WHITE COATS
AND MANY COLORS

Population Diversity
and Its Implications
for Health Care

Emily Friedman
Independent Health Policy and Ethics Analyst

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The U.S. population is becoming more diverse racially and ethnically, and these changes are occurring in areas of society other than those traditionally associated with diversity. Two sectors are always affected first: health care and education.

Health care organizations see themselves as community entities, and it is thus imperative that their leaders understand how their communities are changing, what new needs for care are emerging, and what kind of potential there is for employing members of these new and growing populations.

Although some observers present the growth in diversity as a daunting challenge or even a threat to the status quo, the fact is that the United States has always experienced changes in the makeup of its population and has benefited from the results. Often, the best responses are understanding and innovation, and health care is usually equipped with both. Furthermore, as is documented in this report, many effective responses are simple, inexpensive, and easy to implement.

Population Diversity

- Today, one in four Americans is a member of a racial or ethnic minority group; by 2070, one in two Americans will be.

- Four states—California, Hawaii, New Mexico, and Texas—now have combined minority populations that are larger than the non-Latino white population. Five other states—Arizona, Georgia, Maryland, Mississippi, and New York—have minority populations of 40 percent.

- In 2003, Latinos became the largest minority group in the United States, passing African-Americans and numbering nearly 40 million.

- A much higher percentage of Americans under the age of 50 are members of minority groups than are Americans over 50; this means that there may be important cultural differences between older patients and the people who provide services to them.

- In the future, the population over 65—the heaviest users of health care—will be far more diverse, and the majority of them will be women. Of the “oldest old”—those over 85—70 percent will be women.

Implications for Health Care

- Racial and ethnic disparities in health status, access to care, and access to coverage have become both political issues and major challenges for health care providers.

- Ongoing research suggests that the sources of disparities are complex, but innovative programs demonstrate that disparities can be addressed and overcome.

- Community outreach is essential in order to provide preventive and primary care to diverse populations; programs are most effective when members of the community are involved in the planning, implementation, and evaluation of outreach efforts.

- Cultural competence is a key factor in the quality of health care delivery; it involves not only understanding of population changes, but also sensitivity to and respect for diversity in language, religion, customs, values, and traditions.
More than one in ten Americans was born in another country; although this is a long tradition in the United States, today’s immigrants and refugees are more likely to come from non-English-speaking cultures.

Health care providers can be and often are an anchor for new Americans, offering not only clinical care, but also social services, links to other community organizations, and, often, employment.

Non-citizens are far more likely to lack health insurance, regardless of their work status; fortunately, Congress has provided some relief to hospitals caring for uninsured immigrants.

Diversity goes beyond race and ethnicity; members of community subpopulations may share specific disabilities, lifestyles, and/or beliefs, and health care programs need to be tailored in order to be successful with the distinct characteristics of these groups.

Cultural and language differences present formidable challenges to health care providers, and failure to address them can result in poor care, unsatisfactory outcomes, and unhappy patients.

Literacy is not a given; 10 million Americans cannot read in any language, and 40 million cannot read English at a 5th-grade level. The American Medical Association estimates that 90 million Americans do not understand what they are told by their providers. This all can contribute to substandard quality of care and poor outcomes.

Members of minority groups, especially Latinos, are far more likely to lack health insurance; providers should work with public and private coverage programs to address this problem. Often, there are also barriers (intentional and unintentional) that make it difficult to apply for coverage successfully. This is especially true of Medicaid, the complexities of which can be overwhelming for many people.

At a time when many health care organizations report problems in recruiting and retaining employees, lack of diversity in the ranks of some health care professions is troubling.

Although minority groups are well-represented in lower-echelon positions in the health care work force, they are still underrepresented in medicine, nursing, pharmacy, health services administration, and governance.

An organization that appears to employ racial and ethnic minorities only in low-level positions, with little chance for advancement, is unlikely to be successful in what promises to be an extremely competitive job market.

Minorities and immigrants may well represent much of the potential health care work force of the future, and provider organizations are well advised to work toward the creation of inclusive, welcoming work environments in which members of these groups feel comfortable.

Health care organizations will be deeply affected by growing diversity in the population; the question is whether they will see this change as simply a problem to be addressed, or as an opportunity.
The population of the United States is always changing, but the shifts currently under way are among the most profound in recent history. Most important among these is the growing racial and ethnic diversity of our society. Although the populations of some areas, notably the East and West coasts and the Southwest, have long been more diverse than others, it is now widely realized that our supposedly once-homogeneous population has blossomed into a coat of many colors, faiths, cultures, languages—and expectations.

Traditional patterns of diversity are changing as well. Although, historically, the highest number of Latinos has lived in the Southwest, the second-largest urban Mexican-American population is now in the city of Chicago. Significant numbers of Somali refugees have found their way to Maine. Several non-border states now have populations that are at least 10 percent Latino. Even southern New Hampshire has seen an increase in Spanish-speaking residents. California, Hawaii, New Mexico, and Texas each now have a combined minority population that is larger than the non-Latino white population, making them “minority majority” states.

Furthermore, traditional population categories are becoming more complex; there is diversity within diversity. In the 1850s, an Asian-American was most likely to be of Japanese or Chinese heritage; today, an Asian-American’s roots could be anywhere from Singapore to Indonesia to Malaysia to Bangladesh. A “Latino” might be Mexican-American, Cuban-American, Puerto Rican, or a member of one of a number of other Latino groups. Many Americans claim more than one ethnic background; the 2000 Census found that nearly 2.5 percent of the population reported themselves to be in that category. The century of the hyphenated American has dawned.

When populations change, some areas of society are affected more quickly than others. But there are always at least two areas where the impact is felt immediately: education and health care. School systems across the country are already adjusting to more diverse and complex student populations. Health care providers and insurers are doing the same. But much more must be done, and soon, if the health care system is to continue to provide accessible, high-quality services to all patients.
Overall Trends

**Recent growth in diversity is pronounced**

Although diversity has been accelerating for decades, more sophisticated Census Bureau techniques have brought the portrait of change into sharper focus. From 1900 to 1980, given Census methodology in those years, growth in diversity was evident but not overwhelming.

![U.S. population diversity chart](chart.png)

In 1990, the Census Bureau began counting Latinos separately, and their effect on the U.S. population—an impact that dates back to the 1500s—became apparent: At the time of that census, 9 percent of the population was Latino.

The 2000 Census counted Native Hawaiians and other Pacific Islanders separately, and the profile of the U.S. population became clearer.

![U.S. population diversity charts for 1990 and 2000](charts.png)

Source: Census Bureau, 2002
In June 2003, the Census Bureau announced that Latinos, at nearly 40 million, outnumbered African-Americans for the first time, becoming the largest U.S. minority.

Regionally, the minority proportion of the population was highest in the West and South and lowest in the Midwest in 2000.

Generally speaking, the predominant minorities in the West are Latinos, Asian-Americans, and Native Hawaiians and Pacific Islanders, whereas in the South, African-Americans predominate.

### Percentage of minorities by region, 2000

<table>
<thead>
<tr>
<th>Region</th>
<th>Minority Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwest</td>
<td>18.6%</td>
</tr>
<tr>
<td>Northeast</td>
<td>26.6%</td>
</tr>
<tr>
<td>South</td>
<td>34.2%</td>
</tr>
<tr>
<td>West</td>
<td>41.6%</td>
</tr>
</tbody>
</table>

Source: Census Bureau, 2002

In August 2005, the Census Bureau released new estimates for major population groups that indicated that diversity was accelerating.

### Estimates of major population groups, 2004

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latino</td>
<td>14.1%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>0.3%</td>
</tr>
<tr>
<td>Native American</td>
<td>0.2%</td>
</tr>
<tr>
<td>Asian-American</td>
<td>4.8%</td>
</tr>
<tr>
<td>African-American</td>
<td>13.4%</td>
</tr>
<tr>
<td>Non-Latino White</td>
<td>67.4%</td>
</tr>
</tbody>
</table>

Source: Census Bureau, 2002
Growth in diversity can be expected to accelerate

The Census Bureau reports that minority groups grew 11 times more quickly than the non-Latino white population between 1980 and 2000. It predicts that growth in the Latino and Asian-American populations will triple in the next 50 years. As a result, non-Latino whites may represent less than half the population by 2070.

