T H E B R O N X H E A L T H L I N K, INC.

851 Grand Concourse * Room 914 * Bronx, NY 10451 * 718-590-2648 * execdirtbhl@aol.com

Presentation at Minority Health Council Meeting: Developing Incentives for More Minorities to Become Physicians in Order to Increase Access for Minorities to Culturally and Linguisitically Appropriate Health Care

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Good afternoon. I am Joann Casado, the Executive Director of the Bronx Health Link. I thank you for the opportunity to present our perspective on how to develop incentives that increase the number of physicians serving communities of color.

First, let me tell you a little about the Bronx Health Link. We are a clearinghouse of information for members of the health and human service delivery system of the Bronx. We reach thousands of community members, agencies and other through our electronic mailing list, workgroups, advisory boards, task forces, community based workshops, conferences and forums held throughout the year to inform, educate and organize around issues of importance in the field of health care. Under contract with the New York City Department of Health and Mental Hygiene under the Infant Mortality Reduction Initiative and a contract with the NYS Health Department to operate the Perinatal Information Network, we work extensively with the community and health care providers to improve birth outcomes, prenatal care and the reproductive health of Bronx women. The Bronx Health Link also worked with the Health and Hospitals Corporation as an active participant in the development of the Primary Care Initiative.

Our work has made us acutely aware of the drastic health needs of poor communities of color. According to 2007 census surveys, 27% of Bronx residents (and 38% of children) live in poverty; and in 2005, 29% of adults under 65 were uninsured. Rates of infant mortality, asthma, diabetes and HIV – to name just a few indicators – remain dramatically higher than those for the city and the country.

Second, our presentation will give you the community perspective on this issue. We will also ask that you bear with us because some of our recommendations will go beyond just increasing the numbers of physicians to broader changes in the health system. We are not nor do we represent the health care institutions. Our agency has a long history of exploring and documenting the health needs of the community and using these insights to develop recommendations for action. We have since 2005 produced an annual report on the status of maternal and infant health in the Bronx. TBHL has in the past year participated in community surveys, focus groups, roundtable policy discussions, and formulation of a policy agenda for a number of initiatives. Last

December, TBHL partnered with the citywide Commission on the Public's Health System to sponsor a Bronx Community Health Care Discussion in response to the call by the Obama Transition Team for such meetings to happen locally around the country. The recommendations that emerged from that lively and thoughtful discussion serve as an important part of our proposals to this body.

But first a little historical perspective:

Last year, after a long struggle by Black doctors, the American Medical Association finally issued a public apology for its decades of institutionalized exclusion of Black people from the profession and pledged to expand its efforts to recruit more Black people to be trained as doctors. Until 1939, for example, the AMA's directory listed the few Black physicians as "colored," despite protests, which led to their being denied liability insurance and bank loans. The result of all these practices – and those of medical schools and other institutions -- is that today 2.2% of U.S. physicians are African-American, versus 13% in the overall population. As Dr. Nedra Joyner, board chair of the predominantly Black National Medical Association has noted, this systematic discrimination had a devastating effect on health care for the Black community, as it left most of those patients to be cared for by providers who, at best, lacked the cultural competence to provide effective care, and at worst, led to discriminatory and often substandard care. Latinos have also faced systematic exclusion by the medical profession. In New York State, 4% of physicians are Latino versus 15% of the overall population. Similar statistics for both African Americans and Latinos apply to the nursing profession. According to the University at Albany's Center for Health Workforce Studies, between 1995 and 2006, the New York State population of what it defines as "underrepresented minority groups" – African-Americans, Latinos, and Native Americans - grew by nearly five percentage points, from 28.3% of the general population to 32.9%. Meanwhile, the state's population of physicians of color increased by only 2.5 percentage points, from 7% to 9.5% of all doctors.[1] These numbers reflect what continues to be a large and consistent discrepancy in population parity by race/ethnicity.

There is compelling evidence that people of color have been excluded from medical schools. This historic pattern has improved over the years with the use of affirmative action policies; however, we are now facing an increasing backlash against these programs. We must work collaboratively 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. Many segments of the U.S. population, particularly people of color, reside in medically underserved areas and suffer disparate disease burden and negative health outcomes. Black and Latino physicians are more likely to provide health care to Black and Latino patients; serve poor, uninsured, or Medicaid-insured patients; and locate their practices in underserved areas.

