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A Concept Analysis of Structural Competency

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Structural competency is a concept that offers a way to understand and respond to health inequities and work toward antiracism in health care. This article undertakes a concept analysis of structural competency using Rodgers' evolutionary method. Based on this analysis, structural competency refers to the ability to recognize and act on structural inequities, skill development, multidisciplinary collaboration, and the reproduction of inequity over time. The meanings and use of this concept differ among disciplines. Multidisciplinary applications of structural competency offer insight into how this concept can foster health equity and antiracism in nursing care, education, research, and health services delivery. **Key words:** *health equity*, *social justice*, *structural competency*, *structural inequities*

AS A DISCIPLINE, nursing has long recognized that health is influenced by factors other than those that are purely at the individual level. Nurse scientists from Florence Nightingale to Madeleine Leininger have described the impact of a person's environmental and cultural contexts on their health.[1,2] Over time, the health professional literature has conceptualized these nonbiological factors in various ways. In the last 40 years, scholarly understandings of factors that influence health have moved from those focusing on culture and cultural differences toward those situated in an understanding of social structures, systems, and inequities.[3,4] Racism as a structural determinant of health has particularly been highlighted in scholarship over the last 2 decades.[5]

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.[6] Cultural competency promotes awareness, attitude, and knowledge of other people's cultures in service of improving communication between patients and providers.[7] From this concept later rose the idea of cultural humility, which encourages providers to maintain an attitude of continual learning and situating themselves as the nonexpert.[8]

Although these concepts represent meaningful progress toward conceptualizing health and provision of health care as mediated by aspects of patient and provider identities, cultural competency and cultural humility are limited in their ability to change patients' experience of stigma or improve health outcomes because they remain focused at the level of the individual

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Statements of Significance

What is known or assumed to be true about this topic?

- Structural competency is a nascent concept in health professional literature with attention in the discipline of nursing only since 2018.
- It represents an evolution of cultural competency as a concept by incorporating structural violence, social determinants of health, and elements of critical race theory in conceptualizing how factors far outside the individual locus of control influence individual health.
- These factors include racism, sexism, homophobia, ableism, classism, and their many intersections.

What this article adds:

- This concept analysis uses Rodgers' evolutionary method to examine how disparate meanings and uses of structural competency across nursing, medicine, and other health-related disciplines can be synthesized to inform a multidisciplinary conceptual approach to addressing health inequities and actualizing antiracist health care.
- It offers a crucial and timely analysis for continuing to evolve our understanding of health and health equity through a lens that is responsive to nursing's mandate for social justice.
- It offers a springboard for nursing science's continued engagement in antiracist scholarship. This significant contribution to nursing science is also in keeping with the mandate of *Advances in Nursing Science*.

Standpoint Statement

The authors all identify as women nurses in the academy who have worked primarily with marginalized and disadvantaged populations. As a group of authors, we bring diverse identities of race, ethnicity, sexual orientation, geographic location, and citizenship.

encounter.[9-12] In addition, research demonstrates that despite the integration of cultural competency and cultural humility into health care professional education and practice, health care providers struggle to understand how health systems contribute to health inequities, such as those shaped by racism and racialization.[13,14] Indeed, Koschmann et al[4] state that the "status quo of race-neutral, race-blind, or culturally competent care will only strengthen existing disparities."[(p2)] Approaches focused on the level of individual patient-provider interactions cannot lead to antiracist nursing practice because health inequity underpinned by racism is a structural issue, rather than an interpersonal one. Working toward antiracist nursing practice, then, requires us to look toward concepts that speak through a structural lens.

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. This concept first appeared in the literature in 2014 in a formative article by Jonathan Metzl and Helena Hansen, psychiatrists also trained in sociology and anthropology. Structural competency has been referred to in various ways by subsequent health scholars: a concept,[10] a theoretical framework,[15] a paradigm,[13,16] and a movement.[14] It represents an evolution wherein structure replaces culture as the context for health inequity.[10] Scholars suggest that building structural competency in providers, organizations, and systems is the key to making health systems more equitable

and thus has far-reaching consequences for transforming health systems, supporting providers, changing health care education, and improving patient outcomes.[3,17]

The last 2 years of the COVID-19 pandemic, reckoning with systemic violence 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 critically tasked with examining and responding to ongoing health inequities in new ways, including approaches that address structural harms such as racism.[4,18,19] To dismantle racist structures, institutions, and practices, nursing must continue to evolve the lens through which issues affect a person's health and health care are conceptualized. Examining how the concept of structural competency is conceived of in the literature, and thus in practice, is an important next step and is relevant to the current North American sociopolitical context. In this article, we present a concept analysis of structural competency as a foundational step toward operationalizing strategies that foster or contribute to health equity and antiracism in nursing care, nursing education, nursing research, and health services delivery.

