

Where Are We and Where Are We Going: Experts on Cultural Competence in the Slovenian Healthcare System

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ABSTRACT – The Slovenian society is becoming increasingly diverse, necessitating the development of cultural competence within the healthcare system. Cultural competence is essential for ensuring equitable and high-quality care for all individuals. The first step in fostering cultural competence involves assessing the current state in this domain, which constituted the primary objective of our research. The study was based on qualitative methodology, specifically eight semi-structured interviews with experts in the examined field. Through directed content analysis, the collected data were categorized according to Cross's six-stage continuum of responses to diversity. No evidence of cultural destructiveness was identified. However, elements of cultural incapacity (fear, prejudice) and cultural blindness (universal approaches without adaptation, lack of cultural sensitivity) were observed. The majority of the findings indicated a cultural pre-competence within the healthcare system, characterized by a growing awareness of diversity, initial educational initiatives, and projects focused on cultural competence, yet lacking systemic solutions. We conclude that the healthcare system is moving towards cultural competence, although significant progress remains to be made. Social changes and political discourse can swiftly lead to regression.

Izvirni znanstveni članek

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KLJUČNE BESEDE: raznolikost, zdravstveni sistem, odzivnost, kulturne kompetence

POVZETEK – Slovenska družba postaja vse bolj raznolika, kar zahteva, da zdravstveni sistem razvije kulturno kompetentnost. Ta je ključna za zagotavljanje pravične in kakovostne oskrbe za vse. Prvi korak v razvoju kulturne kompetentnosti je ocena trenutnega stanja na tem področju, kar je bil osnovni namen naše raziskave. Temeljila je na kvalitativni metodologiji – osmih polstrukturiranih intervjujih s strokovnjaki na preučevanem področju. S pomočjo usmerjene vsebinske analize smo pridobile podatke uvrstili v 6-stopenjski kontinuum odzivov na raznolikost po Crossu. Kulturne destruktivnosti nismo zaznali. Identificirali smo elemente kulturne nezmožnosti (strah, predsodki) ter kulturne slepote (univerzalni pristopi brez prilagoditev, pomanjkanje kulturne občutljivosti). Največ podatkov je kazalo na kulturno predkompetentnost v zdravstvenem sistemu, ki jo označujejo naraščajoče zavedanje o raznolikosti, prvi zametki izobraževanj ter projekti na področju kulturne kompetentnosti, ni pa še sistemskih rešitev. Sklepamo, da se zdravstveni sistem premika v smeri kulturne kompetentnosti, čeprav nas čaka še dolga pot. Družbene spremembe in politični diskurz lahko hitro vplivajo na nazadovanje sistema.

1 Introduction

Modern society, both globally and within Europe and Slovenia, is becoming increasingly diverse. This term encompasses differences among people related to ethnicity,

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gender, sexual orientation, language, culture, religion, mental and physical abilities, social class, and immigrant status (UNESCO, 2017). One of the most prominent sociologists, Hofstede, noted long ago that cultural diversity is reflected across all societal systems (1985) and that inequality exists in every society – in a more pronounced way in some than in others (2011).

Thus, cultural diversity is also reflected in its healthcare systems. These represent one of the essential foundations of any country, crucial for ensuring healthcare of individuals, families, and society as a whole. It accompanies individuals throughout their entire lifespan – from birth to death – and thus bears vital and continuous responsibility for their health. Among the most important characteristics of a healthcare system are its responsiveness to the expectations of the population and fairness – the capacity to provide equally high-quality care to all individuals without discrimination (WHO, 2000). The basis of fairness lies in openly recognizing the dignity and autonomy of all society members and ensuring high-quality healthcare regardless of gender, ethnicity, religion, sexual orientation, language, geographic origin, or socio-economic status (Kumagai & Lypson, 2009). Cultural competence in healthcare systems is thus critical in modern society to provide inclusive care and prevent inequalities (Anderson et al., 2003).

In this article, we focused on analyzing the views of experts in cultural competence regarding the status of this concept within the Slovenian healthcare system. The main aim of the research was to investigate how cultural competence experts evaluate its level in Slovenian healthcare from the perspective of responsiveness to diversity as defined by the cultural competence model proposed by Cross (1989). This research formed part of a broader doctoral work, in which we comprehensively studied this phenomenon and, based on the assessment of the current state, developed a model for its further development.

