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CULTURAL RELATIVISM IN HEALTH CARE: BRIDGING GLOBAL HEALTH DISPARITIES FOR MINORITIES AND THE UNDERSERVED

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Abstract

As the world moves towards a patient-centered health care delivery system the need to address culture-responsive health care in an effort to bridge health disparities for minorities and the underserved is paramount. Global ethnocentric health care models require framework revisions that forward cultural relativism. Cultural relative models include health care providers understanding how race, ethnicity, sociocultural, and socio-economic influences impact health education and health care. Expanding health care equity to minorities 'the underserved' will increase profits, expand providers' client base, bridge health care disparities, and demonstrate social responsibility.

Keywords: *Culture-responsive health, health disparities for minorities and the underserved*

1. Introduction

“Leading health care professionals speak of a new awareness of which they are being called on to perform tasks for which they have not been educated, and the niche no longer fits the education, or the education no longer fits the niche resists” (Schon, 1983). It is plausible that traditional management, policies, and practices once used to govern health care systems have become obsolete (Schon, 1983). Physicians, health care administrators, and policy makers attempting to respond to the changing roles of health care may be met with bureaucratic delays which further perpetuate health care disparities, minority health care equity, cultural-specific health education, and access to quality care. The role of the physician, as well as other health care providers will be continually reshaped by the reorganization and rationalization of medical care (Schon, 1983).

Health care is being reshaped by the need of cultural-responsive care, the reduction of readmission rates, and health care reimbursement cuts. Policy makers, providers, physicians, researchers, and health care administrators who have extensive cultural and diversity understanding will practice cultural relative health care for minorities. Providers, networks, and health organizations will benefit by expanding their client base, increased profits, healthy communities, and demonstrating social responsibility.

Cultural relative health care models will reduce readmission rates, decrease patient costs, and improve patient adherence rates. In addition, cultural relative health care will decrease disparities in minority health. Research shows social and economic factors directly impact health (Morales, 2002). Identifying under-serviced needs requires research specific to atypical conditions of subpopulations which extend from race and ethnicity to include social and economic influences. Socioeconomic influences include income, education, marital status, rural and urban dwellings, and employment (Hosseinpoor, 2012). Minorities include immigrants, racial, ethnic, religious, or social subdivision of a society that is subordinate to the dominant group (Dictionary.com, 2010).

2. Demographical Data Collection Systems

Global differences in demographical data collection underestimates the minority population size and geographical distributions of groups. The lack of global unity in demographical data collection could be one factor perpetuating global disparities in minority health care and equity. The demographical data collection systems from The United States, Israel, and Europe will be discussed to highlight variances.

Demographical Data Collection System Used in America

The United States federal guidance requires a minimum of five categories for data collection on race since the revision for the 2000 Census (Executive Office of the President, Office of Management and Budget (OMB), Office of Information and Regulatory Affairs, 1997). The five minimum categories are American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. There are two categories for ethnicity, "Hispanic or Latino" or "Not Hispanic or Latino" (Executive Office of the President, Office of Management and Budget (OMB), Office of Information and Regulatory Affairs, 1997).

Demographical Data Collection System Used in Israel

Israel has implemented a dissimilar demographical data collection method. Israel collects demographic data by religion and population group (CBS, Stastical Abstract of Israel 2010, 2010). Population groups include Jewish, Arabs and Others. "Arabs" includes Muslims, Arab Christians and Druze. "Others" includes non-Arab Christians, and other minority religions not currently being collected by the Ministry of the Interior (CBS, Stastical Abstract of Israel 2010, 2010). Groupings by religion include: Jewish, Muslims, Christians, Druze, Others (CBS, Stastical Abstract of Israel 2010, 2010). The difference between population and religion groupings are the inclusion of religion by Arab race. Jewish Israelis are Jewish as a race and a religion (Jewish Virtual Library, 2016).

Demographical Data Collection System Used in Europe

The European Commission collects population data utilizing a variety of characteristics. These characteristics include marital status, citizenship and country of birth (European Commission, N.D.). The methodology used by the European Commission to collect the data requires EU Member States' National Statistical Institutes and almost all non-EU member states to provide demographical data to Eurostat several times a year (European Commission, N.D.).

Analysis of Demographical Data Collection Systems

Variances in global demographic classification systems may perpetuate health access and equity gaps by fragmenting health care providers and institutions ability to identify the demographics of those most commonly requesting services. Universal framework unifying data collection in health care which includes an expanded race, ethnicity category and incorporating patients' primary language and socio-economic factors could improve research, delivery of care, and accurately identify health disparities while cultivating solutions (Smedley, Stith, & Nelson, 2002). Revising data collection systems to a more expansive and relative model, improving data analytics, transparent reporting, and oversight may require a multidisciplinary collaborative approach.

3. Minority Health Disparities and Cost Impacts

Providers uncertainty on a patient's condition is relative to disparities in treatment (Smedley, Stith, & Nelson, 2002). Misdiagnosis, patient/provider trust concerns, and quality language access, could be contributing factors to readmission rates, lack of patient adherence, and poor follow-up care. Providers' unconscious biases could unknowingly prevent quality care (Blair, Steiner, & &, 2011). In addition, institutional self-governance may allow for bias policies which inadvertently perpetuate disparities in minority care. Implicit bias may also be found within the insurance provider industry and with policy makers (The Henry J. Kaiser Family Foundation, 2008). However, identifying and understanding insurance provider and policy makers' biases requires additional research and is beyond the scope of this paper. Understanding provider and institution biases allows for interventions and education which could dispel barriers, create policies and practices that mirror institutional mission statements, improve access to quality care, reduce readmission rates, and increase patient adherence to treatment plans.

4. The Global Role in Advancing Minority Health Care

Health care administrators, policy makers, and providers who voluntarily opt to collect and utilize ethnic, racial, and socio-economic demographical data to identify patient populations served, could share the findings, to facilitate cultural relative training, encourage research and benefits of ethno/racial medical biomarkers, and reduce stereotypes and prejudice which may influence quality care for minorities (Smedley, Stith, & Nelson, 2002).

Inclusive health care requires comprehensive revisions to existing framework and could significantly benefit from international collaborations. Practicing a stakeholder approach to identify sustainable solutions to complex issues in health care could lead to significant developments in reducing disparities for minority health care and quality health care access.

5. Conclusion

Eliminating minority health care disparities is of global importance. While research identifying minority health disparities is continuing, there are several opportunities to advance equity utilizing the information currently available. Providers, researchers, and policy makers who are aware of personal biases are less likely to be influenced by them, more likely to overcome them, and provide quality care (Ross, 2008). Implementing global framework on race, ethnicity and socio-culture data collection systems, allows for vast comprehensive application and delivery of quality care for minorities. In addition, accurately identifying minorities fosters ethno/racial-specific research, medical biomarkers, and patient-specific health trajectories (Mersha & Abebe, 2015). Furthermore, identifying geographical locations of minorities provides opportunities to address issues related to access. Providers and health care delivery institutions who utilize cultural relative health care models will benefit through financial rewards. Reducing readmission rates, increasing patient adherence to medical plans, and improved follow-up care is financially beneficial for all stakeholders.

Meeting the needs of the global minority population is a global community effort. Focusing on low investment goals, small wins, and shared equity will promote the development of a cultural responsive health care model. Controlled rollouts with systematic implementation will promote adaptation compliance and cost efficiency.

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