

# MISSING PERSONS: MINORITIES IN THE HEALTH PROFESSIONS

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A REPORT OF THE SULLIVAN COMMISSION ON  
DIVERSITY IN THE HEALTHCARE WORKFORCE

EXECUTIVE SUMMARY

EMBARGOED 9/20/2004



THE SULLIVAN COMMISSION

## **ABOUT THE SULLIVAN COMMISSION**

The Sullivan Commission on Diversity in the Healthcare Workforce is an outgrowth of a grant from the W.K. Kellogg Foundation to Duke University School of Medicine. Named for former U.S. Secretary of Health and Human Services, Louis W. Sullivan, M.D., the Commission is composed of 16 health, business, higher education and legal experts and other leaders. Former U.S. Senate Majority Leader Robert Dole and former U.S. Congressman and Congressional Health Subcommittee Chairman Paul Rogers serve as Honorary Co-Chairs. Established in April 2003, the Sullivan Commission will make policy recommendations to bring about systemic change that will address the scarcity of minorities in our health professions.

The work of the Commission comes at a time when enrollment of racial and ethnic minorities in nursing, medicine, and dentistry has stagnated despite America's growing diversity. While African Americans, Hispanic Americans, and American Indians, as a group, constitute nearly 25 percent of the U.S. population, these three groups account for less than 9 percent of nurses, 6 percent of physicians, and only 5 percent of dentists. A study by the Institute of Medicine recommends increasing the number of minority health professionals as a key strategy to eliminate health disparities. Examining the education and training environment in which health professionals learn and develop is critical to efforts to increase the number of health care providers who can, and will, address the health care needs of our nation.

The lack of minority health professionals is compounding the nation's persistent racial and ethnic health disparities. From cancer, heart disease, and HIV/AIDS to diabetes and mental health, African Americans, Hispanic Americans, and American Indians tend to receive less and lower quality health care than whites, resulting in higher mortality rates. The consequences of health disparities are grave and will only be remedied through sustained efforts and a national commitment.

In a series of field hearings across the country, the Sullivan Commission gathered testimonies from health, education, religion and business leaders; community and civil rights advocates; health care practitioners; and students. Drawing upon the expertise and experience of the Commissioners, and the witnesses who provided valuable testimony, the Commission's report, *Missing Persons: Minorities in the Health Professions*, provides the nation with a blueprint for achieving diversity in the health professions.

For more information, visit: [www.sullivancommission.org](http://www.sullivancommission.org).

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**EXECUTIVE SUMMARY (EMBARGOED 9/20/2004)**

By many measures, America has an exceptional health care system. Tremendous advances have made the U.S. health system the most technologically advanced in the world. Yet that system is in trouble. Basic quality care is beyond the reach of far too many Americans. As the population has become increasingly diverse, glaring disparities in the quality of care, especially for racial and ethnic minorities, have led to thousands of premature deaths each year and incalculable hours of lost productivity, pain, and suffering.

Many complex factors are at play. One is rooted in economics and a system that leaves far too many Americans lacking adequate, if any, health insurance. For many reasons—not the least of which is cost—a record 44 million Americans now have no health insurance and untold millions more have inadequate or limited coverage. Those numbers are growing.

The fact that the nation's health professions have not kept pace with changing demographics may be an even greater cause of disparities in health access and outcomes than the persistent lack of health insurance for tens of millions of Americans. Today's physicians, nurses, and dentists have too little resemblance to the diverse populations they serve, leaving many Americans feeling excluded by a system that seems distant and uncaring. In future years, our health professionals will have even less resemblance to the general population if minority enrollments in schools of medicine, dentistry, and nursing continue to decline and if health professions education remains mired in the past and—despite some improvements—inherently unequal and increasingly isolated from the demographic realities of mainstream America. Failure to reverse these trends could place the health of at least one-third of the nation's citizens at risk.

Recognizing the crisis, and continuing its national effort to counter the lack of diversity in medicine, nursing, and dentistry, in 2003 the W.K. Kellogg Foundation issued a grant to Duke University School of Medicine to plan and convene the Sullivan Commission on Diversity in the Healthcare Workforce. Composed of 15 health, education, legal, and business leaders and headed by former U.S. Health and Human Services Secretary Dr. Louis W. Sullivan, this Commission was given the formidable, and unique, task of identifying and understanding the barriers to achieving diversity in the health professions and then to finding solutions.