1.1 Cultural competence in healthcare

In their seminal monograph from 1989, Cross and colleagues formulated a classic and still most frequently cited definition of cultural competence (Chiarenza, 2012; Jongen et al., 2018; Handtke et al., 2019; Li et al., 2023). They defined cultural competence as a set of congruent behaviors, attitudes, and policies existing at the system, organization, and individual provider levels, enabling effective functioning in intercultural contexts. Such a system recognizes and respects the significance of cultural differences, remains sensitive to the dynamics resulting from these differences, evaluates intercultural responses, enhances knowledge in this area, and appropriately adapts services to the specific needs arising from cultural diversity. The authors described the acquisition of cultural competence as a continuous, developmentally oriented process that can be evaluated through the achievement of specific developmental milestones. According to Cross et al. (1989), the initial phase in this process involves assessing the existing state of cultural competence.

The subsequent definitions of cultural competence have primarily focused on the individual level, although several definitions continue to emphasize the systemic

perspective. Betancourt and colleagues, for instance, emphasized that cultural competence represents the capability of a healthcare system to deliver high-quality care and services tailored to patients with diverse values, beliefs, and behavioral patterns, while considering their social, cultural, and linguistic needs (Betancourt et al., 2002). Furthermore, a culturally competent system acknowledges that differences within a single cultural group can often be greater than those between groups, and that individual identity is shaped by a variety of factors – from ethnicity to age, education, geographic origin, and other influences (Engebretson et al., 2008).

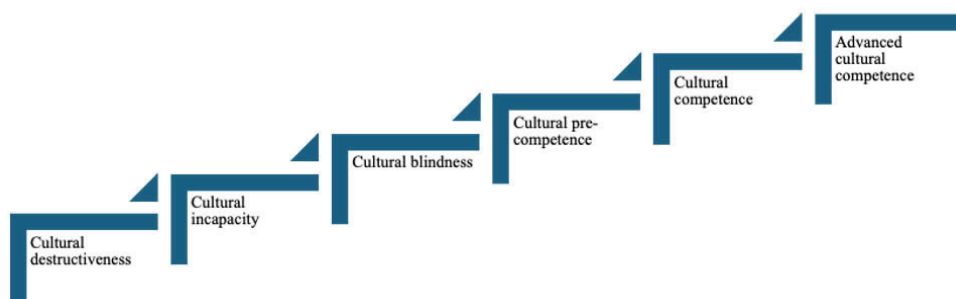
In healthcare, cultural competence thus refers predominantly to the capacity of systems, organizations, and their employees to effectively and sensitively address the needs of diverse patients, their families, and communities (Dreachslin et al., 2017). There is a strong connection between the cultural competencies of individual healthcare providers and broader organizational or systemic cultural competence. An organization's or system's commitment to respecting diversity and providing culturally sensitive care directly influences the behaviors and competencies of employees – and vice versa (Truong et al., 2014, p. 14).

1.2 Continuum of cultural competency

Cross and colleagues illustrated the level of cultural competence within a system and its developmental progression through a linear continuum of responses to cultural diversity (see Figure 1).

Figure 1

Continuum of cultural competency/Lestvica kulturne kompetentnosti



Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. CASSP Technical Assistance Center, Georgetown University Child Development Center.

The continuum includes six stages, reflecting varying levels of organizational and systemic responsiveness – from the most destructive to the most competent and sensitive:

- Cultural destructiveness represents the most negative response to cultural diversity, characterized by behaviors, attitudes, and practices overtly harmful to members of other cultures. This includes cultural genocide, the deliberate destruction of foreign cultural identities accompanied by a belief in the superiority of the dominant culture, justifying the control, exploitation, and systematic oppression of minority groups.
- Cultural incapacity is the second stage, characterized by persistent prejudice, discrimination, and institutionalized exclusion within the system, despite the absence of intentional destructiveness. Minority groups are often patronized and undervalued, and segregation, fear of differences, racism, and limited access to employment and service opportunities prevail.
- Cultural blindness is the central phase of the continuum, where the system formally advocates equality but ignores the significance of cultural diversity. Predominant beliefs include “we are all the same”, and an assumption that services from the majority culture are universally applicable. This approach leads to ethnocentricity and ineffectiveness when working with minority groups. Individuals who fail to achieve outcomes tailored to the majority culture are often personally blamed. Institutional racism remains present, resulting in systematic disadvantages in access to resources, education, and advancement opportunities.
- Cultural pre-competence represents a transitional phase towards a positive response to diversity. At this stage, the system begins to recognize barriers in treating different groups and introduces initial adaptations – such as improvised solutions, collaboration with minorities, and initial educational programs on cultural competence. Although there is an intention to improve accessibility and quality of care, the system can become complacent, believing it has already achieved the goal despite improvements being limited to specific groups, or lose interest if immediate results are not evident.
- Cultural competence signifies a conscious commitment to diversity and the establishment of structures for the sustained inclusion of minority groups. The system continually reflects on its practices, promotes self-assessment, education, and actively involves minorities in policymaking and service design. Cultural competence is integrated into strategic and normative documents of institutions and recognized as an essential component of quality care.
- Advanced cultural competence (also termed cultural proficiency) represents the highest level of responsiveness. It denotes a system actively oriented toward promoting cultural diversity, deliberately incorporating it into all operational levels, employing experts in this field, and investing in development, research, and innovation for long-term improvement of services for culturally diverse groups. Such a system acts as an advocate for diversity and functions as a societal agent striving for justice in a broader social context.

