



THE ROLE PLAYED BY WELSH CULTURE, LANGUAGE AND IDENTITY IN HEALTH AND SOCIAL CARE



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3. Models of Health

The biomedical model focuses on pathology and physical disease. However, in the Welsh context, it is insufficient because it overlooks language, culture, and social determinants.

The social model recognises inequality and structural disadvantage, which are highly relevant in Wales. However, it may lack sufficient attention to individual identity and linguistic experience.

The biopsychosocial model (*Engel, 1977*) integrates biological, psychological, and social dimensions. It recognises language, identity, and community ties, making it the most appropriate framework for understanding health in Wales.

Why is this important? Because the model adopted in practice shapes how professionals interpret risk, communication, and patient safety.
In conclusion: In Wales, the biopsychosocial model provides the most comprehensive and culturally responsive framework for equitable care.



1. Introduction

Health and social care in Wales operate within a distinct cultural and linguistic context shaped by devolution. The Welsh language holds official legal status (*Welsh Government, 2011*). Health is not determined solely by medical treatment. Lalonde (*1974*) argues that biology, lifestyle, environment, and healthcare organisation shape outcomes. The biopsychosocial model further recognises psychological and social influences on illness (*Engel, 1977*).

Why does this matter?

Because language, identity, and social context influence communication, trust, and clinical safety.
In conclusion:
In Wales, health cannot be separated from culture and language.

Research Objectives

- To examine how health is conceptualised within the Welsh social and cultural context.
- To evaluate the relevance of health models in shaping culturally responsive practice in Wales.
- To analyse the relationship between Welsh language, identity, and clinical safety in healthcare delivery.
- To assess how structural inequalities and policy frameworks position language as a determinant of quality and person-centred care.



Research Question

How do Welsh culture, language, and identity influence the delivery of safe and equitable health and social care in Wales?

2. Conceptualising Health in the Welsh Context

To understand how culture and language influence care delivery, it is first necessary to examine how health is conceptualised within the Welsh context.

The WHO defines health as complete physical, mental, and social well-being (*WHO, 1948*). The social determinants model demonstrates how employment, housing, education, and environment shape outcomes (*Dahlgren and Whitehead, 2006*).

Wales has one of the oldest populations in the UK (*Public Health Wales, 2020*). Ageing increases chronic conditions such as cardiovascular disease and dementia. Older adults are more likely to be Welsh-speaking, and individuals with dementia may revert to their first language under stress.

Why is this significant?
Because ageing, rurality, and bilingual identity intersect to affect access, communication, and safety.
In conclusion:
Health in Wales is socially and demographically shaped.

Key Legislative and Policy Frameworks

- Welsh Language (Wales) Measure 2011** (Welsh Government, 2011)
- Strategy for Welsh in Healthcare 2024–2029** (Powys Teaching Health Board, 2024)

Conclusion

Health in Wales is shaped by ageing, inequality, rurality, culture, and bilingual identity. Language is not merely cultural expression but a determinant of clinical safety and equity. Safe and person-centred care therefore requires integration of social determinants theory, the biopsychosocial model, cultural competence, and legislative responsibility.

Language and identity are structural components of equitable healthcare in Wales.

FINDINGS AND DISCUSSION

The following sections present the key findings of the analysis and discuss how Welsh culture, language, and identity influence health and social care delivery in Wales.

4. Welsh Culture and Identity in Health and Care

Welsh identity is rooted in community, language, and shared history (*Williams, 2021*). Community networks support emotional wellbeing and recovery (*Green, 2009*). The Welsh Language Commissioner's Inquiry emphasised that patients access healthcare as individuals rather than representatives of demographic groups, and that their linguistic identity should not be reduced to statistical prevalence (*Welsh Language Commissioner, 2014*). This reinforces the principle that cultural identity remains clinically relevant regardless of the proportion of Welsh speakers within a given locality. Cultural competence is essential to reduce disparities (*Betancourt et al., 2005*).
Why does identity matter clinically? Because loss of cultural familiarity may increase anxiety and reduce trust.
In conclusion: Culture functions as a determinant of wellbeing in Wales.

