



Are There Enough Minority Physicians in California to Go Around?

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The question of whether and to what degree access to health care, in the case of minority populations, may be compromised by a local scarcity of physicians of like race or ethnicity is examined by a recent study that assesses the supply, distribution and migration patterns of minority physicians in California. It is increasingly evident that gaining access to quality health care is difficult for a large number of Californians. A disproportionate share of the residents in the 165 areas in California designated as “medically underserved” or as “health professional shortage areas” (MUAs or HPSAs) are racial/ethnic minorities. In particular, areas scarce in physicians turn out to have relatively high percentages of African-Americans and Hispanics. If one way to remedy cultural and linguistic barriers to health care, as prior research suggests, is to accommodate patient preferences by improving the racial/ethnic match between caregiver and patient, are there enough racially/ethnically concordant doctors in the state to go around?

Access to medical care is an issue that is becoming increasingly important—and increasingly complex—in California as the number of minorities grows. According to the 2000 Census, over 26% of Californians were born outside of the U.S. and approximately 40% speak a language other than English at home. The trend toward ever greater racial/ethnic diversity in this state promises to make the term “minority” itself questionable. (To wit, the California Department of Finance has projected that by 2040 Hispanics will constitute the majority of the state’s population while Caucasians will represent less than a quarter.) Such developments should signal to policymakers that California’s health care system will likely face significant challenges in meeting the health care needs of growing numbers of minorities.

Low income and lack of insurance are hardly the only factors putting health care beyond the reach of minority populations. Both access to care and the quality of the care received can also be adversely impacted by an array of cultural and linguistic disparities

between patient and caregiver. For non-English speakers, language barriers can hinder patients from communicating their symptoms and health needs as well as limit their awareness about treatment options. In a national survey of Latinos from 2002, three in ten Latinos reported having communication problems with providers in the previous year, and half of those whose primary language is Spanish reported language barriers. Cultural differences, such as skepticism towards Western medicine, can compound these barriers

Certain minorities are also hindered by a disproportionate lack of options when choosing among health care providers. For example, 28% of Latinos and 22% of African Americans report having little or no choice in venue. Even among the insured, African Americans and Latinos are twice as likely as Whites to rely upon a hospital clinic or outpatient department as their regular source of care, rather than a private physician or other office-based provider. In fact, in California, the number of physicians practicing in a given community is most closely correlated with the race and ethnicity of the community’s inhabitants, even more than socioeconomic status.

In order to gauge the adequacy of the supply of minority physicians in California to meet patient preference for practitioners of like race/ethnicity, as well as assess local supply trends, we analyzed physician records in the American Medical Association’s (AMA) Physician Masterfile for the years 1995 to 2003. While the racial/ethnic concordance between a given pool of patients and a given pool of physicians does not guarantee that minority patients will be attended by a physician of their own race/ethnicity, it affords a good measure of the opportunity one has to obtain health care from a local practitioner of the same race/ethnicity.

We calculated the degree of mismatch, at the county level, between the supply of minority physicians and the minority populations they serve (or the difference in area-level racial/ethnic concordance) in two ways:

- 1) the degree of under-representation of minority physicians relative to the population was determined by taking the simple difference between the percentage of the physician workforce that is of a given race/ethnicity

and the percentage of the population that is of the same race/ethnicity in any particular area.

2) the availability of racially/ethnically concordant physicians to the residents of any given area was ascertained by taking the ratio of the percentage of the population that is of a given race/ethnicity and the percentage of the physician workforce that is of the same race/ethnicity in any particular area.

FINDINGS

New and important findings to come out of our study about inequities in the racial/ethnic makeup of the physician workforce in California and its consequences for minority access to health care include the following:

Under-representation of minority physicians is a state-wide problem, especially in metropolitan and higher income counties

While there is no shortage of physicians in California, generally speaking, measures of area-level concordance differences indicate that Black physicians are underrepresented by five percentage points and Hispanic physicians by 28 percentage points when compared to the racial/ethnic composition of the general population. Local disparities between Hispanic physicians and Hispanic populations have increased since 1995, and the gap is likely to worsen as more Hispanics take up residence in California.

