Organized Noise:

Partnering with the Community to Address the Shortage of Underrepresented Minorities in the Health Professions

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Introduction: An Equal Voice

A community's voice holds as much weight as government, corporate or academia for each is dependent on the other. Although these social interests have expressed mutual concerns about the overall health of our nation, unequal treatment of racial and ethnic minority groups continues. Minorities are not joining the ranks as future health professionals to the degree that they are represented in the US. In New York State in 2007, Blacks, Hispanic/Latinos and Native Americans made up 35% of the population combined, however, only 10% of the physician workforce, 13% of nurses and 7% dentists. It is becoming increasingly apparent that the combined skills of health professionals from varying backgrounds are needed to close the equity gap in health, to respond to America's increasing diversity, and to ultimately ensure a healthy nation (Sullivan Commission).

In order to eliminate health disparities and meet the demands of a growing multicultural society, efforts to train and support a diverse pool of health care providers and encourage racial/ethnic concordance should be strengthened. In New York, there is a greater sense of urgency to adapt to changing demographics, as the number of minorities increase, the population ages, and 1.1 million previously uninsured individuals receive coverage based on new health reform laws. Brooklyn is often referred to as a splendid example of this diversity. There is a great legacy of immigrants establishing tightly knit neighborhoods throughout the borough, and it also houses the largest population of African descendants of any major US city. Despite Brooklyn's reputation for being diverse, African Americans, Hispanic/Latinos, Native Americans, and some Asian American ethnicities are also starkly underrepresented in the health professions.

Differential health status and limited access to quality health care are pervasive among racial/ethnic minority communities throughout Brooklyn and homegrown health disparities solutions are lacking. Community-based approaches are needed to increase minority representation in the medical field in order to improve health care among underserved groups. Minority health care providers more often provide care in underserved minority communities. Their influence in patient's care decisions and within supportive community-based organizations continues to be an important strategy towards reducing health disparities. Integrating the community in efforts to increase access to pipeline programs that nurture future health care professionals from underrepresented minority backgrounds at all stages of their formal education is the underpinning to this approach.

In short, the community matters and it should take center stage in the policy arena to reduce disparities and increase the number of underrepresented minorities in the health professions. Their voices cannot be ignored.

Equity Begins at Home

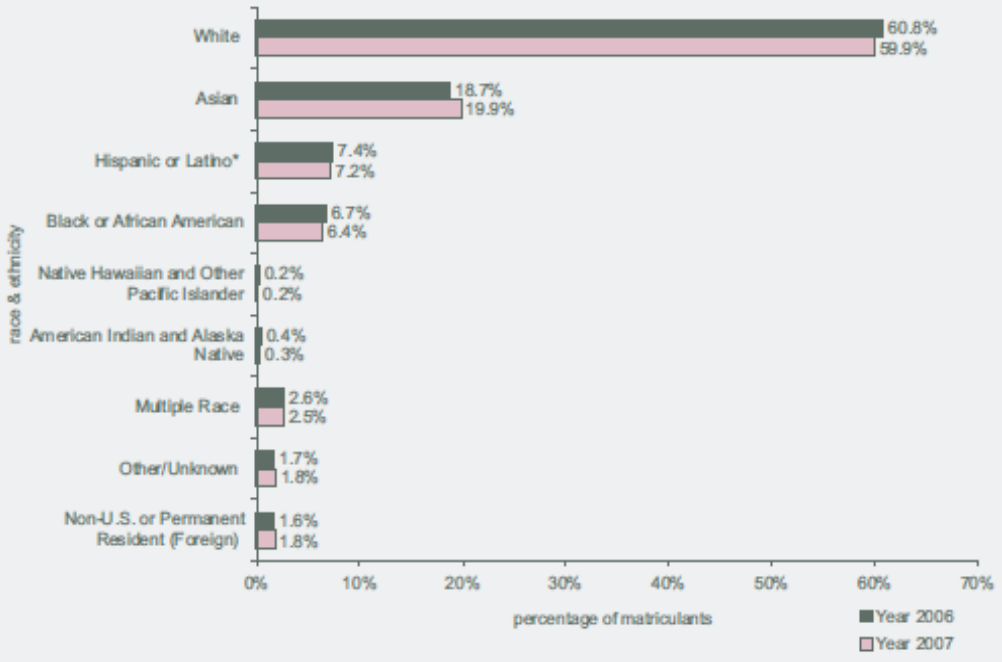
The health care workforce will largely be groomed from the communities in which they live. It has been shown that patients receive a better quality of care from those who are culturally and linguistically connected to them. Planning and implementation of any intervention designed to address diversity in the workforce and reduce disparities must involve community-based organizations. These efforts should be well led, supported with adequate financial resources and linked to change efforts in other localities and nationally.

