Learning Outcomes

After completing this chapter, the student should be able to:

1. Define diversity.
2. Define cultural competency.
3. Define diversity management.
4. Understand why changes in US demographics affect the healthcare industry.

OVERVIEW

Demographics of the US population have changed dramatically in the last three decades. These changes directly impact the healthcare industry in regard to the patients we serve and our workforce. By 2050, the term “minority” will take on a new meaning. According to the US Census Bureau, by mid-century the white, non-Hispanic population will comprise less than 50 percent of the nation’s population. As such, the healthcare industry needs to change and adopt new ways to meet the diverse needs of our current and future patients and employees.

The American Heritage Dictionary of the English Language (4th ed.) defines diversity as: (1) the fact or quality of being diverse; difference, and
(2) a point in which things differ. Drechslin (1998) provided us with a more specific definition of diversity. She defined diversity as “the full range of human similarities and differences in group affiliation including gender, race/ethnicity, social class, role within an organization, age, religion, sexual orientation, physical ability, and other group identities” (p. 813). For our discussions, we will focus on the following diversity characteristics: (1) race/ethnicity, (2) age, and (3) gender.

This chapter will be presented in three parts. First, we will discuss the changing demographics of the nation’s population. Second, we will examine how these changes are affecting the delivery of health services from both the patient and employee perspectives. Because diversity challenges faced by the healthcare industry are not limited to quality-of-care and access-to-care issues, the third part of our discussions will explore how these changes will affect the health services workforce, and more specifically the current and future leadership within the industry.

# CHANGING US POPULATION

There is no doubt that the demographic profile of the US population has undergone significant changes within the past 10 years regarding age, gender, and ethnicity (see Table 2-1).

During the 1990s, the combined US population of black non-Hispanic, Native Americans, Asians, Pacific Islanders, and Hispanics/Latinos grew at 13 times the rate of the white non-Hispanic population (United States Department of Commerce, 2000). In addition, for the first time respondents to the 2000 US Census were allowed to choose more than one racial category. In fact, 1.6 percent of the US population (6.8 million people) did so by identifying with and choosing two or more races (United States Department of Commerce, 2003, p. 24). It is predicted that the number of Americans reporting themselves or their children as multi-racial is expected to increase. In addition to the changing ethnic and racial composition of America, another issue is the aging population. According to the US Census Bureau, 35 million people (12.4 percent of the US population) are 65 years of age or older. This is 3.8 million more people than in 1990 (see Figure 2-1).

Although this was the first time in the history of the census that the population aged 65 and over did not grow faster than the total population, it is predicted that the trend will reverse as the baby boomers (those born between 1946 and 1964) reach age 65 starting in 2011 (see Figure 2-2).

In addition to the increasingly older population, there is a declining number of young people in America. From 1950 to 2000, the percentage of the American population under the age of 18 fell from 31 percent to 26 percent (United States Department of Commerce, 2003, p. 23).
This decline in America’s younger population will have a direct effect on the industry’s ability to recruit healthcare professionals to provide sufficient services in the future. Young people of all ethnicities must be attracted to the healthcare industry as a career choice in order to meet the healthcare needs of the country’s growing population.

Although males and females are almost evenly divided, representing 50.9 percent and 49.1 percent, respectively, in the population under 25 years, males dominate females with 105 males for every 100 females. However, among older adults, the male–female ratio changes, with women outnumbering men. For people 55 to 64 years old, the male–female ratio is 92 to 100, but for those 85 and over, the ratio decreases to only 41 men for every 100 women (United States Department of Commerce, 2003).

### Race/Ethnicity

The US population has continued to diversify during the last 30 years, as minority populations continue to increase at a faster rate than the white, non-Hispanic population. Although the white, non-Hispanic...
population still represents the largest group (69 percent) of the US population, this is down from 83 percent in 1970 (United States Department of Commerce, 2003).

In 2002, the Hispanic population became the largest minority in the United States, representing 13.5 percent of the population. This is up from 4.5 percent in 1970, the first census in which Hispanic origin was identified. The remaining population is comprised of approximately 13 percent black non-Hispanics, 4 percent Asians and Pacific Islanders, 1 percent American Indians and Alaska Natives, and 2.4 percent of the population identified themselves as belonging to more than one race. Interestingly, of the 6.8 million people reporting two or more races, 42 percent were under 18 (United States Department of Commerce, 2003).

The Asian population in the United States is increasing faster than the total population. From 1990 to 2000, the population of those people who identified themselves as being Asian (either alone or in combination with another race) grew 72 percent, while the total population grew only 13 percent (United States Department of Commerce, 2003).

### Aging Population

According to the 2000 US Census, people aged 85 and over showed the highest percentage increase of the country’s population. This group rep-
resented 9.9 percent in 1990 and increased to 12.2 percent of the “older” population in 2000. It is estimated that this group will represent 5 percent of the total US population by 2050 and will represent 31 percent of the older population.

