ACTA SCIENTIFIC PAEDIATRICS (ISSN: 2581-883X)

Volume 2 Issue 11 November 2019

Editorial

Healthcare Needs to Diversify for the Sake of its Patients

Olusimbo Ige*

Global Health Department, General Board of Global Ministries, Altanta, Georgia, USA

***Corresponding Author:** Olusimbo Ige, Global Health Department, General Board of Global Ministries, Altanta, Georgia, USA.

Received: September 20, 2019; **Published:** October 01, 2019

In many countries around the world, the health workforce is tasked with caring for an extremely diverse array of patients with varying cultural, gender, racial, religion, and socio-economic realities. However, when we look at healthcare teams, whether they are dentists, nurses, pharmacists, or physicians we do not see the same diversity as the patient population served. In the United States of America for example, a disproportionately large percentage of the physicians and surgeons are white males. Racial and ethnic minorities are less represented with blacks making up less than five percent of the physicians and Hispanic and Native American populations even less [1]. In addition, the greater majority of medical students and doctors come from affluent, higher socioeconomic status backgrounds [2]. In Europe, diversity has increased with many large cities becoming home to increasing populations of immigrants. Evidence demonstrates that these migrants, faith and minority ethnic groups face a number of barriers when accessing healthcare [2]. Considering the new complexity of diversity within cities, a deeper and multi-faceted understanding of everyday health practices in these contexts is needed to support appropriate healthcare provision [2]. Currently, one-fifth of the population in Germany is considered to be of immigrant origin [3]. Without an understanding of the culture and religion and other diversity dimensions, such as sex and socioeconomic status, health care needs of such populations are likely to remain unmet. Eventually, this will pose challenges to both national and local welfare [4,5]. The predicament of health profession diversity is not limited to North America or Europe, it manifests in other world regions where there are unresolved socio-cultural or religious divisions. Asia is also in the midst of a demographic shift with unprecedented ethnic, racial and cultural diversity [6]. In light of these changes, health care services need to be positioned to respond and serve their increasingly multicultural populations.

Diversity is a fluid concept that is not easy to define because it evolves with changing ideologies and societal dynamics. Traditionally, diversity referred to people of different racial or ethnic backgrounds, gender is also often included in the diversity debate. Currently, the definition of diversity encompasses many characteristics, including but not limited to age, education, culture, heritage, religion, physical abilities, socio-economic status, life experiences, and lifestyle choices [7]. There are several reasons for more diversified health professions. First is the civil rights angle which justifies using diversity to redress the lack of equal opportunity for underrepresented population groups. The public health case is that workforce diversity is a way to eliminate health disparities. This argument is based on literature demonstrating that racial, ethnic, and linguistic diversity among health professionals is associated with better access to and quality of care for disadvantaged populations [8]. From the educational point of view, there is evidence that college students of all ethnicities perform better on several measures of intellectual and civic development when there is racial and ethnic diversity among the student body [9]. The business case is that customer service and competitive advantage are improved when there is a workforce that is culturally and linguistically attuned to their consumers [10]. Within healthcare, a diverse workforce or lack thereof has lasting effects on quality of care and patient-oriented care delivery.

Healthcare professionals are required to personalize care, this means they need to acknowledge and recognize the differences in patients' socio-cultural characteristics during care delivery. A workforce with little or no diversity is limited in its capabilities to connect with their patients. When there is no diversity, the same lens and set of values are often used for all patients. On the other hand, when there is a diverse pool of workers there can be unique

perspectives from different cultures and backgrounds to share with colleagues and patients. This helps improve patient care and helps practitioners to be more understanding and responsive to their patients' needs. The health team needs to be diverse simply because patients are diverse, if we understand our patients' belief systems and values, we will be able to provide better care for them. The more diverse the people are who provide medical care, the better they can be in respectfully and knowledgeably assisting their patients [11].

Attitudes toward health care and treatment can vary among different populations. When a patient cannot find providers that resemble them in their beliefs, their culture, or other facets of their life, it may delay or prevent them from seeking care [2]. This preference is evident in the fact that patients are more likely to choose a physician of similar background when given an option. Increasing diversity in health care also makes it more accessible to underserved patients. Health disparities have been linked to many different causes, including language and cultural barriers, which results in underserved communities not seeking proper care for their ailments [12]. Inadequate access to health care services has remained a major problem within minority populations [13].

There are real differences in the way people experience illness, adhere to medical advice and respond to treatment. These differences tend to influence the outcomes of care. In recognition of this, some health care systems are providing cultural competence education to ensure that providers have a firm understanding of how and why cultural factors influence their patients. This has led to cultural competence education being used as a strategy in high-income English-speaking countries to respond to the health disparities and poorer health outcomes among people from culturally diverse backgrounds. However, there is still a paucity of evidence to link cultural competence education with patient, professional and organisational outcomes. The low quality of available literature makes it difficult to conclude on the impact of these trainings on patient outcomes [14,15].

