

Paying the price of the lack of diversity in US healthcare

- The US healthcare workforce is insufficiently diverse.
- Underrepresentation by historically marginalised groups negatively impacts overall healthcare.
- Professor Christina Goode of California's Western University of Health Sciences has identified contributing factors to this problem.
- The problem is complex, requiring significant social, economic, and educational change.
- Given the country's substantial demographic shifts, those changes are increasingly urgent.

At first glance, there is a glaring lack of diversity in the United States' healthcare workforce. Look deeper, and the dilemma takes on a far more disheartening form. Despite continuous efforts spanning over four decades, there seems to be little shift towards representative parity between the healthcare workforce and the nation it must serve. If anything, things are getting worse. This lack of parity is a significant bulwark to effective healthcare. Professor Christina Goode of the Western University of Health Sciences in California, USA, has identified contributing factors to this dilemma. It is a highly complex state of affairs, and making the necessary shift will require substantial changes beyond that to the country's education system.

The push for greater diversity in America's healthcare workforce is more than an ethical imperative for fairness; practical necessities exist. Studies suggest that medical graduates from underrepresented groups are more likely to serve in primary care and work with underserved communities. There's also evidence that patients have better health outcomes when their healthcare providers share their racial or ethnic background. For example, if they share a patient's language or cultural background, they can communicate more effectively, which is crucial for accurate diagnosis and treatment. Given the extensive diversity of America's population, it therefore makes sense that the country should do all it can to encourage people from historically marginalised communities to enter medicine. In 2018, Goode, together with Professor Thomas Landefeld of California State University-Dominguez Hills, published a sobering assessment of the country's healthcare workforce, showing that the country was failing in this regard.

Keeping the historically marginalised on the fringes

To give a snapshot of how dire the situation was, Goode and Landefeld

showed that as of 2017, only 6% of physicians were Hispanic in a country where 18% of the country identified as such, and while African Americans constituted over 13% of the US population, they represented less than 8% of physicians. Hopes that health professional programmes would correct the imbalance were dashed – the number of Black males entering medicine in 2017 was lower than 35 years previous; additionally, the numbers of American Indian or Alaska Native

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matriculants were also decreasing. Goode and Landefeld point to a US Census Bureau projection that among youth under 18, minorities would outnumber Whites by 2020 which appears to have been correct. The Goode/Landefeld study made it clear that health disparities would remain endemic to America unless there were fundamental shifts along the entire healthcare 'pipeline'.

However, addressing such shifts included acknowledging the bigger picture of racism and discrimination in the country that systematically disadvantaged historically marginalised groups of people, keeping them on the fringes. Goode and Landefeld pointed to factors such as legal challenges to affirmative action that impacted attempts to achieve population parity in medical schools. Yet the problems go further back in the educational system – the researchers identified several barriers to diversity, such as poor academic preparation, lack of exposure to subjects such as biology, and systemic issues in the educational pipeline starting as early as pre-kindergarten, when children are aged around 4 years. Essentially, attempts to get historically marginalised people to become healthcare professionals were hampered before they even got close to college.

The many academic barriers

Goode delved deeper into the issues affecting those underrepresented in medicine with the help of Cynthia Tello-Escudero, a first-generation Latina college graduate and currently a third-year medical student at American University of the Caribbean. In a recent study published in *Frontiers in Psychology*, the researchers used online databases to





Graduates from a health professions pipeline programme.

identify relevant literature published between 1995 and 2023 on barriers affecting the enrolment of underrepresented students in medicine. They identified several systemic issues, including disparity in academic preparation, particularly from K-12 education, which affects performance on standardised tests like the MCAT (the Medical College Admission Test), and how reliance on such tests can result in 'academic redlining' – excluding qualified applicants from underrepresented racial and economic backgrounds.

Goode and Tello-Escudero found the high cost of medical schools disproportionately affects students from lower socioeconomic backgrounds, who are more likely to be from underrepresented groups. Should they secure acceptance and the necessary financing to enter medical school, such students invariably find a lack of diversity amongst faculty, meaning few role models and ever-present racial bias, albeit unconscious. These factors can contribute to the crippling psychological barrier of 'imposter phenomenon' – the

