

The Robert Wood Johnson Foundation's Commitment to Increasing Minorities in the Health Professions

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Robert Wood Johnson Foundation

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Editor's Introduction

This chapter reviews the strategies the Robert Wood Johnson Foundation has pursued to increase the number of minority physicians, nurses, and other health care providers. This has been a priority for the Foundation since it emerged as a national philanthropy in 1972. Among its first grantees, in fact, was a medical school scholarship fund for minorities, women, and inhabitants of rural areas.

The motivation behind the Foundation's interest in minority health practitioners has always been to improve access to and the quality of care for minority patients. Research indicates that minority practitioners are more likely than majority practitioners to work in low-income communities and to have practices that serve larger proportions of minority populations. Studies on sociocultural barriers to health care services show that members of minorities are more likely to seek services from, and follow the medical advice of, minority providers. This is particularly true in the case of non-English-speaking patients.

The authors of the chapter—Foundation senior program officers Jane Isaacs Lowe and Constance M. Pechura—have been active in shaping the Foundation's recent strategies in the areas of minority medical workforce and, more generally, human capital. Lowe heads the Foundation's team on services for vulnerable populations and monitors a number of the programs directed at improving the minority health care workforce. Pechura leads a team overseeing the Foundation's investments to improve human capital in the health sector.

The Foundation's programs to encourage minorities to enter the health care workforce cannot be understood apart from the greater social policy debate about race in the United States. Even though the programs funded by the Foundation cannot reasonably be characterized as affirmative action, they must be seen within the context of this divisive issue. In the chapter, Lowe and Pechura examine the 2003 Supreme Court affirmative action decisions and their potential effect on programs to increase minorities in the health care workforce.

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In the 1960s, major social upheavals had begun to bring permanent and fundamental change to the United States, and the country became galvanized to right the wrongs of the past and take responsibility for its most vulnerable citizens. The civil rights movement reached a pinnacle at this time as freedom rides, boycotts, and civil unrest led to major political actions. The Civil Rights Act, the War on Poverty, and Medicaid and Medicare were all products of the sixties. They were part of a general trend to increase the role of the federal government and federal law in effecting social change. In response to a predicted shortage of health care professionals, Congress passed the Health Professions Educational Assistance Act of 1963. The law provided, for the first time, government-sponsored financial aid for the health professions and increased the number of medical schools. Twenty-five new medical schools were established between 1963 and 1975, and the number of medical students rose from about 33,000 to 56,000.

The philanthropic sector had been working on the problem of underrepresented minorities in medicine even before the 1960s.¹ Some well-established foundations, including the Ford Foundation, the Carnegie Corporation, and the Rockefeller Brothers Fund, were supporting black colleges and the United Negro College Fund. The National Medical Fellowships, which had been established in 1946 as Provident Medical Associates, provided scholarships for African American, Hispanic, and Native American medical students. The Julius Rosenwald Fund, the Field Foundation, the Commonwealth Fund, and the Alfred P. Sloan Foundation provided support to it as far back as the 1940s.²

With the Civil Rights Act in place, other philanthropies became more actively involved. The Josiah Macy, Jr. Foundation, for example, began, in 1966, to fund medical schools to establish formal offices that would address minority recruitment. The Association of American Medical Colleges, or AAMC, embraced these efforts and took an early lead in the effort to increase minorities in medicine. By 1971, the U.S. Office of Economic Opportunity, through the AAMC, was providing funds to increase minority participation in medicine under the Special Health Career Opportunity Grant Program.

