



**Testimony to the Sullivan Commission**

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### ***Introduction***

The Institute for Urban Family Health is a twenty-year old non-profit organization dedicated to providing high quality primary care to underserved communities. Currently the Institute operates six community health centers funded under Section 330 of the Public Health Law, and manages seven practices in collaboration with Continuum Health Partners, a consortium of private hospitals in the New York area. In addition, the Institute provides health care services for people who are homeless at ten community-based locations in Manhattan.

Of particular relevance to the work of this commission are the following activities:

### **Faculty Development**

Training health professionals to work with vulnerable populations has always been an integral part of the Institute's goal. Since its inception, the Institute has initiated and operated two residency-training programs in family medicine designed to teach practitioners about caring for vulnerable inner city communities. We have run a federally funded faculty development program, now in its 20<sup>th</sup> year of operation, that has a track record of providing advanced training to about 25 faculty members per year, 54% of whom are African-American, Latino, or Asians from underrepresented ethnic groups. In addition, the Institute requires that every employee of the company participate in a two-day diversity training program, so that its own employees are conscious of the impact of race in the workplace.

### **Student Placements**

The Institute also provides placements for advanced practice nursing students, social work students, and administrative interns, and runs programs to promote family medicine to medical students. Prior to spearheading the Area Health Education Center program in New York State, the Institute ran a Family Practice Education Program that offered students from schools without departments of family medicine opportunities to obtain hands-on experience in family practice.

### **The New York State Area Health Education System**

The Institute serves as the Metropolitan Regional Office of the New York State Area Health Education System, a program dedicated to increasing the participation of underrepresented groups in the health care workforce at every level, with a focus on increasing the numbers of providers choosing to work in underserved communities. In this role, the Institute is responsible for participating in the leadership of the statewide program, and has developed independent AHEC Centers for the Bronx-Westchester area, and for Brooklyn-Queens-Long Island. We are currently developing an AHEC Center for Manhattan-Staten Island.

### **Bureau of Health Professions National Workforce Data Analysis**

As part of a series of national research projects on health professionals in shortage areas, the Institute has undertaken an analysis of the health professional workforce across the country. The data include information on active physicians, dentists, nurse practitioners, certified nurse midwives, and certified registered nurse anesthetists. The analysis will

result in a report on the characteristics and distribution of health professionals in both rural and metropolitan underserved areas across the country. These data will be presented comparatively, along with recommendations for addressing issues related to the distribution of health professionals in shortage areas.

### **Bronx Health REACH**

The Institute also serves as the lead agency in Bronx Health REACH, a coalition of 16 community-based and 14 faith-based organizations dedicated to the elimination of racial disparities in health outcomes. As part of a statewide advocacy effort to eliminate racial disparities, REACH supports AHEC's goal of recruiting underrepresented groups into health professions, and is seeking to ensure that publicly funded medical schools admit a student body more representative of the population they serve.

### **Coalition to Increase Diversity in the Health Professions**

Finally, the Institute is an active participant in the Coalition to Increase Diversity in the Health Professions, sponsored by Citizen Action of New York. The Coalition is committed to increasing the diversity of the health care workforce by increasing the pools of minority candidates applying to and graduating from health professional schools, and by supporting people of color to advance in health careers.

Each of these programs seeks to examine and address opportunities for exposure to health careers, as well as issues related to the education and training of young people and the distribution of health professionals in the health care system, with the goal of increasing the diversity of the health professional workforce and reducing disparities in health outcomes for racial and ethnic minorities.

### ***Problem***

Simply stated, the problem is that the health care workforce does not adequately represent the population it is designed to serve, nationally or locally. This is true whether we are talking about doctors, nurses, physician assistants, dentists, dental hygienists or pharmacists. The numbers are clear.

In the United States, racial and ethnic minorities comprise 26% of the population, but only 9% of the country's physicians. In New York State, African Americans comprise 16% of the population, but only 5% of the practicing physicians. Latinos comprise 15% of the population, but only 4% of physicians.

This same disproportion holds true for nurses, at 8.9% for African Americans and 2.2% for Latinos; physician assistants, at 5% for each group; dentists, at 2% for African Americans and 4% for Latinos; dental hygienists, at 3% for African Americans and 1% for Latinos; and pharmacists, at 6% for African Americans and 3% for Latinos.

In contrast, there are only a few categories where people of color are over-represented in health professions. As one would expect, these tend to be entry level, lower paying jobs like health aides and orderlies. Perhaps the Reverend Al Sharpton described it best,

dubbing the segregation in the health care industry the Mt. Everest Syndrome – the higher you go, the whiter it gets.

### ***Impact***

We believe there is ample evidence to support the conclusion that the lack of diversity in the health professions adversely affects the quality of health care that people receive, and on the health outcomes they experience.

We ask these questions:

Does having a health care provider who looks like you or talks like you make a difference in the care you receive? Or in the way you respond to that care?

Does having a health care provider who looks like you or talks like you make a difference in whether your child thinks that he or she would like to be a health care provider when they grow up? Or that he or she can be such a provider?

The Institute of Medicine Report cites studies suggesting that minority patients indicate greater patient satisfaction when they see a provider who comes from a similar racial or ethnic background to their own. Minority patients also report that they have greater trust in physicians of the same background as their own, and that trust increases compliance with treatment, resulting in better outcomes.

In addition, physicians of color provide greater access to minority patients due to practice locations, and are more likely to treat low-income patients.

