ABSTRACT The historical narrative on diversity, race, and health would predict that California’s population change from 22 percent racial/ethnic minority in 1970 to 62 percent in 2016 would lead to a massive health crisis with high mortality rates, low life expectancy, and high infant mortality rates—particularly given the state’s high rates of negative social determinants of health: poverty, high school incompletion, and uninsurance. We present data that suggest an alternative narrative: In spite of these negative factors, California has very low rates of mortality and infant mortality and long life expectancy. This alternative implies that racial diversity may offer opportunities for good health outcomes and that community agency may be a positive determinant. Using national-level mortality data on racial/ethnic groups, we suggest that new theoretical models and methods be developed to assist the US in achieving high-level wellness as it too becomes “majority minority.”

Examining the path of health care reform—from the Institute of Medicine’s Crossing the Quality Chasm report1 to the Affordable Care Act and the Robert Wood Johnson Foundation’s Culture of Health2—reveals the need for a paradigm shift from disease and illness at the individual level to the promotion of health and wellness at the societal level. Similarly, the attempt to reform health care at the same time that the US population approaches a “majority-minority” profile requires a paradigm shift in how the health care field conceptualizes diversity, race, and health. The experience of one state—California—with health care reform while also experiencing a demographic shift—from 22 percent minority in 19703 to 62 percent minority in 20164—provides a natural experiment whose outcome can help inform policy makers on how to create a culture of health as their populations become increasingly diverse.

People rely on narratives to communicate experiences—including the experience of health disparities—in meaningful, coherent ways.5 Narrative makers select and emphasize certain aspects of the experiences to promote particular definitions of a problem.6 Therefore, the way a problem is framed narratively can influence health policy.7 For example, some health policy narratives present alcohol abuse or obesity as the result of individual choices and hence guide policy formation toward individual-level interventions, such as encouraging members of the target population to depend on their willpower and self-discipline to achieve better health outcomes.8

This article first explores the historical narrative on diversity, race, and health—a narrative that frames racial/ethnic health disparities as a public crisis—and two of its key aspects: health outcomes for which diversity is health dysfunction, and social determinants of health that are obstacles to good health outcomes. It then examines California’s experience with an emerging alternative narrative about diversity, race, and health, which characterizes diversity as a health opportunity and focuses on social determinants that facilitate health. The article concludes with
The History Of The Narrative On Diversity, Race, And Health

During the Great Society years (1965–80), researchers and policy analysts described minority dysfunction (broken families, unemployment, poverty, low education levels, and so on) as the product of decades of discrimination and segregation. Beginning with the Reagan years (1980–92) and continuing to the present, a new group of researchers and analysts has described minority dysfunction as the result of bad personal values leading to bad personal choices. Through both eras, the narrative of minority dysfunction went largely unchallenged, and this narrative now undergirds much health care research.

HEALTH OUTCOMES: DIVERSITY AS HEALTH DYSFUNCTION The historical narrative holds that nonwhite racial/ethnic populations, sometimes called minorities or populations of color, present poorer health outcomes than white populations do. In announcing its action plan to reduce racial/ethnic health disparities in 2011, the Department of Health and Human Services observed that the then “recently released Centers for Disease Control and Prevention (CDC) report, Health Disparities and Inequalities, demonstrates that African American, Hispanic, Asian American, and American Indian and Alaska Native populations suffer higher mortality rates than other populations.”

Joyce Buckner-Brown and coauthors translate this into policy-actionable terms: “Poor people and people of color are more likely to live shorter and sicker lives, and are less likely to survive a host of chronic illnesses.” The narrative insists that racial/ethnic disparities stubbornly persist, even though the overall health of Americans has improved. Both minority and non-minority poor people suffer worse health outcomes, but because minority communities have a higher percentage of people living in poverty, race and poverty have become intertwined.

SOCIAL DETERMINANTS OF HEALTH: OBSTACLES TO GOOD HEALTH OUTCOMES For decades, low income and education at the individual level have been considered obstacles that result in poor health outcomes at the individual level. The literature has reconceptualized these individual-level determinants as societal-level factors that are associated, for example, with employment; housing; air quality; transportation; public safety; green space; and access to fresh, healthy food. Anita Chandra and coauthors suggest that once social obstacles have been addressed, healthier communities become possible.