Working without the constraints often confronting government or quasi-government panels, Commission members examined existing research, commissioned studies, and traveled the country to gather information. The Commission held six field hearings and a nationally broadcast town hall meeting, and heard from more than 140 witnesses in order to bring the problems into clearer focus and to identify existing models and workable solutions.

This report, *Missing Persons: Minorities in the Health Professions*, emphasizes the need for leadership, commitment, and accountability at the highest levels in institutions of learning and professional organizations, and at the national level in the form of legislation and a Presidential task force to give urgency and focus to the problem. A number of strategies are identified to make education and training in the health professions more attainable and affordable for minority students, including shifting from student loans to scholarships; reducing dependency on standardized tests for admission to schools of medicine, nursing, and dentistry; and enhancing the role of two-year colleges. In all, 37 separate recommendations are put forward to remedy the lack of diversity among health professionals, warning that failure to act quickly will only exacerbate the current disconnect between health care providers and the populations they serve.

Statistics reviewed by this Commission highlighted the diversity gap. Together, African Americans, Hispanic Americans, and American Indians make up more than 25 percent of the U.S. population but only 9 percent of the nation's nurses, 6 percent of its physicians, and 5 percent of dentists. Similar disparities show up in the faculties of health professional schools. For example, minorities make up less than 10 percent of baccalaureate nursing faculties, 8.6 percent of dental school faculties, and only 4.2 percent of medical school faculties.

If the trends continue, the health workforce of the future will resemble the population even less than it does today. Viewed in the context of demographic projections showing that no racial or ethnic group will comprise a majority by the year 2050, that decline could be catastrophic.

Support for a direct link between poorer health outcomes for minorities and the shortage of minority health care providers came from the Institute of Medicine's landmark study, *Unequal Treatment*. That study documented the lower quality of health care and higher rates of illness, disability, and premature deaths among minority populations.

The evidence this Commission reviewed and the testimony heard led its members to conclude that the condition of the nation's health professions workforce is critical and demands swift, large-scale change to protect the future health of the nation. Transforming the system will require changing the face of the American health care system.

The conclusions provide a new vision of health care for America, one that focuses on excellence and that ensures true equality of high-quality care for the entire population. Diversity is a key to excellence in health care. To achieve that new vision, care must be provided by a well-trained, qualified, and culturally competent health professions workforce that mirrors the diversity of the population it serves.

The Sullivan Commission's recommendations were developed to attract broad public support and to encourage academic and professional leadership to share the Commission's vision for a health system modeled on excellence, access, and quality for all people. Three overlying principles are essential to fulfilling that vision.

- 1.) **To increase diversity in the health professions, the culture of health professions schools must change.** Our society is experiencing a significant and rapid demographic shift. The culture of our nation is changing. So too must the culture of our health institutions. As colleges, universities, health systems, and others examine these recommendations, they must also examine the practices of their own institutions.
- 2.) **New and non-traditional paths to the health professions should be explored.** In some health professions, it takes between 10 and 12 years to fully educate and train a provider. This Commission calls for major improvements in the K-12 educational system, with the realization that the degree of diversity in health professions schools cannot remain stagnant while these improvements take shape.
- 3.) **Commitments must be at the highest levels.** Change can happen when institutional leaders support the change. In 1966, Duke University School of Medicine was one of the last two medical schools in the South to admit a black student. Today, Duke University School of Medicine has become a model of diversity and has used its leadership to bring other institutions along a new and inclusive path toward excellence.

In brief, the following summarizes the Commission's specific findings and recommendations:

### **Chapter 1: The Rationale for Achieving Diversity in the Health Workforce**

The rationale for increasing diversity in the health workforce is evident: increased diversity will improve the overall health of the nation. This is true not only for members of racial and ethnic minority groups, but also for an entire population that will benefit from a health workforce that is culturally sensitive and focused on patient care.