METHODS

Rodgers'[20] evolutionary method was selected as the methodological approach for this concept analysis of structural competency. Rodgers[20] views concepts as dynamic, evolving, and context bound. The evolutionary method is also appropriate for concepts that are immature or partially mature in the literature.[21] In addition, Rodgers'[20] method is inductive and incorporates multiple perspectives related to a concept. This method requires the researcher to identify characteristics of the concept (called attributes) as discussed in the literature.[20] Researchers must also identify the contextual features of the concept, namely, what came before, and what comes after; these are referred to as antecedents and consequences.[20] Finally, the literature is reviewed for surrogate terms, data pertaining to applications of the concepts (called references), and related concepts.[20] Rodgers[20] states that a minimum of 30 articles, or 20% of total articles retrieved, must be reviewed for a meaningful analysis.

This method of concept analysis fits well with structural competency, which arises out of the North American—specifically, American—social and health systems context, and represents an evolution of cultural competency, cultural humility, and the social determinants of health.[9,11,16,22] Given that structural competency first appeared only in the health care literature in 2014, and that there are 8 nursing publications on this to date, the concept can be considered immature. Finally, the inductive nature and allowance for multiple perspectives incorporated into Rodgers'[20] method align with concepts such as structural competency, which is multidisciplinary.

Search methods and data analysis

Using the title search term "structural competency," a literature search was conducted through the University of Alberta library on October 12, 2021, in 2 databases: CINAHL and MEDLINE. These databases were selected as they primarily index literature from the health professions. Limits on the searches in both databases included English language journals and peer-reviewed journals only. Fifty-three unique articles were found using this title search. Since this search yielded a significant number of results, abstract and key word searches were not performed. The search revealed articles on structural competency from several health and health-related disciplines: medicine (n = 38), nursing (n = 7), public health (n = 2), bioethics (n = 1), pharmacy (n = 1), psychology (n = 1), and sociology (n = 1). In addition, an article by Drevdahl[3] was selected in a purposive sample, as this is the first article on structural competency from the nursing discipline. In total, 8 nursing articles were located and

retained. Thirty-eight articles from medicine were located; data were saturated after 16 randomly selected articles. All 6 articles from health-related literature were retained. Overall, 57% of articles located were retained, which far exceeds Rodgers'[20] criteria for credible analysis.

Separate coding forms were used to analyze the literature from each discipline represented, per Rodgers'[20] method. Each disciplinary coding form made note of attributes, antecedents, consequences, references, related concepts, and surrogate terms for each item reviewed. As per Rodgers'[20] evolutionary method, these data were first reviewed separately, and then combined to form a working definition of the concept.

RESULTS

Apart from 2 articles written by Israeli nursing scholars, the literature retrieved for this review was entirely written by American scholars. The literature review revealed many similarities in the way that this concept was used in medicine, nursing, and health-related disciplines along with subtle but important differences. The results are presented according to the categories of analysis outlined by Rodgers'[20] method: attributes, antecedents, consequences, references, surrogate terms, and related concepts, which are defined under the "Methods" section.

Attributes

The literature revealed 5 attributes of structural competency: a recognition or identification of structural influences on health; a learned skill set; action or mobilization; an interdisciplinary endeavor; and an understanding of historical discriminatory processes.

The attribute of recognition or identification was common to all literature sources reviewed. Nursing literature tended toward identifying structural competency as the ability to recognize and identify structural influences on health without the paired ability to respond.[3,9,20,23,24] In contrast, the medical literature tended to define structural competency as the "ability to see *and act*"[11,14,15]; the ability to "recognize *and respond*"[16] (italics added). The exception to this phenomenon in the nursing literature was the definition offered by the Israeli scholars, who emphasized the recognized and response aspects in equal measure.[25,26] The health-related literature put much more emphasis on the response aspect, moving immediately to operationalization and intervention.[17,27-30]

Another attribute is the learned ability or capacity for critical thinking skills, ability to hold complexity, and attunement to implicit bias. This attribute highlights the idea that the ability to be structurally competent is not innate. It is something that can be taught and learned.[11,30,31] Moreover, this learned ability leads to acquisition of a skill set that makes it possible to act on the recognition gained previously.[24]

