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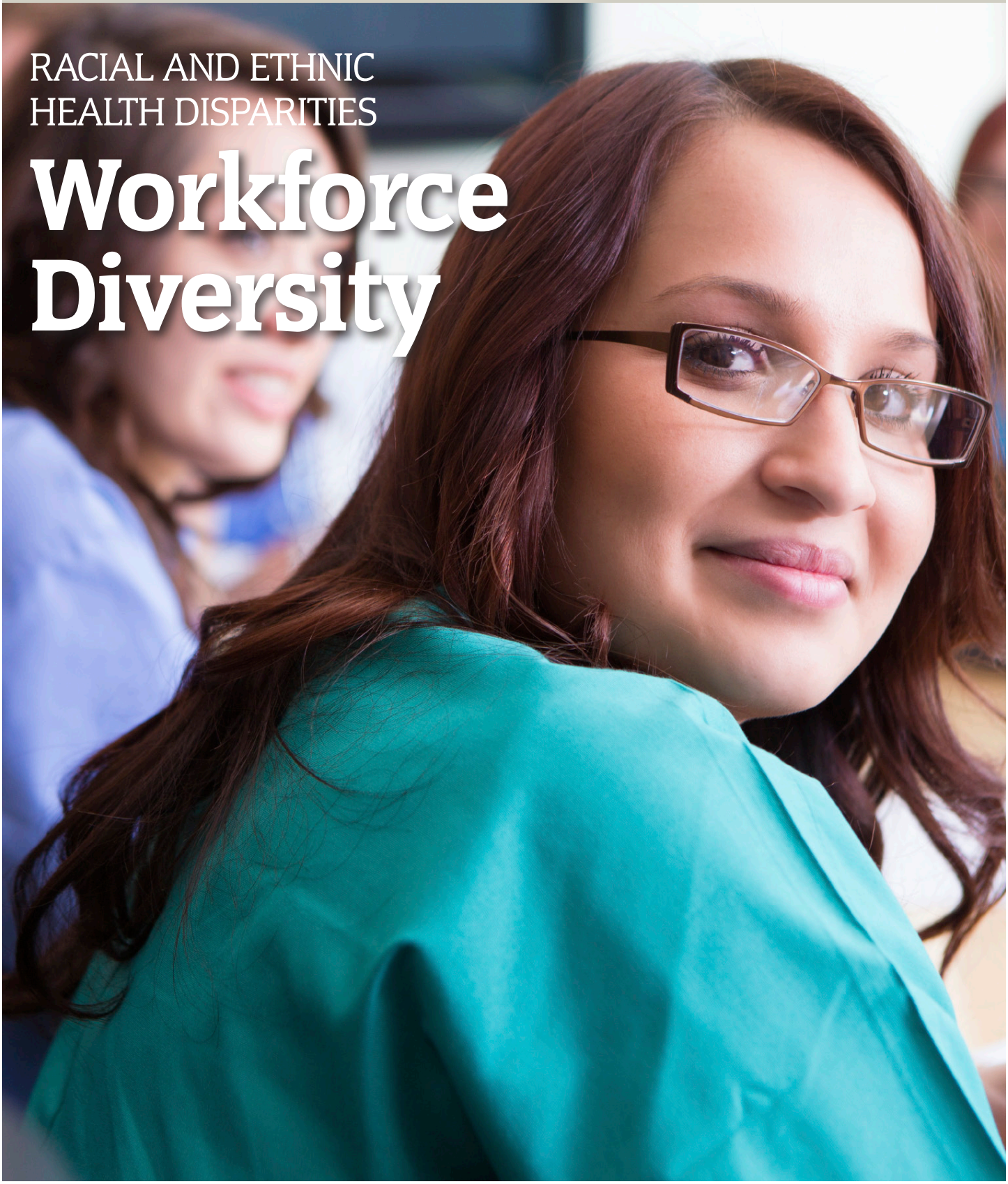
RACIAL AND ETHNIC HEALTH DISPARITIES

