



**Health Professionals
for Diversity Coalition**

Anti-Equal Opportunity Initiatives: Compromising Health and Diversity June 2008

The Civil Rights Initiatives

During the 2008 November election, the citizens of Arizona, Colorado and Nebraska will likely have to decide on the future of race and gender-conscious programming for all public, state-funded programs. The Civil Rights Initiatives are ballot initiatives aimed at altering the constitutions in the aforementioned states and eliminating programs aimed at increasing and enhancing diversity in state and local governments, public colleges and universities, community colleges and school districts.¹ Passage of these ballot initiatives may undo the progress made thus far to meet the health needs of our multicultural society in Arizona, Colorado and Nebraska, as well as across the United States in the following ways:

- Compromising quality health care for all
- Short changing academic environment
- Ignoring health care workforce needs

I. Compromising Quality Health Care for All

The passage of the Civil Rights Initiatives will prevent hospitals, schools, clinics, and other health care settings from implementing innovative strategies to increase diversity. Similar to other states, Arizona, Colorado and Nebraska need to support a variety of diversity initiatives to ensure that qualified health professionals are available to meet everyone's health care needs.

While several gaps in health care quality and access are narrowing, health disparities persist for racial and ethnic minorities and individuals of low socioeconomic status. The *2007 National Healthcare Disparities Report* shows that there are still broad and persistent health care disparities related to race and ethnicity. In general, African Americans and Hispanics are receiving poorer care, and have less access to care, than their white counterparts.² The *Healthy Nebraska 2010* report shows that these same discrepancies are experienced by the 40% of the population living in non-metropolitan areas with decreased access to care.³ In Arizona, language and cultural barriers limit access to care for the state's large American Indian and Hispanic populations.⁴

The national call to help remedy such disparities includes increasing diversity in the health professions.⁵⁻⁷ Research shows that:

- Racial and ethnic minority and women physicians and dentists are more likely to treat patients of low socioeconomic status, patients with Medicaid, and those who are uninsured.⁸⁻¹⁰ The presence

of racial and ethnic minority health professionals also improves access to care for racial and ethnic minority patients, who are disproportionately affected by health care disparities.¹¹⁻¹⁵ A recent study commissioned by the Commonwealth Fund documenting promising practices for patient-centered communication with vulnerable populations underscored the need for workforce diversity as a strategy to overcome linguistic, health literacy, and cultural barriers and improve health care outcomes.¹⁶

- The benefits of diversity extend beyond the clinical encounter to innovations in medical, dental, and public health research.^{17,18} Women and racial and ethnic minority faculty are more likely to conduct biomedical and health services research addressing racial, ethnic, and gender issues.¹⁹ Research is an essential component for understanding the causes and developing solutions to eliminate disparities and to improve health care for all Americans.

II. Short Changing Academic Environments

These ballot initiatives, which are misleadingly called “Civil Rights Initiatives,” stifle efforts in higher education to create environments that reflect our multicultural society. For example, there was a notable decline of minority applicants to dental and medical schools from 1997 to 2002, subsequent to anti-race/gender-conscious planning court rulings and state ballot initiatives (e.g., *Hopwood v. University of Texas* in 1995 and California Proposition 209 in 1996).^{11,20} Ending race/gender-conscious programming and planning will prevent public higher education institutions in Arizona, Colorado and Nebraska from proactively working toward providing enriched and challenging academic environments and preparing a diverse health care workforce.

