

# Why Culture Matters in Health Care



*Getting to the Heart  
of Health Disparities*

Insights from the *Community Voices* summit:  
“Healthcare in a Multicultural Society”

by

Mary B. Cohen

*Community Voices*  
HEALTHCARE FOR THE UNDERSERVED



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A Community Voices Publication  
National Center for Primary Care  
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by

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The National Center for Primary Care at the Morehouse School of Medicine is the program office for the Community Voices initiative. Community Voices is designed to improve healthcare access and quality. The initiative involves eight learning laboratories across the nation and is targeted at ensuring the survival of the safety-net providers and strengthening community support services. For more information on Community Voices, please visit [www.communityvoices.org](http://www.communityvoices.org). The W. K. Kellogg Foundation funds the Community Voices Initiative.

Opinions and conclusions expressed in this publication are those of the author(s) and do not necessarily reflect those of the W.K. Kellogg Foundation.

## FOREWORD

In *Race Matters*, Cornel West suggests that culture goes beyond behavioral attitudes and values. He states, “Culture is as much a structure as the economy or politics; it is rooted in institutions such as the economy or politics; it is rooted in institutions such as families, schools, churches, synagogues, mosques, and communication industries (television, radio, video, music).” If we accept the premise that culture is embedded in institutions and systems, we must then ask ourselves – What does health mean in a multicultural society? How is culture reflected in the healthcare system? And how does or should the healthcare system respond to an increasingly diverse and multicultural society?

Community Voices and the National Center for Primary Care at the Morehouse School of Medicine are both dedicated to the elimination of health disparities and to assuring preventive and primary care, particularly for those who are most underserved. Developing a shared vision of health and healthcare and establishing models of culturally competent healthcare are primary components of the work undertaken by Community Voices and the National Center. It is in this light that thought leaders, decision makers, policymakers, healthcare providers, and community leaders were brought together to discuss the critical issue of healthcare for a multicultural society.

This summit preceded an international meeting on multicultural health at the Salzburg Seminars in Austria. Selected participants brought the insights, strategies, and recommendations of the Atlanta meeting to Salzburg so that these ideas could be vetted in an international forum. Individually and collectively, the participants of the Atlanta and the Salzburg meetings, along with many others from around the world, possess and provide the knowledge, the energy, and the impetus to reform the healthcare system.

The United States healthcare system can no longer afford to ignore the implications of a multicultural society. Data are clear on health disparities that seem to parallel race, ethnicity and poverty as coexisting and contributing factors. Those in communities of color do less well. What’s more, those who are in communities of color who live in poverty are in peril. Natural disasters around the world and in the United States have shown the fragility of those who are poor and the intractability of the public systems that were, in theory, designed to serve them, and all. It is imperative that we collectively engage in efforts to refine and strengthen the healthcare system so that it works for every man, woman, and child regardless of race, class, age, or gender. It is our intent that this report will assist communities, states, and ultimately the nation, in affirming the need for, and subsequently, in developing an equitable and responsive healthcare system.

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## ABOUT THE AUTHOR



**Mary B. Cohen** has 20 years’ experience working with health care organizations, philanthropies, nonprofits, and universities. Since receiving her Masters degree in Communication in 1987, Cohen has focused on writing and editing for print and internet publications; strategic communications planning; instructional presentation on public speaking and working with the media; and group facilitation. A graduate of the University of Michigan Honors Program in 1974, Cohen is married with three grown children and lives in Kalamazoo, Michigan.

## ACKNOWLEDGEMENTS

There are many to whom gratitude can be expressed for the success of *Healthcare in a Multicultural Society*, however the names are too numerous to note individually. Still, there are several whose contributions and efforts were invaluable in helping to create a dynamic program filled with new insights and robust dialogue. Special thanks are extended to Lisa Hartsock, MPH, Project Director, Community Voices North Carolina and Allan J. Formicola, DDS, Vice Dean for Center for Community Partnerships at Columbia University.