Reframing The Narrative From California’s Experience

The narrative based on these two framing premises would lead one to expect that California, with a 62 percent “minority” population, would be one of the unhealthiest states in the nation. In reality, however, our data show that California is one of the leaders in health indicators and healthy communities. This suggests that the current narrative has failed to properly conceptualize and frame health developments in the state as it shifted to a largely minority population. California’s experience, therefore, suggests two alternative premises.

HEALTH OUTCOMES: DIVERSITY AS HIGH-LEVEL HEALTH FUNCTIONING Diversity can offer opportunities for health care reform, especially improving population health. As of 2016, California’s population was quite diverse—39 percent Latino, 6 percent African American, 13 percent Asian/Pacific Islander, 3 percent multiracial, and less than 1 percent American Indian/Alaska Native—and this great diversity did not equate to massive health dysfunction. According to our data, California’s overall health profile was far better than that of the United States as a whole: California had lower death rates, longer life expectancy, and lower infant mortality rates (exhibit 1). Moreover, this better-than-national health profile was driven by strong results from the diverse population groups, particularly Latinos and Asian/Pacific Islanders. Both non-Hispanic whites and African Americans (together accounting for 44 percent of the state’s population) had higher mortality rates and shorter life expectancies than the state norm, while Latinos and Asian/Pacific Islanders (52 percent of the state’s population) had lower death rates and longer life expectancies than the state norm. American Indian/Alaska Natives (less than 1 percent of the state’s population) also had lower death rates than the state norm, but their life expectancies were slightly shorter than the state’s.

All of California’s population groups except African Americans have infant mortality rates that are lower than national rates. The nuances of the African American rate must be understood. African-born immigrant women giving birth in the US have a low infant mortality rate—equivalent to that of non-Hispanic white women—while the high infant mortality rate of US-born African-origin women may be associ-
HEALTH EQUITY

EXHIBIT 1

Selected outcomes for the United States, California, and racial/ethnic groups within California

<table>
<thead>
<tr>
<th>Outcome</th>
<th>US</th>
<th>California</th>
<th>Non-Hispanic white</th>
<th>Latino</th>
<th>African American</th>
<th>Asian/Pacific Islander</th>
<th>American Indian/Alaska Native</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-adjusted all-cause death rates per 100,000 populationa</td>
<td>729.9</td>
<td>619.1</td>
<td>686.4</td>
<td>514.4</td>
<td>807.6</td>
<td>394.5</td>
<td>380.2</td>
</tr>
<tr>
<td>Life expectancy at birth (years)b</td>
<td>78.9</td>
<td>80.8</td>
<td>79.8</td>
<td>83.2</td>
<td>75.1</td>
<td>86.3</td>
<td>80.2</td>
</tr>
<tr>
<td>Infant mortality per 1,000 live birthsc</td>
<td>6.0</td>
<td>4.7</td>
<td>3.9</td>
<td>4.6</td>
<td>9.4</td>
<td>3.8</td>
<td>5.9</td>
</tr>
<tr>
<td>Uninsurance rate for the nonelderly (ages 0–64)d</td>
<td>16.9%</td>
<td>20.2%</td>
<td>11.0%</td>
<td>34.7%</td>
<td>18.9%</td>
<td>15.9%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Adults with incomes below the federal poverty leveld</td>
<td>13.5%</td>
<td>14.2%</td>
<td>10.2%</td>
<td>19.1%</td>
<td>22.6%</td>
<td>11.7%</td>
<td>21.3%</td>
</tr>
<tr>
<td>Adults ages 21 and older who did not graduate from high schoold</td>
<td>13.4%</td>
<td>18.3%</td>
<td>5.7%</td>
<td>39.6%</td>
<td>11.5%</td>
<td>13.7%</td>
<td>18.2%</td>
</tr>
</tbody>
</table>


California’s leading position in its health profile—that is, generally low death rates, long life expectancy, and low infant mortality rates compared to the US as a whole—clearly is not being held back by the fact that Latinos are the largest racial/ethnic group, making up 39 percent of the population.

