STRENGTHENING THE FOUNDATION TO ELIMINATE HEALTH DISPARITIES FOR TODAY'S AND TOMORROW'S ADULTS

Summary article based on a presentation by Joan Y. Reede, MD, MPH, MS at the Fifth Annual Primary Care and Prevention Conference, September 21–24, 2005; Atlanta, Georgia (*Ethn Dis*. 2006;16[suppl 3]:S3-77–S3-79)

INTRODUCTION

The minority population in America is rising: The US Census Bureau has projected that the percentages of Hispanics, Blacks, Asians and Pacific Islanders, and Native Americans will increase from 29.9% in 2000 to 55.7% by the year 2070. At the same time, the nation's demographics are changing. The majority of the immigrant population comes largely from Latin America and Asia, rather from Europe as in the past.

Minority zip codes are concentrated in a "belt" stretching along the lower portion of the nation from California through the South and into New York. This area includes 4,000 of the 30,000 zip codes in the U.S. Seventy percent of all minorities live in this belt.

Despite these trends, racial and ethnic health disparities continue to exist. The evidence is available from many sources: *Healthy People 2010*; a 2002 Institutes of Medicine (IOM) report titled *Unequal Treatment*; the National Health Disparities Report from the Agency for Healthcare Research and Quality (AHRQ); the Massachusetts Commission to Eliminate Racial and Ethnic Health Disparities; and the April 2005 issue of *Health Affairs*.

Multiple factors contribute to racial and ethnic health disparities. They include **social** determinants such as education, poverty and low socioeconomic status; **healthcare** characteristics such as the medical workforce, racism, and medical education; and **access** to healthcare. [Source: Barsam Kasravi, MD, California Endowment Scholar]

Millions of minorities lack health insurance—and the number is rising. In 2004, the U.S. Census Bureau reported the following uninsured rates: 11.3% of non-Hispanic Whites; 19.7% of Blacks; 16.8% of Asians; and 32.7% of Hispanics. Almost 19% of children in poverty are uninsured; 11.2% of all children have no insurance. The percentage of uninsured Black children is almost twice that of White children, while the percentage for Hispanic youngsters is almost triple that of Whites. [Source: *Income, Poverty and Health Insurance Coverage in the United States: 2004*]

In this presentation, two areas were discussed: workforce diversity, leadership in health and education; the need for minority physician, nurses, and dentists; and how the Nation should respond to the lack of minority healthcare professionals.

WORKFORCE DIVERSITY

Workforce diversity is important because it:

- Improves access to healthcare for individuals and communities;
- Improves the quality of care;
- Enhances the quality of health education in terms of cultural competence, awareness of disparities, and preparedness to serve diverse populations;
- Expands the focus and understanding of research by accelerating advances in medical and public health research;
- Improves the customer base by increasing community and political support;
- Increases the labor pool in a scarce labor market;
- Creates more effective teams, resulting in a broader perspective, added creativity and problem solving, and increased legitimacy;
- Saves money by lowering the cost of recruitment, orientation and training; reducing turnover; and reducing potential liability.

[Source: Adapted from *Diversity Leadership*, Janice L. Dreachslin, 1996]

THE IMPORTANCE OF LEADERSHIP POSITIONS IN HEALTH AND EDUCATION

Leadership is another area where action can be taken to eliminate healthcare differences. Underrepresented minority (URM) physicians are more likely to provide healthcare to URM populations. They disproportionately serve Medicaid patients and disproportionately locate their practices in underserved areas.

Data are available to indicate that URM physicians deliver a higher quality of care in terms of providing preventive care [Source: Saha, et al, *Arch Intern Med.* 1999;159: 997–1004]; involving patients in making decisions about their healthcare [Source: Cooper-Patrick et al. *JAMA.* 1999;282:583–589]; and spending more time with patients during office visits [Source: Cooper et al. *Annals of Intern Med.* 2003; 139(11): 907–915].

The American Medical Association reported that 2.4% of US physicians were Black, 3.3% were Hispanic, and 8.4% were Asian for a total of 14.1% minority doctors nationwide in those three minorities in 2003. [Source: www.ama-assn.org/ama/pub/category/12930.html]. Much of the physician workforce is concentrated in metropolitan areas across the nation. [Source: Government Accounting Office, October 2003]

Under-representation of minorities is clearly evident in the dental field. Of the 154,900 dentists in the United States in 1996, only 5,201 were Black; 5,178 were Hispanic; 10,693 were Asians/Pacific Islanders; and 194 were Native Americans. [Source: HRSA 1999S, ASTHO: Issue Report State Public Health Approaches to the Oral Health Workforce Shortage, February 2004]

The racial/ethnic distribution of registered nurses in the workforce also is out of balance. African American nurses make up 4.9% of the workforce, while African Americans comprise 12.5% of the US population. The situation is more uneven for Hispanics, who make up 12.5% of the population but only 2% of the nurse workforce. [Source: Racial/Ethnic Distribution of the Registered Nurse Workforce, 2000]

