Chapter 1

SYSTEMS APPROACH TO CULTURAL COMPETENCE

LEARNING OBJECTIVES

- To clarify what is meant by a systems approach
- To define key terms including diversity, cultural competence, disparities, and strategic diversity management
- To describe the dimensions of diversity that will be discussed throughout this text
- To gain an understanding of health care disparities in the United States
- To become familiar with essential systems approaches to cultural competence and reducing disparities
- To characterize the relationship between strategic diversity management and culturally competent health care delivery
Fundamentally, a system is a structure of interconnected people, policies, and practices designed to work in concert to achieve a common goal. The systems approach is the process of considering how different parts of the whole structure influence and integrate with each other and viewing problems in a system as affecting the system overall. Component parts of a system can best be understood in the context of their relationships with each other. In a well-integrated, smoothly functioning system, each part contributes to the achievement of the goals for which the system was put into place. In the case of the health care system in the United States, the goal is a high level of health within the nation’s population. Thus, this system can be said to be a preventive and curative system. It is also, most important, a major employment system and a key business system. The health care system is an “open system”; that is, elements from outside the system in its environment are constantly affecting and being admitted to the system. In other words, there are transactions across the external and internal boundaries of the system. As this occurs, a well-designed system includes feedback mechanisms so that those operating the system can assess, evaluate, and readjust its structure and processes, enabling it to continue to meet its goals. In this book, we view diversity within the population and disparities in health care access and treatment as factors with which the US health care system must successfully adjust in order to meet its goal of good health for the overall population rather than just segments of the population.

Cultural competence is a major strategy for helping the system successfully meet the challenges of diversity and disparities. From its initial conceptualization in health care, cultural competence was seen as an essential systems component. Cross, Barzon, Dennis, and Issacs (1989) defined it as “a set of congruent behaviors, attitudes and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations” (p. 2). Another excellent definition of cultural competence put forth by the National Quality Forum (2008) is “the ongoing capacity of healthcare systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family centered, evidence based and equitable” (p. 3). Cultural competence incorporates all of the strategies and practices needed to work effectively with patients from diverse groups based on an understanding of their beliefs, values, and social milieu. We take the position in this book that by systematically integrating the philosophy and practices of cultural competence and diversity management into
the processes, transactions, and structures of the health care system, appropriate care for diverse groups and the elimination of disparities could better be accomplished and the goal of good health care across the nation more completely realized.

Figure 1.1 is a visual representation of the authors’ overall conceptualization of a systematic approach to the development of cultural competence and diversity in health care, moving from a rationale for the development of cultural competence in health care, to the adoptions of appropriate attitudes, skills, and knowledge, then to an application of those capabilities in service delivery, and finally to the use of organizational leadership and strategic diversity management to create well-functioning, diverse organizations able to provide appropriate health care to all populations.

This first chapter provides an overview of the seven key dimensions of diversity that will be considered in this book as well as the roots of diversity in the United States. In this text, the term diversity refers to differences that make each person or group unique when compared with other persons or groups. Our individual uniqueness is driven by the groups we are identified with, such as race and ethnicity, socioeconomic status, gender, age and generation, sexual orientation,
and religious preference, and also by what our identity groups mean to others and ourselves. Diversity is important in health care because what patients, caregivers, families, and health care organizations believe about key diversity dimensions affects how patient care is structured and delivered and how the health care workforce is managed. And the United States is changing: not only are we becoming more diverse across multiple dimensions of diversity but our attitudes toward diversity are also evolving. In this chapter we review the diversity demographic trends for the seven key dimensions of diversity that have special implications for health care and are referenced throughout this text: race and ethnicity, gender, sexual orientation, age, language, socioeconomic status, and religion (see Table 1.1). The first three dimensions of diversity are personal, almost immutable, qualities of personhood; the last four are important social variables that create diversity among people, crosscutting the immutable dimensions and contributing to diversity within them. A moment’s reflection also will tell us that these dimensions of diversity frequently overlap and interact with each other and intersect with the health care system in many complex ways. This complexity will be addressed in this book many times over.

This chapter next introduces the critical issue of health care disparities across diverse population groups in the United States. The glaring disparities in access to health care and levels of treatment quality experienced by different groups in the United States is a significant societal problem that can be addressed only through careful assessment of diverse needs and the structuring of appropriate and systematic health care delivery.

Several new approaches to the creation of health care delivery systems that require culturally competent care will be briefly introduced, including evidence-based care, medical homes, person-centered health care, and interdisciplinary professional teams. Cultural competence is seen as an important factor in needs assessment and the creation of appropriate personalized care.

### TABLE 1.1 The Seven Dimensions of Diversity

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Finally, it is clear that the changes needed to create and implement more systematic and culturally competent health care policies and practices will not take place without the informed management and leadership of health care professionals and policy makers. The chapter ends by urging students to take up the challenge of leadership in the creation of health care systems and organizations that truly meet the needs of all the nation’s residents.

DIMENSIONS OF DIVERSITY

The following section examines each of the dimensions of diversity in depth so that when the terms are used throughout the book, the reader will understand exactly what is meant by each term.

Ethnicity and Race

The growing attention to diversity and cultural competence in health care has been in great part driven by the United States’ increasing racial and ethnic diversity and by the fact that health care access and quality of care differ substantially across diverse groups, resulting in critical differences in health status (Smedley, Stith, & Nelson, 2002). The 2010 Census confirmed that, by the middle of this century, the United States will be a majority minority nation; less than half of the population will be non-Hispanic white (Mather, Pollard, & Jacobsen, 2011). Cultural or ethnic groups are not the same as racial groups, though culture and race are both aspects of human diversity. An ethnic group is defined by its culture; it is a group of people whose members identify with each other through a common language, behavioral norms, worldview, history, and ancestry. Culture, like language, is learned, not biologically inherited. An ethnic group is also generally recognized as a discrete group by persons outside the group. Ethnicity is often associated with national origin, but there are usually many ethnic groups within a single nation, and there are ethnic groups that cross national boundaries. Examples of ethnic groups are Mexican-Americans, Navajo, Hmong, Berber, and Zulu.

