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Advancing Cultural Competence in Healthcare System: Insights on Barriers and Required Measures

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Background/Purpose: Cultural competence in the healthcare system is a crucial strategy to ensure the availability, accessibility, acceptability, and quality of healthcare services. However, literature on the systemic implementation of this concept in the Central and Eastern European region is scarce. The aim of our study is to present insights into the barriers to cultural competence and measures for its advancement in the Slovenian healthcare system.
Methods: We employed a qualitative methodology, conducting semi-structured interviews with professionals and experts in Slovenian healthcare system. Data was analysed by directed content analysis.
Results: The identified barriers to cultural competence and measures for its advancement pertained to several areas, including staffing, information for healthcare users, multidisciplinary and multi-level approaches, data collection and research, communication possibilities and skills, legislative foundation, flexibility of the healthcare system, quality standards, and educational efforts and policies.
Conclusions: In our study, we found that most barriers to cultural competence exist at the systemic and organizational level. Consequently, the measures identified to address these barriers should also be implemented at these levels. The first step towards achieving safer and more equitable healthcare services should involve incorporating the core principles of cultural competence into strategies and policies at both systemic and organizational levels of healthcare.

Keywords: *Cultural competency, Patient diversity, Obstacles, Strategies, Healthcare system*

1 Introduction

Cultural competence is an essential necessity in our globalized world, irrespective of industry, profession, or geographical location (Yousef, 2024). In healthcare, experts agree that cultural competence is crucial for the healthcare availability, accessibility, acceptability, and quality (Napier et al., 2017).

The concept has begun to develop in the seventies as a response to recognizing the influences of culture on health and on the vulnerability of certain population groups (Saha et al., 2008). Over the years, it has evolved into a multidimensional concept considered by many experts to be a key condition for achieving equality and quality in healthcare

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(Anderson et al., 2003; Napier et al., 2017; Constantinou et al., 2022).

First definition of cultural competence, applicable to healthcare organisation or a system, but also to an individual healthcare professional, was offered by Cross and colleagues in their scientific monograph of 1989 – this definition is still the most frequently cited (Jongen et al., 2018; Handtke et al., 2019). They proposed that cultural competence is a set of coherent behaviours, relationships, and principles present in the system, as well as in the organization or among practitioners, enabling effective functioning in intercultural situations (Cross et al., 1989). Betancourt and colleagues later defined health care system´s cultural competence as the ability of the system to provide care and adapt services to patients with different values, beliefs, and behaviours, thereby meeting patients' social, cultural, and linguistic needs (2002). Cultural competence is therefore an overarching term that includes both individual-level skills and characteristics of the organizational and/or systemic level of the healthcare system (Cai, 2016). For the purpose of this article, we have adopted the view as described by Constantinou et al (2022). They view it as an umbrella term, encompassing diversity competence, structural competence, intercultural communication, cultural awareness, cultural humility, cultural sensitivity, cultural empathy, and cultural intelligence. These concepts collectively capture the extensive scope of cultural competence, enabling effective, appropriate, and sensitive engagement in an understanding and reflexive manner, not only concerning ethnicity and cultural background but also gender, age, lifestyles, personal choices, and more. No other concept can comprehensively encompass all the skills and knowledge required for appropriately working with diverse patients (Constantinou et al., 2022).

Despite the important role of cultural competence in providing high-quality care and reducing social disparities in healthcare, this concept doesn't seem to be widely recognised as a strategy to improve health care accessibility and quality in the Central and Eastern European (CEE) region. A scoping review on cultural competence interventions in European healthcare has shown a significant lack of research especially in Mediterranean countries, compared to other parts of Europe, and has highlighted the need for increased focus and development of cultural competence (De-María et al., 2024). On the other hand, it has been shown that, for example in Slovenia, vulnerable and marginalized groups face many barriers to health as well as unequal and discriminatory health treatments (Lipovec Čebron & Huber, 2020). Similar findings where shown in the research, conducted in Slovenia, Croatia, Germany and Poland. In all four countries ethnic, national, cultural, and religious minorities, as well as migrants and foreigners, often encounter barriers to healthcare access due to factors, related to the lack of cultural competence (e.g. language barriers, presence of discrimination and discriminatory behaviours, inadequate cultural competence training) (Ramšak et al., 2023). These facts point to the importance of advancement of cultural competence in healthcare systems in the CEE region, but the literature related to the systemic implementation of this concept is scarce.

With our research we aimed to adress this gap in literature by examining the perspectives of Slovenian healthcare and cultural competence experts on the barriers to cultural competence, as well as on the measures for its advancement. We start by literature review on the importance and the characterisitcs of culturally competent health care systems, as well as on the barriers and interventions identified in the previous studies. This is followed by the methodology section, a summary of the results, and a discussion of our findings. Finally, conclusions and suggestions for future implementation and research directions are given.

2 Literature review

Healthcare systems are often marked by formal and informal barriers that affect the accessibility of healthcare services. These barriers can be legislative, communicative, organizational, financial, geographical, and physical (Chiarenza, 2012). Recent study from New Zealand identified barriers as attitudinal barriers (lack of culturally competent healthcare providers, discrimination by healthcare providers, personal, social, and cultural attributes) and structural barriers (policies and frameworks that regulated the accessibility of health services (Kanengoni-Nyatara, 2024). It has been shown that these barriers exist also in the CEE region (Ramšak et al., 2023). Not understanding and addressing these barriers have serious health implications and exacerbate healthcare disparities (Yong-Hing & Khosa, 2023).

Achieving equal access to healthcare services is a complex, ongoing challenge that demands a multifaceted strategy, involving policy reforms, public health initiatives, and cultural shifts within the healthcare system (Hickson, 2024). Cultural competence is a crucial skillset and mindset for delivering high-quality care and reducing social disparities in healthcare (Constantinou et al., 2022). It is based on understanding the barriers to equal access and on understanding the needs of the population it serves (Truong et al., 2014). A culturally competent healthcare system can offer equitable treatment to patients with varied values, beliefs, and behaviors, and can customize the delivery of care to align with patients' social, cultural, and linguistic needs. It contributes to safer, more efficient, timely, and patient-cantered healthcare (Betancourt et al., 2005), to improving health literacy, to reducing the vulnerability of minority groups (Powell, 2016) and may influence patient outcomes (Diamond et al., 2019; Schiaffino et al., 2020), even though the research on patient outcomes is limited (Chae et al., 2020). In culturally competent health-

care system, patients' negative healthcare encounters are reduced, adherence to medical advice is increased (Flynn et al., 2020), many communication misunderstandings are prevented and trust in healthcare professionals is increased (Paternotte et al., 2015; Flynn et al., 2020).

In previous times and continuing today, it was suggested that culturally competent system recognizes and acknowledges the importance of culture at all levels, assesses intercultural reactions, disseminates cultural related knowledge, and adapts services to specific culture-based needs (Cross et al., 1989; Yong-Hing & Khosa 2023). In the culturally competent system, there should also be an awareness that there are far more differences within individual cultural groups than among the groups themselves, and that differences are defined by many factors - not just ethnicity, but also age, region, education, and other influences (Engebretson et al., 2008).

