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Health Affairs 22, no.4 (2003):91-93
doi: 10.1377/hlthaff.22.4.91

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Perspective

A Recurring Theme: The Need For Minority Physicians

Achieving adequate numbers of physicians to meet future population needs requires recruitment from diverse populations.

by Joan Y. Reede

ABSTRACT: There is compelling evidence for the need to increase diversity within the physician workforce to ensure high-quality medical education, access to health care for the underserved, advances in research, and improved business performance. To have enough physicians to meet the future needs of the general public, as well as of minority citizens, we must recruit from diverse populations. The need for physicians, particularly underrepresented minorities, will continue to grow. Addressing shortages requires inventive efforts to counter obstacles created by the anti-affirmative action movement, as well as strategies to encourage institutions to become more engaged in diversity efforts.

Richard Cooper posits that physician supply will not meet future demand for physician services. His historical review of U.S. medical schools reveals two primary mechanisms for enlarging medical school capacity: increasing class size or establishing new medical schools. Both approaches, coupled with affirmative-action measures, have raised the numbers of underrepresented minority matriculants to medical schools during the past thirty-five years. However, these mechanisms are likely to have only a limited impact on workforce requirements in the near future, because of the need to garner political support for financing in constrained economic times, limitations in the pool of qualified applicants, an anti-affirmative action political climate, and the time required to achieve major change.

Past minority enrollment. Past efforts to increase minority enrollment in U.S. medical schools fall into four phases: “social activism,” from the late 1960s to the mid-1970s; “stagnation,” from 1974 to 1990; renewal, from 1990 to 1995; and anti-affirmative action, beginning in 1996.1

In 1964 only 0.5 percent of the students enrolled in eighty-one of the eighty-three U.S. medical schools were black. Two medical schools, Howard and Meharry, accounted for the other 1.7 percent. By 1974 total minority enrollment had increased to 10 percent. This increase, fueled in part by events of the Civil Rights movement, slowed following the 1978 U.S. Supreme Court’s Bakke decision. The number of minority matriculants remained stagnant until the Association of American Medical Colleges’ (AAMC’s) Project 3000 by 2000 initiative began in 1990.2

In 1990–1994 there was an 8.3 percent average annual rate of growth in the number of minority students entering medical school, peak-
ing at 12.4 percent in 1994. After 1996 the number of minority applicants to allopathic medical schools decreased, as did the number of overall medical school applicants. The current decline in applications has been accompanied by a decrease in enrollment, noted primarily in public medical schools and fueled in part by anti-affirmative action initiatives. These actions include the 1995 decision of the University of California regents to ban race- and gender-based preferences; the 1995 Hopwood v. University of Texas decision of the U.S. Court of Appeals for the Fifth District, which struck down affirmative action programs that take race and ethnicity into account in admissions; and passage of the 1996 California Civil Rights Initiative, which eliminated race-, ethnicity-, and gender-based preferences from governmental functions.3  

Racial/ethnic composition. The racial/ethnic composition of the U.S. physician workforce does not reflect that of the general population. While blacks, Hispanics, and Native Americans represented 6 percent of U.S. physicians in 2001, their representation within the general population was 25.7 percent. In 2002, 11.6 percent of matriculating medical students and 5.5 percent of medical school faculty were from these minority groups.4 Although this reflects an increase in the number of minority physicians since 1968, there continues to be a large and consistent discrepancy in population parity by race/ethnicity.5  

Need to increase diversity. There is compelling evidence for the need to increase diversity within the physician workforce, as well as within the medical school student body, faculty, and administration. Diversity ensures high-quality medical education, access to health care for underserved populations, accelerating advances in research, and improved business performance.6 Many segments of the U.S. population, particularly minority groups, reside in medically underserved areas and suffer disparate disease burden and negative health outcomes. Black and Hispanic physicians are more likely to provide health care to black and Hispanic patients; serve poor, uninsured, or Medicaid-insured patients; and locate their practices in underserved areas.7 The percentage of minority medical school graduates reporting plans to practice in underserved areas is more than four times that of other graduates.8 Also, data indicate that there is a positive association between physician-patient racial/ethnic concordance and patients’ receiving preventive care, being satisfied with their care overall, and rating their physicians’ participatory decision-making styles as excellent.9  

Good signs. The increased representation of minority students enrolled in U.S. K–12 schools could help to increase diversity among physicians. Between 1960 and 1996 there was a 24 percent increase, and the U.S. Census Bureau projects a nonwhite school-age population of 58 percent by 2050. Much of this increase has been the result of a rise in Hispanic and black enrollments by 218 percent and 20 percent, respectively, since 1968.10 Between 1976 and 1995 the percentage of underrepresented minority individuals enrolled in U.S. undergraduate schools increased from 16 percent to 20 percent. Also, between 1971 and 2000 the percentage of high school completers ages 25–29 with bachelor’s degrees increased for both blacks (11.5–20.5 percent) and Hispanics (10.5–15.4 percent). Between 1976 and 1999 the proportion of minority first-professional students increased from 9 percent to 26 percent.11 Unfortunately, these modest increases have not been accompanied by concomitant narrowing of the K–12 achievement gap among whites, blacks, and Hispanics. As noted by Cooper, blacks and Hispanics disproportionately fail to enter or graduate from college.  

Addressing the shortages. Addressing the shortages of minority physicians will require inventive efforts to counter the obstacles created by the anti-affirmative action movement, as well as an array of strategies designed to encourage institutions to become more engaged in diversity efforts. These include not only civil rights and equal opportunity approaches but also creative use and expansion of existing financing, regulatory, and community benefit mechanisms to encourage active participation of medical schools. Such efforts
need to address failures in the K–12 educational system; pipeline shortages; lack of science exposure, opportunity, and mentoring for minority and disadvantaged students; and elimination of disparate health burdens in minority and impoverished communities. Current mechanisms such as minority supplements offered by the National Institutes of Health and the Agency for Healthcare Research and Quality, K–12 educational initiatives supported by the National Science Foundation, and workforce development programs such as the Health Careers Opportunity Program of the Health Resources and Services Administration should be expanded. Graduate medical education funding could be modified to provide incentives to programs that successfully address areas such as cultural competency, health disparities, and workforce diversity. Accreditation bodies should require documentation and monitoring of efforts related to cultural competency and workforce diversity for both students and faculty.

The success of efforts to address the overwhelming need to bring more minority individuals into the physician workforce will require mechanisms that recognize the need for multifaceted approaches, that provide monitoring of progress, and that incorporate accountability for the achievement of outcomes.

NOTES
2. Ibid.