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Making the case for nursing workforce diversity

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Recently, I had the opportunity to work on a writing project with a few of my colleagues. We were interested in reviewing the arguments for diversification of the nursing workforce, including the related evidence and reports of "best practices" that would support policy changes. We were surprised at how little evidence we found reported in the literature.

You can surely argue that the nursing workforce should match the ethnic and racial characteristics of the US population as a matter of principle. People have. There is likely an inherent social good in ensuring that there are representatives of many races and cultures who are available to provide care and share the design of the healthcare system, and that argument may be good enough by itself. People have also made the case that increasing diversity of a group improves the quality of the interaction of all group participants. Reasoning from this statement, increasing the diversity of the nursing workforce could improve the overall experience of the nursing workforce and potentially improve their ability to better address the needs of diverse patients. But when it comes to the evidence that nursing workforce diversity makes a difference in health care outcomes or the distribution of health care services, we just do not have much information.

What we do know is largely based on studies of the physician workforce.[1] Particularly in primary care, physicians who are members of minority groups are more likely to seek practice opportunities in settings serving minority and vulnerable populations.[2] But most physicians have the ability to be mobile—to locate where they wish. And although there is good evidence that certified nurse-midwives (CNMs), nurse practitioners (NPs), and physician's assistants (PAs) will locate in areas of service need and meet the needs of vulnerable populations, most nurses still work in institutions and need to be located at the source of the job. Generalizing from the physician workforce to the nursing work force falls short of what is needed to effectively make the case for diversity in nursing.

We assume that a diverse nursing workforce will be more effective in meeting the patient care needs of a diverse population. If we examine that assumption closely, what could we expect to find? Will there be a difference in the quality of the interaction between patient and nurse? For instance, do we believe that when matched on race or ethnicity or even gender, nurses and patients have a higher level of language and cultural understanding? Or is there substantial value found in changing the overall culture of the workforce or design in the delivery of health services when the workforce is diverse or when the workforce matches the characteristics of the patient population? Are we better able to tailor the design of health service delivery when we have racial or ethnic match? Is language or cultural competence enough to make a difference? How much competence is required to effect a clinically significant outcome?

Disparities in health care access and outcomes are widely recognized in the US healthcare system and have been described as moral and economic problems. The Institute of Medicine's report *Unequal Treatment* brought to light the vast differences in access and care outcomes for ethnic and racial minorities in the United States, noting that even after adjusting for access and socioeconomic factors, ethnicity remains a significant predictor of the quality of care received.[3] The IOM report recommendations were extensive, including those addressing the need for a healthcare workforce that was culturally competent and linguistically capable.

The Sullivan Commission's *Missing Persons: Minorities in the Health Professions* reviewed the state of the healthcare workforce for its diversity and match to the profile of the US population.[4] Not surprisingly, the conclusions called for changes—changes in the culture of health professions schools, the development of new pathways to careers in the health professions, and the highest level commitment from government and the private sector. Detailed recommendations on valuing cultural competence, reducing barriers to education, and increasing the responsibility of healthcare systems to set goals and evaluate cultural competence, language match, and diversity were all identified as strategies for change. Schools of medicine, nursing, and dentistry were all called upon to examine admissions policies, place greater value on language and cultural competencies, and take steps to diversify their applicant pools. Given the comprehensive nature of this report and its recommendations, has its impact not been more obvious? Sorting through the underlying issues reveals complexities that must be acknowledged but are difficult to address for their social awkwardness and empirical illusiveness.

Recently, more attention has been directed toward the role of economic diversity, particularly as it relates to admission to institutions of higher education. Kahlenberg has reported that "selective universities give big preferences based on race and almost no preferences based on socioeconomic status."[5] He cites the work of Carnevale and Rose in a Century Foundation study that analyzed the SAT point–equivalent adjustments for students based on race and socioeconomics. They suggest that the interaction between race and class are likely so strong that a robust measure of wealth could overwhelm the predictive value of race.[6] Recognizing that race and class are at play in admissions to health professions education programs, policy solutions should be developed to address the issues inherent in each.

They recommend additional studies that would examine the impact of a diversified workforce in other health professions (for instance, nursing).

The most recent data available on the US nursing workforce comes from the 2008 National Sample Survey.[7] As of March 2008, there were an estimated 3 063 163 licensed, registered nurses in the United States, up 5.3% from the previous survey in 2004. Only about 84.8% of the licensed workforce is actively employed; 63.2% of the employed nurses work full-time. There are roughly 853 employed RNs per 100 000 U.S. population. That is an increase from 825 in the previous survey, but the variations by state are wide and range from a low in Utah of 598 per 100 000 to a high of 1 868 in the District of Columbia. The educational preparation of the registered nurse workforce continues to be predominantly at the associate level (45.4%), with the baccalaureate proportion growing to 34.2% (from 31.5%), largely as a function of the decrease in diploma graduates (down to 20.4% from 25.6%). The nation's nursing workforce is aging. Although in 1988, the modal age was 30 to 34 years, by 2008, the modal age was 50 to 54 years. The profile of age has not changed shape but has shifted forward.

The most recent data suggest that the RN population is becoming more diverse. Although in 2000, 12.5% of the RN population was non-White or Hispanic, that number grew to 16.8% in 2008. However, the racial and ethnic profile of the RN population differs from the US population. The RN sample is disproportionately white and female when compared with the US population and includes a disproportionate number of Asian RNs and RNs of 2 or more races than is found in the population. Hispanic and African-American RNs are underrepresented compared with the population statistic. The diversification of the nursing workforce is accelerating. During the 2005 to 2008 interval, 22.5% of the graduates were non-White or Hispanic compared with 12% graduating between 1981 and 1985. The growth has been steady since 1985.

The mission of the American Academy of Nursing is to serve the public and the nursing profession by advancing health policy and practice through the generation, synthesis, and dissemination of nursing knowledge. In the case at hand, there is a need for a more systematic understanding of the impact of diversity in the nursing workforce. Assuming the demonstrated value of workforce diversity, the strategies necessary to advance the agenda of diversification must be specified. Our assumption is untested and the proposed solutions to expand our diversity are largely untested. I am calling for a clearer understanding of the value of a diverse nursing workforce and, assuming the value, the requisite policy agenda to ensure that we in nursing make it happen.

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