CULTURAL COMPETENCE: WHAT EFFECT ON REDUCING HEALTH DISPARITIES?

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The National Center for Cultural Competence (2000) has linked the cultural competence of researchers and practitioners to the elimination of health disparities among various racial/ethnic groups when compared to Anglo groups in the U.S. In addition there are institutional requirements for cultural competence in providing health care and conducting research. Cultural competence may be a needed component of health care and research, but can we really expect individual practitioners and researchers to have sufficient capacity or scope to eliminate or reduce health disparities by becoming culturally competent? Is there not a societal context to the existence of health disparities that cultural competence alone can not address?

These are not new questions. Florence Nightingale’s dilemma during the Crimean War concerned a central problem in public health: What could be done about the unyielding connections among poverty, sickness, and early death (Small, 1998). Nightingale linked the societal conditions of poverty to illness and death and proposed societal options: charity, technology (sanitation), and social change. It has long been recognized that there is a consistent, global relationship between socioeconomic status and health status (World Development Report, 1993). Socioeconomic status operates as a fundamental cause of disease by allowing people with high socioeconomic status to use broadly serviceable resources such as money, power, and knowledge to avoid risks and to minimize the consequences of disease once it occurs (Link & Phelan, 1996). Mann (1998) also recognized the societal context to the taxonomy of health and noted that a lack of resources and power, discrimination, and violations of human rights are primary pathogenic forces in the formation of health disparities. In the context of the AIDS epidemic, Mann and Tarantola (1996) demonstrated that regardless of where and among whom the epidemic began in a given region, the brunt of the epidemic gradually and inexorably turned to those who bear the societal burden of marginalization, stigmatization, discrimination, and poverty.

Unfortunately, the identification of poverty and discrimination as important contextual factors for understanding social vulnerability to
disease does not serve as a guide for effective action to reduce health disparities any more than does requiring cultural competence in health practitioners and researchers. For while the question of what needs to be done can be answered simply—reduce or eliminate poverty and discrimination—the methods for accomplishing this are not clear. What can health workers and researchers do to address the problems of poverty and discrimination? Mann and Tarantola (1996) propose a human rights approach that is carried out at individual, programmatic, and societal levels.

To reduce health disparities, individuals need to deliver culturally competent health care that focuses on risk reduction, vulnerability reduction, and promotion and protection of human rights. This involves not only information, education, diagnosis, testing, intervention, and treatment, but also respect for the human rights and dignity of people who have been socially cast in inferior roles and subordinate status. Social power and status accrue to clients and research participants through the inclusion of significant roles in planning and carrying out health care and research programs (Flaskerud, 2002). We have found that our research must be designed to address the problem of poverty through the provision of economic resources to participants: salary, reimbursement, child care, transportation, and assistance in obtaining health insurance, disability insurance, and drug assistance programs. The provision of resources may be a more significant factor in health care and research than is cultural responsiveness (Flaskerud & Nyamathi, 2000).

Programs and institutions are involved in reducing health disparities by ensuring that health and social services are provided in a non-discriminating atmosphere and there is organizational vigilance toward respect for human rights and dignity among staff, staff and patients, and staff and community (Mann & Tarantola, 1996).

What are the obligations of nursing institutions in this regard? What can the National Institute of Nursing Research (NINR), nursing journals, Schools of Nursing, and nursing practice organizations do to reduce health disparities? There is evidence of positive outcomes when clients and research participants are involved in designing their own research and health care programs (North American Primary Care Research Group, 1998; U.S. Department of Health and Human Services, 2000). NINR can contribute to reducing health disparities by funding more community-based participatory research (CBPR) programs and including study group members who are experts in this area. The Bureau of Health Professions can do likewise in funding community-based participatory (CBP) nurse training programs. Nursing journals can make a contribution by including reviewers who are experts in participatory
methods and publishing the results of CBPR and the clinical outcomes of CBP nurse training programs. Schools of Nursing can teach participatory methods as part of their research and clinical practice courses. Schools of Nursing can be instrumental in ensuring that the curriculum is well grounded in the concept of culture as the unit of analysis rather than the individual. Schools of Nursing also have a moral and ethical responsibility to recruit more ethnic and racial minorities into nursing. There is a practical side as well to producing a culturally diverse workforce: Many minority health professionals return to their home communities to provide service and thereby provide more access to health care for underserved populations (Rabinowitz et al., 2000; Saha et al., 1999).

Governments and societies have a major role in ensuring human rights through policies of non-discrimination and vigilance toward enforcing these policies. Governments also must recognize the societal vulnerability to disease from a human rights perspective and implement programs that address this view. This will not happen without our involvement as active citizens in forming and overseeing these governments.

REFERENCES