The third attribute of the concept is that of action or mobilization. Structural competency acts as a call to action to health care providers.[11,31-33] An important aspect of action is developing tolerance and willingness to have frank conversations about structural bias and discrimination and wrestle with painful truths about racism, health, and power.[9,23,25,26,30] This attribute also indicates that remedying these structural issues is indeed possible.[12,34] Structural issues are not determinants but rather influencers of health, which can be shaped and changed through human effort.[22]

Multidisciplinary collaboration is a fourth attribute of structural competency. This concept deprivileges the medical model and humbles medicine in the face of social science scholarly work.[34,35] The concept draws upon and integrates knowledge from medical anthropology, medical sociology, public health, health policy, critical race theory, and law.[10,11,16] Achieving structural competency requires relinquishing the current health-related knowledge and practice hierarchy (which places medicine in the top position of power) in service of building horizontal

power structures and collaborative, coalition-based care.[13,33] Structural issues cannot be remedied by an individual or a discipline alone.[13]

The final attribute of structural competency identified in the literature is an understanding of historical processes under which discrimination, inequity, and stigma have developed, operated, evolved, and continue to be enacted.[10,22,25] Authors point to understanding histories of colonialism and imperialism as a fundamental basis for structural competency.[10,22,25] Rather than simply acknowledging and describing the existence of structural discrimination, structural competency requires looking at history through a critical lens to explore the production and reproduction of inequities over time.[35]

Antecedents

Our analysis revealed 4 antecedents of structural competency. These include a sense of decline in health care and social safety nets; an understanding of equity; inability of existing frameworks to address what clinicians encounter in practice; and capacity for critical self-reflection.

The first antecedent to structural competency is a pervasive sense of decline in health care systems and social services. Lack of social safety nets due to chronic underfunding has resulted in concurrent increase in mental health issues and systemic violence.[35] The fact that 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.[10,36]

The second antecedent to structural competency is an understanding of equity. Equity is an approach that seeks to realize fairness and justice by providing more to those who have less and less to those who have more. This antecedent is often discussed in relation to health inequities, which are defined as "differences in health status or the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair."[37] An equity approach diminishes health inequities by allocating resources and burdens across populations in ways that promote fairness.[22,30]

The failure of existing concepts, theories, frameworks, and policies to effectively address the inequities providers see in clinical practice is a third antecedent.[9,10,38] Scholars point to the pervasive societal ideological framework focused on individual choice and responsibility in explaining why social issues are traditionally considered outside the purview of the medical model.[11,24,29] Previous approaches to addressing these issues have simply reproduced this individually focused understanding. Indeed, cultural competency does so in its emphasis on patient-provider–level interactions.[11,24,31]

The fourth antecedent of structural competency is the ability to critically self-reflect on one's own biases, perceptions, and practices. Critical thinking is needed to understand the links between intersectionality and health and bring to light the structural assumptions that provide a common basis for practice and education.[22,39] Providers must become aware of and challenge their own implicit biases to take on this work.[9,24,30,40]

Consequences

Structural competency has 3 main consequences according to the literature reviewed. They are the fulfillment of providers' ethical duty; the development of structural humility; and, paradoxically, either deepening of or relief from discomfort, moral distress, and burnout.

Fulfillment of ethical duty is the most common consequence outlined in the nursing literature. In describing this consequence, several authors refer to the American Nurses Association (ANA) code of ethics,[41] which lists ethical practice, social justice, and advocacy as mandates for the profession.[23,24,41] Structural competency offers a way to realize nursing's commitment to social justice and advocacy by addressing truths about racism

as a key cause of health inequity.[9] It even offers a way to expand the discipline's ethos beyond considering how we can care for vulnerable patients, toward examining what makes them vulnerable in the first place.[3] Importantly, structural competency allows nursing to realize its goal of providing holistic care to patients.[41]

The consequence of structural humility acknowledges that through this work, health professionals begin to recognize that they alone, however knowledgeable and competent, do not have all the answers; rather, they must work in collaboration with patients and communities to address structural inequity.[9,10,28,38,40] This consequence was discussed in both the nursing and medical literature. Structural humility requires health care providers to build alliances with communities, engage in political activism, foster creativity, and engage in lifelong learning.[10,11,14,15,33]

The third consequence of structural competency is discomfort and an effect on burnout and emotional distress. This consequence was discussed solely by the medicine and nursing scholars. Structural competency can either add to burnout and emotional distress or alleviate it. Some scholars stated persuasively that structural competency can alleviate burnout and moral distress and increase empathy.[13,16,42] This was achieved through the ability to shift blame from patients to structures and to create a shared vocabulary with patients.[16,42] Other scholars offered that the increased awareness of inequity clinicians develop by approaching care through a structural competency lens can increase experience of burnout and overwhelm.[23,24,26] These scholars state that addressing burnout and overwhelm in this context remains the topic of needed future research.[23]

