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The Importance of Tracking Diversity of the Health Workforce and Educational Pipeline

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It is well documented in the United States that minority populations, particularly Blacks and Hispanics, have poorer health statuses and shorter life expectancies than Whites. While health disparities in the U.S. by race and ethnicity have multiple causes and will require a multi-pronged approach to address, studies have also documented that having a more diverse workforce that reflects the population to be served contributes to improved access and outcomes. Increasing the diversity of the health workforce to better match the population it serves should be part of any nation's strategy to address existing inequalities.

Findings from our counterparts globally indicate that the health disparities experienced by subsets of the U.S. population are similarly experienced in countries around the world, albeit not necessarily by racial or ethnic subsets of their respective populations. In other countries and regions, disparities exist by other sub-population groups, such as indigenous or tribal populations or specific religious populations and other historically marginalized groups.

In response to occasional reports that Blacks, Hispanics, and Native Americans were underrepresented in medicine and other health professions, we established a system **– the Health Workforce Diversity Tracker** (Diversity Tracker) -- to track and report the diversity of the health workforce, and equally important, the diversity of the educational pipeline which reflects the potential diversity of the future health workforce. We believe that regular reporting that compares the diversity of the workforce and pipeline to the diversity of the general population can promote transparency and accountability.

In 2020, the George Washington University Fitzhugh Mullan Institute for Health Workforce Equity, with foundation support, established the Diversity Tracker. This initiative uses available data on the racial and ethnic diversity of the health workforce and the health professions educational pipeline and compares that diversity to the diversity of the population to develop a diversity index by profession, race, and ethnicity. If the diversity of the workforce in a profession has the same diversity as the population, the diversity index would be equal to 1.0; it would be in parity. On the other hand, if the representation of a racial or ethnic group were half of their representation in the general population, the diversity index would be 0.5.

There are two critical data sources for the diversity index and tracking performance. The first is the American Community Survey (ACS) conducted by the U.S. Census Bureau. The ACS is an annual survey of about 1% of the U.S. population. The data collected in this survey includes data on race, ethnicity, geographical location, and occupation. This is a critical source of data on the diversity of the general population as well as diversity of those working in health occupations. The second key source of data is the Integrated Post-Secondary Data System (IPEDS) collected

by the Federal Department of Education. Basically, every college and university in the U.S. must report basic data on enrollment and graduation by degree level and educational concentration along with student data including sex, race, and ethnicity. This provides the data on the diversity of health professional graduates by school.

By producing reports on a regular basis that compare the extent of diversity by profession, state, and school, the Diversity Tracker can motivate and encourage professions, states, and schools to do more to address the underrepresentation of population groups among health professions. While producing reports that provide data – by name -- on the extent or lack of diversity can be harsh and may very well meet resistance, it is only by shining a spotlight on current performance that we can motivate actions that will hold organizations accountable.

This is not to suggest that the goal is exact parity of diversity between the population and every health profession. Furthermore, this is not to suggest that an individual should only be treated by a health professional of their race, ethnicity, religion, tribe, etc. But when population groups are severely underrepresented in health professions then patients are denied choice. It has also been shown that having a more diverse workforce increases the cultural awareness of all practitioners and can improve the health status of minorities and disadvantaged people.

Notably, the Diversity Tracker represents a singular yet significant response to community priorities. Progress in equity across several health professions has been uninspiring and, in some cases, negligible. The continued calls for further diversification of the American health care workforce represents the growing view of this workforce as an intervention, and the monitoring of progress as an instrument for accountability.

The Diversity Tracker offers a model that may be adopted by others. To develop such a system requires data on the diversity of the population; the diversity of the workforce; and the diversity of the graduates of health education programs. All countries should consider collecting this data including the characteristics associated with health care disparities whether it is race/ethnicity, religion, tribal affiliation or region of origin.

Collecting these three components is consistent with the concept of the importance of an effective data system as outlined by Human Resources for Health (HRH). While not currently part of the HRH accounts reporting system recommended by the World Health Organization (WHO), to address inequalities in health care, we suggest that this data should be part of their basic data collection.

Interventions and policy recommendations to address health inequities can be supported and even sparked by gathering, monitoring, and publicizing the available data on diversity. It will be important to track the diversity of the health workforce and the health educational pipeline on a regular basis to motivate change.