So the stage seemed to be set to increase access to health care for all Americans and to open the doors of health professions to minorities and those previously unable to afford higher education. These two thrusts were thought to be intricately connected, since many people in the field believed that blacks and other minority health professionals would be more likely to practice in poor, minority areas. Yet the percentage of minorities entering the health professions was far below their representation in the total population. In 1970, for example, only 2.4 percent of the nation's medical students and 5.9 percent of its

medical professionals were minorities, even though minorities constituted 16 percent of the general population.³

EARLY PROGRAMMING AT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation was born into this social environment in 1972, with a mandate to improve the health and health care of all Americans. The Foundation's board of trustees established, as one of its first priorities, increasing access to medical care. Reflecting this priority, the Foundation took three early steps. First, in 1972, it funded a scholarship and loan program for women, minorities, and people from rural areas who wanted to attend medical or dental school (awarding the money quickly also helped it to satisfy the requirements of the Internal Revenue Service).⁴ This was supplemented in 1973 by grants to National Medical Fellowships, Inc., to enhance its scholarship fund for minority students. Second, the Foundation made a grant to the College of Medicine and Dentistry of New Jersey for a summer enrichment program for minority students entering medical or dental school. The third step was to provide institutional support to Meharry Medical College, which, at the time, was one of only two four-year medical schools specifically training African Americans. Meharry was training about 40 percent of all black physicians and dentists, and the other school, at Howard University, had substantial, albeit insufficient, federal support. Both the Charles R. Drew Postgraduate School (now the Charles R. Drew University of Medicine and Science) and Morehouse College offered only the first two years of medical school curricula.

Although many members of the staff and the board may have been personally committed to civil rights throughout the 1970s and the early 1980s, the justification for the Foundation's minority programs was strictly a health one—to increase access to care among underserved populations. Grants to enable more minorities (and women and those living in rural areas) to become physicians and dentists were justified by the belief that these groups would be more likely to practice primary care in inner cities and rural areas. Later studies have provided evidence to support this belief.

The student financial aid programs that began in the early 1970s were frequently adjusted, and they resulted in a variety of funding mechanisms. These included grants to individual medical and dental schools for minority student financial aid, continued support to the National Medical Fellowships program (which, over the years, amounted to more than \$10 million), and a guaranteed student loan program.

Within the Robert Wood Johnson Foundation, the early work to increase minority representation in medicine and dentistry provided tangible evidence of the Foundation's commitment to increasing access to care. It also formed part of a broader strategy to improve the quality and balance of the health care workforce, as exemplified by initiatives such as the Clinical Scholars Program and the Health Policy Fellowships Program.⁵

Outside the Foundation, the admission of minorities to medical schools was affected by the controversy over affirmative action programs. These were hotly debated and challenged in the courts. Medical school admissions policies came under direct attack in the mid-1970s with the lawsuit of Allan Bakke against the Regents of the University of California, which was decided by the U.S. Supreme Court in 1978. A deeply divided Court struck down the medical school's admissions system, which reserved a certain number of seats for minorities. Justice Lewis Powell, who cast the deciding vote, concluded in his opinion that race, among other factors, could be used as a plus factor in admissions decisions if racial diversity supported the educational mission of the school.

Although the Bakke case appeared to provide support for affirmative steps in admissions policies as long as the steps did not involve quotas or set-asides, the ambiguities in the Court's fragmented decision increased the wariness of medical schools in employing affirmative action policies. This wariness decreased in the 1980s because few other court challenges to admissions policies were attempted, and none of them were successful.

In addition to the legal concerns, the high cost of medical and dental education impeded minority enrollment in medical schools, raising the question of whether financial aid was sufficient to attract minority students, whose financial positions were often weak to begin with.

THE 1980S AND A CHANGE IN FOCUS

At its July 1980 board meeting, the Robert Wood Johnson Foundation's board of trustees charged the staff with examining four options for increasing the number of minority students attending medical school:

- Creating a national organization to spur interest among minority college students in applying to medical school.
- Supporting programs of intense preparation during college for minority students.
- Continuing support for Meharry Medical College.
- Continuing the Foundation's participation in medical student loan and scholarship programs.

