**Policy Brief 1: Rationale for Cultural Competence in Primary Health Care**

# Policy Brief 1

GEORGETOWN UNIVERSITY CHILD DEVELOPMENT CENTER ■ CENTER FOR CHILD HEALTH AND MENTAL HEALTH POLICY ■ UNIVERSITY AFFILIATED PROGRAM

## Rationale for Cultural Competence in Primary Health Care

Nationally, health care organizations and programs are struggling with the challenges and opportunities to respond effectively to the needs of individuals and families from racially, ethnically, culturally and linguistically diverse groups. The incorporation of culturally competent approaches within primary health care systems remains a great challenge for many states and communities. Numerous reasons justify the need for cultural competence in health care at patient-provider level. These include but are not limited to the following:

- the perception of illness and disease and their causes varies by culture;
- diverse belief systems exist related to health, healing and wellness;
- culture influences help seeking behaviors and attitudes toward health care providers;
- individual preferences affect traditional and non-traditional approaches to health care;
- patients must overcome personal experiences of biases within health care systems; and
- health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system.

These patient-provider issues substantiate the need for primary health care organizations to develop policies, structures, practices and procedures to support the delivery of culturally and linguistically competent services. The rationale to incorporate cultural competence into organizational policy are numerous. The National Center for Cultural Competence has identified six salient reasons for review in this policy brief.

### Why is there a compelling need for cultural competence?

■ *To respond to current and projected demographic changes in the United States.*

The make-up of the American population is changing as a result of immigration patterns and significant increases among racially, ethnically, culturally and linguistically diverse populations already residing in the United States. Health care organizations and programs, and federal, state and local governments must implement systemic change in order to meet the health needs of this diverse population. Data from the 1990 census reveal that the number of persons who speak a language other than English at home rose by 43 percent to 28.3 million. Of these, nearly 45 percent indicate they have trouble speaking English. The results of a March 1997 survey conducted by the Census Bureau reveal that one in every ten persons in the United States is foreign-born. Currently, the US foreign-born population comprises a larger segment than at any time in the past five decades. This trend is expected to continue. The Children's Defense Fund predicts that early in the first decade following the year 2000, there will be 5.5 million more Latino children, 2.6 million more African-American children, 1.5 million more children of other races and 6.2 million fewer white, non-Latino children in the United States.

■ *To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.*

Nowhere are the divisions of race, ethnicity and culture more sharply drawn that in the health of the people in the United States. Despite recent progress in overall national health, there are continuing disparities in the incidence of illness and death among African Americans, Latino/Hispanic Americans, Native Americans, Asian Americans, Alaskan Natives and Pacific Islanders as compared with the US population as a whole. In recognition of these continuing disparities, the President of the United States has targeted six areas of health status and committed resources to address cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS and child and adult immunizations aggressively.

U.S. Department of Health & Human Services Public Health Service HRSA Health Resources & Services Administration

*Cancer.* Research shows, in general, that people of diverse racial, ethnic and cultural heritage are less likely to get regular medical checkups, receive

BPHC Bureau of Primary Health Care

MCHB Maternal and Child Health Bureau

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immunizations, and be routinely tested for cancer, when compared with the majority U.S. population.

- Cancer deaths are disproportionately high among Latino/Hispanic Americans and African Americans.
- Vietnamese women are five times more likely to have cervical cancer and Chinese Americans five times as likely t have liver cancer.

*Cardiovascular disease*. Disparities exist in the prevalence of risk factors for cardiovascular disease (corona heart disease and stroke). Racial and ethnic groups have higher rates of hypertension, tend to develop hypertension at an earlier age and are less likely to undergo treatment to control their high blood pressur

- Mexican-American men and women have elevated blood pressure rates.
- Obesity continues to be higher for African American and Mexican-American women.
- Only 50 percent of Native Americans, 44 percent of Asian Americans and 38 percent of Mexican Americans have had their cholesterol checked within the past two years.
- Coronary heart disease mortality is higher for African Americans
- Stroke is the only leading cause of death for which mortality is higher for Asian-American males.

*Infant mortality*. Current studies document that despite recent advances, African American and Native American babies still die at a rate that is two to three times higher than the rate for white American babie

- Statistics reveal that among Native Americans and Alaskan Natives, the incidence of Sudden Infant Death Syndrome (SIDS) is more than three to four times the rate for white American babies.
- While the overall infant mortality rate has declined, the gap between black and white infant mortality rates has widened.

*Diabetes*. Studies indicate that diabetes is the seventh leading cause of death in the United States. Approximately 16 million people in the US have diabetes.