While there is a growing and long overdue presence of cultural competence trainings in the health professions, surveys with providers and interviews with patients make clear that among

[1] Martiniano R, Mulvaney P, Moore J, and Armstrong D. *A Profile of New York's Underrepresented Minority Physicians* Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany. July 2008. Available at http://chws.albany.edu/index.php?id=11,0,0,1,0,0.

white providers, stereotypes and negative attitudes still persist. Furthermore, studies have shown repeatedly that when people of color are served by health professionals from their racial or nationality group, there are improvements in the quality of care, patient satisfaction, and adherence to treatment.

In June of this year, The Bronx Health Link held a series of focus group with Mexican women to document their experiences with the health care system in the Bronx. All the participants stated that there was a lack of Latino physicians (when asked who were the doctors, all the participants said whites and East Asians, primarily from India). All discussed the endemic lack of translation services, the difficulties in securing translation services and the need to rely on a family member, partner or friend who would serve as a translator and navigator. Finally, many also discussed their medical providers' lack of cultural awareness about their community and the fact that the brochures, flyers and posters did not include people who looked like them.

We also held a focus group with a group of Bengali women in the Parkchester section of the Bronx to ask them how to create culturally relevant educational materials. We found that they requested information in their native language. In terms of pictures, they wanted images and illustrations to "look like us."

Both groups of women from disparate backgrounds and different immigration patterns and practices expressed a need for translation services and the use of materials that used images of them in outreach and educational resources.

To address the interrelated problems that flow from the underrepresentation of medical professionals of color and the lack of cultural competence, we need to look at all the possible venues of change. Overall, we need to create and invest in the educational pipeline from cradle to medical/professional schools that prepare students of color and disadvantaged students for careers in medicine and other health professions and then admit them and provide financial, academic and other support for them in those medical/professional schools. Thus, based on our work and that of several other policy organizations in this field, we recommend the following:

1. **Address failures in the K–12 educational system**, including pipeline shortages; lack of science exposure, opportunity, and mentoring for students of color and disadvantaged students. Specifically:

- Include information on health professional careers in school curricula, beginning in elementary school, to expand the pool of students prepared and motivated to enroll in health-profession training schools.

- Expand funding for "minority supplements" offered by the National Institutes of Health and the Agency for Healthcare Research and Quality and the K–12 educational initiatives supported by the National Science Foundation.

2. **Provide funding to community-based schools that can recruit, retain and graduate students who are interested in careers in the health field**.

- The model of the Harlem Children's Zone is one example of a community-based school working with parents to ensure that children attend school, master the subject matter and graduate and attend college. What makes the model of the HCZ unique is its involvement early on in the education of students, the involvement of parents and the provision of support and incentives.

- Support hands-on programs like the Area Health Education Centers (AHEC) which provide high school students with exposure to a broad spectrum of health careers to people of all ages. Secure long range, comprehensive funding to ensure that these opportunities to engage students outside of the classroom remain available to students in underserved communities.

3. **Address the reality that low-income people of color will certainly not be able to enter medical school if they cannot first afford to enter undergraduate college programs**, so the assistance must also be expanded at that level. In addition, with entrance exams playing an ever-more important role in determining med school admissions, there must be assistance available to attend prep courses. Also, beyond direct financial assistance, it is important to expand school mentoring programs by people of color for people of color.

4. **Promote diversity as a key part of expanding medical education, both in New York State and nationwide**. Specifically:

- Fight for and expand health professional schools' affirmative action programs, which have been under systematic attack for three decades now around the country. Require publicly funded medical schools and their affiliated private hospitals to admit students in close proportion to their representation in the population.

- Change admissions criteria for professional schools – including medical, nursing, dental and MPH programs – to include measuring the applicants' commitment to return to provide service to their communities.

- Fund comprehensive programs, both at the New York State and federal levels, to recruit members of underrepresented communities of color into the health professions. Specifically:

    - Increase funding for pipeline and workforce retention programs (such as the Health Careers Opportunity Program of the federal Health Resources and Services Administration) and student-loan forgiveness programs that encourage individuals from communities of color to pursue careers as direct healthcare workers and train them to enter the medical field without a financial burden.

    - Provide adequate funding for need-based scholarships and loans (many of which have been cut in recent years) so that all who seek to enroll in schools for health professionals, including people from the full gamut of racial and cultural backgrounds, can do so.