References

The literature referred to structural competency in the context of health professional education, as a transformative pedagogy[24] and a framework to be used in curricula.[9,30,40,43] This is how the concept was initially described in the article by Metzl and Hansen.[10] It is also referred to as a theoretical interdisciplinary model for health,[11] a paradigm,[13,42] and an approach to clinical training and practice.[33] In nursing, it has been regarded as a concept that can inform nursing research, theory, education, and practice.[3]

Surrogate terms

No surrogate terms were identified in the literature. Although structural competency draws on many related concepts, authors are clear that it is distinctive in the literature.[3,10,14,22,23]

Related concepts

Structural competency builds upon existing concepts of cultural competence and cultural humility.[3,9,23] It also builds upon the concept of the social determinants of health.[3,23,26] Per the literature, the concept of social determinants differs from structural competency in that it describes the existence of health inequities and the conditions linked to these rather than the historical origins and contemporary reproductions of such inequities.[3,9,23,26]

Other related concepts mentioned in the literature reviewed include structural violence, a concept developed in health professional literature by Farmer et al.[39] Structural violence refers to the embedded social structures or institutions that prevent people from being able to meet their basic needs and achieve health.[39] These include institutionalized racism, sexism, homophobia, classism, and ableism. Structural competency is conceived as a response to structural vulnerability, which is the state of being that people find themselves in because of the forces of structural violence.[44] Critical race theory, which examines how structures and institutions create and maintain racial oppression and inequity,[45] also informs the concept of structural competency.[9,46] Other related concepts that appear in the literature on structural

competency include structural/systemic racism,[3] decolonization,[22] naturalization of inequity,[16] cultural humility,[9,11] cultural safety,[3] social justice,[9,22,23] health equity,[22,42] and beloved community.[47] Beloved community is a concept popularized by Dr Martin Luther King Jr and describes a vision for an inclusive world where economic and social justice have been realized in the service of eliminating all forms of discrimination, prejudice, and poverty.[47]

DISCUSSION

This concept analysis presents a detailed conceptualization of structural competency, based on examination of how it has been described in the medical, nursing, and health-related literature. Structural competency is an approach that encompasses both recognition of and action on structural inequity, the learned ability to critically self-reflect and hold complexity, multidisciplinary collaboration, and an understanding of past and present as mutually reinforcing contexts. This attribute of multidisciplinarity helps put to rest the question of how structural competency relates to nursing. As a multidisciplinary concept by nature, nursing is already invited to expand upon this concept. Even so, it may be useful to consider nursing theories that offer resonance with structural competency.

Several scholars have emphasized nursing's commitment to providing holistic care,[42] which structural competency can facilitate by providing guidance around how nurses can locate patients in the particular contexts of their own lives. Structural competency also aligns with nursing's mandate for social justice, which is reflected in both the American Nurses Association's (ANA)[41] and Canadian Nurses Association's[48] (CNA) codes of ethics. The ANA's code mandates nursing to reduce health disparities and integrate social justice into its work.[41] The 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.[48] Made explicit, structural competency is implicit in our profession's ethos and mandate across North America.

Although the literature is relatively consistent in describing some aspects of structural competency, such as antecedents, surrogate terms, and related concepts, there were several key differences in attributes that were linked to how consequences were viewed. Authors who conceived of the attributes of structural competency as solely a recognition of existing structural barriers were more likely to report consequences of feeling overwhelmed and increased burnout.[23,24] In contrast, authors who included the importance of response and action in defining the attributes of structural competency were more likely to report that structural competency could alleviate distress and burnout.[16,43] For the ethos of structural competency to be fully realized, it is thus imperative that its attributes include both recognition and response. However, even when a response is included as an attribute, discomfort remains a consequence. This concept also requires nurses, health care providers, and systems to acknowledge and understand the realities of discrimination and health inequity based in racism, sexism, classism, homophobia, and ableism, and wrestle with truths about how they have perpetuated these ills whether consciously or unconsciously.[9,15,38]

