prognosis and condition \( (OR \ 4.5; 95\% \ CI, 1.73–11.79) \). Similarly, Mazor et al. [8] found that a 10-week medical Spanish course for pediatric emergency department physicians was significantly associated with decreased use of interpreter services in patient care post-intervention \( (OR \ 0.34; 95\% \ CI, 0.16–0.71) \) and increased patient satisfaction in terms of perceived physician concern \( (OR \ 2.1; 95\% \ CI, 1.0–4.2) \), respectfulness \( (OR \ 3.0; 95\% \ CI, 1.4–6.5) \) and listening/communication \( (OR \ 2.9; 95\% \ CI, 1.4–5.9) \). In other examples, the CC of practitioners was positively correlated with minority patient satisfaction with received medical care \( (\hat{R}^2 = 0.193, P < 0.05) \) [39] \( (r = 0.32, P < 0.001) \) [40] and decreased blood pressure among hypertensive patients \( (r = -0.18; P < 0.05) \) [40]. These findings are further backed up in other research and appear to be relevant in a broad range of health-care settings [41–44].

As such, CC in health care can best be defined as practitioner flexibility and adaptability in terms of working effectively within a variety of cultural and ethnic contexts. This includes linguistic abilities, as well as cultural knowledge, awareness, sensitivity and respect [32]. Considering the increasing ethnic and cultural diversity in health-care clientele, CC is, thus, an integral aspect of PCC.

The current review

PCC and CC have been found to be complementary in terms of improving health-care quality and outcomes [15]. Whereas patient-centeredness aims to improve health-care quality by
emphasizing the inclusion of the patient’s perspective generally in caregiving, CC centers on circumventing cultural barriers between the health-care provider and client [45]. As such, both concepts focus on improved health care with an emphasis on patient-centeredness that in turn begs for acknowledgment of patient diversity. On this backdrop, PCC and CC approaches aim for the development of effective communication and clinical capabilities in health practitioners. For this reason, PCC and CC have been used interchangeably in the literature [45]. Nonetheless, there are relatively few PCC models that specifically incorporate a CC component and fewer still that have a cultural focus and have been empirically developed and evaluated [12, 46]. Thus, the aim of the following systematic review is to examine the effectiveness of PCC models that incorporate a CC perspective, in improving health outcomes among CALD patients.

**Method**

**Protocol**

This review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines that can be accessed at www.prisma-guidelines.org (Fig. 1).

**Information sources**

A search of the following databases was conducted during August 2011: Academic Search Complete, Academic Search Premier, CINAHL with Full Text, Global Health, MEDLINE with Full Text, PsycINFO, PsycARTICLES, PsycEXTRA, Psychology and Behavioural Sciences Collection, Pubmed, Web of Knowledge and Google Scholar.

**Search strategy and study selection process**

The search terms used were based on MeSH keywords for ‘PCC’ and ‘cultural competency’. Searches were conducted on the following terms simultaneously:

(i) Cultural competency terms (MeSH terms): Competency, Cultural; Cultural Competencies; Cultural Competence; Competence, Cultural.

(ii) PCC terms (MeSH terms): Care, Patient-Centered; Patient-Centered Care; Nursing, Patient-Centered; Nursing, Patient Centered; Patient-Centered Nursing; Patient-Centered Nursing; Patient-Focused Care; Care, Patient-Focused; Patient-Focused Care; Medical Home; Home, Medical; Homes, Medical; Medical Homes;

(iii) Other terms (text word): Prejudice, Health care; Racism, Health care; Attitude, Health care.

Reference lists for relevant papers were also manually searched for additional citations. Studies were included in the review based on the following criteria:

(i) The study was published in a peer-reviewed scientific journal.

(ii) The full text was available in English.

(iii) The population under study comprised health-care professionals and/or students and/or ethnic minorities.

(iv) The study centered on the development and effectiveness of patient-centered health-care models with a CC focus.

(v) The date of the publication was no earlier than 1 January 2000.

