



National  
Center  
for  
Cultural  
Competence

# Policy Brief 1

GEORGETOWN UNIVERSITY CENTER FOR CHILD AND HUMAN DEVELOPMENT ■ UNIVERSITY CENTER FOR EXCELLENCE IN DEVELOPMENTAL DISABILITIES

## Rationale for Cultural Competence in Primary Care

The National Center for Cultural Competence views mental health as an integral and inseparable aspect of primary care. For the purposes of this brief, the term primary care refers to both health care and mental health services, and to the providers of such services.

Nationally, organizations and programs that provide primary care are struggling 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 care systems remains a great challenge for many states and communities. Numerous reasons justify the need for cultural competence at the 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, mental health, healing and well-being;
- culture influences help-seeking behaviors and attitudes toward primary care providers;
- individual preferences affect traditional and other approaches to primary care;
- patients must overcome personal experiences of biases within primary care systems; and
- primary care providers from culturally and linguistically diverse groups are under-represented in current service delivery systems.

These patient-provider issues substantiate the need for primary care organizations, delivering both health and mental health care services, to develop values, policies, structures and practices that are culturally and linguistically competent. The rationale to incorporate cultural competence into organizational policy are numerous. The Center has identified seven 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 continues to change as a result of immigration patterns and significant increases among racially, ethnically, culturally and linguistically diverse populations already residing in the United States. Primary care organizations and Federal, state and local governments must implement systemic change in order to meet the health and mental health needs of this diverse population. 2000 Census data show that over 47 million persons speak a language other than English at home, up nearly 48% since 1990. Although the majority are able to speak English, over 21 million speak English less than “very well”, up 52% from 14 million in 1990 (Census, 2000). Since 1990, the foreign-born population has grown by 64% to 32.5 million persons, accounting for 11.5% of the U.S. population (Schmidley, 2003). The trend is expected to continue. By the year 2030, the Census Bureau predicts that 60% of the U.S. population will self-identify as White, non-Hispanic, and 40% will self-identify as members of other diverse racial and ethnic groups.

#### ■ 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 than 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 U.S. population as a whole. The U.S. Department of Health and Human Services (DHHS), through its 2010 Objectives, established goals for the elimination of racial and ethnic disparities in health. Six major areas of health status have been targeted for elimination including cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS and child and adult immunizations. Regrettably, since this Brief was originally published in 1999, there has been little change in these indicators of illness and death.