By July 1981, the staff had examined some of these options and was considering a number of new approaches. But about that time outside events caused it to reconsider the wisdom of funding new minority programs. First, the federal government threatened to stop funding college student enrichment programs such as the Health Careers Opportunity Program. Second, the government threatened to reduce financial aid for students, even as the cost of a medical education was rising. Third, and most important, the Graduate Medical Education National Advisory Committee issued an influential report that predicted a surplus of 70,000 physicians by 1990 and 145,000 by 2000, and recommended cutting back medical school enrollment. These events led the Foundation to delay authorizing new minority programs in favor of renewing existing ones on a case-by-case basis.

The first case was that of Meharry Medical College, which at the time was beset with fiscal, management, and staffing problems. At its July 1981 meeting, the board considered a staff report examining whether the Foundation should continue its support of Meharry—the nation’s largest single educator of black physicians and dentists, a very high percentage of whom practiced in poor, underserved areas and in the rural South. There were potential partners to help the Robert Wood Johnson Foundation: Congress was considering a \$4 million to \$6 million appropriation of annual special assistance to support Meharry; a national committee of prominent business leaders had taken on the job of leading a major capital campaign; and other foundations (including the Charles Stewart Mott Foundation, the John D. and Catherine T. MacArthur Foundation, and the Commonwealth Fund) had contributed funds to support Meharry’s reorganization. The board decided to continue funding Meharry. With the Foundation’s support and that of the federal government, members of the business community, and other foundations, Meharry survived.

In March 1982, the Educational Testing Service completed an analysis of the assumptions underlying Robert Wood Johnson Foundation– supported programs aimed at increasing the pool of minorities applying to medical school and improving the performance of minority medical students.⁶ The analysis found that minority students did less well than whites on the Medical College Admissions Test, or MCAT, and that the number of qualified African American applicants to medical schools had actually decreased. In 1975, African Americans represented 7.5 percent of the students entering medical school, but that percentage dropped to 6.5 percent by 1980. The decline was due, in part, to increased opportunities for minority candidates in other professional fields, such as engineering and law.⁷ The analysis concluded that minority students needed to be better prepared to qualify for, and succeed in, medical school.

Using the results of this study, the Foundation's minority medical education programs began to emerge in 1982. Initially, the Foundation funded three relatively small projects. The first supported the Charles R. Drew Postgraduate School and the Los Angeles Unified School District in building a magnet school to attract minority high school students to the health professions. The second funded a University of Southern California consortium that provided tutorial services to disadvantaged and minority medical school applicants. The third assisted the National Fund for Medical Education in continuing its summer remedial programs for incoming minority medical students.

These experiments in enhancing the skills of minority high school and college students were to lead to a major initiative, but even before that occurred, the Foundation's attention turned to a parallel concern: the role of medical school faculty in the recruitment and retention of minority medical students. A 1978 AAMC task force report on minorities in medicine had called for an increase in the number of minority medical faculty members. The report had made it clear that a major barrier to success for minority students was the scarcity of faculty who "looked like them" or were likely to have come from similar backgrounds. According to the AAMC report, in the 1971–72 academic year there were only 334 African Americans with M.D.'s on medical school faculties, compared with 17,376 whites. That is, African Americans constituted less than 2 percent of the nation's medical school faculty. Four years later, in the 1975–76 academic year, African Americans still constituted less than 2 percent of the nation's medical school faculty members.

The Robert Wood Johnson Foundation's response to this situation was the Minority Medical Faculty Development Program, authorized in 1983. Since success in research was critical to an academic career, the program provided funds for young minority faculty members to spend 70 percent of their time pursuing their research interests. It gave the fellows' institutions money to cover salary, partial research costs over a four-year period, and mentors to help guide the young faculty members in their research efforts. For an applicant to be successful, the choice of a mentor was as important as the project proposed. The active involvement of the program's National Advisory Committee members with each fellow strengthened the mentoring process. A 1995 evaluation of the Minority Medical Faculty Development Program confirmed that the mentoring component was of exceptional importance.⁸

To date, the Minority Medical Faculty Development Program has supported more than two hundred junior minority faculty members. Over 80 percent have remained in academic medicine, and many have become leaders in their fields.⁹ Some of its graduates now sit on the National Advisory Committee and

have become mentors themselves. Since 1983 the Foundation has invested nearly \$80 million in this program.