**Validity assessment**

Search results were assessed in three rounds. First, articles were filtered based on their title. Second, articles were retained or excluded after reviewing their abstracts. Third, the full-text versions of the remaining articles were obtained and reviewed. The empirical quality of the studies was assessed according to critical appraisal skill program guidelines (see Table 1).

**Data extraction process**

Data were extracted from the studies using a piloted form, including fields for study research design, population under study, setting, sample size, study results and limitations.

### Table 1 Data extraction strategy

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the paper peer reviewed and is the full text available?</td>
<td>Proceed</td>
<td>Exclude</td>
</tr>
<tr>
<td>Does the study focus health-care delivery to ethnic minorities?</td>
<td>Proceed</td>
<td>Exclude</td>
</tr>
<tr>
<td>Does the study involve the development and assessment of (an) intercultural PCC model(s)?</td>
<td>Proceed</td>
<td>Exclude</td>
</tr>
<tr>
<td>Final decision</td>
<td>Include</td>
<td>Exclude</td>
</tr>
</tbody>
</table>
Results

Study selection
A total of 1450 papers were identified in the initial search. The majority of these were rejected based on one or more of the following factors: the paper focused on general healthcare delivery models without a CC component; the paper described culture-related training programs that were not part of PCC programs; the paper described CC healthcare models, but with no empirical evaluation or evidence base; the paper was about work culture rather than ethnic culture; the paper did not cite empirical research (commentaries, book reviews, etc.); or a combination of the above. Overall, 13 studies met the inclusion criteria (see Table 1).

Study characteristics and samples
Seven of the studies reviewed were from the USA, four from Canada and two from the UK (see Table 1). The majority of the research was conducted in a professional (clinical/hospital) setting (n = 9) [47–55], but student settings were also used (n = 5) [49, 56–59]. All participants were adults over 18 years of age. The studies predominantly (n = 11) relied on quantitative research designs, including randomized controlled trials (RCT), longitudinal design, cross-sectional design and descriptive correlational design (see Table 1). Qualitative research designs were employed in the remaining studies (n = 2). Outcome measures comprised patient satisfaction with care, health outcome or practitioner behavior in four of the studies [50–52, 54], whereas the remaining nine studies generally used practitioner knowledge and/or awareness of PCC and CC issues as evaluation measures [47–49, 53, 55–59] (Table 2).

Summary of findings
Two studies examined patient health outcomes as an evaluation measure. Majumdar et al. [51] investigated the effects of a CC course on 114 nurses and homecare workers. Effects of the program were also observed for 133 patients. Health-care workers who received the training demonstrated significantly higher understanding of multiculturalism than a control group (P < 0.0001). Similar findings were evident for cultural awareness (P = 0.0001), understanding of cultural differences (P = 0.001), cultural beliefs (P = 0.004), adopting health-care literature (P = 0.001), considering patient social circumstances (P = 0.011) and regarding culture as important in successful health-care treatment (P = 0.001). These results persisted over time. There were no significant findings in terms of patient health outcomes—however, this was possibly due to attrition in the patient participant group [51].

Thom et al. [54] assessed the effectiveness of a CC training curriculum administered to 53 physicians. The training program comprised cultural knowledge, intercultural communication and cultural brokering (engaging the patient in the development of a treatment plan in a culturally sensitive fashion). The impact of the intervention was measured in terms of the CC of the physician as rated by the patient. Secondary measures included patient satisfaction with received health care and outcomes. The study yielded no significant effects across all evaluation variables. Limitations were noted, however, and related to the brevity of the training curriculum (3–5 h), insufficient follow-up assessments and the fact that over 70% of participating physicians were of another ethnicity than Caucasian and, therefore, possibly already culturally capable [54].

The remaining eight studies relying on quantitative research designs examined practitioner training and education programs, with the exception of a single study that looked into African-American patient satisfaction and perception of physician CC [52]. Here, the effectiveness of the ‘Ask Me 3’ intervention was evaluated. The program focused on increasing the quality of PCC and CC, by encouraging African-American patient involvement in the clinical process [52]. Results indicated no improvements in physician CC as rated by the patient. Significant progress was evident, however, in satisfaction for patients who saw their regular physician (P = 0.014). Thus, an interaction effect of physician familiarity and the intervention appeared to increase patient satisfaction with care received. Limitations mainly related to a small sample size (n = 64) [52].

