Structural Competency in Health Care

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KEY POINTS

- Structural competency is an evolution of cultural competency, founded on understandings of the social determinants of health and related concepts such as structural violence and structural vulnerability.
- Structural competency offers an alternative framework to the medical model that is strongly aligned with the values of nursing as a profession. This is a powerful position for advocacy and allyship.
- Nurses work with patients who have experienced harms owing to structural violence and vulnerability. The American Nurses Association and Canadian Nurses Association Codes of Ethics require nurses to act on health disparities and work toward social justice.
- Nurses can work to achieve structural competency in clinical practice on the individual, interpersonal, clinic, and community levels.

INTRODUCTION

It has long been recognized that individual health is influenced by factors other than those that are purely biological. The father of "social medicine," Rudolf Virchow, stated more than 200 years ago that health is ultimately a social and political outcome.[1] Over the last 3 decades, there has been a shift in health professions literature in how to consider factors that influence and shape a person's health and health outcomes, from focusing on individual lifestyle choices to acknowledgment and examination of broader factors external to the individual.

The concept of cultural competency in health care was introduced in the 1980s as an important step toward addressing factors that mediate health and the equitable provision of health care.[2] Cultural competency promotes awareness, attitude, and knowledge of other people's cultures in service of improving communication between patients and providers.[3] However, cultural competency over time reduced culture to stereotypes about individuals and groups.[4] It has also been justifiably critiqued on

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grounds that someone can never be competent in a culture that is not their own. From this critique arose the idea of cultural humility, which recognizes that one cannot be competent in another culture; rather, it encourages providers to maintain an attitude of continual learning and situating themselves as the nonexpert.[4]

However well-intentioned, both cultural competency and cultural humility fail to change patients' experience of stigma or improve health outcomes because they remain focused at the level of the individual encounter.[5,6,7] In addition, Farmer and colleagues[8] observed that although providers working in clinical care are readily aware of the effect of social and structural determinants on the health of patients, health care providers often lack a formal framework that allows them to apply structural understandings to everyday clinical care.

The framework of structural competency has evolved in response to the significant limitations of cultural competency to fully conceptualize barriers to health faced by patients, and how to address these issues (**Table 1**). Metzl and Hansen[5] define structural competency as follows:

The trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases … also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health. (p. 128)

Scholars suggest that building structural competency is the key to making health care and health systems more equitable, and thus has far-reaching consequences for transforming clinical care and improving patient outcomes.[8] It is important to state that in this context, competency is not synonymous with clinical mastery, as it often is in nursing curricula and clinical evaluation of students. Here, competency refers to the ability to conceptualize the complexity of structures that influence patient health and patient-clinician interactions.[6]

This article describes interventions for working toward structural competency on multiple levels, in the service of improving patient outcomes. Like the US Substance Abuse and Mental Health Administration model of trauma-informed care,[9] achieving structural competency is a multilevel endeavor. This article focuses only on the individual, interpersonal, clinic, and community levels of the framework, as acting on policy and research are outside the purview of immediately actionable interventions.

DEFINITIONS
Clinical Relevance

The literature clearly demonstrates that people facing structural barriers to health and health care owing to institutionalized racism, classism, sexism, homophobia, and ableism, and intersections of these aspects of identity, have significantly higher prevalence of chronically poor health outcomes than those who do not face these barriers.[16–18] The COVID-19 pandemic has starkly reillustrated this reality, both across North America and on a global scale. Statistics show that people of lower socioeconomic status, people of color, and LGBTQ+ people have suffered a disproportionate burden of illness as well as challenges related to the COVID-19 pandemic, such as financial hardship and social isolation.[19,20] The COVID-19 pandemic has occurred in the United States in the context of an already tenuous social safety net and concurrent increase in mental health issues and systemic violence.[21] Even prepandemic, these crises persist when more is known than ever before about the biological impact of social ills on health casts these issues in an even more desperate light.[22] In addition to