Once the faculty development program was launched, the Foundation refocused its attention on minority college students. Informal assessments of the previously funded small enrichment programs indicated that they needed to be more structured. In 1987, to provide minority college students with a rigorous academic enrichment on a larger scale, the Foundation established the Minority Medical Education Program. It was set up as a six-week summer residential program for minority students to increase their knowledge and skills, thereby increasing their chance of being accepted into medical school. Funds to the four initial sites supported a standard residential enrichment program, student stipends, and travel costs. Each site offered a structured and multicomponent program, including advanced science and math courses; analytical, writing, test-taking, and oral presentation skills; admissions testing review; application process tutoring; mentoring; and an introduction to clinical practice.

An evaluation of the Minority Medical Education Program found that compared with nonparticipants, significantly higher percentages of the program's participants were accepted into medical schools.¹⁰ Between 1989 and 2001 approximately 10,000 students participated in the Minority Medical Education Program. Nearly all of them have graduated from college, though some are still in school. Of the program participants who already have graduated from college, approximately 49 percent have applied to medical school, and 63 percent of those have been accepted. Those who have completed medical school are represented in all fields of medicine. Since 1987, this program has grown from four to twelve sites, with approximately 1,300 students participating each summer, drawn from colleges and universities across the United States.

Moreover, the model is now widely utilized. By the end of the 1980s, more than a third of the nation's medical schools were sponsoring some type of academic enrichment program for premedical students and students at the postbaccalaureate level, and many were placing high school students in laboratories during the summer.¹¹ In addition, the Bureau of Health Professions of the U.S. Department of Health and Human Services, through its Health Careers Opportunities Program and Centers of Excellence, continued to provide support to health professions schools for minority students. The Howard Hughes Medical Institute and the National Institutes of Health were funding research opportunities for college students. The Josiah Macy, Jr. Foundation and the Henry J. Kaiser Family Foundation supported magnet

high schools that emphasized health and science, as well as after-school and summer programs that provided academic enrichment, counseling and information about careers in medicine.

Yet, although the numbers have risen, the percentage of minority physicians was still substantially lower than their representation in the general population. A 1987 Special Report on the Foundation's minority medical training programs suggested that after nearly 20 years, these programs did not reach sufficiently large numbers of students and did not address a significant cause of minority underrepresentation—educational disparities in public school education.¹²

THE 1990S AND THE EXPANSION OF THE PIPELINE

In response to growing evidence documenting a leveling in the number of minority medical students, the AAMC designed a program to address inequities in math and science education, particularly in secondary school. Lack of math and science knowledge was seen as the main obstacle to increasing minority admissions to medical school. At the 1991 annual meeting of the AAMC, Robert Petersdorf, the organization's president, challenged medical schools to enroll three thousand underrepresented minority students by the year 2000.¹³ Project 3000 by 2000 was launched in 1991 with a Science Education Partnership Award from the National Institutes of Health. This highly promoted initiative encouraged medical schools to increase the size and the quality of underrepresented minority applicants by forming partnerships with elementary and secondary schools, colleges, and community groups.

In 1994, building on the work of the AAMC, the Robert Wood Johnson Foundation developed the Health Professions Partnership Initiative as a way to support the efforts of academic medical centers engaged in Project 3000 by 2000. The aim was to help medical schools and other health professions schools build partnerships with K–12 school systems, colleges, and the communities to improve the quality of math and science teaching and increase students' interest in health careers.