Brathwaite and Majumdar [47, 48] assessed the effects of a PCC educational program offered to 76 nurses at a Canadian hospital. The evaluation centered on pre- and post-intervention scores on the Cultural Knowledge Scale. Significant increases in CC over time were evident (P < 0.02) —specifically in relation to cultural knowledge, awareness, confidence and use of lessons learned [47, 48].

A study in the USA assessed the Cultural Competence and Mutual Respect program that was delivered over 3 years to 1974 health-care students [57]. Evaluation was based on pre- to post-scores of the Inventory for Assessing the Process of Cultural Competence-Revised scale (ranging from 25 to 100 points), and significant improvements in student CC were evident with males increasing by 4.1 points (P < 0.001) and females by 3.8 points (P < 0.001) [57].

Comparable findings were established in four other studies. [49, 53, 56, 59] One study [58] assessing the impact of a CC PCC educational program on university students found no significant improvements in CC post-intervention. This was, however, probably due to limitations of the measurement scales used and the brevity of the intervention period [58].

Finally, two qualitative studies were included in the review. Kirmayer et al. [50] evaluated a program implemented as a cultural consultation service for mental health practitioners and primary care clinicians. Assessment of the service occurred through practitioner observation, reason for consultation, examining cultural formulations and recommendations as well as consultation outcome in terms of clinician satisfaction [50].Patients comprised immigrants, refugees and asylum seekers (n = 102). The most common reasons for consultation with the service were difficulties with diagnosis (58%) and treatment planning (45%) as well as requests for assistance with specific ethnic groups or clients (25%) [50]. It was further evident that the main themes in terms of practitioner cultural
Table 2: PCC models with a CC scope—from 2000 to present

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>Location</th>
<th>Experimental design</th>
<th>Sample (n)</th>
<th>Integrated cultural care model</th>
<th>Outcome measures</th>
<th>Results and limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brathwaite[48]</td>
<td>Canada</td>
<td>Longitudinal pre- to post-intervention study</td>
<td>Registered nurses (76)</td>
<td>Brief CC training course.</td>
<td>Scores on the CKS.</td>
<td>Results showed that the course was effective in increasing participants’ levels of CC (P &lt; 0.000). Limitations relate to the small sample size and the lack of patient health outcome effects.</td>
</tr>
<tr>
<td>Brathwaite and Majumdar [47]</td>
<td>Canada</td>
<td>Longitudinal pre- to post-intervention study</td>
<td>Registered nurses (76)</td>
<td>Five-week CC training course.</td>
<td>Scores on the CKS.</td>
<td>Nurses’ CKS scores increased significantly (Wilks’ Lambda P &lt; 0.01). Limitations relate to small sample size, generalizability and lack of patient health outcome effects.</td>
</tr>
<tr>
<td>Crandall et al. [56]</td>
<td>USA</td>
<td>Longitudinal pre- to post-intervention study</td>
<td>Second-year medical students (12)</td>
<td>Adaptation and integration of cultural awareness, sensitivity and knowledge in medical practice.</td>
<td>Multi-national Assessment Questionnaire pre- to post-intervention scores.</td>
<td>A positive impact was apparent pre- to post-intervention. Further research to establish whether effect decays or persists. Lack of assessment of patient health outcome effects.</td>
</tr>
<tr>
<td>Ghallager-Thompson et al. [49]</td>
<td>USA</td>
<td>Longitudinal pre- to post-intervention study</td>
<td>Health-care professionals and students (340)</td>
<td>The Alzheimer's Hispanic Outreach, Resource and Access Project.</td>
<td>Participant knowledge of CC and related attitude and clinical behavior.</td>
<td>Significant improvements in the measured variables were evident post-intervention (P &lt; 0.05–0.005).</td>
</tr>
<tr>
<td>Kirmayer et al. [50]</td>
<td>Canada</td>
<td>Qualitative study</td>
<td>Minority mental health patients (100)</td>
<td>Cultural consultation service; integrating different perspectives of psychiatry and medicine.</td>
<td>Referring clinicians’ satisfaction with patient progress.</td>
<td>Clinicians reported increased insight into cases, improved treatment, therapeutic alliance, understanding and communication. Limitations relate to the small sample size.</td>
</tr>
<tr>
<td>Majumdar et al. [51]</td>
<td>Canada</td>
<td>RCT</td>
<td>Health-care providers (114) and patients (133)</td>
<td>Cultural sensitivity training for health-care providers, cultural awareness, communication and understanding.</td>
<td>Health-care provider attitude and cultural competency and patient health outcomes.</td>
<td>The program improved knowledge and attitudes of health-care providers in the experimental group (P = 0.011–0.0001). There were significant improvement in patient health outcomes and satisfaction.</td>
</tr>
<tr>
<td>Michalopoulou et al. [52]</td>
<td>USA</td>
<td>RCT</td>
<td>African-American patients (64)</td>
<td>Culturally sensitive GP practice of Ask Me 3 intervention. Encouraging active patient participation in clinical process, Communication and interaction.</td>
<td>Patient-Perceived Cultural Competency Measure score.</td>
<td>No significant differences were found between experimental and control groups. Individuals seeing their regular GP reported significantly higher levels of satisfaction with care, than patients seeing their regular GP. Limitations include small sample size and a single ethnicity under study.</td>
</tr>
</tbody>
</table>