Effecting changes towards cultural competence within the system necessitates a shift in organizational culture, with patient safety serving as the paramount guiding principle (Chassin & Loeb, 2013). Patient safety also encompasses cultural safety, wherein patients feel socially, spiritually, emotionally, and physically secure during their treatment. It underscores the dedication of healthcare personnel and institutions to foster an environment devoid of bias and inequality, ensuring that every patient feels embraced (Curtis et al., 2019). Regulatory bodies and health organizations should prioritize the incorporation of cultural competencies, mandating them to ensure regulations that are modern, fair, compassionate, and equitable for diverse populations. Consequently, comprehensive training on cultural competence, sensitivity, and diversity intelligence should be seamlessly integrated into all facets of the fitness-to-practice processes (Singh, 2023). However, the concept requires more than just culturally competent healthcare personnel; it must encompass the entire organization, which must be committed to effective diversity management (Rechel et al., 2013). Some of the most important barriers in the advancement of cultural competence in the healthcare system include organizational culture that does not prioritize cultural competence; staff attitudes that lack interest in diversity topics and tend to stereotype different groups; and a lack of information about the diversity of the population served by healthcare organizations (Taylor, 2005; Reese et al. 2017). Ramšak et al. (2023) identified significant challenges in providing diversity-responsive healthcare, including healthcare underfunding, language barriers, insufficient cultural training or interpersonal competencies, and lack of institutional support.

Strategies for the advancement of cultural competence are diverse. Experts warn against their inefficiency when fragmented approach is employed, focusing solely on one aspect in the healthcare system without clear consideration of their effects on other levels or their interconnections (Jongen et al., 2018). A scoping review of strategies for the advancement of cultural competence identified twenty strategies on four levels. Strategies on individual level included linguistic and/or cultural matching interventions, use of adapted written or visual material, and inclusion of families. Strategies on the organisational level included, but were not limited to, cultural competence training, integration of interpreter services and patient data collection and management. Strategies to implement culturally competent healthcare start with needs assessment and monitoring of organisational changes as well as creation of positions to monitor and supervise the process. Finally, strategies to provide access to culturally competent healthcare consist of integration of community health workers, user engagement, outreach methods and others (Handtke et al., 2019).

In Slovenia, there is a need for a deeper understanding of the healthcare system's relationship with population diversity and their needs. We must understand the perspective through our own "cultural lense" within the healthcare system. The aim of our research was therefore to examine the perspectives of Slovenian healthcare and cultural competence experts on the barriers to cultural competence, as well as on the measures for its advancement. The research was conducted as part of a broader doctoral thesis research, investigating various aspects of cultural competence in the Slovenian healthcare system. For purpose of this article, we have focused on two research questions, namely:

RQ1. What are the most significant barriers to cultural competence in the Slovenian healthcare system?

RQ2. What are the most important measures for advancing cultural competence in the Slovenian healthcare system?

3 Methodology

We employed a qualitative methodology, conducting semi-structured interviews on purposive sample - professionals from various levels of the healthcare system. In the field of cultural competence, qualitative methods are particularly suitable as they allow for a holistic view of social phenomena and sensitive data collection in natural settings (Bradshaw et al., 2017). The obtained results offer a complex description and interpretation of the discussed topic and often signal the need for action (Creswell, 2012). This methodology is also suitable at the national level, as demonstrated by Betancourt and colleagues in 2005, when they assessed the state, key perspectives, barriers, and trends in the development of cultural competence in the United States through interviews with experts (n = 37) (Betancourt et al., 2005).

We interviewed three different groups of healthcare system professionals and experts in Slovenia. Our first group consisted of key decision makers (KD) - representatives of various regulatory bodies of the healthcare sys-

tem, including Ministry of Health, National Public Health Institute, National Chambers of various healthcare professionals and others (n=14). Second group consisted of management of healthcare institutions (medical directors and head nurses of hospitals and healthcare centres - HM) (n=14), and our third group consisted of experts in the field of healthcare cultural competence (researchers and authors of scientific articles in this field - EX) (n=8). A total of 36 interviews were conducted.

The questionnaire for semi-structured interviews was informed by our research questions in consideration of the chosen data processing methodology - directed (deductive) content analysis. In this methodology, targeted questioning on predetermined topics is important. The questions therefore included targeted questions on barriers to cultural competence in the healthcare system and on the measures needed for its advancement (In your opinion, what are the most pressing barriers to advance cultural competence in the healthcare system? What are the necessary measures for the advancement of cultural competence?). Interviews also included questions related to the understanding and familiarity with the concept of cultural competence and other perspectives related to this field (for example: How do you assess the attitude and response of your work environment to the cultural diversity? How do you assess the need for cultural competence in your work environment, particularly in the Slovenian healthcare system? Do you believe that access to the healthcare system and within it is equal for everyone?) as well as questions on the specific indicators of cultural competence (for example: What are the opportunities for education in the field of cultural competence in your work environment? What measures to improve cultural competence have you taken/implemented in the last five years? Do you participate in initiatives to reduce cultural and language barriers - if so, which ones and in what way?).

All interviewees were briefed on the purpose and procedure of the study, as well as on the protection of personal data, and we obtained their written consent for the collection and processing of interview data. The interviews were recorded using the Voice Memos application. The average duration of each interview was 27.5 minutes. Interviews were transcribed and entered into the Atlas.ti application, version 8.4.4., where further data analysis took place.

Data was analysed by the directed (deductive) content analysis. We chose this methodology because it is recommended for extensive textual data (Pope et al., 2000), although despite its frequent use, there is relatively little literature available to assist researchers (Assarroudi et al., 2018). We conducted content analysis in steps, recommended by Elo and Kyngäs (2008). In the first, preparatory step, we have predetermined themes based on our research questions, prepared the manifested data and performed multiple readings of the data. In the second step, we have organised the data – all data, recognized as barriers to cultural competence and measures for its advancement, were assigned to these two predetermined themes. In the subsequent rounds, data was coded within those themes and sorted into categories. Our last step was devoted to the creation of the data report.

4 Results

4.1 Theme: Barriers to cultural competence

We have identified a total of 159 quotations, which we have assigned to 19 codes and 7 categories. Table 1 depicts identified categories and codes whereas the number of identified quotations according to the interview group in each category is depicted in Picture 1.