One of the most striking characteristics of the older population is the change in the ratio of men to women as people age (United States Department of Commerce, 2003). In 2000, for the group aged 65 and over, there were 70 men for every 100 women, and 41 men for every 100 women in the group over 85. It is predicted that in 2050 men will represent 37 percent of the 85 and over group, and 46 percent of the 65 and over group. Therefore, in the future the elderly population will be 46 percent men and 54 percent females.

The elderly comprise a nonhomogeneous population. The racial composition of the older population differs from the racial composition of the US population as a whole. In 2000, the US population, as a whole, included 69 percent white non-Hispanic, 12 percent black non-Hispanic, 12 percent Hispanic, 4 percent Asian, and approximately 3 percent other races. A much higher proportion of the population over 65 is white non-Hispanic (more than 86 percent). Eight percent of the older population is black non-Hispanic and 5 percent is Hispanic. Asians make up just over two percent of this group, with other races forming the remainder. This racial composition will change over the next two decades. By 2030, it is predicted that black non-Hispanic, Hispanic, and Asian populations will show the greatest population increase (United States Department of Commerce, 2004).
Gender
As previously noted, according to the US Census Bureau, in 2000 50.9 percent of the US population was female, and 49.1 percent was male. That translates to 96 men for every 100 women. However, the ratio of men to women varies significantly by age group. There were about 105 males for every 100 females under 25 in 2000, reflecting the fact that more boys than girls are born every year and that boys continue to outnumber girls through early childhood and young adulthood. However, the male–female ratio declines as people age. For men and women aged 25 to 54, the number of men for each 100 women in 2000 was 99. Among older adults, the male–female ratio continued to fall rapidly, as women increasingly outnumbered men. For people 55 to 64, the male–female ratio was 92 to 100, but for those 85 and over, there were only 41 men for every 100 women (United States Department of Commerce, 2003). These male/female ratios reflect a new trend occurring since 1980. From 1900 to 1940, there were more males. Beginning in 1950, there were increasingly more females due to reduced female mortality rates. This trend reversed between 1980 and 1990 as male death rates declined faster than female rates and as more men immigrated to the United States than women did (United States Department of Commerce, 2003).

When we look at education, it appears that females are outpacing men. Among the population aged 25 and over, 84 percent of both men and women were high school graduates. However, in this age group, 28 percent of men had graduated from college as compared to 25 percent of women. But in the 25 to 29 age group, more college graduates are women than men, with 30 percent of women holding a bachelor’s degree or higher, in comparison to 28 percent of men. However, even with college degrees, a high number of women continue to be employed in administrative support positions. Therefore, it is not surprising that only 5.5 percent of working women reported earnings of $75,000 or more as compared to 15.8 percent for men.

■ IMPLICATIONS FOR THE HEALTHCARE INDUSTRY
The changing demographics of America’s population affect the healthcare industry two-fold. First, healthcare professionals need to have cultural competence to provide effective and efficient health services to diverse patient populations. However, before we continue our discussion, we need to define what is meant by cultural competence (see Hofstede’s Cultural Dimensions, Exhibit 2-1). Although the literature provides many definitions of cultural competence, such as “ongoing commitment or institutionalism of appropriate practice and policies for diverse populations”
Exhibit 2-1 Hofstede’s Cultural Dimensions

One of the most extensive cross-cultural surveys ever conducted is Hofstede’s (1983) study of the influence of national culture on organizational and managerial behaviors. National culture is deemed to be central to organizational studies because national cultures incorporate political, sociological, and psychological components.

Hofstede’s research was conducted over an 11-year period, with more than 116,000 respondents in more than 40 countries. The researcher collected data about “values” from the employees of a multinational corporation located in more than 50 countries. Based on his findings, Hofstede proposed that there are four dimensions of national culture, within which countries could be positioned, that are independent of each other. Hofstede’s (1983, pp. 78–85) four dimensions of national culture were labeled and described as:

• **Individualism – Collectivism.** This dimension measures culture along self-interest versus group interest scale. Individualism stands for a preference for a loosely knit social framework in society wherein individuals are supposed to take care of themselves and their immediate families only. Its opposite, Collectivism, stands for a preference for a tightly knit social framework in which individuals can expect their relatives, clan, or other in-group to look after them in exchange for unquestioning loyalty. Hofstede (1983) suggested that self-interested cultures (e.g., Individualism) are positively related to the wealth of a nation.

• **Power Distance.** This is the measure of how a society deals with physical and intellectual inequalities, and how the culture applies power and wealth relative to its inequalities. People in large Power Distance societies accept hierarchical order in which everybody has a place, which needs no further justification. People in small Power Distance societies strive for power equalization and demand justification for power inequalities. Hofstede (1983) indicated that group interest cultures (e.g., Collectivism) have large Power Distance.