Insights from “**Healthcare in a Multicultural Society**,” a three-day summit sponsored by CommunityVoices: Healthcare for the Underserved and the National Center for Primary Care at Morehouse School of Medicine in Atlanta, Georgia.

## Why Culture Matters in Health Care

### *Getting to the Heart of Health Disparities*

In August 2004, thought leaders from health care systems, state agencies, health organizations, and mainstream media came together with community leaders, elected representatives, and foundation program officers at The Carter Center in Atlanta, Georgia. For three days, some of the people who make institutional and public policy sat with those who see patients in treatment rooms, prepare the next generation of health professionals, educate the public about health, and retrofit programs on the ground. The subject of their discussion was the role of culture in health and health care. And their conclusion was this: The institutions that recognize and respond to the integral role of culture in health will be the architects of vibrant 21<sup>st</sup> century systems of care.

Those who attended “Healthcare in a Multicultural Society” – 126 participants from 22 states and Jamaica – represent a vanguard for health programs and policies.<sup>1</sup> Led by former Surgeon General Dr. David Satcher, now Director of the National Center for Primary Care at Morehouse School of Medicine, and keynote speaker Dr. Paul Farmer, the respected founder of the international Partners in Health, participants exemplified the combination of high moral purpose and down-to-earth pragmatism that characterizes solution-makers. As practitioners, administrators, and teachers they are reducing health disparities by applying hard science in real time and measuring the results. As forerunners of a movement, they stand ready to share what they’ve already learned about how to design functioning health systems for today’s multi-cultural communities.

Community Voices programs are already hammering away at health disparities in urban and rural communities across the United States.<sup>2</sup> They know that acknowledging existing gaps in access to care, health

coverage, oral health, mental health, and representation in health professions is a necessary starting point. And the health improvement partnerships they forge to improve health in specified geographic regions reach across sectors and income levels to connect with Latino, African American, Asian, and other traditionally underserved groups. In comments and questions throughout the summit, participants shared information about these models already up-and-running in their communities. Health systems can learn from these adaptive living laboratories.

Understanding culture is the foundation, they say – not only the culture of the patients who seek care, but the culture of existing health systems and the society that shapes them. “We have to decide whether we believe that health is a right or a commodity to be traded in the marketplace to the highest bidder,” Dr. Satcher said at the outset of the summit. “That’s a cultural issue.” And now is the time to tackle it.

By every indicator, our nation’s population is only becoming more diverse – and the health disparities in U.S. communities more pronounced.<sup>3</sup> As John Quinones of ABC News 20/20 noted, “To be non-white is to be doomed to a life that is significantly less healthy. Why is that?” Quinones and fellow participants pull no punches about the causes: poverty, racism, ignorance, and unequal distribution of an abundance of health resources are at the root, they believe. But they don’t stop there. They trace the scope and depth of disparities primarily to find ways to eradicate them. In the process they debunk myths, discover untapped resources, and generate groundbreaking models of care, so be it. Their ultimate goal is healthier people in healthier communities.

Three days of conversation is not a road map to the ultimate goal, of course. But in presentations, panel

<sup>1</sup>For a complete list of panelists and participants, please page 9-14.

<sup>2</sup>To learn more about Community Voices programs and communities, visit [www.communityvoices.org](http://www.communityvoices.org).

<sup>3</sup>The Institute of Medicine website at [www.iom.edu](http://www.iom.edu) is only one of the many sources of data on health disparities referenced at “Healthcare in a Multicultural Society.”

discussions, and question-and-answer sessions, Summit participants zeroed in on the principles that will guide the way. Their insights suggest promising avenues for practitioners, administrators, the media, foundations, and public officials searching for methods to propel lasting change.