Table 1: Identified barriers to cultural competence

Category	Codes
Lack of time and personnel	Time constraints, Insufficient staff
Lack of information for users	Lack of simple language materials, Lack of materials on healthcare organisation and rights, Lack of foreign language materials
Lack of legislative foundation	Contradicting laws, Lack of regulation on Interpreters and Intercultural Mediators
Lack of multidisciplinary and multilevel approach	Lack of multidisciplinary cooperation, Lack of coordination among healthcare levels, Lack of national solutions
Lack of data	Inability to collect data, Insufficient research, Insufficient dissemination of available data
Lack of communication possibilities and skills	Poor communication skills, Linguistic barriers, Misunderstandings
Lack of technological and space resources	Digitalisation barriers, Outdated technology, Lack of space

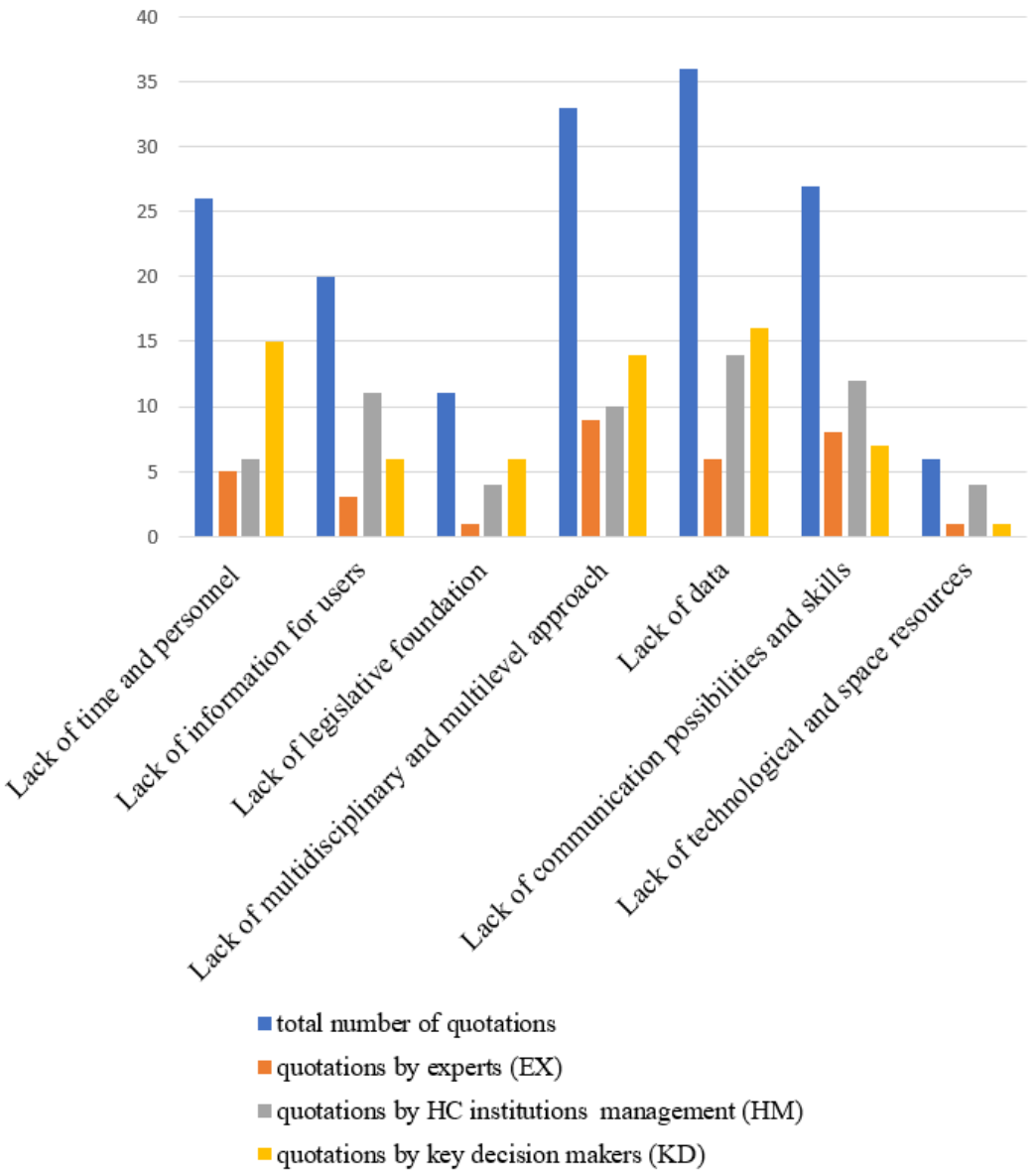

Figure 1: Barriers to cultural competence: number of quotations by category and interview group

The most frequently cited barrier to advancing cultural competence, particularly by key decision-makers and managers of healthcare institutions, was the lack of data. This was followed by the absence of a multidisciplinary and multilevel approach, a barrier most frequently highlighted by experts in comparison to other obstacles. Another significant barrier identified was the lack of communication possibilities and skills. This was followed by a lack of time and personnel, insufficient information available to healthcare users, and the absence of a legislative foundation. Additionally, the lack of technological and spatial resources was noted as a barrier, especially in data provided by managers of healthcare institutions. Representative quotations corresponding to each barrier category are presented in Table 2.

Table 2: Representative quotations of barriers to cultural competence in the Slovenian healthcare system

Category	**Representative quotations**
Lack of time and personnel	"It's hard for me to criticize or blame a doctor or nurse for not behaving culturally competent when they have 60 people waiting, when they're pressed for time, when they have to work 12 hours instead of 8 because there aren't enough nurses, when they have to go from night duty to the clinic. It's difficult, really difficult for healthcare workers to maintain an acceptable and high level under these circumstances." (EX-1)
Lack of information for users	"Lack of adequate information or information presented in a user-friendly manner. This emerges as one of the main barriers in all environments. The fact that they don't have the right information. Very basic information regarding the healthcare system, insurance, or what services the health centre or health promotion centre even provides...This really manifests as a pressing problem." (KD-8)
Lack of legislative foundation	"The Patient Rights Act states that you must provide care in the Slovenian language... on the other hand, you must ensure that they understand what you are saying. Here comes the conflict, and we have pointed this out, but as I said, there wasn't much receptiveness." (HM-10)
Lack of multidisciplinary and multilevel approach	"This is not part of a system, we are dealing with it or focusing on it only within a very narrow group of healthcare workers, mostly nurses... So, doctors are not reached. The first barrier that arises is that the decision-makers are doctors." (EX-5)
Lack of data	"Even if we look only at the population level, regarding the Statistical Office for collecting data, they are not allowed by law to collect data on religion, not even the Roma community, unless they themselves identify as Roma. Here, we actually don't have an accurate number unless we go into the field and ask them." (KD-8)
Lack of communication possibilities and skills	"What's lacking is adequate communication. We don't know how to communicate, neither with patients nor with each other. Even just for us to talk, communication... we're barefoot here. We don't have that. Communication is dismal. Even Slovenian-speaking communication." (KD-9)
Lack of technological and space resources	"And here we're not even talking about electronic matters, such as e-referrals and e-prescriptions, which are perceived as barriers from multiple perspectives, not just because of understanding but also due to access to the internet, to computers. That's one thing." (KD-8)

Table 3: Identified measures for advancement of cultural competence

Category	Code
Expansion of Human resources	Implementing staffing standards, Increasing the number of healthcare workers, Inclusion of other professionals in healthcare team
Policies and procedures	Policies on national level, Policies and procedures on healthcare organisation´ level
Linguistic measures	Use of interpreters and intercultural mediators, Availability of linguistically adjusted materials
Inclusion and advocacy	Inclusion of diverse groups in healthcare policy creation, Empowerment of healthcare workers to act as advocates
Sensibilisation and education	Measures in basic training, Continuing education measures, Training of stake holders and decision makers
Flexible organisation	Adjustment of service delivery, Adjustment of service location, Less bureaucracy
Research and data collection	Research initiatives, Data collection, National data dissemination
Implementation of Quality standards	Quality certification, Quality fostering culture
Improvement in clinical communication	Clinical communication basic education, Clinical communication ongoing training, Clinical communication standards

4.2 Theme: Measures for advancement of cultural competence

We have identified a total of 178 quotations, which we have assigned to 23 codes and 9 categories. Table 2 depicts identified categories and codes whereas the number of identified quotations according to the interview group in each category is depicted in Picture 2. Each category is accompanied by a representative quotation in Table 4.