• **Uncertainty Avoidance.** This dimension reflects the degree to which members of a society feel uncomfortable with uncertainty and ambiguity. The scale runs from tolerance of different behaviors (i.e., a society in which there is a natural tendency to feel secure) to one in which the society creates institutions to create security and minimize risk. Strong Uncertainty Avoidance societies maintain rigid codes of belief and behavior and are intolerant toward deviant personalities and ideas. Weak Uncertainty...
Avoidance societies maintain a more relaxed atmosphere in which practice counts more than principles and deviance is more easily tolerated.

- **Masculinity versus Femininity.** This dimension measures the division of roles between the genders. The masculine side of the scale is a society in which the gender differences are maximized (e.g., need for achievement, heroism, assertiveness, and material success). Feminine societies are ones in which there are preferences for relationships, modesty, caring for the weak, and the quality of life.

Hofstede proposed that the most important dimensions for organizational leadership are Individualism/Collectivism and Power Distance, and the most important for decision making are Power Distance and Uncertainty Avoidance. Uncertainty Avoidance plays an integral part of a country’s culture regarding change. For example, Nahavandi and Malekzadeh (1999, pp. 495–496) point out that countries such as Greece, Portugal, and Japan have national cultures that do not easily tolerate uncertainty and ambiguity. Therefore, the resultant behavior emphasizes issue avoidance or the importance of planned and well-managed activities. Other countries such as Sweden, Canada, and the United States are able to tolerate change because of the potential for new opportunities that may come with change.

The question frequently asked is whether Hofstede’s (1983) cultural dimensions are still applicable today? Patel (2003) found that the characteristics of Chinese, Indian, and Australian cultures corroborated Hofstede’s study results. Patel’s study of the relationship between business goals and culture, measured by correlating the relative importance attached to the various business goals with the national culture dimension scores from Hofstede’s study, found that although the four cultural dimension scores were nearly 20 years old, they were validated in this large, cross-national survey. In a study that measured 1,800 managers and professionals in 15 countries, statistically significant correlations with the Hofstede indices validated the applicability of the first study’s cultural dimension findings (Hofstede, Van Deusen, Mueller, & Charles, 2002). The findings from these studies suggest that Hofstede’s cultural dimensions continue to be robust and are still applicable measure components of national culture differences.

Hofstede (1991) subsequently included an additional dimension based on Chinese values referred to ‘Confucian dynamism’. Hofstede renamed this dimension as a long-term versus short-term orientation in life.
a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities. (HHS Office of Minority Health, 1999)

Second, due to changing demographics of the nation’s population, the healthcare industry needs to ensure that the healthcare workforce mirrors the patient population it serves, both clinically and managerially. As noted by Weech-Maldonado et al. (2002), healthcare organizations must develop policies and practices aimed at recruiting, retaining, and managing a diverse workforce in order to provide both culturally appropriate care and improved access to care for racial/ethnic minorities.

Diversity Issues within the Clinical Setting

Consider the following:

Scenario One: An insulin-dependent, indigent black non-Hispanic male was treated at a predominantly Hispanic border clinic. Later, he was brought back to the clinic in a diabetic coma. When he awoke, the nurse who had counseled him asked if he had been following her instructions. “Exactly!” he replied. When the nurse asked him to show her, the monolingual Spanish-speaking nurse was startled when the patient proceeded to inject an orange and eat it.

Scenario Two: As Maria (an elderly, monolingual Hispanic female) was being prepared for surgery, which was not why she came to the hospital, her designated interpreter (a young female relative) is told by an English-speaking nurse to tell Maria that the surgeon is the best in his field and she’ll get through this fine. The young interpreter translated, “the nurse says the doctor does best when he’s in the field and when it’s over you’ll have to pay a fine!”

These may seem rather humorous misunderstandings, but real-life experiences such as these happen every day in the United States (Howard, Andrade & Byrd, 2001). For example, a recent survey by the Commonwealth Fund (2002) found that black non-Hispanics, Asian Americans, and Hispanics are more likely than white non-Hispanics to experience difficulty communicating with their physician, to feel that they are treated with disrespect when receiving health care, to experience barriers to access to care such as lack of insurance or not having a regular physician, and to feel they would receive better care if they were of a different race.
or ethnicity. In addition, the survey found that Hispanics were more than twice as likely as white non-Hispanics (33% vs 16%) to cite one or more communication problems such as not understanding the physician, not being listened to by the physician, or not asking questions they needed to ask. Twenty-seven percent of Asian Americans and 23 percent of black non-Hispanics experience similar communication difficulties.

Cultural differences between providers and patients affect the provider–patient relationship. For example, Fadiman (1998) related a true and poignant story of cultural misunderstanding within the healthcare profession. Fadiman described the story of a young female epileptic Hmong immigrant whose parents believed that their daughter’s condition was caused by spirits called “dabs,” which had caught her and made her fall down, hence the name of Fadiman’s book *The Spirit Catches You and You Fall Down*. The patient’s parents struggled to understand the prescribed medical care that only recognized the scientific necessities but ignored their personal belief about the spirituality of one’s soul in relationship to the universe. From a unique perspective, Fadiman examined the roles of the caregivers (physicians, nurses, and social workers) in the treatment of ill children. She studied the way the medical care system responded to its own perceptions that the family was refusing to comply with medical orders without understanding the meaning of those orders in the context of the Hmong culture, language, and beliefs.

