



## THE STUDENT NATIONAL MEDICAL ASSOCIATION

### Position on Funding for Health Professions Programs

The Student National Medical Association (SNMA) is the nation's oldest and largest medical student organization focused on the needs and concerns of medical students of color as well as the minority health community at large. As such, we recognize the importance of diversity in the healthcare workforce and the elimination of health disparities for all Americans. Pipeline programs, such as the Health Careers Opportunities Program (HCOP) and Centers of Excellence (COE) that have benefited many underrepresented minority medical students and physicians, are currently being threatened with extinction, as Congressional appropriations for these programs are under attack.

The afore mentioned programs are just two of the programs covered under Title VII and Title VIII of the Public Health Service Act. These titles authorize a myriad of programs for students and institutions to improve the geographic distribution, quality, and racial and ethnic diversity of the healthcare workforce. Title VIII programs have traditionally dealt with the nursing shortages in this country, while Title VII programs have centered on medical education. In addition to HCOP and COE, these Titles fund faculty loan repayment programs and provide scholarships for disadvantaged students.

Numerous studies have shown that healthcare disparities exist in this country. There are multiple proposed etiologies for these disparities including healthcare affordability, transportation, and geographic access. Data from the Institute of Medicine Report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, suggest that health disparities in this nation could be improved by increasing the number of minority physicians, especially in primary care specialties. Because minority physicians have a tendency to care for more uninsured or Medicaid insured patients than their white counterparts, diversity in the healthcare workforce is associated with improved access to care for the nation's underserved.

While the efforts made to increase the numbers of underrepresented minorities (URM) in medicine have yielded some success, in 2003, URMs represented only 11% of all the total matriculants into medical school. The recent challenges to affirmative action threaten to decrease this number even further. While URMs make up more than 20% of the patient population, they only account for 10% of all US physicians.<sup>6</sup> This is unacceptable. Title VII and Title VIII programs have benefited a number of current minority medical students. Their funding must be continued to assist the next generation of future physicians and to make serious strides toward the elimination of health disparities in this country.

Therefore, we, the members of the Student National Medical Association, call for:

1. Continued funding for Title VII and Title VIII programs at or above fiscal year 2003 levels for all programs until the diversity of the healthcare workforce reflects that of the general population.
2. Additional funding for increased numbers of scholarships, grants, and fellowships, either through new programs or existing ones, to encourage the pursuit of primary care specialties and practice in medically underserved areas.
3. Research evaluating the efficacy of Title VII and Title VIII programs and for modification of program goals and design in order to maximize efficacy in accomplishing the goals set forth in the Public Health Service Act and the amendments thereunto of 1994.
4. Federal and state financial support for programs aimed at strengthening the educational foundation of all students from grades K-12.
5. Financial support of other pipeline efforts focusing on mentoring and support at the primary, secondary, pre-med, and graduate levels, including SNMA Programs, such as YSEP, HPREP, and MAPS.



## THE STUDENT NATIONAL MEDICAL ASSOCIATION POSITION STATEMENT ON FUNDING FOR HEALTH PROFESSIONS PROGRAMS Appendix

### Why do we need pipeline programs?

Lower socioeconomic status is associated with lower overall healthcare regardless of race, even among those with health insurance. The pathways that affect this finding include healthcare affordability, geographic access, transportation, knowledge, and competing demands such as work and child care.<sup>3</sup> The Institute of Medicine (IOM) Report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, has documented numerous studies that expose these health disparities and suggest a plan of action to combat this social dilemma. The IOM recommended increasing racial and ethnic diversity among health professionals as one method to combat health disparities. Evidence shows that diversity in the workforce is associated with improved access to care for minority patients and greater patient choice and satisfaction. Minority physicians have a tendency to care more often for patients who are either uninsured or on Medicaid than do their white counterparts.<sup>7,8</sup> Although multiple etiologies of health disparities exist, provider bias is documented to be an important contributor. The IOM report also suggests that prejudicial attitudes of white Americans toward minorities remain more common than not and that patients' race/ethnicity influences diagnostic and treatment decisions made by healthcare providers.<sup>5</sup> Lower socioeconomic position and minority race are associated with poorer outcomes and shorter overall survival.<sup>3</sup> Minorities receive poorer quality of care for a number of disease states, including cardiovascular disease, cancer, diabetes, and HIV/AIDS.<sup>4,5</sup> Noticeably, our physician workforce is not representative of the patients who experience these racial and ethnic health disparities. While blacks and Hispanics are more than 20% of the patient population, these same groups collectively account for less than 10% of all US physicians.<sup>6</sup> These are crisis proportions.