A much higher percentage of younger Americans belongs to minority groups

Although less than 20 percent of Americans over age 65 are members of minority groups, nearly 40 percent of those under 25 are. In some areas, the differential is even more pronounced; in California, two-thirds of those over 50 are non-Latino whites, whereas two-thirds of those under 50 are minorities. This will inevitably produce something of a cultural mismatch, to a greater or lesser degree, between older Americans who require social and other services and the people who provide those services. This is already being seen in education, where teachers who can effectively serve increasingly diverse and often non-English-speaking student populations are sorely needed.
Patterns of diversity vary greatly at state and county levels

Differences in the level of diversity in states are obvious; however, county populations also vary strikingly. For example, Carroll County, New Hampshire, one of our most homogeneous counties, bears little resemblance to Los Angeles County, the most diverse county in the United States.

And although the traditional pattern of diversity is strongest on the coasts and in the Southwest, the distribution of American minorities is now much more widespread.
These patterns mean that the older population—the heaviest users of the health care system—will be far more diverse in the future.

The common perception of older Americans is that most of them are white, and that is still true. But the future over-65 population will be far more diverse.

**Older Americans by race/ethnicity, 2000-2050**

The majority of this more diverse senior population will be women, especially among the “oldest old,” or people over 85.

Overall, the majority of the population is women; this pattern is more pronounced in older groups. Indeed, 70 percent of people over 85—the fastest-growing population group in the country—are women. And in the future, many of them will be minorities.

**Population over 65 by gender, 2000-2060**
Many providers are already highly experienced in treating patients from diverse backgrounds, races, ethnicities, and cultures. Others are probably only seeing the first signs of diversity. But whether the tide has already shifted or change is only a glint on the horizon, the ability of the health care system to adapt will be a huge factor in determining the future of that system.

**Racial and Ethnic Disparities in Health Status**

In a speech at the New York Academy of Medicine in 1999, then-U.S. Surgeon General David Satcher, M.D., said that one of the primary objectives of the health care system in the 21st Century should be the elimination of racial and ethnic disparities in health status. Three years later, his successor, Richard Carmona, M.D., told a Texas audience, “We must close the gap on disparities. We have ample scientific evidence they exist. We must now confront them vigorously.” U.S. Senate Majority Leader Bill Frist, M.D. (R-Tenn.), announced in early 2003 that the elimination of racial and ethnic disparities in health status would be one of his highest priorities—especially the persistently shorter life expectancy of African-Americans. “Health care disparities, minority versus nonminority, is something I feel strongly about,” he said in a Senate press briefing. Since then, several major federal initiatives have been launched to combat the problem.

- **Racial and ethnic disparities in health status persist, despite many efforts to close the gap**

Historically, different racial and ethnic groups have fared better or worse in terms of their health status. For decades, the classic measure was infant mortality. Although data tend to be delayed due to the complexity of gathering them, the pattern has remained distressingly static: More white infants survive than do the newborns of other groups. Furthermore, African-American mothers are four times as likely to die in childbirth as whites, and are more than twice as likely to do so as mothers in other minority groups.

Data for 2002 show that African-American infants are almost twice as likely to die as U.S. infants overall, and Native American infants are more likely to die than those in most other groups. Asian-American infants have a significantly greater chance of survival.

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**Infant mortality by race/ethnicity, 2002***

(*Last year for which full data are available*)

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Infant Mortality Rate per 1,000 Live Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>7.0</td>
</tr>
<tr>
<td>Non-Latino White</td>
<td>5.8</td>
</tr>
<tr>
<td>African-American</td>
<td>13.8</td>
</tr>
<tr>
<td>Native American</td>
<td>8.6</td>
</tr>
<tr>
<td>Asian-American/Pacific Islander</td>
<td>4.8</td>
</tr>
<tr>
<td>Latino</td>
<td>5.6</td>
</tr>
</tbody>
</table>

Source: NCHS, 2005
More sophisticated information gathering has revealed a universe of health status disparities

From hypertension to diabetes, from obesity to cervical cancer, data on disparities have begun to emerge. According to recent work by Dr. Satcher and his colleagues, 83,750 annual deaths among African-Americans could be prevented if the mortality gap between them and white Americans could be eliminated. Women of Vietnamese heritage are five times more likely than white women to develop cervical cancer; Latina women are twice as likely to develop the disease. Diabetes has been described by federal officials as occurring in near-epidemic proportions in some minority groups, especially Native Americans; for example, 80 percent of members of the Pima tribe of Arizona over the age of 50 have the disease.

Age-adjusted prevalence of diabetes, by race and ethnicity, 2002

The reasons behind racial and ethnic health status disparities are complex and not well understood

The growing body of research on disparities has identified at least four causes for disparities in health status, although there are undoubtedly many more. First, genetic factors obviously play a role. Second, specific conditions tend to be associated with each other, such as diabetes and obesity. Third, financial status is closely identified with health status; overall, the more affluent the individual, the better his or her health status. Because non-whites tend to have a higher level of poverty, it follows that their health status is at risk of being poorer. Fourth, both access to care and access to coverage affect health status—and non-whites have less of both (see the sections on Insurance and Medicaid).

Poverty rate by race/ethnicity, 2003-2004

Source: Census Bureau, 2005
Disparities exist not only in health status, but also in the provision of health care
Research has also shown that people of different racial and ethnic groups are often treated differently by the health care system, regardless of their income or insurance status. Again, the reasons are complex and poorly understood, and it can be assumed that conscious discrimination on the part of providers is not the main reason.

It is known that having a regular physician improves health status. But even when insurance is taken into consideration, minority adults are far less likely to have a regular physician than whites.

Percentage of adults with no regular doctor, 2001

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Non-Latino White</th>
<th>African-American</th>
<th>Latino</th>
<th>Asian-American</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>23%</td>
<td>19%</td>
<td>28%</td>
<td>41%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Source: Commonwealth Fund, 2002

And even among Medicare managed care members, all of whom have private coverage, disparities in services are evident.

Disparities in care, Medicare managed care members, 2001

<table>
<thead>
<tr>
<th>Service</th>
<th>White</th>
<th>African-American</th>
<th>Disparity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer screening</td>
<td>70.9%</td>
<td>62.9%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Diabetic eye exams</td>
<td>50.4%</td>
<td>43.6%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Beta blocker use</td>
<td>73.8%</td>
<td>64.1%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Mental illness follow-up</td>
<td>54.0%</td>
<td>33.2%</td>
<td>20.7%</td>
</tr>
</tbody>
</table>

Source: Commonwealth Fund, 2002

Eliminating disparities will require a variety of approaches
Disparities in health status have existed as long as there have been different populations in the United States. Indeed, some disparities have improved over time; the health status and life expectancy of many African-Americans today are better than that of their slave ancestors. Addressing and eliminating disparities, however, will be a daunting task. Among the highest priorities should be:

- More research on disparities in specific population groups
- More research on the causes of disparities
- Development of workable solutions
- Application of both research and solutions at the patient care level
- Education of providers about disparities and their solutions
- Funding of all such activities
Before she became Surgeon General of Michigan, Kimberlydawn Wisdom, M.D., M.S., was a senior staff physician at Henry Ford Health System in Detroit. For too long, she watched African-American men come to the emergency department with severe illness, often as the result of diabetes. She often found that even if they knew they had the disease, they did not know how to manage it. One of her patients said, “We’ll be macho and half dead before we do something about it. If there are 10 men in a room and you ask the Black ones about what kind of health issues they have, 90 percent of them will say, ‘Ask my doctor; he knows.’ “

Through research, she found that African-American male diabetics usually present for care later in the course of the disease and that their diabetes is often complicated by hypertension. Furthermore, she learned that these men often may be unwilling to admit that they are ill because it implies weakness.

In 1999, supported by grants from her organization and other sources, Dr. Wisdom launched the African-American Initiative for Male Health Improvement (AimHi). Using a mobile van, visiting places in southeastern Michigan where health care access is compromised, AimHi staff offer screenings for and education about diabetes, cholesterol, hypertension, and eye conditions. They go to locations ranging from community centers to churches to barber shops. The van visits 60 sites a year.

There are now two AimHi clinics in Detroit. They accept men, women, and children; 50 percent of clinic patients are women who have accompanied men to the center. In the past five years, AimHi has been able to screen more than 8,000 people; at least a third tested positive for either diabetes or hypertension.

Dr. Wisdom explained in 2003: “For the African-American man to reach healthy middle age, he must overcome three major obstacles: infant mortality, adolescent crises, and premature death as a result of chronic disease. We are hoping that through our work, we can see to it that those men who have overcome the first two obstacles can do the same with the third.”

