Missing Persons?

Health Care Workforce Diversity in New Hampshire

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Beyond Supply and Demand is a 15-month study which seeks to understand how health care workers in Southern New Hampshire access employment and advancement opportunities throughout their careers. This study utilizes qualitative interviews and social network analysis to reveal the structure of employment networks, the resources passed along through these networks, and whether and how opportunities vary for workers from diverse backgrounds.

The *Healthcare Employer Research Initiative* is a four-year partnership of the Institute on Assets and Social Policy at Brandeis University with the New Hampshire Office of Minority Health and Refugee Affairs. The goal of this initiative is to identify New Hampshire health care employer needs, challenges, and best practices for increasing diversity in the health care workforce.

Both studies inform policy recommendations for employers, workforce development programs, training institutions, and job seekers.

Introduction

In 2004, a landmark report, *Missing Persons: Minorities in the Health Professions*,[1] drew attention to the fact that African Americans, Hispanics, American Indians, and certain segments of the Asian/Pacific Islander population were "missing" from the U.S. health care workforce. This workforce gap has health consequences. In clinical encounters, stereotyping, biases, and uncertainty can contribute to unequal treatment, resulting in care delivery that does not match a patient's needs.[2, 3]

The gap contributes to racial and ethnic health disparities, which are prevalent in all regions of the U.S., including New Hampshire.[4] Ten years after the release of *Missing Persons*, with a rapidly diversifying population and a health care sector that employs over 80,000 people each year, it is time for New Hampshire to assess the diversity of its health care workforce to ensure that all residents are given an opportunity to achieve good health.

Access to stable employment in jobs with benefits also impacts employee health and well-being. Therefore, closing the workforce gap will improve health for patients as well as for New Hampshire's workforce.[5]

This brief answers the following questions:

- To what extent, if at all, is New Hampshire "missing" certain groups of people in its health care workforce?
- What are some key trends by race and ethnicity in Southern New Hampshire's health care workforce?

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Establishing a Baseline

The state's diversity has grown rapidly in recent years (to 8% from 4.9% in 2000).[6] The concept of workforce diversity has growing relevance for New Hampshire as a whole, and immediate relevance for Hillsborough County, which contains Manchester and Nashua, the state's largest and most diverse cities.

New Hampshire's future patient and workforce populations are certain to be more diverse than today's. From 2000-2010, the non-Hispanic white youth population shrank by 12.8%, with 37,000 fewer youth, while the total minority youth population grew by 14,700, or 72.1%.[7]

Table 1. Population by Race and Ethnicity (2008-2012)

	New Hampshire	Hillsborough County (Includes Manchester and Nashua)	Manchester	Nashua
Total Population	1,317,474	401,101	109,786	86,823
Race				
White	94.20%	91.30%	86.90%	85.70%
Black or African American	1.20%	2.10%	4.50%	2.10%
American Indian and Alaska Native	0.20%	0.20%	0.10%	0.20%
Asian	2.20%	3.30%	3.90%	7.00%
Native Hawaiian and Other Pacific Islander	0.00%	0.00%	0.00%	0.00%
Some other race	0.70%	1.40%	2.20%	2.70%
Two or more races	1.60%	1.70%	2.30%	2.30%
ETHNICITY				
Hispanic or Latino (of any race)	2.80%	5.30%	7.30%	9.70%
Not Hispanic or Latino	97.20%	94.70%	92.70%	90.30%
Total Racial and Ethnic Minority* Population (rounded)	**8%**	**12%**	**18%**	**21%**

Source: ACS (2008-2012)

*For the purposes of this brief, the term "minority population" includes both racial and ethnic minorities - those who identify racially as non-white or two or more races, and those who identify as Hispanic or Latino. In Table 1, this percentage was calculated by subtracting the non-Hispanic white population from 100%.

Table 1 shows that Manchester and Nashua have different baseline populations. In both cities, the Hispanic/Latino population comprises the largest minority group. However, in Manchester the second largest minority group is black and African American (4.5% of the population), whereas in Nashua it is Asian (7%). Just as these cities have distinct residential patterns, they also have distinct labor markets that operate at a local level. Table 1 presents the most accurate and current data available for population counts by race and ethnicity, as estimated by the American Community Survey. These are likely to be conservative estimates, because they are averaged over 5 years. Today the actual population is likely to be even more diverse. Nevertheless, these numbers provide a baseline from which to assess whether minorities are "missing" in health care, compared to their growing presence in the total resident population.