2 Methodology

The purpose of the research was a comprehensive examination of selected experts' views on cultural competence regarding the current state of this concept in the Slovenian healthcare system. Our aim was to thoroughly evaluate the status of cultural competence using the theoretical framework of Cross's continuum of responses to cultural diversity (1989), thereby providing a foundation for developing strategies for its further advancement. In this way, we contribute to understanding the state of cultural competence in Slovenian healthcare and raising awareness about the importance of this concept for ensuring equitable, high-quality, and inclusive healthcare.

We posed the following research question:

How do healthcare cultural competence experts assess the current level of cultural competence in the Slovenian healthcare system?

In the research, we applied a qualitative approach, allowing an in-depth understanding of complex phenomena, such as cultural competence in healthcare. Data collection involved conducting eight semi-structured interviews with selected experts working in the field of healthcare cultural competence. This method has proven effective in other national-level studies as well. Betancourt and colleagues successfully used this method in the United States to capture the assessment of the situation, key perspectives, perceived barriers, and development trends in the field of cultural competence (2005). The sample was therefore purposive, comprising experts engaged in cultural competence as researchers, publicists, and educators. Among them were three physicians, three nursing experts, one anthropologist, and one sociologist. Seven respondents were women, and one was a man.

The interview instrument consisted of a specially designed questionnaire developed based on the selected method of analysis – directed (deductive) content analysis. This required formulating questions based on predefined content categories, thus employing the continuum of cultural competency by Cross et al. (1989) as our analytical framework. Despite originating in the late 1980s, this model remains one of the most frequently cited (Li et al., 2023), and its relevance is confirmed by its application in numerous studies in this field (Engebretson et al., 2008; Van Ngo, 2009; Diaz-Cruz & Hagan, 2020; Cormier, 2021).

Data obtained from interviews were processed following the procedure for data analysis in deductive content analysis (Elo & Kyngäs, 2008). We prepared predefined categories according to the selected model (cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, advanced cultural competence). This was followed by immersion in the data (repeated readings) and the classification of data into these categories. In subsequent iterations, the data within categories were organized into codes, and their correctness of classification was reviewed again. In preparing the report on the results, we paid particular attention to ensuring data protection and the anonymity of the respondents.

Throughout the entire process, we adhered to ethical guidelines applicable to research.

3 Results

During the analysis, we identified a total of 70 relevant quotes for our purpose. Among these, none of them could be classified under cultural destructiveness, nor were any quotes indicating the presence of cultural competence or advanced cultural competence detected. However, we identified quotes categorized as responses of cultural incapacity, cultural blindness, and cultural pre-competence.

3.1 Cultural incapacity

We categorized 10 quotes under the category unit of cultural incapacity. All quotes were marked with the common code Fear, prejudice, and discrimination. Participants highlighted a lack of understanding and tolerance, both in general society and within the healthcare system, which can manifest as rejection of diversity and unequal treatment. Below are two examples demonstrating elements of cultural incapacity, with offensive expressions replaced with neutral descriptions to respect the dignity of the mentioned groups:

"Today, in addition to strong anti-Roma sentiments, I observe clearly anti-refugee, anti-immigrant sentiments in various locations, with frequent repetition of certain clichés and severe racist beliefs about them. Here again, I notice considerable unwillingness to open up to people who are different but live among us." KK-EX-2

"Every day, I hear expressions like 'that [derogatory term for a woman from the Albanian community] came in, this [derogatory term for a woman from the Roma community] is waiting.' Nobody ever says anything... I've never heard anyone say: 'Don't use such terms!' Let alone report it." KK-EX-3