- African Americans are 1.7 times more likely, Latino/Hispanic Americans are 2.0 times more likely, and Alaskan Natives and Native Americans are 2.8 times more likely to have diabetes than whites.
- The Pima Tribe of Arizona has the highest known prevalence of diabetes of any population in the world.
- Native Americans and African Americans have higher rates of diabetes related complications such as kidney disea and amputation as compared to the total population.

*HIV/AIDS*. Recent data from prevalence surveys and from HIV/AIDS case surveillance continue to reflec the disproportionate impact of the epidemic on racially, ethnically and linguistically diverse groups, especially women, youth and children.

- African Americans and Hispanic/Latino groups accounted for 47 and 20 percent, respectively, of persons diagnose with AIDS in 1997.
- Among African Americans, 56 percent of new HIV infections and AIDS cases are a result of intravenous drug usag for Hispanic/Latino groups, 20 percent of new HIV infections and AIDS cases result from intravenous drug use.
- Seventy-five percent of HIV/AIDS cases reported among women and children occur among diverse racial and ethnic groups.

*Child and Adult Immunizations*. Statistics from *the Presidents's Initiative on Race* reveal that for the most critical childhood vaccines, vaccination levels for preschool children of all racial and ethnic groups are abo the same. However, immunization levels for school age children and elder adults of diverse racial and ethn backgrounds continue to lag when compared to the overall vaccination rates of the general U.S. populatio

- While 79 percent of white preschoolers are fully immunized by two years of age, only 74 percent of African American and 71 percent of Hispanic/Latino children, including preschoolers and school-aged children, are fully vaccinated against childhood diseases.
- Annually approximately 45,000 adults die of infections related to influenza, pneumococcal infections and hepatitis despite the availability of preventive vaccines.
- Among the elderly, there is a disproportionate amount of vaccine preventable diseases in racial, ethnic and underserved populations.

Although the reasons for these disturbing gaps are not well understood, it appears that disproportionate poverty, discrimination in the delivery of health services and the failure of health care organizations and programs to provide culturally competent health care to diverse racial, ethnic and cultural populations are al contributing factors.

- ***To improve the quality of services and health outcomes.***

Despite similarities, fundamental differences among people arise from nationality, ethnicity and culture, as well as from family background and individual experience. These differences affect the health beliefs and behaviors of both patients and providers. They also influence the expectations that patients and providers

have of each other. The delivery of high-quality primary health care that is accessible, effective and cost-efficient requires health care practitioners to have a deeper understanding of the socio-cultural background of patients, their families and the environments in which they live. Culturally competent primary health services facilitate clinical encounters with more favorable outcomes, enhance the potential for a more rewarding interpersonal experience and increase the satisfaction the individual receiving health care services.

Critical factors in the provision of culturally competent health care services include understanding of the:

- beliefs, values, traditions and practices of a culture;
- culturally-defined, health-related needs of individuals, families and communities;
- culturally-based belief systems of the etiology of illness and disease and those related to health and healing; and
- attitudes toward seeking help from health care providers.

In making a diagnosis, health care providers must understand the beliefs that shape a person's approach to health and illness. Knowledge of customs and healing traditions are indispensable to the design of treatment and interventions. Health care services must be received *and* accepted to be successful.

Increasingly, cultural knowledge and understanding are important to personnel responsible for quality assurance programs. In addition, those who design evaluation methodologies for continual program improvement must address hard questions about the relevance of health care interventions. Cultural competence will have to be inextricably linked to the definition of specific health outcomes and to an ongoing system of accountability that is committed to reducing the current health disparities among racial, ethnic and cultural populations.

- ***To meet legislative, regulatory and accreditation mandates.***

As both an enforcer of civil rights law and a major purchaser of health care services, the Federal government has a pivotal role in ensuring culturally competent health care services. Title VI of the Civil Rights Act of 1964 mandates that no person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Organizations and programs have multiple, competing responsibilities to comply with Federal, state and local regulations for the delivery of health services. The Bureau of Primary Health Care, in its *Policy Information Notice* 98-23 (8/17/98), acknowledges that: *Health centers serve culturally and linguistically diverse communities and many serve multiple cultures within one center. Although race and ethnicity are often thought to be dominant elements of culture, health centers should embrace a broader definition to include language, gender, socio-economic status, housing status and regional differences. Organizational behavior, practices, attitudes and policies across all health center functions must respect and respond to the cultural diversity of communities and clients served. Health centers should develop systems that ensure participation of the diverse cultures in their community, including participation of persons with limited English-speaking ability, in programs offered by the health center. Health centers should also hire culturally and linguistically appropriate staff."*

The Maternal and Child Health Bureau, through its program efforts related to state accountability and Healthy People Year 2000/2010 Objectives includes an emphasis on cultural competency as an integral component of health service delivery. The National Health Promotion and Disease Prevention Objectives emphasize cultural competence as an integral component of the delivery of health and nutrition services.

