Cultural Competence in Health Care:
Implications for Human Resource Development

Rosemarie Angela Taylor and Mary V. Alfred
Florida International University, USA

Abstract: This paper reviews the need for cultural competence in health care, the barriers faced by health care professionals as they attempt to deliver culturally competent care, and the implications for human resource development initiatives.

Already the most ethnically diverse country in the world, the US, is experiencing dramatic increases in its ethnic mix. As Taylor (2005) notes, these changing demographics have presented significant challenges for health care professionals as they attempt to meet the special needs of ethnically and linguistically diverse clients. The responses to these challenges have resulted in extensive research and theory building, providing conceptual clarity for the meaning of cultural competence and the need for cultural competence in health care (Burchum, 2002) as well as demonstrating empirical evidence of the promise of cultural competence in reducing racial disparities (Brach & Fraser, 2000). However, as McPhatter and Ganaway (2003) observe, cultural competence in health care still remains elusive. Therefore, the purpose of this paper is to explore, using evidence from the literature, the need for, benefits of, and barriers to culturally competent health care, highlighting the human resource development (HRD) interventions needed to make cultural competence a reality.

Method

This is a conceptual paper, drawn from the literature on cultural competence as it relates to the provision of health care to culturally diverse clients. The databases that were searched for the review of the literature were CINAHL, Medline, Proquest, and Psychinfo. Search terms included cultural competence alone and in combination with barriers, effectiveness, evaluation, training, education, and models. Other terms were culture in combination with disparities, bias, and prejudice. Empirical research literature as well as conceptual documents were used in analyzing information for this manuscript. Additionally, the standards for culturally and linguistically appropriate services (CLAS) were used to support the analysis. The CLAS standards refer to standards for culturally and linguistically appropriate services developed by the federal government.

The Need for Cultural Competence in Health Care

According to the Bureau of Census (2000), in the year 2000 minority groups comprised 30% of the U. S. population, (approximately 86 million persons). Approximately 31 million people were born outside the U.S.; approximately 18% or 50 million speak a language other than English, and 8% reportedly speak English less than very well. Additionally, in most large cities, minority groups comprise the majority, for example, in Miami Hispanics represent 57% of the population. With this growing ethnic, cultural, and linguistic diversity comes the challenge of providing health care that is responsive to the diverse needs and is effective in achieving the desired health outcomes (Ahmann, 2002). Together with the growing diversity, the need for cultural competence in health care is grounded in the long-standing disparities between the health status of minorities and Whites, the contrasting health beliefs among these groups, and language differences.

Health Disparities

The disparity between the health status of minorities and Whites has been the driving force behind many of the efforts to promote cultural competence in health care (Ahmann, 2002). While there have been overall improvements in the health status of the population, significant disparities continue to exist between the health status of minority groups and that of Whites (Satcher, 2000). As Ahmann (2002) wrote, "nowhere are the divisions of race, ethnicity and culture more sharply drawn than in the health of the people of the U.S." (p. 134). The mortality rate for heart disease is more than 40% higher in African Americans than for Whites. The death rate for all cancers is 30% higher for African Americans than for Whites. The incidence of prostate cancer is more than double in African American men when compared to White men. The incidence of HIV/AIDS in this group is more than seven times that of Whites (Satcher, 2000). Other minorities experience similar results. Hispanics are twice as likely to die from diabetes than Whites. They also have higher rates of hypertension and obesity in comparison to their white counterparts. The incidence of diabetes for American Indians is twice that of whites. The life expectancy for this group is five years less than the national average (Satcher, 2000). While differences in socioeconomic, educational, and lifestyle factors contribute to these disparities, there is growing concern among many health professionals that racism and stereotyping play a significant role (Smedley, Stith, & Nelson, 2002).

Contrasting Health Beliefs

There are significant differences between the health-related values and beliefs of minority and foreign-born persons and those of western medicine. The primary differences relate to the causation and treatment of disease, the role of the patient, knowledge of how the body functions, and the importance of prevention (Helman, 2000). For example, the underlying assumptions of biomedicine, also referred to as the medical model, include the belief that diseases have an organic cause and treatment is based on scientifically proven methods (Helman, 2000). In contrast, many ethnic groups believe supernatural and natural forces can cause illness and treatment should be based on those beliefs (Grossman, 1994; Johnson, 2002). While health care providers operate from an understanding of the anatomy and physiology of the human body, believe in early diagnosis and treatment, and are aware of treatment options (Helman, 2000), many ethnic minority patients lack this knowledge. With over one hundred cultural and ethnic groups in the U.S., health care providers must be cognizant of the differences in their beliefs about health and those of the patients they serve if they are to be effective.