In Summary

- New Hampshire has a minority population of 8%.
- Manchester and Nashua are more diverse, with minority populations of approximately 20%.
- Tomorrow's workforce will be more diverse.

The Status of Workforce Diversity in New Hampshire Health Care

Figures 1 and 2 illustrate the percentage of racial and ethnic minorities working in the three industry sub-sectors (ambulatory health care services, hospitals, and nursing and residential care facilities) that most accurately comprise the health sector.

Comparing percentages in the three health care sub-settings with the the total resident minority population (7.8% in New Hampshire) helps to explain the extent to which the workforce reflects the patient population. As the red line in Figure 1 indicates, minorities are overrepresented in nursing and residential care facilities—which tend to have high turnover, lower wages, and fewer opportunities for advancement[8, 9]—and underrepresented in ambulatory care and hospital settings—which tend to have higher paying stable jobs, and more opportunities for advancement.

Figure 1. Minority Health Care Workforce New Hampshire*

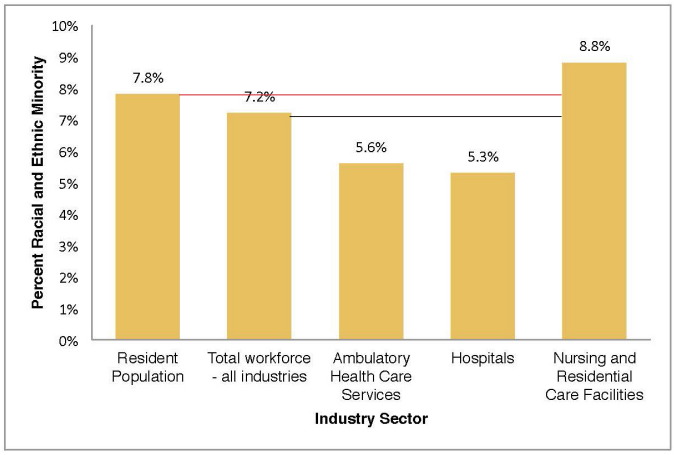
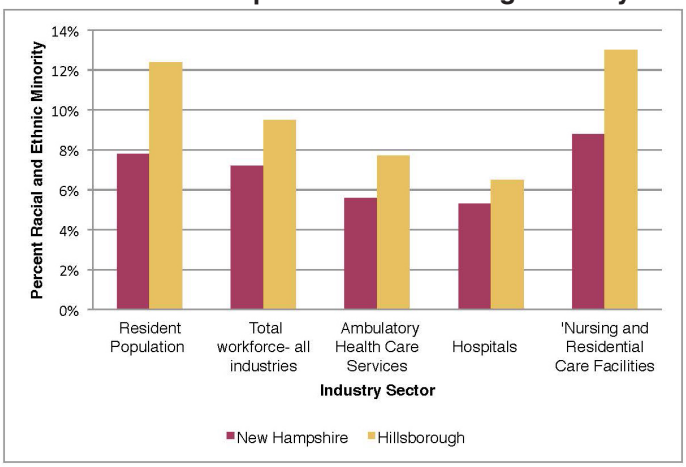


Figure 2. Minority Health Care Workforce New Hampshire v. Hillsborough County



The black line in Figure 1 compares the percentage of minorities in specific sub-sectors with the percentage of minorities in the total workforce (7.2% for New Hampshire). This comparison helps to explain the extent to which minorities are participating in certain sectors at the same or different rates as non-Hispanic whites.

This pattern is replicated, but the between-sector disparity is more pronounced in Hillsborough County (see Figure 2). For New Hampshire, the difference between the minority hospital and nursing/residential care workforce is 3.5 percentage points, whereas in Hillsborough county it is 6.5 percentage points.

Average Monthly Wages (2012) **	
Ambulatory Care:	$5,288
Hospitals:	$4,395
Nursing/Residential Care:	$2,436

*Source for all workforce data: Quarterly Workforce Indicators from the Census Bureau's Local Employment Dynamics database, downloaded February 2014, averaging Quarters 1-4 (2012). Total workforce figures exclude retirees, unemployed, and self-employed. Figures for the Resident Population come from the American Community Survey (2008-2012).

**Wages are not adjusted for number of hours worked and may reflect differences in PT/FT status. They may also reflect different levels of care provided to patients in each setting. These wages are not adjusted for the number and type of professionals employed in each subsector.