- **Cancer.** Research shows, in general, that people of diverse racial and ethnic groups are less likely to get regular medical checkups, receive immunizations, and be routinely tested for cancer, when compared with the majority U.S. population.
  - African-Americans have the highest rates of cancer of any racial/ethnic group in the U.S.
  - Cancer deaths are disproportionately high among Latino/Hispanic Americans.
  - Vietnamese women are five times more likely and Mexican and Puerto Rican women 2 to 3 times more likely to have cervical cancer than White women. (Intercultural Cancer Council, 2001).
- **Cardiovascular disease.** Disparities exist both in the prevalence of risk factors for cardiovascular disease (coronary heart disease and stroke) and the way in which care is delivered.
  - African Americans have by far the highest death rate for stroke and coronary heart disease, and the prevalence of high blood pressure in African Americans is among the highest in the world (American Heart Association, 2002).
  - Stroke is the only leading cause of death for which mortality is higher for Asian-American men.
  - Obesity continues to be higher for African American and Mexican-American women compared to non-Hispanic White women. (CDC, 2002).
  - Schulman et al (1999), in a study published in the *New England Journal of Medicine*, found that physicians were significantly less likely to refer African-American women for catheterization than White men.
  - In a study by Nelson et al. (2002), African Americans and Mexican Americans were less likely to report serum cholesterol screening than Whites. African Americans and Mexican Americans were also less likely than Whites to take cholesterol-lowering agents when identified as having high cholesterol requiring medication.
- **Infant mortality.** Current studies document that despite recent advances, African American and Native American babies still die at a much higher rate than the rate for White American babies (Health, United States, 2002).
  - Sudden Infant Death Syndrome (SIDS) mortality rates for Native Americans are almost 3 times higher and for African-Americans more than 2 times higher than for Whites (National Vital Statistics Systems, cited by DHHS).
  - While the overall infant mortality rate has declined, the gap between Black and White infant mortality rates has widened.
- **Diabetes.** Diabetes has been recently described as reaching epidemic proportions in the United States. Studies indicate that diabetes is the sixth leading cause of death in the United States (National Vital Statistics Report, 2002). Approximately 17 million people in the United States have diabetes (DHHS, 2002). Disparities in the treatment of diabetes are also well documented in the literature.
  - American Indians and Alaska natives are 2.6 times as likely and Mexican-Americans and African-Americans are 2 times as likely as non-Hispanic Whites to have diagnosed diabetes (CDC, 2002).
  - Native Americans, Hispanic/Latinos and African Americans have higher rates of diabetes-related complications such as kidney disease, blindness, and amputation as compared to the White population.
  - African-Americans are more likely to develop end stage renal disorder due to diabetes but Whites receive 92% of all transplants (Isaacs et al, 2000). Even among patients who expressed a “very certain” desire for kidney transplantation, African Americans are significantly less likely than Whites to be referred by medical personnel for transplantation (Ayanian, 1999).
- **HIV/AIDS.** Recent data from prevalence surveys and from HIV/AIDS case surveillance continue to reflect the disproportionate impact of the epidemic on racially and ethnically diverse groups, especially women, youth and children.
  - Of AIDS cases reported to CDC through 2001, African Americans and Hispanics accounted for 78% of the cases among women and 82% of the cases among children (CDC, 2002).
- **Child and Adult Immunizations.** Immunization levels for school age children and elder adults of diverse racial and ethnic backgrounds continue to lag when compared to the overall vaccination rates of the general U.S. population.
  - Even with the same insurance, Hispanic elderly were less likely to receive flu and pneumonia immunizations (Mark & Paramore, 1996 as cited in Mayberry et al, 1999).
  - Even with the availability of vaccines, the rate of Hepatitis B in adults and high-risk groups is 3 to 4 times higher for African Americans and Asians than for Whites; and twice as high for Native Americans as Whites (CDC Wonder, retrieved 7/17/01).

The evidence clearly suggests a complex array of factors contribute to racial and ethnic disparities in health. Many of these factors are well documented, some are interrelated, while others are not well understood and

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require more research. The groundbreaking report by the Institute of Medicine (IOM), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002), verifies this premise with compelling evidence. Selected findings of the IOM state that:

- racial and ethnic disparities in healthcare occur within the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life.
- many factors—including health systems, healthcare providers, patients and utilization managers—may contribute to racial and ethnic disparities in healthcare.
- bias, stereotyping, prejudice and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare.

■ **To eliminate disparities in the mental health status of people of diverse racial, ethnic and cultural groups.**

Racial and ethnic disparities in mental health are as prevalent as the previously described areas of health disparity. The literature documents the complicated correlation of risk factors, disease incidence, and social, biological and behavioral factors that contribute to these disparities.

- The first ever Surgeon General’s report on mental health issued in 1999 emphasized the importance of culture for both patients and providers. “The cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services.” (Executive Summary). This report documents pervasive disparities in mental health care and that racially and ethnically diverse groups:
  - are less likely to receive needed mental health services and more likely to receive poorer quality of care.
  - are over represented among the vulnerable populations who have higher rates of mental disorders and more barriers to care.
  - face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health.
- Moreover, there is a clear correlation between chronic physical illness and mental illness. According to the Supplement to the Surgeon General’s Report (2001), chronic physical illness is recognized as a risk factor for mental illness when risk is considered for individuals. A single risk factor increases the probability of mental illness and must also be considered within the presence of other individual, family and community risk factors along with the presence of protective factors such as spirituality, supportive family relationships and availability of health and social services within the community.
- The IOM published a report entitled *Health and Behavior: The Interplay of Biological, Behavioral, and Societal Influences* (2001) which defines health broadly, including the positive concept of well-being. According to the IOM, almost half of all the deaths in the U.S. are linked to behavioral and social factors.

These reports lend credence to the world view of many cultural groups whose belief systems integrate physical, emotional and spiritual well-being, and hold that all three are necessary for their overall health and well-being.

■ **To improve the quality of services and primary care outcomes.**

Despite similarities, fundamental differences among people arise from such cultural factors as nationality, ethnicity, acculturation, language, religion, gender and age, as well as those attributed to family of origin and individual experiences. 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 care that is accessible, effective and cost-efficient requires providers to have a deeper understanding of the socio-cultural background of patients, their families and the environments in which they live. Recent studies have shown that culturally and linguistically competent primary care increases patient satisfaction, health outcomes, and higher levels of preventive care (Lasater et al, 2001; Lee et al, 2002; Saha et al, 1999).