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### **“Culture is a prism.”**

— **Harold P. Freeman, M.D.**, Director, Center to Reduce Cancer Health Disparities, National Cancer Institute, National Institutes of Health

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**W**hen light hits a prism, its rays are bounced every which way as the tiniest elements of a single beam are magnified and separated in an instant. Culture has the same effect on health by exposing “the human circumstances” surrounding illness, Harold Freeman said. “Diseases can be understood scientifically, but they always occur under human circumstances. And these human circumstances are the principle determinants of survival and quality of life.”

In 35 years as a surgeon in Harlem, New York, Dr. Freeman has come face to face with the barriers – financial, experiential, and social – that often prevent his African American and Latino patients from pursuing the best treatment options for their cancer diagnoses. Learning how to overcome those barriers has been a lengthy process, Freeman admitted recalling his expectations as a young cancer surgeon: “I came to a community believing I could cut cancer out of Harlem.” Putting his training to the test, he helped establish a cancer screening clinic and opened its doors. “It was beautiful, but people didn’t come,” he said. “That forced me to go back to the community and see what was driving the point.” Trust, he found, was the missing element.

“There is a lot of distrust in the African American community and perhaps in other communities about the healthcare system. I had to convince them they could trust me,” he said. Eventually Freeman gained the confidence of his community by listening to patients and heeding their counsel. “Perhaps some of the deepest and wisest and most substantive answers came from the people themselves,” he said. “I have learned more from the people of Harlem than they have learned from me.”

Together with the community, Freeman began to reshape one hospital’s system of care around “an intense approach to providing education, access, diagnosis, and treatment.” And the cancer survival rates tell the story. “We found that if people are helped through the system, we get better results,” he said – even though the poverty level and other social barriers remained the same. “Equal treatments at the same stage of disease for breast, lung, and colon cancer result in equal outcome. This is a hopeful point,” Freeman emphasized. “In Harlem Hospital, we have increased the five-year survival for breast cancer from 39 percent to 70 percent by providing screening and navigation.”

Patient navigators are community people who identify barriers to treatment and ease individuals and their families through complex health systems. And while Harlem Hospital data show the dramatic impact of patient navigators, Freeman added, “We have not given it the test that it needs.” That is why the National Cancer Institute issued a request for appropriations to determine if this system innovation in health care delivery would change outcomes in other communities. “Over the next five years, we hope to test this in a scientific way,” he said. “So we may get the answer.”

With culture as a lens to recognize and respond to the social forces that shape community health, practitioners and system administrators stand to do more than better understand problems. They can generate solutions that have real impact on patients, their families, and communities as a whole.

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### **“Healthcare disparities are a cultural disconnect.”**

— **Ian Smith, M.D.**, Medical Reporter,  
New York Daily News, Men’s Health Magazine

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**D**r. Ian Smith talked about the culture clash between patients and health care “insiders” (doctors, nurses, lab technicians, receptionists) as part of a larger systemic issue. “We tell you how to suture, but no one sits you down and says, ‘This is how you deal with these different kinds of situations,’” Smith explained. “‘You have a mother who is HIV positive, three

children, there's no father at home. This is how you talk with this patient. This is how you work with this patient," he said. "You can't treat every patient through a cookie-cutter method."

Disparities in health status, health outcomes, and treatment delivery are driven by this kind of disconnect. Providers and patients don't speak the same language. And in public hospitals and strained health systems, patients fare badly. "On a daily basis I see patients falling through the cracks," Smith said. "When I was at Mount Sinai, which is a big private hospital in New York, these kinds of things never would have happened. There are too many safeguards and checkpoints in place at large, wealthy, private hospitals." Without system safeguards, even very sick patients may forego proper treatment because they don't understand what their providers are recommending, don't know how to access or pay for it, or don't see a way to manage their lives if they do.