Race is a term used by scientists and the general public to identify groups of people by physiological characteristics such as skin color, hair texture, facial features, bone structure, and the like. As pointed out by Byrd and Clayton (2002) in Unequal Treatment, “Scientists who study race consider it a socially determined category based on shared physical characteristics . . . most commonly dividing
the human family into three to five major racial groups” (p. 474). Very recently, population geneticists studying the genetic constitution of populations around the world through genomewide studies have been able to link genetic heritage with the ancient continental, geographic distribution of populations that correspond closely with commonly used racial designations such a Caucasian (Europe and Middle East), African, Asian, Pacific Islander (for example, New Guinean and Melanesian), and Native American (Li et al., 2008; Risch et al., 2002). However, it is clear that virtually none of the authorities contend there are “pure” races because many groups overlap the racial classification systems that have been used and are blurred due to migration, contact, and intermarriage. It should be noted as well that there are almost always many ethnic groups falling within a racial category (Collins, 2004). Research has been able to link disease resistance, risk, and response to pharmaceuticals to these different racial heritage groups as well as to some ethnic groups whose gene pools have been isolated for extended periods of time. This is just one of the several reasons why epidemiological studies usually consider race and ethnicity as important variables in determining health care disparities across population groups. To take note of the genetic aspects of race, however, is not to deny the importance of historical and current social constructions around the meaning of race and ethnicity because these are critical to understanding the environmental, economic, and societal factors that are associated with disparities in health status, health care access, and treatment. Our understanding of the complex relationship between self-reported race and ethnicity, genetics, and health continues to evolve and will be discussed in the context of disparities in Chapter Two.

As a result of the immigration history of the United States, it has also been common to describe segments of the US population by nation of origin. Clearly, most nations are made up of several ethnic and racial groups. An individual, for example might be a British national but ethnically Pakistani and racially Asian. Sometimes persons from a particular nation are thought to subscribe to a national culture that adds to and overlies the cultures of various groups making up its population. In contemporary society, the historic connection between ethnicity and nationality is growing weaker. In the United States, national identity or citizenship is by design and values distinct from ethnic or racial identity, a topic that we will discuss in greater detail later in this book.

The ethnic, racial, and national background characteristics of the US population are mostly the result of US policy regulating immigration to the country
during the country’s history. Although the United States prides itself on being a nation of immigrants, not all races, ethnicities, and nationalities were accepted with equally open arms. To a great extent, immigration policies have been driven by the nation’s need for specific types of labor over the years. Black Americans were enslaved and forcibly brought to the United States to meet the labor needs of the agricultural South. The need for unskilled labor during the building of the transnational railroads in the latter part of the 1800s allowed the immigration of many workers from China, and, later, Mexico. When that need was over, very restrictive policies such as the Chinese Exclusion Act of 1882 were enacted. The country’s need for Mexican labor has waxed and waned, and immigration policies have restricted or encouraged immigration from that nation accordingly. In the late 1800s and early 1900s, the huge waves of immigrants from southern and eastern Europe who found employment in the burgeoning industries of America as well as the fewer immigrants from northern and western Europe came to work in mainly low-skilled factory work. By 1921, however, the Emergency Quota Act was passed; in it, the incoming immigrant population was limited to 198,082 from northern and western Europe, and 158,367 from southern and eastern Europe. A few years later, the National Origins Act strictly limited the number of persons who could emigrate from any eastern hemisphere country. During the Depression and before and after World War II, immigration was severely curtailed. The Immigration and Nationality Act of 1952 continued restrictions based on nationality quotas with an emphasis on allowing European immigration more than from other parts of the world. The outcome of these various policies through the generations was a very homogeneous, primarily white US population in the two decades just following World War II. This apparent homogeneity enabled little appreciation of diverse health care needs. At the same time, the health care of black Americans was relegated to black institutions or segregated facilities (Skloot, 2010).

Radical policy change came with the Hart-Celler Immigration Act of 1965, which removed quotas based on national origins and labor needs. The major source countries of immigration shifted from Europe to Latin America and Asia. Thousands of undocumented persons also entered the country from Mexico and Central America, many of whom were granted amnesty in 1986 through the Immigration Reform and Control Act. Following the Vietnam War in 1975, large numbers of southeast Asians, such as Hmong, Mien, and Vietnamese, were granted admission. Refugees from Afghanistan, Pakistan, Iran, Somalia, and other war-torn nations sought asylum and settled in the country. After the first terrorist
attack on the World Trade Center occurred in 1992, public support for restricted immigration and curtailment of undocumented entry began to grow again. Nevertheless, as a result of the push-pull policies of the prior three decades (Orchowski, 2008), the nation’s population had become more ethnically, racially, and linguistically diverse than it ever had been in its history.

This cultural and linguistic diversity was making itself felt in the patient populations of the country’s hospitals and clinics. Health care organizations and personnel, surprised and unprepared to respond to diversity of this magnitude, were often reluctant to make changes that would enable them to better serve diverse patients. Further, assessment of the health status of the different races and ethnic groups revealed very significant disparities in health status across several of the country’s population groups, which included but were not restricted to black-white differences. These circumstances gave rise in the early to mid-1990s to the beginnings of the cultural competence movement in health care and to national policies that were directed to the reduction of serious disparities in health care access and treatment. Whereas the differing racial and ethnic health statuses first prompted these directions within health care, proponents soon realized that the women’s health movement, issues related to sexual orientation made more explicit by the HIV epidemic, and the aging of the population made a broader understanding of diversity and health disparities necessary.