The W.K. Kellogg Foundation and the Robert Wood Johnson Foundation collaborated in this program. The two foundations funded a total of 26 new partnerships between 1996 and 2000, including five targeted to increasing underrepresented minorities interested in public health. The lead agency was either a medical or other health professions school; partners were public schools, community agencies, or, in some cases, universities. Each site received \$70,000 a year for five years, and all the partners were expected to contribute their own resources toward the program.

The types of activities undertaken by the partnerships varied from academic enrichment programs (tutoring, summer intensive science programs, and instruction in general academic skills) to programs aimed at enhancing schools and teaching (curriculum development, teacher training, and new resources for math and science education).

At the end of the 1990s, the Foundation continued to support the Minority Medical Education Program and the Minority Medical Faculty Development Program. The field is currently emphasizing kindergarten through grade 12 and college pipeline programs to prepare students for careers in medicine and in health services more broadly.¹⁴ Private philanthropic organizations, such as the Howard Hughes Medical Institute and the Josiah Macy, Jr. Foundation, and the federal government, through programs offered by the Bureau of Health Professions, the National Institutes of Health, and the National Science Foundation, provide grants for science and math curriculum reform at the public school level, and enrichment and research programs for high school, college, and medical school students.

OBSERVATIONS

1. First and foremost, expanding the numbers of minority students who are prepared for college and graduate health professions schools remains a high priority.

The pipeline theoretically begins in elementary school and then flows to junior high, to high school, to college, to graduate education (medical school, nursing), to careers and career advancement. If the problem were in fact that simple, well defined, and linear, it would have been solved decades ago. Instead, the educational systems are failing large numbers of children early on, resulting in a pipeline with large leaks. It is no secret that there are tremendous racial and ethnic disparities in education. Achievement gaps between minority and majority students begin in kindergarten and widen in elementary school. Curriculum tracking begins in middle school, formalizing the gap. This achievement gap has been documented not only in poor inner city schools but also in more affluent suburban schools.¹⁵

The challenge is to design programs that help to promote high academic achievement and reduce the numbers of students who leave secondary education underprepared. Public school reform, driven at both the state and federal levels, offers an opportunity to create a more equitable educational system.

What role should health foundations and health professions schools play in education reform, given their commitment to increasing the pool of minority students but their lack of expertise in public education? The Foundation's board of trustees raised this question when considering the Health

Professions Partnership Initiative. While it expressed concern about investing in middle and high school students, it also recognized that efforts targeted at college students often came too late. The appropriate role for health foundations such as the Robert Wood Johnson Foundation appears to be in supporting the educational pipeline strategy by forming partnerships with medical schools, colleges, high schools, and secondary public schools.

At the high school level, a recent evaluation of the Health Professions Partnership Initiative stressed the importance of partnerships contributing to the general health and well-being of students and their communities.¹⁶ Those programs considered to be successful focused on both basic educational reform (such as teacher preparation in math and science education and curriculum redesign) and career development for older, primarily middle and high school, students.

On a college level many students do not remain in the health professions pipeline because of poor secondary school preparation, little or no academic counseling from the pre-health education advisers, and a lack of financial support. One way to address educational barriers is to provide minority students with effective pre-health education professional advice. Students who have participated in the Minority Medical Education Program say that pre-health education advising is uneven across college campuses and that advisers often discourage minority students from pursuing careers in medicine. Recognizing this as an area of importance, the Minority Medical Education Program sponsored a series of workshops in 2002 to provide pre-health education advisers with updated knowledge, skills, and incentives for working with minority students.

In addition to academic obstacles, financial barriers can be significant. Students in the Minority Medical Education Program often graduate from college with more than \$50,000 of debt. The idea of adding more debt is often a barrier to pursuing a career in medicine. Recognizing the growing financial burdens on students, a financial seminar has been added to the curriculum.¹⁷ This seminar is designed to provide an overview of how to manage money and how to finance a medical education. It has been so well received that a plan for expanding it to other minority college students interested in the health professions is being explored.