Because of our increasingly diverse population, healthcare professionals need to be concerned about their cultural competency, which is more than just cultural awareness or sensitivity. Although formal cultural training has been found to improve the cultural competence of healthcare practitioners, a recent study found that only 8 percent of US medical schools and no Canadian medical schools had formal courses on cultural issues (Kundhal, 2003).

However, changes are occurring within the industry to reduce the healthcare disparities among different minority groups (see Exhibit 2-2) by assisting healthcare practitioners in developing their cultural competences as they encounter more diverse patients.

One leader in this effort has been the Commonwealth Fund. The Commonwealth Fund (2003), in addition to funding initiatives regarding quality of care for underserved populations, has also initiated an educational program that assists healthcare practitioners in understanding the importance of communication between culturally diverse patients and their physicians, the tensions between modern medicine and cultural beliefs, and the ongoing problems of racial and ethnic discrimination. The goals of this program are for clinicians to:

1. Understand that patients and healthcare professionals often have different perspectives, values, and beliefs about health and illness that can lead to conflict, especially when communication is limited by language and cultural barriers.
2. Become familiar with the types of issues and challenges that are particularly important in caring for patients of different cultural backgrounds.

3. Think about each patient as an individual, with many different social, cultural, and personal influences, rather than using general stereotypes about cultural groups.

4. Understand how discrimination and mistrust affect the interaction of patients with physicians and the healthcare system.

5. Develop a greater sense of curiosity, empathy, and respect toward patients who are culturally different, and thus be encouraged to develop better communication and negotiation skills through ongoing instruction.

In addition to the Commonwealth Fund, the W.K. Kellogg Foundation has led efforts to lessen the recognized disparity of racial and ethnic minority groups’ representation among the nation’s health professionals. It was the Kellogg Foundation that requested the recent Institute of Medicine’s (2004) study entitled *In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce*. The Institute of Medicine found that racial and ethnic diversity is important in the health professions because:

1. Racial and minority healthcare professionals are significantly more likely than their peers to serve minority and medically underserved
communities, thereby helping to improve problems of limited minority access to care.

2. Minority patients who have a choice are more likely to select healthcare professionals of their own racial or ethnic background. Moreover, racial and ethnic minority patients are generally more satisfied with the care that they receive from minority professionals, and minority patients’ ratings of the quality of their health care are generally higher in racially concordant than in racially discordant settings.

3. Diversity in healthcare training settings may assist in efforts to improve the cross-cultural training and competencies of all trainees.

In addition to the Commonwealth Fund and the W.K. Kellogg Foundation, other organizations have begun to bridge cultural differences in the attempt to lessen health disparities due to cultural differences. For example, the OMH has developed a list of 14 standards for Culturally and Linguistically Appropriate Services (CLAS), which healthcare organizations and practitioners should use to ensure equal access to quality health care by diverse populations. The 14 standards are:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.

2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.

3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and, as appropriate, treatment planning.

4. Develop and implement a strategy to recruit, retain, and promote qualified, diverse, and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.

5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.

6. Provide all clients with Limited English Proficiency access to bilingual staff or interpretation services.

7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language, informing them of their right to receive no-cost interpreter services.

8. Translate and make available signage and commonly used written patient educational material and other materials for members of the predominant language groups in service areas.
9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or nonclinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.

10. Ensure that the clients’ primary spoken language and self-identified race/ethnicity are included in the healthcare organization’s management information system as well as any patient records used by provider staff.

11. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological, and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

12. Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.

13. Develop structures and procedures to address cross-cultural ethical and legal conflicts in healthcare delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services.

14. Prepare an annual progress report documenting the organization’s progress with implementing CLAS standards, including information on programs, staffing, and resources.

Aging Population

In addition to the changing ethnic and racial composition of America, another area of concern is the growing elderly population. Technology has given us the ability to enhance longevity; the challenge now is whether or not the healthcare profession can learn how to best serve this growing population of patients.

As our citizens grow older, more services are required for the treatment and management of both acute and chronic health conditions. The profession must devise strategies for caring for the elderly patient population. America’s older citizens are often living on fixed incomes, have small or nonexistent support groups, and are facing the challenges of where and how to obtain expensive medicines. Americans have begun obtaining prescription medications from Canada and Mexico, something that would have been unheard of in previous years. While this may be considered an American infrastructure dilemma, the reality is that medical professionals must be able to understand and empathize with poor, sick, elderly people of all races, sexes, and creeds.
Ageism can be defined as “any attitude, action, or institutional structure, which subordinates a person or group because of age or any assignment of roles in society purely on the basis of age” (Traxler, 1980, p. 4). Healthcare professionals often make assumptions about their older patients based on age rather than on functional status. This may be due to the limited training physicians receive in the care and management of geriatric patients. For example, Warshaw (2002) related that only 10 percent of US medical schools require coursework or rotation in geriatric medicine. Although medical schools offer geriatric courses as electives, fewer than 3 percent of medical school graduates choose to take these courses. A report from the Alliance for Aging Research (2003) related that there continue to be medical shortcomings in medical training, prevention screening, and treatment patterns that disadvantage older patients. The report outlined four key recommendations to safeguard against ageist bias:

1. Increase training and education of healthcare providers and research into aging. The training infrastructure needs to be enhanced so physicians, nurses, pharmacists, and allied health professionals receive appropriate exposure to geriatrics. Geriatrics competency and knowledge should be part of licensing and credentialing examinations wherever appropriate.