**Gender**

Although more boys than girls are born each year, the US population overall is about 51 percent female and 49 percent male. Researchers attribute this to differences in mortality that favor women over men, and, due to their longer life expectancy, women predominate in the oldest age cohorts that consume relatively more health care services. Interestingly, prior to the 1950 Census, the male-to-female ratio was over 100, indicating that there were more males than females in the United States. From 1950 through 1990, the male-to-female ratio dipped below 100 but began a gradual rise from 94.5 in 1980 to 96.3 in 2000, which researchers attribute to the combined effects of immigration, which has brought in more men than women, and a decline in the male death rate that exceeded the decline for women during the same time period (Smith & Spraggins, 2001).

Prior to the 1970s, women’s health needs were rarely differentiated from those of men. Research examining medical, health-related, and pharmaceutical
agents infrequently included women, and, if women were included, results were seldom broken out by gender. It was assumed the women’s bodies differed from men’s only by their reproductive organs. However, the feminist movement had a women’s health thrust, the women’s health movement. At first, the major concerns centered on birth control, abortion, and reproductive health but the focus soon expanded as it became clear that there was widespread dissatisfaction among women regarding their health care and the attitudes about women prevalent in the medical community. The publication of Our Bodies, Ourselves (Boston Women’s Health Collective, 1973) was a milestone in women’s early articulation of their special health needs. In 1985 a United States Public Health Service task force concluded that exclusion of women from clinical research was detrimental to their health, in 1986 the National Institutes of Health (NIH) adopted guidelines urging the inclusion of women in clinical studies, and in 1993 NIH mandated that women and members of minority groups be included in all government-sponsored research (Society for Women’s Health Research, nd). The research literature now robustly shows that differences between the genders exist in the prevalence and severity of a broad range of diseases and conditions and at every stage of life. The National Institute of Medicine summarized much of what is known so far about gender differences in health in the book, Exploring the Biological Contributions to Human Health: Does Sex Matter? (Wizemann & Pardue, 2001) and more recently have updated the progress of women’s health research in Committee on Women’s Health Research, Women’s Health Research: Progress, Pitfalls, and Promise (2010).

As Owens (2008) observes, women consume more health care services overall than do men: “Research spanning several decades shows that in comparison with men, women use more physician services, have more episodes of acute illness, require reproductive care, and need more long-term care over their longer life span. An analysis of Express Scripts’ integrated database of medical and pharmacy claims revealed that women contribute to 60% of medical spending and consume 59% of the prescription volume. In addition, women represent the majority of Medicare beneficiaries” (p. S2).

Health care insurance premium prices and the proportion of the uninsured also vary by gender. Historically, insurers have employed gender rating, that is, routinely charged women more than men for individual health care insurance policies. Effective in 2014, the Affordable Care Act of 2010 will prohibit this practice.
Biology most certainly plays a role in the significance of gender to health care. However, as with the other dimensions of diversity discussed previously, what we believe about gender is driven by our cultures’ values and behavioral norms. These beliefs in turn shape gender roles and relationships in society, such as spousal and parenting behaviors. They influence career choices, patient-clinician interactions, and treatment seeking as well as health care decisions.

**Sexual Orientation**

Estimating the proportion of the US population that self-identifies as lesbian, gay, bisexual, or transgender (LGBT) is challenging for researchers, producing figures ranging from less than 2 percent to about 5½ percent. Estimates will vary depending on how sexual orientation is defined and how questions about sexual orientation are posed. The Williams Institute at UCLA Law puts the percentage of lesbian, gay, or bisexual US adults at 3½ percent and transgender at .3 percent (Gates, 2011). Lofquest (2011), using data from the 2010 American Community Survey (ACS), estimates that 1 percent of couples sharing a household in the United States are same-sex domestic partners. ACS data reveal that the percentage of same-sex couple households ranged from .29 percent in Wyoming to 4.01 percent in the District of Columbia, and nearly 20 percent of same-sex couple households in the United States have children. Dade (2011) notes an 80 percent increase in the percentage of households consisting of same-sex domestic partners from Census 2000 to Census 2010. Dade (2011) attributes this to growing acceptance of LGBT relationships in the United States and a concomitant willingness to disclose sexual identity on government surveys such as the census. Based on 2010 census data, Gates (2011) observes that the percentage of same-sex couples that are interracial or interethnic (20.6 percent) is higher than for either different-sex unmarried couples (18.3 percent) or different-sex married couples (9.5 percent).

Because of the social stigma attached to any sexual orientation other than heterosexual, prior to the 1980s and the AIDS epidemic, the LGBT population was a hidden population as far as health data were concerned. Societal adjustment in perspectives has occurred during the last three decades, and there is greater acceptance of and attention to the health needs of people of different sexual orientations in many of the nation’s health care organizations. The LGBT community has itself worked to build an infrastructure to address its health needs and
has lobbied successfully to obtain recognition of these needs from scientific bodies and the government (Committee on Lesbian, Gay, Bisexual and Transgender Health Issues, 2011).

Sexual orientation is relevant to health in myriad ways that will be discussed throughout this book. Although LGBT people share with the rest of society the full range of health risks, they also face a set of additional risks due to social stigma. One of these risks is their “invisibility” to health care providers because of their reluctance to come out to health care professionals and the failure of providers and health care institutions to foster an accepting environment. Domestic partner health benefits for the workforce of health care organizations, hospital visitation rights, the health care decision-making role and space for a patient’s domestic partner, and establishing trust to encourage disclosure of sexual orientation are among the issues relevant to patients and employees who self-identify as LGBT.

There are still challenges to obtaining clear, generalizable data on the health risks of the LGBT population that are related to appropriately defining inclusion criteria for studies, reluctant self-identification of research subjects, and the costs of obtaining and analyzing data from small or hidden populations (Dean et al., 2000; Gilbert & Sabin, 2008). Nevertheless, an actionable picture of the needs of the LGBT population throughout the life course is emerging (Committee on Lesbian, Gay, Bisexual and Transgender Health Issues, 2011) and there are indications that some health systems are responding to the needs of the LGBT community in positive ways. In considering culturally competent approaches to the LGBT group, it is important to realize that different racial and ethnic and religious groups perceive sexual orientation issues differently and that LGBT persons need to be understood in terms of the larger group in which they are culturally embedded.