Carlos Ugarte, Deputy Vice President of the National Council of La Raza, told the story of designing a "culturally-competent survey instrument" that was going to "make a difference in the way we work with our community." Fresh from earning his masters in public health and an emissary from the Comprehensive Cancer Center for the State of Florida, he went to the clinic to interview patients in Spanish. And the very first cancer patient he talked to was a woman who said, "Thanks very much, but right now I'm thinking of how I'm going to pay for my kids' food tomorrow. I don't have time to think about cancer at this point."

The cultural disconnect is this gap between what Ugarte termed "the reality of our communities" and how health systems conceptualize the work at hand. Right now certain groups in our society – people of color, the poor, women, the mentally ill – bear the brunt. But they are not the only patients who chafe at the way things are. Anne Beal of The Commonwealth Fund referred to the poor health of the underserved as "canaries in the coalmine" – the signal that health care systems are facing fundamental issues. In fact, in a Commonwealth Fund healthcare quality survey<sup>4</sup>, only half of white, middle-class respondents claimed confidence "that they would be able to get good

quality healthcare in the future," Beal noted. So fragile communities are not the only ones that stand to gain by addressing cultural disconnects.

Still, participants agreed that part of the push and pull of generating solutions is getting society as a whole to acknowledge the issue. Gail Christopher, Director of the Health Policy Institute of the Joint Center for Political and Economic Studies, pointed out that "fifty-two percent of people in this country – particularly people who are white – don't believe that health disparities exist." Robert E. Moffitt, Director of The Heritage Foundation's Center for Health, added that misperceptions about health care and coverage skewed problem-solving efforts. "There is a tendency among the general public to see the uninsured population as somehow marginal," Moffitt said. "The truth is that people from all walks of life are uninsured. Eight out of ten uninsured people are working. Three out of four of the uninsured are not in coverage because their employer doesn't offer it."

Given these perceptions, Ian Smith said participants and the media working together have a golden opportunity. "For all of its 'badness' – and we have our problems – the media is underutilized by thinkers like you," Smith said. "One of the biggest ways to impress patients and reach people is through the media. Everyone knows the old saying, 'If it bleeds, it leads in the media.' And that's still true. But there is a tremendous amount of programming out there – from radio to print to broadcast – where you're able to communicate some of these issues. More stories – and the solutions, which is what you guys work on – have got to get out."

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### ***"At-risk is a transitional state."***

— **John Rich, M.D., MPH**, Medical Director,  
Boston Public Health Commission

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**H**omelessness is something you can transition out of," John Rich reminded participants. "Young black men become middle-aged black men." People are more varied and complex than any label can suggest. And that is why circumstances at one point in time do not necessarily mark the boundaries of an individual's

<sup>4</sup>Please see [www.cmwf.org](http://www.cmwf.org) for the Commonwealth Fund's Healthcare Quality Survey and other publications.

character, personal resources, or long-term possibilities. So while Rich and others acknowledged the importance of support “focusing on people who have already had something bad happen to them and who are at risk for something else bad,” they cautioned against the kind of categorizing for “special populations” that misses “the larger part of people’s lives.”

Systems can foster equal opportunity in health care by recognizing that the people “in the soup” today can help all of us get out of it later. As an example, Dr. Rich explained the rationale behind changing the City of Boston’s policy on criminal background checks in hiring. “We realized we had to move to a case by case evaluation,” he explained. “If we are hiring substance abuse counselors, we cannot exclude people who were arrested because they possessed something they were addicted to. Sometimes those findings represent a unique life experience that we need to incorporate into our organizations,” Rich said. “We’ve had to think about our job as broader than that.”

For Rich as Medical Director of the Boston Public Health Commission it’s a “we issue” – an indicator that the system creates opportunities for people based on where they are today.<sup>5</sup> Other participants chimed in with examples of policies and practices changed by broader thinking among health care administrators and practitioners. Carolyn Ballard, MPH, CHE, National Program Deputy Director for State Action for Oral Health Access<sup>6</sup>, told of an Oregon program that’s weaving oral health care into primary care for pregnant women. “In Oregon, there’s an emphasis on caring for children and helping to prevent early childhood caries,” she said. Since many women are open to adopting new health habits during pregnancy, patients periodically see a dentist as well as an obstetric provider at clinic visits. By bringing the dentist to the primary care site and eventually giving new mothers a dental care “home,” administrators are creating a system pathway for families to access dental care.

