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Topic : Cultural Sensitive Health Care*

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Summary

- The potential of health care services and health care reality show a considerable miss-match
- A major reason of the miss-match is a lack off reflection of social and cultural preferences, values and behaviour of patients as well as their families and relatives
- A systematic Integration of cultural sensitiveness into health care can considerably improve the quality and effectiveness of care
- The European qualification framework (EQF) provides an appropriate context to develop respective education and qualification concepts that currently are developed

* Draft English version without references

1. Potentials and Limits of Health Care

Medical and technological innovations have contributed to an increase in the quality of life as well as economic growth without doubt. Infant mortality has decreased and life expectancy has increased during the last decades. Many diseases like heart disease or cancer can be treated well today and further substantial advances are expected especially from bio molecular research in the next years. Most people treated in hospitals can be released successfully and the death rate in German hospitals for example equals only about 2 percent. At the same time employment in the health care sector has increased considerably. In Germany the employment in the health care sector has reached at 4.6 Mio. almost six times as many as in the automobile sector. The WHO estimates a world wide shortage of health care professionals of 2.4 Mio., indicating that education and training in the health care sector is a large and growing market.

The improvements in health care have especially been made possible by high efforts in research about innovative treatments and new medical products. The clinical trials database of the American NIH registered about 70.000 clinical trials in more than 160 countries in spring of 2009. New opportunities of treatment are tested in these clinical trials. The evidence of advancements and security of new treatments have to be proven in these trials prior to their approval for clinical practice.

Despite the undeniable advancements and high efforts in research questions about the benefit for patients have to be raised however. A recently published study on diabetes including more than 4.000 patients in Germany shows that only a minority of patients have been treated successfully. Success has even decreased between 2002 and 2007. Whereas 43 percent of patients had an appropriate blood glucoses level in 2002 the share dropped to 37 percent until 2007. Almost all patients suffered from hypertension, high cholesterol, obesity, lack of activity and others failing most of the intended targets of therapy.

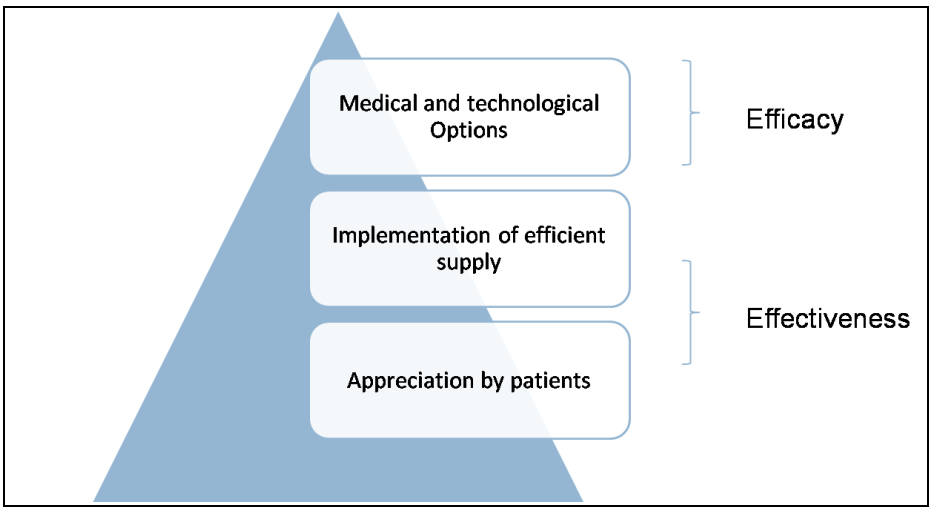
The example of diabetes is no exception. Of more than 200.000 stroke patients in Germany two thirds showed co morbidity of hypertension, 28 percent had diabetes, 27 percent atrial fibrillation and 17 percent coronary heart diseases. Effective treatments for these risk factors of stroke are available but do not seem to be applied sufficiently. Although there exist well elaborated guidelines and clinical pathways for the treatment of these risk factors the treatment potentials and the treatment reality differ considerably. International studies show comparable results for many diseases in other countries.