Despite the need to increase the diversity of the healthcare workforce, underrepresented minorities (URMs) represent only approximately 11% of all matriculants into medical school.<sup>9</sup> Underrepresented minorities, as historically defined by the Association of American Medical Colleges (AAMC), are Blacks, Mexican Americans, mainland Puerto Ricans, and Native Americans. In 1995, the proportion of URMs in medical school reached a record 12%, which was the goal of the AAMC's 1970 task force report *written 25 years prior*. However, 1995 marked the beginning of major anti-affirmative action challenges in states such as California and Texas. Consequently, 1996 saw a decline in the number of accepted URM's, despite a record number of applicants. From 1996 to 2001, a total of 1,353 URM applicants were denied admission into medical school—an average of 225 applicants per year. Given that there are 125 allopathic U.S. medical schools, it is estimated that each school would have had to admit only 2 additional URM applicants each year to maintain the 1995 numbers.<sup>9</sup> The recent challenges to affirmative action have the potential to decrease the numbers of underrepresented minorities admitted to medical school once again, even though the U.S. Supreme Court upheld race-based admissions in 2003. Although many support programs have shown success in helping URMs get into medical school,<sup>21</sup> many of these programs are being threatened with disbandment given the attacks on affirmative action policies. Recognizing the importance of increasing/maintaining diversity in medical education, the AAMC, as well as other prominent organizations, has advocated for the continuation of affirmative action practices in medical education.

A crisis also exists in the geographic distribution of physicians and healthcare professionals. One study of physicians in California found that communities with high proportions of black and Hispanic residents were four times as likely as others to have a shortage of physicians.<sup>8</sup> This crisis in geographic distribution is problematic across the country, particularly reflected in the lack of healthcare professionals



found in rural areas. The question then becomes, what are the barriers preventing physician practice in rural, low economic areas, and areas with large minority populations? The answer, at least in part, lies in the decreasing number of medical students choosing careers in primary care specialties. In 1982, 36.1 % of graduating seniors were planning careers in family medicine, general internal medicine, or general pediatrics. Ten years later, in 1992, the number of seniors pursuing these specialties dropped to 14.6 %.<sup>10</sup> This trend has continued in recent years with the percentage of family practice residency positions filled by US seniors falling from 62.1% in 1999 to 42.0% in 2003. In internal medicine, 60.2% of the positions offered were filled with US seniors in 1999, while only 55.2% filled those slots in 2003. Finally, pediatrics showed a decrease from 82.8% in 1999 to 71.3% in 2003.<sup>12</sup> While the cost of financing medical education continues to rise, the salaries for generalists, such as family practice physicians and pediatricians, remain significantly lower than those of specialists.<sup>11</sup> Concern over educational debt has forced some individuals to choose fields other than primary care.

Financial barriers to the pursuit of medical education exist as well. The costs associated with health professions training pose a significant barrier for many URM students, whose economic resources are fewer, on average, than those of their non-URM counterparts.<sup>7</sup> Tuition costs are increasing.<sup>22</sup> This trend, coupled with the trend of decreased need-based aid,<sup>9</sup> results in higher levels of unmet need for disadvantaged students. Low-income students with high unmet need are significantly less likely to expect to finish college; plan to attend a 4-year college after graduating from high school; take entrance exams; and apply, enroll, and persist to degree completion than high-income students with low unmet need.<sup>7</sup> For those that are able to attend, more underrepresented minorities enter medical school with some form of debt than do their non-URM counterparts (75% vs. 47%).<sup>9</sup> Traditionally scholarships, grants, and loan repayment programs are provided to encourage more individuals to practice medicine in geographically underserved areas. Many of these programs are supported through federal funding. However, congressional appropriations for these programs continue to decrease, posing financial hardships for underrepresented minority students.