The Henry Ford Health System now has an Institute on Multicultural Health, which endeavors to facilitate research on minority health; provide community-based services to raise health awareness in minority populations; increase provider understanding of culturally appropriate care; identify strategies to improve clinical outcomes and patient satisfaction; and disseminate the findings of its work.

In 2005, the Henry Ford Health System won the Foster G. McGaw Prize for community service, in part because of its efforts to improve minority health.
Community Outreach

The days when hospitals and clinics simply waited for patients to walk in the door are long over. The need to detect and treat illness earlier in its course, to prevent injuries and violence, and to create healthier communities has become imperative. Furthermore, increasing evidence that many patients will not show up on their own has led to a blossoming of outreach efforts. Growing population diversity will give new urgency to those activities.

- In many communities, members of minority groups are in greater need of preventive services

Whether the effort involves flu shots, immunizations for children, screenings for disease, mental health activities, or follow-up to previous treatment, in many cases, minority groups are not reached by traditional health care as much as whites are.

Rates of preventive care by race/ethnicity, 2001

- Some members of the community are unlikely to seek preventive care or other services in traditional health care system settings

It may be that the nearest hospital or clinic is miles away, or that local physicians do not accept the patients’ insurance (if they have any). Fear that immigration status may lead to problems also keeps people away. Furthermore, many people are unaware of the importance of prevention, early detection, and treatment.
Therefore, outreach efforts in diverse communities need to go to where the patients are.

Hundreds of provider organizations now sponsor and/or operate mobile care centers that offer a variety of services; these range from small vans to highly sophisticated vehicles. Outreach workers are also learning to visit locations where patients are likely to be and are likely to be receptive: community centers, beauty salons, barber shops, laundromats, shopping malls, church events, and the like. Indeed, in several cities, health educators are recruiting barbers to provide health information to their customers. Some outreach workers go door to door.

These efforts are particularly important in light of the fact that many members of minority groups live in tight-knit, sometimes isolated communities, and may seek most services within those communities.

Outreach efforts are most successful when members of the targeted community are involved.

Trust is extremely important in health care relationships. The most successful outreach programs include defining specific needs in the community (both in terms of community health assessment and in determining how services are best delivered), as well as involving members of the community in the planning, execution, and evaluation of the activities. This helps to build trust and makes later efforts easier. It also counters suspicion of “outsiders.”
MOMobile Car Seat Program
St. Joseph’s Hospital, Phoenix, Arizona

The Maternity Outreach Mobile Unit, known as the MOMobile, is a sophisticated traveling clinic designed for the provision of prenatal, postnatal, and well-child care. It visits sites in three communities each week.

When then-Governor Jane Hull’s office announced a child car seat initiative in 2002, St. Joseph’s wanted to get involved, especially because young children were often brought to the emergency department with head injuries caused by lack of car seat use. Antonietta Salomon, the MOMobile’s outreach coordinator, was sent to the American Automobile Association, which was heading up the governor’s efforts to increase proper use of seats. Ms. Salomon, a social worker by profession, was trained by the Phoenix Fire Department and became a certified car seat technician. Personnel from other hospitals, fire departments, police departments, and other organizations received the same training.

Every organization that sent an employee for training received free car seats to be given to patients. St. Joseph’s received 50 seats, and soon every MOMobile patient with an infant or young child was taught how to use a seat properly and was given one if needed. However, Ms. Salomon says, “Some of our patients, who are first-generation immigrants, are not familiar with car seats, so they sometimes tend to put their kids’ futures ‘in God’s hands.’ We wanted to ensure that the use of car seats does not appear to be incompatible with their faith.”

Ms. Salomon and Lisa Grimaldi, an emergency department worker who is also a certified car seat technician, decided to arrange for a car seat blessing ceremony in late 2002. News media were informed, patients and community members were invited, and the Phoenix Fire Department brought a bright red fire engine, which was parked in front of the hospital. Bishop Thomas O’Brien of the Phoenix Archdiocese held a mass in the hospital chapel and then blessed the car seats, using a prayer for guardian angels.

The blessed seats were distributed almost immediately, and Ms. Salomon is already seeing results. “I’ve seen a big change in our clients. Many more of them are asking for or buying seats and asking us how to use them. They are not only using them, but also using them correctly.”

Meanwhile, members of the fire department are working to create a small figurine of a car seat that can be blessed and then affixed to any working seat.
Immigrants and Refugees

The United States has traditionally described itself as “a nation of immigrants,” and people born in other countries continue to arrive, often taking low-wage jobs with no health benefits and filling a vital niche in the economy. In December 2002, the Center for Labor Market Studies at Northeastern University issued a study, based on Census data, that found that immigrants were “vital” to economic growth during the boom years of the 1990s; indeed, eight out of ten new male workers were immigrants who had arrived during that decade. The report concluded that without immigrant workers, “male labor shortages would have been widespread in many areas of the country.”

Health care is paramount among the services that new residents need. On the other side of the equation, given critical shortages in many health care professions, immigrants represent a key potential resource as future employees.

The percentage of U.S. residents who are foreign-born is lower than it was for much of the 20th Century

Immigration levels have fluctuated over the past 150 years, largely due to world events and U.S. public policy.

Foreign-born population as a percentage of total U.S. population, 1850-2004

Source: Census Bureau, 2005
The home regions of today’s immigrants are different from those of the past, creating a complex picture

The pattern of immigration has shifted over the past 100 years. In the last century, due to U.S. policy and other factors, immigrants were more likely to originate in Europe; today, they are more likely to come from Latin America and Asia. For health care providers, this change means that greater cultural, religious, and language challenges will emerge as the patient population becomes less “familiar.”

Source of immigration to the United States, 2000

![Source of immigration to the United States, 2000](image)

Although there are traditional sites of immigrant settlement, today’s new residents are moving to many different places

Historically, immigrants settled in areas closest to where they entered the United States, or where they had family, or where people from their home countries lived. As a result, the top five states in terms of numbers of foreign-born residents in 1900 were New York, Pennsylvania, Illinois, Massachusetts, and Michigan. In 2000, the pattern had changed markedly, and the top five states were California, New York, Florida, Texas, and New Jersey.

Beyond these gross figures are singular local patterns. There is a higher percentage of foreign-born residents in Massachusetts than in Arizona. Many Vietnamese immigrants moved to southern Texas. Somalis have established a strong presence in Columbus, Ohio, and also in Lewiston, Maine. In the latter city in 2002, in the state with the second-highest proportion of non-Latino whites in the United States, the city hired a manager of immigrant and refugee programs.

Health care providers are central sources of services and potential employment for immigrants

Health care providers in traditional and newly minted immigrant communities alike are seeking to provide appropriate services to a sometimes-dazzling array of new neighbors. And where tensions might arise between old and new residents, health care organizations can be a valuable source of services for the new community members and of leadership in resolving problems. Health care organizations can also serve, not only as sources of care, but also of information, comfort, and employment.
Lack of public financing for health care for immigrants is a serious problem for many hospitals and other providers

Most foreign-born residents of the United States qualify for Medicare when they reach the age of eligibility, even if they are not citizens. Medicaid is a different matter. Citizens, whether native or foreign-born, qualify for Medicaid if they meet the program’s eligibility requirements. Undocumented immigrants usually are not eligible for Medicaid except for emergency services, and then only if they meet all program requirements. Most legal immigrants are eligible for emergency care under Medicaid if they meet program requirements, but they may not be eligible for other Medicaid services, depending on whether they came to the United States before or after August 22, 1996. Those who arrived before that date are Medicaid-eligible in most states, if they meet all program requirements; those arriving after that time are largely ineligible for five years after entry. Then states may grant them eligibility if they meet all other requirements, or may deny it until such time as they become citizens. There are certain exceptions for aged and disabled non-citizens. Some states use their own funds to provide Medicaid eligibility to non-citizen pregnant women and children. A few states, notably Colorado and Arizona, are embroiled in heated debates over Medicaid eligibility for non-citizen legal immigrants.

The complexity and variability of these rules necessarily make life difficult for providers who serve non-citizen immigrants and refugees. Moreover, the rules are so confusing for many of these patients that they are unaware of their eligibility for certain services, and they may be hesitant to apply for them. It has been reported that many new arrivals are afraid to ask about public programs for fear of deportation, even if they are in the country legally.

The burden on hospitals can be significant. In 2002, the U.S.-Mexico Border Counties Coalition reported that U.S. hospitals on the Mexican border provided $200 million in care to undocumented immigrants; $74 million of that amount was provided by Texas hospitals. In January 2003, the Florida Hospital Association reported that 57 of the state’s hospitals had provided $40 million in unreimbursed care to undocumented patients. The federal government provides Florida with $2 million in funds annually to cover such costs.