3.2 Cultural blindness

We identified 28 quotes classified under cultural blindness. Within this category, we sorted data into two codes: Universal services and Lack of cultural sensitivity. The first code denotes statements about the healthcare system's organization, which employs universal treatments without considering cultural or other individual specifics, failing to recognize or accommodate diverse users' needs. This especially relates to communication barriers and other obstacles requiring temporal and spatial adjustments. Example of a quote marked with the code Universal services:

"If we consider other areas involving some form of social diversity, similarly, if patients are health-illiterate, they require significantly more time for consultation. Flexibility of the healthcare system – allowing health professionals to adjust their time management in clinics and even conduct home visits if needed – would certainly be highly desirable. Currently, our system does not allow for any of this flexibility." KK-EX-1

With the code Lack of cultural sensitivity, we marked statements suggesting the belief that the healthcare system operates equally effectively for all individuals (and if not, it is usually seen as the user's fault), alongside the presence of ethnocentric views among healthcare providers. The following is an example from this group of statements:

"So, everyone somehow assumes that everyone sees the world as I see it. Doctors believe everyone sees the world as medicine sees it, nurses are astonished at the 'silly' questions patients ask, when in reality, these are merely cultural misunderstandings." KK-EX-5

3.3 Cultural pre-competence

The largest portion of the data (32 quotes) was found within the category of cultural pre-competence, reflecting various forms of initial movements toward more sensitive and inclusive practices. The statements were categorized into the following codes: Awareness of diversity, Education initiatives, Projects towards cultural competence development, and Influence of individuals.

The quotes marked with the code Awareness of diversity indicated a growing recognition of diversity existence, its impact on patient needs and an increasing demand for cultural competence. This is reflected in the following quote:

"I think that the generations coming up now are a bit more aware of the need for cultural competence. This doesn't mean that the current working generations aren't open to people, patients from other cultures – far from it. But perhaps it's mostly this awareness, seeing this as an important part of their work." KK-EX-6

We also identified considerable data about the efforts to establish educational programs in this area, as well as some existing courses. We labelled the data as Education initiatives, as they mostly represented initial and not yet systematically established programs. An example of an educational initiative in cultural competence was identified in the following quote:

"... they want to introduce an elective subject on cultural competence or something like this. Likely, it will be a mix of everything. Similar developments are happening at the medical faculty ... Last year, we had something related to cultural competence within the Erasmus exchange presentations, where a professor from Slovakia spoke about it. Colleagues were extremely enthusiastic. I'd rate these activities at the medical faculty positively." KK-EX-3

Additionally, we recognized data related to Projects towards cultural competence development within the healthcare system. These projects primarily addressed communication barriers and educational programs, although interviewees expressed concerns about the lack of systematic implementation of measures in the healthcare system. One such quote is:

"Currently, it's rather sporadic – some projects exist if there is a specific group of people ... yes, it's mostly project-based, sporadic, time-limited, targeted at a specific

population. Certainly, this isn't something systematically embedded into the healthcare system." KK-EX-8

Finally, we also identified statements about the Influence of individuals on cultural competence, reaffirming that solutions are primarily dependent on individual initiative rather than systematic measures. One participant noted:

"There might be one person who is receptive and holds a position enabling their institution to behave more positively towards foreigners. Conversely, there are institutions without such individuals, functioning disastrously. It's not systematically regulated – it's a matter of our characters and how much of ourselves we invest." KK-EX-3

4 Discussion

In the research, we found that fear, prejudice, and discrimination, elements of cultural incapacity, still exist within the healthcare system. Mlinšek already highlighted the presence of discrimination and rejection in healthcare in the past, as well as the lack of research attention dedicated to these phenomena (2012). Bogataj et al. (2019) found that as many as 8% of migrant women in Slovenia have experienced discrimination or violence within the healthcare system. Lipovec Čebren (2021) addressed the phenomenon of patient blaming within the Slovenian healthcare system, observing that healthcare workers often attribute responsibility to patients facing intercultural challenges, particularly language barriers, labelling them as "insufficiently motivated" or "not trying hard enough" to adapt. She warns that such attitudes often border on racism. It is crucial to emphasize that stereotypes and prejudices can quickly lead to discriminatory behaviour (Wright & Taylor, 2007), resulting in unequal and lower-quality care for culturally, linguistically, or socially diverse individuals and groups (Marcelin et al., 2019). Additionally, evidence shows that healthcare workers often employ their personal reference framework when planning care, making it difficult to establish empathy with those who differ from them. "Othering" opens the door to difficult communication and potential conflicts during care provision. Cultural awareness and sensitivity are essential for reflecting on implicit biases and their impact on practical care delivery, making them key prerequisites for culturally competent care (Claeys et al., 2021). Regardless, racism and prejudice must be met with zero tolerance. Health professionals and organizations should receive ongoing training on these issues, supported by regulatory and educational bodies. Civil society must hold leaders accountable for enforcing these commitments (Abubakar et al., 2018).