Workforce Diversity



The increasing diversity of the United States population has significant implications for the structure of the health care workforce. People of color now constitute a majority in 48 of the largest cities in the U.S., and five states have "minority majorities." The percentage of people that identify themselves as belonging to an ethnic or racial minority is growing—later in this century, it is predicted that nonwhite racial and ethnic groups will constitute a majority of the American population.[1] A more racially and ethnically diverse population may necessitate a reflection of such diversity in the health care workforce to ensure the delivery of high quality services. This may be desirable to support the elimination of disparities in health and health care, given the evidence that racial and ethnic minorities suffer disparities in areas such as health services utilization, and are underrepresented in the health care workforce.[2] With at least 90% of the U.S. population growth between 2010 and 2050 expected to come from minority groups the issue of workforce diversity is important.[3] A more diverse health care workforce has been shown to help improve access to health and health care for communities of color.[4] State policymakers seeking to address the health needs of racial and ethnic minority populations are exploring and identifying opportunities to diversity the health care workforce.

WHY IS WORKFORCE DIVERSITY IMPORTANT?

Racial and ethnic disparities in health (how people feel) and health care (the services people receive) still exist in the United States, however. Communities of color are more likely than their white counterparts to suffer from worse health outcomes, lack health insurance, receive lower quality care, rate their health statuses lower and die prematurely.[5] The causes of these inequities typically relate to access to care, poverty, genetics and various social determinants of health such as education and environmental issues. Given the increased diversity of the U.S. population, health providers must be equipped to provide care in a cross-cultural context, which is an important part of a comprehensive strategy to reduce health disparities.

These disparities also represent inefficiencies in the system that highlight where expensive quality gaps exist. Eliminating these health disparities can save a lot of money, research suggests. It's been estimated that about 30 percent of direct medical care expenditures for African Americans, Asians and Hispanics are because of health disparities. As minority groups become a larger percentage of total health care consumers, meeting their needs in cost effective and high quality ways might be the difference between balancing the budget and breaking the bank.

IS THERE REALLY A LACK OF DIVERSITY?

The current health care workforce does not reflect the nation's diversity; people of color represent more than 25 percent of the total population, but only 10 percent of health professionals.[6] In a 2004 landmark publication, the Institute of Medicine recommended increasing workforce diversity within health care as a strategy to address health disparities.[7] Despite the attention to increase the number of racial and ethnic minorities in health care careers in the last decade, progress has been slow.

WHY DIVERSITY IS DESIRABLE—CREATING A CULTURE OF EQUITY

According to Dr. Jordan J. Cohen, professor of medicine and public health at George Washington University and president emeritus of the Association of American Medical Colleges (AAMC), and his colleagues, there are at least four practical reasons for states to diversify their workforce:

- **It is a successful method of advancing cultural competency;**
- **It may help increase access to high-quality health care services;**
- **It will strengthen the medical research agenda;**
- **It will help to develop leaders and managers who can usher in the "new" health care system.**[8]

ADVANCING CULTURAL COMPETENCY

A culturally competent health care provider or team of providers recognizes when cultural differences matter. Understanding patients' distinct cultures, languages, home lives and values helps providers adapt how they communicate with patients about their health or needed health care. Cultural competence involves avoiding stereotyping and over-generalizing and requires providers to tailor medical instructions and guidance to the individual patient. It does not require providers to be the same race or ethnicity as their patients. Given the rapidly changing U.S. demography, it is reasonable to assume that the majority of future health care professionals will care for patients from many diverse backgrounds. Most educators agree that cultural competency is best learned in working environments that reflect the diversity of patients providers will serve.[9] Furthermore, when patients observe staff of different racial and ethnic backgrounds working collaboratively, they see that the organization is a safe place where all values and beliefs are respected and appreciated.[10]

IMPROVING ACCESS TO CARE

Inadequate access to health care services remains a concern for minority populations. Access to health care has two components: 1) the ability to purchase health care, either directly out-of-pocket or through some sort of health coverage like private insurance or Medicaid; and 2) being able to make appointments with providers who are near you geographically and who accept your payment method. While many federal and state health re-

Current Workforce: A Review

About 13 percent of all payroll employment is in the health care sector; that is one in eight people employed in the health care sector.

