The Case For Diversity In The Health Care Workforce

Interventions to improve the racial and ethnic diversity of the U.S. medical workforce should begin well before medical school.

by Jordan J. Cohen, Barbara A. Gabriel, and Charles Terrell

PROLOGUE: The notion that substantial improvements in the health indicators of U.S. racial and ethnic minority populations have been achieved over the past fifty years is relatively uncontroversial. By way of example, David Mechanic recently reported in *Health Affairs* (Mar/Apr 02) that infant mortality among African Americans fell from 43.9 deaths per thousand in 1950 to 13.8 in 1998. However, as Mechanic also noted, the troubling fact that infant mortality among African Americans remained 130 percent higher than that among whites as recently as 1998 dramatically illustrates that despite improvements in absolute numbers, the issue of health disparities is an independent question that retains much contemporary salience.

The popular media have widely reported the results of recent studies finding that even when insurance status, income, age, and severity of condition have been adjusted for, minorities tend to receive lower quality of care than whites do. The emergence of something approaching a critical mass of evidence documenting these inequities may be driving a fundamental shift in the discourse on minority health from inquiries into whether disparities do, in fact, exist to discussions of strategies aimed at diminishing or eliminating them. Among such proposed solutions are efforts crafted to boost minority representation in the health care workforce.

In the paper that follows, Jordan Cohen, Barbara Gabriel, and Charles Terrell argue that given changing U.S. demographic trends, achieving greater diversity in the health care workforce will likely yield the practical benefits of producing a culturally competent workforce, improving access to high-quality care for the medically underserved, increasing the breadth and depth of the U.S. health research agenda, and expanding the pool of medically trained executives and policymakers ready to take up leadership positions in the health care system of the future. The authors also evaluate the efficacy of past efforts to improve minority representation in medicine and provide insight into future approaches targeted at bridging the diversity gap. Cohen is president of the Association of American Medical Colleges (AAMC). Gabriel is the senior writer and editor for the AAMC, and Terrell is vice-president of the AAMC's Division of Community and Minority Programs.
ABSTRACT: Increasing the racial and ethnic diversity of the health care workforce is essential for the adequate provision of culturally competent care to our nation’s burgeoning minority communities. A diverse health care workforce will help to expand health care access for the underserved, foster research in neglected areas of societal need, and enrich the pool of managers and policymakers to meet the needs of a diverse populace. The long-term solution to achieving adequate diversity in the health professions depends upon fundamental reforms of our country’s precollege education system. Until these reforms occur, affirmative action tools in health professions schools are critical to achieving a diverse health care workforce.

W ere the United States not a country with a rich variety of races and ethnicities, let alone one that is rapidly becoming more diverse, the case for diversity in the health care workforce would arguably be moot. But the facts are clear: Our country is undeniably becoming home to an ever-increasing number of individuals from distinct racial and ethnic backgrounds. Census figures vividly document that our minority populations are increasing at a much faster pace than is the majority white population. Between 1980 and 2000, while the country’s white population grew by about 9 percent, the African American population increased by about 28 percent; the Native American population, by 55 percent; the Hispanic population, by 122 percent; and the Asian population, by more than 190 percent. As a result, somewhere near the middle of this century more than half of U.S. citizens will be members of “minority” groups. Figures from the 2000 census show that African Americans, Hispanics, Asians, and Native Americans already account for more than half of California’s population. Forty-five percent of Texans self-identify as members of minority groups, as do one in three residents of New York, New Jersey, and Florida.

Recognizing these striking demographic trends does not in itself establish the case for diversity in the health professions. To do that would require convincing arguments that absent sufficient ethnic and racial diversity, the health care workforce would be unable to fulfill its fundamental obligations to the public: protecting, restoring, and improving the health of all Americans. The following discussion summarizes the arguments favoring greater diversity in the health care workforce, reviews results of previous efforts to increase the proportion of minorities in medicine, and considers the prospects for future progress in closing the still sizable diversity gap.

The Case For A Diverse Health Care Workforce

Putting aside issues of equity and fairness for the moment, at least four practical reasons can be put forth for attaining greater diversity in the health care workforce: (1) advancing cultural competency, (2) increasing access to high-quality health care services, (3) strengthening the medical research agenda, and (4) ensuring optimal management of the health care system. Although the focus of this paper is on the M.D. workforce, there is every reason to suspect that these ar-
arguments apply equally well to the other health professions (osteopathy, dentistry, public health, nursing, pharmacy), which have also experienced difficulty in recruiting persons from minority backgrounds in adequate numbers to achieve optimal diversity. The recruitment of these persons into the educational pipeline of the health professions is, of course, what determines not only their ultimate representation in the workforce but also their influence on the educational process itself.