**Age and Generation**

The US population as a whole is growing older. The US Census Bureau (2008) predicts that by 2030, 20 percent of the population will be sixty-five and older, which is more than double the 2008 proportion. Whereas the eighty-five and older population will triple by 2050, the working age population will decline from 63 percent in 2008 to 57 percent. There is perhaps is no greater challenge to the health care institutions of the United States than that posed by its aging population. Much has been made recently of the leading front of the baby boomer age wave.
passing into retirement and into the embrace of Medicare. Another issue that has not been as widely discussed is the fact that the aging population is predominantly white and the younger working age population is increasingly made up of people of color, a large proportion of whom have lower levels of education and have difficulty entering a health care workforce that is increasingly technical, specialized, and cybernetic in nature. As will be noted in Chapter Three, the black and Latino pipeline for future professional level jobs in health care is very narrow. This situation is exacerbated by the fact that the health care workforce is itself highly stratified and hierarchical, with most professional and high-level administrative positions requiring postgraduate educations. This age, race, and ethnic workforce gap is a critical diversity issue facing the US health care system.

The health care issues surrounding the aging of the population aren’t just those of changes in the ratio of age cohorts. People in the United States are living much longer than they used to. For example, under current mortality conditions, people who survive to age 65 can expect to live an average of 18.5 more years, about 4 years longer than people aged 65 in 1960 (Federal Interagency Forum on Age-Related Statistics, 2010). Along with extended life spans come much more chronic disease and multiproblem illness that lower functioning levels and require more intensive and ongoing health care. And, whereas chronic diseases such as type 2 diabetes can be modified with behavioral changes, such interventions need to be culturally sensitive to diverse populations in order to be effective. Differing cultural groups also have long-held beliefs about aging and caretaking of the elderly that are important to consider in planning for elder care. For example, cultural concepts around death and dying are important issues in end-of-life decision making that are critical to elders and their families.

Related to and yet distinct from age is the concept of generational diversity. With its origins in consumer marketing, this body of research studies cultural differences among generational cohorts in the United States: veterans (1922–1943); baby boomers (1943–1960); generation X (1960–1980), and generation Y (1980–2000). Due to shared social, political, economic, and technological events during their formative years, each generation has developed a set of beliefs and core values that undergird their work style and choices, including career decisions as well as health care expectations and preferences (Howe, 2009; Zemke, Raines, & Filipczak, 2000). These generational shifts in expectations and preferences will require change in health care delivery organizations. Issues as diverse as the replacement of paper with electronic medical records, expanding modes of communication between patient
and provider, and addressing shortages of personnel in key clinical roles including registered nurses and primary care physicians are among those that health care organizations must address.

Additionally, another common use of the word *generation* in health care literature and epidemiology refers to whether an individual is first generation in the United States, that is, immigrated from another country; second generation, the child of an immigrant; and so on. An understanding of a patient’s generational remove from immigrant status is useful in evaluating his or her knowledge of the US health care system, perceptions around disease etiology, and the like, all necessary to operating within a culturally competent framework.

**Socioeconomic Status**

Although people in the United States like to think of themselves as a highly socially mobile, almost classless society, the facts belie this belief. The country is highly stratified by every measure of social class. A measure that is often used, socioeconomic status (SES), is an economic and sociological composite measure that is based on a combination of three highly related factors: income (and sometimes wealth or accumulated assets), education, and occupation. Typically, socioeconomic status is broken into three levels called *classes*: low, middle, and high. Some analyses use finer breakdowns, for example, lower-middle, middle-middle, and upper-middle as indicated by SES of individual and family of origin. Often, as in the US Census, individuals, families, and households are categorized separately by each of the three indicators, income, education, and occupation. Recently, much has been written about the economic decline of the middle class and a growing wealth disparity between the very wealthy and the remainder of the US population. These changes in wealth distribution cannot help but affect access to and delivery of health care in important ways.

Socioeconomic status is a diversity factor that crosscuts all of the other diversity indicators in critical ways. For example, SES is associated with race and ethnicity. In 2009, the median family income for whites was $54,461; for Asians, $65,469; for Hispanics, $38,039; and for blacks, $32,584. With the official poverty level for a family of four set at $22,128, more than 24 percent of black and Hispanic families fell at or below that level, and just slightly more than 10 percent of white and Asian families did (DeNavas-Walt, Proctor, & Smith, 2010). Because SES differs so dramatically across racial and ethnic groups, many measures of health
status and access are linked to racial and ethnic identification through SES. Blacks, for example, are disproportionately represented among the uninsured and lower SES (Williams, 1999). SES is a strong predictor of health behavior, health status, and mortality (Marmot, 2004). SES is of course linked to the ability to buy good health insurance and concomitant access to the most recent advances in care. Asians, as a whole, because of their higher incomes and educations, fare better, healthwise, than many other population groups, although this is not the case with all Asian groups. Education levels, also racially and ethnically linked, also affect health literacy, a growing issue as health care becomes more technologically and genetically driven.

Because race and ethnicity are so closely associated with SES, it is often difficult to determine whether health behavior is influenced by cultural or economic factors; in many cases, both need to be considered as skilled professionals, trained in considering all aspects of a patient’s diversity, are able to do. Low SES often interacts with gender, compounding health access problems because of the growing number of female-headed, single-income families in all racial and ethnic groups.

**Language**

The variety of languages spoken in the United States creates significant problems in health care settings, where good communication between patients and health care providers is critical. The report *Language Use in the U.S.: 2007*, produced by the US Census in 2010 with data from the American Community Survey, showed that of 281 million people over age five, 55,444,485 million, or 20 percent, spoke a language other than English at home. This didn’t mean that all these millions of Americans couldn’t speak any English, but many reported that they didn’t speak English well. For example, 29 percent of Spanish speakers and 22 percent of Asian and Pacific Island language speakers reported limited proficiency in English. Spanish was by far the most predominant language other than English spoken in the home, followed by Chinese, Tagalog, Vietnamese, French, German, and Korean. Language is, of course, a learned diversity factor, but a native language is learned rapidly in childhood and quickly embeds the culture from which it springs.