- Over 93 percent of health care workers have a degree beyond high school.
- Almost one-third of all professional degrees are in health care.
- Relative to the U.S. population, African Americans and Hispanics are still significantly underrepresented within the ranks of physicians, nurses and dentists.
- Fewer than 5 percent of physicians or dentists are African American or Hispanic.
- Only 5.4 percent of nurses are African American; by comparison, 83.2 percent are white.

Source: Center on Education and the Workforce. Office of Management and Budget

forms over the last five years have focused on increasing access, many minorities still face barriers to accessing health care. For example, many of the country's designated health professions shortage areas (HPSAs) are populated predominantly by minorities. African American, Hispanic and Native American physicians are much more likely than white physicians to practice in underserved communities and to treat larger numbers of minority patients, irrespective of income.[11] Moreover, African American, Hispanic and female physicians are more likely to provide care to the poor and to those on Medicaid.[12] None of these data 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; however, these data suggest that a diverse workforce might contribute to removing barriers to high quality care.

STRENGTHENING THE MEDICAL RESEARCH

The shortage of minority participants and researchers in medical clinical research continues despite heightened awareness that inclusion of minorities will help identify unique health needs and outcomes for their population. Today, minorities make up only about 36 percent of participants in all clinical trials.[13] Factors such as sex and gender, race and ethnicity, age and geographic location are important in determining if populations may benefit from the results of clinical interventions. Including women and minorities in research (referred to as "inclusion") is not just a matter of enrolling women and minorities in clinical studies, but requires changing norms of how research is designed, long before a volunteer signs up for a study.[14] According to health services researchers, including investigators or researchers from diverse backgrounds is likely to help identify research questions for individual communities, and could improve engagement of vulnerable populations, as well as dissemination and translation of research for a variety of stakeholders.[15]

CREATING LEADERS FOR THE "NEW" HEALTH CARE SYSTEM

Minorities are not only under-represented among providers, but among those in leadership and management positions in the health sector. Diversification of the health care workforce would expand the pool of trained employees available to assume management roles in the future health care system. According to research done by the Center for Creative Leadership, the top priority for leadership development in the healthcare sector is to "improve the ability to lead employees and work in teams." Leaders in healthcare organizations, the research found, generally should develop a more participative management style, improve their ability to build relationships and lead teams. The research also found that healthcare organizations need to create strategies to "provide current and future leaders broad, cross-organizational experiences and learning."[16]

Providing appropriate health care services to an ever-more diverse population is an increasingly difficult management challenge for provider organizations, health care funders, public and private program managers, and local, state and national governments. By generating a more diverse talent pool, the health care sector may be better prepared for the county's shifting demographics and for the emerging team-based models for treating patients.

STATE POLICY OPTIONS TO INCREASE WORKFORCE DIVERSITY

While state policymakers are not the sole architects of the composition of their state's health care workforce, there are many policies and programs that legislators can require, encourage or fund that help increase the diversity of the health care workforce. Below is a summary of these strategies and some states that are implementing them.

Pipeline

Training a diverse workforce is a long-term process, beginning with students in the K-12 system and continuing through college, health professions training (e.g., medical school, nursing, pharmacy, dentistry, etc.) and into community practice. States are adopting varied approaches to ensure an adequate health care workforce. Improving graduation rates and academic readiness among young students is a key focus for many states. Underrepresented young people are not prepared to enter health professions training— either because they lack the required math, science and study skills or because they did not graduate from high school. Underrepresented students include minority students and those who live in underserved areas. Research shows that under-represented students who receive support are more likely to deliver care in underserved communities once they are practicing providers. States are creating clear career paths, or pipelines, to help underrepresented people get the training they need to enter the health care workforce.

For example, California's Health Careers Training Program awards "mini-grants" to encourage underrepresented students to explore health careers through academic support, internships, career fairs and Saturday academies.[17] Another example, focused

ACA Provisions Related to Diversification of the Health Care Workforce

SECTION	AIM
5101	Determine whether health workforce can meet population needs
5102	Develop comprehensive health care workforce development strategies
5103	Develop information describing and analyzing health care workforce
5201-5205	Increase financial support for students in health profession programs
5301	Increase diversity among primary care providers
5303	Increase diversity among dentists
5306	Increase diversity among mental health providers
5309-5311	Increase diversity in nursing professionals
5313	Increase utilization of community health workers
5401	Increase diversity of applicant pool for health professionals
5403	Enhance workforce education programs/ Increase retention and representation of minority faculty members

on rural students, is the Rural Medical Scholars Program (RMSP) at the University of Alabama. Established in 1996, this pre-med and medical education program is open to college seniors and graduate students who plan to go to medical school and practice medicine in a rural area. As part of their RMSP pre-med experience, the scholars take graduate level courses and farm field trips, shadow rural physicians, participate in community service projects and attend lectures and workshops pertaining to rural community health topics.