Teaching hospitals and academic medical centers are in prime positions to nurture community-based partnerships in order to address the

shortage of underrepresented minorities in the health professions. These institutions serve greater numbers of elderly, low income and uninsured residents. Seventy-five percent of physicians practicing in New York trained at one of its teaching hospitals or major medical centers. Out of the 6 academic medical schools in New York City, Brooklyn is home to one, which trains more than 700 medical students each year. Many physicians educated in foreign countries face barriers to gaining proper credentials to practice medicine in the US. This is significant for Brooklyn, as many foreign trained doctors begin practices in communities of color, and practitioners from underrepresented minority groups are more likely to return to their communities after completing their formal education. For New York City and Brooklyn, including more minorities and immigrants in the health professions is paramount.

- The top three causes of under representation in the sciences by minorities are lack of quality science and math programs in poorer school districts, persistent stereotypes that minority students can't cut it, and financial issues related to the cost of education (Bayer, 2010).
- 40% of Native Americans, 38% of Latinos and 36% percent of African Americans in New York City did not graduate from high school (Black Equity Alliance, 2010).
- Underrepresented minorities make up 9% of nurses, 6% physicians, and 5% dentists in the US (Zayas & McGuigan, 2006).
- A 2003 American Dentistry Education Association survey showed that national pipeline schools in dentistry recruited a higher number of Blacks than non-pipeline schools (8% vs. 3%) (Andersen et al, 2004).

Figure 12: Percentage of U.S. Medical School Matriculants by Race and Ethnicity, 2006-2007



Note: Categories are Non-Hispanic, with the exception of Hispanics and foreign/unknown citizenship. Since 2002, individuals have the option of reporting both their race and ethnicity alone or in combination with some other race or ethnicity. In this figure numbers are reported for race alone; those that reported more than one race are included under Multiple Race.
*Includes Cuban, Mexican American, Puerto Rican, Other Hispanic, and Multiple Hispanic.
Source: AAMC Data Warehouse: Applicant Matriculant File, as of 1/6/2008.

- One half of all African American medical school graduates plan to practice in underserved areas in comparison to 33% Latino and 18% White (Zayas & McGuigan, 2006).
- Out of all US medical schools, 3 out of 6 New York City medical schools ranked in the bottom 20 for meeting a social mission, such as providing community benefit; there were no medical schools in the Northeast that ranked in the top 20 (Mullan F et al, 2010).
- 77% of women and underrepresented minority scientists said that more of them are missing from the science fields because they were not identified, encouraged or nurtured to pursue these studies early on (Bayer, 2010).

Academic institutions, corporations, and government should take concerted action with community groups to make organized noise around these workforce shortages in light of new health reform efforts. Acknowledging the role and impact of institutional racism, which has perpetuated low recruitment and retention of underrepresented minorities in the health field is an initial step. However, all sectors of the community, with those of African American, Hispanic/Latino, Native American heritage at the helm, should become the sounding board for health disparities solutions. A multi-disciplinary task force that is well supported and linked to the communities in which it served is a starting point. In underserved communities like Brooklyn, these solutions should be in keeping with community-based approaches that seek to eliminate health disparities, and improve recruitment and retention of underrepresented minorities in health care careers.