For years, hospitals have called for federal assistance with the costs of caring for undocumented residents. In 2003, as part of the Medicare Modernization Act, Congress allocated $1 billion over four years to reimburse hospitals, physicians, and ambulance operators for these expenditures.
Non-citizens are far more likely to be uninsured, regardless of work status

Because of the above-described Medicaid limitations, a high rate of poverty and near-poverty, and a lack of employer-provided health insurance, foreign-born Americans are far more likely to be uninsured than are native-born residents, and non-citizens are more likely to lack coverage than are naturalized citizens. This places a singular burden on those providers who serve non-citizen populations.

Immigrants, and especially refugees, may be hesitant to seek health care services, even for their children

The immigrant population ranges from affluent, highly-educated professionals to low-income, unsophisticated, even illiterate refugees. Their experiences with health care prior to their arrival in the United States have been equally diverse. Some are able to learn about and use the system and acquire coverage almost immediately; for others, it is a daunting experience. Still others may not seek care at all, either because they are unaware of the value of services such as prenatal care, immunization, and screening, or because of a fear of the consequences of contacting providers. For refugees, especially, the concept of government may not be a benign one, and public health services may, therefore, be seen as more of a threat than a help.

Services for immigrants and refugees should be population-specific and sensitive

Programs that are sensitive to the concerns of immigrants and refugees are more successful, especially if they use members of patients’ racial, ethnic, religious, and/or national groups as outreach workers and caregivers. Cultural competence on the part of all health care workers is also essential. Services that are provided in the community, rather than in distant institutions, are less likely to be intimidating and may lessen fear of mistreatment. Furthermore, as new arrivals move up the economic ladder, they are likely to remember where they had early positive health care experiences, and will return to those providers, as patients or as employees.
Somali Refugee Outreach Program
Mount Carmel Health System, Columbus, Ohio

Mariam Dahir lived in Somalia until the brutal civil war there. She sometimes worked as a translator for United Nations forces, but they could not protect her family; her 10-year-old son was killed. She came to Columbus, Ohio, and found work in the housekeeping department at Mount Carmel West Hospital. Several years later, a clinical manager for the health system’s outreach programs asked Mariam if she knew about a large and growing population of Somali refugees living near the hospital. Not only did she know of them; she knew many of them personally. The housekeeping supervisor agreed to “loan” Mariam to the outreach program to provide translation, and the refugee became a caseworker—and an aspiring nurse. “We owe her a huge debt of gratitude,” says the health system’s senior vice-president for mission, Sister Barbara Hahl. Somalis began to settle in Columbus only a few years ago; today, they number at least 50,000, living in concentrated communities within the city. Although the city has welcomed them with other services, their health care needs were not being sufficiently met at first.

Mount Carmel’s outreach van, offering immunizations and primary care, began to visit three Somali communities and a refugee welcome center, and visits new Somali mothers who gave birth at a Mount Carmel facility. Outreach workers also discuss other needs with clients. The health system has established a health center that primarily serves Somali patients and a school for English as a second language.

Mariam Dahir’s work is focused on a Somali community in an apartment complex near Mount Carmel West Hospital. She and her colleagues bring the outreach van or go door to door, checking on the health of residents and asking if the children are immunized. Many clients are war refugees and carry physical and emotional scars. Half the women are raising children without their fathers—men who died in the war, are trapped in African refugee camps, or simply disappeared.

Despite those horrors, these women trust the outreach workers and nurses. They stand in long lines waiting for a visit with a nurse, and patients have been known to return to thank their caregivers, sometimes in newly-learned English. According to Mount Carmel’s Director of Outreach Services, Joy Parker, this community is “an isolated place. Most people in Columbus don’t even know these apartments exist. Thank God the hospital makes it possible for the refugees to come here.”

Just part of our job, says Sister Barbara: “This is what we do in all our hospitals for people in any circumstances. We have an open-door policy; we turn no one away. So this was a natural place for us to go. It is part of our mission, our philosophy, and our history.”
Special Populations

Cultural differences do not stop at race and ethnicity; special populations with specific health care needs exist in many forms. The Kansas School for the Deaf is located in Johnson County, where more than 30,000 hearing-impaired residents make their homes (and where the Olathe Medical Center Charitable Foundation operates an award-winning program of services for them). There are significant Amish communities in 22 states, especially Ohio and Pennsylvania. San Francisco and Northampton, Massachusetts have large gay populations. Many cities and some rural areas have subpopulations of substance abusers.

- **In providing services to special populations, one size doesn’t fit all**
  
  Programs that work with larger, more “traditional” special populations may not be as successful with these smaller groups. Often these are insular communities, where there may be suspicion about “outsiders.” Especially if they have experienced mistreatment or discrimination in the past, members of some of these communities may be resistant to traditional health care approaches. Programs, therefore, must be targeted to the particular situation if they are to be effective, and, whenever possible, members of the population should be involved in the planning, execution, and evaluation of those programs.

- **Special populations often have different health problems and health status indicators**
  
  For reasons that can be genetic, environmental, cultural, or historical, special populations face specific health risks. For example, although the pattern of AIDS is shifting toward heterosexuals, in the early days of the epidemic, gay men were at greater risk of contracting the disease. Some groups have higher rates of tuberculosis. Intravenous drug abusers have a higher chance of contracting hepatitis C and other liver diseases. Commercial sex workers are more likely to have sexually transmitted illnesses and AIDS.

  Health assessments (conducted gently) are critical to ensuring that the health care needs of special populations are met. Providers need to dig deeper into the fabric of their communities to unearth groups that may not be found through traditional demographic analysis.
The Amish Initiative
Punxsutawney Area Hospital, Punxsutawney, Pennsylvania

Punxsutawney Area Hospital is a 50-bed rural facility whose service area includes more than 3,000 Amish residents. The Amish are a conservative branch of the Mennonite Church who do not use electricity or automobiles and reject most modern technologies and many contemporary practices. They live in insular communities, use horses and buggies for transportation, work mostly in agriculture, and have large families. Unfortunately, they are also at higher risk of hemophilia, dwarfism, measles, PKU, tuberculosis, and glutaric aciduria than the general population.

In 1995, the staff of Punxsutawney Area Hospital, after meeting with Amish leaders and residents, concluded that “not only did the hospital not understand the Amish people, but we were not meeting their needs for services,” according to Ben Hughes, Director of Professional and Corporate Services for the hospital. Problems ranged from the difficulties that hemophiliac patients faced in getting to the hospital using horses and buggies to a serious measles outbreak. Hospital CEO Dan Blough launched the Amish Initiative: “A simple plan for a simple people.”

Working with Amish leaders, the hospital staff conducted a needs assessment (which was difficult, given the closed nature of the community), identified barriers to care, and went to work. All hospital employees were (and are) educated in Amish cultural and health care issues. Although many Amish are eligible for Hill-Burton funds for their care, they refused to apply for them because their faith does not acknowledge government programs. In 1996, the hospital petitioned the Department of Health and Human Services for a waiver for Amish patients, which was granted. As they wish to pay for their care, the Amish are allowed a heavily discounted price by the waiver.

In 1999, the hospital established a primary care clinic in the middle of the Amish settlements. Because Amish women insist on being treated by a female physician, the hospital recruited a husband-and-wife physician couple to Marion County. The physicians have a working farm, which makes them welcome in this agricultural area. The program is funded entirely by the hospital and costs $900,000 a year.

As a result of the Amish Initiative, the measles epidemic ended. Hemophiliac patients are often able to receive treatment in their homes from visiting nurses. Emergency department visits are down, and primary care visits and screenings are up.

Hughes says, “We believe that embracing diversity is part of our mission. We do not have qualifying statements about that mission. To solve the myriad problems associated with providing care to the Amish population, we had to first rethink our views and embrace philosophies of care that may be different from our own. In doing this, we were positioned to realize success.”
Culture and Language

Although racial and ethnic differences can cause problems because of racial tensions and historical sensitivities, many of the important challenges posed by an increasingly diverse society involve issues of culture and language. What one group believes is rejected by another group; what one subpopulation sees as acceptable or even laudable is considered venal by another. Furthermore, subtleties of language are lost when patient and caregiver speak different tongues, especially if interpretation services are inadequate or unavailable. In a health care system where the majority of the caregiving professionals speak English as their first language, the collisions can be significant—and sometimes dangerous.