Table 1
Definition of structural competency and related concepts

Term	Definition
Structural competency	"The trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (eg, depression, hypertension, obesity, smoking, medication "noncompliance," trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health"[5]
Structures	"The policies, economic systems, and other institutions (policing and judicial systems, schools, etc) that have produced and maintain social inequities and health disparities, often along the lines of social categories such as race, class, gender, and sexuality"[5]
Structural humility	"The capacity of health care professionals to appreciate that their role is not to surmount oppressive structures but rather to understand knowledge and practice gaps vis-à-vis structures, partner with other stakeholders to fill these gaps, and engage in self-reflection throughout these processes"[11]
Cultural competency	"A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations"[3]
Cultural humility	"A lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities"[10]
Social determinants of health	"The physical, environmental, and social conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks"[12]
Structural violence	"The avoidable impairment of fundamental human needs or…the impairment of human life, which lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible"[13]
Structural vulnerability	"The outcome of a combination of socioeconomic and demographic attributes (gender, socioeconomic status, race/ethnicity, sexuality, citizenship status, institutional location), in conjunction with assumed or attributed status (including health-related deservingness, normality, credibility, assumed intelligence, imputed honesty)"[14]
Structural racism	"The totality of ways in which societies foster racial discrimination, through mutually reinforcing inequitable systems (in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, and so on) that in turn reinforce discriminatory beliefs, values, and distribution of resources, which together affect the risk of adverse health outcomes"[15,16]

the COVID-19 pandemic, the last several years of reckoning with systemic racism against black and indigenous peoples across North America, and accelerating climate crises have laid bare the inequities in North American society. Nursing and other health care professions are now critically tasked with examining and responding to health inequities in a different way than before.[23,24] Part of this response must be to recognize and incorporate understandings of factors far outside the individual locus of control that affect health, and act on dismantling such barriers.

RESEARCH

The concept of structural competency is still relatively new in the health care literature, and much of the work on operationalizing this concept relates to doing so in the context of health care professional curricula.[5,6,25,26] However, scholars suggest that structural competency can be the focus of intervention on multiple levels.[21,27–29] Drawing from Neff and colleagues'[27] conceptualization of levels of intervention for structural competency, the remainder of the article summarizes literature that demonstrates structurally competent interventions at the individual, interpersonal, clinic/organizational, and community level. Although policy and research are also crucial levels at which to intervene in working toward structural competency, they represent more long-term solutions that are beyond the scope of this article, which seeks to provide clinical pearls for implementation in practice.

Individual Level: Self-Reflection and Awareness

Scholars define reflection as a "purposeful activity whereby, the individual seeks to look beyond an experience … towards gaining insight into looking at doing things in a better way, guiding future development."[28] Self-reflection is a foundational aspect of working toward structural competency because the reflective process allows the clinician to recognize what assumptions, values, opinions, and experiences they bring to the clinical encounter, and how these aspects of personal identity consciously, and more often, unconsciously, shape our interactions with clients. Self-reflection allows health care professionals to build awareness of how structures affect them and their clients and subsequently identify ways to assist clients with these barriers.[11] Self-reflection is also emphasized as a component of lifelong learning, which is a professional expectation of nursing.[30] The literature demonstrates that engaging in the process of self-reflection improves communication skills, clinical reasoning skills, and in turn, patient outcomes.[19,31]

The Addressing framework by Hays[32] can be used as a guide to begin the process of critical self-reflection on identity, intersectionality, difference, and power. The Addressing framework facilitates awareness and understanding of the complexities of personal identity in the United States and Canada, including recognition of aspects of socially ascribed identity, such as age, developmental and acquired disabilities, religion, ethnicity, socioeconomic status, sexual orientation, indigenous heritage, national origin, and gender. Addressing offers an exercise whereby the practitioner reflects on each aspect of their identity, and in which aspects they hold power and in which they do not in the context of their lives.[32] This represents the first step in recognizing and understanding how differences in power lead to differences in understandings. It also offers the clinician the opportunity to reflect on the concept of intersectionality in identity as something that must be recognized and negotiated in the provision of clinical care.[33] As a subsequent step, the Addressing framework aids the clinician in thinking through how a patient's multidimensional identity may put them in a position whereby they are more likely to be victims of structural violence and loss of power.