Finally, there is a need for better information and coordination. A simple search of the Internet revealed hundreds of programs aimed at increasing the numbers of minority students in medicine and other health professions. Some of these programs are summarized on a regional basis, yet there is no central repository where students can find out what is available; nor is there a guide for how to plan when to

participate in what program. Also, there is little or no coordination between programs. For example, students in the Foundation's Health Professions Partnership Initiative and the Minority Medical Education Program would have benefited from better synergy between these two programs and from help in learning about other premedical and research programs.

2. Many of the programs designed to help underrepresented minorities pursue a career in the health professions have been affected by the anti-affirmative action backlash.

Beginning in the mid-1990s, several courts ruled that race cannot be used as a factor in admissions, and propositions were passed in California and Washington banning the use of racial preferences in admissions, hiring, and contracting.¹⁸ These have resulted in a decrease in the number of minority applicants to medical and other health professions schools in these states.¹⁹ Although these cases have had their biggest impact on public educational institutions, private institutions also face the same issues.

A decrease in applications to become sites for the expansion of the Minority Medical Education Program in 1999 may have been linked to medical schools' concerns that their participation might be challenged. In 1998, to allow the sites to be more inclusive, the program decided to go beyond the AAMC definition of "underrepresented minorities" (see box), which it had traditionally followed. The program now accepts all Hispanics (not just mainland Puerto Ricans and Mexican Americans) and gives each site the option of admitting a select number of students who are underrepresented in their region (Cambodians or rural whites, for example). Organizations are beginning to wrestle further with the question of what constitutes an underrepresented minority, and the AAMC is exploring a revision of its historic definition of underrepresented minorities. The issues of race and income, as well as systematic discrimination and exclusion, will be central to this discussion.

3. Leadership is crucial to success.

Having both minority and majority leaders strongly support the goal of increasing the numbers of minorities in the health professions has been a critical factor in achieving results. Over the decades, a large number of people the Foundation has supported have emerged as public spokespersons, as members of the Foundation's National Advisory Committees, and as leaders of academic health centers, federal government agencies, and foundations. Collectively, they have helped keep the issue of a diverse medical workforce on the social and health policy agenda, even in the face of mounting opposition.

Strong leaders have been instrumental in forming the partnerships that have increased the numbers of minority students pursuing careers in the health professions. Yet partnerships between health professions

schools, public schools, colleges, and community agencies have been difficult to develop and sustain. The evaluation of the Health Professions Partnership Initiative identified several elements of effective partnerships. They include common goals that matter to each partner; regular communication among all partners; methods for decision making and conflict resolution; a strong leader; and the ability of each partner to commit resources. Furthermore, for programs to be effective, they must be part of the fabric of health professions schools, garnering the support of senior faculty members and administrators. Partnerships can launch a successful program, but broad leadership is required to ensure long-term stability.

The philanthropic sector also can play a leadership role by developing partnerships between health and education foundations. Such partnerships can target resources more effectively, foster working relationships between educational institutions and health professions schools, and draw attention to using evidence-based initiatives from both sectors to make change. Foundations can set an example for the larger field by coordinating their separate efforts, sharing information, and bringing more cohesion to programs. These efforts should be linked to relevant federal government programs.

4. More rigorous evaluation of program strategies is needed.

Measuring the results of programs to increase the numbers of minorities entering the health professions when involvement begins in high school and proceeds through college presents a number of challenges. Obviously, the outcome—entering medical school—takes place well after the initial involvement. The efforts to enhance the preparation of minority students are fragmented, programs do not follow one strategy or design, and it is difficult to attribute results to a single effort.

For the most part, knowledge about the effectiveness of minority programs comes from accumulated case studies. Taking this knowledge and using it to design more standardized evaluations presents a particularly strong challenge. For example, a significant failing of the Health Professions Partnership Initiative was its lack of attention to developing cohorts of students in each partnership program that were followed over time. The only information available derives from anecdotes and some small-scale studies that describe the success or the limitations of certain components of each program. There is no way to ascertain what combination of strategies was most effective or what the effective dose was. What is known more generally is that programs need to begin early, to be intense and sustained over time, to address nonacademic barriers, and to choose partnership institutions carefully.