The gap between treatment potentials and treatment reality may have multiple reasons. The controlled situation in clinical trials with selected patients, sophisticated designs and highly qualified staff may not meet the reality in every day life. In addition the dissemination of new treatment approaches may take a long time until it reaches all patients. The coordination and communication of different suppliers of health care may be insufficient causing inconsistence in the treatment process. And the patients may behave different as expected from a scientific medical perspective. The effectiveness of the treatment therefore does not only depend on the scientific potentials but also on the implementation of treatment under real life conditions as well as the values behaviour of patients.

The appropriateness of health care therefore includes more than the scientific potential. It also has to include the dissemination and implementation processes of treatment opportunities as well as values and preferences of patients. Whereas much effort and resources are spend for clinical research and the development of new products and treatment procedures there is comparably

little research on their dissemination and preferences and appreciation by the patients. Further questions therefore will have to address the appropriateness of health care that includes the efficacy as well as the effectiveness of treatment and its implementation as well as the appreciation by patients.

Fig. 1: Appropriateness of Health Care



The implementation of innovations in health care depends on the organisation of different health care systems, the education and further training activities (life long learning) and the incentives for health care professionals. The appreciation by patients and their relatives depends to a large extend on the accessibility and acceptance of health care supply. Especially the socio-cultural values and preferences of patients need more attention in the design of health care and health care systems. This individual perspective has to be integrated into research as well as education and further training programs in order to increase the appropriateness of a supply oriented health care.

2. Intercultural Differences in Health Care

Differences in health care outcome become especially obvious in the case of the migrant population. Although there have been quite some efforts to consider specific needs and problems of this group systematic inclusion into the health care system still lacks effectiveness. Barriers to the access of the health care system still exist due to language and communication problems, cultural differences in the perception of health and diseases, a lack of health care professionals with own migrant background or a lack of activating concepts. Especially socio-cultural differences in the values, preferences and behaviours are not considered sufficiently in the case of migrant population. These differences are especially distinct in this case but can be observed in other populations as well.

Meanwhile the share of population with migrant background in Germany amounts to up to 20 percent. In comparison to the over all population they show a considerable lack in the state of health. This is especially the case in urban areas and among the population with socially disadvantaged status. Although there still are quite some empirical deficits some indicators may illustrate the poor health status of migrant population in all age groups.

- In migrant population infant mortallity exceeds with 11.1 per 1000 the German population with 4.6 per 1000 considerably.
- Obesity at the time of school enrolment is almost twice as high in the population with migrant background compared to German kids.
- The share of people with diabetes is almost twice as high in the migrant population.
- The participation of people with migrant background in rehabilitation or professional geriatric care is marginal compared to the German population.

Especially limited access to health care seems to be one reason for these differences. Participation in pre natal prevention is less among the migrant population, the acknowledgement of health hazards is less developed, the importance of mobility and nutrition are valued differently, health campaigns e.g. in case of stroke prevention do not reach the migrant population appropriately and there exist cultural barriers in the participation of health and geriatric care. Reasons for the limited access to health care are not so much problems of information but problems in mutual acceptance between supply and demand and the customisation of the supply.

Numerous projects and campaigns try to address the limited access of migration population to health care for example by including health care professionals with migrant background into the supply or by providing native language information. These measures improve communication but do not change the supply itself. In order to address the patients as customers it is rather necessary to adapt the supply to their preferences and values. This is not only the case in migrant population with heterogeneous preferences and values among themselves but as well for different preferences and values among the native population which are not necessarily oriented at scientific professional medical standards.

3. Approaches to Cultural sensitive Health Care

The focus of cultural sensitive health care therefore has to be the orientation at the elementary preferences of the target group. In the case of geriatric care a concept of “daily physical and psychological needs of individuals under consideration of cultural differences” has been implemented into the planning and process of health care. This concept has been applied in the education of formerly unemployed youth with Turkish migration background in a pilot project in the city of Gelsenkirchen, Germany.