Within educational settings, research has substantiated that multicultural environments serve as catalysts for civic participation and idea generation, testing assumptions, and expanding perceptions regarding racial, ethnic, and cultural differences.²¹⁻²⁵ There is evidence that both diverse faculty and student bodies foster educational environments that contribute to improved intellectual and social outcomes for all in academe.²⁶

- Students with higher levels of interaction with diverse peers tend to exhibit increased cognitive ability to identify, distinguish and integrate various perspectives.²⁴ Diversity is valued amongst health professions students because it adds to the educational experience, particularly in clinical settings where competency in treating diverse patients is often enhanced.²⁷
- A diverse faculty contributes to an enriched learning environment. Research shows that racial and ethnic minority and women faculty are more likely to incorporate readings on race, ethnicity, or gender in the curriculum in comparison to their white, male counterparts. They are more likely to conduct research focusing on race, ethnicity, or gender.¹⁹
- The absence or limited access to diverse health professions faculty presents obstacles for both junior faculty and students.²⁸⁻³² Diversity in faculty provides opportunities to develop “allies and mentors” that help to minimize isolation, provide assistance with acclimating to the new environment, serve as role models, and defy stereotypes.³³ This issue is significant for women and men in the health professions. In nursing, males identify the paucity of male nurses in

clinical settings and the absence of male faculty as a barrier in their professional development.^{31,34} Also, in a study of medical students, all students considered diversity in clinical faculty and basic science faculty an important element in their education.²⁷

Research consistently demonstrates that diversity begets diversity. The presence of a diverse faculty and opportunities for research in ethnic minority and gender issues help to facilitate recruitment and retention of a diverse student body.³⁴⁻³⁶

- In psychology doctoral programs, admissions directors noted that existing minority student representation was a factor in successful recruitment.³⁵ This was also evident in dental hygiene programs.³⁶

A diverse student body will also help address our nation's health care workforce needs. Across the health professions, including veterinary medicine, increasing diversity in the student body is recognized as a strategy to address projected workforce shortages.^{14,28,32,33}

III. Ignoring Health Care Workforce Needs

Nationally, nursing and dentistry shortages persist, and there is a need to increase the national physician workforce by 30%.^{31,32,37} Ever-changing demographics in the United States require workforce development strategies to draw qualified health care professionals from all segments of society. Race/gender-conscious programs provide tools to facilitate the development of a workforce that can address the health care needs of Arizona, Colorado, and Nebraska.

By the year 2050, racial and ethnic minorities will represent half of the US population.³⁸ However, this diversity is not reflected in our health care workforce.³⁹ Diversity in the health professions provides all consumers of health care services with increased access to and options for health care.⁴⁰ In addition to the reasons noted earlier in this issue brief:

- Studies show that, for all racial and ethnic groups, when patients have the option, they are more likely to choose a health professional of their own racial and ethnic background.⁴¹⁻⁴⁸
- In race-concordant patient-practitioner relationships, patients report better interactions with their health care provider and satisfaction with care.^{42, 49} Research also shows that patients report higher levels of respect⁵⁰ and trust,⁴³ and they are more likely to recommend their practitioner to others when they have a health professional of the same racial or ethnic background.⁵⁰

Furthermore, men as well as women are affected by the termination of race/gender-conscious programs. For example, initiatives aimed to address the underrepresentation of males in the nursing profession are jeopardized if race/gender-conscious programs are to be terminated.

Ballot initiatives that render race/gender-conscious programs unlawful effectively thwart efforts by employers and educators to recruit and retain a qualified, diverse health care workforce. This has been the case in states such as California, Michigan, and Washington, where such ballot initiatives have passed. If similar ballot initiatives are



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passed in Arizona, Colorado and Nebraska, the results are likely to be the same to the detriment of the people living there.