■ There is a growing need for cultural competence in the delivery of health care services

Cultural competence, according to a Commonwealth Fund report, is defined as the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs (Joseph R. Betancourt, Alexander Green, and J. Emilio Carrillo, Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches, October 2002). Although some providers show a sincere or even profound commitment to this concept, the performance of the health care system in this regard has been less than excellent in the eyes of many members of minority patient populations.

Percentage of minorities reporting difficulty in communicating with physicians, 2001

<table>
<thead>
<tr>
<th>Minority</th>
<th>Difficulty Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>19%</td>
</tr>
<tr>
<td>White</td>
<td>16%</td>
</tr>
<tr>
<td>African-American</td>
<td>23%</td>
</tr>
<tr>
<td>Latino</td>
<td>33%</td>
</tr>
<tr>
<td>Asian-American</td>
<td>27%</td>
</tr>
</tbody>
</table>

Source: Commonwealth Fund, 2002
Furthermore, many patients believe—rightly or wrongly—that their difficulties in communicating with providers and receiving needed care are rooted in racial or ethnic discrimination.

Speaking of the African-American patients in his clinic in Pittsburgh, Bruce Block, M.D., who is Jewish, has said, “There are times when they are in the exam room when they feel like they’re being treated by the enemy” (American Medical News, January 13, 2003, page 1). Historical patterns of discrimination, major differences in race and ethnicity between patients and health care professionals, and demonstrated differences in care for various subpopulations all feed this perception. This obviously has profound implications for providers seeking to conduct community outreach, offer preventive care programs, and provide follow-up services, as well as for outcomes of care and malpractice litigation.

For many patients, the discomfort is rooted in a lack of mutual understanding of strongly held values and beliefs.

Whether it involves female patients who feel they cannot disrobe in the presence of a male physician; immigrant patients who think that the pills they are given are “too large” for them and, therefore, cut them in half; religious differences; dietary rules; or a lack of knowledge of which days are holy to which faith, many minority patients believe that they are not being treated with either understanding or respect.
As a result, some patients may believe that the quality of their care is substandard—and that may be the case

Although it undoubtedly happens, most health care professionals would not knowingly provide sub-optimal care to a patient because of a difference in race, ethnicity, or religion. However, data on disparities in the provision of care show that differential quality for different patient populations is a fact. Whether it is fact or perception, the belief that quality of care is dictated by the patient’s or provider’s racial or ethnic background can affect not only the quality, but also the outcomes, of care. As a result, objective oversight of both delivery and outcomes of care is particularly important for providers serving diverse population groups.

Latinos are less satisfied with the quality of their care

![Diagram showing satisfaction rates for different groups](source: Commonwealth Fund, 2002)

Even if there is no cultural conflict, problems involving language can affect the quality of the patient’s experience and of care itself

The 2000 Census found that nearly one in five U.S. residents speaks a language other than English at home (although this does not imply that these people do not also speak English). Those who speak Spanish at home account for about 60 percent of minority-language speakers; however, many other tongues are involved. For example, more than 100 languages are spoken by residents of Los Angeles County. This is obviously a challenge for health care providers, especially smaller facilities, clinics, and physicians’ offices, where the cost of interpretive services can be prohibitive. Some provider organizations offer instruction in English as a second language to residents in their service areas, which is a constructive response.

Percentage of U.S. residents speaking English or another language at home, 2000

![Pie chart showing language proficiency](source: Census Bureau, 2002)
Health care providers are mandated by federal policy to provide adequate access to care for non-English speakers

Title VI of the Civil Rights Act of 1964 specifically prohibits any entity receiving federal funds from discriminating on the basis of race, color, or national origin. This applies to people whose English-language skills are weak or nonexistent. Although a heated policy battle continues over whether professional health care interpreters must always be made available, the general consensus is that this option is far preferable to the use of family members, especially children. In addition, providers’ lack of ability to communicate complex health care information and patients’ inability to comprehend it can obviously affect the quality and safety of care.

Literacy, in terms of ability to read (in any language) and the ability to understand health care information, is another significant problem

It is estimated that 10 million people in the United States cannot read in any language, and that another 40 million cannot read English at a 5th-grade level. One estimate suggests that one in three Americans has a limited ability to read and/or understand health care information. The American Medical Association estimates that 90 million patients each year do not understand what they are told by health care professionals regarding their care, the results of which cost $73 billion annually. Health care providers should always determine, in a polite way, if a patient can read before relying on printed health education, self-care, or prescription drug materials.
DIVERSITY Rx
www.DiversityRx.com

Diversity Rx is an Internet Web site offering information, materials, and models to assist health care providers in extending culturally competent and linguistically appropriate care to patients. This comprehensive online clearinghouse includes, among other services:

- Model programs in cultural competence and language interpretation services
- Information on state and federal policies affecting cross-cultural health care
- Profiles of training programs and curricula
- Research on cross-cultural health care issues
- On-line interactive forums for policymakers, managed care organizations, health care language interpreters, and researchers
- Development of and assistance with conferences and workshops focusing on health care diversity and language issues
- On-site and telephone technical assistance and consultation services
- Referrals

Says Julia Puebla Fortier, editor of Diversity Rx, “All major health care organizations—including the National Committee on Quality Assurance, the Joint Commission, and the Institute of Medicine—have highlighted physician-patient communications as critical to avoiding medical errors. These same organizations now recognize the increased risk when physicians (or other providers) and patients don’t speak the same language. Just one or two mistranslated words from a well-meaning child or an untrained interpreter can make the difference between an accurate diagnosis and malpractice.

“Many physicians and the American Medical Association object to having to use interpreters for non-English-speaking patients. But research published in the most respected journals shows that using children, or friends, or the janitor, frequently leads to communication errors that risk misdiagnosis, misunderstanding, and compromise of patient safety. My guess is that no conscientious health care provider wants to bear that kind of burden.”
Insurance and Access

Because members of minority groups are far more likely to be uninsured, the most obvious insurance implication of a more diverse patient population is that fewer Americans may have coverage in the future.

■ Members of minority groups, especially Latinos, are far less likely to have private health insurance than non-Latino whites

The reasons for this differentiation in health insurance status are many, and include the much-higher percentage of minorities whose income is below the federal poverty level, the fact that employers in many of the sectors where minorities are commonly employed do not or cannot afford to offer health insurance, the transient or part-time nature of their employment, the significant proportion who are self-employed and cannot afford to purchase coverage on their own, and government restrictions on Medicaid eligibility for non-citizens.

Lack of health insurance coverage by race/ethnicity, 2003-2004

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Coverage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latino (any race)</td>
<td>32.7%</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>21.3%</td>
</tr>
<tr>
<td>Native American</td>
<td>29.1%</td>
</tr>
<tr>
<td>Asian-American</td>
<td>17.8%</td>
</tr>
<tr>
<td>African-American</td>
<td>19.6%</td>
</tr>
<tr>
<td>Non-Latino Whites</td>
<td>11.2%</td>
</tr>
<tr>
<td>All</td>
<td>15.7%</td>
</tr>
</tbody>
</table>

Source: Census Bureau, 2005

■ The pattern of uninsured residents closely follows the pattern of minority populations

Some states with high percentages of minority residents—such as Florida, New Mexico, Oklahoma, and Texas—are more likely to also have high percentages of uninsured residents. Similarly, states with high percentages of white residents—Minnesota, Iowa, Maine, and Vermont among them—have much lower proportions of uninsured residents.

Uninsured, selected states, 2003-2004

<table>
<thead>
<tr>
<th>State</th>
<th>Coverage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>15.7%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>8.8%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>9.9%</td>
</tr>
<tr>
<td>Maine</td>
<td>10.2%</td>
</tr>
<tr>
<td>Vermont</td>
<td>10.3%</td>
</tr>
<tr>
<td>Iowa</td>
<td>10.4%</td>
</tr>
<tr>
<td>Texas</td>
<td>24.8%</td>
</tr>
<tr>
<td>New Mexico</td>
<td>21.5%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>20.1%</td>
</tr>
<tr>
<td>Montana</td>
<td>19.2%</td>
</tr>
<tr>
<td>Florida</td>
<td>19.0%</td>
</tr>
</tbody>
</table>

Source: Census Bureau, 2005
However, even members of minority groups who are insured can have access problems

For people new to the United States and for those who do not read or speak English well (if at all), health insurance can be a very confusing matter. More than a few new immigrants and members of minority communities have been victimized by insurance fraud. Furthermore, in many minority communities, physicians may not accept certain kinds of insurance—if there are physicians in the community at all. Also, managed care has proven to be difficult to navigate even for well-insured, English-speaking, middle-class enrollees; for others, the barriers to access can be significant, whether self-inflicted or resulting from insurers’ policies. One health plan found that some of its minority or non-English-speaking patients sought to leave the hospital before physicians thought it wise, because the patients mistakenly believed that they would have to pay out of pocket for every day that they were hospitalized.