Gail Christopher of the Joint Center for Political and Economic Studies told about a Hamden County, Massachusetts sheriff who “decided he was going to make sure the inmates in his jail had adequate medical care” and dramatically changed corrections system

outcomes in the process. The people who received attention to their health issues while incarcerated were less likely to return to jail when released. “These were criminal justice system workers who saw the problem in terms of health needs, addressed it, and reduced recidivism rates,” she explained. “The implications of that are phenomenal.”

Addressing the health needs of prisoners in the United States is not an idea with much “political saliency,” Christopher noted. But prison inmates may be the best example of people in a transitional at-risk state. According to Kimberly Arriola, Assistant Professor at the Rollins School of Public Health of Emory University, “Ninety-five percent of state prison inmates come out eventually and they’re coming home to our communities.” And Dr. Michelle Staples-Horne, Medical Director for the State of Georgia Juvenile System, reminded participants, “One hundred percent of juveniles will go back to the community.”

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### **“None of these are insuperable problems.”**

— **Paul Farmer, M.D., Ph.D.,**  
Co-founder, Partners in Health

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CNN’s Sanjay Gupta asked Paul Farmer if his first experiences in Haiti as a young medical student prompted “a sense of despair” or an “I can fix this” response. And Farmer replied, “I think that one of the things that struck me was how a modicum of effort could save lives.” He used the example of tuberculosis in many parts of the world. “Until AIDS came along, TB was the leading infection killer of young adults from age 20 to 50. Now why is that shocking?” Farmer asked the audience. “Well, because it’s a completely curable disease since the 1950s – with drugs that cost as little as \$12 a year.”

For Dr. Farmer, bringing the resources of medical science to bear on health challenges is something of a “no-brainer.” Partners in Health, the international organization he co-founded, successfully takes on HIV-AIDS in Haiti, multi-drug resistant TB in Peru, and epidemics in the prisons of Russia<sup>7</sup>. Project

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<sup>5</sup>For more information about the Men’s Health Initiative, see articles at [www.communityvoices.org](http://www.communityvoices.org).

<sup>6</sup>Please see Center for Health Care Strategies, Inc. at [www.chcs.org](http://www.chcs.org) for additional information.

experience is the basis of “the Haitian model” of community-based care. “It’s actually a higher standard of care” for the diseases that ravage impoverished communities, he explained. And for Farmer, understanding the method is not particularly complicated. “Where do the interventions get made?” he asked. “The answer is, ‘All along the way.’”

Farmer juxtaposed health data tables and graphs with the images of “supposedly incurable patients” who live in the central plains of Haiti, the slums of Lima, and Russian jails. DOT-plus, or directly-observed therapy plus the support of community health workers, adequate nutrition, and other non-medical treatments, is one part of the Partners in Health story. Farmer and his colleagues have illustrated how medical care woven into community practices can improve the health of the most vulnerable communities. They have also created a pathway to deal with “transnational cases” of airborne diseases. When a lethal case of multi-drug resistant TB surfaced in Massachusetts, Partners in Health helped figure out the source and built on that experience to modify accepted health system practices. “You don’t close the door on epidemics,” Farmer said. “And you certainly don’t close the door on airborne epidemics.”

Another dimension of Partners in Health projects is the creative diligence of practitioners who don’t back down when it comes to their patients. “This is my patient and he or she needs this intervention,” Farmer paraphrased to describe how a practitioner can approach seemingly insoluble problems. “The intervention exists. I’m interested in my patient’s well-being.” It’s a way of thinking that drives solutions for patients and health systems. “I insist that there be a reasonable solution in this problem that ends up in a good outcome for the patient,” he explained. “That is not a policy, but that can be a building block to policy.”

