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Book Review

Diversity and Cultural Competence in Healthcare: A Systems Approach

Janice L. Dreachslin, M. Jean Gilbert, Beverly Malone California: JOSSEY-BASS A Wiley Imprint Publishing, 2002, 480 pages

Sunmi Kim
Health Insurance Review and Assessment, South Korea

Diversity and Cultural Competence in Healthcare: A Systems Approach offers readers the chance to learn how to establish a culturally competent health system using the U.S.'s historical background. It also emphasizes the importance of this diversity issue to students. It contains both principles and practice and is structured to explain and confirm concepts with learning objectives, summaries, key terms, and learning activities. Korea also should construct a culturally competent system due to increases in foreign patients. This book is of excellent help for policymakers, organization managers of medical institutions, health care professionals, and students who want to learn to reduce the disparity between diverse cultures using culturally competent care delivery.

> "Healthcare Disparities in the United States—A critical diversity issue confronting health care institutions throughout the United States is that of seemingly intractable disparities in health access and status across population groups" (p. 20).

American society has undergone a long period of change with various ethnic groups. Not all races were originally treated equally. Black people were forced to engage in agriculture in the south to meet labor demands. Chinese and Mexican immigrants constructed railways. After such demand ended, restrictions were established such as the Chinese

Exclusion Act (1882), which prevented Chinese immigration after demand disappeared. Afterward, in the early 1800s and early 1900s, many Europeans from the south and east migrated for factory work, even low-skilled labor. Additional legislation prevented migration from the eastern hemisphere—the emergency Quota Act (1921). Since then, immigration shrank significantly before and after the Great Depression and World War II.

The Immigration and Nationality Act 1952 made it possible for more Europeans to immigrate. Under the influence of these policies, this generation was homogeneous and for 20 years after World War II, the American population was mainly composed of white people. This homogeneity led to little consideration of health care's diverse needs, and Black people were demoted to quarantine or Black facilities.

Due to radical policy changes, the Hart-Celler Immigration Act (1965) was implemented, and the quota for labor demand disappeared. Immigration from Europe to Latin America and Asia changed. Many undocumented immigrants came from Mexico and Central America, several of whom were pardoned in 1986 through immigration reform and control legislation.

Since the Vietnam War in 1975, immigrants from Southeast Asia, such as Hmong, Mien, and Vietnamese, have been allowed to enter. People from Afghanistan, Pakistan, Iran, Somalia, and other countries that faced destruction from the war sought asylum and settled in the U.S. Due to push-and-pull policies, the national population became more ethnically, religiously, and linguistically diverse.

Culturally and linguistically diverse patients wanted to experience hospitals and clinics similar to those in their own countries. However, health care organizations and staff were amazed, unprepared, and skeptical about the need to provide better services to the diverse patient population. Additionally, the gap in health status among racial groups was severe. These situations arose in the early 1990s, and cultural competence movements began in the health care sector, with a national policy aimed at reducing significant differences in access and treatment in health

care organizations, because these racial and ethnic health differences were first apparent within the health care sector.

Differences in the healthcare field are studied across the health system in terms of accessibility, prevention, treatment, health literacy, and health outcomes. Discrepancies between racial and ethnic groups are strongly related to socioeconomic differences, and such tendencies diminish when controlling for these variables. However, the authors suggest that reducing such disparities will ultimately depend on whether the linguistic and cultural competencies are managed systematically by healthcare policies, delivery systems, organizations, and clinicians.

> "Reduction of disparities will ultimately depend on the cultural and linguistic competencies of health care policies, delivery systems, organizations, and practitioners systematically organized" (p. 21).

Many studies show that cultural competency can reduce the disparity between cultures and increase healthcare access, and this book supports that opinion. In a cultural familiarity study, people with low scores tended to show discriminatory behavior or language in interactions. The broadening of awareness, attitudes, and knowledge could eradicate nationalism, racism, and unequal relationships. A study conducted by the Institute of Medicine (IOM), "Unequal Treatment: Racial and Cultural Inequality in Health Care," refers to the possibility that doctors are unfamiliar with other cultures and may provide improper care.

Providers, institutions, organizations, and governmental bodies aim to provide equal service without discrimination toward people of diverse cultures by building a systematically culturally competent system. The U.S. has reduced cultural barriers, educated students and staff to be culturally competent, recruited teams to represent minorities, and provided interpreters at the organizational level.

In Chapter 4, the authors explain national and international standards as a foundation for structuring cultural competence in health care. The

Joint Commission (JCI) considers that providing appropriate cultural and linguistic healthcare services is vital for quality and safety issues, so it is included in the institutional certification evaluation item. The National Commission on Quality Assurance (NCQA) also emphasizes cultural competencies in a program called Innovative Practices in Multicultural Health and has developed and distributed 45 reportable skills required to provide safe and culturally responsive services. IOM, the Institute of Health and Medical Sciences, is a CLAS standard and has established standards for cultural and linguistic health organizations to provide appropriate services.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (chapter 4, p. 127)
The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in cultur-

ally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals with limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally, and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. Engagement, Continuous Improvement, and Accountability:
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic

appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Having cultural competency in the health care field means providing services to patients with diverse values, beliefs, and behaviors to meet their social, cultural, and linguistic needs. A culturally competent health care system recognizes the importance of culture, evaluates and integrates intercultural relationships, and recognizes the potential impact of cultural differences. It also expands and retains cultural knowledge and coordinates services to meet unique cultural needs. Ultimately, national and racial imbalances can be reduced by educating health professionals and organizations.

Cultural competencies include awareness, attitudes, knowledge, and skills. Regarding awareness, one must evaluate and recognize oneself, be aware of the dynamics in which culture communicates with other cultures, and be able to objectively judge whether he/she is biased or looks at others with prejudice. Knowledge refers to learning about their characteristics, equipping them with a variety of cultural experiences, and learning about health-related beliefs, cultural values, prevalence, and incidence of diseases in each culture. Skills refer to collecting information about a patient's problem/situation while understanding cultural diversity (race, ethnicity, age, gender, religion, sexual orientation). Healthcare professionals with cultural competence should ensure that they can deliver optimal service to the patient's culture and situation with this awareness, attitude, knowledge, and skills.

I believe that efforts must be made to respond to the increasing number of foreign residents and visitors. In particular, in the healthcare

field, as the care delivery model changes from a disease-oriented to a patient-centered model, communication with patients becomes more critical. Prevention is emphasized rather than treatment, leading to chronic diseases and lifestyle-related diseases. With these changes, personalized diagnoses considering individual characteristics and dietary habits are essential, and communication for patient-specific prescriptions also important. Furthermore, epidemics such as SARS, MERS, and Covid-19 have increased the importance of awareness of other cultures. However, compared to the U.S., Korea's foundation is weak in managing diversity. Therefore, this book can give us substantial insight to inspect our society in more detail, and we can benchmark their system.

Biographical Note

Sunmi Kim (Ph.D. in Public Health, Occupational Therapist), Researcher of the Health Insurance Review and Assessment in Korea. She has published on the stress of nurses caring for foreign patients, determinants of healthcare utilization in Uganda, regional distributional characteristics of orthopedics and rehabilitation clinics in Korea, information needs and satisfaction of medical tourists, and the healthcare system of North Korea. E-mail: kimssmi@gmail.com