

CDI Evaluation Addendum
Model for Identifying Health Disparities
and
Recommendations for Future Activities

by Thomas Lonner, Ph.D. and Clancy C. Clark
The Cross Cultural Health Care Program

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The authors are aware of the large and growing literature that indicates that disparities in health status and health care outcomes are linked to race and ethnicity. Across large population studies, different factors are adduced to explain this linkage, such as genetics, socioeconomic status, environment, and discrimination in access to and provision of quality health care. We are not in a position to comment on the sufficiency of findings from this research to guide policy and practice.

However, we also note in this literature that the concepts of “race” and “ethnicity” are actually quite complex variables. Indeed, they may be surrogates for clusters of other social, cultural, environmental, economic, and historical variables, any one of which might be more closely predictive of disparity in health status than the larger surrogate itself. Thus, within race and ethnicity is a great deal of variation that, if accounted for, might have greater explanatory power and practical applicability than race or ethnicity alone.

We did not conduct a large population study, but a very small study, focused intentionally on two matters – ethnicity/culture and diabetes self-management; self-management was hypothesized to be key to ultimate health status for patients dealing with their own diabetes. Culture is a key factor because its elements (such as worldviews, ways of seeing and interpreting reality) actually shape or profoundly influence the ways in which people behave. We anticipated that different cultures would interpret the challenge of diabetes differently and, thus, the resulting self-management behaviors might be different. We understood that no culture provides its members with a single “script” for how to think and behave when challenged by this disease, but that a range of options were open to individuals within each culture.

What we felt that we saw, among individuals within the three cultures they were part of, were different “stances” toward the disease, from denial to rejection to acceptance and incorporation. We did not know what produced these stances within each individual – culture, family, personal history, personality, context of daily life, and so on. However, these stances, we argue, are directly predictive of very different self-management behaviors, some of which were unlikely to produce better health outcomes. So, our next question would be, what if the distribution of such stances derived significantly from culture? That is, what if, within each culture, there was a predisposition to respond to a disease, such as diabetes, by adopting one stance more than any of the available others? It might then be more important to know this aspect of culture than a person’s race or ethnicity.

Based on this possibility of cultural patterns in patients’ stances toward diabetes, we then suggest

1. a larger study of the importance, utility, and variation of culturally-linked stances
2. the development of easily applied tools (e.g., sentence completion tests) so that clinicians can readily discover the stance of the patient before them
3. the development of clinical responses to each stance, either to find culturally-appropriate ways to alter the stance or to work within the stance to mobilize the patient’s resources and behaviors in the patient’s behalf
4. the development of alternative applied social support systems, specific to the stance of the patient and his/her social, economic, and family situations

Understanding the origin and results of specific responses will enable providers and health care institutions to better address different populations and/or individuals. Investigations will need to be comparative studies focusing on different patient populations, defined by specific cultural and personal attributes, such as ethnicity, socioeconomic status, education, family size, household income, religion, social supports,

gender, personal role in family life, history of diabetes in the family, length of residence in the United States, and place of residence.

We think this approach to the experiential world of the patients, both minorities and non-minorities, would prove a useful adjunct to other formulations about disparities