The evaluation of the project showed that a consequent orientation at the elementary preferences of the patients in combination with professional standards of geriatric care and the systematic consideration of psychological and physiological dimensions does not only increase the acceptance and compliance by the patients. This orientation also increased the satisfaction of involved health care professionals as well as the performance and effectiveness of the participating health care institutions. The essential difference of the approach to other concepts of health care has been the systematical consideration and acceptance of different preferences and values of patients in education and health services. The tension between scientifically based professional standards of health care and the also scientifically based analysis of differences in the preferences of the target group can not be resolved in favour of one side or the other but has to be integrated into the health care processes systematically.

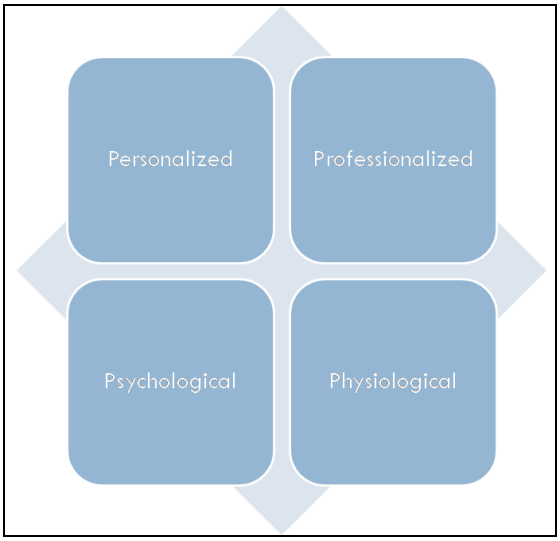
This approach is not only favourable for the population with migrant background but as well for native patients and the health care institutions. The differences in social and cultural preferences

are not only based on heritage but are the result of a complex socialisation of patients as well as health care professionals. Institutionally the integration of differences of elementary preferences into the processes of health care reduces conflicts and frictions and increases staff and customer satisfaction. This also improves the profitability of the health care institutions.

In general this approach is transferable to all levels of health care starting with prevention programs, the acute care situation, rehabilitation and geriatric care. It reflects the constitutional principles of personal services were the provider and the customers have to cooperate and match the professional standards of the provider and the individual expectations and preferences of the customer. Therefore the individualisation of planning and implementation of health care processes based on social and cultural differences of preferences and values is an essential element for the effectiveness of health care which reaches far beyond the employment of staff with different social and cultural background.

Core requirement of this approach is the integration of individual and professional as well as of psychological and physiological dimensions under consideration of individual differences into the guidelines and pathways of health care. All four dimensions require sound and systematically founded concepts that are not isolated from each other but harmonised and interrelated. This leads to a quasi “magical square” for the design of cultural sensitive health care that has to be considered in education, planning and implementation.

„Magical Square“ of cultural sensitive Health Care



Personalization and professionalization can be differentiated according to their fundamental orientation at individual preferences on the one side and professional standards on the other. Especially the personalization of health care needs a much more fundamental foundation than up to now. The orientation at individual lifestyles, the consideration of social milieus and institutional settings takes concepts of socialisation of the patients into account. These are complemented by aspects of cultural heritage and religious and other values which interact among each other and influence the individual potentials, preferences and behaviour considerably. Lifestyles reflect individual conditioning of behaviour. They influence factors like nutrition or activity, consumer preferences and the organisation of leisure time and have considerable influence on health be-

haviour. This behaviour can not simply be changed on request but has to be integrated into the design of health care. The milieus additionally consider influences of social groups on preferences and behaviour and intensify lifestyles. Settings complement these values by institutional conditions including influences by kindergarten, schools, workplace, health care institutions, local or regional conditions and influence preferences and behaviour as well as circumstances in which patients act considerably.