### **Background on Title VII and VIII Programs**

Title VII and Title VIII of the Public Health Service Act authorize a myriad of programs for students and institutions to improve the geographic distribution, quality, and racial and ethnic diversity of the health care workforce. The programs are administered through the Bureau of Health Professions in the Health Resources and Services Administration (HRSA). The monies allotted for Title VII programs support physician, dentist, and allied health profession training, the bulk of which is dedicated to dentistry and primary care training, as well as to medical student diversity. Title VIII programs fund nursing education and nursing workforce diversity. In 1998, the Health Professions Education Partnerships Act consolidated the Title VII and Title VIII programs into seven categories: Minority and Disadvantaged Health Professions; Primary Care Medicine and Dentistry; Interdisciplinary, Community-Based Linkages; Health Professions Workforce Information and Analysis; Public Health Workforce Development; Nursing Education Act; and Student Financial Assistance.<sup>1</sup> These categories encompass a number of pipeline programs created to increase the number of qualified minority applicants applying to medical school. Programs such as the Health Careers Opportunity Program (HCOP), and Centers of Excellence (COE) have benefited many members of SNMA, as well as other underrepresented minority medical students across the country. The history of this legislation dates back over twenty years.

Funding for Title VII and Title VIII programs is administered through HRSA, which receives its funding through the U.S. Department of Health and Human Services. In 2002, approximately \$115 million dollars were allotted for diversity training programs (i.e. COE, HCOP, faculty loan repayment, and scholarships for disadvantaged students).<sup>2</sup> Between FY2003 and FY2004, these programs saw a decline in their appropriated funding. Centers of Excellence saw a decrease of 0.6%, as did the HCOP,



faculty loan repayment, and scholarships for disadvantaged students program.<sup>2</sup> The FY2005 budget requests \$6.6 billion dollars for HRSA, a net decrease of \$610 million from the FY2004 level. Additionally, it calls for a \$283,000 decrease in health professions training activities- a 96% decrease from the budget from the previous year.<sup>2</sup> Clearly, if such a trend continues, pipeline programs such as HCOP will virtually be eliminated. This is unacceptable.

## **Effectiveness of Title VII and Title VIII Programs**

How effective have the programs set forth within Title VII and Title VIII of the Health Professions Education Partnership Act been in accomplishing their goal of providing high quality health care across the U.S. population? Unfortunately, there is little good evidence saying one way or the other. Very few studies have been done to examine the impact these programs have had on changing the demographics among health care providers today.<sup>13</sup>

Most studies that have been cited to show the effects and importance of Title VII and VIII programming compare the numbers of physicians in primary care before and after the initiation of these programs. Other studies cite the relationship between health outcomes and the provision or availability of primary care. Very few studies have looked exclusively at the effect that Title VII and VIII programming has had on increasing the numbers of physicians entering primary care career paths.

One study attempted this task by correlating the number of years of Title VII funding allotted a given school and the numbers of physicians graduating from these schools and entering primary care.<sup>20</sup> This study specifically examined the percentage of medical school graduates entering primary care from private schools, since public schools have alternative sources of support for primary care medical education. By doing so, this study hoped to elucidate the unique contribution that Title VII programs have made to increase the number of primary care physicians in this country. Unlike two other studies cited by this paper, these investigators noted a direct correlation between the number of years of Title VII funding and the percentage of a medical school class entering the field of primary care. Private medical schools with more years of Title VII funding were noted to have a higher output of medical generalists.<sup>20</sup>

A study done by the Robert Graham Center, which performs policy studies in family practice in primary care, surveyed physicians who graduated from medical school between the years of 1981 and 1993 with regard to their choices of practice specialty and practice location in the year 2000.<sup>14</sup> Graduates from schools that did not receive Title VII funding during their tenure were compared with graduates from schools who did receive Title VII funding. Schools that received any Title VII funding showed 15.8% graduates in family practice, compared with 10.2% in schools without Title VII funding. Furthermore, 1.5% of Title VII-supported graduates practiced in primary care health personnel shortage areas (PCHPSA) compared with 1.2%; 12.7% of graduates practiced in rural areas, compared with 9.5% in non-Title VII schools.<sup>14</sup>