- **Culturally competent workforce.** This brings us to the first and perhaps most compelling reason for increasing the proportion of medical students and other prospective health care professionals who are drawn from underrepresented minority groups: preparing a culturally competent health care workforce. The term *cultural competence* denotes the knowledge, skills, attitudes, and behavior required of a practitioner to provide optimal health care services to persons from a wide range of cultural and ethnic backgrounds. Given the rapidly changing U.S. demography, it is axiomatic that the majority of future health care professionals will be called upon to care for many patients with backgrounds far different from their own. To do so effectively, health care providers must have a firm understanding of how and why different belief systems, cultural biases, ethnic origins, family structures, and a host of other culturally determined factors influence the manner in which people experience illness, adhere to medical advice, and respond to treatment. Such differences are real and translate into real differences in the outcomes of care. Physicians and other health care professionals who are unmindful of the potential impact of language barriers, various religious taboos, unconventional explanatory models of disease, or traditional “alternative” remedies are not only unlikely to satisfy their patients but, more importantly, are also unlikely to provide their patients with optimally effective care.

Health care professionals cannot become culturally competent solely by reading textbooks and listening to lectures. They must be educated in environments that are emblematic of the diverse society they will be called upon to serve. The logic here is analogous to that upholding the value of diversity in all aspects of higher education. Consider the views of Lee Bollinger, president of Columbia University. He asserts that racial and ethnic diversity in the educational setting is paramount to a student’s ability to effectively live and work in a diverse society. A series of empirical analyses of existing data on diversity in higher education support Bollinger’s assertion. Presented in an expert report used in the lawsuits challenging the University of Michigan’s undergraduate and law school admissions policies, these analyses “confirm that racial diversity and student involvement in activities related to diversity had a direct and strong effect on learning and the way students conduct themselves in later life, including disrupting prevailing patterns of racial separation.”

Only by encountering and interacting with individuals from a variety of racial and ethnic backgrounds can students transcend their own viewpoints and see them through the eyes of others. A heterogeneous campus helps students to recog-
"Stagnation in minority representation in the physician workforce will have unwelcome consequences for the health of the nation."

Recognize that their own opinions are influenced by their unique race, gender, origin, and socioeconomic status. Coupled with the additional need of medical students to become culturally competent practitioners, these overarching principles for achieving good-quality higher education constitute the first of several compelling arguments for diversity in our nation's medical schools.

Access for the underserved. A second reason for favoring greater diversity in medical education, and hence in the physician workforce, is to provide improved access to high-quality health care for persons in our society who remain underserved. Inadequate access to health care services remains a major problem within minority populations. Many of the country's designated health professions shortage areas (HPSAs) are populated predominantly by minorities. In California, physician supply has been shown to be inversely related to the number of resident African Americans and Hispanics, even after income levels are adjusted for. Members of minority groups who do gain access are likely to receive lower-quality care, even when insurance status and income are controlled for. For example, studies indicate that African Americans and Hispanics are less likely to receive bypass surgery when medically indicated, are less likely to receive adequate pain management, and are less likely to be treated with medications for HIV infection. Minorities are also more likely to undergo procedures such as bilateral orchietomies (removal of the testicles) and amputation, which are generally avoidable with optimal medical care.

Abundant data now exist documenting that African American, Hispanic, and Native American physicians are much more likely than white physicians are to practice in underserved communities and to treat larger numbers of minority patients, irrespective of income. Moreover, African American and Hispanic physicians, as well as women, are more likely to provide care to the poor and to those on Medicaid. Evidence also suggests that racial and ethnic concordance between physician and patient results in greater patient satisfaction. Furthermore, racial and ethnic concordance is not exclusively the result of physician practice location; it also appears to be a result of patient choice.

None of these data should be misconstrued to suggest either that minority physicians have an obligation to serve minority populations or that white physicians do not contribute much to the care of the underserved. These and similar data serve merely to substantiate the current reality that physicians from minority backgrounds are more likely to choose to practice in underserved areas than are other physicians and that patients are more satisfied with the services rendered by physicians of their own racial or ethnic heritage. Thus, it is reasonable to conclude that greater racial and ethnic diversity in the physician workforce would serve to reduce the gap in access to care that characterizes America's health care system.
Conversely, in light of changing U.S. demographics, stagnation or reduction in minority representation within the physician workforce will, in all probability, have unwelcome consequences for the health of the nation.

Racial and ethnic disparities in health and health care services are well documented, and their eradication is one of the prime targets of Healthy People 2010. African Americans have a lower life expectancy than whites; they are more likely to die from stroke, cancer, and diabetes mellitus. Infant mortality rates are higher among African American and Native American populations. African Americans, Hispanics, and Native Americans have higher rates of HIV infection than whites do and are more likely to die from homicide. Population-specific studies across the nation have found that African Americans are also more likely to suffer from uncontrolled hypertension, leading to more coronary heart disease–related events. A Chicago study indicated that African American women are twice as likely to die from cervical cancer than white women are, and a national study found that African Americans are at an increased risk of dying from asthma complications, even after income and education levels are controlled for.

Differences in racial and ethnic background, socioeconomic status, environment, and other risk factors notwithstanding, researchers agree that many of these negative health outcomes are preventable with appropriate outpatient management. Evidence also points to biases on the part of health care providers and institutions as greatly contributing to unequal medical treatment. Without adequate access to diverse and culturally competent health care providers drawn from all sectors of society, it is difficult to imagine how America can eradicate these and other health disparities.