Clearly, the languages spoken in the United States reflect the immigration patterns of the last fifty years. Although these major languages are associated with nations of origin, there are also many languages such as Hmong, Mien, and Mixteco
that are associated with ethnic groups within donor nations. The Census Bureau codes for 381 languages spoken in the United States including Native American languages! However, and fortunately for most health care institutions, speakers of languages other than English are not distributed evenly across the nation. For example, just 2 percent of West Virginians over the age of five spoke a language other than English at home and 43 percent of people in California, a state that is home to many Chinese, Vietnamese, Hmong, and Spanish speakers, reported speaking a language other than English in the home. Even within states certain metropolitan areas have concentrated clusters of foreign languages speakers such as Khmer (Cambodian) in Long Beach, California, Somali in Minneapolis, and Hmong in Fresno, California. Thus, health care institutions can often concentrate their language-access services on specific languages spoken within their catchment areas.

Because communication is so critical in health care, providers and health care organizations often make attention to language-access needs their first step in integrating cultural competence into their systems of care. As they accomplish this, it opens wide the door to greater cultural understanding and appreciation. Later in this book we will look at how language access is being provided in many health care institutions and the growth of a new medical profession: the medical interpreter.

Religion

Because illness, injury, and death are critical issues in peoples’ lives, they have, from time immemorial, been linked to religious beliefs and practices. Concepts about birth, the vital functioning of the body, the association between body and spirit, belief in the efficacy of prayer and personal agency, dietary practices, illness and punishment, and death and dying are very frequently religion based and dramatically affect the acceptance and compliance with health care prevention and treatment practices. Recognizing this, health care professionals have grown to accept that patient’s religious and spiritual lives need to be considered as part of their diversity, and that health care systems should accommodate patients’ varying religious practices when at all possible. This is no easy task when the complexity of the religious landscape in the United States is appreciated and its changing nature is considered.

Religion is one of the crosscutting diversity dimensions. One’s religious beliefs, like language, are usually learned (or not) through socialization. The Pew Forum on Religion and Public Life released its most recent US Religious Landscape
Survey (2008) and concluded that “religion in the United States is often described as a vibrant marketplace where individuals pick and choose religions that meet their needs and religious groups are compelled to compete for members” (p. 22). Although religious and ethnic identities continue to be strongly related, the survey reports that 28 percent of US residents have changed their religious affiliation from the one in which they were raised; this percentage would be even higher (44 percent) if changes between denominations within a religious tradition, for example, Protestantism, were included as well. Rates of change in religious affiliation vary by racial and ethnic group, with lower rates for Hispanics and Asian ethnicities and higher rates for African Americans and whites.

Based on current trends, the Landscape Survey projects that the United States will become less Protestant, that an ever-growing proportion of Catholics will be Latino, and that immigration patterns will continue to add to America’s religious diversity with a small but growing proportion of the population, mostly people of Middle Eastern background, affiliating with the Muslim faiths and persons of Asian or South Asian heritage remaining Buddhist or Hindu. The percentage of US residents who report no religious affiliation is also growing but varies with race, ethnicity, and age. African Americans, for example, are the least likely racial ethnic group to report having no religious affiliation. One quarter of all adults under age thirty are not affiliated with any religion, which is three times the percentage of people seventy and above.

The American Religious Identity Survey (ARIS) (Kosmin & Keysar, 2009) reveals related trends. Although in 1990, 86 percent of US adults identified as Christian, that number declined to 76 percent in 2008. The decline is attributed to an increasing percentage of Americans reporting no religious preference or self-identifying as atheist or agnostic, from 8.2 percent in 1990 to 15 percent in 2008. ARIS also saw growth in religions other than Christianity from 3.3 percent of the US population in 1990 to 3.9 percent in 2008. Those reporting a Jewish religious identity declined from 1.8 to 1.2 percent of the population whereas respondents reporting a Muslim religious affiliation doubled from .3 percent of the population to .6 percent in 2008. ARIS reported that affiliations with Eastern religions as a group, including Buddhism, Hinduism, Taoism, Baha’i, Shinto, Zoroastrian, and Sikh, more than doubled during this same time frame.

As these trends demonstrate, religion is truly a diversity dimension that is not immutable. However, ethnicity and religious identities are still closely associated and immigration patterns will continue to drive increasing religious diversity in
the United States. As the US Religious Landscape Survey (2008) reported, “immigration is adding even more diversity to the American religious quilt. For example, Muslims, roughly two-thirds of whom are immigrants, now account for roughly 0.6 percent of the U.S. adult population; and Hindus, more than eight in ten of whom are foreign born, now account for approximately 0.4 percent of the population” (p. 11).

HEALTH CARE DIVERSITY CHALLENGES

The seven dimensions of diversity discussed in the previous section present health care with a number of challenges. A major goal of this book is to clarify these challenges in detail and point out ways in which integrating cultural competence into the health care system equips the reader with the necessary knowledge and skills to respond effectively.

Research confirms that we develop a sense of community not through our differences but through our similarities. Differences in fact generate conflict unless they are managed appropriately. Health care providers will need to hone the diversity management and cultural competencies needed to create inclusion and deliver patient-centered care in the context of diversity (Dreachslin, 2007).

Following are just a few of the many implications of the changing demographic and cultural landscapes discussed in the previous section:

- An aging population increases the demand for health care services.
- Generational differences in work style preferences may exacerbate the shortage of nurses and other professionals unless addressed by role and work redesign.
- The gap between the levels of technical and scientific education required of health care workers and the levels of education currently achieved by blacks and Hispanics may perpetuate the concentration of Asians and non-Hispanic whites in professional, administrative, and policy-making positions.
- Provider bias and lack of cultural awareness can contribute to disparities in health care, as can poorly structured service delivery.
- The issue of language access caused by the high number of limited English speakers will call for innovative and cost-effective solutions.
The association of low SES with racial and ethnic groups that are underrepresented among physicians, nurses, and the allied health professions can make concordance difficult; that is, it may be difficult to provide patients with clinicians who share their racial or ethnic identity.