In their concept analysis of cultural competency, Henderson et al[6] state that the attributes and antecedents of cultural competency indicate only a superficial level of understanding of patient's lives required by this concept, and that health care practitioners must be able to critically reflect on social norms and systems to sustainably operationalize cultural competency. We argue that structural competency's attention to historical injustices and resulting legacies of systemic discrimination and inequity differentiates it from cultural competency. This is also what differentiates the social determinants

of health from structural competency. Although models of the social determinants of health incorporate the impact of political systems, economic ideologies, and labor markets on health outcomes, understanding of colonialism and legacies of oppression is either not explicitly integrated or seen as too distal to be the target of intervention.[49]

Another notable difference is in the breadth of use of structural competency specifically between medicine and nursing. Except for Drevdahl[3] and Waite and Hassouneh,[22] the nursing literature focuses on structural competency as a concept for integration into nursing curricula.[9,23-26,42] However, scholars in medicine offer it as a concept that can transform education, clinical practice, and health systems delivery.[10,14,16,35,43] Overall, the medical literature is much more radical and persuasive than the nursing literature with respect to operationalizing this concept. Given that nursing is a profession with a mandate for social justice, this was a surprising finding. Perhaps this is explained by Hansen and Metzl's[14] comment that when it comes to health in North America, physicians and clinical providers disproportionately hold the financial, social, and symbolic capital with which to influence health systems. Nursing may not recognize itself in this description of power.

Far more than the medical or nursing literature, the health-related literature focused on the operationalization of structural competency in care delivery congruent with their various disciplinary lenses. This included integrating structural competency into programs for substance users involved in the forensic system by prerelease planning,[17] for recipients of psychotherapy services by enacting therapist-client solidarity,[27] for survivors of domestic violence through changing responses to domestic abuse disclosures,[28] for sexual and gender minority youth in schools through bolstering of Gay-Straight Alliances,[29] and for genetic counseling by incorporating structural influences in genetic predictive models of disease risk.[36] The nursing literature remains comparatively challenged in conceptualizing response and action as guided by structural competency.

Implications

This concept analysis of structural competency offers some direction for further development of the concept. First, structural competency must be developed in nursing beyond curricular frameworks. The Structural Vulnerability Assessment Tool by Bourgois et al[44] offers a resource for standardized assessment and treatment planning for patient experience of structural discrimination, as well as critical self-reflection questions for the clinician treating these patients. Further research is needed to examine its use and application to nursing practice, programs, and health care systems. There is some guidance in the health-related literature on how to apply structural competency to program development.[28,34] Additional nursing research on this topic includes creating a framework wherein this concept can be operationalized at provider, organizational, and systems-level contexts, in addition to the educational context. Although beyond the scope of a concept analysis process, testing components of structural competency, including the conceptualization of agency, is another area for future work. Similarly, the evaluation of structural competency in agents, such as clinicians, organizations, and health care systems, and the assessment of impact on patient health outcomes and nurse satisfaction as well as self-efficacy outcomes require further research. Second, examining the use of structural competency in contexts outside of the United States will yield rich data about its relevance and viability as a guiding framework. Most of the literature on structural competency arises from the United States' social and health care systems, which is predominantly for-profit and fragmented. This differs considerably from the Canadian context, for example, where provincial and territorial health care systems are underpinned by the principles of public administration, comprehensiveness, universality, portability, and accessibility, as established by the Canada

Health Act.[50] To date, there is no published literature on structural competency from the Canadian context.

CONCLUSION

Health care systems are increasingly faced with the grand challenge of responding to health and social inequities that influence patient and population health. The concept of structural competency builds on established concepts of cultural competency, cultural humility, critical race theory, and social determinants of health. Structural competency integrates the importance of understanding historical injustice; recognizing and taking action to address structural influences on health equity; and building the necessary skills to enact such change. All of these are critically important skills to achieving antiracist nursing education, practice, and research. Structural competency thus provides a useful guidepost for considering approaches, interventions, structures, and research that contribute toward the goal of dismantling racism in nursing practice.

A new, structurally minded approach to conceptualizing barriers to health and health care is critical at this present sociopolitical moment in North America. The undeniably disproportionate impact of the COVID-19 pandemic on racialized communities, women, low-income people, and people with disabilities is forcing nursing and other health care disciplines to seek alternative understandings and approaches to ensuring equitable access to health and well-being.[18,19] Structural competency offers promise in transforming nursing care and health systems delivery in the service of addressing barriers to care and inequities in health outcomes and in providing a lens through which the discipline can approach antiracist praxis. Structural competency is a means not only to analyze structural factors such as racism that affects health inequity but also to operationalize interventions that acknowledge and act to reduce such inequities.[13] It is time for nursing to embrace structural competency and to cultivate radical vision in moving our profession toward antiracist education, practice, service delivery, and research.

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