Among the essential measures for fostering cultural competencies, we distinctly recognized substantial data highlighting the necessity for awareness-raising and educational efforts, especially in the data obtained from experts and key decision-makers. Data from managers of healthcare institutions indicates the importance of expanding human resources, measures related to inclusion of vulnerable groups and their advocacy, and linguistic measures, such as use of interpreters and availability of linguistically adjusted materials. Linguistic measures were also commonly cited by experts and key decision-makers. Other measures, such as integrating policies and procedures to support cultural competence, implementing quality standards, improving clinical communication, enhancing research and data collection, and increasing organizational flexibility, had similar overall frequencies of citations. Representative quotations corresponding to each measure category are presented in Table 2.

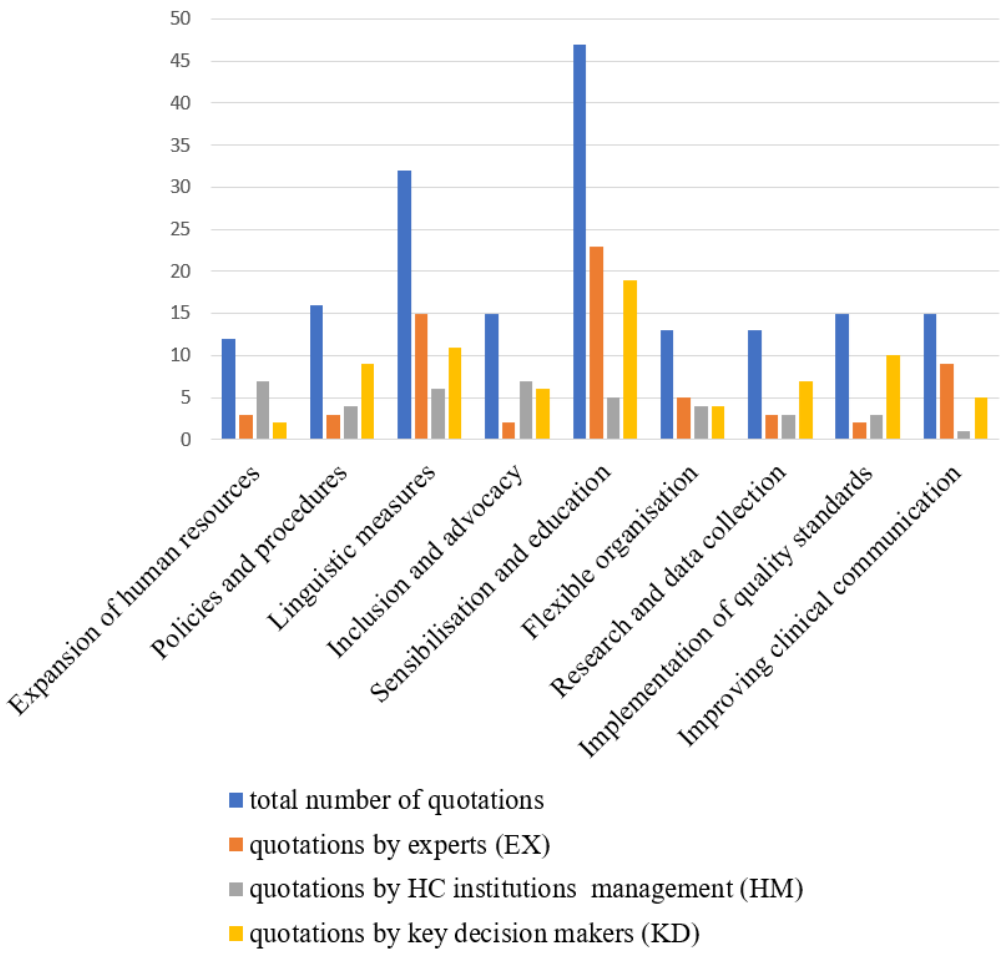

Figure 2: Measures to advance cultural competence: number of quotations by category and interview group

Table 4: Representative quotations of identified measures for advancement of cultural competence

Category	Representative Quotation
Expansion of Human resources	"I definitely see the greatest need in strengthening the workforce of the system. That's a fact." (KD-1)
Policies and procedures	"At the institutional level or even at the national level, it's time to address this very seriously, also as part of the strategy" (HM-2)
Linguistic measures	"We have very concrete needs for interpreters, which are notably lacking, let alone interpreters for healthcare needs. This is something that would help us to communicate at all." (EX-3)
Inclusion and advocacy	"Anyway, essential, I mean, very important is this inclusion because otherwise... Experts have their own prism, and we think we're doing the best, but with the best intentions, we're completely wrong." (EX-8)
Sensibilisation and education	"Firstly, it is necessary to establish an understanding, as we said earlier, that cultural dimensions even exist. Until healthcare workers are aware of this, they don't know that they have a need for intercultural competence." (EX-2)
Flexible organisation	"The flexibility of the healthcare system to allow healthcare workers some flexibility in terms of time organization at the clinic, and ultimately even for home visits, if necessary, would, of course, be very, very desirable." (EX-1)
Research and data collection	"In order to master this cultural competence, from my perspective, it would be necessary to first assess where we stand. To check where we are in Slovenia or in a particular hospital, what tools we have, what this cultural competence is, and based on that, start with education or training." (KD-2)
Implementation of Quality standards	"We only began to think about this when we embarked on obtaining this certification. That's when we really started to think about all these things." (HM-10)
Improvement in clinical communication	"Without a doubt, we really need to seriously start dealing with medical humanism and communication in healthcare. Someone should realize that this is currently among the most pressing issues, almost as much as waiting lists. By the way, I personally strongly believe that waiting lists in at least a third of cases are the result of poor communication." (EX-5)

5 Discussion

The essential condition for the cultural competence advancement is having sufficient information about the requirements and needs within the system, and often the problem lies precisely in the lack of available information. Our research indicates that lack of data related to diverse healthcare system users and their needs is an important barrier. None of the interviewees had data regarding vulnerable or other relevant groups residing in the institution's area of operation, the size of these communities, or their health-related characteristics.

