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Guest editorial

Cultural and linguistic competence: a global issue

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In 1998, a group of healthcare organisations, policymakers, researchers and advocates in the United States convened for the first time to plan a national conference on a topic that was either forward-thinking or marginal, depending on your point of view. *Cultural and linguistic competence* didn't mean much in the mainstream of healthcare, so it was decided to have the meeting focus on quality healthcare for culturally diverse populations.

It was an exciting challenge to identify programmes around the country that would exemplify best practices and policies. A few regions had a strong record of developing programmes that were appropriately designed for minority, immigrant and indigenous populations, but most areas were just getting started. We were strongly motivated by the opportunity to link both groups together, to have the newcomers learn first-hand from the more experienced, and to bypass the all-too-common reinventing of the wheel.

We also hoped to build on the work of medical anthropologists, transcultural nurses, multicultural psychologists and others who had been working internationally for several decades to highlight the importance of culture in service delivery. We identified programmes and experts from other countries, such as Canada, Switzerland, and the UK. But we were stunned when we received a stack of presentation proposals from Australia. So comprehensive and well supported were their programmes and policy frameworks that we jokingly offered to turn the conference over to them. In the end, a delegation came to the US to deliver presentations, and then gamely toured several federal health agencies showing our policymakers what could be done. Overall, it was deeply inspiring for all to see that what we only imagined had already been realised in another part of the world (DiversityRX.org, 1998).

Ten years on, the globalisation of healthcare is in full force. Migration trends, propelled by conflict, disaster, environmental degradation and economic factors, are moving people from villages to megacities, from country to country, and from one expat opportunity to another. Medical capitalism and medical tourism send corporations and individuals across borders in search of new markets and cheaper prices for elective surgeries or dental care. International health is no longer about sending aid professionals to developing countries; as the renamed *global health*, it looks at the constant interchange of populations, diseases, and health professionals criss-crossing the world.

Diversity has come to every corner of the earth, and will soon be faced by every health and social care provider and organisation. We know this diversity is not just cosmetic, but has deep implications for how care is designed, delivered and received. It affects those who deliver it, and those whose lives depend on its effectiveness.

The delivery of health and social services is, at its essence, an interaction between people who often have different frames of reference. The entire patient-centred care movement is based on understanding and tailoring treatment to fit the patient's needs and operating reference point. Being able to fully communicate with patients in a language they can understand and relate to is the first step. Appreciating the social and cultural forces that shape how they view their bodies, disease processes, medical professionals, healthcare institutions, and government programmes is essential to gaining their trust so that they accept and benefit from treatment.

Just as patients and clinicians can have different vantage points, so too can advocates for addressing the cultural and linguistic factors that affect health and social services. At a meeting convened last fall by the International Centre for Migration and Health on the development of an international curriculum for teaching cultural competence to health professionals, it was eye-opening to observe how much people from different countries – Switzerland, France, the UK, Taiwan, Kuwait and the USA – were eager to share with each other, and how much they diverged with respect to terminology, conceptual frameworks, organisational constraints, and political realities.

These kinds of cross-national conversations are proliferating: the World Health Organization's work on social determinants of health and consideration of resolutions on migration and health (World Health Organization, 2008); the UN Population Fund's

initiatives on cultural sensitivity and faith-based organisations (United Nations Population Fund, 2008); the 2007 European Union Presidency focus on migrants and health (European Union and Ministry of Health, 2007); the International Network on Indigenous Health Development and Knowledge (2008); the WHO Health Promoting Hospitals Task Force on Migrant Friendly and Culturally Competent Health Care (Health Authority of Reggio Emilia and The Health Promoting Hospitals Network, 2008); the Critical Link (2007) meetings on community interpreting; and undoubtedly, many others exist. Each effort has its own unique emphasis, but there is also a great deal of commonality, much of it coming back to how we address the cultural, linguistic, spiritual and other social issues that come up in care delivery.

How can we take these initiatives one step further? What are the benefits of talking internationally about the role of culture in service delivery, especially across different population segments such as minority populations, migrants, and indigenous peoples? Who do we need to engage to get this topic on the agendas of key decision-makers? Is it possible and desirable to launch a global dialogue on culture and health?

These are questions we intend to explore at the 10th year anniversary of the first US conference on culture and health, to be held in Minnesota this September (Drexel University and Resources for Cross Cultural Health Care, 2008). Engaging participants from many countries and international organisations, we will convene a roundtable discussion that will address how we each see the challenge of addressing culture in service delivery, and what could be gained by formalising an ongoing conversation among national and international organisations. The aim would be to:

- raise the profile and the legitimacy of the impact of culture on service delivery, especially among key stakeholder organisations
- identify commonalities and differences in frameworks and approaches
- share practices, resources, ideas, and concerns
- explore the possibilities for professional networking.

The opportunities and challenges for launching and sustaining such a global interchange are many. How can we bridge the distances, and differences in perspectives, to learn from and build on each other's experiences? The tried-and-true models include publishing in journals and participating in conferences and meetings. These fora offer tangible benefits, including building the evidence base, disseminating large amounts of information in one setting, and facilitating face-to-face connections.

Even more exciting are the possibilities offered by information sharing and social networking on the internet. Encyclopaedias of information can be collaboratively developed on wikis; best practices and resources can be shared on websites; learning and networking opportunities can be supported by online communities of practice, web-based conferences and dialogues, podcasts, blogs and other Web 2.0 tools. All are approaches being experimented with in some countries, and in the fields of HIV/AIDS, reproductive health, and other areas of international health.

Distances can be daunting, but one country should not have to start from scratch when others have experience and expertise to share – and are happy to do so. We have much to learn from each other, and the forces of globalisation will ensure that we have many opportunities to do so. Our challenge is to embrace and shape these opportunities so that our interactions are positive and productive, and always directed towards improving quality, effectiveness, and satisfaction.

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