- Expand graduate schools' financial and academic supports aimed at achieving larger numbers of students of color who are able to graduate.

- To accomplish these initiatives, develop more partnerships with community-based organizations.

- Support targeted federal investments and resources to Hispanic-serving institutions (HSIs), tribal colleges and universities (TCUs), historically black colleges and universities (HBCUs), and other minority-serving institutions (MSIs) to enable these institutions to expand their capacity to significantly increase the representation of people of color and culturally and linguistically-competent healthcare professionals.

5. Modify funding of graduate education for physicians and other health professionals 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. In addition, such training should be required as part of the state medical licensure process, as New Jersey has now done. Such a requirement is increasingly gaining support from physicians' associations and is now the subject of a bill in the New York State Legislature.

6. **Increase incentives for physicians to work in underserved communities.** Expand the National Health Service Corps, including incentives for primary care providers. Adopt the best parts of the California model: Concerned about the lack of reliable data on Californians' ability to have access to doctors, the California Medical Association (CMA) sponsored legislation requiring the Medical Board of California to collect data on ethnicity, hours spent in patient care, languages spoken, specialty and location upon renewal of a physician's license every two years. The first report issued after the bill's enactment in 2001 revealed that although there are over 100,000 physicians licensed to practice in California, only 62,000 are active in full-time patient care, echoing CMA's long-held concerns about an overall physician supply problem in the state. The report also included a proposal to provide up to $105,000 in loan repayment to new physicians who agree to serve in an underserved area for at least three years. The CMA is seeking federal legislation that would revamp the Medicare Physician Scarcity Area (PSA) and the Health Care Professional Shortage Area programs to improve access to physicians in rural areas. A new payment structure could help retain current physicians in the programs and lay the groundwork to attract new physicians. Similar initiatives are recommended for New York State.

The massive health care reform legislation now being shaped in Congress includes provisions addressing some of these issues. So now is a critical time to monitor the legislative process and advocate for the strongest possible provisions. According to an analysis provided by the policy organization Health Care for America Now that compares the bill from the Senate Health, Education, Labor and Pensions (HELP) Committee with the combined House bill:

Re: grants or loan forgiveness for training:

- HELP bill - doubles funding for the National Health Service Corps; provides new or expanded programs for such service by medical students, nurses, mental health practitioners, and pediatric practitioners.
- House Bill - expands the National Health Service Corps; provides new or expanded scholarships, loans, and loan repayment programs for primary care doctors and dentists, dental hygienists, and public health workers in underserved areas,

Re: pipeline/career programs:

- HELP bill – contains various programs directed at nurses, doctors and other medical personnel.
- House bill - provides grants for training programs to increase diversity

Re: retention programs:

- HELP bill - provides grants to practitioners and instructors of color.
- House bill - does not explicitly speak to the issue.

The Bronx Health REACH, a consortium of faith-based, health care and community organizations working to reduce racial disparities in the Bronx, which made some of the recommendations listed earlier,[2] also notes that all these initiatives to address institutional racism will help nourish organizational transformations that will support the increased promotion of people of color into leadership positions in medical institutions.

And finally, we would emphasize that all efforts to increase the diversity of the medical professional workforce must be linked to measures to reduce racial and class disparities in access to health care. Most important in that regard, we note the broad call by those present at our Bronx Community Healthcare Discussion for the adoption of a universal health care coverage system that covers all residents, including undocumented people, and that employs a simplified enrollment process. We should emphasize that the specific recommendation was that such a universal system should be single-payer – i.e., government-financed -- to remove the destructive role of the private health insurance industry that has denied care to so many millions of people through unaffordable rates, exclusionary policies, and wasteful administrative expenses.

This is a critical moment in the national dialogue about health care reform, and a perfect opportunity to broaden the agenda to include the vital importance of incorporating robust measures to reverse the unacceptable racial and ethnic disparities in health care access and quality of care in this country. Many providers, consumers, and community institutions are working every day on these issues – let's seize this moment to maximize the best of those efforts and work to achieve meaningful gains towards racial justice in health care.

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[2] Institute for Urban Family Health, Testimony to the Sullivan Commission. Available at http://institute2000.org/bhr/files/SullivanCommission2003.pdf. and Bronx Health REACH, End Health Disparities Now. Available at http://institute2000.org/bhr/files/LegislativeAdvisory.pdf