2. Include older patients in clinical trials. Older people are consistently excluded from clinical trials, even though they are the largest users of approved drugs.

3. Utilize appropriate screening and treatment methods. Older patients are less likely than younger people to receive preventative care and are less likely to be tested or screened for diseases and other health problems. As such, proven medical interventions for older patients are often ignored, leading to inappropriate or incomplete treatment.

4. Empower and educate older Americans. Older patients neglect to bring health problems to the attention of their care providers, contributing to the symptoms to old age.

DIVERSITY MANAGEMENT

Diversity management is a challenge to all organizations. Diversity management is “a strategically driven process whose emphasis is on building skills and creating policies that will address the changing demographics of the workforce and patient population” (Svehla, 1994; Weech-Maldonado et al. 2002). A study by the National Urban League (2004) found that few American workers believed their companies had effective diversity programs. The two-year study, entitled Diversity Practices That Work: The American Worker Speaks, surveyed more than 5,500 American workers regarding their views on diversity. Although 45 percent believed that diversity was part of the organization’s corporate cul-
Diversity in their respective employers, only 32 percent believed that their company had an effective diversity initiative. The study found that workers tended to have more favorable perceptions of diversity initiatives at companies where:

1. Leaders demonstrated a personal commitment to diversity and held themselves and others accountable.
2. Diversity training increased diversity awareness and provided a link to improving business results.
3. There was an established track record for recruiting people of diverse backgrounds.
4. Employees earned rewards for their contributions in diversity.

Studies on diversity within the healthcare industry reflect that it has been slow to embrace diversity management. For example, a study by Motwani, Hodge, and Crampton (1995) found that only 27.7 percent of healthcare workers in six Midwest hospitals felt that their institutions had a program to improve employee skills in dealing with people of different cultures and only 38.9 percent felt that management realized that cultural factors were sometimes the cause of conflicts among employees. The healthcare industry may be slow to embrace diversity management due to the low percentage of demographic diversity in senior management positions.

Healthcare Leadership

The American College of Healthcare Executives (ACHE), the National Association of Health Services Executives (NAHSE), and the Institute for Diversity in Healthcare Management (IFD) released a study in 2003 that measured the representation of black non-Hispanics, Hispanics, women, and other minorities in healthcare executive leadership roles. This study was a follow-up to similar studies completed in 1992 and 1997. The study, completed in 2002, was based on a random-sample survey of 1,621 healthcare executives. Respondents worked in a variety of settings—hospitals, healthcare provider organizations, government health agencies, and consulting and educational institutes (see Table 2-2).

Although the results of the 1997 study reflected improvements in diversity over the 1992 study, the 2002 results indicated that the healthcare industry did not do as well in promoting minorities and women in positions of chief executive officers, chief operating officers, and senior vice presidents as in subsequent years. In the 2002 ACHE study (see Table 2-3), only 23 percent of black non-Hispanic female respondents held senior management positions in 1997 as compared to 26 percent in 2002. Although white non-Hispanic female healthcare senior managers made progress, from 35 percent in 1997 to 40 percent in 2002 (see Table 2-4), the gap between white non-Hispanic males and females holding senior healthcare management positions widened from 16 percent in 1997 to 22 percent in 2002.
## Table 2-2 American College of Healthcare Executives 2002 Diversity Study

<table>
<thead>
<tr>
<th></th>
<th>1992</th>
<th></th>
<th>1997</th>
<th></th>
<th>2002</th>
<th></th>
<th>Native</th>
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<tbody>
<tr>
<td></td>
<td>Black</td>
<td>White</td>
<td>Black</td>
<td>White</td>
<td>Hispanic</td>
<td>Asian</td>
<td>Black</td>
<td>White</td>
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<tr>
<td>Population</td>
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<td>1,623</td>
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<td>235</td>
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<tr>
<td>Sample</td>
<td>517</td>
<td>966</td>
<td>767</td>
<td>802</td>
<td>662</td>
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<td>408</td>
<td>264</td>
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<tr>
<td>Response Rate (%)</td>
<td>46.2</td>
<td>58.5</td>
<td>53.5</td>
<td>50.9</td>
<td>39.9</td>
<td>52.8</td>
<td>33.4</td>
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<tr>
<td>Males</td>
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<td>242</td>
<td>177</td>
<td>192</td>
<td>154</td>
<td>76</td>
<td>497</td>
<td>742</td>
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<tr>
<td>%</td>
<td>50.3</td>
<td>46.2</td>
<td>46.6</td>
<td>49.7</td>
<td>64.2</td>
<td>66.1</td>
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<tr>
<td>Females</td>
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<td>282</td>
<td>203</td>
<td>194</td>
<td>86</td>
<td>39</td>
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<tr>
<td>%</td>
<td>49.7</td>
<td>53.8</td>
<td>53.4</td>
<td>50.3</td>
<td>35.8</td>
<td>33.9</td>
<td>55.3</td>
<td>51.6</td>
</tr>
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</table>