We also identified a lack of cultural sensitivity in the category of cultural blindness. Under this category, we included statements indicating a failure to recognize diversity and its impact on healthcare provision. Cultural sensitivity involves approaching patients from different cultural and ethnic backgrounds by recognizing differences, attempting to understand them, and establishing relationships based on respect and trust. Such an approach leads to higher quality and more effective healthcare relationships (Uzun & Sevinç, 2015). Cultural blindness is based on the flawed belief

that providing the same service equally accessible to everyone is inherently “fair,” or that a healthcare system created by a dominant culture should work equally well for all cultures. Even superficial knowledge of diversity refutes this misconception (Gulati & Weir, 2022). Consequently, it is not surprising that alongside insufficient cultural sensitivity, we also identified the phenomenon labelled Universal services. This phenomenon refers to universalistic approaches based on the “same for everyone” principle, resulting in inadequate adaptation of services to the needs of vulnerable groups. We gathered data indicating various types of deficiencies in adaptation, particularly concerning communication and language barriers. Numerous studies in Slovenia confirm the prevalent presence of language barriers and frequent communication misunderstandings in daily healthcare practice, emphasizing the urgent need for systemic solutions to improve the situation in this field (Milavec Kapun et al., 2017; Lipovec Čebren, 2017; Pokorn, 2019). Although the Slovenian healthcare system generally provides relatively good accessibility compared to some other countries (Perko et al., 2019), it is undeniable that practical issues exist in ensuring accessibility and adapting services for culturally diverse groups, as confirmed by extensive literature (Lipovec Čebren & Bombač, 2018; Pistotnik, 2019; Huber et al., 2020).

The largest portion of the data in our study fell under the cultural pre-competence response. Within this response, we identified data indicating growing awareness about the existence of diversity, the influence of individuals on the development of this field, and the presence of projects aimed at adapting services and overcoming diverse barriers. Data was also indicative of many education initiatives. In this respect, it is important to emphasize that cultural competence is not an innate trait, but rather a lifelong skill-acquisition process (Tehee et al., 2020), which can be successfully developed and enhanced through continuous education (Lin & Hsu, 2020). However, current undergraduate educational programs across various healthcare professions show significant deficiencies regarding the inclusion of cultural competence content. Research analysing nursing curricula at four European universities revealed markedly inadequate representation of cultural competence, prompting authors to call for clear guidelines and standards for inclusion in educational curricula (Antón-Solanas et al., 2021). A similar situation is evident in medical education. In 2015, a group of experts from 11 European countries formulated recommendations for incorporating cultural competence into medical school curricula (Sorensen et al., 2017). However, subsequent evaluations of implementing these recommendations across medical faculties in Europe have indicated very poor implementation (Sorensen et al., 2019). Additionally, international research highlights further issues related to continuous education of healthcare professionals in cultural competence. A review of educational programs designed for healthcare workers to improve accessibility and quality of healthcare for migrants and ethnic minorities showed these programs are often poorly structured and insufficient (Chiarenza et al., 2019). Nevertheless – or precisely because of this – we view the numerous educational initiatives and projects in cultural competence identified in our findings as encouraging and significant for the field’s further development. However, experts warn that individual efforts provide limited benefits without a comprehensive, long-term approach to cultural competence (Shepherd, 2019).

In assessing the level of cultural competence, we employed the theoretical continuum of cultural competence. As previously highlighted, this model remains among the most cited in research in this field and is widely applied in international scientific literature. In 2008, Engebretson et al. further developed this model by adding a parallel model of clinical relevance, emphasizing the connection between cultural competence and contemporary, evidence-based healthcare. However, some authors have criticized this and similar models. Lipovec Čebren et al. (2019) warn that these models are problematic and resemble outdated cultural-evolutionary, unilinear models. Criticisms primarily focus on the conceptual rigidity of the model, which assumes uniform developmental stages and identical final developmental goals for all cultural groups. Although we acknowledge these limitations, we deemed the model appropriate for examining cultural competence within the Slovenian healthcare system. Importantly, we do not perceive the model as static, nor do we see the individual stages as strictly separate. In our research, we particularly highlighted the coexistence and overlapping of various forms of responses. Nonetheless, certain predominant trends in expert perceptions are identifiable, facilitating placement of the healthcare system on the continuum of cultural competence.