Diversity in the health workforce will strengthen cultural competence throughout the health system. Cultural competence profoundly influences how health professionals deliver health care. Language is a critical component, with two out of ten Americans speaking a language at home other than English. The cultural challenges posed by a shifting patient demographic can best be addressed by health professionals educated and trained in a culturally dynamic environment.

The business community has long recognized that workforce diversity is essential to success and maintaining competitiveness in the marketplace. Corporate executives as well as local chambers of commerce describe the economic benefits of developing a workforce that reflects the customer base. Business support for diversity was demonstrated in the unprecedented number of amicus curiae briefs filed with the Supreme Court in support of the University of Michigan's affirmative action admissions policies. Business leaders find diversity in higher education necessary to the development of skills required to compete in a global economy, skills such as the ability to understand, work, and build consensus with individuals of different ethnic and cultural backgrounds.

Some business benefits from diversity are specific to the health care sector. Poor health outcomes for members of racial and ethnic minorities, attributable to a lack of diversity in the health workforce, translate to a loss of productivity, unnecessary absenteeism, and increased health care costs. The business community recognizes that promoting diversity in the health workforce, as well as in the general workforce, is essential to a strong economy.

## **Chapter 2: Historical Roots of Health Care Inequality**

Many people living today remember a time when admission to college and to professional schools was systematically limited by race, sex, national origin, and religion. The civil rights movement of the 1960s eventually ended the more visible racial and ethnic barriers, but it did not eliminate entrenched patterns of inequality in health care, which remain the unfinished business of the civil rights movement.

Historically, racial and ethnic minorities have always been underrepresented in the health professions in America (Smith, 1999; Byrd & Clayton, 2002), just as members of these populations have always been more likely to receive a lower quality of care, experience higher rates of illness and disability, and die at earlier ages than members of the white population (IOM, 2003; PHR, 2003).

Schools of medicine, dentistry, and nursing have been among the last to integrate their classrooms, and their professional organizations have been equally slow in recruiting minorities into their ranks. Significant improvements have been made. In many health professions, including some medical specialties, women have achieved parity and due recognition. Further, some of the most accomplished and highly respected people in the health professions are members of minority groups who overcame the barriers of a once-segregated medical establishment.

Today, talented minority students are among the most sought-after applicants at some leading universities and professional schools. Strong steps must be taken to expedite inclusion of underrepresented minority groups among the various health professions. The Commission recommends:

- 2.1 The complementary strategies of increasing diversity and ensuring cultural competence at all levels of the health workforce should be endorsed by all in our society, with leadership from the key stakeholders in the health care system.
- 2.2 There should be increased recognition of underrepresented minority health professionals as a unique resource for the design, implementation, and evaluation of cultural competence programs, curriculums, and initiatives.
- 2.3 Public and private funding entities, including U.S. Public Health Service agencies, foundations, and corporations, should increase funding for research about racial disparities in health care and health status, including, but not limited to: research on culturally competent care, how to measure and eliminate racial bias and stereotyping, and strategies for increasing positive health behaviors among racial and ethnic groups.
- 2.4 Health systems should set measurable goals for having multi-lingual staff and should provide incentives for improving the language skills of all health care providers.
- 2.5 Health professions schools should work to increase the number of multi-lingual students, and health systems should provide language training to health professionals.
- 2.6 Key stakeholders in the health system should promote training in diversity and cultural competence for health professions students, faculty, and providers.

### **Chapter 3: State of Diversity in Today's Health Professions Schools and Workforce**

The ghosts of segregation continue to haunt the health professions. Appropriately, the Commission began its field hearings in Atlanta, birthplace of the civil rights movement. Testimony there highlighted the problems confronting efforts to improve diversity among the health professions workforce. For example, in 1997, the incoming class at the state-sponsored Medical College of Georgia included only one black student, even though approximately 30 percent of the citizens of Georgia are black. The problem in Georgia is not unique. The nation's upcoming medical school graduating classes for 2007 include only 2,197 black, Hispanic, and Native Americans out of a total of more than 16,000 students. The picture in nursing and dentistry is similar.