Language Differences

Along with the cultural needs come the linguistic needs of ethnic minorities. The presence of language barriers is associated with poor medical care and misdiagnoses (Flores & Vega, 1998), higher rates of diagnostic tests since a full history cannot be obtained (Brach & Fraser, 2000), and noncompliance. Research shows that language barriers have a negative impact on health care utilization (Derose & Baker, 2000), client satisfaction, and possibly adherence to medical advice (Kaiser Family Foundation, 1999). Stevens & Shi's (2002) study of mothers of Hispanic children found fewer feelings of affiliation and poorer relationships with their physicians than English-speaking mothers. Some studies have found that patients who spoke a different language from their provider were more likely to miss appointments or drop out of treatment (Brach & Fraser, 2000).

Benefits of Cultural Competence

The goals of cultural competence in health care are to make the health care system more responsive to the needs of all clients, to increase their satisfaction with, and access to health care,

decrease inappropriate differences in the quality of care provided (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003), and to reduce racial and ethnic health disparities (Brach & Fraser, 2000). The term cultural competence began to appear in the health literature in the 1990s. Although definitions vary, most are variants of that of Cross, Bazron, Dennis, & Isaacs (1989) who define cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable the system, agency, or those professionals to work effectively in cross-cultural situations" (p.17).

The term cultural competence in healthcare has to do with providing culturally and linguistically appropriate care and has evolved as a priority consideration for the industry. There is agreement among most theorists that the demonstration of cultural competence in clinical practice involves performing a cultural assessment that considers the client's cultural beliefs and values related to health care; providing language services through a trained interpreter, when indicated; providing care that is respectful and responsive to the client's cultural values and beliefs; and providing care that is beneficial, safe, and satisfying to the client (Burchum, 2002).

There is empirical evidence to show that when language services are provided, communication between patient and practitioner is improved (Baker, Hayes, & Fortier, 1998). Improved communication results in increased patient satisfaction (Baker et al., 1998), enhanced adherence to treatment, and reduction in misunderstandings ((Beach et al., 2005). Additionally, when there is concordance between the ethnicity of the health care provider and patient, satisfaction and trust among the patients are improved (Cooper & Powe, 2004). Training of staff on the knowledge, skills, and approaches needed for culturally competent care has been shown to enhance caregivers' knowledge, attitudes, and skills, as well as improve client satisfaction and compliance with follow-up care (Beach et al., 2005). Finally, culturally competent health promotion, based on the knowledge of the communities served, has been shown to improve health behavior (Kalichman, Kelly, Hunter, Murphy, & Tyler, 1993). Yet, despite the promise of cultural competence in producing these benefits, its integration into care delivery has not yet been fully realized.

The federal government, in its efforts to reduce long-standing health disparities between minorities and Whites and to address the need to promote culturally competent care, has developed standards for culturally and linguistically appropriate services (Office of Minority Health, 2001). These 14 standards are directed at health care organizations and include provisions for language services, recruitment and retention of staff that is representative of the population served, staff development and training, community involvement, profile of the communities served, and overall organizational competence as defined by the CLAS standards. The standards also represent a framework for further research and HRD efforts. However, while they have existed since 2001, there is no mandate for health care organizations to comply with their requirements.

Barriers to Cultural Competence

Many health care professionals have, for several decades, attempted to respond to the very evident differing beliefs and health behaviors of the various ethnic and cultural groups. The major professional organizations have made cultural competence as well as reducing health disparities a priority. The American Medical Association, the American Nurses Association, and the National Association of Social Workers all have in place policies and standards for cultural competence.

Yet, while health care professionals have been attempting to provide care that is responsive to the needs of patients with differing health beliefs, it is becoming increasingly

apparent that without the support of the organizations in which they work, they will not be successful (McPhatter & Ganaway, 2003). There is general agreement among researchers in the field that health care providers feel ill equipped to handle the challenges of caring for a culturally and ethnically diverse population (Bond, 2001; Kirkham, 1998). The difficulties fall into four major categories: lack of awareness of cultural differences, communication difficulties, ethnocentrism and prejudice, and lack of organizational support.