In our study, we examined the healthcare system's response as a whole, but it is worth noting that a more detailed analysis of responses by specific parts of the system to particular culturally, linguistically, or otherwise diverse groups might yield a different picture. Additionally, the selection and number of interviewees pose another limitation. Even so, we have observed the trend of data saturation and trust that experts provide valuable insightful perspectives on the system.

5 Conclusion

Based on the findings of our research, we can conclude that the healthcare system in Slovenia demonstrates a level of cultural pre-competence regarding its responsiveness to cultural diversity, although notable elements of cultural blindness and cultural incapacity are still present. However, considering the scope and heterogeneity of the obtained data, we assess that the system is gradually progressing toward a higher level of cultural competence on the continuum of responses. Even so, further development is difficult to predict, as current social trends indicate that the perception and acceptance of diversity is a sensitive political issue, subjected to rapid changes. Shifts in attitudes toward this issue could quickly reverse the direction of cultural competence development. Achieving the goal of higher cultural competence requires the involvement of the broader societal community, but too often government policies, significantly influencing social discourse, favour populist strategies promoting xenophobia and racism instead of actively working towards their prevention.

It is important to recognize that the development of the healthcare system toward greater cultural competence is primarily an issue of social justice, as well as ensuring patient safety. The latter includes not only physical safety but also cultural safety, en-

compassing the patient's social, spiritual, emotional, and physical well-being during healthcare provision. It involves a commitment to creating an environment free of prejudice, discrimination, and inequality, ensuring each patient feels respected and accepted.

According to all forecasts, diversity will continue to increase and deepen in the future, further emphasizing the urgency of promptly implementing the concept of cultural competence into the healthcare systems. A long journey lies ahead, requiring significant efforts in research, education, and continuous improvement; however, the crucial point is that we move forward thoughtfully, persistently, and in the right direction, guided by ethical principles.

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Kje smo in kam gremo: eksperti o kulturni kompetentnosti v slovenskem zdravstvu

Sodobne družbe po vsem svetu, vključno z evropskimi in slovensko, postajajo vse bolj raznolike. Ta raznolikost vključuje razlike v etnični pripadnosti, spolu, spolni usmerjenosti, jeziku, verskih prepričanjih, telesnih in duševnih sposobnostih, socialno-ekonomskem statusu ter geografskem ozadju (UNESCO, 2017). Prepoznavanje in prilagajanje tem razlikam je ključno za vse družbene sisteme, še posebej za zdravstveni sistem, ki pomembno vpliva na blaginjo posameznikov in skupnosti. Odzivnost zdravstvenega sistema na raznolikost in njegova zmožnost zagotavljanja pravične oskrbe sta osrednja elementa, ki prispevata k splošni družbeni pravičnosti (WHO, 2000). Za učinkovito spopadanje z izzivi, ki jih prinaša raznolikost, morajo zdravstveni sistemi razviti kulturno kompetentnost (Anderson idr., 2003) – kombinacijo vedenj, stališč in politik, ki omogočajo učinkovito delovanje v medkulturnih situacijah (Cross idr., 1989). Ta prispevek kritično ocenjuje trenutno stanje kulturne kompetentnosti v slovenskem zdravstvenem sistemu, pri čemer uporablja uveljavljeni model kontinuuma kulturne kompetentnosti, ki so ga predlagali Cross s sodelavci (1989). Model zajema stopnje od kulturne destruktivnosti na najnižji ravni, preko stopenj nezmožnosti, slepote, predkompetentnosti, kompetentnosti, do napredne kompetentnosti na najvišji ravni. Z razumevanjem trenutnega stanja želi ta raziskava prispevati k oblikovanju strategij za izboljšanje kulturne kompetentnosti v slovenskem zdravstvu.

