

Cultural Competency

By Moon Chen, Jr., PhD, MPH, Chair, Division of Health Behavior and Health Promotion
College of Medicine and Public Health, Ohio State University
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Cultural competence has three components: purpose, attitude, and skills. The purpose of cultural competence is to achieve improved health outcomes. Attitude is the willingness to adapt oneself to others' needs. And skills are those competencies or behaviors that exemplify correctness of technique in interactions between the professional and the patient.

Minority health professionals are individuals most likely to be the impetus to empower their own communities for health improvement. Hence, increasing the number of trained minority health professionals is one strategy that must be pursued. They are the ones most likely the racial and ethnic communities who need to be targeted because of their disparate health status.

In analyzing the empowerment of ethnic minorities in human service organizations, L.M. Gutierrez discusses appreciating and understanding diversity of minority clients, rather than just considering their human service needs. She outlined the following steps for ethnic sensitive services: 1) Developing access to services such as hiring bilingual and bicultural staff members; 2) Tailoring interventions through learning another culture; 3) Modifying services such as integrating traditional medicine with Western medicine; 4) Initiating an appropriate organization development model and a specialized program model such as initiating a Native Hawaiian health care system. Another model by Arthur Himmelman discusses empowerment in a continuum of collaboration strategies. He indicates that this continuum is differentiated by the degree to which time, trust, and turf can be overcome.

Networking, the first stage, is defined as exchanging information for mutual benefit. While networking reflects initial trust, commitments of time and turf are limited. The next stage is coordinating, and results in exchanging information and altering activities to achieve a common purpose. Mutual investments of time, trust, and turf shar-

ing are increased. Cooperating is the third stage, and requires greater organizational commitments than either networking or coordinating. The final stage is collaborating.

Dr. Pui-Ling Li, a U.K. workshop presenter, illustrated how she had empowered the Chinese community in London. First, she compiled demographic data on the Chinese population in the U.K. From an analyses of that data, she discovered that the largest group was age 20-44 and that nearly 30 percent of that group is born in the U.K. She also discovered that nearly all older people born outside of the U.K. don't speak English and that 25 percent of the older group had an education beyond the primary school level.

The majority of Chinese people in the U.K. work in the food catering trade. Dr. Li documented that access to health care meant taking into account work schedules of 12 or more hours per week each day. She founded the London Chinese Health Resource Center in London's Chinatown as a means of empowering the Chinese community to meet its needs. The center not only provides linguistically and culturally competent health services, but also English lessons. The center has become an identifiable organization and creates a focus for coordinating Chinese health care. It is rooted in community and is forming an infrastructure to influence district and national levels of health policy.

Both the U.S. and the U.K. are nations of immigrants and are increasingly becoming more demographically diverse. Based upon the 1990 Census, the only original inhabitants of the U.S., American Indians and Alaska Natives, made up approximately one percent of the population. It is clear that at the individual and social levels in both the U.S. and the U.K., overcoming linguistic and cultural barriers is fundamental. As the population becomes increasingly diverse, these issue of empowerment will become even more complex. ❖

