HEALTHCARE WORKFORCE DIVERSITY: DEVELOPING PHYSICIAN LEADERS

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Thank you for this invitation to testify regarding the importance of workforce diversity in healthcare. My name is Anne Beal. I am a physician and a Senior Program Officer for the Commonwealth Fund, a national private foundation dedicated to helping people become more informed about their healthcare, and to improving care for vulnerable populations such as children, elderly people, low-income families, minority Americans, and the uninsured. I commend Dr Sullivan for convening this special commission, and for bringing attention to the issue of diversity in the healthcare workforce. This is a critical time to develop a healthcare system that is responsive to, and reflects, the reality of American racial and ethnic diversity.

Racial disparities in clinical care and health outcomes are a well-described public health problem in the United States. National efforts to eliminate disparities include multiple strategies, with an emphasis placed on increasing diversity in the healthcare workforce. While diversity in the health care workforce is a crucial mechanism for improving the health system's ability to care for minority patients, we should also pay attention to diversity among physician leaders. Physician leaders develop health policies that influence regulation, financing and delivery of health care. In addition, those who serve as medical school faculty set research agendas, influence medical education, and serve as role models for the recruitment and retention of both minority and majority students. These physician leaders do more to address disparities than individually care for patients; they are in positions to address disparities by influencing healthcare training and health systems as a whole.

Several barriers keep minority students from training to enter the healthcare workforce, which leads to their underrepresentation in medicine, or URM,[1] status. The impact of those barriers is most evident by the small number of minority medical students who go on to become medical faculty. Once they do become faculty, underrepresented minorities face further difficulties with promotion through the academic ranks.

Fortunately, there are programs in place to develop underrepresented physician leaders in health policy and academia. However, these programs are few in number, and further work must be done to develop other opportunities for URM faculty training and advancement to senior ranks in healthcare. The graduates of these programs are making significant contributions in research, education, and policy. And it is because of the

[1] The Association of American Medical Colleges (AAMC) redefined underrepresented minorities to underrepresented in medicine (URM), which means "those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population." (http://www.aamc.org/meded/urm/start.htm).

efforts of minority physician leaders, among others, that the issue of health disparities is now on the national agenda.

Health Disparities

Health disparities were highlighted as a national problem by the Clinton Administration's Initiative on Race,[2] and the elimination of health disparities was included as one of the *Healthy People 2010* goals.[3] Previous national reports that have called attention to this issue include *The Report of the Secretary's Task Force on Black and Minority Health* (the Heckler Report),[4] *The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equality,*[5] and most recently the Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,*[6] a project that received support from The Commonwealth Fund.

Last year, the Commonwealth Fund released a report with findings from our new national Health Care Quality Survey. This report, *Diverse Communities, Common Concerns,* clearly documents many differences in access to care, healthcare quality, and health experiences across racial and ethnic groups.[7]

Access to care is severely limited for patients without health insurance coverage. Hispanic and African American adults, age 18-64 have the highest rates of being without health insurance. Nearly one half of Hispanic adults (46 percent) and one-third of African American adults (30 percent) were uninsured all or part of the previous year compared to one-fifth of Asian Americans and whites. Minority populations are less likely to have a regular doctor, have less choice in where they can go for care, and are more likely to rely on emergency departments for healthcare **[slides 1, 2, 3, 4]**.