Health care education continues to lag in producing a labor force prepared to take on the complexities of culture, ethnicity, and race. Flores, Gee and Kastner (2000) found that only 8% of medical schools had a separate course addressing cultural issues. Most medical schools addressed cultural issues in one to three lectures in other clinical courses, inadequate to meet the needs of medical students. Similarly, graduating nurses feel inadequately prepared to care for ethnically and culturally diverse clients (Bond, Kardong-Edgren & Jones, 2001). They cite a lack of knowledge of cultural differences as a major obstacle (Kirkham, 1998). With the lack of preparation in training programs, it is up to health care organizations to address the need for training on cultural competence (McPhatter & Ganaway, 2003).

Lacking awareness of differences, many professionals practice a one-size fits all approach with clients regardless of large group differences (Bond et al., 2001). The results are noncompliance with treatment, low satisfaction among clients (Kaiser Family Foundation, 1999), complications, and poor health outcomes among these groups (Brach & Fraser, 2000).

Due to the linguistic diversity, as well as cultural differences, communication between patients and providers is often hampered (Brach & Fraser, 2000). Nurses have reported difficulties they face in forming relationships with patients who have limited English proficiency (Gerrish, 2001). For physicians, linguistic and cultural differences make diagnosis and treatment more difficult, since obtaining an accurate history is compromised (Brach & Fraser, 2000).

Probably the most troubling barrier health care professionals face is ethnocentrism and prejudice (Sutherland, 2002). Anthropologists claim that every individual is ethnocentric and subconsciously views others with their own cultural customs as the standard for all judgments (Sutherland, 2002). Several studies conducted with health care professionals have revealed such biases and prejudice (Kirkham, 1998; Bond et al., 2001). The presence of bias and racism in medicine was also revealed in a large-scale study conducted by the Institute of Medicine (Smedley, Stith, & Nelson, 2002). A review of over 100 studies revealed that minorities were less likely than Whites to receive needed services, even when insurance and ability to pay for the services were the same. Most of the studies, reviewed by these authors, revealed bias, prejudice, and stereotyping on the part of physicians; this shocked the medical community. Finally, health care providers cite a lack of resources and support from the organization as barriers to delivering culturally competent care (Kirkham, 1998). Specifically, they cited a lack of human resources, handouts and materials for patient education, and a lack of time as obstacles.

Implications for Human Resource Development

The implications for training and organizational development are fairly evident. In order to bolster the ability of health care professionals to deliver culturally competent care, organizations must provide their staff with the necessary knowledge, skills, resources, and support (McPhatter & Ganaway, 2003; Office of Minority Health, 2001). The CLAS standards provide a framework for these organizational interventions, which include providing language services, hiring staff that is reflective of the community, integration of culturally competent behaviors into job descriptions, evaluations, and the incentive program. Health care organizations also need to provide educational materials that are culturally and linguistically

appropriate and factor in the time health care professionals need to address the special needs of these groups. Unless health care organizations respond to these challenges, individual efforts will not be successful (McPhatter & Ganaway, 2003). Herein lies the challenge for HRD professionals: to foster health care organizations' buy-in to commit to the delivery of culturally competent care and support for providers in their efforts at providing such care.

The review of the literature also reveals several implications for practitioners. In order to develop the awareness, knowledge, and skills needed for cultural competence, Taylor (2005) suggests health care professionals pursue training on the need for cultural competence in health care, knowledge on the influence of culture on health, and how to use interpreters effectively. Additionally, knowledge of the governmental standards can strengthen their ability to obtain support from the organization. Finally, there is a need for practice standards and specific behavioral measures of cultural competence in the clinical setting. While many professional organizations have some guidelines in place, most practitioners do not belong to their respective organizations and will not be familiar with the standards. The organization must provide the appropriate training and development activities that would prepare providers to deliver culturally competent care.

References

Ahmann, E. (2002). Developing cultural competence in health care settings. *Pediatric Nursing, 28(2)*, 133-137.

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.

Baker, D. W., Hayes, R., & Fortier, J. P. (1998). Interpreter use and satisfaction with interpersonal aspects of care with Spanish-speaking patients. *Medical Care*, *36(*10), 1461-1470.

Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., et al. (2005). Cultural competence: A systematic review of health care provider educational interventions. *Medical Care, 43*(4), 356-373.

Bond, M. L., Kardong-Edgren, M.S., & Jones, M. E. (2001). Assessment of professional nursing students' knowledge and attitudes about patients of diverse cultures. *Journal of Professional Nursing*, *17*(6), 305-312.

Brach, C., & Fraser, I. (2002). Reducing disparities through culturally competent care: An analysis of the business case. *Quality Management in Health Care, 10*(4), 15-28.

Burchum, J. L. (2002). Cultural competence: An evolutionary perspective. *Nursing Forum*, *37*(4), 5-15.

Cooper, L. A., & Powe, N. R. (2004). *Disparities in patient experiences, health care processes, and outcomes: The role of patient-provider racial, ethnic, and language concordance.* The Commonwealth Fund. Retrieved on December 13, 2004 from: http://www.cmwf.org.

Cross, T. L., Bazron, B. J., Dennis, K. W., & 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.

D'Avanzo, C. E. (1992). Barriers to health care for Vietnamese refugees. *Journal of Professional Nursing, 8*(4), 245-253.

Derose, K. P., & Baker, D. W. (2000). Limited English proficiency and Latinos' use of

physician services. *Medical Care Research and Review*, *57*(1), 76-91.

Flores, G., Gee, D., & Kastner, B. (2000). The teaching of cultural issues in U.S. and Canadian medical schools. *Academic Medicine, 75*(5), 451-455.

Flores, G., & Vega, L. R. (1998). Barriers to health care access for Latino children: A review. *Family Medicine*, *30*(3), 196-205.

Gerrish, K. (2001). The nature and effect of communication difficulties arising from interactions between district nurses and South Asian patients and their carers. *Journal of Advanced Nursing, 33,* 91-99.

Giger, J. N., & Davidhizar, R. (2003). *Transcultural nursing: Assessment and intervention (4th ed.).* St. Louis, MO: Mosby.

Grossman, D. (1994). Enhancing your cultural competence. *American Journal of Nursing, 58*, 60-61.

Helman, C. (2000). *Culture, health and illness* (4th ed). Oxford, England: Butterworth-Heinemann.

Johnson, W. K. (2002). Hmong health beliefs and experiences in the western health care system. *Journal of Transcultural Nursing, 13*(2), 126-132.

Kaiser Family Foundation. (1999). *Race, ethnicity and medical care: A survey of public perceptions and experiences.* Menlo Park, CA: The Henry J. Kaiser Family Foundation.

Kalichman, S. C., Kelly, J. A., Hunter, T. L., Murphy, D. A., & Tyler, R. (1993). Culturally tailored HIV-AIDS risk-reduction messages targeted to African American urban women: impact on risk sensitization and risk reduction. *Journal of Consulting Clinical Psychology, 61,* 291-295.

Kirkham, S. R. (1998). Nurses' descriptions of caring for culturally diverse clients. *Clinical Nursing Research*, *7*(2), 125-146.

McPhatter, A. R., & Ganaway, T. L. (2003). Beyond the rhetoric: Strategies for implementing culturally effective practice with children, families, and communities. *Child Welfare*, *2,* 103-124.

Office of Minority Health, *Standards for Culturally and Linguistically Appropriate Services.* Retrieved June 22, 2000, from: http://www.omhrc.gov/clas

Satcher, D. (2000, May 11). U.S. Public Health Service, Department of Health and Human Service Before the House Commerce Committee: Subcommittee on Health and Environment, Washington, D.C.: U.S. Public Health Service, Department of Health and Human Services.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2002). *Unequal treatment: Confronting racial and ethnic disparities in healthcare*. Washington, DC: National Academy Press.

Stevens, G., & Shi, L. (2002). Effect of managed care on children's relationships with their primary care physicians. *Archives of Pediatric and Adolescent Medicine*, *156,* 369-377.

Sutherland, L. L. (2002). Ethnocentrism in a pluralistic society: A concept analysis. *Journal of Transcultural Nursing, 13*(4), 274-281.

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

U.S. Bureau of the Census. (2000). *Statistical abstract of the United States*. Washington, DC: US Government Printing Office.