Differences also result from heritage and religious values which are especially significant in the migration population. They have considerable influence on the way people deal with diseases and death. This results in differences of the expectations and appreciation of health care. Islamic concepts such as life being "halal" or "haram" do not only affect the well being of patients but also the behaviour of families and relatives. Without consideration of these values in health care concepts the acceptance and compliance of patients will hardly be achieved. Therefore the anticipation of social and cultural differences is a precondition to health care utilization and acceptance of professional standards.

Personalization

- Addressing life styles
- Consideration of milieus
- Taking account of different settings
- Consideration of cultural differences
- Consideration of religious values
- Acceptance of values and behaviour
- Customer/patient as orientation

It is self evident that professional standards and criteria are as important as the individualisation. In this dimension the orientation is focussing on the competencies of the health care professionals, their standards and methods. Respective standards are available in many cases in principle, but the diffusion and application still shows deficits. Therefore quiet some effort is needed to improve the implementation of standards and guidelines. It is important however, that the professional standards also reflect the individualized dimension in order to be sensitive to the expectations of their patients. A missing reflection of the personalized dimension is one reason for the lack of acceptance of professional treatment and compliance by the patients. Professionalization on the other hand can not be compensated by voluntary health care within families or neighbourhoods where a lot of compassion but missing standards may cause more harm than being helpful. Therefore the voluntary support always has to be complemented by professional health care.

Professionalization

- Addressing Competencies of Health Care Professionals
- Definition of Standards
- Review of Methods
- Specification of Criteria
- Acknowledgement of Contexts
- Health Care Professional as Core Focus

Personalization and professionalization therefore are complementary and have to be integrated into health care services that consider supply and demand side at the same time. The complementarity can not be resolved unilaterally but requires consideration in the design of health care and its implementation process. Standardisation always will have to reflect the acceptance of differences and its potentials in a customised approach in order to achieve acceptance and compliance.

Comparable to the personalisation and professionalization is the situation of psychological an physiological dimension. They are complementary as well and address the behaviour and mental state on the one side and anatomical situation and symptoms of the patients on the other. The requirement of physical and psychological well being addresses the existing symptoms due to

physical or psychological deficits and in dependence of personalized and professionalized standards leads to therapeutic requirements.

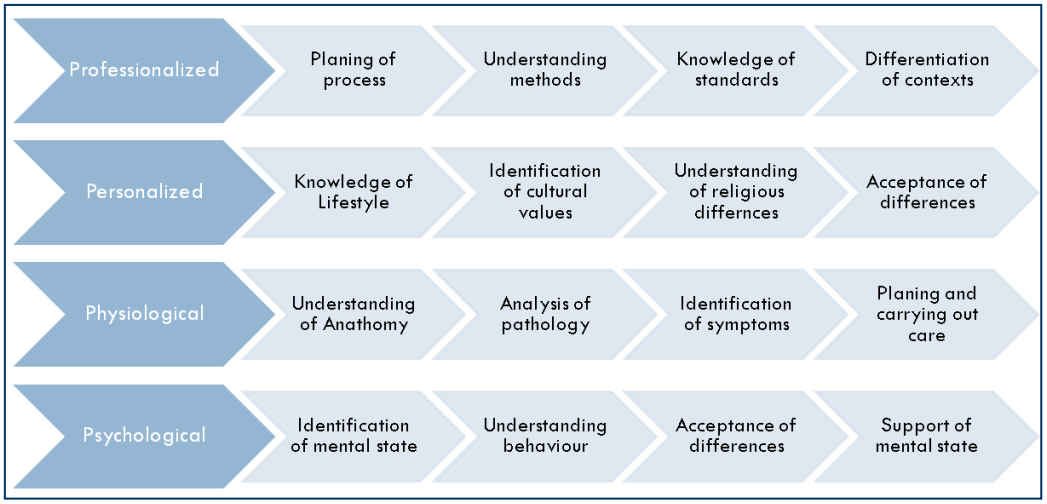
Physiological	Psychological
▪ Anatomic view of patient ▪ Pathological analysis ▪ Identification of symptoms ▪ Planning and carrying out therapy ▪ Rehabilitation and care	▪ Behaviour of patient ▪ Mental state ▪ Identification of symptoms ▪ Social condition ▪ Therapy and care