Providing Loan Repayment and Financial Incentives

Loan repayment, loan forgiveness and other financial incentive programs may help increase diversity in the health care workforce by providing financial offsets to one of the biggest challenges to attracting a diverse pool of trainees or students: cost, both the cost of school and the opportunity costs associated with leaving the marketplace to enter a training program. At least 33 states have some sort of financial incentives to attract qualified professionals to study or to practice in their state.[18]

For example, Massachusetts' Primary Care Workforce Initiative promotes primary care as the foundation of health care delivery. With funding from public and private partners—the Commonwealth, Bank of America, the Neighborhood Health Plan and the Blue Cross Blue Shield Foundation—Massachusetts developed a loan repayment program that offers financial incentives for medical students, residents, physicians and nurse practitioners. Another example, the New Mexico Health Service Corps Act, offers commitment stipends of $30,000 for health professional students and licensed health professionals who serve in an eligible community for at least two years.

Using Workforce Data to Drive Policy and Planning

Policymakers use data and information about the current and future health care workforce to drive policy and planning. Some states, for example, establish workforce centers to monitor the supply and demand for specific health care providers and evaluate the effectiveness of educational and workforce strategies.

In 2007, the California Legislature established a health care workforce clearinghouse to collect data on supply and demand, diversity, geographic distribution and other factors. Among its many activities, the clearinghouse is charged with conducting a needs assessment to determine workforce and educational needs and identify a user-friendly, comprehensive data infrastructure.

Professional Curricular Development Strategies

Another option available to policymakers is to work with their professional training schools (e.g. medical, dental, pharmacy and nursing school) to encourage increasing diversity as a key objective. Diversification of these schools goes beyond simply changing the demographics of the student body, according research. Universities may also want to review the curriculum and internal

culture to ensure an environment that provides opportunities for shared learning among individuals from diverse backgrounds.[19] There have been efforts by accreditation bodies to enhance the diversity standards without putting undue burden on schools and accounting for differences among states. State policymakers can help guide this process in their state and district, both in their role as community leader and legislator, by keeping abreast of efforts in their states and ensuring their state's educational institutions meet national standards.

Creating the "Right" Teams to Reduce Health Disparities

Some states are looking to improve culturally competent care by including community health workers an integral part of the team of professionals.

Community health workers go by a number of names—promotoras, village health workers, health aides, community health promoters and lay health advisers. Regardless of their titles, they often are recruited from the communities they serve and trained on the culture of medicine and health systems—they learn the language of providers and how to navigate the health system.

Legislators are able to pave the way for community health workers to be part of provider teams by encouraging Medicaid and the managed care companies that contract with Medicaid to employ them and supporting the development of educational and training standards for these providers. Six states created some sort of training and certification program and at least a dozen other states are exploring this strategy.

FEDERAL ACTIONS TO INCREASE THE HEALTH CARE WORKFORCE DIVERSITY

The Affordable Care Act (ACA), signed into law in March 2010, included provisions aimed at increasing the diversity within the primary care, dental, mental health and long-term care workforce. These provisions include requiring the collection of workforce diversity data; expanding workforce diversity grants to include nurses; investing in the development and evaluation of culturally competent curricula in educational training; supporting cultural competence training for primary care providers; and providing some preference for loan repayment for individuals who have cultural competency experience.

In 2011, the federal Department of Health and Human Services'

Advisory Committee on Minority Health released a paper on diversifying a competent health care workforce. The recommendations are:

- Expand partnerships and funding sources to make the health care workforce more representative and reflective of diverse communities.
- Strengthen the quality of the K-16 educational system and access to professional schools.
- Increase the diversity of leadership in the health care service and education systems and build the capacity of institutions to support the ongoing development and advancement of leaders.
- Examine and modify accreditation and licensure procedures to ensure cultural competency, diversity, adequate training opportunities, and quality of health care providers.[20]

In addition, two reports, the National Stakeholder Strategy for Achieving Health Equity (NSS) and the Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities, both released in 2011, called for increased federal involvement to create a more diverse health care workforce.