Enrollment of minority students in health professions schools increased slightly during the 1960s, 1970s, and 1980s. However, the numbers have failed to keep up with the growth of minority populations, particularly in medicine where minority enrollment is now declining. This situation makes it more difficult for students at many of the nation's leading health professions institutions to share different socioeconomic and cultural experiences so essential to the training of health professionals destined to work with an increasingly diverse population.

Excellence in health professions education is difficult to achieve in a culturally limited environment. Missing the experience of cultural diversity diminishes the overall quality of health professions education and adversely affects the health status of minority populations.

The limited pool of leaders and mentors in the health professions needs to be addressed. Currently, underrepresented minorities account for only 4.2 percent of medical school faculties in the United States, less than 10 percent of the baccalaureate and graduate nursing school faculties, and 8.6 percent of dental faculties. This lack of leadership and sparse representation among faculties sends a chilling message to current and potential minority students.

#### **Chapter 4: The Pipeline to the Health Care Professions**

Collectively, the nation's medical, nursing, and dental schools have not succeeded in their efforts to achieve greater diversity among their students and, in turn, to develop a health professions workforce with the skills and diversity needed to maintain the nation's position as a world leader in health care. Few models of successful minority student development and recruitment efforts exist despite the frequent, and loudly voiced, agreement that this is a problem that can, and must, be solved.

The problem is seen at the beginning of the pipeline where primary and secondary schools are failing too many students. On average, when compared with white students, racial and ethnic minority students receive a K-12 education of measurably lower quality, score lower on standardized tests, and are less likely to complete high school. Those who do graduate from high school are far less likely to graduate from a four-year college than white students. Approximately 36 percent of white students graduate with a four-year degree, compared with 18 percent of African American, and 11 percent of Hispanic students (U.S. Census Bureau, 2003).

Even talented minority students who do succeed at primary, secondary, and collegiate levels, and who are committed to pursuing a career in one of the health professions, often find it difficult to gain admission to a health professions school. The barriers they encounter include an over-reliance on standardized testing in the admissions process, unsupportive institutional cultures, insufficient funding sources, and leadership without a demonstrated commitment to diversity.

A number of strategies to broaden the health professions pipeline were identified, including efforts to provide extra support for disadvantaged and minority students through strategies such as mentoring, counseling and training in test-taking and interviewing skills, and efforts to include more students from two-year colleges and allied health professionals seeking second careers. The Commission recommends:

- 4.1 Health professions schools, hospitals, and other organizations should partner with businesses, communities, and public school systems to: a) provide students with classroom and other learning opportunities for academic enrichment in the sciences; and b) promote opportunities for parents and families to increase their participation in the education and learning experiences of their children.
- 4.2 The U.S. Public Health Service, state health departments, colleges, and health professions schools should provide public awareness campaigns to encourage underrepresented minorities to pursue a career in one of the health professions. Such a campaign should have a significant budget, comparable to other major public health campaigns.
- 4.3 For underrepresented minorities who decide to pursue a health profession as a second career, health professions schools should provide opportunities through innovative programs.
- 4.4 Baccalaureate colleges and health professions schools should provide and support “bridging programs” that enable graduates of two-year colleges to succeed in the transition to four-year colleges. Graduates of two-year community college nursing programs should be encouraged (and supported) to enroll in baccalaureate degree-granting nursing programs.
- 4.5 Key stakeholders in the health system should work to increase leadership development opportunities in nursing in order to prepare minority nurses with graduate degrees for roles as scholars, faculty, and leaders in the profession.
- 4.6 Key stakeholders in the health system should work to increase leadership training and opportunities for underrepresented minority physicians and dentists.
- 4.7 Colleges, universities, and health professions schools should support socio-economically disadvantaged college students who express an interest in the health professions, and provide these students with an array of support services, including mentoring, test-taking skills, counseling on application procedures, and interviewing skills.
- 4.8 The Association of American Medical Colleges, the American Association of Colleges of Nursing, the American Dental Education Association, and the Association of

Academic Health Centers should promote the review and enhancement of health professions schools admissions policies and procedures to: a) enable more holistic, individualized screening processes; b) ensure a diverse student body with enhanced language competency and cultural competency for all students; and c) develop strategies to enhance and increase the pool of minority applicants.