Healthcare quality is often measured by receipt of preventive care services and management of chronic diseases. The Commonwealth Fund Health Care Quality Survey found Hispanics and Asian Americans to be consistently less likely to receive this care. Preventive services, including physical exams, checking cholesterol and blood pressure, and screening tests for cancer, were more frequently received by African American and white men and women than by Hispanic and Asian American men and women. Physician counseling on smoking cessation was also higher for white and African American

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[2] http://www.hhs.gov/asl/testify/ t000511a.html.
[3] *Leading Health Indicators for Healthy People 2010: Final Report* (Washington, D.C.: IOM, 1999).
[4] Department of Health and Human Services, 1985.
[5] U.S. Commission on Civil Rights Report, 1999.
[6] IOM, 2002.
[7] K. S. Collins et al., *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans* (New York: The Commonwealth Fund, March 2002).

smokers (82 percent and 78 percent) than for Hispanic and Asian American smokers (59 percent and 68 percent) **[slides 5, 6, 7]**. In another project supported by the Fund, Dr. Eric Schneider and colleagues reported results from analyses of Medicare managed care quality data, which found significant disparities in quality measures between white and African American beneficiaries.[8] These measures assessed aspects of quality of care for patients with diabetes, heart disease, and mental illness as well as screening women for breast cancer; African American patients did worse than white patients in all conditions **[slide 8]**.

The healthcare experiences of minorities are often marked by problems communicating with their providers. Sixteen percent of white patients report a communication problem with their providers while 23 percent of African American and 33 percent of Hispanic patients have difficulties with communication. Among those who speak Spanish at home, 43 percent report one or more problems communicating with their physicians **[slides 9, 10]**. These poor experiences lead to less confidence in the healthcare system for minorities. Fifteen percent of African Americans, 13 percent of Hispanics, and 11 percent of Asian Americans feel they would have gotten better care if they had been of a different race or ethnicity, compared with 1 percent of whites **[slide 11]**. Patients who feel treated disrespectfully may not return or follow through with needed healthcare. Minority patients are significantly more likely to feel they have experienced this kind of treatment. Sixteen percent of African Americans and eighteen percent of Hispanics said they felt treated with disrespect during a recent healthcare visit **[slide 12]**. Overall, minority patients are less confident they will receive good quality care in the future **[slide 13]**.

Workforce Diversity

Recognizing that communication and the patient/provider relationship is often enhanced by ethnic, cultural, and linguistic concordance, the Health Resources and Services Administration plan, *Eliminating Health Disparities in the United States,*[9] includes a strategy to diversify the healthcare workforce. The IOM's *Unequal Treatment* report,[6] also makes recommendations to increase the proportion of underrepresented minorities among healthcare professionals; these recommendations are based on studies that show racial concordance between patients and providers is associated with greater patient

[8] E. Schneider, A. Zaslavsky, and A. Epstein, "Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care" *Journal of the American Medical Association* 287 (2002): 1288–94.

[9] http://www.hrsa.gov/OMH/OMH/disparities/default.htm.

satisfaction and patient adherence to treatment,[10] and that minority physicians are more likely to work in minority communities.[11,12]

Recent Census data show that minorities currently make up 29 percent of the population, and projections estimate that by 2050 people of color will be nearly half of the U.S. population.[13] **[slides 14, 15]** Most of us are familiar with the "pipeline" issues: we know that there is a falling-off of minority students at every step in the academic ladder. Beginning in middle school and on through high school and college, minority students face several challenges that decrease their likelihood of matriculation to graduate programs in healthcare -- and ultimately healthcare leadership. On the first rung of the medical education ladder we find that 32 percent of all 18-year-olds are underrepresented minorities, while only 19 percent of students entering college are minorities.[14] In the past 30 years, efforts to recruit underrepresented minorities into medical school have been fruitful: between 1974 and 2001, minority medical school applicants increased by approximately 50 percent.[12] However, despite this improvement, medical schools lag behind in diversifying their student bodies and are far from producing medical school graduating classes that reflect the diversity in American society **[slide 16]**. In 2001, 11 percent of students accepted to medical school were from underrepresented racial and ethnic groups, while approximately 25 percent of the US population were from these groups.[15]

Over the past 10 years, the number of URM faculty at predominantly white medical schools has more than doubled **[slide 17]**. Despite this growth, few nonminority schools have managed to develop a significant body of URM faculty. In addition, although there are greater numbers of minority faculty, a smaller proportion of minority medical graduates are entering academic medicine. In 1999, 10.7 percent of minority graduates from the class of 1981 were identified as medical school faculty, compared with only 6.6 percent of minority graduates from the class of 1993.[16] After medical school and residency we have less than 5 percent of medical faculty from underrepresented groups.[12] **[slides 18, 19]**

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[10] L. Cooper-Patrick et al., "Race, Gender, and Partnership in the Patient–Physician Relationship," *Journal of the American Medical Association* 282 (1999): 583–89.