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

- beliefs, values, traditions and practices of individuals and families within their cultural context;
- culturally-defined strengths and needs related to health and mental health of individuals, families and communities;
- culturally-based belief systems of the etiology of illness and disease and those related to health, healing and well-being; and
- attitudes toward seeking help from primary care providers.

Providers must understand the beliefs that shape a person’s approach to health, well-being and illness. Knowledge of customs and healing traditions are indispensable to treatment and interventions. Primary care—health and mental health services—must be received *and* accepted to be successful.

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

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

The requirement for care to be delivered in a culturally and linguistically competent manner is increasingly emphasized by legislative, regulatory and accrediting bodies.

■ ***Legislative and Regulatory***

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.” In 2000, the Office of Civil Rights issued a policy guidance for Title VI. Also in 2000, DHHS, Office of Minority Health published the final national standards on culturally and linguistically appropriate services (CLAS) in health care.

The Health Care Fairness Act of 1999 was passed as PL 106-525, the Minority Health and Health Disparities Research and Education Act of 2000, to establish a Center at the National Institutes of Health for the purpose of addressing continuing disparities in the burden of illness and death experienced by diverse racial, ethnic and cultural groups.

■ ***Accreditation***

State and Federal agencies rely on private accreditation entities to set standards and monitor compliance. The Joint Commission on the Accreditation of Healthcare Organizations, which accredits hospitals and other health care institutions, the Liaison Committee on Medical Education, the accrediting organization for medical education, 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.

**Bureau of Primary Health Care Policy  
Information Notice 98-23, (8/17/98)**

*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.*

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### ■ To gain a competitive edge in the market place.

A significant proportion of publicly financed primary care services continue to be delegated to the private sector. In the current social and political environment, skyrocketing health care costs, quality and effectiveness of service delivery continue to be of utmost concern. Organizations that embrace the values of cultural competence, and which infuse such practices in the provision of primary care are not only well positioned in the current market place, but also for the future as the diversity of the U.S. population continues to increase. Primary care organizations must be able to support their providers to acquire cultural knowledge, and develop skill sets that will enable them to work effectively with diverse patient populations. Implementing culturally competent service delivery systems can positively impact provider recruitment and retention, patient access to and satisfaction with care, and maintain or increase market share. The literature cites the challenges and opportunities that health care and mental health organizations must undertake to both reach this market and provide services in an effective and culturally competent manner.

- Roberto Suro (2000) states that “For both public and private healthcare providers, a burgeoning new market awaits, replete with disproportionately young, child-bearing, and often upwardly mobile consumers. But gaining access to that market requires a running jump across many cultural divides” (p. 2).
- Racially and ethnically diverse customers spent \$25 billion on pharmaceuticals in 1999. Despite this, Thorne (2001) states that these customers represent “largely untapped markets” and notes that “historically, the industry has been more comfortable with addressing linguistic rather than cultural differences” (p. 3).

### ■ To decrease the likelihood of liability/malpractice claims.

Lack of awareness about cultural differences, and failure to provide interpretation and translation services, may result in liability under tort principles in several ways. For example, providers may discover that they are liable for damages as a result of treatment in the absence of informed consent. Also, primary care organizations and programs face potential claims that their failure to understand beliefs, practices and behaviors 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 reduce the likelihood of malpractice claims. A study appearing in the *Journal of the American Medical Association* (1997) indicates that the patients of physicians who are frequently sued had the most complaints about communication. Physicians who had never been sued were likely to be described as concerned, accessible and willing to communicate. When providers treat patients with respect, listen to them, give them information and keep communication lines open, therapeutic relationships are enhanced and risks of malpractice lawsuits can be reduced.

Effective communication between providers and patients may be even more challenging when there are cultural and linguistic barriers. Primary care organizations and programs must address linguistic competence—ensuring for accurate and effective communication in languages other than English and addressing the communication needs of persons with disabilities and those who are not literate or with low literacy. This will require policy, structures, practices, procedures, and dedicated resources to support this capacity (Goode & Jones, 2002).

