POLICY at Healthforce Center at UCSF

Diversity Matters: Evidence to Diversify California's Health Care Workforce

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Overview

The evidence is clear: California needs a diverse health care workforce to meet the needs of an increasingly diverse population.[1] This issue brief explores what we know about the diversity of California's licensed health care workforce, what works to increase the diversity of health care workers, and provides examples of how to implement these strategies. An accompanying policy brief summarizes these strategies into policy recommendations.

Problem

California needs a health care workforce ready to improve quality, access, outcomes, and costs of health care for its diverse population. Yet, there is a large mismatch between the diversity of health care workers and our population, especially in health care professions that require graduate or professional degrees.

Why it matters

Increasing the diversity of lived experiences and identities (such as race and ethnicity, gender, sexual orientation, geography, languages spoken, and socioeconomic background) among health care workers improves health care access and quality.[2,3] When patients and health care providers share similar backgrounds and experiences; communication, trust, and satisfaction improves as patients feel more respected, heard, and understood.[4] Providers from systematically underrepresented racial-ethnic minoritized groups are more likely to care for systematically disadvantaged patient populations, improving access to care, use of preventive services, and, ultimately, health outcomes.[5]

Diversity today

California has invested in gathering and reporting demographic data of the licensed health care workforce through the California Department of Health Care Access and Information (HCAI). HCAI's current dashboards and publicly available reports tell us a lot about the racial/ethnic and linguistic diversity within these professions:

- Racial/ethnic diversity among health care workers decreases as the level of education and training required increases (Figure 1).
- California's health care professionals are less likely to speak Spanish than the population (Figure 2).
- Regional inequities in racial/ethnic and linguistic diversity are most pronounced in the Central Coast, San Joaquin Valley, Inland Empire, and Los Angeles and Orange Counties.

Figure 1. Racial/ethnic representation in certain licensed health care professions vs. the general population

	Level of education required	Black, non-Hispanic (%)	Hispanic (%)	Pacific Islander, non-Hispanic (%)	American Indian, non-Hispanic (%)	Asian, non-Hispanic (%)	White, non-Hispanic (%)
California population		**5.4**	**40.0**	**0.3**	**0.3**	**14.7**	**35.8**
Dental assistants	Certificate	2.4	50.2	0.9	0.5	13.8	28.6
Pharmacy technicians	Certificate	5.2	41.0	1.5	0.3	26.9	20.6
Licensed vocational nurses	Certificate or associate degree	10.5	33.7	1.8	0.4	30.3	18.7
Registered nurses	Associate or bachelor's degree	5.0	16.5	1.2	0.2	33.1	39.5
Marriage and family therapists	Master's degree	4.5	20.3	0.2	0.3	6.3	63.4
Dentists	Doctoral degree	1.8	9.1	0.5	0.2	42.2	40.8
Pharmacists	Doctoral degree	2.7	3.8	0.4	0.2	60.9	27.7
Physicians	Doctoral degree	3.6	8.2	0.0	0.1	35.5	48.9

Source: HCAI, 2023 (row percentages)

Figure 2. Languages spoken by California's licensed health care workers vs. the general population