In 1992, amendments were passed by Congress to reauthorize Title VII and VIII. With that reauthorization came a mandate to evaluate the effectiveness of these programs. The General Accounting Office thus released a report in 1994 in answer to this mandate. They found that, although the numbers of primary care physicians and minority physicians had increased overall, they were unable to show that such increases had increased access to care. Further, in the case of primary care physicians, although the numbers had increased, they had not increased equally in all geographic areas. Specifically, those areas with shortages continued to have shortages. However, the writers themselves note that the available data is insufficient to draw conclusions on the efficacy of these programs.

Clearly, changes have occurred since the initiation of these programs. Studies continue to show that primary care is associated with better health outcomes.<sup>15</sup> The Institute of Medicine report *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce* released February 2004 continues to support the idea that diversity among health professionals is associated with increased access to care for racial and ethnic minorities.<sup>7</sup> The principles and needs which brought about the birth of Title VII and VIII still stand and still need to be addressed.



The dearth of research on the efficacy of these programs serves as fuel for the argument that they are not effective and thus that funding should be eliminated. However, it is apparent that there is insufficient information at this time to confidently say what impact these programs have had. Since the need for equitable access to care across this country remains, it is illogical to discontinue funding a program designed to address that need until a real effort has been made to adequately assess the impact of that program or to modify the program in order to make it more effective.

### **Title VII and Title VIII Programs Still Needed**

Title VII and Title VIII programs are still needed, because the goals for which they were created have not been achieved. Disparities in health status continue to exist in this nation and need to be addressed. Unfortunately, the very existence of health disparities has been challenged in some arenas. According to Dr. Christopher Fordham of the University of North Carolina at Chapel Hill School of Medicine: “To argue that this [health] disparity is not a problem for the health-professional educational community is to suggest that social justice and the proper care of an increasingly diverse population are not among our top priorities. That simply cannot be the case.”<sup>16</sup> Because patients are more likely to choose the services offered by a physician who shares a similar cultural background, it would behoove the medical establishment to produce a physician workforce that more accurately reflects the changing demographics of the country.<sup>6</sup> This change will lead to better health outcomes for the minority patient who regularly sees and is treated by a minority physician. Unfortunately, the health professional community has yet to accomplish such a crucial task.

In 2001, the number of all applicants to medical school declined for the fifth successive year, from 46,965 to 34,859. This is the lowest number of applicants since 1990. Between 1996, when the applicant pool was at its peak, and 2001, underrepresented minority (URM) applicants declined by nearly 21% (from 5,127 to 4,097).<sup>17</sup>

Between 1974, when the AAMC began to collect data on the race/ethnicity of applicants, and 2001, the number of URMs applying to medical schools increased by nearly 50%.<sup>17</sup> The increase in the number of URM applicants is due to many factors, including the increase in the number of medical schools and the number of URMs attending and graduating from college. Perhaps the most significant factor, however, is the impact of affirmative action on URM applicants’ perception that pursuing a medical degree can be a realistic career option.<sup>17</sup>

By 1996, the applicant pool to U.S. medical schools reached a record number—46,965, including 5,157 underrepresented minority applicants. The steady increase since 1990 ended in 1997, however, when the number of all applicants to medical school dropped to 43,016, a decline of 8.4%. At the same time, URM applicants dropped to 4,563, a decline of 11.5%.<sup>17</sup> The year 1997 was pivotal due to the implementation of two major legal events affecting the use of race and ethnicity in admitting students to medical school: Proposition 209 and Regents SP-1 took effect in professional schools in California; as well as the U.S. Fifth Circuit Court’s decision in *Hopwood v. Texas*, which affected admissions in Texas, Mississippi, and Louisiana.<sup>17</sup> Both of these court cases hurt admission rates for URMs by excluding race and ethnicity as a factor in admissions.