State and Federal agencies increasingly rely on private accreditation entities to set standards and monitor compliance with these standards. Both the Joint Commission on the Accreditation of Healthcare Organizations, which accredits hospitals and other health care institutions, and the National Committee for Quality Assurance, which accredits managed care organizations and behavioral health managed care organizations, support standards that require cultural and linguistic competence in health care.

- ***To gain a competitive edge in the market place.***

The provision of publicly financed health care services is rapidly being delegated to the private sector. Issues of concern in the current health care environment include the marketing of health services and the cost-effectiveness of health care delivery. The potential for improved services lies in state managed-care contracts that can increase retention and access to care, expand recruitment and increase the satisfaction of individuals

seeking health care services. To reach these outcomes, managed care plans must incorporate culturally competent policies, structures and practices to provide services for people from diverse ethnic, racial, cultur and linguistic backgrounds.

- ***To decrease the likelihood of liability/malpractice claims.***

Lack of awareness about cultural differences may result in liability under tort principles in several ways. Fo example, providers may discover that they are liable for damages as a result of treatment in the absence of informed consent. Also, health care organizations and programs face potential claims that their failure to understand health beliefs, practices and behavior on the part of providers or patients breaches professional standards of care. In some states, failure to follow instructions because they conflict with values and beliefs may raise a presumption of negligence on the part of the provider.

The ability to communicate well with patients has been shown to be effective in reducing the likelihood of malpractice claims. A 1994 study appearing in the Journal of the American Medical Association indicates that patients of physicians who are frequently sued had the most complaints about communication. Physicians v had never been sued were likely to be described as concerned, accessible and willing to communicate. Whe physicians treat patients with respect, listen to them, give them information and keep communication lines op therapeutic relationships are enhanced and medical personnel reduce their risk of being sued for malpracti

Effective communication between providers and patients may be even more challenging when there are cultural and linguistic barriers. Health care organizations and programs must address linguistic competenc insuring for accurate communication of information in languages other than English.

## Rationale for Cultural Competence: Policy Making Implications for Primary Health Care Organizations and Programs

In the past three years, the National Center for Cultural Competence (NCCC) has documented that policy is most underdeveloped area of the current cultural competence initiatives within Maternal and Child Health (Title V) programs serving children with special health care needs and their families. This observation extenc other human services including primary health care, mental health, social services and education. A recent review of the literature reveals that many of the current health care initiatives lack the policies, planning procedures and institutional structures that support culturally competent practices at the community level. T NCCC recognizes that systematic efforts must be implemented by policy makers or planners of services in o to effect systems change, enhance quality of services and improve health care access and outcomes for racial ethnically and culturally diverse groups.

The conceptual framework of the cultural competence model that is used by the NCCC is based on the following beliefs:

- there is a defined set of values, principles, structures, attitudes and practices inherent in a cultural competent system of care;
- cultural competence at both the organizational and individual levels is an ongoing developmental process; and
- cultural competence must be systematically incorporated at every level of an organization, includ the policy making, administrative, practice and consumer/family levels.

A wealth of literature and other resources has been published and widely disseminated to assist practitione and direct service providers to deliver culturally competent services. The integration of culturally competen principles within the policy realm of primary health care delivery systems remains a great challenge for ma states, communities and programs.

The following checklist is targeted to individuals who have a role in the shaping of policy at the Federal, state and program levels. Policy makers may be board members of private agencies, public agency officials, legisl commissioners, advisory committee members, agency directors and staff of consumer/family organizations goal of this checklist is to facilitate policy making that supports culturally and linguistically competent prin health care services. The questions directly relate to the six areas of rationale presented in this policy brief.

# Checklist to Facilitate the Development of Culturally and Linguistically Competent Primary Health Care Policies and Structures

**Does the primary health care system, organization or program have:**

- ☐ A mission statement that articulates its principles, rationale and values for culturally and linguistically competent health care service delivery?
- ☐ Policies and procedures that support a practice model which incorporates culture in the delivery of services to racially, ethnically, culturally and linguistically diverse groups?
- ☐ Structures to assure for consumer and community participation in the planning, delivery and evaluation of its services?
- ☐ Processes to review policy and procedures systematically to assess their relevance for the delivery of culturally competent services?
- ☐ Policies and procedures for staff recruitment, hiring and retention that will achieve the goal of a diverse and culturally competent workforce?
- ☐ Policies and resources to support ongoing professional development and inservice training (at all levels) for culturally competent health care values, principles and practices?
- ☐ Policies to assure that new staff are provided with training, technical assistance and other supports necessary to work within culturally and linguistically diverse communities?
- ☐ Position descriptions and personnel/performance measures that include skill sets related to cultural competence?
- ☐ Fiscal support and incentives for the improvement of cultural competence at the board, agency, program and staff levels?
- ☐ Policies for and procedures to review periodically the current and emergent demographic trends for the geographic area it serves?
- ☐ Methods to identify and acquire knowledge about health beliefs and practices of emergent or new populations in service delivery areas?
- ☐ Policies and allocated resources for the provision of translation and interpretation services?
- ☐ Policies and resources that support community outreach initiatives for limited English proficient and/or non-literate populations?
- ☐ Requirements for contracting procedures, announcement of funding resources and/or development of request for proposals that include culturally and linguistically competent practices?