Within the Minority Medical Education Program, data are available to track who applied to and entered medical school, but there are no data on what happened to student participants who did not go on to medical school. There is no tracking of whether they entered other health professions or pursued professional careers outside of health. Future programs need stronger data so that they can best determine how to use limited resources to help create a diverse and strong health professions workforce.

Definition of "Underrepresented Minorities"

Over the past three decades, the definition of "underrepresented minorities" has become increasingly controversial as the population of the United States has become more diverse. The most consistently used definition of underrepresented minorities was developed by the AAMC in 1970. The AAMC defined underrepresented minorities as blacks, Mexican Americans, Native Americans (that is American Indians, Alaska Natives and Native Hawaiians), and mainland Puerto Ricans. In 1971 the definition of minorities was modified to exclude Puerto Ricans living on the island of Puerto Rico, and in 1981 the definition was broadened to include permanent residents, as well as American citizens, who fall into these four broad categories.

The federal government has used an expanded version of this definition. With respect to the health professions, it defines underrepresented minorities as those racial and ethnic populations that are underrepresented in the health professions relative to the number of individuals who are included in the population involved. This definition includes black or African American, Hispanic or Latino, American Indian or Alaskan Native, and Native Hawaiians or other Pacific Islanders. Asians are not considered to be underrepresented minorities. In addition, many federal programs, such as the Centers of Excellence or the Health Careers Opportunity Programs, combine the definition of underrepresented minority with the concept of disadvantage in setting the criteria for their programs.

A "disadvantaged" student is defined as a student from an environment that has inhibited the individual from obtaining the knowledge, the skills, and the abilities to succeed in a health professions school or a program providing education or training in an allied health profession, *and/or* a student from a family with an annual income below a level based on low-income thresholds according to family size. Students must be U.S. citizens, noncitizen nationals or foreign nationals with a visa permitting permanent residence in the United States.

Sources: <http://bhpr.hrsa.gov/diversity/definitions.htm>; <http://crchd.nci.nih.gov/spn/about/def.html>; <http://coe.stanford.edu/mingroups.html>

The Changing Environment

Minority populations are the fastest-growing segment of the American population. By 2010, Hispanics, African Americans, Native Americans and Asian Pacific Americans will make up 32 percent of the population, and 48 percent of the population by 2050. Health professionals need to have the cultural competence to address the health needs of diverse populations and to improve the quality of care for minority populations. The lack of providers in disadvantaged minority communities continues to be a critical impediment to health care access.

The disparity in the care received by minorities and majorities remains a significant problem, with new efforts being directed to closing the racial and ethnic gaps. In *Unequal Treatment*, a 2002 Institute of

Medicine report, an argument was made for reducing disparities by increasing the number of minorities in the health care workforce and by improving the competence of the health care workforce in working with racial and ethnic populations.²⁰ This twofold strategy was adopted in a recent Foundation workforce program, Pipeline, Professional and Practice: Community-Based Dental Education, which is designed to address the problem of disparities in access to dental care. Under this program, which builds on a study funded by the Josiah Macy, Jr. Foundation, eleven dental schools will undertake a three-pronged strategy: finding approaches to attract low-income and minority students to attend dental schools; redesigning the dental schools' curricula to make them more relevant to community-based practice; and creating accessible dental services sites in the communities. The Kellogg Foundation is providing scholarship support for minority students attending the eleven dental schools. Based on the Foundation's model, the California Endowment is funding programs in four additional California dental schools and also will be providing scholarship support.