	California population (%)	Licensed providers (%)	Difference in representation (%)
English only	**55.00**	**52.70**	**-2.30**
Spanish	**28.76**	**17.60**	**-11.16**
Asian and Pacific Islander	**9.77**	**15.5**	**5.73**
Chinese (including Mandarin, Cantonese)	3.53	2.62	-0.91
Tagalog (including Filipino)	2.09	7.94	5.85
Vietnamese	1.54	1.64	0.10
Korean	0.96	1.30	0.34
Other languages of Asia	0.36	0.09	-0.27
Japanese	0.35	0.31	-0.04
Ilocano, Samoan, Hawaiian, other Austronesian languages	0.35	1.07	0.72
Thai, Lao, or other Tai-Kadai languages	0.21	0.22	0.01
Hmong	0.19	0.22	0.03
Khmer	0.19	0.08	-0.11
Other Indo-European	**5.34**	**7.00**	**1.66**
Other Indo-European languages	0.73	0.16	-0.57
Persian (including Farsi, Dari)	0.67	0.85	0.18
Hindi	0.58	1.47	0.89
Armenian	0.54	0.59	0.05
Russian	0.48	0.66	0.18
Punjabi	0.46	0.90	0.44
French	0.35	0.64	0.29
Portuguese	0.28	0.24	-0.04
German	0.25	0.29	0.04
Other Slavic languages	0.22	0.15	-0.07
Telugu	0.20	0.11	-0.09
Urdu	0.18	0.39	0.21
Gujarati	0.14	0.28	0.14
Italian	0.14	0.17	0.03
Yiddish, Pennsylvania Dutch, other West Germanic languages	0.06	0.08	0.02
Polish	0.06	0.08	0.02
Other	**1.09**	**3.70**	**2.61**
Arabic	0.56	0.74	0.18
Amharic, Somali, or other Afro-Asiatic languages	0.15	0.13	-0.02
Hebrew	0.12	0.20	0.08
Other and unspecified languages	0.10	2.41	2.31
Yoruba, Twi, Igbo, other languages of Western Africa	0.10	0.10	0.00
Swahili or other languages of Central/Eastern/Southern Africa	0.04	0.12	0.08
Native languages of North America	0.02	0.00	-0.02

Source: HCAI and American Community Survey data summarized by the Migration Policy Institute, 2023 (column percentages), difference in representation calculated from subtracting the percentage of licensed providers from the percentage of the California population.

Find more information about the diversity of California's health care workforce

California's go-to source for information on the licensed health care workforce is the California Department of Health Care Access and Information (HCAI). Explore their datasets, dashboards, and reports for detailed information. This brief focuses on the licensed health care workforce as HCAI maintains their databases based on information that is tied to license renewal processes. Data on health care workers who are not licensed are harder to come by and more out of date; however, the data we have suggests many of these roles are diverse.

Evidence-based practices and policies

Outlined below are the education strategies, practices, and policies that work to improve the diversity of the health care workforce, organized along the training pathway from K-12 exposure through training and into practice. Implementing and integrating a greater number of these recommended practices consistently will have greater success in diversifying the health care workforce long-term.[6,7]

Support and cultivate diverse populations' interest in health careers and access to higher education with bridge, pathway, and postbaccalaureate programs:

- "Bridging" or summer enrichment programs that provide high school and undergraduate students with academic support and experiences to enhance their ability to become health professionals (e.g., improving academic performance).[8] The Robert Wood Johnson Foundation's Summer Health Professions Education Program (SHPEP), in operation since 1989, improves acceptance, matriculation, and graduation from health professions programs; increases student self-efficacy; and strengthens intentions to practice with systematically disadvantaged patient populations.[9,10] **EXAMPLES:** JumpStart for incoming first-year University of California (UC) Riverside students interested in the health professions; SHPEP for undergraduates with interests in health careers (national program, currently offered at UC Los Angeles/Charles R. Drew University and Western University of Health Sciences in California).
- Pathway programs, also known as pipeline programs, identify, expose, and nurture potential health workers with educational and career support, exposure to the field, and mentorship opportunities, and result in enhanced academic achievement and increased odds of future enrollment in health professions programs.[11] Some programs are cohort-based and identify undergraduate students from diverse backgrounds who are interested in health careers and provide robust mentoring, enrichment, and guaranteed admission to a graduate program in the health professions. Programs are often funded through philanthropic, state (e.g., Health Professions Careers Opportunity Program through HCAI), and national (e.g., Health Careers Opportunity Program through the Health Resources and Services Administration or HRSA) funds. **EXAMPLES:** Bridges to Baccalaureate (B2B) programs for community college students interested in research opportunities (e.g., B2B at UC Davis); the California Medicine Scholars Program supports community college students across California through medical school and training (e.g., AvenueM at UC Davis); the San Joaquin Valley Program in Medical Education (SJV PRIME+), an 8-year program that combines a 4-year baccalaureate program at UC Merced with guaranteed admission to UC San Francisco's 4-year School of Medicine program.
- Postbaccalaureate programs increase admissions to graduate programs for college graduates with systematically underrepresented backgrounds.[6] They also improve graduation rates, increase the number of diverse trainees choosing primary care careers, and the number of providers practicing in medically underserved areas.[12–15] **EXAMPLE:** California Postbaccalaureate Consortium – a partnership of postbaccalaureate premedical programs at the Schools of Medicine at Charles R. Drew University, UC Davis, UC Irvine, UC Los Angeles,

UC San Francisco, and Tribal Health - Cal Poly Humboldt – for students who are committed to practicing in medically underserved communities of California.