References

1. Consequences of Ward Connerly's Anti-Affirmative Initiatives <<http://www.civilrights.org/issues/affirmative/details.cfm?id=36637>>. Accessed September 15, 2006. The Civil Rights Coalition for the 21st Century, Washington DC, 2005.
2. Agency for Healthcare and Research Quality. 2007 National Healthcare Disparities Report. Rockville, MD: U.S. Department of Health and Human Services, 2007.
3. Healthy Nebraska 2010 < <http://www.hhs.state.ne.us/puh/oph/docs/Rural-2010.pdf>>. Accessed April 29 2008.
4. Healthy Arizona 2010 < <http://www.azdhs.gov/phs/healthyaz2010/strtg.htm>>. Accessed April 29 2008.
5. Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Smedley BD, Stith AY, Nelson AR (eds). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academies Press, 2003.
6. Institute of Medicine Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Healthcare Workforce. Smedley BD, Butler AS, Bristow LR (eds). In the Nation's Compelling Interest: Ensuring Diversity in the Healthcare Workforce. Washington, DC: National Academies Press, 2004.
7. Sullivan Commission on Diversity in the Healthcare Workforce. Missing Persons: Minorities in the Health Professions. Washington DC: The Sullivan Commission, 2004.
8. Moy E, Bartman BA. Physician race and care of minority and medically indigent patients. JAMA.1995;273(19):1515-20.
9. Solomon ES, Williams CR, Sinkford JC. Practice location characteristics of black dentists in Texas. J Dent Educ. 2001;65:571-4.
10. Weaver RG, Haden NK, Valachovic RW. Annual survey of dental school seniors: 2002 graduating class. J Dent Educ. 2002;66:1388-1404.
11. American Dental Association. Dentists and patients by race ethnicity. Chicago, IL: American Dental Association Survey Center, 2000.
12. Cantor JC, Miles EL, Baker LC, Barker DC. Physician service to the underserved: Implications for affirmative action. Inquiry.1996;33:167-81.
13. Komaromy M, Grumbach K, Drake M, et al. The role of black and Hispanic physicians in providing health care for underserved populations. NEJM. 1996;334:1305-10.
14. Grumbach K, Vranizan K, Bindman AB. Physician supply and access to care in urban communities. Health Affairs. 1997;16:71-86.
15. Brotherton SE, Stoddard JJ, Tang SS. Minority and nonminority pediatricians' care of minority and poor children. Arch Ped Adolesc Med. 2000;154:912-17.
16. Wynia M, Matiasek J. Promising Practices for Patient-Centered Communication with Vulnerable Populations: Examples from Eight Hospitals. The Commonwealth Fund, August 2006.
17. Cohen JJ. The consequences of premature abandonment of affirmative action in medical school admissions. JAMA. 2003;289:1143-9.
18. Gurin P, Dey EL, Hurtado S, et al. Diversity and higher education: theory and impact on educational outcomes. Harvard Ed Rev. 2002; 72:330-366.