5. The Role of Welsh Language in Healthcare



The Welsh Language (*Wales*) *Measure 2011* established legal rights to bilingual healthcare. **Standard 110** requires health boards to publish a five-year plan outlining their capacity to deliver clinical consultations in Welsh and actions to improve this (*Welsh Language Standards, 2018; Powys Teaching Health Board, 2024*). The Strategy for Welsh in Healthcare frames Welsh-medium consultations as a matter of quality and patient safety (*Powys Teaching Health Board, 2024*), while the *NMC Code (2018)* identifies effective communication as central to safe practice. However, evidence cited in the Welsh Language Commissioner's Inquiry indicates **that 58%** of healthcare practitioners expressed neutral or negative attitudes towards the Welsh language (*Roberts et al., 2004, cited in Welsh Language Commissioner, 2014*), highlighting a gap between legislative entitlement and consistent culturally responsive care. Without Welsh-language provision, assessment accuracy and informed consent may be compromised. **For example**, an 82-year-old patient with early dementia may struggle to understand treatment explanations without support in his first language, increasing anxiety and clinical risk. **In conclusion:** In Wales, language is a determinant of safety, dignity, and lawful care.

6. Health Inequalities in Wales: Cultural and Geographical Barriers

Wales experiences higher rates of cardiovascular disease and mental health difficulties (*Public Health Wales, 2020*). Income inequality is associated with poorer health outcomes (*Wilkinson and Pickett, 2009*). Census data demonstrate substantial internal geographical variation in Welsh language prevalence, **ranging from 7% to 48%** across areas of Powys, despite an overall **rate of 16.4%**, **slightly** below the Wales average (*Powys Teaching Health Board, 2024*). This uneven distribution presents distinct challenges for equitable service planning. Rurality, ageing, deprivation, and limited Welsh-speaking staff intersect to restrict equitable access. The Strategy for Welsh in Healthcare further identifies three fundamental causes preventing Welsh-medium consultations: insufficient workforce language skills, organisational processes and attitudes, and weak systems for recording patient language preference (*Powys Teaching Health Board, 2024*).
Why do these inequalities persist? Because demographic variation, workforce capacity, and institutional systems interact, producing cumulative disadvantage for Welsh-speaking communities.
In conclusion: Health inequalities in Wales are structural, demographic, and linguistic.

7. Culturally Safe and Person-Centred Care

Person-centred care requires recognition of identity, language, and community context **as integral components of assessment and care planning**. Culturally safe practice **involves** proactive language provision, psychological safety, and the integration of social determinants into clinical decision-making. **What happens if culture is ignored?** Care may be clinically appropriate yet emotionally unsafe, undermining trust, engagement, and adherence to treatment. **In conclusion:** Culturally safe care is essential for equitable and effective practice.

8. Legislation and Policy Supporting Welsh Language and Identity

Key frameworks include the *Welsh Language (Wales) Measure 2011* (*Welsh Government, 2011*), More Than Just Words (*Welsh Government, 2022*), and *Standard 110* under the Welsh Language Standards (*Welsh Government, 2018*), which mandates measurable improvement in Welsh-medium consultations. *Standard 110* is described as laying the foundations for a health service in a bilingual country, framing Welsh-medium clinical consultations as a matter of quality and patient safety (*Powys Teaching Health Board, 2024*). The principle of the *Active Offer* shifts responsibility from the patient to the provider, requiring services to proactively offer Welsh rather than waiting for request. **The strategy identifies three structural barriers to delivering consultations in Welsh:** 1) Insufficient workforce language skills; 2) Organisational processes and behaviour; 3) Weak systems for recording language preference
Policy - Practice Gap: Although legislation establishes formal rights to bilingual care, implementation depends on workforce capacity and institutional culture. The strategy cautions against reliance on interpretation alone, noting that theoretical capacity to provide Welsh-language services does not guarantee meaningful delivery. This exposes a structural gap between statutory entitlement and operational reality (*Powys Teaching Health Board, 2024*).
In conclusion: Policy establishes entitlement; practice determines impact.