Public Education and Pipeline Programs

The dismal conditions of many public schools do not bode well for underserved youth aiming for careers in the health professions. By and large, public education systems are failing minority students by limiting their exposure to the sciences early on and bypassing their interests once they have been identified. For foreign-born students, oftentimes they do not have a chance at higher education because of the documentation required to enroll in college and financial constraints. Strategic educational partnerships among high schools, health professions schools, healthcare institutions, government, and community organizations could help to overcome systemic obstacles that shape the learning environment in underserved communities (Zayas, LE & McGuigan, D., 2006).

Institutional-level commitments are needed to help generate a large enough pool of health professionals from underrepresented minority groups. Over thirty years ago, the Association of American Medical Colleges initiated Project 3000 by 2000, which had a goal of enrolling 3000 underrepresented minority medical school students by the year 2000. Although the program gained traction in many schools across the nation, it failed to produce the intended results. However, the seeds for pipeline programs had been planted.

Pipeline programs, which link primary education to careers in the health professions, are vital for minority students. The New York State Council on Graduate Medical Education provides funding support for pipeline programs; however the funding is not consistent nor is it contingent on enduring community partnerships. By providing early exposure to the health field and career development support, many underrepresented minorities have benefited from community-based pipeline programs, excelled in the health

professions and contributed to the reduction of health disparities. Pipeline programs have the potential to reduce health disparities and should be integrated fully into the underrepresented minority communities they serve in order to improve health outcomes across the board.

Community Integration: Leadership & Accountability

Students may also be deterred from pursuing the health professions due to the lack of minority faculty in leadership positions within health professions schools. For underrepresented minorities that have joined the ranks as faculty, many of them are not advancing in the ranks to the degree of their White counterparts. Therefore, it is essential for academic institutions engage in faculty development, mentorship and support of underrepresented minority students and health professionals. These exchanges enrich the experiences of the faculty and students, and ultimately impact the way care is delivered in underserved communities.

The Sullivan Commission on Diversity in the Healthcare Workforce issued a national report in 2004 that outlined several recommendations for holding stakeholders accountable to the issue. Community benefit is a guiding principle that improves accountability of non-profit, tax-exempt institutions to the racial/ethnic communities they serve. Academic medical centers, teaching hospitals and professional associations should provide leadership, governance, mentorship, and mission statements that clearly articulate their social contract to improving diversity and health for communities of color. The number of underrepresented minorities enrolled, those working in an underserved area, and the number of primary care physicians are measurements of social mission. Monitoring and oversight of hospitals and academic medical centers of their adherence to a social mission has proven that more needs to be done. Overall, systems barriers that limit equal opportunity for underrepresented minorities to enter health professions must be reconciled with the requirements of a diverse health care workforce. Community-driven health disparities solutions should be embraced in response to 21st century arrangements.

Recommendations

- Assemble and finance a separate, local multi-disciplinary task force of community, academic, and government representatives to monitor and develop incentives for public education and health career pipeline activities from primary school through graduate medical education.
- Utilize the New York City Council of Graduate Medical Education formula for pipeline programs to promote the development of community-academic partnerships.
- Research and report hiring practices of minority faculty at academic medical institutions to ensure equitable representation from historically underrepresented groups and develop mentoring programs to support them.
- Publicize community benefit scorecards to assess the social mission of teaching hospitals and academic medical centers in New York City.
- Improve access for historically-disenfranchised students, including foreign-born students, to become educated and/or credentialed in the health professions.
- Develop a shared consensus agenda linking community-based partnerships to initiatives to eliminate health disparities.
- Incorporate provisions within the new health reform law to direct programs and funding towards community-based, health care workforce diversity initiatives.

Conclusion

The United States is rapidly changing and in order to prepare future leaders in science and medicine to meet tomorrow's demands, efforts must be strengthened locally by utilizing community-academic partnerships. Health disparities occur within the context of a community's social, economic and political environment. Families, schools, faith-based groups, and community-based organizations naturally contribute to the development of future health professionals and as such are committed to ensuring that adequate numbers of community-oriented, culturally-competent health professionals from underrepresented minority groups are produced. Community engagement works. Shared expertise, resources, common goals and resultant action will improve the health and overall quality of life of underserved residents. For diverse communities like Brooklyn, supporting community-based efforts to recruit and retain more historically underrepresented minorities is essential.

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