The federal government also supports many programs to help diversify the health care workforce. For more information on these programs, please visit (OMH please give guidance on federal websites to direct legislators).

CONCLUSION

The United States has always been a nation rich in diversity—and as a nation we are getting more diverse. As minority groups become a larger percentage of total health care consumers, meeting their needs in cost effective and high quality ways might be the difference between balancing the budget and breaking the bank. One option policymakers are investigating to address the needs of minority populations is to increase the diversity of the health care workforce—diversifying the health care workforce has been shown to help improve access to health and health care for communities of color.

— BY MELISSA K. HANSEN

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NOTES

1. The National Academies Press, *In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce*, "Executive Summary" (Washington, D.C.: The National Academies Press, 2004).

2. Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: The National Academies Press, 2002).

3. U.S. Department of Health and Human Services, Advisory Committee on Minority Health, *Reflecting America's Population: Diversifying a Competent Health Care Workforce for the 21st Century. A Statement of Principle and Recommendations* (Washington, D.C.: U.S. DHHS, 2011), http://minorityhealth.hhs.gov/Assets/pdf/Checked/1/FinalACMHWorkforceReport. pdf.

4. S. Shimasaki, *Health Equity and Racial and Ethnic Workforce Diversity* (Denver: Colorado Trust, 2013).

5. Ibid.

6. A. Noonan, I. Lindone, and V. Jaitley, "The Role of Historically Black Colleges and Universities in Training the Health Care Workforce," *American Journal of Public Health* (2012).

7. M.E. Peek et al., "A Study of National Physician Organizations' Efforts to Reduce Racial and Ethnic Health Disparities in the United States," *Academic Medicine* 87, no. 6 (June 2012): 694–700.

8. J.J. Cohen, B.A. Gabriel, and C. Terrell, "The Case for Diversity in the Health Care Workforce," *Health Affairs* 21, no. 5 (September 2002): 90-102.

9. Ibid.

10. S. Shimaski, *Health Equity and Racial and Ethnic Workforce Diversity*.

11. R. Kington, D. Tisnado, and D.M. Carlisle, "Increasing Racial and Ethnic Diversity among Physicians: An Intervention to Address Health Disparities?" in Smedley et al., eds., *The Right Thing to Do* (Los Angeles, UCLA School of Public Health, 2001), 62.

12. J.C. Cantor et al., "Physician Service to the Underserved: Implications for Affirmative Action in Medical Education," *Inquiry* (Summer 1996): 173.

13. J. Hahm and A. Ommaya, eds., *National Research Council (US) and Institute of Medicine (US) Committee on Opportunities to Address Clinical Research Workforce Diversity Needs for 2010* (Washington, D.C.: National Academies Press, 2006).

14. Ibid.

15. B. Johnson and E. Holve, "Diversity in the Health Services Research Workforce: The Current Landscape," *Academy Health* (2013).

16. H. Browning, D. Torain, and T. Patterson, Collaborative Healthcare Leadership: *A Six-Part Model for Adapting and Thriving During a Time of Transformative Change* (Colorado Springs: Center for Creative Leadership, 2011).

17. State of California, Office of Statewide Health Planning and Development, Healthcare Workforce Development Division, www.oshpd.ca.gov/hwdd/HCTP_mini_grants.html; page last revised April 28, 2014.

18. U.S. Department of Health and Human Services, Health Resources and Services Administration, National Health Service Corps, *State Loan Repayment*, http://nhsc.hrsa.gov/loanrepayment/stateloanrepaymentprogram/, accessed June 28, 2014.

19. T. Perez, P. Hattis, and K. Barnett, *Health Professions Accreditation and Diversity: A Review of Current Standards and Processes* (East Battle Creek: W.K. Kellogg Foundation, 2007).

20. U.S. Department of Health and Human Services, Advisory Committee on Minority Health, *Reflecting America's Population*.

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