1. Responses were analyzed if they were from employed healthcare executives who gave their gender.
2. Composed of 683 ACHE members, 375 of whom were sampled, and 224 of whom responded; and 1020 NAHSE members, 625 of whom were sampled, and 186 of whom responded (233 having proved unlocatable).
3. Composed of 296 ACHE members, 179 of whom responded, and 366 members and contacts of AHHE, 85 of whom responded.
4. Composed of 949 ACHE members, 539 of whom were sampled and 282 of whom responded and 1337 NAHSE members, 1034 of whom were sampled and 244 of whom responded.
5. Composed of 281 ACHE members, 159 of whom responded and 168 AHHE members, 56 of whom responded.
6. Composed of 51 ACHE members, 29 of whom responded and 102 EDLP members, 39 of whom responded.

Source: American College of Healthcare Executives, Reprinted with permission.
<table>
<thead>
<tr>
<th>Position Level In Hierarchy</th>
<th>1992</th>
<th>1997</th>
<th>2002</th>
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<tr>
<td></td>
<td>Black</td>
<td>White</td>
<td>Black</td>
</tr>
<tr>
<td>CEO</td>
<td>23%</td>
<td>35%**</td>
<td>17%</td>
</tr>
<tr>
<td>COO/Senior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vice President</td>
<td>48</td>
<td>65</td>
<td>43</td>
</tr>
<tr>
<td>Department Head</td>
<td>20</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>Staff/Other</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1</td>
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<td>8</td>
<td>11</td>
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<tr>
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<td>3</td>
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<td>4</td>
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<tr>
<td>5+</td>
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</tr>
<tr>
<td>n</td>
<td>(163)</td>
<td>(240)</td>
<td>(168)</td>
</tr>
</tbody>
</table>

*Chi-square significant p < .05
**Chi-square significant p < .01
***Chi-square significant p < .001
1Responses may not total to 100 due to rounding.

Source: American College of Healthcare Executives, Reprinted with permission.
### Table 2-4 American College of Healthcare Executives 2002 Diversity Study

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>CEO</td>
<td>Black</td>
<td>White</td>
<td>Black</td>
<td>White</td>
<td>Hispanic</td>
<td>Asian</td>
</tr>
<tr>
<td>Black</td>
<td>13%</td>
<td>9%*</td>
<td>9%</td>
<td>10%</td>
<td>6%</td>
<td>5%*</td>
</tr>
<tr>
<td>White</td>
<td>9%</td>
<td>10%</td>
<td>6%</td>
<td>5%*</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>COO/Senior Vice President</td>
<td>31</td>
<td>34</td>
<td>23</td>
<td>35</td>
<td>26</td>
<td>15</td>
</tr>
<tr>
<td>Vice President</td>
<td>17</td>
<td>28</td>
<td>22</td>
<td>24</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>Department Head</td>
<td>20</td>
<td>14</td>
<td>33</td>
<td>25</td>
<td>33</td>
<td>23</td>
</tr>
<tr>
<td>Department Staff/Other</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
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<td>161</td>
<td>280</td>
<td>203</td>
<td>191</td>
<td>80</td>
<td>39</td>
</tr>
</tbody>
</table>

**Chi-square significant p < .05**

**Chi-square significant p < .01**

**Chi-square significant p < .001**

Responses may not total 100 due to rounding.

Source: American College of Healthcare Executives, Reprinted with permission.
In 2003, the National Center for Healthcare Leadership (NCHL) commissioned a study to identify specific strategies to advance careers of women and racially/ethnically diverse individuals in health care management. Dreachslin and Curtis’s (2004, p. 456) literature review confirmed the findings of the 2002 ACHE report that career advancement of women and racially/ethnically diverse individuals in health care management was characterized by: (1) underrepresentation, especially in senior level management positions; (2) lower compensation, even controlling for education and experience; and (3) more negative perceptions of equity and opportunity in the workplace. The researchers identified three areas that are key organization-specific factors for shaping career outcomes for women and racially/ethnically diverse individuals: (1) leadership and strategic orientation (i.e., senior management’s commitment for successful implementation of diversity initiatives), (2) organizational culture/climate (i.e., the depth and breadth of the organization’s strategic commitment to diversity leadership and cultural competence), and (3) human resources practices (i.e., establishing best practices in advancing the management careers of women and racially/ethnically diverse individuals, such as formal mentoring programs, professional development, work/life balances, and flexible benefits).