(continued)
Table 2 Continued

<table>
<thead>
<tr>
<th>Author (year)</th>
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<th>Results and limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musolino et al. [57]</td>
<td>USA</td>
<td>Longitudinal pre- to post-intervention study</td>
<td>IHSS, professionals in medicine [60], pharmacy, nursing and PT (1974)</td>
<td>Cultural Competency and Mutual Respect education program.</td>
<td>Pre- to post-intervention scores on Campinha-Bacote’s Inventory for Assessing the Process of Cultural Competence-Revised.</td>
<td>Overall progress toward CC was observed pre- to post-intervention ($P &lt; 0.001$). Cultural proficiency was not attained in IHSS, however. Further research needs to look into how the program can be delivered more effectively and its specific effect on health outcomes.</td>
</tr>
<tr>
<td>Reichert &amp; al. [58]</td>
<td>USA</td>
<td>Case control study/ pre-, post-test.</td>
<td>PT students (26)</td>
<td>CC educational program.</td>
<td>Yang Social Interaction survey [46] scores and Wilcoxon Rank Sum Test scores pre- to post-intervention.</td>
<td>There were no overall improvements in student knowledge and attitudes pre- to post-interventions. Limitations relate to small sample size and lack of examination of patient health outcomes effects.</td>
</tr>
<tr>
<td>Smith [53]</td>
<td>USA</td>
<td>Two group longitudinal pre- to post-intervention study</td>
<td>Registered nurses (94)</td>
<td>CC curriculum.</td>
<td>CSES scores and knowledge base scores.</td>
<td>Scores on the CSES and knowledge base were significantly better for intervention group ($P = 0.015$). Limitations relate to the sample size and the lack of assessment of patient health outcome effects.</td>
</tr>
<tr>
<td>Tang et al. [59]</td>
<td>USA</td>
<td>Cross-sectional pre- to post-intervention study</td>
<td>Medical students (167)</td>
<td>Socio-cultural Medicine Program</td>
<td>Student attitudes to socio-cultural medicine.</td>
<td>Significant improvements were noted post-intervention in terms of general attitude, understanding of cultural issues in health care, importance of culture in doctor–patient relationship and patient health behavior ($P &lt; 0.01–0.001$). There was no discernable impact of the intervention on patient health and attitude. Limitations relate to the brevity of the intervention.</td>
</tr>
<tr>
<td>Thorn et al. [54]</td>
<td>USA</td>
<td>RCT</td>
<td>Primary care physicians (53) and patients (429)</td>
<td>CC curriculum for resident and practicing physicians.</td>
<td>Patient-Reported Physician Cultural Competence score; secondary outcomes were changes in patient health status and satisfaction.</td>
<td>CC and antiracism training were well received by professionals. It was a positive experience for trainees and perceived to be relevant to their practice. Appropriate and non-threatening training in CC change attitudes, behaviors and practice, including promoting good practice in communication across linguistic and cultural differences. Limitations relate to lack of measurement of patient satisfaction and health outcomes.</td>
</tr>
<tr>
<td>Webb and Sergison [55]</td>
<td>UK</td>
<td>Qualitative study</td>
<td>Health-care professionals and students, social services professional and education professionals (140)</td>
<td>CC and antiracism training.</td>
<td>Self-reported cultural and racism awareness, knowledge and changed behavior.</td>
<td></td>
</tr>
</tbody>
</table>