[11] M. Komaromy et al., "The Role of Black and Hispanic Physicians in Providing Healthcare for Underserved Populations," *New England Journal of Medicine* 334 (1996): 1305–10.

[12] AAMC, *Facts and Figures 2002.*

[13] http://www.census.gov/prod/3/98pubs/p23-194.pdf.

[14] http://www.manhattan-institute.org/ewp_03.pdf.

[15] http://www.ama-assn.org/ama/pub/category/168.html. Based on AAMC data.

[16] M. L. Lypson, L. Gruppen, and D. T. Stren, "Warning Signs of Declining Faculty Diversity," *Academic Medicine* 77 (2002): S10–S12.

Minority Faculty Advancement

Although there has been some improvement in the recruitment and representation of minority faculty, medical schools have been less successful at helping minority faculty achieve senior rank. Medical school faculty engage in a variety of activities, but promotion comes quickest to faculty who conduct research or provide leadership in teaching medical students and residents. Minority medical faculty are often the "only one" in their department. If they are interested in minority health issues, they may find themselves professionally isolated, without peers or mentors who share their interests or who can provide a collegial environment. Moreover, minority faculty are often called upon to mentor minority students, serve on admissions committees, engage in community-based programs to present a "brown face" that represents their institution, and to serve as a representative for any committee that wants minority input. None of these activities help faculty advance; and due to their small numbers, minority faculty are asked to be involved in these activities to a greater degree than non-minorities. This excess service, sometimes called the "black tax,"[17] diverts professional time from activities that lead to academic advancement and promotion.

In 2002, the Association of American Medical Colleges reported that less than 10 percent of URM faculty are full professors, compared with about 30 percent of nonminority faculty[18] **[slide 20]**. Since most minority faculty are relatively recent graduates from medical school, the differences at the full-professor level are not surprising. However, in a study published in the *Journal of the American Medical Association,* Fang and colleagues[19] found that underrepresented faculty were less likely to be promoted than their same-age majority peers. Among associate professors, URM faculty were less likely to be tenured, or on tenure tracks, and were less likely to be recipients of RO1 and other National Institutes of Health awards—two major predictors of academic advancement. Fifty percent of white associate professors were promoted, compared with 36 percent of URM faculty. At the assistant professor level, over time, 46 percent of white assistant professors had been promoted, while 29 percent of black, 29 percent of Mexican American, 30 percent of Puerto Rican, and 45 percent of American Indian or Alaska Native assistant professors were promoted **[slide 21]**. The disparities in promotion remained even when controlling for factors such as degrees, type of medical school, and receipt of NIH awards. Thus, we see that barriers to advancement are a problem at the faculty level just as they are at every other step of the academic ladder.

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[17] B. Smedley et al., *Right Thing to Do: Smart Thing to Do* (Washington, D.C.: IOM, August 2001).

[18] AAMC, *Minority Students in Medical Education: Facts and Figures XII.*

[19] D. Fang et al., "Racial and Ethnic Disparities in Faculty Promotion in Academic Medicine," *Journal of the American Medical Association* 284 (2000): 1085–92.