And as “consumer-driven” health insurance (through which employees or individuals choose their own coverage based on a series of offerings) becomes more common, minority patients, like all other patients, could find it difficult to navigate.

Insurance products need to be appropriate for different populations, and information about how to use insurance should be readily available to these patients

Insurance information should be written in the languages that patients are able to read—if they are able to read. If literacy is an issue, reliable counselors should provide information orally. A related issue is computer literacy; as health care becomes more dependent on the Internet, patients who are not “online” should not be forgotten. Insurers and governments should make every effort to provide information to potential customers, policyholders, and public enrollees about their coverage, what their benefits are, how to use coverage and providers, and how the system works. There should also be adequate provision of such information by telephone or other means for insured persons who have questions. Although it is not their responsibility, providers may be called upon to provide assistance in this area.

Providers should ensure that patients are aware of how insurance works, how to use it, and what remedies there are for problems

Those who provide health care can play a valuable role in seeing to it that persons from diverse backgrounds know how to use their insurance, what their rights are, and how to protect themselves in case of problems.
Kaiser Permanente is a non-profit integrated health system serving 8.3 million members in nine states and the District of Columbia. The system’s membership is a microcosm of national and world diversity, representing more than 130 spoken languages and an equally broad range of beliefs, values, traditions, and behaviors. To serve this diverse membership, the organization has initiated a series of efforts involving training, research, development of practical tools, and formation of coalitions with organizations outside of Kaiser Permanente.

Through the leadership of its National Diversity Council, Regional Diversity Councils, and National Diversity Department, the system has launched a number of initiatives to advance linguistically and culturally competent care. Among these are:

- Publishing culturally competent care handbooks to provide knowledge and tools for providers regarding specific diverse populations

- Sponsoring numerous conferences and workshops to educate providers, staff, and communities

- Establishing an Institute for Cultural Competence with attendant Centers of Excellence in Culturally Competent Care, which are health care facilities that develop and utilize culturally-influenced clinical practices for the delivery of care that are responsive to the unique cultural beliefs and health needs of diverse populations

- Implementation of national interpretation and translation service initiatives, including a unique Health Care Interpreter (HCI) Certificate Training Program that addresses the lack of trained, qualified interpreters in health care. Funded in part by the California Endowment and the Robert Wood Johnson Foundation, this one-year college program is practice-oriented and seeks to increase community capacity for providing high-quality health care interpretation. The program has graduated approximately 800 students as of 2005. As a result of this program, a trained and qualified pool of health care interpreters is now available, representing the Spanish, Portuguese, Cantonese, Mandarin, Vietnamese, Russian, Korean, Japanese, Armenian, and Farsi languages.

Kaiser Permanente has also implemented a Qualified Bilingual Staff Model that is designed to embed culturally and linguistically competent skills within the organization’s work force. It has assessed, trained, and certified approximately 3,000 employees across the system.
Although the majority of Medicaid beneficiaries are white, a disproportionate number are members of minority groups

Ethnic and racial diversity in Medicaid enrollment varies by state. However, in many states, a disproportionate number of beneficiaries are members of minority groups. This, of course, is directly related to the size of the state’s minority populations and the state’s Medicaid policies.

Rate of Medicaid enrollment by race/ethnicity, 2003
(For persons under 65)

Because the Medicaid program can be difficult to understand for anyone, special care should be taken to ensure that minority beneficiaries understand their benefits, rights, and responsibilities

A cartoon once depicted a wise man who lived on top of a mountain explaining to a visiting pilgrim, “I can explain to you the secret of life, but I don’t dare try to explain how the Medicaid program works.” New citizens born elsewhere, non-English-speaking beneficiaries, those with insufficient education or language skills, and other vulnerable Medicaid patients may need special help to understand the program’s complexities. This problem has been recognized by public, private non-profit, and private for-profit organizations that are now involved in efforts to enroll eligible beneficiaries in public programs.
Medicaid managed care can be even more difficult for some patients to comprehend

In the 1990s, many state Medicaid programs, desperate to control rising costs, turned to mandatory enrollment in public or private managed care programs as a solution. As of 2003, 59.1 percent of the 43 million total Medicaid beneficiaries were enrolled in some kind of managed care.

Some states with diverse populations are leaders in Medicaid managed care, with Tennessee, South Dakota, Arizona, and Michigan among those with the highest percentage of beneficiaries enrolled in plans.

Because abuses have occurred in the past—including denial of access, inappropriate limits on needed care, and a lack of culturally and linguistically appropriate services—care should be taken to ensure that all Medicaid managed care members are protected.

With virtually all states wrestling with budget deficits and increased Medicaid spending, the program’s beneficiaries are at risk

As of 2004, at least 44 of 50 states were in deficit; most had cut Medicaid spending in one way or another, and many had cut it twice. In 2005, Congress tentatively approved $10 billion in Medicaid cuts as part of its overall budget resolution, although opponents promised an aggressive fight. The terrible costs of Hurricanes Katrina and Rita promised to make this debate even more fierce.

For most minority Medicaid beneficiaries, the program is the end of the line; they have extremely low incomes, and, if they are working, their employers do not offer coverage. Erosion in Medicaid coverage, especially for low-income minority populations, can only result in more uninsured Americans.
The catastrophe at the World Trade Center on September 11, 2001 changed virtually every aspect of American life. Among these was a profound effect on the state’s Medicaid program and the city’s population. Among the services that were lost when several buildings were destroyed was the telephone communications system over which Medicaid information was processed. Thus, although enrollment and eligibility information was retained, it could not be processed or communicated electronically. In addition, although some of the dead were corporate executives and stockbrokers, others were low-income workers, many of them immigrants, whose families were left without a breadwinner—or health insurance. Furthermore, the city lost 87,000 jobs almost overnight.

A massive effort by the state of New York, with federal approval, resulted in the establishment, in slightly more than a week, of the Disaster Relief Medicaid (DRM) program, designed to enroll New Yorkers eligible for Medicaid. The city government administered it and many philanthropies (including the United Hospital Fund of New York), providers, health plans, and community organizations worked to support the effort. Using “radically simplified” one-page paper applications and bypassing income documentation standards (after all, as James M. Tallon, Jr., president of the United Hospital Fund, observed, “This isn’t the offshore tax shelter crowd”), DRM also determined eligibility very quickly—often on the spot—and issued authorization cards immediately. The program enrolled almost 350,000 people in four months.

Although complete data on the new enrollees is not yet available, a small study subsidized by the United Hospital Fund determined that Latinos were the largest racial or ethnic group of applicants, followed by African-Americans (or black people who were not born in the United States), Asians, and South Asians. At some enrollment sites, ethnic Asians constituted between 50 percent and 84 percent of applicants; at one hospital, there was so much interest that enrollment was hampered by a lack of Chinese-language interpreters.

Obviously, the majority of these applicants were not directly related to families affected by the September 11 attacks. However, a court decision handed down in June 2001 required New York state to make Medicaid coverage available to all eligible legal residents, regardless of their citizenship status. That decision, coupled with one of the worst disasters in the history of the United States, opened the door to coverage for low-income minority working families.

As Mr. Tallon later noted, “If you design an eligibility process that is easy from the beneficiaries’ point of view, they will sign up. This program met the beneficiaries on their terms, not ours.”
Work Force

(Note: In 2002, the American Hospital Association released a comprehensive report on hospital and health care work force issues, In Our Hands: How Hospital Leaders Can Build a Thriving Work Force. Because of the existence of this document, comments on work force issues in this paper are limited.)

The top ranks of clinical health professions are far less diverse than the patient population

The ranks of physicians, pharmacists, laboratory technicians, and especially nurses are far less diverse than the general population; in some states, the mismatch is of major proportions. As the AHA report noted, “Attracting a more diverse work force is a hospital business imperative.”

Demographic profile of selected health professions, 2001

This mismatch means, among other things, a lack of role models and mentors for members of minority groups, a probable concern that the chances of advancement in one’s chosen health care profession are limited, and the strong possibility that “the best and the brightest” will seek careers in other economic sectors.
Nursing can serve as an example of lagging diversity in the health professions

Nurses in the U.S. health care system are far more likely to be white than members of the general population; although Asian-Americans are represented in the general population and in nursing in about equal proportions, non-Latino African-American and Latino nurses lag far behind the proportions of their population groups in the overall U.S. population.