Cultural competence cannot be acquired by just reading textbooks and listening to lectures, health care professionals need to interact with individuals from a variety of racial and ethnic backgrounds that mirror the patient population they will serve. Diversity in health care needs to start at the beginning of the educational pipeline. Learning alongside individuals from a variety of racial and ethnic backgrounds leads to broadened perspectives of racial, ethnic and cultural similarities and differences. This requires that educational institutions ensure adequate representation of students from various backgrounds during the admission process and make efforts to emphasize diversity and inclusion at every stage of training. This will lead to a future generation of medical professionals with the perspectives, aptitudes, and skills needed to provide responsive health services [11]. This boils down to decisions about which people have the opportunity to enter professions that bring prestige, influence, and high incomes and how we are responding to the long-standing and fundamental social inequities in the populations we serve.

Since the divide between diversity in the healthcare workforce and the populations they serve has persisted [16], we need to continue to reiterate that healthcare needs to diversify for the sake of its patients. Institutional ability to meaningfully address diversity and inclusion depends on effective leadership and commitment. As race, ethnicity, religion and other differences become more important to patient care and outcomes of care in diverse populations, some healthcare systems have begun producing guides to raise awareness among healthcare professionals. Some hospitals are implementing additional non-medical services, such as the provision of specific types of food and clothes to patients or the hiring of chaplains, to accommodate the needs of patients with different religious requirements [3,16]. While these are useful steps, diversity is about providing the best possible care for a variety of patients by recruiting a variety of providers. The American Academy of Pediatrics (AAP) has recognized that the health of all children depends on the ability of pediatricians to practice culturally effective care. The AAP recommends that 4 domains need to be addressed: workforce diversity, cultural competency, leadership diversity, and the development of a knowledge base regarding diverse populations [17]. Addressing one of these domains without the others will not produce the desired results. At all levels and across world regions concerted and sustained efforts are necessary to overcome the educational, organizational, and other barriers that limit disadvantaged populations from joining the health workforce [15,18].

As the discussion of diversity becomes broadened to include not only race, ethnicity, and language but also cultural attributes such as gender, religious beliefs, lifestyle, disability and other factors which may affect health, I envision a future where patients would be able to choose from a wide assortment of male and fe-

male doctors who have different colors, religions, nationalities, specialties, and even sexual orientations. And at the end of the day, it's about providing the best possible care for all patients. Representation is what puts patients at ease.

Bibliography

1. US Census Bureau. Tables for EEO Tabulation 2006-2010 (5-year ACS data) (2017).

2. Phillimore J., *et al*. "Understanding healthcare practices in superdiverse neighbourhoods and developing the concept of welfare bricolage: Protocol of a cross-national mixed-methods study". *BMC International Health and Human Rights* 15 (2015): 16.

3. Jhutti-Johal J. "Understanding and coping with diversity in healthcare". *Health Care Anal HCA* 21 (2013): 259-270.

4. Brzoska P., *et al*. "Considering diversity in nursing and palliative care - the example of migrants". *Z Gerontol Geriatr.* 51 (2018): 636-641.

5. Nørredam M. "Are we prepared to handle cultural diversity in the Danish healthcare system?". *Ugeskrift for Læger* 178 (2016): V67698.

6. Chongsuvivatwong V., *et al*. "Health and health-care systems in southeast Asia: diversity and transitions". *The Lancet* 377 (2011): 429-437.

7. The new look of diversity in healthcare: Where we are and where we're headed.

8. Saha S., *et al*. "The rationale for diversity in the health professions: a review of the evidence". Hyattsville, Md.: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions (2006).

9. Gurin P., *et al*. "Diversity and Higher Education: Theory and Impact on Educational Outcomes". *The Harvard Educational Review* 72 (2002): 330-366.

10. Grumbach K and Mendoza R. "Disparities In Human Resources: Addressing The Lack Of Diversity In The Health Professions". *Health Affairs* (Millwood). 27 (2008): 413-422.

11. Nivet MA and Berlin A. "Workforce diversity and community-responsive health-care institutions". *Public Health Reports* 129 (2014): 15-18.

12. Stewart SM., *et al*. "Treatment of culturally diverse children and adolescents with depression". *Journal of Child and Adolescent Psychopharmacology* 22 (2012): 72-79.

13. Cohen JJ., *et al*. "The Case For Diversity In The Health Care Workforce". *Health Affairs (Millwood).* 21 (2002): 90-102.

14. Horvat L., *et al*. "Cultural competence education for health professionals". *Cochrane Database System Reviews* (2014): CD009405.

15. Butler M., *et al*. "Improving Cultural Competence to Reduce Health Disparities". Rockville (MD): Agency for Healthcare Research and Quality (US) (2016).

16. Alegría M., *et al*. "The time is now: tackling racial and ethnic disparities in mental and behavioral health services in Massachusetts". *Issue Brief Mass Health Policy Forum* (2014): 1-53.

17. Jenkins RR. "Diversity and Inclusion: Strategies to Improve Pediatrics and Pediatric Health Care Delivery". *Pediatrics* 133 (2014): 327-330.

18. Committee on pediatric workforce. "Enhancing pediatric workforce diversity and providing culturally effective pediatric care: implications for practice, education, and policy making". *Pediatrics* 132 (2013): e1105-1116.

Volume 2 Issue 11 November 2019