Having built health systems and changed health outcomes in Haiti, Farmer spoke plainly about the opportunities here at home. “In a country like ours we have abundant resources if there were the political will and mandate to use them equitably,” he said. “Low birth weight, the life expectancy for African American men – none of the disparities in Dr. Satcher’s report could not be touched by the resources already at hand.”

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## “It’s not just a PR thing to do.”

— Anne Beal, M.D., Senior Program Officer, The Commonwealth Fund

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Medical errors and low staff morale can be signs of the same cultural disconnect that drives health disparities, participants emphasized. “Provision of language access services is not just the nice thing to do,” Anne Beal of The Commonwealth Fund explained. “It helps to prevent medical errors. It helps reduce our risk in terms of medical-legal issues. So when they’re saying, ‘We really don’t have the money for this,’ all it takes is one lawsuit from a patient who doesn’t speak the language to make people find a way to provide these services.”

Beal and others raised the issue of health literacy as emblematic of hidden cultural gaps that interfere with treatment. “As a clinician, it is very obvious and clear to me when my patients don’t speak English,” she said. “It is not so obvious and clear to me when they are reading at a third grade level or they don’t understand the things I’m talking about.” The push to encourage patients to speak up in their care is bumping up against “the new frontier of low health literacy.” And medical providers attending the Summit acknowledged they have a role to play in addressing it. Dr. Jean Bonhomme, President of the National Black Men’s Health Network observed, “I’ve seen a cardiologist talk to a lay patient using terms like myocardium and stenosis. And the patient has no idea what is going on. I have to slow down and say, ‘Myocardium is heart muscle.’”

As Ian Smith said, “I’ve seen this happen. At the end of a very complicated, very emotional conversation, the patient will opt out of a treatment that is probably better and more curative simply because they had no clue what the doctor was talking about.” In order to meet people where they are and draw them into systems of care, recognition of language and literacy issues are critical.

The flip side of the coin is how addressing cultural issues can uplift and encourage staff in health systems. Paul Farmer talked about motivation and retention in health professions when he observed, “Your doctors, nurses, community health workers – when they don’t

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<sup>7</sup>To learn more about Partners in Health project experience, visit [www.pih.org](http://www.pih.org).

have the tools that they need to do their work, then you're going to pay a price." No matter how dedicated health professionals are, "it's just too debilitating," he said. Seeing results – people who get better, communities that rebound – helps health system staff continue to serve organizations in good faith.

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### ***“Documentation beats conversation any time.”***

— **Mary G. McIntyre, M.D., MPH**, Medical Director,  
Alabama Medicaid Agency

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**M**ary McIntyre built a public-private partnership to provide oral health care to 150,000 of Alabama's neediest children<sup>8</sup>. And she has three words for people interested in following in her path: "Data, data, data." Like her peers in state agencies across the country, she came smack up against widespread need and no funding. "So basically what we did was come up with a plan and then we went out to find how we could fund it," McIntyre said. Shuttling between dental care providers, other state agencies, and the legislature deepened McIntyre's conviction that information is crucial. "I can tell you all day long how bad it is, but I need to be able to give you the proof to show you that," she said.

Under McIntyre's stewardship, Medicaid claims processing in Alabama has been simplified and payment rates for dental services adjusted. Thanks to one-on-one detailing of dental practices, the number of dentists who will accept Medicaid clients is rising, too. And Alabama legislators are beginning to acknowledge the connection between oral health, education, and economic issues in their state. But McIntyre emphasized that the need for more – and more targeted – information still exists. "In Alabama, there is no idea of what the ethnic makeup of the oral health workforce is currently. The dental board doesn't capture it; neither does the medical board. This is something that's not even on the radar," she said. "When we talk about building a multicultural workforce, the information is not there."