Examining the trends by applicants’ legal state of residence indicates that nearly one-third of the drop in URM applicants can be attributed to declines in applicants from two states—California and Texas.<sup>17</sup> With the exception of applicants from the Commonwealth of Puerto Rico, applicants from all racial and ethnic groups have declined substantially since 1996. Among URM applicants, the largest decline occurred for Native Americans, a decline of 34.1%.<sup>17</sup>



In 2001, the number of URMs accepted into medical school declined for the sixth year in a row, to 1,881. This represents a decline of 12% from 1995, the year when the greatest number of URM applicants (2,142) was accepted.<sup>17</sup>

Acceptance rates vary by individual racial and ethnic group. Among URM applicants, the acceptance rate for Blacks was lower (42.6% of 2,887), while the acceptance rate for mainland Puerto Ricans was highest (60.4% of 197). White and Asian or Pacific-Islander applicants had approximately the same acceptance rate (51.7% versus 51.1%, respectively).<sup>17</sup>

The proportion of underrepresented minorities who matriculated to medical school increased slowly but steadily from the mid-1970s to late 1980s, from 8.6% to approximately 8.9%.<sup>17</sup> The proportion began to grow more rapidly only in 1992. By 1995, the proportion of URM matriculants finally reached 12%—the goal of the AAMC's 1970 Task Force Report.<sup>9</sup> Rates have yet to again reach or surpass this percentage since 1995.

Between 1996 and 2001, the ability for schools in several states to use race/ethnicity as one element in the admissions process was limited by public referenda or court challenges. This has had a negative effect on URM matriculation rates. In 1996, schools in California, Louisiana, Mississippi, Texas, and Washington matriculated 22% of all underrepresented minorities. In 1997, when laws took effect in all the affected states (except Washington), these same schools accounted for 18.5% of URM matriculants.<sup>17</sup> Since 1997 (when Proposition 209 and the Hopwood legal decision took effect), Texas and California schools have used other means to increase their numbers of URM matriculants in the affected states. However, the total number of URM matriculants still lags behind the 1996 high of 22%.<sup>17</sup>

The class entering medical school in 2001 was among the most diverse ever, with nearly 34% of all matriculants being racial or ethnic minorities. Despite this diversity, *underrepresented* minority students accounted for fewer than 11% of new entrants. In contrast, these same four groups—Blacks, Native Americans, Mexican Americans, and mainland Puerto Ricans—accounted for nearly 25% of the U.S. population in 2000.<sup>9, 17</sup>

While the number of underrepresented minorities enrolled in medical school declined in 2001, between 1980 and 2001, the number of all minority faculty-- including underrepresented minorities—increased at medical schools. Furthermore, within this time period, the number of URM faculty rose by 250%, from 1,140 to 4,060. During this same period, full-time medical school faculty increased 110%, from 45,220 to 96,211. However, even with the doubling in their numbers, URM faculty still account for only 4.2% of U.S. medical school faculty members.<sup>19</sup>

Approximately 20% of URM faculty are located at six schools—Howard University College of Medicine, Meharry Medical College, Morehouse School of Medicine, and the three Puerto Rican medical schools (Universidad Central del Caribe School of Medicine, Ponce School of Medicine, and the University of Puerto Rico School of Medicine).<sup>18</sup> If these six schools are excluded, the number of URM faculty at the remaining 119 U.S. medical schools drops to 3,305, or 3.5%.<sup>9, 19</sup> Although the number of URM faculty at non-minority medical schools has more than tripled within the last twenty years, few have yet to achieve a “critical mass” of URM faculty, reflecting the diversity of the general population.

Most underrepresented minority faculty work in clinical departments. Fewer than 7% of URM faculty hold appointments in basic-science departments. Underrepresented minority faculty are more likely to hold appointments in family medicine or obstetrics/gynecology. They are least likely to hold appointments in a basic-science department. Less than 10% of URM faculty at non-minority medical schools are full professors.<sup>19</sup>



While the ultimate goal of eradicating healthcare disparities in the U.S. must include the education and graduation of physicians with cultural competency skills of all races and ethnic backgrounds, no reasonable approach can begin without a plan to increase the minority physician representation. So, one would expect that increasing the number of minority medical students would serve two purposes: 1) increase the diversity of ideas shared and discussed throughout medical training which would lead to more culturally competent non-minority physicians; and 2) produce more minority physicians who would bring a more culturally sensitive perspective to the encounter with minority patients. The benefit of increasing the number of minority physicians is intuitive. Because trust and communication are key issues in the patient-physician relationship, then a relationship which maximizes these variables will lead to better health outcomes and help to eliminate health disparities in this nation. A diversified physician workforce will increase the number and distribution of qualified care-givers available for patients and will improve access to healthcare.