Koncept sistemske kulturne kompetentnosti je relativno mlad. Eni izmed prvih raziskovalcev tega področja, Cross s sodelavci (1989), so kulturno kompetentnost opredelili kot niz skladnih vedenj, stališč in politik, ki v sistemu, organizaciji ali posameznim strokovnjakom omogočajo učinkovito delovanje v medkulturnih kontekstih. Kulturna kompetentnost ne pomeni zgolj razumevanja in spoštovanja kulturnih razlik, ampak zajema tudi njihovo vključevanje v vsakodnevno zdravstveno prakso in politiko (Dreachslin idr., 2017). V zadnjih desetletjih je potreba po kulturni kompetentnosti

vse bolj v ospredju zaradi naraščajoče mobilnosti prebivalstva, globalizacije in posledične večkulturnosti družb. Zdravstveni delavci se soočajo z izzivom zagotavljanja oskrbe, ki spoštuje in se odziva na zdravstvena prepričanja, prakse ter kulturne in jezikovne potrebe raznolikih pacientov.

Naša študija je temeljila na kvalitativni raziskovalni metodologiji, ki velja kot najbolj ustrezna za poglobljeno razumevanje kompleksnih pojavov, kot je kulturna kompetentnost. Zbiranje podatkov je vključevalo izvedbo osmih polstrukturiranih intervjujev s strokovnjaki, ki delujejo na področju kulturne kompetentnosti v zdravstvu. Udeleženci so bile tri zdravnice, dve strokovnjakinji in en strokovnjak s področja zdravstvene nege, ena antropologinja in ena sociologinja. Izbrani so bili z namenskimi vzorčenjem na podlagi svojih prispevkov pri edukaciji, raziskovanju in publiciranju na področju kulturnih kompetenc v Sloveniji. Vprašanja so bila strukturirana glede na vnaprej določene kategorije, ki so izhajale iz modela kontinuuma kulturne kompetentnosti po Crossu (1989). Analiza podatkov je bila izvedena z uporabo usmerjene (deduktivne) vsebinske analize, ki vključuje razvrščanje zbranih podatkov v vnaprej določene kategorije (Elo in Kyngäs, 2008). Te so predstavljale različne stopnje kontinuuma – kulturno destruktivnost, nezmožnost, slepoto, predkompetentnost, kompetentnost in napredno kompetentnost.

V celotni raziskavi smo dosledno spoštovali etične standarde raziskovanja z udeleženci, vključno z zagotavljanjem anonimnosti in zaupnosti.

Intervjuji so obravnavali različne razsežnosti kulturne kompetentnosti, vključno z osebnimi izkušnjami strokovnjakov, opazovanji institucionalnih praks ter ocenami obstoječih izobraževalnih in političnih pobud za izboljšanje kulturne občutljivosti v zdravstvu. Podatki so bili kodirani in analizirani, da bi prepoznali ponavljajoče se vzorce, vpoglede in razhajanja med posameznimi stopnjami kontinuuma kulturne kompetentnosti.

Analiza zbranih kvalitativnih podatkov je razkrila pomembna spoznanja o kulturni kompetentnosti slovenskega zdravstvenega sistema:

- *Kulturna destruktivnost:* V raziskavi niso bile zaznane prakse, vedenja ali stališča, ki bi ustrezala tej najbolj negativni stopnji, za katero so značilna odkrito škodljiva dejanja proti pripadnikom manjšinskih kulturnih skupin. To kaže na to, da na sistemski ravni v slovenskih zdravstvenih ustanovah ni zaznati namernega prizadevanja za škodovanje ali zatiranje kulturne raznolikosti.
- *Kulturna nezmožnost:* Prepoznali smo elemente kulturne nezmožnosti, ki smo jih označili s kodo Strah, predsodki in diskriminacija. Strokovnjaki so v zvezi s tem opozorili na vztrajajoče težave, zlasti usmerjene proti marginaliziranim skupinam, kot so romske skupnosti in begunci. Ti negativni odnosi so se kazali kot nestrpnost, izrazi rasizma in strah pred kulturnimi razlikami v zdravstvenem okolju.
- *Kulturna slepota:* V raziskavi smo zaznali podatke, ki kažejo na sistemsko zane-marjanje vpliva raznolikost (označeno s kodo Univerzalne storitve) in nezavedanje o kulturni raznolikosti (označeno s kodo Pomanjkanje kulturne občutljivosti). Zdravstvene prakse so večinoma univerzalno standardizirane, brez potrebnih prilagoditev za raznolike paciente. Strokovnjaki so posebej izpostavili komunikacij-

ske in jezikovne ovire. Podatki govorijo tudi o obstoju prepričanja, da je enaka obravnava vseh pacientov ne glede na njihovo kulturno ozadje dovolj, kar pa dejansko vodi v marginalizacijo tistih s specifičnimi kulturnimi potrebami.