Growing religious diversity will require health care organizations to review and adapt their human resource policies and patient care practices, for example, holiday leave and accommodations for religious observances, hospital diets, and family involvement in care.

Learning to understand and value diversity’s multiple dimensions will help health care providers adhere to the many new standards, accreditation measures, and legislation calling for patient-centered communication. For example, the Joint Commission’s (2010) accreditation standards for culturally competent, patient-centered care prohibit “discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression” (p. 61).

**HEALTH CARE 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. Disparities in health status across different population groups have become an important topic in the ongoing dialogue about the cost, quality, and cultural competence of health care in the United States. This has not always been the case, so it is important to understand just what is meant when the term *disparities* is used. The National Institutes of Health (2000) defines health care disparities as “differences in the incidence, prevalence, mortality, and burden of diseases and other health conditions that exist among several populations in the United States” (p. 4). Put simply this means that groups living in this country, when compared with each other, do not enjoy the same life expectancies or levels of good health. Disparities in health status across population groups in the United States are so significant that they may in part be responsible for the unfavorable comparison of the United States to other industrialized nations with respect to key health indicators.

The study of disparities is a special issue in the overall science of epidemiology, that is, the study of risk for and occurrence of disease and disorders in
population groups. The great preponderance of attention focused on health care equity has centered on racial and ethnic disparities that are so large as to affect the nation’s overall health landscape and significant enough to erode trust in health institutions among minority groups. These racial and ethnic disparities will be explored in detail in Chapter Two, as will disparities related to gender, age, and sexual orientation.

Little notice of disparities in health status across racial and ethnic groups was taken before the 1980s. A pivotal research report, published by the NIH in 1986, the Secretary’s Task Force Report on Black and Minority Health, and subsequent research done on Hispanics (Mexican Americans, Cubans, and Puerto Ricans) as an adjunct to the National Health and Nutrition Survey conducted from 1982 to 1985 by the National Center for Health Statistics (1985) and referred to as the HHANES, made the existence of racial and ethnic health disparities across populations very clear. However, it wasn’t until the mid-nineties, when the US population began to diversify even further through immigration, asylum, and natural increase and the disparities noted in the earlier reports appeared intractable, that disparities began to be associated with the cultural and linguistic competence of health care providers and organizations as well as the structuring of health care delivery. The disparities in health status revealed in early and current studies are consistently reflected in research that shows disparities across the entire health care system: access, prevention, treatment, health care literacy, and health outcomes. Health care disparities across racial and ethnic groups are strongly linked to socioeconomic differences and tend to be reduced when these factors are controlled but many disparities have been shown to remain after these factors are accounted for. Therefore, the causes of disparities in health status across population groups are as multiple and complex as the disparities themselves, and will be covered in Chapter Two. Reduction of disparities will ultimately depend on the cultural and linguistic competencies of health care policies, delivery systems, organizations, and practitioners systematically organized.

**CHANGING THE US HEALTH CARE SYSTEM**

No one who is familiar with topics of current interest can fail to be aware that the structure of health care delivery in all its aspects has been a major subject of focus and debate in US public policy for at least four decades. There is significant
agreement across all sectors of the health care establishment that reform is needed and that culturally competent care will play a role in that reform.

Starting with the creation of Medicaid and Medicare by the Social Security Act of 1965 through the recent passage of the Patient Protection and Affordable Care Act of 2010, the structure, cost, and outcomes of the national health care system have been constantly under discussion and reorganization. As the costs of US health care have mounted and the nation’s health profile has declined in comparison with those of other developed nations, the government, health care providers, health care institutions, evaluators and accreditors, as well as private philanthropic organizations have sought solutions to the costly disarray and lack of systematic approaches that characterize much of US health care (Shea, Shih, & Davis, 2008). Important critiques, for example, can be found in three of the publications of the national Institute of Medicine (IOM). To Err Is Human: Building a Safer Health System (Kohn, Corrigan, & Donaldson, 1999) caused national dismay over its revelation of the massive number of medical errors that harmed tens of thousands of patients as a result of uncoordinated and fragmented medical care. Crossing the Quality Chasm: A New Health System for the 21st Century (Committee on Quality of Healthcare in America, 2001) stated unequivocally, “Indeed, between the health care that we now have and the health care we could have lies not just a gap, but a chasm” (p. 1). This chasm was seen to be, in great part, a failure to translate the new learnings of medical science and rapid technological development into safe and integrated systems of practice. The report states that the delivery of care is often overly complex and uncoordinated, requiring steps and patient “handoffs” that slow down care and decrease patient safety, wasting resources. Finally, in Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare (Snedley, Stith, & Nelson, 2002), the IOM documents the differences in medical treatment experienced by different population groups in the United States that are “not due to access-related factors or clinical needs, preferences, and appropriateness of care” (p. 3) but asserted that these differences are the result of the way health care systems operate within their regulatory contexts as well as discrimination at the individual patient-provider level. These differences in treatment, coupled with socioeconomic and environmental factors, underlie the enormous disparities in health status across different population groups.

Overall, the picture that has emerged from the many analyses of health care delivery in the United States is that there is little that is actually systematic at all in
health care. Health care organizations, hospitals, and provider groups typically operate in silos with imperfect communication among them. In a delivery structure with lacunae in shared information, extreme specialization, and, often, dispersed treatment locales, it is often left up to patients low in health literacy to make connections and attempt to create order out of a seemingly impenetrable “un-system.” These access and delivery problems are exacerbated when class, language, cultural, and discriminatory barriers are also present.