Interpersonal Level: Patient Assessment and Care Planning

Use of an assessment tool to guide clinicians in thinking through social and structural factors that are impacting patients' health can be helpful in starting to build structural awareness. Bourgois and colleagues'[14] Structural Vulnerability Assessment Tool (SVAT) operationalizes structural vulnerability for clinical care delivery by highlighting hierarchical clusters and power relationships that influence individual's health issues. The tool is a 43-item questionnaire that assesses patient needs across 6 domains:

financial stability, physical environment, food security, social support, legal status, and education. It offers a set of questions to ask patients, as well as a set of critical self-reflection questions for the clinician to ask themselves about how they may subconsciously perpetuate structural violence against each patient.[14] It is widely available via an online engine search and has included various repositories of assessment tools validated to assist in measuring health disparities.[34,35] Depending on the clinical setting, the SVAT can also be combined with other screening tools, such as the Barriers to Access to Care Evaluation scale[36] and the Questionnaire on Anticipated Discrimination,[37] to assess patients' internalized stigma related to structural barriers and to capture a picture of what clinic clients are facing overall.[38]

Clinic/Institutional Level: Diverse Hiring and Staff Training

Working toward structural competency at a clinic/institutional level requires organizations to examine how they can foster an understanding of structures affecting health among clinic staff. This includes implementing hiring practices that are holistic and seeking to bring in staff with a wide variety of lived and work experience, and that are attuned to and interested in attending to structural factors as part of clinical care. Another key aspect of structural competency at the clinic level is training opportunities. The training resources available through the Structural Competency Working Group (https://structuralcompetency.org/structural-competency/) are free and available to all; this group is also available for customized consultation and workshop training.[39]

Community Level: Collaboration

At the community level, nurses, staff teams, and clinics can collaborate with community partners to broaden their capability for addressing structural barriers to health. One model of integration that has become increasingly popular in the United States, and demonstrated to contribute to improved patient health outcomes, is the medical-legal partnership (MLP). MLPs are collaborative interventions between health care clinics and community law partners (often nonprofit legal agencies or law schools) that recognize and address the impact of social and environmental factors on health by providing legal remedy.[40] Examples of issues that MLPs work to address include establishing eligibility and accommodations for disability, food stamps, identity-affirming documentation changes, housing rights, eviction assistance, immigration status, domestic violence, family law, and guardianship.[41] In this model, health care lawyers join the interprofessional team on site to provide low-barrier access for clients struggling with these issues.[40] Screening tools, such as the i-HELP, can be used by nurses to identify clients who may need assistance with legal issues and thus facilitate referrals.[41] MLPs are often used to support a particular target population, for example, people living with HIV, immigrants, and/or veterans.[40,42,43] In the United States, the Department of Veterans Affairs and the Health Resources Service Administration support and fund MLPs as tools to improve health equity.[44,45]

DISCUSSION

Incorporating practices of self-reflexive inquiry, assessment tools to identify patients who are at risk for structural violence, clinic-wide training, and collaborative partnerships allows nurses and their organizations to take the first step toward addressing structural barriers at several levels. However, successful implementation of these interventions requires a foundational ability on behalf of health care providers and organizations to have and build capacity for distress tolerance and asking – and answering

– uncomfortable questions. Interventions such as diversifying hiring practices in the name of working toward structural competency are doomed to fail to do so if health care providers, staff, managers, and leaders, both individually and collectively, are not prepared to really listen to and encounter difficult conversations with said new colleagues about how to move forward with change.

Although dismantling structural barriers to health care is neither an easy nor a comfortable endeavor, it is a task we are called to do by our professional mandate as nurses. Structural competency aligns with nursing's mandate for social justice, which is reflected in both the American Nurses Association's (ANA) and the Canadian Nurses Association's (CNA) code of ethics.[46,47] The ANA's code mandates nursing to reduce health disparities and integrate social justice into its work.[46] CNA's code guides nurses to recognize and work to address organizational, social, economic, and political factors that influence health and well-being; recognize and address the social determinants of health; work for social justice; and advocate for change to unhealthy policies.[47] Made explicit, structural competency is implicit in the nursing profession's ethos and mandate across North America.

SUMMARY

Structural competency offers a broad and timely framework through which to consider and act on addressing health inequities. It moves beyond cultural competency and the social determinants of health to situate understandings of health inequity in historical contexts and allow nurses to see how these inequities are continually reproduced in status-quo health care. Structural competency offers an alternative framework to the medical model that is strongly aligned with the values of nursing as a profession. This is a powerful position for advocacy and allyship. Nurses can work to achieve structural competency in clinical practice on the individual, interpersonal, clinic, and community levels.

CLINICS CARE POINTS

Achieving structural competency in health care can take place at the following levels, with examples of appropriate interventions for each level[27]:
- Individual level: critical self-reflection and self-awareness
- Interpersonal level: screening tools to identify and assess clients at risk for structural violence/vulnerability
- Clinic/organizational level: diversifying hiring practices and workplace training
- Community level: medical-legal partnership collaboration

DISCLOSURE

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