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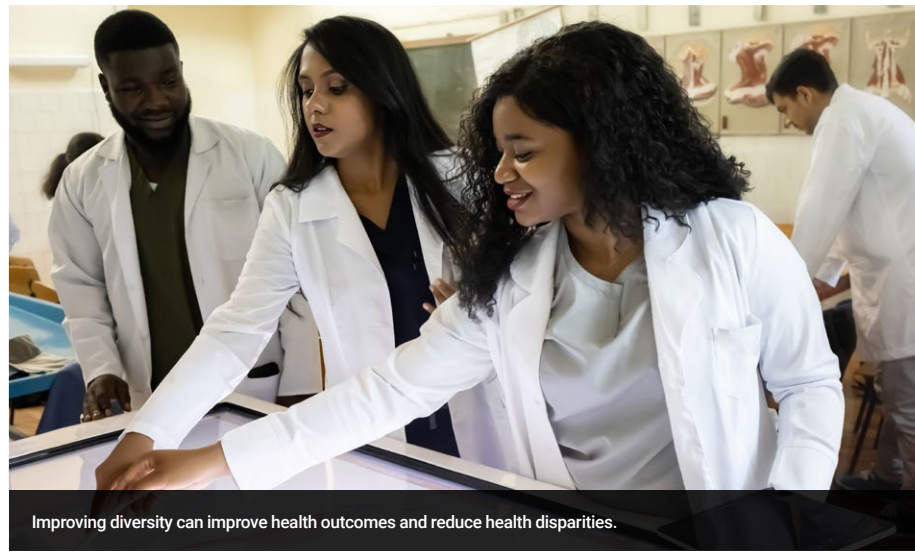
feeling of not belonging – which can lead to higher stress levels and lower persistence in the field. So, even if underrepresented students enter medical school, they are more likely than majority students to take longer to graduate. Tragically, the imposter phenomenon can become a reinforcing factor within the inhibiting systemic issues.

A heavy price

America's healthcare system is on the back foot in terms of diversity. As Goode's



Goode and Tello-Escudero identified contributing factors to the lack of diversity in the US healthcare workforce.



Improving diversity can improve health outcomes and reduce health disparities.

research has shown, the systemic and psychological barriers preventing historically marginalised people from entering and then graduating from medical school have broad and far-reaching consequences. By limiting how many underrepresented medical professionals will go on to serve their communities, these barriers are perpetuating current health disparities within the country. More than that, they are an omen to a far bigger problem.

The country's population is on a path to becoming increasingly racially and ethnically diverse. The US Census Bureau projects that by the mid-2040s, no single racial or ethnic group would constitute a majority, but most of the population would be non-white. Yet, the need for diversity within its healthcare workforce will be unchanged. If the country does not immediately implement the necessary fundamental social, economic, and educational shifts to meet that need, it will pay a heavy price.

Personal response

The barriers to achieving population parity in America's healthcare workforce are many; which seem the most resistant to change?

Most resistant is emphasis on metrics... schools will not lower the metrics because of 'reputation' and rankings. An additional resistant barrier is the problems with early schooling which disadvantages underresourced communities.

What in your research made you feel despondent?

The lack of progress despite the money invested and the lack of easily accessible data on outcomes.

Where is a good place to effect the necessary change?

Support the preparation of marginalised students to be successful in the academic

requirements of professional schools. This can be through pipeline programmes and pre-matriculation programmes.

What in your research gave you hope?

That improving diversity does improve health outcomes and reduces health disparities.

Could you describe a United States where there is a robust diversity within its healthcare workforce?

This is a very difficult question since diversity takes so many forms. If we are just looking at racial diversity the problem is that the data is not disaggregated by state so it is impossible to really know. Several states do have funded initiatives designed to increase diversity, including California, Michigan, Texas and New York, but as we have shown these have had limited success.

Details



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Bio

Christina Goode earned her PhD in biochemistry at the University of Guelph in 1984. For over 30 years, she conducted research and taught as a professor at California State University Fullerton, securing multiple grants for her work on membrane receptor proteins and her commitment to minority affairs. Since 2015, she has been at Western University of Health Sciences, where she most recently served as Associate Dean of Academic Affairs.

Thomas Landefeld holds a PhD in Reproductive Endocrinology from the University of Wisconsin (Madison) and spent 25 years as an Associate Professor of Pharmacology at the University of Michigan Medical School, successfully securing grants from the National Institutes of Health. He later joined California State University-Dominguez Hills as a Professor of Biology and Prehealth Advisor, with a primary focus on addressing minority health disparities.

Cynthia Tello-Escudero received a MS in Medical Sciences from Western University of Health Sciences. She is currently a third-year medical student.

Funding

College of Dental Medicine, Western University of Health Sciences

Further reading

Tello, C, Goode, CA, (2023) [Factors and barriers that influence the matriculation of underrepresented students in medicine](#), *Frontiers in Psychology*, 14.

Goode, CA, Landefeld, T, (2018) [The lack of diversity in healthcare: Causes, consequences, and solutions](#), *Journal of Best Practices in Health Professions Diversity*, 11(2), 73–95.

Goode, CA, Talbot, C, (2016) [A special Master's program as a pipeline to increase diversity at an osteopathic medical college](#), *Journal of Best Practices in Health Professions Diversity*, 9(2), 1198–1216.



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