Many participants underscored the value of collecting and sharing data to get a more accurate picture of

disparities in workforce representation, treatment practices, and other issues related to the role of culture in health care. As Anne Beal observed, "I used to receive notices on what proportion of my asthmatic patients received the influenza vaccine every single year. Those were quality indicators. But what if they had then stratified that by race and ethnicity and told me, 'Well you're doing right by this group of patients but not so well by that group,'" she explained. "Just the data alone would have been a very powerful tool to get me to change my behavior if I was giving a different standard of care to my patients." Data related to culture can drive practice and health system decisions and, with the right leadership, improve processes and outcomes.

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### ***“We have basically changed to a patient-based model of care.”***

— **Emilio Carrillo, M.D., MPH**, President and Chief  
Medical Officer, New York Presbyterian Community  
Health Plan

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**A**ppreciating culture is more than a process of slotting patients into ethnic categories. As Emilio Carrillo, President and Chief Medical Officer of New York Presbyterian Community Health Plan said in mock exasperation: "In the literature there is a reference to 'the Latino patient' who is all about family, all about respect, and fatalistic. I don't think I'm fatalistic!" Such stereotypes about culture only oversimplify the needs of individuals and obscure the dynamics of communities.

"Culture is a shared pattern of values, beliefs, and behaviors," Carrillo emphasized. "Culture is not race, not ethnicity, not status. There's no such thing as a Latino patient, a black patient, an Asian patient." But there are quantifiable disparities in health coverage, health outcomes, and health status among people of varying ethnicities and those signal a problem.

"Healthcare access has a definitive link – an evidence-based link – to disparities and poor health outcomes," Carrillo noted. Latinos and African Americans are far more likely to be uninsured than their white counterparts and the domino effect of lack of access to care,

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<sup>8</sup>For more information about Alabama's Medicaid program visit [www.medicaid.state.al.us](http://www.medicaid.state.al.us).

less preventive care, and delayed treatment for illness are driving poor health outcomes. Understanding the interplay among factors was the key to reorienting New York Presbyterian's model of care. The "patient-based model of care" helps providers and patients straddle language issues as well as "things that in all cultures are sensitive issues – like gender, authority, confidentiality," said Carrillo.

"The personal perspective is very important," he explained – for patients and providers. "As providers of care, we have the biomedical culture that affects it and also our own personal culture. So recognition of the culture is the first and most important thing. Then to be able to understand what this means to the patient, what's at stake for the patient. To earn the trust, we need to acknowledge, explain, and negotiate with the patient."

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***"All of us as health professionals need to be involved. That is really the health policy implication at the moment."***

— **Jack Geiger, M.D.**, Arthur C. Logan  
Professor Emeritus, City University  
of New York Medical School

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**D**r. Jack Geiger reminded participants that promoting health and human rights on behalf of patients is an important part of every provider's "lifelong professional activity." After more than 60 years of labor and leadership in addressing the root causes of health disparities, Geiger acknowledged that progress toward genuine equity in society seems to occur in "relatively limited bursts . . . followed by much longer periods of stagnation and regression." Referring to the Civil Rights struggle in the United States, he observed: "We are confronting still the same basic problems of racism and inequality that we were forty years ago. They affect the kinds of disparities we have been talking about."

Only addressing disparities in health care will not get to the root of health inequities, Geiger explained. "Health status does not depend primarily upon – and will not be fixed primarily by – interventions in the healthcare system, but rather by changes in the social determinants of health," he stated. "Income and

housing and nutrition and dignity and the absence of stress and all the other things we've talked about need to be policy concerns of those of us in the health professions." As scientific data accumulates to support the strong links between social conditions and health status, medical providers are in a unique position to help public and institutional policy makers pay attention to the role culture plays in community health.