Lack of data was justified in our research by inability to collect data due to legislative background of data collection, prohibiting inquiries about religion, ethnicity, social background, and similar characteristics. Indeed, European regulation on the protection of individuals with regard to the processing of personal data states that the processing of data revealing, among other, racial or ethnic origin, religious or philosophical beliefs, sex life or sexual orientation shall be prohibited (Regulation (EU) 2016/679, Article 9(1)). However, it is stipulated in the same article in paragraph 2 that this does not apply when processing is necessary for the purposes of preventive medicine, medical diagnosis, the provision of health or social care or management of health or social care systems and services. It is also allowed when there is a substantial public interest in the area of public health, such as for ensuring high standards of quality and safety of healthcare (Regulation (EU) 2016/679). Recommendations from the World Health Organization also indicate that collecting data on vulnerable groups and differences in their health outcomes compared to the general population is crucial for equality in healthcare (WHO, 2021). Carefully considered measures in this direction could therefore be possible and should be implemented. This observation was also acknowledged by our study participants, who identified researching and acquiring data relevant to vulnerable groups as an important measure.

However, several researchers emphasized that the focus of research and data collection should not be limited to vulnerable groups. More importantly, it should include an

examination of how the healthcare system and structural factors contribute to inequality (Kapilashrami et al., 2015; Hui et al., 2020) – addressing these issues is a key requirement for ensuring cultural safety (Curtis et al., 2019). In our research, this aspect was not identified; however, it is important to acknowledge it due to its growing recognition and significance.

Our findings revealed a notable barrier to achieving cultural competence in the healthcare system due to the absence of a multidisciplinary and multi-level approach. We have observed that there are many individual efforts to advance cultural competence on various levels, especially in primary care, but they are lacking connection and coordination. It has been shown in other research that culturally competent actions are often not systematically promoted through organizational contexts but are primarily supported by the individual efforts of staff members (Schenk et al., 2022). Fragmentation within healthcare systems can hinder coordinated efforts to address health disparities (Okolo et al., 2024), thus an effective approach necessitates a multidisciplinary and multi-level commitment (McCalman et al., 2017; Mews et al., 2018). It is therefore imperative that healthcare organizations, as well as regulatory bodies, ensure a coordinated and multidisciplinary approach in their efforts to advance cultural competence.

When discussing multidisciplinary commitment, the role of anthropologists in the advancement of cultural competence should not be neglected. Their advocacy for heightened focus on the socio-cultural aspects of health has been crucial to advancing cultural competencies within healthcare (Lipovec Čebron & Huber, 2020). Our research has shown that the inclusion of additional experts in the healthcare team is a crucial measure; however, the specific role of anthropologists was not acknowledged. We speculate that the role of anthropologists is not well understood by healthcare workers.

Integration of cultural competence into healthcare policies is another crucial step to advance cultural competence. This concept requires a foundation in the strategic documents of healthcare organizations to ensure responsiveness to the diverse needs of populations. It has been shown that values associated with population diversity must be clearly articulated, and leadership must support diversity and ensure that these values are reflected in practice (Okolo et al., 2024). One of the key values is also readiness and ability to adjust, or in other words, organizational flexibility, which was emphasized by our interviewees as an important measure. Flexibility is undoubtedly a crucial requirement for operating in the uncertain and evolving environment characteristic of healthcare (Kumar et al., 2018). With increasing diversity, it is required across all organizational levels, requiring close and constructive collaboration (Van Gool et al., 2017, Schenk et al., 2022).

Quality accreditation and quality fostering culture has also been identified in our research as an important measure for cultural competence advancement. Increased level of quality and safety can indeed be achieved thru these measures (Mitchell et al., 2020), however, quality certification must encompass issues related to diversity. Curtis et al recommend that evidence of cultural safety is a requirement for accreditation and ongoing certification (2019).

Our research has also identified lack of communication abilities and skills as an important barrier to cultural competence. It is well known that clear and effective communication between healthcare professionals and users is crucial for accessible, high-quality, and safe healthcare (Jongen et al., 2018) and is indeed closely linked to cultural competence (Henderson et al., 2018). Intercultural communication is among the skills that is increasingly required (Železnik et al., 2017). Key communication tasks for the purpose of cultural competence include understanding the patient's background, providing information, involving the patient in healthcare decisions, understanding the patient's beliefs and values, gaining the patient's trust, and providing appropriate support (Brown et al., 2016). Language barriers, which we have recognised in our research, can render all these tasks impossible or exceedingly difficult in practice. They may affect the outcome of the treatment, which is also valid for Slovenian healthcare (Ramšak et al., 2023). Primary responsibility for tackling these obstacles lay within the healthcare system (Škraban, 2020). From an organizational perspective, it is crucial to establish clear guidelines for integration of professional interpreters and intercultural mediators into healthcare practices (Lundin et al., 2018) - the necessity of this measure can be confirmed with our observations.

Our research indicates that enhancing overall clinical communication skills is as important as overcoming the language barriers. Patient rights advocates in Slovenia agree and emphasize the need to improve communication at all levels. They state that the cause of complaints often lies in unclear communication between the patient and the healthcare professional. According to the State Report on the Status of Patient Rights for the year 2019, advocates for patient rights highlight frequent grievances concerning patients' rights to information and involvement, underlining the pressing need for improved communication (Government of the Republic of Slovenia, 2020).

Linguistic measures identified in our study should also address the lack of linguistically adjusted information for diverse healthcare system users. It is essential that all health-related information is equally accessible to everyone. This entails not only more efficient dissemination of information to non-native speakers but also employing language that accommodates various levels of health literacy (Davidson et al., 2013). Furthermore, presenting information in a manner that mitigates the digital gap is crucial. The availability of internet access has influenced the distribution of influence and resources within society (Sparks, 2013). While global studies indicate a decline in

disparities in access to information based on ethnicity, discrepancies linked to socioeconomic status and especially older age are exacerbating (Hong & Cho, 2016; Mubarak & Suomi, 2022). Though it is important to employ health information technology in healthcare, it is also important to guarantee equitable access across diverse populations (Saeed & Masters, 2021).

Interview participants also emphasized the constraints of time and shortage of personnel in the healthcare system as obstacles to achieving cultural competence. Especially managers of healthcare institutions saw the expansion of human resources as an important measure. While the lack of personnel is a well-known fact in today's healthcare system across the world, acquiring cultural competence should not impose additional burdens on existing healthcare staff. Instead, this strategy can aid in retaining personnel (Delphin-Rittmon et al., 2013). There is, however, a notable paucity of literature examining the impact of cultural competence on the necessary staff ratio. Research in this area rather indicates that prioritizing the recruitment of personnel from diverse backgrounds is a critical measure, as it promotes culturally competent behaviors (Handtke et al., 2019; Schenk et al., 2022). Interestingly, our study did not identify having a culturally diverse workforce as a necessary measure.