- 4.9 Dental and medical schools should reduce their dependence upon standardized tests in the admissions process, the Dental Admissions Test and the Medical College Admissions Test should be utilized, along with other criteria in the admissions process as diagnostic tools to identify areas where qualified health professions applicants may need academic enrichment and support.
- 4.10 Diversity should be a core value in the health professions. Health professions schools should ensure that their mission statements reflect a social contract with the community and a commitment to diversity among their students, faculty, staff, and administration.
- 4.11 Health systems and health professions schools should use departmental evaluations as opportunities for measuring success in achieving diversity, including appropriate incentives.
- 4.12 Health systems and health professions schools should have senior program managers who oversee: a) diversity policies and practices; b) assist in the design, implementation, and evaluation of recruitment, admissions, retention, and professional development programs and initiatives; c) assess the institutional environment for diversity; and d) provide regular training for students, faculty, and staff on key principles of diversity and cultural competence.
- 4.13 Health professions schools should increase the representation of minority faculty on major institutional committees, including governance boards and advisory councils. Institutional leaders should regularly assess committee/board composition to ensure the participation of underrepresented minority professionals.

## **Chapter 5: Financing Health Professions Education**

The burden of financing an education in the health professions has put the dream of becoming a health professional beyond the reach of far too many qualified, underrepresented minority students. Many of these students come from families with significantly lower incomes and fewer financial assets than their white counterparts. In 2001, the median income for white families was 40 percent higher than that of blacks and 39 percent higher than that of Hispanics. Even the most talented students from these minority families tend to view the cost of professional educa-

tion as overwhelming and insurmountable. Financial realities mean many low-income students who do graduate from high school do not plan to attend a four-year college or to take the necessary qualifying exams and apply to a health professions school. Those who do pursue their dream for a health professions education experience high unmet financial needs, coupled with excessive loan and work burdens.

The situation demands creative responses to increase funding to support diversity programs and eliminate the financial barriers that discourage so many minority students. Failure to address the cost problem increases the growing diversity gap between the health professions and the populations they serve.

The Commission recommends:

- 5.1 Congress should substantially increase funding to support diversity programs within the National Health Service Corps, and Titles VII and VIII of the Public Health Service Act. Such funding should also provide for collection of data on diversity.
- 5.2 To reduce the debt burden of underrepresented minority students, public and private funding organizations for health professions students should provide scholarships, loan forgiveness programs, and tuition reimbursement strategies to students and institutions, in preference to loans.
- 5.3 Public and private entities should significantly increase their support to those health professions schools with a sustained commitment to educating and training underrepresented minority students.
- 5.4 Businesses, foundations, and other private organizations should be encouraged to support health professions schools and programs to increase financial resources needed to implement the recommendations of the Sullivan Commission.
- 5.5 The President and Congress should increase the funding for the National Institutes of Health's National Center for Minority Health and Health Disparities Loan Repayment Programs, with a special emphasis on programs for underrepresented minority students.
- 5.6 The National Institutes of Health should develop a Centers of Excellence program for schools of nursing.

## Chapter 6: Accountability

From field hearings and witnesses, the commission learned the essential value of leadership. Often, the commitment of a university president, chancellor, or dean has been instrumental in developing and implementing new policies and procedures and, at the same time, has changed the cultures and attitudes that blocked diversity.

Strong leadership is required to ensure that goals and commitments to achieve diversity are met. That, in turn, demands accountability. For health professions schools, that accountability must address four key principles: quality care, measurement of progress, benefit to the community, and institutional commitment.

Leadership beyond the institutional level is essential. Professional organizations, and federal and state agencies need to promulgate guidelines, set standards and regulations, and develop other devices for promoting cultural competence and diversity within the health professions. To ensure success, federal and state legislation is needed to strengthen the institutions that serve underrepresented populations, and a Presidential interagency task force should develop and implement a comprehensive strategy to improve diversity in the health workforce.