Based on Dreachslin’s and others’ research, the NCHL, ACHE, IFD, and the American Hospital Association developed the Diversity and Cultural Proficiency Assessment Tool for Leaders (see Exhibit 2-3). The assessment tool begins the process of developing a cultural awareness for the organization’s workforce.

In order to best serve their patient base, healthcare organizations and providers must be willing to invest the time, money, and effort needed to educate all their employees. Educating senior staff is important, but so is educating the entire healthcare workforce. For healthcare managers to transform their organizations into an inclusive culture where all employees feel the opportunity to reach their full potential, Guillory (2004, pp. 25–30) recommended a ten-step process:

1. Development of a customized business case for diversity for your organization. In other words, how does diversity relate to the overall success of the organization?
2. Education and training for your staff to develop an understanding of diversity, its importance to your organization’s success, and diversity skills to apply on a daily basis.
3. Establishment of a baseline by conducting a comprehensive cultural survey that integrates performance, inclusion, climate, and work/life balance.
4. Selection and prioritization of the issues that lead to the greatest breakthrough in transforming the culture.
5. Creation of a three- to five-year diversity strategic plan that is tied to organizational strategic business objectives.
### Exhibit 2-3  A Diversity and Cultural Proficiency Assessment Tool for Leaders

**CHECKLIST**

*As Diverse as the Community You Serve*

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you monitor at least every three years the demographics of your community to track change in gender, racial and ethnic diversity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you actively use these data for strategic and outreach planning?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your community relations team identified community organizations, schools, churches, businesses and publications that serve racial and ethnic minorities for outreach and educational purposes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a strategy to partner with them to work on health issues important to them?</td>
<td></td>
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</tr>
<tr>
<td>Has a team from your hospital met with community leaders to gauge their perceptions of the hospital and seek their advice on how you can better serve them, both in patient care and community outreach?</td>
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</tr>
<tr>
<td>Have you done focus groups and surveys within the past three years in your community to measure the public’s perception of your hospital as sensitive to diversity and cultural issues?</td>
<td></td>
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<tr>
<td>Do you compare the results among diverse groups in your community and act on the information?</td>
<td></td>
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</tr>
<tr>
<td>Are the individuals who represent your hospital in the community reflective of the diversity of the community and your organization?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When your hospital partners with other organizations for community health initiatives or sponsors community events, do you have a strategy in place to be certain you work with organizations that relate to the diversity of your community?</td>
<td></td>
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</tr>
<tr>
<td>As a purchaser of goods and services in the community, does your hospital have a strategy to ensure that businesses in the minority community have an opportunity to serve you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are your public communications, community reports, advertisements, health education materials, Web sites, etc. accessible to and reflective of the diverse community you serve?</td>
<td></td>
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</tr>
</tbody>
</table>
Culturally Proficient Patient Care

- Do you regularly monitor the racial and ethnic diversity of the patients you serve?  
  YES  NO
- Do your organization's internal and external communications stress your commitment to culturally proficient care and give concrete examples of what you're doing?  
  YES  NO
- Do your patient satisfaction surveys take into account the diversity of your patients?  
  YES  NO
- Do you compare patient satisfaction ratings among diverse groups and act on the information?  
  YES  NO
- Have your patient representatives, social workers, discharge planners, financial counselors and other key patient and family resources received special training in diversity issues?  
  YES  NO
- Does your review of quality assurance data take into account the diversity of your patients in order to detect and eliminate disparities?  
  YES  NO
- Has your hospital developed a “language resource,” identifying qualified people inside and outside your organization who could help your staff communicate with patients and families from a wide variety of nationalities and ethnic backgrounds?  
  YES  NO
- Are your written communications with patients and families available in a variety of languages that reflects the ethnic and cultural fabric of your community?  
  YES  NO
- Based on the racial and ethnic diversity of the patients you serve, do you educate your staff at orientation and on a continuing basis on cultural issues important to your patients?  
  YES  NO
- Are core services in your hospital . . . such as signage, food service, chaplaincy services, patient information and communications attuned to the diversity of the patients you care for?  
  YES  NO
- Does your hospital account for complementary and alternative treatments in planning care for your patients?  
  YES  NO

continues
Exhibit 2-3  continued

Strengthening Your Workforce Diversity

- Do your recruitment efforts include strategies to reach out to the racial and ethnic minorities in your community?  YES NO
- Does the team that leads your workforce recruitment initiatives reflect the diversity you need in your organization? YES NO
- Do your policies about time off for holidays and religious observances take into account the diversity of your workforce? YES NO
- Do you acknowledge and honor diversity in your employee communications, awards programs and other internal celebrations? YES NO
- Have you done employee surveys or focus groups to measure their perceptions of your hospital’s policies and practices on diversity and to surface potential problems? YES NO
- Do you compare the results among diverse groups in your workforce? Do you communicate and act on the information? YES NO
- Have you made diversity awareness and sensitivity training available to your employees? YES NO
- Is the diversity of your workforce taken into account in your performance evaluation system? YES NO
- Does your human resources department have a system in place to measure diversity progress and report it to you and your board? YES NO
- Do you have a mechanism in place to look at employee turnover rates for variances according to diverse groups? YES NO
- Do you ensure that changes in job design, workforce size, hours and other changes do not affect diverse groups disproportionately? YES NO
Expanding the Diversity of Your Leadership Team