Of course, the national debate over affirmative action affects educational programs that seek to promote a more diverse health care workforce. The U.S. Supreme Court handed down two decisions in June 2003 regarding the University of Michigan's undergraduate and law school admissions policies. The Court held that diversity in the student body is a compelling interest that can justify the use of race as a plus factor in admissions decisions. It found in favor of Michigan Law School's practice of giving individualized consideration to all applicants in order to achieve a "critical mass" of underrepresented minorities. At the same time, it struck down the undergraduate admissions policy that awarded extra points to minority applicants.

The message from these decisions is that in the admissions process, only individualized consideration that gives substantial weight to diversity factors other than race will be constitutional. This will present challenges to universities seeking diverse student bodies since such tailored approaches will be difficult for the many undergraduate programs that receive thousands of applications every year. Affirmative action admissions systems will be subject to case-by-case challenges. These have often been successful in the past, although with the guidance given by the Supreme Court, universities may be able to craft programs that will withstand the challenges.

Despite court challenges and ballot initiatives, momentum has been building to create a diverse health workforce. In August 1996, the AAMC created a coalition of Health Professionals for Diversity. Made up of more than 30 of the nation's leading medical, health and education associations, the coalition serves as an advocate for the continued use of race, ethnicity, and gender as factors in the admissions process. In

1998, a Pew Health Professions Commission released a report calling for a major increase in racial, ethnic, and socioeconomic diversity in the health care workforce.²¹ The report warned that without such diversity health professionals in the 21st century would be poorly equipped to care for an increasingly diverse population.

Many other organizations have made the case for diversity in the health care workforce. Jordan Cohen, president of the AAMC, and his colleagues articulated the case cogently. Writing in *Health Affairs* in 2002, they argued that adequate representation among students and faculty of the diversity in American society was indispensable for quality medical education; that increasing the diversity of the physician workforce would improve access to health care for underserved populations; that increasing the diversity of the research workforce could accelerate advances in medical and public health research; and that diversity among managers of health care organizations made good business sense.²²

CONCLUSION

The promise of the 1960s to solve our nation's racial and ethnic inequalities has not been realized. Despite the large amount of resources invested, underrepresented minorities constitute only 10.6 percent of physicians, 5 percent of dentists, and 12.3 percent of nurses. Yet the 2000 census data reveal that over 25 percent of the U.S. population is African American, Hispanic, or Native American/Alaskan Native, and these percentages are growing rapidly. Thus, persistent underrepresentation of minorities in the health professions remains a major challenge.

Meeting the challenge—that is, developing a health professions workforce that looks like the general population—goes well beyond issues of access to, or cultural competence in, health care. It touches on society's obligation to eliminate educational inequities that harm the health, well-being, and potential of large numbers of our citizens. Now more than ever, programs that address the educational barriers faced by minorities must be protected and strengthened.

Notes

¹ For this chapter, *minority* is used to mean underrepresented minorities except where otherwise noted.

² *Changing the Face of Medicine: Celebrating 50 Years (1946–1996)*. National Medical Fellowships, Inc., 1997.

³ *Report of the Association of American Medical Colleges Task Force on Minority Student Opportunities in Medicine*. June 1978.

⁴ In general, a foundation is required to make grants amounting to 5 percent of its assets each year to qualify for tax-exempt status.

⁵ Isaacs SL, Sandy LG and Schroeder SA. "Improving the Health Care Workforce: Perspectives from 24 Years' Experience." In *To Improve Health and Health Care 1997: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 1997.

⁶ Baratz J and Keyser-Smith J. *Report to the Robert Wood Johnson Foundation: Expanding Medical Education Opportunities for Minority Students*. Educational Policy Research Institute, Educational Testing Service, Mar. 1982.

⁷ Keyser-Smith J. *Black Participation in Engineering Education*. Washington, D.C.: Educational Policy Research Institute, Oct. 1981.

⁸ Bridges K and Smith L. *Evaluation Report to the Robert Wood Johnson Foundation on the Minority Medical Faculty Development Program*. (Unpublished). 1995.

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