Research on Culturally Competent Healthcare Systems
Less Sensitivity, More Statistics

David E. Hayes-Bautista, PhD

The good news is that America’s cultural diversity is greater than ever and continues to grow. In large states such as California and Texas, Latino children alone comprise nearly half the pediatric population, and all minority children combined—adding African American, Asian/Pacific Islander (A/PI), and American Indian—make up close to two thirds.

The bad news is that a sound understanding of our diverse cultures, and the importance of culture to health, is still lacking. In assessing current methods to improve the cultural competence of healthcare systems, the Task Force on Community Preventive Services (the Task Force) concluded a careful, thoughtful review of the literature by stating that “...a research base on program effectiveness that would allow informed decision making, is lacking.”

The ugly news is that the entire project of cultural competence in healthcare services has become trivialized, even ridiculed, as a well-meaning but ultimately unproductive public-relations effort that does not advance the practice of medicine or contribute to the science on which that practice is based. The widely read Chronicle of Higher Education carried an article by Mangan in the summer of 2002 that criticized medical school efforts in cultural-competence education as “distractions that produce warm and fuzzy doctors who are ill-informed about human biology and disease.”

Few programs. Little support. No evidence. Should cultural-competence efforts be abandoned? No. Cultural understanding is more crucial to health care than ever. Demographics tell us that the nation is changing, and as it does, America’s health concerns are changing, too. Yet the scope of cultural-competence efforts does need to be broadened. To date, cultural-competence initiatives have focused on the interpersonal aspects of medical care—language, provider sensitivity, ethnic concordance—and as the population becomes more diverse, these efforts at a more appropriate “bedside manner” will continue to be useful. What is really needed, however, is good, hard-nosed, science-based research into the relationships among culture, behavior, and health outcomes. Our work at the Center for the Study of Latino Health and Culture (CESLAC) at the School of Medicine, University of California, Los Angeles, has convinced us that culture and health are strongly linked, and that understanding this link could benefit all Americans, as the strengths of one culture could be applied to others. Yes, strengths. Minority cultures have much to teach the medical establishment about good health. Culture is not a barrier to good health, but an integral part of it.

Most health policy on minority populations and health begins with the “minority health disparity” assumption, i.e., “African Americans, American Indians/Alaska Natives, Asian and Pacific Islander, and Hispanic citizens suffer poorer health and higher rates of premature death than the majority population” due to their higher risk factors: lower income, less education, and poorer access to health care. But by measuring the minority health disparity concept against actual data, as we have done at CESLAC, we discover that it does not hold true.

In California, for example, nearly one of every three residents is now Latino. Latinos do, indeed, have lower incomes, education levels, and access to care than the non-Hispanic white, African-American, or A/PI populations. Yet, Latinos have an overall age-adjusted mortality rate that is 26.0% lower than the non-Hispanic white rate, and about 52.1% lower than the African-American rate. A/PI populations likewise have mortality rates 36.4% lower than the non-Hispanic whites. Infant mortality shows a similar picture: Latinos and A/PI have infant mortalities equivalent to that of non-Hispanic whites. Latinos and A/PI also have 5 to 7 years’ longer life expectancy at birth than non-Hispanic whites (data on American Indians are not yet uniformly available, hence not presented in Table 1).

While the better health profile of A/PI might be imputed to their high educational levels, the surprisingly good profiles for Latinos defy explanation and indeed contradict the Office of Minority Health’s assertion about minority health disparity. This surprisingly

From the Center for the Study of Latino Health and Culture, Division of General Internal Medicine and Health Services Research, The David Geffen School of Medicine at UCLA, Los Angeles, California

Address correspondence to: David E. Hayes-Bautista, PhD, Professor of Medicine, Director, Center for the Study of Latino Health and Culture, Division of General Internal Medicine and Health Services Research, The David Geffen School of Medicine at UCLA, 924 Westwood Blvd, Suite 730, Los Angeles CA 90024. E-mail: dhayes@ucla.edu.
good Latino mortality profile—the “Latino epidemiologic paradox”—is not unique to California; it can be observed nationally and has been consistently noted for nearly 2 decades.

An important research question for a culturally competent healthcare delivery system ought to be this: How can a racial/ethnic population with such high risk factors have such robust health outcomes? The data are clear, obdurate, and unarguable. Latino populations have reduced risk, compared to non-Hispanic white, for the top three causes of death: 35% lower mortality for heart disease, 43% lower for cancers, and 25% lower for stroke. Clearly, this positive result is not due to high income, high educational levels, or superior access to high-quality healthcare services. Instead, the answer must be sought in a rigorous study of Latino culture, behavior, and health: the foods Latinos eat, the families they form, the spiritual communities they create, their very definitions of health and illness, and the like. This is a wide-open, virtually unexplored field of study. Instead, the answer must be sought in a rigorous study of Latino culture, behavior, and health: the foods Latinos eat, the families they form, the spiritual communities they create, their very definitions of health and illness, and the like. This is a wide-open, virtually unexplored field of study that can, and should, be approached with cold, objective scientific rigor. The benefits to understanding the Latino epidemiologic paradox will accrue, oddly enough, not to Latinos, but mostly to non-Hispanic whites and African Americans. An understanding of the interdependence of culture, behavior, and health could save thousands of lives every year through improved outcomes for heart disease, cancer, and stroke alone.

True cultural competence in medicine should not be limited to issues of provider sensitivity. Instead, a large-scale, rigorous, science-based approach to understanding the links among culture, behavior, and epidemiology should be the goal of cultural-competence endeavors. If we understood the mechanisms that make the Latino epidemiologic paradox possible, thousands of American lives could be improved. Once new models have been developed that can explain this seeming paradox, we will have a new conceptual base from which to develop “culturally competent” healthcare delivery systems, and they will probably look rather different from the attempts we are currently making.

I would argue that the Mangan article has it wrong. Lack of science-based research on the relationships among culture, behavior, and health means that we are shortchanging medical students who will practice for the rest of their professional lives in an even more diverse population than today’s. We need more research and effort on cultural competence, not less. The Task Force’s conclusion that research on cultural competence is incomplete does not mean that we have finished. It means we have only begun.

References


Table 1. Mortality rates

<table>
<thead>
<tr>
<th>Percent of population (n in millions)</th>
<th>NH white</th>
<th>Latino</th>
<th>Afri Amer</th>
<th>A/PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-adjusted mortality (%)</td>
<td>431.7</td>
<td>319.5</td>
<td>666.6</td>
<td>274.7</td>
</tr>
<tr>
<td>Infant mortality (%)</td>
<td>5.4</td>
<td>5.6</td>
<td>13.2</td>
<td>4.0</td>
</tr>
<tr>
<td>Life expectancy at birth (%)</td>
<td>77.3</td>
<td>82.5</td>
<td>71.1</td>
<td>83.7</td>
</tr>
</tbody>
</table>

NH white, non-Hispanic white; Afri Amer, African American.