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

The NCCC has documented since 1995 that policy is the most underdeveloped area of the many cultural competence efforts within Maternal and Child Health (Title V) programs serving children with special health care needs and their families. This observation extends to other service systems including primary health care, mental health, social services and education. A recent review of the literature reveals that many of the current efforts in health and social services lack the values, policies, planning processes and organizational structures that support culturally competent practices at both the institutional and community levels. Systematic efforts must be implemented by policy makers and planners of services to: (1) effect change within systems and organizations, (2) enhance quality of services and access to primary care, and (3) improve outcomes for racially and ethnically diverse groups. Such sustained efforts can have a profound impact on the goal to eliminate racial and ethnic disparities in both health and mental health care.

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The National Center for Cultural Competence embraces a conceptual framework and model for achieving cultural competence based on the Cross et al. definition (1989). Cultural competence requires that organizations:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
- incorporate the above in all aspects of policy making, administration, practice/service delivery and involve systematically consumers/families.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum.

A wealth of literature and other resources has been published and widely disseminated to assist practitioners and direct service providers to deliver culturally competent services. The integration of culturally competent values and principles within the policy realm of primary care service delivery systems is both a challenge and an opportunity.

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

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

Does the primary care system, organization or program have:

- a mission statement that articulates its principles, rationale and values for culturally and linguistically competent health and mental health care service delivery?
- policies and procedures that support a practice model which incorporates culture in the delivery of services to culturally and linguistically diverse groups ?
- structures to assure the meaningful participation of consumers and communities in planning, delivery and evaluation of 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 awareness, knowledge and skills in the area of cultural and linguistic competence?
- 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 and linguistic 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, and communication in alternative formats?
- policies and resources that support community outreach initiatives for those with limited English proficiency and/or populations that are not literate or have low literacy skills?
- requirements that contracting procedures and proposals and/or request for services include culturally and linguistically competent practices?

## References Used to Prepare This Policy Brief

- American Heart Association. (2002). *Cardiovascular Disease Statistics*. Retrieved August, 2002, from [www.americanheart.org](http://www.americanheart.org)
- Ayanian, J. Z., Cleary, P. D., Weissman, J. S., & Epstein, A. M. (1999). The effect of patient's preferences on racial differences in access to renal transplantation. *The New England Journal of Medicine*, 341(2), 1661-1669.
- Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Human Services. *BPHC policy information notice: 98-23 Date: August 17, 1998*. Retrieved March 27, 2003, from <http://bphc.hrsa.gov/Grants/wordocs/Pin98-23%20HC%20Prog%20Expectations.pdf>
- Centers for Disease Prevention and Control, CDC Wonder. *Data 2010: The healthy people 2010 database, June 2001 edition*. Retrieved July 17, 2001, from [www.cdc.gov](http://www.cdc.gov)
- Centers for Disease Prevention and Control, CDC Wonder. *Data 2010: The healthy people 2010 database (2000): Focus area: 01-Access to quality health services*. Retrieved July 17, 2001, from [www.cdc.gov](http://www.cdc.gov)
- Centers for Disease Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion. (2002). *National diabetes fact sheet*. Retrieved March 3, 2003, from <http://www.cdc.gov/diabetes/pubs/estimates.htm>
- Centers for Disease Prevention and Control, National Center for Health Statistics. (2002). *Health, United States, 2002*. Retrieved March 3, 2002, from <http://www.cdc.gov/nchs/>
- Centers for Disease Prevention and Control. (2002). *HIV/AIDS among African-Americans: Key facts*. Retrieved March 3, 2003, from [www.cdc.gov](http://www.cdc.gov)
- Centers for Disease Prevention and Control. (2002). *HIV/AIDS among Hispanics in the United States*. Retrieved March 27, 2003, from [www.cdc.gov/hiv/pubs/facts/hispanic.htm](http://www.cdc.gov/hiv/pubs/facts/hispanic.htm)
- Centers for Disease Prevention and Control, National Center for Health Statistics. (2002). *Prevalence of overweight and obesity among adults: United States 1999-2000*. Retrieved March 3, 2003, from <http://www.cdc.gov/nchs/>
- Centers for Disease Prevention and Control, National Center for Health Statistics. (2002). *Prevalence of overweight among children and adolescents: United States 1999-2000*. Retrieved March 3, 2002, from <http://www.cdc.gov/nchs/>
- Centers for Disease Prevention and Control. (1990). Topics in minority health: Health beliefs and compliance with prescribed medication for hypertension among Black women—New Orleans, 1985-86. *Morbidity and Mortality Weekly Report*, 39(40), 701-704.
- Clayton, L. A., & Byrd, W. M. (1993). African-American cancer crisis, part 1: The problem. *Journal of Health Care for the Poor and Underserved*, 4(2), 83-101.
- Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care, vol. 1*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.
- Goode, T., & Jones, W. (2002). *Definition of linguistic competence*. Washington, DC: National Center for Cultural Competence, Georgetown University for Child and Human Development.
- Institute of Medicine. (2001). *Health and behavior: The interplay of biological, behavioral, and societal influences*. Washington, DC: Committee on Health and Behavior: Research, Practice and Policy, Board on Neuroscience and Behavioral Health.
- Intercultural Cancer Council. *Native Hawaiians and Pacific Islanders and cancer*. Retrieved July 9, 2001, from <http://icc.bcm.tmc.edu/>
- Intercultural Cancer Council. *Asian Americans and cancer*. Retrieved July 9, 2001, from <http://icc.bcm.tmc.edu/>
- Intercultural Cancer Council. *Hispanics/Latinos and cancer*. Retrieved July 9, 2001, from <http://icc.bcm.tmc.edu/>
- Isaacs, R. B., Lobo, P. I., Nock, S. L., Hanson, J. A., Ojo, A. O., & Pruett, T. L. (2000). Racial disparities in access to simultaneous pancreas-kidney transplantation in the United States. *The American Journal of Kidney Diseases*, 36(3), 526-533.
- The Kaiser Family Foundation. (1999). *Key facts: Race, ethnicity and medical care*. Retrieved July 9, 2001, from [www.kff.org](http://www.kff.org)
- The Kaiser Family Foundation. (1999). *Survey of race, ethnicity and medical care: Public perceptions and experiences*. Retrieved July 9, 2001, from [www.kff.org](http://www.kff.org)
- The Kaiser Family Foundation. (2000). *Key facts: HIV/AIDS and African Americans*. Retrieved July 9, 2001, from [www.kff.org](http://www.kff.org)