Social Determinants of Health: Facilitators of Good Outcomes California has higher percentages of adults without insurance, living in poverty, and without a high school education, compared to national averages. This is because Latinos have higher rates of uninsurance, poverty, and low education. These common social determinants would be expected to yield poor Latino health outcomes. Yet Latinos in California have better health outcomes than non-Hispanic whites, who enjoy higher levels of insurance, income, and education.

Poverty and low levels of education (not being a high school graduate) traditionally have been considered to be powerful predictors of adverse health outcomes—perhaps as important as race/ethnicity itself.18–21 The online appendix shows the results of linear regressions involving the effects of poverty and low education on low birthweight in non-Hispanic white, Latino, and African American births in California in 2008–13.22 While both income and education do appear to be powerful predictors of differences in birthweight between non-Hispanic whites and African Americans, the same variables have little predictive power for Latino rates of low-birthweight births. A similar lack of predictive power for Latino health outcomes has been seen in death rates and behavioral areas such as drinking, smoking, and drug use.23

Implications For The Nation

Race As An Opportunity For High-Level Health Outcomes Accounting for nearly two-thirds of the country’s inhabitants, trends among non-Hispanic whites drive the US death rate; interestingly, though, their death rate is slightly higher than the national rate (747.7 versus 729.9 deaths per 100,000 population) (exhibit 2). The African American rate (853.9 deaths per 100,000 population) is higher than that of non-Hispanic whites. But the three remaining groups—Latinos, American Indian/Alaska Natives, and Asian/Pacific Islanders—have death rates that are quite a bit lower (27.7 percent, 18.6 percent, and 45.8 percent lower, respectively) than the national rate.

Place Matters The state with the lowest age-adjusted mortality rate is Hawaii, followed by California, New York, Connecticut, and Minnesota. The five states have a combined average mortality rate of 630.3 deaths per 100,000 population. The state with the highest rate is Mississippi, followed by West Virginia, Alabama, Kentucky, and Oklahoma, for a combined average rate of 923.9 deaths per 100,000 population. The bottom five states have a combined average rate that is 46.6 percent higher than that of the
top five. Place definitely matters.

Based on these data, race combines with place in unexpected ways. While the historical narrative holds that race is an “innate, individual” characteristic, the “place of the race” may matter more. The combined average African American death rate in the top five states is 682.8 deaths per 100,000 population. In contrast, the combined average non-Hispanic white death rate in the bottom five states is 921.9 deaths. The African American death rate is 25.9 percent lower in the top five states than the non-Hispanic white rate in the bottom five states. The place of the race definitely matters, perhaps even more than race or place alone.

PLACE, RACE, AND DIVERSITY The “high” and “low” markers in each column of exhibit 2 show the range of variation for each racial/ethnic group by state: the state with the highest death rate is at the top, while the state with the lowest is at the bottom. The death rate for all people was highest in Mississippi and lowest in Hawaii. But each racial/ethnic group has different states for highest and lowest death rates: For non-Hispanic whites, the highest state is West Virginia, and the lowest is the District of Columbia. Interestingly, for Latinos, the highest state is Hawaii, and the lowest is West Virginia.

While the historical narrative paints diversity as an indicator of health dysfunction, the alternative narrative emerging out of California’s experience is that diversity may offer overlooked opportunities to build a culture of health and wellness. For example, Latinos have lower smoking rates than non-Hispanic whites, so efforts to prevent uptake may be more appropriate in that minority community, compared to efforts on cessation in the non-Hispanic white population.

COMMUNITY AGENCY AS A SOCIAL DETERMINANT Not only do Latinos have high rates of poverty, unemployment, and lack of a high school degree in California, but Latino communities in the state suffer from a severe shortage of Latino physicians: There are only 50 Latino physicians per 100,000 Latino population, compared to 390 non-Hispanic white physicians per 100,000 non-Hispanic white population. While the historical narrative would predict dire health outcomes given these woeful social determinants, the emerging narrative points to other social determinants that may facilitate health.