We have, however, identified measures related to the inclusion and advocacy of diverse groups of healthcare users. In Slovenia, the involvement of not only vulnerable groups but users in general in the healthcare politics is relatively rare. An almost decade old study comparing user involvement in England, Slovenia, and Poland showed that the healthcare system in England was proactive in incorporating user opinions into healthcare policy, while users in Slovenia traditionally had a more passive role, and the concepts of genuine inclusion were still in their infancy (Lichon et al., 2015). Kavčič et al noted that in Slovenia, healthcare policies were primarily formulated by experts and decision-makers whereas users were not offered equitable partnership or influence on healthcare strategies (2015). In terms of cultural competence development, the inclusion of vulnerable groups, including those with cultural and linguistic diverse backgrounds, is a strategy of paramount importance (McCalman et al., 2017) – it has been proven, that cultural competence and effective consumer engagement are closely linked (Harrison, 2019).

Most important measure identified in our study was to increase cultural sensibility and provide education on the topics of diversity and cultural competence. The impact of cultural competence education in improving knowledge, attitudes, self-confidence, and skills among healthcare workers is supported by solid evidence (Jongen et al., 2018; Lin & Hsu, 2020). According to our results, education and awareness-raising activities should be strengthened at all systemic and organizational levels, as well as in intersecting systems (education, social welfare). It was somewhat surprising that in our research, the need for these measures were frequently found in the data obtained from experts and key decision makers, but less frequently from managers of healthcare institutions. Healthcare managers are namely responsible for cultivating a workforce capable of meeting the diverse needs of patient populations. This includes promoting diversity among healthcare personnel, providing ongoing training in cultural competence, and cultivating an inclusive environment (Okolo et al., 2024). Involving leadership and decision-makers in the educational efforts is the only way to achieve sustainable results (Weech-Maldonado et al., 2018).

5.1 Study limitations

We ensured the reliability of our results by adhering to recommendations applicable to qualitative research. In doing so, we relied on a plethora of scientific articles in the field of qualitative methodology and standards for reporting such research (Giacomini et al., 2000; O'Brien et al., 2014; Johnson et al., 2020). We have ensured the reliability through data saturation and triangulation, achieved by conducting semi-structured interviews with various groups of healthcare professionals and experts. We have also continuously adhered to the principle of reflexivity, which means that the researcher must constantly examine their own beliefs, assumptions, and biases, as well as their influence on data collection and interpretation of results (Johnson et al., 2020). Nevertheless, it cannot be denied that the characteristics of the researchers, including personal traits, qualifications, experiences, assumptions, and the like, can influence the study (O'Brien et al., 2014; Johnson et al., 2020). Further limitations relate to the fairly unknown concept of cultural competence in Slovenia, characterised by new terminology and large complexity of the field, potentially leading to varying understanding of the topic being explored.

6 Conclusion and recommendations

The cultural competence of the healthcare system is vital for attaining equality and quality in healthcare delivery. It also plays a crucial role in ensuring healthcare is safer, more effective, timely, and patient-centred. This concept is not an unreasonable expectation, as it aligns with fundamental human rights and principles of social justice that underpin modern society. Cultural competence, along with cultural humility, should be a standard requirement for every contemporary healthcare system. However, achieving it necessitates the integration of this concept across all levels and aspects of the system, requiring systematic and cohesive actions at the individual, team, organizational, and broader societal levels.

Our research has identified multiple barriers to cultural competence within the Slovenian healthcare system, with most of them occurring at the systemic and organizational level. Correspondingly, most of the identified measures to address these barriers must also be implemented at these levels. Isolated individual efforts and improvised solutions in this area are insufficient for enabling the healthcare system to successfully transition toward achieving comprehensive cultural competence. However, systemic and organizational measures can ensure that cultural competence becomes an integral part of the healthcare system.

We have demonstrated that majority of necessary measures have a solid evidence base. Nevertheless, studies on related topics mainly come from countries where cultural competence has been a known concept for decades, while our research is one of the few originating from South-Central Europe. We believe that the failure to recognize cultural competence as a crucial strategy for addressing healthcare inequalities in the studied geographical area may be a cause for concern. The first step towards achieving safer and more equitable healthcare services should involve incorporating the core principles of cultural competence—such as respect for diversity, adaptability, continuous education, and effective communication—into strategies and policies at both systemic and organizational levels. Subsequently, efforts should be made to address the barriers identified in our research and other related studies. These include lack of data and research in this area. Data concerning diverse groups or individuals in our region are notably scarce, not only regarding their needs and the obstacles they encounter within the healthcare system but also in terms of the magnitude of these issues and their consequences. Additionally, there is a lack of data on potential efforts and their effectiveness in addressing the needs of diverse populations. Future research should thus prioritize gathering additional locally sourced data to facilitate culturally specific solutions in advancing cultural competence.

Literature

Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., & Normand, J. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine*, *24*(3), 68-79. https://doi.org/10.1016/S0749-3797(02)00657-8.

Assarroudi, A., Heshmati Nabavi, F., Armat, M. R., Ebadi, A., & Vaismoradi, M. (2018). Directed qualitative content analysis: the description and elaboration of its underpinning methods and data analysis process. *Journal of Research in Nursing*, *23*(1), 42-55. https://doi.org/10.1177/1744987117741667

Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches* (Vol. 576). New York, NY: Commonwealth Fund, Quality of Care for Underserved Populations.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: key perspectives and trends. *Health Affairs*, *24*(2), 499-505. https://doi.org/10.1377/hlthaff.24.2.499

Bofulin, M., Farkaš-Lainščak, J., Gosenca, K., Jelenc, A., Keršič-Svetel, M., Lipovec **Čebron**, U., ... & Zaviršek, D. (2018). *Kulturne kompetence in zdravstvena oskrba: priročnik za razvijanje kulturnih kompetenc zdravstvenih delavcev* [Cultural Competence and Healthcare: Manual for cultural competence development of healthcare workers]. Nacionalni inštitut za javno zdravje.

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research*, 4. https://doi.org/10.1177/2333393617742282

Brown, E. A., Bekker, H. L., Davison, S. N., Koffman, J., & Schell, J. O. (2016). Supportive care: communication strategies to improve cultural competence in shared decision making. *Clinical Journal of the American Society of Nephrology*, *11*(10), 1902-1908. https://doi.org/10.2215/CJN.13661215

Cai, D. Y. (2016). A concept analysis of cultural competence. *International Journal of Nursing Sciences*, *3*(3), 268-273. https://doi.org/10.1016/j.ijnss.2016.08.002

Chae, D., Kim, J., Kim, S., Lee, J., & Park, S. (2020). Effectiveness of cultural competence educational interventions on health professionals and patient outcomes: A systematic review. *Japan Journal of Nursing Science*, *17*(3), e12326. https://doi.org/10.1111/jjns.12326

Chassin, M. R., & Loeb, J. M. (2013). High-reliability health care: getting there from here. *The Milbank Quarterly*, *91*(3), 459-490. https://doi.org/10.1111/1468-0009.12023

Chiarenza, A. (2012). Developments in the concept of cultural competence. In *Inequalities in health care for migrants and ethnic minorities*, *2*, 66-81. Antwerp: Garant.check

Constantinou, C. S., Andreou, P., Nikitara, M., & Papageorgiou, A. (2022). Cultural competence in healthcare and healthcare education. *Societies*, 12(6), 178. https://doi.org/10.3390/soc12060178

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. Los Angeles: Sage Publication Inc.