**Broadened research agenda.** A third reason for advocating greater diversity in medicine is to broaden and strengthen the U.S. health research agenda. As just noted, the United States is plagued by unsolved health problems, many of which disproportionately affect minority populations. Few would argue that we have sufficient understanding of these problems to craft appropriate solutions. A great deal of additional research—particularly clinical and health services research—is clearly needed. Why has the necessary research not been done already? One explanation is that the U.S. research agenda is set in large measure by those who have chosen careers in investigation. Individual investigators, in turn, tend to do research on problems that they “see” and have an interest in. And what people see, what excites their curiosity, depends to a great extent on their personal cultural and ethnic filters. Thus, it is reasonable to conclude that finding solutions to our country’s most recalcitrant health problems, even being able to conceptualize what the real problems actually are, will require a research workforce that is much more diverse racially and ethnically (as well as by gender) than we now have. Creating that workforce begins with ensuring a diverse student body, as well as faculty, within U.S. health professions schools, particularly in M.D., Ph.D., and M.P.H. programs.

The extent to which the needed research will require the adequate participa-
tion of individuals from minority populations constitutes yet another argument for a more diverse cadre of investigators. As a case in point, a recent study of the attitudes of African Americans toward participation in cancer-related clinical trials found considerable distrust of government-backed medical research, with African American men citing the Tuskegee syphilis experiment as their principal source of concern. Study participants also expressed a preference for health care providers and researchers who "looked like them," an attitude that was found to be an important factor in their willingness to participate in clinical trials.

- Diversity in related workforces. A fourth reason for seeking greater diversity in education in the health care professions is to augment the pool of medically trained executives and public policymakers available to assume management roles in the future health care system and to contribute to governmental efforts that address important health care issues. Providing appropriate health care services to an ever-more diverse population is bound to pose an increasingly difficult management challenge for provider organizations, health care funders, public and private program managers, and local, state, and national governments. Within the private sector, it seems self-evident that having a comparably diverse management team—including key members with medical training—to make crucial strategic and tactical decisions would be, at minimum, advantageous and in many cases decisive for success. As is the case for virtually all sectors of the U.S. economy, it is simply smart business for health care organizations to draw their leadership from a richly diverse talent pool, adequately reflecting the gender, racial, and ethnic mélange of the country. Likewise, medically trained health care policymakers who more accurately reflect the face of the American public can have a substantial influence on the future of health care policy for all Americans. The paucity of such individuals in the current health professions workforce and influential policy-making posts constitutes yet another barrier to achieving high-quality health care for all Americans. Indeed, the lack of minorities from the ranks of medical management and public policy roles reflects the long heritage of underrepresentation of minorities in the health care workforce in general.

**Historical Efforts To Increase Diversity In Medicine**

Prior to the late 1960s, the racial (and gender) composition of medical school classes, and hence of the medical profession in this country, was monotonously white (and male). Despite a progressively expanding presence in our population, groups now designated as underrepresented minorities (African Americans, Mexican Americans, Native Americans, and mainland Puerto Ricans) made up only about 2 percent of medical school matriculants (Exhibit 1), and three-quarters of those attended either Howard University College of Medicine or Meharry Medical College School of Medicine as late as the mid-1960s. The typical medical school of that era admitted, on average, one minority student every other year. Racial segregation was as fully evident in medicine as it was in virtually every other
EXHIBIT 1
Percentage Of Underrepresented Minorities Among Medical School Matriculants And In The U.S. Population, 1950–2001

<table>
<thead>
<tr>
<th>Year</th>
<th>Medical school matriculants</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1950</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1960</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>1970</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>1980</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>1990</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>2000</td>
<td>25</td>
<td>50</td>
</tr>
</tbody>
</table>


NOTE: For this comparison, "underrepresented minorities" are African Americans, Mexican Americans, Native Americans, and mainland Puerto Ricans.

sector of American society, just as it had been for many preceding decades.

Things began to change with the advent of the civil rights movement in the late 1960s. The subsequent assassination of Martin Luther King Jr. and a rash of urban riots woke many people up to the flagrantly discriminatory practices that characterized so much of American society. The institution of medical education was inextricably influenced by the gains of minorities in other professions made possible by the breaking down of barriers to their professional advancement. Trends in medical school enrollment during this turbulent period in U.S. history were accordingly influenced by the tremendous societal changes brought about by the efforts of civil rights pioneers and activists.

The result was a striking rise in the number of minority medical students. What changed, however, was not a dramatic rise in academic achievement among minority applicants, as measured by such yardsticks as test scores and grade-point averages. Rather, what led to this upsurge was the commitment by schools across the country to take a closer look at barriers to access and consider affirmative actions to increase the racial and ethnic diversity of their classes. The federal government also played a key role by establishing financial aid and other programs for socioeconomically disadvantaged and minority students.

These programs continue to serve the interests of diversity today. However, a number are under threat of reduced funding, including an array of programs authorized by Titles VII and VIII of the Public Health Service Act. These programs support financial aid to health professions students, offer enrichment and training