Recommendations about how to reform the health care industry so that it is a truly equitable enterprise whose parts work smoothly and effectively with each other center on several broad courses of action. First, there is general agreement that practices within the health care system need to be based on data-driven and evidence-based strategies that are patient centered. Each of these recommendations carries implications for incorporating cultural competence approaches that will support and strengthen them.

In terms of reducing disparities and addressing the needs of diverse groups, a culturally competent approach to building an evidence base means that the health needs and risks of various segments of the population need to be consistently assessed, locally and nationally, and then treatment modalities used to address these needs implemented and evaluated for their efficacy, with the results of these assessments fed back into the system so that upgrades and modifications can be made. Chapter Two includes a discussion of this data-driven strategy.

Second, to reduce fragmentation and discontinuities in care, the interrelated concepts of medical homes, patient-centered care, and interprofessional or multidisciplinary teams have been proposed and are being put into practice. Together, these three elements enhance continuity of care and improve patient outcomes through a systems approach. In each of these formulations for practice, the individual patient or health care professional is seen in the context of his or her multiple and interrelated connections to all the components involved in the delivery of services. Aspects of the patient’s cultural environment and the social determinants affecting the care process are emphasized.

The patient-centered medical home is a model of care in which each patient has an ongoing relationship with a personal health care provider who leads a team that takes collective responsibility for patient care over extended periods of time. Care is coordinated and actively managed across specialists, allied health staff, hospitals, home health agencies, and nursing homes. Key to the success of the medical home is centralized care management. Communication is facilitated by
integrated data systems and electronic medical records accessible to all members of the care team. Emphasis is given to preventive care as well as curative care (Abrams, Davis, & Harran, 2009). Medical homes set into various communities need to be sensitive to the dimensions of diversity within those communities; the perspectives and practices of cultural competence are critical in achieving this sensitivity.

Patient-centered care emphasizes that the specific characteristics of each patient, such as gender, age, sexual orientation, ethnicity, and race as well as the patient’s social environment, are considered as equally important as medical status or diagnosis. Of great importance, patients and their families are involved with health care decision making facilitated by transparent processes and information sharing. Culturally and linguistically sensitive communication is critical to accurate information sharing and trust building in this context. Here again we see the importance of cultural competence in the system.

According to at least one assessment, Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from The Commonwealth Fund 2006 Health Quality Survey (Beal et al., 2007), racial and ethnic disparities in access and quality are reduced or eliminated when patients have a medical home that provides continuity of care. With the implementation of centralized care, access to routine preventive screenings and management of chronic conditions are also greatly improved. Although the medical home model of care is just one example of a coordinated system, it points the way to how institutional policy makers and managers can work with frontline care-giving professionals and managers in the integration of overall philosophies and specific practices that are responsive to the needs of diverse patient populations. For an excellent review of case studies of coordinated care systems, large and small, see The Commonwealth Fund’s report, Organizing for Higher Performance: Case Studies of Organized Delivery Systems—Series Overview, Findings, and Methods (McCarthy & Mueller, 2009). This report documents the characteristics of health plans, clinics, independent practice associations, safety net providers, and multispecialty group practices, demonstrating that systematic care models can be successfully integrated into a variety of health care delivery structures.

The interprofessional or multidisciplinary team is now considered critical to all models of systematically organized health care. The creation of a synergistic team made up of health care professionals with different areas of specialized expertise works against the fragmentation of care that the proliferation of areas of
expertise has tended to produce. Leadership by providers and shared responsibility for the care of patients creates a system of accountability to patients and members of the team. Distribution of patient-related data and information sharing across different areas of expertise gives rise to innovative approaches to patient care. Care teams often include physicians, nurses, pharmacists, social workers, and behavioral health specialists, physical therapists, medical interpreters, and other allied health professionals. Interprofessional teams are particularly useful in managing the care of patients with chronic or multiple illnesses such as diabetes or metabolic syndrome. Given the current cultural and racial diversity of the health care workforce as well as its very hierarchical nature, retraining in areas of cultural competence and skills in working in diverse teams is gaining in importance. A report by the IOM, *Health Professions Education: A Bridge to Quality* (Greiner & Knebel, 2003), recommends that skills development for interprofessional teams should include the following:

- Learning about other disciplines’ areas of expertise, background, and values
- Identifying individual roles and processes
- Acquiring basic group collaboration skills including communication, negotiation, delegation, and time management
- Managing transitions and hand-offs
- Acquiring conflict-resolution techniques
- Learning to communicate in a common language
- Creating and adhering to shared guidelines.

In an industry in which professions and positions have typically been extremely hierarchical and partitioned, acquiring and practicing these skills requires mind-set and philosophical changes. When the care is patient centered, the leadership of the interprofessional team is situationally, not traditionally, determined. Additionally, the health care workforce brings together persons of many backgrounds and cultures whose perspectives on work relations and patient-provider relations may differ significantly. Multidisciplinary teams are usually diverse beyond occupational specialization. Cultural competency training around workforce issues is useful for revealing and dealing with different perspectives on leadership and workgroup interactions as well as attending sensitively to the needs of diverse patients.
SYSTEMS APPROACH IN THE HEALTH CARE DELIVERY ORGANIZATION

Coordinated, patient-centered, and culturally competent systems of care need to begin at the policy-making and planning levels of management within health care delivery organizations. Because communities are very different from each other in terms of their diversity, much planning needs to be done at the local level, where policy makers need to be knowledgeable about and consider the diversity characteristics of the community or communities served.

Strategic diversity management includes a careful evaluation of the health care delivery system and its personnel to ensure that it is actually able to meet the needs of the community or communities that make up its catchment area. Information about the populations in the service area and their specific health, cultural, and language needs should be part of ongoing training for staff and health professionals. Goal setting and quality-improvement efforts intended to reduce disparities in access, treatment, and health outcomes need to be focused on evidence-based measures broken down by populations groups whenever feasible. Opportunities for management, staff, patient, and data feedback loops into the system should be built. These policy-making, planning, and quality improvement processes and their importance for the care of diverse patients and the elimination of disparities will be discussed throughout this book.