CKS, Cultural Knowledge Scale; IHSS, interdisciplinary health science students; PT, physical therapy; CSES, Cultural Self-Efficacy Scale.
formulation and awareness were largely related to communication issues and ignorance of traditions, different family structures, identity conceptions and religious issues. [50].

Clinicians indicated favorable reviews of the consultation service and reported overall greater CC [50]. In a similar study, Webb and Sergison [55] examined the effectiveness of the CC PCC training course, Equal Rights Equal Access. Of the respondents, 75% (n = 36) believed that the course had been effective in teaching CC and in particular communication and use of interpreter services [55]. Other notable themes were related to increased self-reported clinician awareness of the specific needs of ethnic minorities, embracing diversity in their clientele and alertness to own stereotypical views and generalizations [55].

Discussion

This review examined the effectiveness of PCC models that incorporate a CC perspective, in improving health outcomes among CALD patients. There were 13 studies that met the inclusion criteria for this review. Overall, we found evidence supporting the effectiveness of CC PCC training in increasing knowledge levels, self-reported practice and patient satisfaction. However, whereas increases in cultural knowledge and awareness were evident, no studies reported any significant findings in terms of patient health outcomes. In fact, only two studies used this variable as an outcome measure [51, 54], and both of these studies were hampered by participant attrition or small sample sizes and short intervention periods. Importantly, the fact that most of the research on CC PCC programs measured effectiveness in terms of practitioner knowledge and not patient health represents a major shortcoming to the current research on this topic, as patient health outcome is one of, if not the most important indicator of effectiveness of any care model. Thus, the current results in this regard are limited, and more research is required to properly assess the impact of the reviewed interventions on patient health.

Limitations

As mentioned above, a major limitation to the research reviewed pertains to the lack of patient health outcome measures in the majority of studies. Only two studies included such an evaluation variable, and both generated non-significant impacts—most likely due to low participant numbers and participant attrition. Future research should include evaluation of the practical effects of CC in PCC programs in terms of patient health outcomes. Another limitation comprises the fact that the review did not include studies published in languages other than English, thus limiting an international viewpoint. The current review was unable to include non-English language studies due to lack of funds to meet costs related to translation services. Finally, the difference in research design across studies—and the consequent difficulty in synthesizing and comparing the results of the research—also represents an important limitation.

Conclusion

The objective of this systematic review centered on the effectiveness of PCC models that incorporate a CC perspective, in improving health outcomes among CALD patients. Of the initial 1450 studies identified in the first search round, 13 met the final inclusion criteria and were included in the review. The majority of the research demonstrated effectiveness of PCC models in terms of clinician/practitioner cultural knowledge, awareness and sensitivity. Only two articles examined effects of the intervention programs on patient health outcomes, with both studies reporting non-significant results on these variables. As such, although the programs may increase practitioner knowledge and awareness, there is no evidence that this translates to improved patient health. More research is, thus, required to properly examine the impact, if any, of CC PCC models on health outcomes.

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References


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