One important social determinant is a community’s exercise of its agency—that is, its ability to take action on the world around it. As California was beginning its massive demographic shift in the 1970s, many of its minority communities’ needs were not addressed by mainstream health providers. The Latino community (among others) exercised agency by creating an alternative system of health care and policy, independent from then-existing public and private entities. As of 2018 more than 1,300 nonprofit, community-based clinics provide services to underserved communities. Some of these clinics are quite large, such as La Clínica de la Raza—which operates out of twenty-eight sites in Alameda, Contra Costa, and Solano Counties—and AltaMed (formerly known as the Barrio Free Clinic) operates twenty-nine sites in Los Angeles and Orange Counties and enrolled more people in Covered California (the state’s insurance Marketplace) than any other entity in the state in 2014 and 2015.

Many of these community clinics began in the early 1970s—decades before the Institute of Medicine’s “quality chasm” report—with a vision of healthy, empowered communities that were capable of addressing upstream causes of poor health, including low-wage employment, poorly functioning educational systems, unhealthy living conditions, high-risk behaviors, immigration status, and gender identity. Cross-ethnic coalitions created policy groups such as the Alameda Health Consortium, the California Pan-Ethnic Health Network, and the California Primary Care Association, whose activities created the mandates for patient governance on their boards in the 1970s—those activities also led to the passage of SB-853, the Health Care

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**Exhibit 2**

Age-adjusted deaths per 100,000 population in the US, by racial/ethnic group, 2013-15

![Chart showing death rates by racial/ethnic group and state](chart_url)

**Source:** Authors’ analysis of data from National Center for Health Statistics. Health, United States, 2016, with chartbook on long-term trends in health (see note 24 in text). **Note:** The whiskers indicate the states with the highest and lowest rates.
Language Assistance Act of 2003.\textsuperscript{34} New health-oriented foundations created in the 1990s—including the California Endowment,\textsuperscript{35} Cal Wellness,\textsuperscript{36} and California Health Care Foundation—have chosen to work closely with these alternative organizations.

Community agency may also be at work in less formal institutional ways that also facilitate good health outcomes in spite of individual poverty and poor education. One possible noninstitutional way that has received some research attention is the so-called barrio advantage: the oft-observed finding that daily life in poor, but densely populated, Latino barrios has significant protective effects on individuals beyond individual factors such as income, education, and rates of insurance coverage.\textsuperscript{38} This benefit has been observed in much better-than-expected breast cancer outcomes,\textsuperscript{39} cardiovascular health,\textsuperscript{40} birthweight and infant health,\textsuperscript{41} mental health,\textsuperscript{42} and fall risk in the elderly.\textsuperscript{43} The barrio advantage warrants further research as a social determinant that facilitates good health outcomes.

Conclusion

Over the next thirty to forty years, the US population as a whole will become a “majority-minority” one.\textsuperscript{44} California’s experience with diversity, race, and health calls for the development of new theoretical models and analytic methods that are better able to identify and track health disparities in large, very diverse populations. We suggest creating a new set of models based on the epidemiology of diversity, which would be better able to manage the nuances of race, place, and diversity than the current models that are based on an outdated narrative of minority dysfunction.

For example, our data show that low income and education have little predictive power for low birthweight among Latinos. The anomalously positive health outcomes for Latinos (low mortality rates, long life expectancy, and low infant mortality rates) do not fit the narrative of minority dysfunction and are not explainable by any of our current models of minority health. In most research, after the Latino anomalies are noted, they are often shunted aside as a paradox that cannot be explained by analysts.\textsuperscript{45}

This article has used the experience of “minority” racial/ethnic groups in California as a basis for developing an alternative narrative that can widen the framing of discussions of health equity from a narrative of public health crisis to one of public health opportunity.

The authors gratefully acknowledge the support of Adventist Health White Memorial’s Center for Hispanic Health.

NOTES

15 Woolf SH. Progress in achieving health equity requires attention to...