Minorities are less likely to be represented as professors, associate professors, assistant professors and instructors on medical school faculties. They also are less apt to be deans or department chairs of medical schools. [Source: AAMC Faculty Roster System, January 2002] At dental schools across the nation, only 4% of faculty members are African Americans and only 4.6% are Hispanics/Latinos. [Source: American Dental Education Association Survey of Dental Educators 2002–2003] Nursing schools have a similar lack of representation by minorities on their faculties. In 2003, only 9.4% of fulltime nurse faculty members were minorities, including 5.6% African Americans, 1.5% Hispanics/Latinos, 1.9% Asians/Native Hawaiians/Pacific Islanders, and .4% Native Americans/Alaska Natives. [Source: Berlin, Stennett and Bednash, Sullivan Commission Report, 2004]

The disparity in healthcare leadership is also evident in females vs males, with females less likely to hold top positions in health care. [Source: A Race/Ethnic Comparison of Career Attainment in Healthcare Management Summary Report: 2002] People of color, whether male or female, are less likely to be in leadership positions and are often lost through leaks in the pipeline between childhood and a productive adult life. The leaks include: unrecognized potential, inadequate awareness of opportunities, underdeveloped relationships, poor academic preparation, and lack of social supports.

The issues facing institutions in educating future healthcare workers are the same issues that exist in society as a whole. In a study of 100 kindergarten children, 87% of African Americans graduated from high school, 50% completed some college, and only 18% obtained at least a bachelor's degree. Among Latinos, 63% finished high school, 32% completed some college, and only 11% received a bachelor's degree. Among White kindergarteners, this compares with 93% who graduated from high school, 65% who completed some college, and 33% who graduated from college. [Source: Education Trust, Inc.: US Department of Commerce, Bureau of the Census. March Current Population Surveys, 1971–2001, in *The Condition of Education 2002.*]

The College Board reports students nationwide averaged a score of 1,026 on the SAT in 2004. The average for Black students was 857, while the score for students of Hispanic origin was just over 900.

THE INCREASING NEED FOR PHYSICIANS, NURSES, AND DENTISTS

Richard Cooper of the Health Policy Institute at the Medical College of Wisconsin recommended that medical schools increase their output of physicians by 35% by the year 2020. Other experts have called for similar increases over the next 10 to 15 years. Dental schools reported a 40% decline in graduates between 1986 and 2000. [Source: ASTHO: Issue Report State Public Health Approaches to the Oral Health Workforce Shortage, February 2004]

The nursing shortage continues to be a detriment to healthcare delivery. The nation will need one million new and replacement nurses by the year 2012. [Source: U.S. Bureau of Labor Statistics, *Monthly Labor Review*, February 2005] Thirty states had a shortage of RNs in 2000. [Source: HRSA, July 2002] Long-term care facilities, with a turnover of 50%, are in need of 100,000 nurses on any given day. [Source: National Commission on Nursing Workforce for Long-Term Care, *Act Now for Tomorrow*, May 2005] A total of 126,000 nurses were needed for hospital vacancies in 2001. [Source: American Hospital Association, *TrendWatch*, June 2001]

The public health workforce is aging rapidly. Workforce shortages and high vacancy rates exist in public health nursing, epidemiology, laboratory science, and environmental health. Many workers are eligible for retirement, while many others choose to work elsewhere, creating a high turnover rate. [Source: ASTHO, State Public Health Employee Worker Shortage Report, 2004]

HOW SHOULD THE NATION RESPOND TO THE LACK OF MINORITY HEALTHCARE PROFESSIONALS?

Two recent reports contain recommendations for increasing the percentages of African Americans, Hispanics and other minorities in the health workforce. The Institutes of Medicine (IOM) offered the following strategies:

- Improve admission policies and practices.
- Reduce financial barriers to health professions training.
- Encourage diversity efforts through accreditation.
- Apply community benefit principles to diversity efforts.
- Devise mechanisms to encourage support for diversity efforts.

The Sullivan Commission described a health system modeled on excellence, access, and quality for all people. It said that the culture of health professions schools must change, that new and nontraditional paths to the health professions should be explored, and that commitments must be at the highest levels.

Creating the Next Generation of Leaders

The Office for Diversity and Community Partnership is a multi-faceted effort to prepare future leaders and serves as a model for other institutions. It includes educational programs for high school, undergraduate, and graduate students, as well as cooperative activities in the community.

An initiative known as the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy (CFHUF) enrolls healthcare professionals with MPH and MPA degrees in a program to broaden their horizons and increase their contacts with current intellectual leaders. The fellows attend 28 sessions on topics such as communications, human resource management, journal writing, financial management, negotiation, and marketing. They make site visits to Atlanta, where they tour the CDC, the American Cancer Society, the Fulton County Department of Health, and Morehouse School of Medicine; and to Washington, DC, where they meet with heads of federal agencies and attend Congressional caucuses. The fellows also attend professional association meetings and "shadow" leaders in the health field.

The alumni fellows are contributing their talents: All have engaged in policy, research, and/or service delivery to minority health; 60% serve on national/federal committees or advisory boards; 71% serve on state or local committees; 60% have been published and many have presented results; and 75% have held academic appointments at schools of medicine and public health.

CONCLUSION

To make a difference, we need minority leaders who can: walk in the doorway, have a seat at the table, set the agenda, ask the questions, interpret the answers, determine the priorities, establish the policies, and allocate the resources.