The coordination of all four dimensions provides the conditions to overcome the gap between health care potentials and health care reality. It goes along with high requirements in the design of health care services, their implementation and the qualification of health care professionals. Appropriate development of education and qualification criteria that consider all four dimensions will be necessary especially due to increasing internationalisation, migration and complexity of social contexts of patients and their environment.

The European qualification framework (EQF) provides a suitable reference for the development of respective qualification schemes that take differences of health care systems, educational status and patient preferences into account. The different levels of education in different health care systems can be matched within the framework providing transparency and comparability in an international perspective (s. Annex).

Within the Leonardo program of the EU the implementation of the education for cultural sensitive care is developed as a prototype for geriatric care. This initiative operationalises all four dimensions along the European Credit System for Vocational and Educational Training (ECVET) and develops curricula on different educational levels. Basis for this development is the process of geriatric care and the necessary knowledge, skills and competences.

Implementation of cultural sensitve care in education in the context of ECVET



Annex: European Qualification Framework: Knowledge, Skills and Competencies of Different Qualification Levels

Level 1	• Basic general knowledge • Basic skills to carry out simple tasks • Work or study under direct supervision in a structured context
Level 2	• Basic factual knowledge of the field of work • Basic cognitive and practical skills required to use information in order to carry out tasks and solve routine problems using simple ruse and tools • Work or study under supervision with some autonomy
Level 3	• Knowledge of facts, principles, processes and general concepts in a field of work or study • A range of cognitive and practical skills required to use relevant information in order to carry out tasks and solve problems by seeking and applying basic models to solve routine problems using simple rules and tools • Work or study under supervision with some autonomy
Level 4	• factual and theoretical knowledge in broad contexts within a field or study • a range of cognitive and practical skills required to generate solutions to specific problems in a field of work or study • exercise self-management within the guidelines of work or study contexts that are usually predictable, but are subject to change supervise the routine work of others, taking some responsibility for the evaluation and improvement of work or study activities
Level 5	• comprehensive, specialized, factual and theoretical knowledge within a field of work or study and an awareness of the boundaries of that knowledge • a comprehensive range of cognitive and practical skills required to develop creative solutions to abstract problems • exercise management and supervision in contexts of work or study activities where there is unpredictable change review and develop performance of self and others
Level 6	• advanced knowledge of a field of work or study involving a critical understanding of theories and principles • advanced skills, demonstrating mastery and innovation, required to solve complex and unpredictable problems in a specialised field of work or study • manage complex technical or professional activities or projects, taking responsibility for decision making in unpredictable work or study contexts take responsibility for managing professional development of individuals and groups
Level 7	• highly specialised knowledge, some of which is at the forefront of knowledge in a field of work or study, as the basis for original thinking and/or research critical awareness of knowledge issues in a field and at the interface between different fields • specialised problem-solving skills required in research and/or innovation in order to develop new knowledge and procedures and to integrate knowledge from different fields • manage and transform work or study contexts that are complex, unpredictable and require new strategic approaches take responsibility for contributing to professional knowledge and practice and/or for reviewing the strategic performance of teams
Level 8	• knowledge at the most advanced frontier of a field of work or study and at the interface between fields • the most advanced and specialised skills and techniques, including synthesis and evaluation, required to solve critical problems in research and/or innovation and to extend and redefine existing knowledge or professional practice • demonstrate substantial authority, innovation, autonomy, scholarly and professional integrity and sustained commitment to the development of new ideas or processes at the forefront of work or study contexts including research

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