Communication and language barriers are minimized when providers and patients share racial and ethnic characteristics.

Finally, studies performed on medical students found that white students often assigned a lower quality of life to patients of color for non-medical reasons. This was not true for students of color.

We assume, therefore, that increasing the numbers of providers of color in the health care system will have a positive impact on the problem of racial disparities in health outcomes.

### ***Recommendations***

Our recommendations focus on the fact that we cannot correct disparities in the health care work force without simultaneously addressing disparities in the delivery of health care. Training health professionals in institutions that overtly or covertly discriminate against people of color, whether they are staff or patients, works against the goal of resolving disparity in the health care workforce.

## **To promote diversity in the health care workforce,**

### **1. End segregation in health care facilities by:**

- **supporting strict compliance with and enforcement of existing government regulations, and promoting new legislation to ensure equal care for all patients;**
- **creating mechanisms that bring greater accountability to the distribution of uncompensated care funds given to institutions; and,**
- **working toward a comprehensive health care delivery system to ensure access to care for all, starting with simplifying the enrollment process for existing government-funded health insurance programs so that all eligible residents participate, and working toward the rapid implementation of universal health insurance.**

Hospitals often maintain segregated facilities and provide differential care based on insurance coverage, even though these actions violate government health plan contracts already in place in New York State. Therefore, people who have public insurance, or are uninsured, receive care from less experienced physicians with limited appointment availability, often in different facilities. A survey conducted by Bronx Health REACH found this to be true at virtually every academic hospital it contacted. Because people of color are more likely to be publicly insured and uninsured than whites, this results in de facto discrimination by race. By training health professionals in this environment, we communicate that this type of segregation, borne of racism, is acceptable and unavoidable. To address this, we must make sure that every individual has access to the same quality of health care services regardless of their source of payment, and make health care institutions accountable for funds they receive to support charitable care.

### **2. Support diversity training at academic and health care facilities that receive any public funds, and require that health care providers receive ongoing cultural competence training as part of their state licensure process.**

Not only are there insufficient numbers of people of color in the workforce as a whole, they are even further underrepresented in positions of authority within the health care industry. As a result, health professionals of color often feel marginalized in their own institutions. Effective diversity training programs can promote institutional change and address institutional racism, even as we address the longer-term problem of increasing the numbers of health professionals in the workforce. This process will help promote people of color into leadership positions within these institutions. At the same time, cultural competence training will help providers understand the critical role that culture and language play in health education, clinical encounters, and patient-provider relationships, often resulting in failed communication which compromises both diagnosis and compliance with treatment plans.

- 3. Make public funds available to reimburse ancillary services like translation and social services. This serves the dual role of improving provider-patient communication and promoting careers in health care where people of color are better represented in the workforce.**

The presence of translators and social service providers makes a difference in patients' ability to navigate the health care system effectively. But most health care facilities have an inadequate number of these critical support personnel because there are no reimbursement mechanisms for their services. By supporting efforts to develop reimbursement streams, we will both improve communication between providers and patients, and, at the same time, create job pathways for health professional staff whose training does not require the same rigor as becoming a clinical provider. Such revenue streams will also increase the perceived value of these professionals within the industry.

- 4. Fund programs that recruit minorities into the health professions, and advocate for greater diversity in the student bodies of publicly funded medical schools.**

Comprehensive programs should be funded to recruit underrepresented minorities into the health professions. Publicly funded medical schools and their affiliated private voluntary hospitals should be required to admit students in close proportion to their representation in the population. This will require developing partnerships with community-based organizations that work with students, and rethinking medical school admission processes.

- 5. Make sure that affirmative action programs, scholarships and tuition assistance, as well as remedial programs for college students, remain available.**

Without such supports, students from disadvantaged backgrounds will be unable to obtain the education they need to enter health professional training programs.

- 6. Support hands-on programs like AHEC which provide exposure to a broad spectrum of health careers to people of all ages.**

A high school student in the Bronx said it best after a summer working as an intern to a pharmacist. He told us he'd never realized how important pharmacists were in the community, and that he'd decided to keep his grades up so he'd be able to get into college to become one. Mentoring and internship programs like AHEC are continuously on the Federal chopping block. We must secure long range, comprehensive funding to ensure that these opportunities to engage students outside of the classroom remain available to students in underserved communities.

- 7. Direct public funds for community-based public health education, especially in communities comprised largely of underserved and vulnerable populations.**

Recent history has taught us that health promotion programs work when they are treated seriously. Tobacco use has declined dramatically, and seatbelt use has become a national habit. By doing the same with health behavior changes to decrease obesity and diabetes, for example, we will not only address serious public health problems, but put the importance of health and health care on the community's agenda. By increasing the number of health educators and health science teachers practicing in the community and in the schools at every grade level, we will add career role models into the day-to-

day lives of young people and community residents. We suggest that a fixed percentage of public funds used for acute hospital care be redirected annually to community-based health education programs.

In summary, we can recommend no “magic bullets” to solve the problem of racial disparity in the health care workforce or the health care system. Rather, it will take a comprehensive, long-term approach to addressing racism and its legacy in the communities where people live and in the institutions where people are trained and receive care. It will require the involvement and commitment of all of us - community members and leaders, as well as leaders of educational institutions, leaders of health care institutions, health professional organizations, and health workers’ unions – all of us, working together, to make health equality a reality and to create career paths for underrepresented minorities in the health professions.

The Institute for Urban Family Health stands ready to work alongside the Sullivan Commission to address these critical issues.