19. Milem JF. Increasing Diversity Benefits: How Campus Climate and Teaching Methods Affect Student Outcomes. In *Diversity Challenged: Evidence on the Impact of Affirmative Action*. Orfield, G (ed). Cambridge, MA: Harvard Ed Publishing Group. 2001; 233-239.
20. Association of American Medical Colleges. *Minorities in Medical Education: Facts and Figures 2005*. Washington, DC: AAMC, 2005.
21. Astin AW. *What Matters in College? Four Critical Years Revisited*. San Francisco, CA: Jossey-Bass, 1993.
22. Gurin P. The compelling need for diversity in higher education: Expert testimony in *Gratz, et al. v. Bollinger, et al.* Michigan J of Race & Law. 1999;5:363-425.
23. Smith DG & Associates. *Diversity works: The emerging picture of how students benefit*. Washington, DC: Association of American Colleges and Universities, 1997.
24. Antonio AL, Chang MJ, Hakuta K, et al. Effects of racial diversity on complex thinking in college students. *Psych Sci.* 2004;15:507-10.
25. Nemeth CJ, Wachtler J. Creative problem solving as a result of majority vs. minority influence. *European J of Social Psychology.* 1983;13:45-55.
26. Bowen W, Bok D. *The Shape of the River: Long-Term Consequences of Considering Race in College and University Admissions*. Princeton, NJ: Princeton University Press, 1998.
27. Whitla DK, Orfield G, Silen W, et al. Educational benefits of diversity in medical school: A survey of students. *Acad Med.* 2003;78:460-66.
28. Sinkford JC, Valachovic RW, Harrison SG. Continued vigilance: enhancing diversity in dental education. *J Dental Ed.* 2006;70:199- 203.
29. Bright CM, Duefield CA, Stone VE. Perceived barriers and biases in the medical education experience by gender and race. *JNMA.*1998;90:681-688.
30. Price EG, Gozu A, Kern DE, et al. The role of cultural diversity climate in recruitment, promotion, and retention of faculty in academic medicine. *JGIM.* 2005;20:565-571.
31. Smith JS. Exploring the challenges for nontraditional male students transitioning into a nursing program. *J Nursing Ed.* 2006;45:263-9.
32. Brady MS, Sherrod DR. Retaining men in nursing programs designed for women. *J Nursing Ed.* 2003;42:159-162.
33. Vasquez MJT, Lott B, Garcia-Vazquez E, et al. Barriers and strategies in increasing diversity in psychology. *Am Psychologist.* 2006;61:157-172.
34. O'Lynn CE. Gender-based barriers for male students in nursing education programs: prevalence and perceived importance. *J Nursing Ed.* 2004;43:229-236.
35. Munoz-Dunbar R, Stanton AL. Ethnic diversity in clinical psychology: Recruitment and admission practices among doctoral programs. *Teaching of Psychology.*199;26(4):259-263.
36. Dhir I, Tishk MN, Tira DE, Holt LA. Ethnic and racial minority students in U.S. entry-level dental hygiene programs: a national survey. *J Dental Hygiene.* 2002;76:193-201.
37. AAMC Calls for 30 Percent Increase in Medical School Enrollment. <<http://www.aamc.org/newsroom/pressrel/2006/060619.htm>>. Accessed September 15 2006. Association of American Medical Colleges, Washington DC, 2006.
38. United States Census Data 2000 <<http://www.census.gov/population/cen2000/phc-t1/tab01.txt>>. Accessed May 16 2006. United States Census Bureau, Washington DC, 2005.
39. U.S. Census Bureau. *Census 2000 Special Equal Employment Opportunity (EEO) Tabulation*. Washington, DC: U.S. Census Bureau, 2006

40. Rabinowitz HK, Diamond JJ. The impact of multiple predictors of generalist physicians' care of underserved populations. *Am J Pub Health*. 2000;90:1225-28.
41. Saha S, Arbelaez JJ, Cooper L. Patient-physician relationships and racial disparities in the quality of health care. *Am J Public Health*. 2003;93:1713-9.
42. Cooper-Patrick L, Gallo JJ, Gonzales JJ, et al. Race, gender and partnership in the patient-physician relationship. *JAMA*. 1999;282:583-89.
43. Tarn DM, Meredith LS, Singer-Kagawa M, et al. Trust in one's physician: The role of ethnic match, autonomy, acculturation, and religiosity among Japanese and Japanese Americans. *Ann Fam Med*. 2005;3:339-47.
44. Laveist TA, Nuru-Jeter A. Is doctor-patient concordance associated with greater satisfaction with care? *J Health Soc Behavior*. 2002;43:296-306.
45. Saha S, Taggard SH, Komromy M, Bindman AB. Do patients choose physicians of their own race? *Health Affairs*. 2000;19:76-83.
46. Bach PB, Pham HH, Schrag D, Tate RC, Hargaves JL. Primary care physicians who treat blacks and whites. *NEJM*. 2004;351:575-84.
47. Gray B, Stoddard JJ. Patient-physician pairing: Does racial and ethnic congruity influence selection of a regular physician? *J Comm Health*. 1997;22(4):247-59.
48. Coleman HLK, Wampold BE, Casali SL. Ethnic minorities' ratings of ethnically similar and european american counselors: A meta-analysis. *J Counseling Psychology*. 1995;42:55-64.
49. Cooper LA, Roter DL, Johnson RL, Ford DE, Steinwachs DM, Powe NR. Patient-centered communication, ratings of care and concordance of patient and physician race. *Ann Intern Med*. 2003;139:907-15.
50. Malat J. Social distance and patients' rating of healthcare providers. *J Health Soc Behav*. 2001;42:360-72.

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