Geiger admitted that providers are working against a culture "in which populations of people of color are all too frequently regarded first as sinkholes of pathology rather than with any concern for the strength and resilience and abilities they may contain." That's why he called upon today's providers "to train a next generation of physicians and dentists and community health workers and community people" committed to involvement in both patients' lives and the political and social forces that shape health care systems.

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***"The key policy trick is how do you address genuine systemic problems in the healthcare system while retaining what is best about it?"***

— **Robert E. Moffitt, Ph.D.**, Director,  
Center for Health, The Heritage Foundation

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**T**he good news is that Americans are living longer and they are in fact healthier than ever before in our history," Robert Moffitt reminded participants. Added to that, "we are the undisputed world leader in medical science and technology," he said – thanks to antibiotics, antiviral medicines, sophisticated imaging technology, and a growing "medicine chest" for treating cardiovascular disease, diabetes, arthritis, depression, and other chronic diseases. "That's the good news," Moffitt summarized, "and it's really good." But it's not the whole story.

"The bad news is largely rooted in healthcare financing," he continued – "financial problems that are related to both public and private systems." Double-digit increases in the cost of care and gaps in health coverage make "health insurance markets become less competitive with every passing day." As employers large and small wrestle with the economics of health care, the pressure for change will grow. "Health care

costs are soaring,” Moffitt said, “and it’s driving policymakers at the federal and state level mad. I talk to state officials all the time – Republicans, Democrats, liberal, conservative. They sweat blood over this.”

As the cost-driven forces for change gather, Moffitt suggested trying “to change the conversation in this country on cost and focus it more on value – value for the money. The dollars we’re spending, we’re going to spend a lot more,” he acknowledged. “We’ve got 40 million people on Medicare now. When I retire – I’m part of the baby-boomer generation – we’re going to have 80 million on Medicare. The costs are going to be explosive. The point is: Are we getting the best value for the money?” Looking at healthcare quality, access, and accountability puts the people who design healthcare delivery and financing mechanisms in a better position to change and improve systems. “There’s certainly no disagreement I know among my colleagues that insurance coverage is a social good,” Moffitt added. “But the policy of the federal government is to distribute the tax benefits for this social good to upper income people who frankly need it the least.” The good news-bad news combination is an opportunity, he told participants, to promote lasting change in systems.

## **Culture as the Starting Point for Reshaping Systems**

The collective insights of those who participated in “Healthcare in a Multicultural Society” are not easily distilled into a set of recommendations. But the discussion and shared experience of the Summit point to a growing body of knowledge that can guide practitioners, administrators, and health professions educators, as well as those who shape institutional and public policies. And participants agree that at the heart of this emerging field are some practical dictums that can be applied to serious work at any level of health planning or care.

### **■ Take Culture Seriously.**

Acknowledge disparities, identify cultural disconnects, and give them your full attention. Whether you are a practitioner, health system administrator, or public policy maker, listen to patients and heed their counsel. Then apply what you learn to patient care, health professions education, and health care financing. The fault lines exposed by one group or community put many others at peril. So at every opportunity, build pathways, checkpoints, and safeguards to bridge system gaps.

### **■ Form Partnerships Across Sectors.**

Practitioners alone cannot improve health outcomes. Providers and patients must work alongside media, community organizations, and public and institutional policy makers to change systems. Success stories and hard data culled from program experience illustrate what is possible in health systems. But to generate the necessary resources, desire, and political will to solve systemic problems, healthcare providers, administrators, and communities will need strong, resilient partnerships and lots of them.

### **■ Use and Adapt Groundbreaking Models.**

Every single person who attended the Summit is a resource, a problem-solver, a visionary. The models of care they create, refine, and share are the building blocks of more adaptive, effective health care systems. The financing and regulatory and operational hurdles they overcome hold the keys to problem-solving on a much larger scale. So these models need to be talked about, written about, and tried elsewhere. And the people who know them best need opportunities to help others learn from work already underway.

# Healthcare in a Multicultural Society

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