Progress has been made since Title VII and Title VIII were first passed. This country has increased its numbers of minority and primary care physicians. However, health disparities still exist for minority patients, patients of lower socioeconomic status, and patients living in rural areas. The health care status of this nation can be improved further. For these reasons, we, the members of the Student National Medical Association, support continued funding of programs for the development of health care professionals.

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## References:

1. Press release from the American Dental Education Association. Accessed at [www.adea.org](http://www.adea.org) on July 7, 2003.
2. HRSA- Fiscal Year 2004 Budget. Accessed at <http://newsroom.hrsa.gov/NewsBriefs> in March 2004.
3. Fiscella K et al. Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care. *JAMA*. 2000; 283: 2579-2584.
4. Guidance for the National Healthcare Disparities Report. Accessed at [www.nap.edu](http://www.nap.edu) in February 2004.
5. Report Brief. Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Healthcare from *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. Smedley B, ed. Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Healthcare, Board on Health Sciences Policy. The National Academies Press, Washington, DC. 2003.
6. Katz J. Patient preferences and health disparities. *JAMA*. 2001; 286: 1506-1509.
7. *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Work Force*. Institute of Medicine, Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Health Care Workforce, Board on Health Sciences Policy. The National Academies Press, Washington, DC.
8. Komaromy M, et al. The role of black and Hispanic physicians in providing health care for underserved populations. *NEJM* 1996; 334: 1305-1310.
9. Association of American Medical Colleges. Minority students in medical education: Facts and Figures XII. 2002. Accessed at [www.aamc.org](http://www.aamc.org) in February 2004.
10. Petersdorf R. Financing medical education- a universal "Berry plan" for medical students. *NEJM*. 1993; 328: 651-654.
11. Physician salaries table. Accessed at [www.allmedicalschoools.com/faqs/medical\\_salaries.php](http://www.allmedicalschoools.com/faqs/medical_salaries.php)
12. Selected data tables. National Resident Matching Program. March 2003 Match data. Accessed at [http://www.nrmp.org/res\\_match/tables/table1\\_2003.pdf](http://www.nrmp.org/res_match/tables/table1_2003.pdf) March 2004.
13. US General Accounting Office. *Health Professions Education: Role of Title VII/VIII Programs in Improving Access to Care is Unclear*. Washington, DC: US General Accounting Office; 1994.
14. Meyers D, et al. Title VII funding is associated with more family physicians and more physicians serving the underserved. *Am Fam Physician* 2002; 66: 554.
15. Shi L, et al. Income inequality, primary care, and health indicators. *J Fam Pract* 1999; 48: 275-284.
16. Fordham C. *The urgency of diversity in the health professions: a time for resolution and resources*. The University of North Carolina at Chapel Hill, Chapel Hill, NC. 2002.
17. Association of American Medical Colleges. AAMC Data Warehouse 2002. Accessed at [www.aamc.org](http://www.aamc.org)
18. Association of American Medical Colleges. AAMC Student Record System 2002. Accessed at [www.aamc.org](http://www.aamc.org)
19. Association of American Medical Colleges. AAMC Faculty Roster System 2001. Accessed at [www.aamc.org](http://www.aamc.org)
20. Politzer, RM et al. The impact of Title VII departmental and predoctoral support on the production of generalist physicians in private medical schools. *Arch Fam Med* 1997; 6: 531.
21. Odom K, et al. Students' Perspectives on Affirmative Action Among Underrepresented Minority Medical Students. Article in Progress.



22. Association of American Medical Colleges. Tuition and Student Fees Reports. Accessed at [www.aamc.org](http://www.aamc.org)