The role of the "black tax" and how it prevents academic advancement for URM faculty cannot be overstated. Clearly, those extra activities affect productivity, eating into the time available to publish peer-reviewed articles and obtain grants. If URM faculty did have the same level of scientific productivity, could we expect them to be promoted? Palepu and colleagues[20] surveyed medical school faculty and asked about promotion as well as involvement in community and scholarly activities. They studied promotion rates and controlled for such factors as years as medical school faculty, differences in number of peer-reviewed publications, research grant funding, proportion of time in clinical activities, sex, and tenure status. They found that race alone was a major hindrance to academic advancement. Black faculty were 67 percent less likely to be promoted than white faculty. Hispanics were 64 percent less likely and Asians (who are not considered underrepresented) 42 percent less likely to be promoted **[slide 22]**.

Whether academic medical environments are overtly hostile or passively neglectful, URM faculty find themselves challenged to attain professional rewards for their efforts. It is not surprising that URM faculty are reported to be less satisfied with their careers and more likely to consider leaving academic medicine.[21] The contribution of URM faculty is critical to medical education, health care, and, specifically, disparities in care. URM faculty are in a position to influence research and education. They can mentor the next generation of physicians and highlight problems with disparities as well as develop solutions to this problem through their work as researchers and advocates. Physicians who go on to serve in policy roles often come from academic medicine. These physicians are able to take leadership and address disparities in care through regulation, financing, and education. Their survival must be ensured, and we should do all that we can to promote their careers.

Promoting Minority Physician Leaders

Numerous initiatives have been designed by professional schools and associations, government agencies, foundations, and health organizations to address the problem of underrepresentation. However, none of these programs has examined the critical element of leadership. To adequately address these disparities and the increasing health needs of a diverse population, it is imperative that the perspectives and concerns of all racial and ethnic groups be considered during the process of establishing, implementing, and evaluating the impact of health policy. To this end, the leadership roles of minority physicians must be expanded in the areas of research, education, public health policy, and

[20] A. Palepu, "Minority Faculty and Academic Rank in Medicine," *Journal of the American Medical Association* 280 (1998): 767–71.

[21] A. Palepu et al., "Specialty Choices, Compensation, and Career Satisfaction of Underrepresented Minority Faculty in Academic Medicine," *Academic Medicine* 75 (2000): 157–60.

practice. With these expanded roles, it becomes mandatory that minority physicians receive training for advancement to leadership positions.

Academic Medicine

The Commonwealth Fund's commitment to eliminating disparities in health and healthcare is demonstrated through our program work. The Fund's Program on Quality of Care for Underserved Populations works to identify disparities in health care quality and to promote innovations that improve the health system's ability to meet the needs of an increasingly diverse population. Our projects are addressing issues that we think are essential to eliminating healthcare disparities: communication and quality of care, improving clinical services, advancing data reporting and quality measurement for racial and ethnic minority patients, cultural competency of health care providers and health systems, as well as increasing awareness of healthcare disparities. Much of our work is being conducted by minority medical faculty. The Fund recognizes that they contribute work that addresses disparities, while we contribute to the advancement of their careers.

For example, in a report published by The Commonwealth Fund, Dr. Joseph Betancourt of Harvard Medical School mapped out a framework for achieving cultural competency in healthcare.[22] His work has applications in medical student and residency training, as well as in cultural competency initiatives within health care settings. Dr. Lisa Cooper-Patrick at Johns Hopkins University works in the area of patient–physician communication and the role of racial concordance in those interactions. Her research found that patients who received care from physicians of their own race were more satisfied with their care and more involved with medical decision-making.[23] Her work was cited in the IOM's *Unequal Treatment* report, and it served as a basis for recommendations to diversify the workforce. Dr. Leo Morales, who is based at UCLA and RAND, is studying the impact that access to interpreter services has on the health care experiences of Latino and Asian patients. Dr. Yvette Roubideaux of the University of Arizona recently convened a conference to discuss the application of quality-of-care surveys to American Indians and Alaskan Natives to review what is known about the quality of care for this population and to develop recommendations for a quality improvement agenda for researchers and policymakers. Dr. Glenn Flores of the Medical College of Wisconsin was recently funded to conduct a randomized controlled trial to implement and evaluate a community-based intervention that could become a national model for improving the quality of asthma care for minority children. All of these projects were led by minority medical faculty, and they provide valuable contributions to

[22] http://www.cmwf.org/programs/minority/betancourt_culturalcompetence_576.pdf.