- Lasater, L. M., Davidson, A. J., Steiner, J. F., & Mehler, P. S. (2001). Glycemic control in English vs. Spanish speaking Hispanic patients with type 2 diabetes. *Mellitus Archives of Internal Medicine*, 161, 77-82.
- Lee, L. J., Batal, H. A., Maselli, J. H., & Kutner, J. S. (2002). Effect of Spanish interpretation method on patient satisfaction in an urban walk-in clinic. *J. Gen Intern Med*, 17(8), 641-645.
- Levinson, W., Roter, D. L., Mullooly, J. P., Dull, V. T., & Frankel, R. M. (1997). Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. *Journal of the American Medical Association*, 277(7), 553-559.
- Like, R. (1998). *Treating and managing the care of diverse patient populations: Challenges for training and practice*. Paper presented at national conference at Center for Health Families and Cultural Diversity, Robert Wood Johnson Medical School, on Quality Health Care for Culturally Diverse Populations: Provider and Community Collaboration in a Competitive Marketplace, New Brunswick, NJ.
- Mason, J. (1998). *Rationale for cultural competence in health and human services, training and technical assistance resource manual*. Paper presented at national conference on Culturally Competent Services and Systems: Implications for Children With Special Health Needs, Rio Grande, Puerto Rico.
- Mayberry, R., et al. (1999). *A synthesis of the literature: Racial and ethnic differences in access to medical care*. Morehouse Medical Treatment and Effectiveness Center (MMEDTEC). Retrieved July 9, 2001, from [www.kff.org](http://www.kff.org)
- Nelson, K., Norris, K., & Mangione, C. M. (2002). Disparities in the diagnosis and pharmacologic treatment of high serum cholesterol by race and ethnicity. *Archives of Internal Medicine*, 162, 929-935.
- Robbins, J. M., Vaccarino, V., Zhang, H., & Kasl, S. V. (2000). Excess type 2 diabetes in African-American women and men aged 40-74 and socioeconomic status: evidence from the third national health and nutritional examination survey. *Journal of Epidemiological Community Health*, 54, 839-845.
- Saha, S., Komaromy, M., Koepsell, T. D., & Bindman, A. B. (1999). Patient-physician racial concordance and the perceived quality and use of health care. *Archives of Internal Medicine*, 159, 997-1004.
- Schulman, K. A., Berlin, J. A., Harless, W., Kerner, J. F., Sistrunk, S., Gersh, B. J., et al. (1999). The effect of race and sex on physicians' recommendations for cardiac catheterization. *The New England Journal of Medicine*, 340, 618-626.
- Schmidley, D. (2003). The foreign-born population in the United States: March 2002. *Current Population Reports*, P2-539. Washington, DC: U.S. Census Bureau.
- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.) (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Institute of Medicine.
- Suro, R. (2000). Beyond economics. *American Demographics*, 22, 2.
- Thorne, S. (2001). Reaching the minority majority. *Pharmaceutical Executive*, 21, 4.
- U.S. Census Bureau. 1990 Census lookup, summary level: Nation. Retrieved June 19, 2001, from [www.census.gov](http://www.census.gov)
- U.S. Census Bureau. *Projections of the total resident population by 5-year age groups, race, and Hispanic origin with special age categories, middle series*. Retrieved June 19, 2001, from [www.census.gov](http://www.census.gov)
- U.S. Census Bureau. *Overview of race and Hispanic origin from Census 2000*. Retrieved June 19, 2001, from [www.census.gov](http://www.census.gov)
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. Retrieved March 2, 2003, from <http://www.mentalhealth.org/cre/default.asp>
- U.S. Department of Health and Human Services. (1998). *The initiative to eliminate racial and ethnic disparities in health*. (Policy statement). Washington, DC.