Again, a system is a structure of interconnected people, policies, and practices designed to work in concert to achieve a common goal. Despite the fragmentation of the US health care system in general, health care organizations themselves can independently follow a systems approach to strategic diversity management and culturally and linguistically appropriate health care delivery. In fact, even if recommended changes to the US health care system overall were in place, individual health care organizations would still need to follow a systems approach within their own organization. Figure 1.2 is a visual representation of the systems approach to diversity and cultural competence at the health care organization level. Fundamental to the systems approach is executive leadership’s diversity-sensitive orientation. The organization’s top administrators, who are sometimes referred to as C-suite level administrators because their titles often begin with the letter C (CEO, CFO, COO, CNO, CMO, etc.), must believe that workforce and patient diversity are important drivers of strategy or the systems approach will not even get out of the gate. With diversity-sensitive orientation at the C-suite level, the
organization will have a diversity strategic plan that is data driven and evidence based and a commitment to continuous improvement, as indicated by the feedback loop at the bottom of Figure 1.2. Diversity management practices, with a focus on the workforce, policies, and practices, are the building blocks of strategic diversity management, which in turn creates a culture of inclusion, in which diverse individuals, families, and communities can perform to their highest potential. A culture of inclusion provides a context in which culturally and linguistically appropriate care is the norm and patient satisfaction is paramount. The result: improved health outcomes for diverse individuals. The role of the systems approach in ameliorating disparities in the process and outcome of health care delivery at the health care organization level will be emphasized throughout this book.

**THE IMPORTANCE OF LEADERSHIP**

Leadership commitment is essential to the systems approach, to the well-functioning multidisciplinary health care team, and ultimately to the amelioration of disparities in health care and to career accomplishment and satisfaction in health
care organizations. Leaders at every level from the C-suite to the patient’s bedside set the context for effective or ineffective diversity management. Leadership commitment is reflected in the culture and climate leaders create and in the policies, practices, and workforce that make up the health care organization.

Who is a leader? Most fundamentally, leaders are those who others follow. Some leaders are followed because of their appointed positions of power in the organization and others are followed because of their social influence in a group. Factors that can affect a leader’s level of social influence include information, charisma, communication skills, role, and status in the group. Although research into organizational behavior, which will be discussed in detail in Chapter Ten, clearly identifies those with formal positions of power in organizations as having the most influence on the organization’s commitment to the systems approach to strategic diversity management and cultural competence, everyone in the organization can exercise his or her social influence to improve the diversity climate and show cultural competence in everyday interactions with patients and team colleagues. The primary goal of this book is to equip the reader with the knowledge, skills, and abilities to lead effectively in the context of growing workforce and patient diversity.

**SUMMARY**

The United States is made up of many groups. Some are ethnic and defined by their culture. Some are racial and defined loosely by genetic characteristics and ancestry. Within these groups there are men and women, persons of various sexual orientation and age, persons of different social class and religions, as well as persons who speak a variety of languages. Historically, the US healthcare system has tended to reflect the view that health care issues were basically the same for everyone even though the US population has changed significantly in the last few decades. However, a growing body of research refutes this view and shows that each of these groups has distinct health needs and that there are significant disparities in health status across groups. Many of the health disparities are long standing, though a few have developed from the immigration of new groups. Some disparities are certainly the result of personal or institutional discrimination or, at the very least, indifference. Health care in the United States has been fragmented and lacking systematic approaches; the consequence of this is that
many people do not enjoy good health, having fallen through the cracks of a disjointed system. Since about 2000, efforts to right the delivery of health care services and eliminate disparities have focused on a systems approach that is based on evidence, personalized care, and continuity of care. Cultural competence conforms well with the new directions in health care and can inform and strengthen them. However, incorporating the philosophy and practices of cultural competence as a vital element of this evolving health care system is, as can be seen in this initial chapter, complex because health care systems are made up of many interlocking and interacting elements: the people served; the people doing the serving; the processes, practices, and environment involved; and the policy and planning that unites all the pieces. The goal of this book is to help students examine these pieces and understand the roles played by cultural competence and diversity management in the health care system so that they can assume leadership in meeting the health needs of all this nation’s peoples.

KEY TERMS

crosscutting

cultural competence

culture

data-driven strategies

disparities

diversity

ethnicity

evidence-based strategies

identity groups

immutable

inclusion

interprofessional or multidisciplinary teams

medical homes

patient-centered care

personalized care

race

strategic diversity management

system

systems approach

worldview

REVIEW QUESTIONS AND ACTIVITIES

1. What are your own ethnic, racial, and national backgrounds? How many generations are you from immigrant status? Which of these identities dominates in your concept of self? Why do you think this is? Are there other dimensions
of diversity that play an important role in your life? Compare and share your thoughts about your identity with your classmates.

2. Go to www.census.gov. Look up the racial and ethnic, age, and gender demographics of your city or state. List at least three implications of these demographics for diversity management and culturally competent health care. Support your list with logical argument and factual information.

3. Why is there a strong association among race, ethnicity, and socioeconomic status? Why is lower SES associated with lower health status? Justify your answer.

4. Go to https://www.thinkculturalhealth.hhs.gov/ and join the Center for Linguistic and Cultural Competence in Health Care (CLCCHC). Then, complete one of the free continuing education programs available on the site and list three things you learned from the program.

5. Go to http://www.culturecareconnection.org/index.html and read two of the ethnic group–specific fact sheets accessible through the home page. Identify an area of difference between the two groups and describe how a culturally competent health care provider might address the difference.

6. Imagine you are the primary care physician for three diverse patients diagnosed with type 2 diabetes. Explain how a systems approach that incorporates patient-centered care and cultural competence could be tailored to produce the best outcome for each patient. Assume differences in one or more immutable and crosscutting diversity dimensions among your three patients.

7. Identity three ways in which the systems approach to diversity and cultural competence in an individual health care organization contributes to improved outcomes (see Figure 1.2).

REFERENCES