[23] L. Cooper-Patrick et al., "Race, Gender, and Partnership in the Patient–Physician Relationship," *Journal of the American Medical Association* 282 (1999): 583–89.

our understanding of the prevalence of disparities and, more importantly, to the mechanisms by which they may be eliminated. The importance of their work is obvious, as is the importance of providing them support to develop their careers. It is worth noting that only one of these innovative investigators has an academic rank beyond the assistant professor level.

Health Policy

The Commonwealth Fund's single greatest contribution to promoting minority physician leadership is the Commonwealth Fund/Harvard University Fellowship in Minority Health Policy. Several years ago, our president, Karen Davis, decided that she no longer wanted to attend high-level health policy meetings at which no minorities were "sitting at the table." Recognizing that there were no training programs to prepare healthcare professionals to enter public health and health policy leadership positions—and none that specifically targeted the training of minority physicians for leadership roles—the Fund's board of directors approved the establishment of the fellowship. Under the leadership of Dr. Joan Reede, the dean for Diversity and Community Partnership and director of the Minority Faculty Development Program at Harvard Medical School, the fellowship was initiated in July 1996.

The goals of the fellowship are to improve the capacity of the health care system to address the health needs of minority and disadvantaged populations; to remedy the underrepresentation of minority physician leaders who are well-trained academically and professionally in clinical medicine, public health, health policy, and health management; and to prepare them to pursue careers that bridge the academic and public service arenas.

The fellowship combines an intensive year of training in health policy, public health, and management with special programs focused on minority health issues. Participants in the program complete academic work for a master's degree in public health or public administration at the Harvard School of Public Health or the Kennedy School of Government. Through fellowship seminars and leadership forums, the program provides multiple opportunities to interact with physician leaders. Last year's presenters included Woodrow Myers, former commissioner of health for the state of Indiana and commissioner of health for New York City, the U.S. Surgeon General Richard Carmona, and Philip Lee, professor of Professor Emeritus of Social Medicine at the University of California, San Francisco. Our fellows must also complete a practicum. Some of the topics have included creating legislative agendas to eliminate racial disparities in healthcare, evaluating services for minority victims of domestic violence, and defining and identifying medical translation errors.

At present, 35 alumni physician fellows are actively engaged in health policy, research, and service delivery to minority communities. Most hold appointments at schools of public health or medicine, and several have assumed leadership roles in departments of public health or community health centers. Alumni fellows also serve on numerous local and national advisory committees related to minority health. Among our alumni are:

- **Joseph Betancourt,** senior scientist at the Institute for Health Policy and program director for multicultural education at Massachusetts General Hospital, as well as member of the IOM committee that produced the *Unequal Treatment* report
- **Durado Brooks,** director of the Prostate and Colorectal Cancers program for the American Cancer Society
- **Dora Hughes,** staff member of the Senate Committee on Health, Education, Labor and Pensions
- **Roderick King,** director of the Boston Field Office for the U.S. Health Resources and Services Administration
- **Creshelle Nash,** assistant professor in general internal medicine and assistant dean pro tem for professional relations at the University of Arkansas for Medical Sciences, College of Public Health
- **Nawal Nour,** director of the African Women's Health Practice at Brigham and Women's Hospital in Boston, expert in treating women for conditions related to female circumcision, and recent recipient of a MacArthur "genius award"
- **Yvette Roubideaux,** assistant professor at the University of Arizona College of Public Health, expert in American Indian health issues, and current Commonwealth Fund grantee

In the brief time that it has been in existence, the Commonwealth/Harvard Fellowship in Minority Health Policy has produced a small cadre of minority physician leaders whose work is addressing disparities in a variety of venues. It is the only national program in existence that trains minority physicians for health policy leadership. We are extremely proud of what our fellowship alumni have accomplished so far, and we look forward to watching their careers unfold as they continue to provide leadership in the area of healthcare disparities.