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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

Institute of Medicine. (2002). *Guidance for the National Healthcare Disparities Report*. Washington, DC. Available at [www.iom.edu](http://www.iom.edu)

The Association of State & Territorial Health Officials and the National Association of County and City Health Officials (2001). *Health Departments Take Action: A Compendium of State and Local Models Addressing Racial and Ethnic Disparities in Health*. Available at <http://www.astho.org/pubs/nabookfull.pdf>

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, 57(Suppl. 1): 181-217.

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

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.

"Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans" 3/6/2002. The Commonwealth Fund, Washington, DC. Webcast available at [www.kaisernetwork.org](http://www.kaisernetwork.org)

The Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation. *Opening Doors: Reducing Sociocultural Barriers to Health Care*. Washington, DC, 1997. Available from <http://www.rwjf.org/reports/npreports/opendoorse.htm>

## **TOPIC AREA** Responding to Current and Projected Demographics

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. (2002). *Racial and Ethnic Approaches to Community Health (REACH 2010): Addressing Disparities in Health At A Glance 2002*. Available from [http://www.cdc.gov/nccdphp/aag/aag\\_reach.htm](http://www.cdc.gov/nccdphp/aag/aag_reach.htm)

U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services. *Fiscal Year 2001 Statistical Yearbook*. Washington, D., 2002. Available from <http://www.immigration.gov/graphics/shared/aboutus/statistics/index.htm>

## **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, DC, 1997. Available from <http://www.rwjf.org/reports/npreports/opendoorse.htm>

Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*. The Commonwealth Fund. Available at [http://www.cmwf.org/programs/minority/betancourt\\_culturalcompetence\\_576.pdf](http://www.cmwf.org/programs/minority/betancourt_culturalcompetence_576.pdf)

BostonWorks.com has a feature called "Diversity Works" on their web site with information and resources on <http://bostonworks.boston.com/diversity>

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

**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

**Opening Doors: Reducing Sociocultural Barriers to Health Care: Lessons Learned**

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HSC Healthcare System  
1808 I Street, NW, Suite 600  
Washington, D.C. 20006  
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#### **About the**



National  
Center  
for  
Cultural  
Competence

The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems. The NCCC conducts an array of activities to fulfill its mission including: (1) training, technical assistance and consultation; (2) networking, linkages and information exchange; and (3) knowledge and product development and dissemination. Major emphasis is placed on policy development, assistance in conducting cultural competence organizational self-assessments and strategic approaches to the systematic incorporation of culturally competent values, policy, structures and practices within organizations. The NCCC is a component of the Georgetown University Center for Child and Human Development and is housed within

the Department of Pediatrics of the Georgetown University Medical Center. It is funded by and operates under the auspices of Cooperative Agreement #U93- MC-00145-08 and is supported in part from the Maternal and Child Health program (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

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