Indeed, registered nurses are far more likely to be non-Latino whites (and to be female) than members of virtually any other high-ranking health care profession.

The reasons for this are complex and include historical patterns of limited educational opportunities, misperceptions of the possibility of entry into the profession, the ability to afford nursing education, and failures of primary and secondary schooling.

However, nursing should not be singled out; other high-ranking health care professions have similar patterns, although not as pronounced. But the fact is that members of those health care professions that are the most admired, best-remunerated, and most powerful are still disproportionately non-Latino white, and, in the case of nursing, disproportionately single-gender as well.
In an increasingly diverse society, a health care system that suffers periodic, severe staff shortages must be able to recruit workers from diverse backgrounds

Many health care organizations are currently suffering shortages of a wide range of health care workers, from nurses to pharmacists to technicians. Although the reasons for these shortages are multiple and complex, it must be admitted that a failure on the part of health care professions and health care employers to reach out to potential employees who are members of minority groups is one of the primary factors.

This means that efforts to attract young people to the health professions must start at an early age; that outreach must include people with less-than-perfect English skills; that health care must compete with other sectors for immigrants and others new to the job market; and that recruitment must take place in a broader array of sites than the traditional ones. This includes reaching out to potential employees while they are still in secondary or even primary school.

A diverse work force requires an employment setting where non-discrimination and a welcoming environment are the norm

It is one thing to recruit a diverse work force; it is another thing to retain its best members. Among the efforts required to retain the best workers are a top-down, sincere organizational commitment to nondiscrimination in recruitment, retention, and advancement; a zero-tolerance policy regarding discriminatory behavior; and continuous training of all staff in proper behavior in a multicultural and multilingual environment. These efforts not only help to promote a harmonious work force, but also improve patients’ experiences.
International Rescue Committee Hiring Program
Parkland Memorial Hospital, Dallas, Texas

War and violence have been part of life in Sudan for longer than anyone cares to remember. Among the victims of the seemingly endless conflict were young men known as the “lost boys,” who fled into unoccupied desert areas and died of starvation, injury, illness, or even attacks by predatory animals. The lucky ones found their way to refugee camps—homeless, without family, and penniless.

The International Rescue Committee (IRC) is a non-profit organization that seeks to find resettlement opportunities for people such as the “lost boys.” Its requirements are strict: resettled refugees must become self-sufficient in six months or less, and they must learn to speak workable English in that time. The IRC provides a new start each year for 10,000 people who would not be safe in their home countries.

In 2001, the IRC asked Parkland Memorial Hospital if it would be willing to participate in the resettlement and employment of some of the young survivors of the terrors of the Sudan. Parkland’s response was a resounding “yes.”

Danny Davila, Parkland’s employment manager, reports that the several dozen Sudanese refugees who have been hired have proven to be “dependable, reliable, hard-working, and ambitious.” They work as patient care assistants, linen services technicians, environmental services technicians, and dietary aides.

The transition is not always smooth. Some of the new workers did not know how to eat with a knife and fork, and their English was not always satisfactory. The IRC provided them with counselors, language interpretation, and other services, and tried to pair them with previously settled refugees who could serve as mentors. Parkland, meanwhile, offered instruction in English as a second language.

William Namomauot, whose parents were killed in the Sudan violence when he was 13, is one of the former “lost boys,” now working in Linen Services at Parkland. “It is God’s wish,” he says; “I am so happy to be here.”

Approximately 30 refugees are working at Parkland through the hospital’s partnership with the IRC. Richard Hoelscher, associate director of Linen Services, says, “They want to learn everything they can and are interested in just about anything. It is wonderful to have people on our team who are so enthusiastic about work.... They show us that our lives are easy compared to other parts of the world.” Mr. Davila adds, “They are excited about their possibilities.”

Parkland also receives refugee referrals from Catholic Charities of Dallas.
Health Care Leadership

In the end, the ability of health care providers to respond to growing population diversity will depend in large measure on the quality and nature of the leadership of their organizations. Although there are some outstanding programs seeking to broaden the ranks of leadership, the fact is that the demographics at the top have remained distressingly non-diverse. As a May 2000 cover story in *Hospitals and Health Networks* noted, “We talk about executive diversity. We form committees. We hire recruiters. And nothing changes.”

In 1997 and again in 2002, a cooperative research effort among the American College of Healthcare Executives, the Association of Hispanic Healthcare Executives, the Institute for Diversity in Health Management, and the National Association of Health Services Executives examined the career attainments of men and women of various ethnic groups who were members or affiliates of the participating organizations. Although no group of women was well represented in the highest positions, white and African-American women were most likely to be CEOs; white women were also significantly more likely to be COOs or senior vice-presidents.

**Job positions of female ACHE, NAHSE, and AHHE members, 2002**

Among men surveyed in the study, whites were far more likely to be CEOs; the distribution of those in COO and senior vice-president positions was relatively equal.

**Job positions of male ACHE, NAHSE, and AHHE members, 2002**

Source: ACHE, 2003
The top jobs in health care are still disproportionately held by white men

Although this is a pattern common in almost all areas of American society, it has particularly negative implications for health care. For one thing, prospective health care leaders may be unwilling to commit to careers in a field that is unlikely to offer them the opportunity to fulfill their potential. For another, succession planning will suffer if current health care organization leaders are not willing or able to broaden the pool of aspiring executives.

Governance may be part of the problem

Because governing boards choose CEOs and often have a say in the selection of other top executives, the racial, gender, and ethnic composition of boards may directly affect that selection. Unfortunately, data on the diversity of governing boards in health care (or lack thereof) are, for all intents and purposes, nonexistent. Nonetheless, anecdotal evidence would suggest that, despite the fact that trustees are supposed to be the bridge between the community and the health care organization, many boards look nothing like the patient populations they serve.

Fortunately, hospital leaders are working to increase racial and ethnic diversity on boards of trustees. Prominent among these efforts is the Greater New York Hospital Association’s Center for Trustee Initiatives and Recruitment, founded in 2005 with the mission of increasing the pool of qualified minority candidates for hospital trusteeship positions. The GNYHA also has an Advisory Task Force on Diversity in Health Care Leadership, which provides guidance and support to health care organizations in New York in the areas of greater board diversity; more diversity in senior management; and improvement of access to high-quality care for all patients, especially those with limited English proficiency.
As part of an ongoing effort to increase diversity in health care leadership, in 2005 the Greater New York Hospital Association (GNYHA) established the Center for Trustee Initiatives and Recruitment. Its mission is to promote diversity in trustee representation in order to enhance the quality of services for the increasingly diverse patient populations served by its member hospitals.

Mary Medina, the Center’s executive director, is a social worker and also an attorney with 20 years’ experience in health care. She seeks out minority candidates from investment firms, business organizations, and professional associations. “We are looking for individuals who have a great deal to offer in terms of expertise,” she says. Despite their accomplishments, however, “Many minority professionals tell me that they have been approached about serving on school boards and social service organization boards, but not hospital boards.”

One candidate is Julio Urbina, Ph.D., M.P.H., senior program officer, the Fan Fox and Leslie R. Samuels Foundation, Bronxville, NY. He has specific goals for trusteeship: “If a hospital board only wants someone with a lot of money, I have neither the resources nor the desire to serve under those circumstances. If, however, they want someone to help them think about how to serve their community differently, then I am happy to serve. But I don’t want this to be tokenism. I grew up in Queens and attended an Ivy League school and earned a doctorate, and I am not representative of a poor Latino community. My interest is in disparities in health care for minorities, and I think I have a better sense of these needs than some others might. I want my participation to have an effect on hospital policies and programs that affect communities.”

Anne C. Beal, M.D., M.P.H., senior program officer for quality of care for underserved populations at the Commonwealth Fund in New York City, is an African-American pediatrician who has also expressed interest in board service. “Being a person of color and a physician, and having been an administrator, a researcher, and a front-line health care worker, I think I can really speak to the issues that are important for hospital systems from the perspective of rich and well-informed experience. I think leadership in providing better service to diverse and undeserved populations is absolutely critical. But I have never been in a situation where my work and input did not make a difference, and I do not want this to be an exception.”

Medina is confident about the Center’s efforts: “We have been missing out on the opportunity to recruit individuals who are successful in their business enterprises and who have a wealth of expertise in finance, management, and other areas critical to hospitals. Most important, these are people who very much want to serve, and who feel a need to give back to their communities.”
How will health care attract “the best and the brightest” if leadership opportunities are not there?