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

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S. J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity In Health*, *18*, 1-17. https://doi.org/10.1186/s12939-019-1082-3

Lipovec Čebron, U., & Huber, I. (2020). Cultural Competence and Healthcare. Experiences from Slovenia. *Etnološka tribina*, (43), 68-88. https://doi.org/10.15378/1848-9540.2020.43.02

Davidson, E. M., Liu, J. J., Bhopal, R. A. J., White, M., Johnson, M. R., Netto, G., ... & Sheikh, A. (2013). Behavior change interventions to improve the health of racial and ethnic minority populations: a tool kit of adaptation approaches. *The Milbank Quarterly*, *91*(4), 811-851. https://doi.org/10.1111/1468-0009.12034

De-María, B., Topa, G., and López-González, M. A. (2024). Cultural competence interventions in European healthcare: a scoping review. *Healthcare*, 12(10), 1040. https://doi.org/10.3390/healthcare12101040

Delphin-Rittmon, M. E., Andres-Hyman, R., Flanagan, E. H., & Davidson, L. (2013). Seven essential strategies for promoting and sustaining systemic cultural competence. *Psychiatric Quarterly*, *84*, 53-64. https://doi.org/10.1007/s11126-012-9226-2

Diamond, L., Izquierdo, K., Canfield, D., Matsoukas, K., & Gany, F. (2019). A systematic review of the impact of patient–physician non-English language concordance on quality of care and outcomes. *Journal of General Internal Medicine*, *34*, 1591-1606. https://doi.org/10.1007/s11606-019-04847-5

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107-115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

Engebretson, J., Mahoney, J., & Carlson, E. D. (2008). Cultural competence in the era of evidence-based practice. *Journal of Professional Nursing*, *24*(3), 172-178. https://doi.org/10.1016/j.profnurs.2007.10.012

Flynn, P. M., Betancourt, H., Emerson, N. D., Nunez, E. I., & Nance, C. M. (2020). Health professional cultural competence reduces the psychological and behavioral impact of negative healthcare encounters. *Cultural Diversity & Ethnic Minority Psychology, 26*(3), 271–279. https://doi.org/10.1037/cdp0000295

Giacomini, M. K., Cook, D. J., Evidence-Based Medicine Working Group, & Evidence-Based Medicine Working Group. (2000). Users‘ guides to the medical literature: XXIII. Qualitative research in health care A. Are the results of the study valid?. *Jama*, *284*(3), 357-362. https://doi.org/10.1001/jama.284.3.357

Government of Republic of Slovenia. (2020). *Državno poročilo o stanju varstva pacientovih pravic za leto 2019* [State report on the patients' rights protection for year 2019]. https://www.gov.si/assets/ministrstva/MZ/DOKUMENTI/Drzavno-porocilo-o-stanju-varstva-pacientovih-pravic-za-leto-2019.pdf

Handtke, O., Schilgen, B., & Mösko, M. (2019). Culturally competent healthcare–A scoping review of strategies implemented in healthcare organizations and a model of culturally competent healthcare provision. *PloS one*, *14*(7), e0219971. https://doi.org/10.1371/journal.pone.0219971

Harrison, R., Walton, M., Chauhan, A., Manias, E., Chitkara, U., Latanik, M., & Leone, D. (2019). What is the role of cultural competence in ethnic minority consumer engagement? An analysis in community healthcare. *International Journal for Equity in Health*, 18, 1-9. https://doi.org/10.1186/s12939-019-1104-1

Henderson, S., Horne, M., Hills, R., & Kendall, E. (2018). Cultural competence in healthcare in the community: A concept analysis. *Health & Social Care in the Community*, *26*(4), 590-603. https://doi.org/10.1111/hsc.12556

Hickson, S. V. (2024). Healthcare disparities. *Clinics in Integrated Care*, 22, 100181. https://doi.org/10.1016/j.intcar.2023.100181

Hui, A., Latif, A., Hinsliff-Smith, K., & Chen, T. (2020). Exploring the impacts of organisational structure, policy and practice on the health inequalities of marginalised communities: Illustrative cases from the UK healthcare system. *Health Policy*, 124(3), 298-302. https://doi.org/10.1016/j.healthpol.2020.01.003

Jongen, C., McCalman, J., Bainbridge, R., & Clifford, A. (2018). *Cultural Competence in Health: a Review of the Evidence.* Singapore: Springer.

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A review of the quality indicators of rigor in qualitative research. *American Journal of Pharmaceutical Education*, 84(1), 7120. https://doi.org/10.5688/ajpe7

Kavčič, M., Pahor, M., & Domajnko, B. (2015). User involvement in Slovenian healthcare. *Journal of Health Organization and Management*, 29(5), 595-610. https://doi.org/10.1108/JHOM-06-2014-0095

Kanengoni-Nyatara, B., Watson, K., Galindo, C., Charania, N. A., Mpofu, C., & Holroyd, E. (2024). Barriers to and recommendations for equitable access to healthcare for migrants and refugees in Aotearoa, New Zealand: An integrative review. *Journal of Immigrant and Minority Health*, 26(1), 164-180. https://doi.org/10.1007/s10903-023-01528-8

Kapilashrami, A., Hill, S., & Meer, N. (2015). What can health inequalities researchers learn from an intersectionality perspective? Understanding social dynamics with an inter-categorical approach?. *Social Theory & Health*, *13*, 288-307. https://doi.org/10.1057/sth.2015.16

Kumar, P., Bera, S., Dutta, T., & Chakraborty, S. (2018). Auxiliary flexibility in healthcare delivery system: An integrative framework and implications. *Global Journal of Flexible Systems Management*, *19*(2), 173-186.

https://doi.org/10.1007/s40171-018-0183-y

Lichon, M., Kavcic, M., & Masterson, D. (2015). A comparative study of contemporary user involvement within healthcare systems across England, Poland and Slovenia. *Journal of Health Organization and Management*, *29*(5), 625-636. https://doi.org/10.1108/JHOM-05-2014-0088

Lin, M. H., & Hsu, H. C. (2020). Effects of a cultural competence education programme on clinical nurses: A randomised controlled trial. *Nurse Education Today*, *88*, 104385. https://doi.org/10.1016/j.nedt.2020.104385

Lundin, C., Hadziabdic, E., & Hjelm, K. (2018). Language interpretation conditions and boundaries in multilingual and multicultural emergency healthcare. *BMC International Health and Human Rights*, *18*, 1-14. https://doi.org/10.1186/s12914-018-0157-3

McCalman, J., Jongen, C., & Bainbridge, R. (2017). Organisational systems' approaches to improving cultural competence in healthcare: a systematic scoping review of the literature. *International journal for equity in health*, *16*, 1-19. https://doi.org/10.1186/s12939-017-0571-5