- *Kulturna predkompetentnost: Večina pridobljenih podatkov je nakazovala naraščajočo ozaveščenost (označeno s kodo Zavedanje o raznolikosti) in začetna prizadevanja za prilagajanje kulturni raznolikosti (Zametki izobraževanj, Projekti v smeri razvoja kulturne kompetentnosti, Vpliv posameznikov). Zdravstveni delavci so torej začeli prepoznavati obstoječe izzive in ovire, pri čemer so bili opaženi tudi začetni izobraževalni programi in številni projekti. Vendar so ta prizadevanja večinoma nesistematična, projektno usmerjena in brez dolgoročne integracije v zdravstveni sistem. Strokovnjaki so omenili tudi prisotnost posameznikov v sistemu, ki delujejo kot pobudniki kulturne kompetentnosti in v svojih ustanovah spodbujajo spremembe, čeprav brez širše sistemske podpore.*
- *Kulturna kompetentnost in napredna kulturna kompetentnost: Nobeden izmed izsledkov ni nakazoval, da bi slovenski zdravstveni sistem dosegal višji stopnji, ki ju zaznamujejo strukturirana, integrirana in stalna izobraževanja na področju kulturne kompetentnosti, aktivno vključevanje manjšinskih skupin v oblikovanje politik ter celoviti strateški pristopi za dolgoročne izboljšave.*

Slovenski zdravstveni sistem torej kaže značilnosti kulturne predkompetentnosti, ob sočasni prisotnosti elementov kulturne slepote in kulturne nezmožnosti. Čeprav so začetni koraki k večji ozaveščenosti in občasnim pobudam za naslavljanje raznolikosti obetavni, tem prizadevanjem trenutno manjkata sistemska podpora in integracija v širšo zdravstveno infrastrukturo.

Za napredovanje proti višjim stopnjam kulturne kompetentnosti bodo potrebne pomembne organizacijske in sistemske spremembe. Te vključujejo vgradnjo kulturne kompetentnosti v zdravstvene politike, stalno izobraževanje in usposabljanje zdravstvenih delavcev ter strateško načrtovanje za trajno izboljšanje prakse, ki temelji na vključenosti in zavedanju o potrebah raznolikih posameznikov in skupin. Poleg tega mora varnost pacientov preseči fizično zdravje in vključevati tudi kulturno varnost, s poudarkom na čustvenem, socialnem, duhovnem in kulturnem počutju pacientov.

Študija poudarja nujnost celovitega in trajnostnega pristopa h kulturni kompetentnosti, saj je ta ključna za zagotavljanje pravične zdravstvene oskrbe. Odločevalci, vodilni kadri in strokovnjaki morajo spodbujati okolje, ki je brez diskriminacije, predsodkov in neenakosti ter ki aktivno promovira vključevanje in razumevanje kulturne raznolikosti v zdravstvu. Za doseg te ciljev so potrebna široka podpora družbe, premišljeno oblikovanje politik in stalne izobraževalne pobude, prilagojene specifičnim potrebam vse bolj raznolike slovenske populacije.

Nadaljnji razvoj je težko napovedati, saj trenutni družbeni trendi nakazujejo, da je sprejemanje raznolikosti občutljivo politično vprašanje, podvrženo hitrim spremembam. Spremembe v odnosu do tega vprašanja lahko hitro preusmerijo smer razvoja kulturne kompetentnosti. Doseganje višje ravni kulturne kompetentnosti zahteva sodelovanje širše družbene skupnosti, vendar vladne politike, ki pomembno vplivajo na družbeni diskurz, prepogosto dajejo prednost strategijam, ki spodbujajo ksenofobijo

in razizem, namesto da bi si aktivno prizadevale za njihovo preprečevanje. Ob tem je treba opozoriti, da je premik zdravstvenega sistema v smer večje kulturne kompetentnosti predvsem vprašanje družbene pravičnosti, pa tudi zagotavljanja varnosti pacientov. Slednja ne vključuje zgolj fizične varnosti, temveč tudi kulturno varnost, ki zajema pacientovo socialno, duhovno, čustveno in telesno blaginjo med zdravstveno obravnavo. Gre za zavezanost zdravstvenih delavcev in ustanov k ustvarjanju okolja brez predsodkov, diskriminacije in neenakosti, kjer se vsak pacient počuti spoštovana in sprejetega.

Pred nami je dolga pot, na kateri bomo morali opraviti številne raziskave, izobraževanja in stalne izboljšave; a ključno je, da se po tej poti premikamo premišljeno, vztrajno in v pravo smer, vodeni z etičnimi načeli.

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