Best practices for recruiting, admitting, and supporting diverse students in college/university training:

- Recruitment:
    a. To improve recruitment and enrollment of systematically disadvantaged and racial-ethnic minoritized communities, colleges/universities should establish and maintain collaborations with a wide range of partners in their regions, including community-based organizations, community colleges, and historically Black, minority-serving, and K-12 educational institutions.[6,16–18] **EXAMPLE:** UC Los Angeles' Center for Community College Partnerships works closely with local community colleges to strengthen academic support programs and increase the diversity of UC Los Angeles' transfer admit pool.
    b. Before, during, and after the application process, conduct purposeful outreach to diverse prospective students and considering hosting sponsored experiences for these students.[6,16,18]
- Admissions:
    a. Use a holistic review process for selection of prospective students and making admissions decisions.[6,19–22] Holistic review takes a comprehensive view of an applicant's personal, community, and professional backgrounds; all things that may influence academic performance and contribute to a student's success in health professions programs. Holistic review also deemphasizes standardized test scores (e.g., MCAT, SAT, GRE, or ACT) and grade point averages relative to other criteria emphasizing qualities that are central to the institutional mission (e.g., commitments to serve systematically disadvantaged populations or geographies, students who speak the same languages as their priority patient populations). **EXAMPLE:** UC Davis' distance traveled score which considers factors like family income level, parental education and occupation, a childhood in an underserved area, and an applicant's contribution to family income in deciding who to admit to their health professions programs.
    b. Support applicants from lower socioeconomic backgrounds in the application and review process with supportive policies (e.g., offer virtual interview options or fee waivers and travel stipends) and consider socioeconomic status as an alternative review metric in the holistic review process.[23,24]
    c. Ensure admissions committee members reflect the diversity of the applicant pool (consider providing incentives for diverse faculty participation on admissions committees),[16,25] and require implicit bias training for all committee members, applicant reviewers, and decision makers.[16,18,26]
- Support and retention:
    a. Institutionalizing diversity, equity, and inclusion (DEI) in policy and school culture, for example through the institution's mission statement and strategic plan, demonstrates unwavering commitments to students from diverse backgrounds.[6,16,18,27] Additional examples include requiring DEI and health equity in each program's curricula, establishing zero tolerance policies for discrimination (paired with effective reporting systems in place), and regularly collecting and assessing campus climate, student experiences, and working to support unmet student needs.[18,27]
    b. Establishing and maintaining opportunities for mentorship, advising, and academic support is critical for ongoing support of trainees, especially if the support programs pair

students with mentors with shared experiences or identities.[16,18,20,25,28] More equitable investment in specific pre-health advising, resources, and support at all levels of education (community colleges, public and private colleges and universities), is needed to increase equity in access to these critical resources.[29]

c. To meet mentorship goals, diversifying faculty and staff at each educational institution is required. Demonstrated efforts should be in place to recruit and retain faculty and staff who reflect the cultural diversity of students from systematically underrepresented backgrounds.[16,18,30] All faculty and staff should be required to take implicit bias and anti-discrimination training.[16,18,26] More closely aligning faculty diversity with trainee diversity improves student retention.[31]
d. Providing direct financial support for students from diverse, systematically disadvantaged backgrounds through scholarships removes financial barriers during training so they can focus on academic success and wellbeing.[16,18,20] Often paired with a commitment to practice in systematically underserved areas after graduation, scholarships can be an effective way to increase the diversity of the health workforce; however, better long-term outcomes are observed when scholarship recipients' service placements are closely tied to their backgrounds (e.g., recipients from rural backgrounds are more likely to continue practicing in rural areas).[7] **EXAMPLE:** HCAI has several scholarship programs for students enrolled in health professions programs, many of which require a commitment to practice in systematically underserved areas after completion of their program.