Other Programs

The unique feature of the Commonwealth/Harvard fellowship is its emphasis on health policy. But there are other programs designed to promote minority medical faculty.

Although very few in number, these programs' impact is seen through the influence of their alumni.

The Robert Wood Johnson Minority Faculty Development offers four-year research fellowships to minority physicians who are committed to careers in academic medicine. Each of the fellows receives a stipend and a grant to support research activities, and each fellow conducts research in association with a senior faculty member located at an academic medical center. Keith Black, neurosurgeon and director of the Cedars-Sinai Neurological Institute, and Roderic Pettigrew, director of the National Institute of Biomedical Imaging and Bioengineering at the National Institutes of Health, are just two of their alumni.

Although not a program geared specifically for minority physicians, the **Robert Wood Johnson Clinical Scholars Program** has produced several well-known physician leaders. The program was authorized by the Robert Wood Johnson Foundation's Board of Trustees in 1972, the first sites entered the program in 1974. Based on a pilot program begun jointly by the Carnegie Corporation and The Commonwealth Fund in 1969, its purpose is to allow young physicians committed to clinical medicine to acquire new skills and training in nonbiological sciences that are important to medical care systems. Over the years, more than 800 individuals have participated. Minority alumni include: David Satcher, M.D., former U.S. Surgeon General; the late Herbert Nickens, M.D., former vice president for Minority and Community Programs at the American Association of Medical Colleges; Risa Lavizzo-Mourey, M.D., president of RWJF; Mark Smith, M.D., president of the California HealthCare Foundation; and Robert Ross, M.D., president and CEO of the California Endowment and former director of the Health and Human Services Agency in San Diego County, California.

The **AAMC Minority Faculty Health Services Research Institute** was developed by Herbert Nickens in 1991 with funding from what was then called the Agency for Healthcare Policy and Research. The purpose of the program was to develop a cadre of minority health services research investigators and to promote their professional development and promotion in academic centers. The 18-month fellowship was a series of two- to three-day conferences featuring lectures on research methods, the academic environment, and personal professional development. The program has trained 104 fellows, 90 of whom are in academic medicine. Alumni of the program include Kristy Woods, director of the Maya Angelou Center at Wake Forest University; Rubens Pamies, vice chancellor for academic affairs at the University of Nebraska Medical Center; Eric Whitaker, Illinois Commissioner of Health; John Rich, medical director for the Boston Public Health Commission; and three academic department chairs.

Native Elder Research Center (NERC) was funded 1997 by the NIA and NINR. It is charged with: a) increasing the number of doctoral level (MD and PhD) Native investigators capable of conducting high quality studies that suggest ways to reduce the differential in health status and access to needed care that characterizes older Indian and Native people and b) facilitating the involvement of Indian and Native communities in research of this nature. The NERC has developed an intensive 2-year mentorship program that draws upon a widely dispersed faculty to provide instructional guidance and serve as professional role models.

Research Supplements for Underrepresented Minorities. This federal program was established to increase the number of underrepresented minority scientists in biomedical research and the health related sciences. It provides funds for administrative supplements to existing federal grants from the NIH and AHRQ for the support and recruitment of underrepresented minority investigators and students.

Minority Faculty Fellowship Program. This is a federal program of DHHS HRSA Bureau of Health Professions. This program provides grants to health professional schools to increase the number of health professions faculty who are underrepresented racial and ethnic minorities in the health professions. Through these grants schools can provide a stipend and a training allowance to faculty. Grantees for this past year are Northern Arizona University, UCSF-Fresno, Tufts University School of Medicine, and the University of South Carolina School of Medicine.