Mews, C., Schuster, S., Vajda, C., Lindtner-Rudolph, H., Schmidt, L. E., Bösner, S., ... & Knipper, M. (2018). Cultural competence and global health: Perspectives for medical education–Position paper of the GMA committee on cultural competence and global health. *GMS Journal for Medical Education*, *35*(3). https://doi.org/10.3205/zma001174

Mitchell, J. I., Graham, I. D., & Nicklin, W. (2020). The unrecognized power of health services accreditation: more than external evaluation. *International Journal for Quality in Health Care*, *32*(7), 445-455. https://doi.org/10.1093/intqhc/mzaa063

Mubarak, F., & Suomi, R. (2022). Elderly forgotten? Digital exclusion in the information age and the rising grey digital divide. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 59, 00469580221096272. https://doi.org/10.1177/00469580221096272

Napier, A. D., Depledge, M., Knipper, M., Lovell, R., Ponarin, E., Sanabria, E., & Thomas, F. (2017). *Culture matters: using a cultural contexts of health approach to enhance policy making*. World Health Organization. Regional Office for Europe.

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: a synthesis of recommendations. *Academic Medicine*, *89*(9), 1245-1251.. https://doi.org/10.1097/ACM.0000000000000388

Okolo, C. A., Ijeh, S., Arowoogun, J. O., Adeniyi, A. O., & Omotayo, O.(2024). Healthcare Manager´**s** role in Adressing Health Disparities: A review of strategies. *International Journal of Applied Research in Social Sciences,* 6(4), 518-531. https://doi.org/10.51594/ijarss.v6i4.989

Paternotte, E., van Dulmen, S., van der Lee, N., Scherpbier, A. J., & Scheele, F. (2015). Factors influencing intercultural doctor–patient communication: A realist review. *Patient education and counseling*, *98*(4), 420-445. https://doi.org/10.1016/j.pec.2014.11.018

Pope, C., Ziebland, S., & Mays, N. (2000). Analysing qualitative data. *BMJ,* 320(7227): 114–116. https://doi.org/10.1136/bmj.320.7227.114

Powell, D. (2016). Social determinants of health: Cultural competence is not enough. *Creative Nursing,* 22(1): 5–10. https://doi.org/10.1891/1078-4535.22.1.5

Ramšak, M., Orzechowski, M., Bielińska, K., Chowaniec, A., Doričić, R., Nowak, M., ... & Steger, F. (2023). Diversity awareness, diversity competency and access to healthcare for minority groups: perspectives of healthcare professionals in Croatia, Germany, Poland, and Slovenia. *Frontiers in Public Health*, 11, 1204854. https://doi.org/10.3389/fpubh.2023.1204854

Rechel, B., Mladovsky, P., Ingleby, D., Mackenbach, J. P., & McKee, M. (2013). Migration and health in an increasingly diverse Europe. *The Lancet*, *381*(9873), 1235-1245. https://doi.org/10.1016/S0140-6736(12)62086-8

Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC. http://data.europa.eu/eli/reg/2016/679/oj

Reese, D. J., Buila, S., Cox, S., Davis, J., Olsen, M., & Jurkowski, E. (2017). University–community–hospice partnership to address organizational barriers to cultural competence. *American Journal of Hospice and Palliative Medicine*, *34*(1), 64-78. https://doi.org/10.1177/1049909115607295

Saeed, S. A., & Masters, R. M. (2021). Disparities in health care and the digital divide. *Current Psychiatry Reports*, *23*, 1-6. https://doi.org/10.1007/s11920-021-01274-4

Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association*, 100(11), 1275-1285. https://doi.org/10.1016%2Fs0027-9684(15)31505-4

Schenk, L., Sonntag, P. T., Beck, P., Khan, Z., Peppler, L., & Schouler-Ocak, M. (2022). Organisational and staff-related effects on cultural competence in the hospital setting: a cross-sectional online survey of nursing and medical staff. *BMC Health Services Research*, 22(1), 644. https://doi.org/10.1186/s12913-022-07947-x

Schiaffino, M. K., Ruiz, M., Yakuta, M., Contreras, A., Akhavan, S., Prince, B., & Weech-Maldonado, R. (2020). Culturally and linguistically appropriate hospital services reduce Medicare length of stay. *Ethnicity*

& Disease, 30(4), 603-610. https://doi.org/10.18865/ed.30.4.603

Singh, I. (2023). Understanding of cultural competence is essential for the delivery of compassionate, fair, and proportionate medical regulations. *The Lancet*, 402(10400), 434-435. https://doi.org/10.1016/S0140-6736(23)00524-X

Sparks, C. (2013). What is the "digital divide" and why is it important?. *Javnost-The Public*, *20*(2), 27-46. https://doi.org/10.1080/13183222.2013.11009113

Škraban, J. 2020. Uvod k slovenski izdaji [Introduction to the Slovenian Edition]. In Verrept, H., & Coune, I. *Standardi medkulturne mediacije v zdravstvu* [Guide for intercultural mediation in healthcare] (J.Škraban, trans.). Ljubljana: Nacionalni inštitut za javno zdravje.

Taylor, R. (2005). Addressing barriers to cultural competence. *Journal for Nurses in Professional Development*, *21*(4), 135-142.

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC Health Services Research*, *14*, 1-17. https://doi.org/10.1186/1472-6963-14-99

Van Gool, F. W. R., Theunissen, N. C. M., Bierbooms, J. J. P. A., & Bongers, I. M. B. (2017). Literature study from a social ecological perspective on how to create flexibility in healthcare organisations. *International Journal of Healthcare Management*, *10*(3), 184-195. https://doi.org/10.1080/20479700.2016.1230581

Weech-Maldonado, R., Dreachslin, J. L., Epané, J. P., Gail, J., Gupta, S., & Wainio, J. A. (2018). Hospital cultural competency as a systematic organizational intervention: Key findings from the national center for healthcare leadership diversity demonstration project. *Health Care Management Review*, *43*(1), 30-41. https://doi.org/10.1097/HMR.0000000000000128

WHO (World Health Organization). 2021. *The Global Health Observatory. Health equity monitor: About the Health Equity Monitor.*

Yong-Hing, C. J., & Khosa, F. (2023). Provision of culturally competent healthcare to address healthcare disparities. *Canadian Association of Radiologists Journal*, 74(3), 483-484.2023;74(3):483-484. https://doi:10.1177/08465371231154231

Yousef, K. (2024). Intercultural Communicative Competence in Virtual and Face-to-Face Teamwork: A Quantitative Analysis of Culturally Diverse Teams. *Organizacija*, 57(2), 139-150. https://doi.org/10.2478/orga-2024-0010

Železnik, D., Kokol, P., & Blažun Vošner, H. (2017). Adapting nurse competence to future patient needs using Checkland's Soft Systems Methodology. *Nurse Education Today* 48: 106–110. https://doi.org/10.1016/j.nedt.2016.09.015

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