- 6.1 Health systems and health professions schools should gather data to assess institutional progress in achieving racial and ethnic diversity among students, faculty, administration, and health services providers, as well as monitor the career patterns of graduates.
- 6.2 Health professions schools and health systems should have strategic plans that outline specific goals, standards, policies, and accountability mechanisms to ensure institutional diversity and cultural competence.
- 6.3 Health professions organizations and accrediting bodies for health professions education and health care programs should promote the development and adoption of measurable standards for cultural competency for health professions faculty and health care providers.
- 6.4 Accrediting bodies for programs in medicine and the other health professions should embrace diversity and cultural competence as requirements for accreditation.
- 6.5 State licensure boards for nurses, physicians, and dentists should determine the value of having continuing education in cultural competence as a condition of licensure.
- 6.6 Community and civil rights organizations should collaborate with health care organizations and health professions schools to advance institutional diversity and cultural competence goals, including community needs assessment and evaluation.

- 6.7 Federal and state regulatory agencies should monitor and enforce health care institutions' fulfillment of community-benefit obligations pertaining to diversity and cultural competence. Data collected should be readily available to the public.
- 6.8 The Department of Health and Human Services should establish and report national standards and measurements for diversity and cultural competence in the health workforce and health professions schools in the Agency for Healthcare Research and Quality's National Health Care Disparities Report.
- 6.9 The Department of Education should work with the appropriate accrediting bodies to ensure that health professions education institutions promulgate, monitor, and implement standards for diversity and cultural competence for students, faculty, staff, and administration.
- 6.10 The Department of Labor and the Department of Health and Human Services should ensure that the appropriate accrediting bodies hold medical residency and health professional training programs accountable for promulgating and implementing standards for diversity and cultural competence.
- 6.11 The Commission recommends the passage and funding of comprehensive state and federal legislation that will: 1) ensure the development of a diverse and culturally competent workforce; and 2) strengthen health care institutions that serve minority and underserved populations.
- 6.12 The President should appoint an advisory council or interagency task force on health workforce diversity to develop and implement a more effective national response to the shortage of minorities in the health professions.

The Commission believes its vision for American health care can be achieved within the next two decades. In that time, a new generation of physicians, dentists, nurses, and other health professionals will have been trained to care for a population where the terms “majority” and “minority” have become obsolete.

The health professions have reached a crossroads, a point where dramatic change is required and wise decisions must be made. Either health professions training will remain entrenched in the status quo and become increasingly out of touch with the demographic realities and health needs of the nation, or the professions can choose to change, and lead to a new era of excellence in health care.

From the streets of Harlem to the barrios of East Los Angeles, the Commission saw shining examples of young students and professionals who can lead to this new era. Many share a dream of returning to their communities as physicians, dentists, and nurses to provide care for friends, neighbors, and relatives. They face huge financial obstacles, but new financing mechanisms can put a health professions education within their reach. Further reducing the debt burden will broaden access to a health professions education.

“I had incredible support that allowed me to pursue my dreams and fight to get my education,” testified Claribel Sanchez, a University of California, Berkeley, student born and raised in East Los Angeles, a neighborhood that has seen more than its share of crime and violence. “Even if I’m here on loans, I’m not letting money become an issue. It’s the only way I can get through and I’m not going to give up.”

With change, new role models will provide hope to medically underserved communities which currently see health care as a luxury, not a reality. New ways for providing quality care to those who now receive little will be discovered.

Tracy Brewington, a nursing student at Howard University, told the Commission: “I’m looking forward to going back home to Philadelphia, to the inner city, where I will have the opportunity to give back to my community. I feel like even if just one person could do something to try to eliminate these health disparities, it could be me. I’m here to make a difference.”

The goal of the Commission is to increase diversity in the health professions. By its very nature, diversity allows more people from different backgrounds to look at the same problem and to explore different approaches and different solutions. To the goal of diversity, the Commission added the goal of excellence in order to achieve a health care system where no American would feel excluded and all would experience the same high level of quality care. The Commission believes the task of transforming the health system to achieve that level of excellence requires a strong commitment from all in our society, with particular leadership from the generation that was born into the post-Civil Rights Era, and is committed to seeing the “dream” truly fulfilled. In the ever-cogent words of the Rev. Dr. Martin Luther King, Jr., “The time is always right to do what is right.”