There are few programs that target minority physician leaders. However, the accomplishments of the physicians who participated demonstrate the impact these programs can have on the careers of minority physicians. In turn, these physicians go on to make significant contributions through their leadership and innovation. As can be seen from the work of the physicians we have mentioned, they are addressing disparities in care at a level that can impact more patients than any one physician can serve. The potential contributions of future minority physician leaders will be critical to our ability to address disparities, and we must do all that is possible to support and promote their careers.

Recommendations

- **Establish enrichment programs for young students**

Academic medicine has not met its own goals for recruiting members of underrepresented minorities into the medical profession. To a large extent, this failure represents a broader societal failure to successfully educate members of its minority

populations, starting in the earliest grades. Science enrichment programs in elementary and middle schools would help engage and attract minority students to the field of medicine. While many medical schools and residency programs recognize the need to attract more minority students and physicians to their programs, they must redouble their efforts to realize this goal.

- **Leaders in academic medicine need to assess if they are asking young minority faculty to assume too many administrative responsibilities**

While the "pipeline issues" are important, my thesis today is that professional mentorship does not end with residency training. The development of minority physician leaders is critical to advancing a national agenda to eliminate racial and ethnic disparities in the United States. The support system that exists for young white physicians may not work for minority faculty. Young physicians of color are often isolated and, as the data indicate, promoted at a slower rate than their white counterparts. Programs like the Fund's Fellowship in Minority Health Policy seek to create an active alumni network to support minority physicians as they proceed with their careers. Current leaders in academic medicine need to acknowledge the "black tax" and evaluate whether they are asking young minority faculty to assume a disproportionate amount of administrative responsibilities. The school's or hospitals' thirst for input from minority faculty undermines the faculty members' ability to advance as leaders and the institution's long-term objective of workforce diversity.

- **Academic medical centers need to launch a comprehensive strategic plan to increase the institution's emphasis on racial and ethnic minorities that includes a review of the educational curricula, training programs and research agenda.**

Academic institutions need to create an environment that is inclusive and supportive. The onus should not be placed on minority faculty to address cultural competency, workforce diversity, curriculum development, research in disparities and culturally sensitive communication skills. Instead, the medical schools, hospitals and majority faculty need to take a proactive, leadership role in reviewing and revising the educational curricula, the training programs and the research agenda to ensure the inclusion of minority health issues in all aspects of research and education. This type of coordinated, thoughtful and strategic approach should include non-minority faculty which will create an environment that will attract minority students and faculty, will increase the diversity of the workforce, and will ultimately lead to appropriately serving the nation's diverse population.

- **Continued and adequate support for federal programs that encourage workforce diversity**

Several federally-funded programs have been vital to the development of physician leaders. The Minority Investigator Research Supplements, supported by the National Institutes of Health and the Agency for Health Care Quality and Research, have provided much-needed support to enable investigators to pursue research careers focused on underserved populations. The U.S. Health Services and Research Administration supports programs that are enhance workforce diversity. Some examples include:

- The Health Careers Opportunity Program (HCOP), which provides low-income students with opportunities to develop the skills necessary to enter the health professions.

- The Centers of Excellence, which enable health profession training programs to enlarge their minority applicant pool, and

- Minority Faculty Fellowship Program, which assists health professions training programs to increase the number of URM represented serving on their faculties.

Continued and adequate funding of these programs is important to help expand the number of minority students, physicians and physician leaders.

My remarks today have focused on physician leaders, reflecting both my personal experience and the expertise and investment of the Commonwealth Fund. However, diversification of the health care workforce must occur across all the health professions, including nursing, dentistry, pharmacy, nurse practitioners and physician assistants. Development of physician leadership is critical, but only one important step toward providing more appropriate care to the US population. The Fund has a longstanding history of supporting projects to improve the health of minority Americans. We stand ready to partner with others to make a difference in eliminating racial and ethnic health disparities.