- Has your Board of Trustees discussed the issue of the diversity of the hospital’s board? Its workforce? Its management team?  
  **YES**  **NO**
- Is there a Board-approved policy encouraging diversity across the organization?  
  **YES**  **NO**
- Is your policy reflected in your mission and values statement? Is it visible on documents seen by your employees and the public?  
  **YES**  **NO**
- Have you told your management team that you are personally committed to achieving and maintaining diversity across your organization?  
  **YES**  **NO**
- Does your strategic plan emphasize the importance of diversity at all levels of your workforce?  
  **YES**  **NO**
- Has your board set goals on organizational diversity, culturally proficient care and eliminating disparities in care to diverse groups as part of your strategic plan?  
  **YES**  **NO**
- Does your organization have a process in place to ensure diversity reflecting your community on your Board, subsidiary and advisory boards?  
  **YES**  **NO**
- Have you designated a high-ranking member of your staff to be responsible for coordinating and implementing your diversity strategy?  
  **YES**  **NO**
- Have sufficient funds been allocated to achieve your diversity goals?  
  **YES**  **NO**
- Is diversity awareness and cultural proficiency training mandatory for all senior leadership, management and staff?  
  **YES**  **NO**
- Have you made diversity awareness part of your management and board retreat agendas?  
  **YES**  **NO**
- Is your management team’s compensation linked to achieving your diversity goals?  
  **YES**  **NO**
- Does your organization have a mentoring program in place to help develop your best talent, regardless of gender, race or ethnicity?  
  **YES**  **NO**
- Do you provide tuition reimbursement to encourage employees to further their education?  
  **YES**  **NO**
- Do you have a succession/advancement plan for your management team linked to your overall diversity goals?  
  **YES**  **NO**
- Are search firms required to present a mix of candidates reflecting your community’s diversity?  
  **YES**  **NO**

6. Leadership’s endorsement of and financial commitment to the plan.
7. Establishment of measurable leadership and management objectives to hold managers accountable to top leadership for achieving these objectives.
8. Implementation of the plan, recognizing that surprises and setbacks will occur along the way.
9. Continued training in concert with the skills and competencies necessary to successfully achieve the diversity action plan.
10. Survey one to one and a half years after initiation of the plan to determine how inclusion has changed.

The Future Workforce

As part of diversity management, healthcare managers need to devise strategies for attracting younger workers to enter the healthcare field while maintaining positive relationships with older workers. As Barney (2002, p. 83) points out,

employers are realizing that Generation X-ers (people born between 1963 and 1977) are more concerned with meaningful work than high pay, impressive titles, and fancy offices. They reject paternalistic workplaces and want managers who listen, consider their ideas, and treat them as peers. They want to be part of the decision-making process and want to be flexible in their work environment because they value their time and freedom.

Healthcare organizations need to be flexible to change to meet these challenges. The greatest barrier to the industry’s success may be its inability to understand and appreciate the increasing diversity within our population whether relating to patients or employees.

End-of-Chapter Discussion Questions

1. Discuss what the term diversity means.
2. Explain the meaning of cultural competency.
3. What do we mean when we say “diversity management”?
4. Explain why and how changes in US demographics affect the healthcare industry.

Exercise 2-1

You have been asked recently to join the hospital’s task force for developing a plan to increase the organization’s workforce diversity from its current 10 percent level to 30 percent over the next five years. What recommendations would you make as a member of the task force?
Exercise 2-2

Cross Cultural Interview and Analysis

Interview a healthcare professional who was born and raised in a country other than your own. Focus on the following topics:

- Family background
- Cultural background
- Educational background
- Community
- Religious background

Analysis: List some of the major differences between your background and the interviewee. What are some of the similarities? Discuss what you believe some of the major challenges will be in health care in raising the profession’s awareness of diversity.

References


**Suggested Reading**

Health management students need a full understanding of diversity and its effect on healthcare outcomes. Below is a listing of various websites and publications for suggested reading.
1. The Institute of Medicine's 2004 Report: In the Nation’s Compelling Interest: Ensuring Diversity in the Healthcare Workforce. This text is available in two locations:
   b. http://www.nap.edu/catalog/10885.html A copy of the full text of the study can be found at this website.

2. A full list of reference texts discussing cultural beliefs and influences, issues, and how to identify/develop materials can be found at http://www.culturalhealing.com/patientedu.htm.

3. A discussion of cultural issues involved in providing health care to international students can be found at http://www.healthcenter.unt.edu/internat/culture.htm.


5. Discover how language and culture affect the delivery of quality services to ethnically diverse populations at http://www.diversityrx.org/.