The severity of racial/ethnic mismatch varies from county to county. Many counties in California have a low number of Black and Hispanic physicians available to the Black and Hispanic populations, with the largest shortages occurring in metropolitan and higher income counties. As of 2003, Hispanic physicians are under-represented in all counties, with the lowest concordance levels to be found in the Central Valley, Southern California, and around the San Francisco Bay Area.

In large, higher-income, metropolitan areas—where there are also higher concentrations of minorities—Black and Hispanic physicians are the most under-represented relative to physicians of other races and ethnicities as well as to the racial/ethnic composition of the local population. The paucity of Hispanic physicians is not only worsening, but also becoming more prevalent state-wide (in both urban and rural counties) as the growth of Hispanic populations outpaces the growth in the supply of Hispanic physicians.

Black and Hispanic patients have fewer opportunities than Whites or Asians to see a physician of their own race/ethnicity.

In comparison to Whites and Asians, Black and Hispanic patients have considerably fewer opportunities to see a physician of their own race/ethnicity in California. African Americans have half to one-third as many African American physicians available to them and Hispanic populations only one-seventh. Although a Black patient's chances of seeing a Black physician have improved since 1995, they are still far from equitable, especially in counties along the coast, within the San Francisco Bay Area, and throughout Southern California.

Conversely, both Whites and Asians enjoy racial/ethnic concordance ratios greater than one, indicating that higher proportions of racially/ethnically concordant physicians are available for relatively fewer proportions of Whites and Asians in California.

Migration patterns of minority physicians suggest that policy intervention is needed to reverse current trends.

While the overall supply of physicians has been steadily growing in California over the past ten years, those who relocate within the state do not tend to move to places of worse racial/ethnic concordance. And although Black physicians in California are not declining in number, more are leaving the state than are entering. Reversing this trend via policy-based mechanisms so that we have a net in-migration of Black physicians would likely improve racial/ethnic concordance between African American patients and caregivers in California.

POLICY RECOMMENDATIONS

When one looks through the lens of race and ethnicity, Latinos and African Americans are seen to be disproportionately under-represented within California's stock of physicians and, by extension, disproportionately under-served as seekers of medical care that is sensitive to their needs. While the measures used in this study effectively reveal inequities in the racial/ethnic match between physicians and patients in any given area, they exclude other relevant factors, such as cultural competency and linguistic skills on the part of care providers that are not race- or ethnic-specific. Currently such data are not available.

In order to refine our analysis of California's supply

of physicians so as to reduce racially/ethnically-based barriers to accessing care, more information about the competencies of California's physicians will need to be known. Hence, above and beyond outreach efforts to increase the flow of minority students through the medical educational pipeline, we propose the following recommendations to state policymakers that are aimed at addressing the immediate lack of culturally and linguistically competent physicians in California.

1. Mandate cultural competency education.

Continuing education in cultural competency should be mandated for all California physicians to ensure basic awareness of multicultural health issues and improve patient-provider understanding where racial/ethnic concordance is not attainable. The State of New Jersey, which has already instituted such mandates, may furnish models worth considering.

2. Identify specific areas in the state where equitable numbers of culturally competent physicians are not available to minority populations.

Current state-funded programs aimed at alleviating provider shortages in MUAs and HPSAs should be modified to include areas where the current physician workforce has inadequate cultural and linguistic skills relative to the needs of the population. Eligibility requirements for state-funded programs—such as the Steven M. Thompson Physician Corps Loan Repayment Program, the Song-Brown Family Physician Training Program, and Shortage Area Medical Education and Training Program—should also be modified to target areas where physicians' cultural/linguistic competencies are insufficient to meet the needs of the local population.

3. Develop licenses for medical interpreters.

Licenses for medical interpreters should be developed to ensure that translation services are available when linguistically competent care providers are not available. Current interpreter licenses do not ensure that translators are versed in medical terminology. Such a licensing system can be modeled on that of legal interpreters.

4. Institute data collection on physicians' cultural/linguistic skills.

Data on the cultural/linguistic skills of California physicians needs to be collected in order to assess whether California's physicians meet the needs of California's minority populations and to identify areas where culturally and linguistically-based barriers to accessing medical care exist. Supplementary questions attached to the physician licensing processes can quickly survey physicians' skills and background, and could be updated every two years (based on the existing renewal requirements).

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