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# For More Information...

*For more information on the topics covered in this policy brief, please see the listing of resources below.*

### TOPIC AREA Eliminating Disparities in the Health Status of People of Diverse Racial/Ethnic Backgrounds


American Academy of Ambulatory Care Nursing. "Communicating Across Cultures: Valuing Diversity and Utilizing Cultural Competency in Health Care." *AAACN Viewpoint*, vol.18(5), 1996.

Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry. Office of the Associate Director for Minority Health. (policy statement). Atlanta, GA, 1998.

Community and Family Health Multicultural Work Group, Washington State Department of Health. Building Cultural Competence: A Blueprint for Action. Olympia, WA, 1995. (Originally published by The National Maternal and Child Health Resource Center on Cultural Competency for Children With Special Health Care Needs and Their Families, Austin, 1995).


### TOPIC AREA Improving Quality of Services and Health Outcomes


Harvard Pilgrim Health Care. *The Diversity Journal.* (Brookline, MA, Harvard Pilgrim Health Care Incorporated, 1997).

Roizner, Monica. *A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations*. Boston, MA, Judge Baker Children's Center., 1996.

Texas Department of Health, Center on Cultural Competency. Journey Towards Cultural Competency: Lessons Learned. Washington, DC, Health Resources and Services Administration, Maternal and Child Health Bureau, 1996.

The Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation. Opening Doors: Reducing Sociocultural Barriers to Health Care. Washington, DC, 1997.

## TOPIC AREA Responding to Current and Projected Demographics

Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry. "Minority Health is the Health of the Nation." December 1998: http://www.cdc.gov/od/admh/window/htm.

U.S. Department of Immigration and Naturalization Services. Fiscal Year 1996 Statistical Yearbook. Washington, D.C., 1996.

## TOPIC AREA Gaining a Competitive Edge in the Marketplace

The Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation. Opening Doors: Reducing Sociocultural Barriers to Health Care. Washington, D.C., 1997.

*Ordering information for specific materials referenced in the resource list.*

**Building Cultural Competence: A Blueprint for Action**
Washington State Department of Health
Maternal and Child Health Community
and Family Health
New Market Industrial Campus, Building #7
P.O. Box 47880
Olympia, WA 98504-7880
Phone: (360) 236-3504 or (206) 389-3052
Fax: (360) 586-7868

**The Diversity Journal**
Harvard Pilgrim Health Care
Office of Diversity
10 Brookline Place West
Brookline, MA 02146-7229
Phone: (617) 730-7710
Fax: (617) 730-4695

**A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations**
The Technical Assistance Center for the Evaluation of
Children's Mental Health Systems
Judge Baker Children's Center
295 Longwood Avenue
Boston, MA 02115
Phone: (617) 232-8390
Fax: (617) 232-4125

**Journey Towards Cultural Competency: Lessons Learned**
The Maternal and Child Health Clearinghouse
Phone: (703) 821-8955
Fax: (703) 821-2098
Catalog Information: www.nmchc.org

**Opening Doors: Reducing Sociocultural**
Barriers to Health Care: Lessons Learned
National Program Office
c/o Hospital for Sick Children Health System
1025 Connecticut Avenue, NW, Suite 1100
Washington, DC 20036
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**About the**


The National Center for Cultural Competence (NCCC) is a funded project of the Health Resources Services Administration (HRSA). The project is a collaboration between: the Maternal and Child Health Bureau's (MCHB) Division of Services for Children With Special Health Needs and its Infant and Child Health Branch; and the Bureau of Primary Health Care (BPHC). The mission of the NCCC is to increase the capacity of health care programs to design, implement and evaluate culturally competent service delivery systems. The NCCC is focusing on HRSA funded programs including: 1) Maternal and Child Health Title V programs concerned with children with special health needs and their families; 2) primary health care programs such as Community Health Centers, Migrant Health Centers, Health Care for the Homeless Grantees, Healthy Schools, Healthy Communities grantees, Primary Care Associations and Primary Care Offices; and 3) programs supporting families affected by Sudden Infant Death Syndrome and Other Infant Death.

The NCCC is a component of the Georgetown University Child Development Center, Center for Child Health and Mental Health Policy, and housed within the Department of Pediatrics of the Georgetown University Medical Center. For additional information contact:

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