Health care in the early 21st Century confronts a daunting array of issues, challenges, and full-blown crises. Among these are the needs, demands, and questions of the changing patient population. It should not be necessary that every administrative team, every medical and nursing staff, and every governing board exactly reflect the demographic profile of the community or communities the organization serves; but if there is a total disconnection between those at the top, those working in the rest of the organization, and those in the community, the chances of the most talented and committed future leaders choosing health care as a career are greatly lessened.

Ironically, the overall health care work force is highly diverse; a majority of its members are women, and in many areas, minorities are heavily represented. However, these areas tend to be lower-echelon departments such as housekeeping, food service, plant management, and security. Thus, when potential minority employees look for role models among the organization’s leaders, they often find few, if any. They are therefore more likely to seek positions in other fields, where advancement seems more possible. If health care organizations wish to be the providers—and employers—of choice, diversity in leadership is essential.
The Institute for Diversity in Health Management was founded in 1994 in response to a study that found that members of minority groups held less than 1 percent of top health care management positions. Although it remains an independent organization, the Institute affiliated with the American Hospital Association in 2002.

The Institute’s hallmark initiative is a Summer Enrichment Program, through which undergraduate and graduate minority students with an interest in health care leadership are provided with scholarships; more than 500 students have completed this program. The Institute has also placed promising minority health care executives in residencies and fellowships in organizations nationwide.

Another Institute service, www.diversityconnection.org, provides information on job opportunities, fellowship and grant programs, and other activities to interested members of minority groups.

According to its mission statement, the Institute “collaborates with educators and health services organizations to expand leadership opportunities to ethnic minorities in health services management. The mission of the Institute is to increase the number of ethnic minorities in health services administration and to improve opportunities for professionals already in the health care field.”

Frederick D. Hobby, President and CEO of the Institute, comments, “One of the issues that we have been working very hard on is helping organizations realize that there is not only a moral imperative for diversity in leadership, but that there is also a business case for diversity. Organizations need to adopt these perspectives and build their programs, based on the realities that surround them in the communities they are serving. The business case is different for every organization, depending on its circumstances and the demographics of its markets. But a key consideration is how diversity is linked to the challenge of trying to decrease racial and ethnic disparities in health status, which we see as very much a leadership issue. Many times, when health care organization leaders talk about the issue of disparities, they focus on clinical interventions and access to care, which are, of course, very important. But unless there are people at the table who have first-hand knowledge of minority health issues and can contribute to making resource allocation and planning decisions regarding patient populations that are becoming increasingly diverse, then those organizations are not going to be able to change.”
Health care organizations can lead in responding and adapting to population change, or they can lag behind; it is their choice

The changes that are coming to American society as a result of population shifts are inevitable, are accelerating, and are profound. The choice facing every health care organization is whether it will be a leader in developing creative responses to these changes, whether it will do the minimum required, or whether it will try to resist the winds of change entirely. It is each organization’s choice; but each organization’s future depends on that choice.


Cooper, Rachel; Sheinbaum, Anne-Mindy; and Dutton, Melinda. *Disaster Relief Medicaid Enrollment in the Community Medicaid Offices: How Did it Work?* New York City: United Hospital Fund of New York, March 27, 2002.


*Health Affairs*. Vol. 24, No. 2, March/April 2005. This issue was devoted to studies of racial and ethnic disparities in health status and possible solutions.


New York City Health and Hospitals Corporation. HHC’s experience with enrollees of Disaster Relief Medicaid. Press release, August 2002.


____________. Number of foreign-born up 57 percent since 1990, according to Census 2000. Press release, June 4, 2002.

____________. One in five U.S. residents either foreign-born or first generation, Census Bureau reports. Press release, February 7, 2002.


Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
2101 E. Jefferson St., Suite 501
Rockville, MD 20852
Telephone: (301) 594-1364
www.ahrq.gov

AHRQ awards grants and supports and disseminates research in a variety of areas involving the health of minorities, including special efforts geared toward reducing racial and ethnic disparities in health status.

American Hospital Association
One North Franklin
Chicago, IL 60606
(312) 422-3000
www.aha.org (click on Diversity/Disparities on the right-hand side)

AHA’s key issue page on racial and ethnic disparities provides a wide variety of resources for hospitals from AHA and other sources, including self-assessments, case examples, and tools to address cultural competency and the elimination of racial and ethnic disparities.

The Commonwealth Fund
One East 75th Street
New York, NY 10021-2692
(212) 606-3800
www.cmwf.org

The Fund supports research and issues a wide range of publications focusing on the health, insurance status, and quality of care of many population subgroups, including women and racial and ethnic minorities.

Diversity Rx
www.diversityRx.com

This Internet site provides detailed information on federal policies involving language interpretation and cultural competence in health care, as well as providing information on model programs and offering conferences and consultations.
Health Research & Educational Trust
One North Franklin
Chicago, IL 60606
www.hret.org/hret/programs/disparities.jsp

HRET is the independent research and education affiliate of the AHA. Their site provides access to their research on racial and ethnic disparities in health care and their work with a consortium of six leading hospitals and health systems to develop ways to eliminate disparities.

Health Resources and Services Administration
Bureau of Health Professions
5600 Fishers Lane
Rockville, MD 20857
(301) 443-5794
www.bhpr.hrsa.gov

The Bureau conducts studies, awards grants, holds conferences, and supports other activities involving the health care work force.

The Henry J. Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025
(650) 854-9400
www.kff.org

Washington Office:
1330 G Street, NW
Washington, DC 20005
phone: (202) 347-5270
fax: (202) 347-5274

The Foundation sponsors studies and reports, supports conferences, offers news and analysis services on-line, and provides other information on the health and insurance status of minorities (especially Latinos), health care work force issues, state-level demographics and health statistics, and immigration topics.
Institute for Diversity in Health Management
One North Franklin
Chicago, IL 60606
(800) 233-0996
www.diversityconnection.org

The Institute works to promote greater racial and ethnic diversity in the management and executive ranks of health care organizations, cosponsors studies in this area, supports a minority internship program, and presents employment opportunities through its Internet site.

Institute of Medicine
National Academy of Sciences
2101 Constitution Ave. N.W.
Washington, DC 20418
(202) 334-2352
www.iom.edu

The Institute conducts and releases studies of insurance status, access, and quality of care, and has also conducted detailed recent analyses of racial and ethnic disparities in health status.

Population Reference Bureau
1875 Connecticut Ave., N.W.
Suite 520
Washington, DC
(202) 483-1100
www.prb.org

Using data from the Census Bureau and other sources, the Bureau conducts studies and issues a wide range of publications on domestic and international demographics topics, including the health care work force and health status issues of population subgroups.

United States Census Bureau
U.S. Department of Commerce
Washington, DC 20230
(301) 763-3691
www.census.gov

The Bureau collects and analyzes myriad population data and issues data sets, reports, studies, charts, graphs, and other products. Almost all of them are available on its Internet site.
Emily Friedman is an independent writer, lecturer, and health policy and ethics analyst based in Chicago. She is an adjunct assistant professor at the Boston University School of Public Health and a consultant on information dissemination to the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. She is also an honorary lifetime member of the American Hospital Association and a Fellow of the Academy for Health Services Research and Policy (AcademyHealth). Ms. Friedman has an abiding interest in population changes and their impact on society in general and the health care system in particular, and has written and lectured on these topics for many years.
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Emily Friedman
The data presented in this briefing paper are drawn from reliable data sources. However, data collection procedures change over time, and as a result, some of the data in this paper do not exactly match other data. The most important change is that, prior to 1990, the decennial census did not count Latinos as a separate ethnic group; as a result, many pre-1990 figures include Latinos in other groups, usually whites or Other. Data on Native Hawaiians and Pacific Islanders were not broken out until the 2000 census; previously, they were included with the Asian-American population. Furthermore, according to Census Bureau standards, Latinos may belong to any racial or ethnic group, and as a result their data are often reported separately—but not always. In some charts presented in this report, Latino data are presented separately; in other cases, they are not. This is due to differences in data sources. Also, in some cases, totals do not add up to 100 because of rounding. Finally, the latest data available were used whenever they could be found; in some cases, they are not all that recent, either because of a time lag between the collection and reporting of information, or because the study was not repeated at a later time.

These minor statistical differences do not significantly affect the basic information, trends, or conclusions of this report.

—E.F.