Best practices for supporting diverse health professionals in further training and practice, especially for systematically disadvantaged populations from similar backgrounds:

- Creating specialized training tracks or programs within graduate health professional schools designed to train students to care for specific systematically disadvantaged populations (e.g., rural, Tribal, and other systematically racial-ethnic minoritized populations) is an effective way to "grow your own" health care workforce: programs recruit students from the regions they are aiming to serve, train them within those settings, and provide mentorship and support throughout their training. In return, students are more likely to practice in settings similar to their training environment (whether rural, urban, or safety net).[7,32] **EXAMPLES:** UC Programs in Medical Education (UC PRIME), which include PRIME-LC (Latino Community) at Irvine, Rural PRIME at Davis, PRIME-LEAD-ABC (Leadership Education to Advance Diversity – African, Black, and Caribbean) at Irvine and Riverside, San Joaquin Valley PRIME at UC San Francisco-Fresno, Tribal Health PRIME (Indigenous Community) at Davis, among other PRIME programs. Programs for internationally trained health professionals (e.g., UC Los Angeles International Medical Graduate Program) are another example of cohort programs designed to support training and practice in systematically disadvantaged communities.
- State training grants and graduate medical education (GME) can include requirements targeting growth in certain specialties and geographic areas to better address state health care workforce needs, which could financially support more diverse trainees with backgrounds similar to those in systematically underserved areas within the state.[33] **EXAMPLE:** Song-Brown workforce training programs increase the number of health professionals trained in primary care in areas of unmet need across California.
- In addition to providing scholarships to diverse students, loan repayment programs paired with service obligations can be an effective method for supporting diverse health professionals ready to practice, particularly if they are motivated to care for populations with similar backgrounds to theirs.[34,35] **EXAMPLES:** HCAI has several loan repayment programs, as do other state (e.g.,

CalMHSA and CalHealthCares) and federal agencies (e.g., HRSA and National Health Service Corps).

Reduce barriers to enrollment and advancement with educational reform and promote accountability with accreditation/certification and ongoing monitoring:

- Streamlining educational pathways to health careers (e.g., making credentials stackable so that students get credit for prior education and experiences) reduces barriers to entry and advancement for all students, and, when paired with other strategies to recruit and retain a diverse study body, improves the diversity of students choosing health careers.[36,37] **EXAMPLE:** The California Community College Chancellor's Office has mapped out behavioral health career pathways to reduce barriers to entry for several behavioral health careers, and many community colleges are implementing these strategies.
- The accreditation and certification process for health professions education programs is a powerful lever to demand institutional DEI policies to advance the diversity of the health workforce.[18,38]
- Measuring and monitoring progress in diversifying the health workforce is critical for ongoing advancement.[1] State agencies like HCAI should monitor the diversity of the health professions to track whether implementation of the programs and policies described in this brief improves workforce diversity. Enhancing data collection and reporting by disaggregating racial-ethnic groups (e.g., Asian), providing more regional data (e.g., county), and adding other demographic information (e.g., gender, sexual orientation, etc.), and encouraging more coordination and data sharing across all state agencies that license and certify health care workers will help to centralize and standardize demographic data collection, analysis, and reporting. **EXAMPLE:** AB 133 restructured the former Office of Statewide Health Planning and Development (OSHPD) into HCAI in 2021, enhancing its role and ability to collect, analyze, and report health care data, including data on the licensed health workforce.

Conclusion

A diverse health care workforce is a critical component of a high-functioning health care system and promotes social justice by providing economic opportunities for everyone to thrive. We echo the California Future Health Workforce Commission's call to "invest in, support, and build a healthy, diverse, and robust workforce that all Californians need and deserve." Review the accompanying policy brief for specific policy recommendations.

Find more research and evidence from Healthforce Center at UCSF on the diversity of the health workforce and approaches to improve equity.

About us

Policy at Healthforce promotes health workforce diversity and economic opportunities in California through a responsive, community-informed research and policy agenda rooted in social justice, with support from The California Endowment. Policy at Healthforce is part of Healthforce Center at UCSF, a trusted partner to funders, policymakers, and health care

organizations, delivering impactful research, evaluation, policy insights, and capacity building programs. Grounded in equity and built on deep relationships across California's health care landscape, our work breaks down silos and drives system transformation—advancing better health for all.

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