In Summary

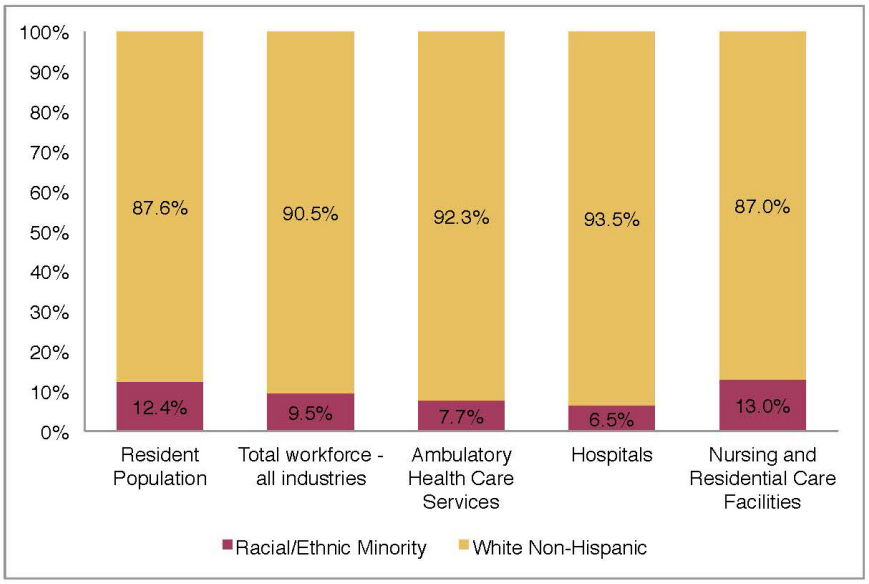
- Minorities are underrepresented in ambulatory care and hospitals and overrepresented in nursing and residential care.
- This trend is present in Hillsborough County as well as for the state as a whole.

The Full Picture

So far, we have begun to examine only one side of the equation—the presence of racial and ethnic minorities in health care. What are the patterns for non-Hispanic whites, and what does this mean for the workforce as a whole?

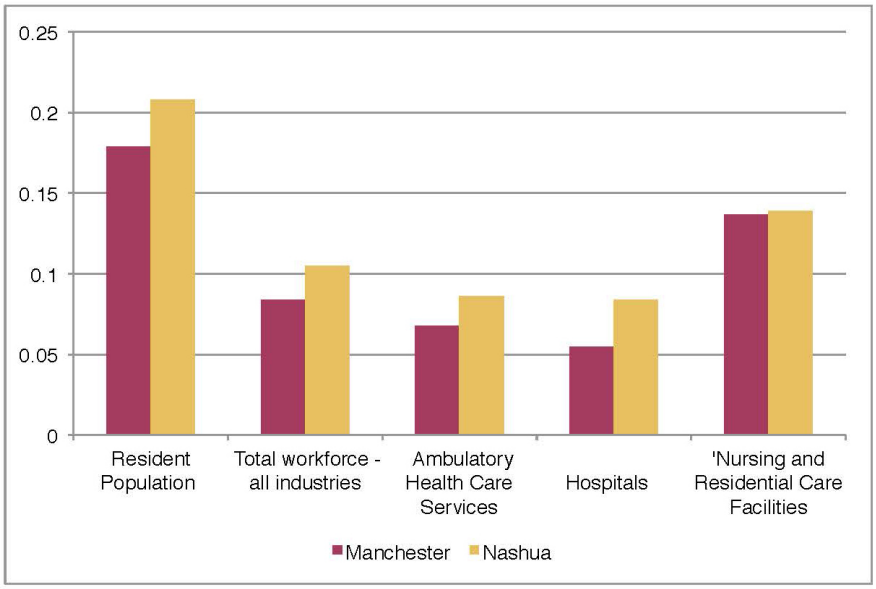
Using Hillsborough County as an example, in the hospital and ambulatory care sectors, minorities are underrepresented, and non-Hispanic whites are overrepresented. These settings offer jobs that pay more, while nursing and residential care facilities pay less. Whites are proportionately less likely to be found in the nursing and residential care sector.

Figure 3. White v. Minority Workforce - Hillsborough County



While this overrepresentation of non-Hispanic whites in certain health care settings is the logical inverse of underrepresentation of minorities, we must view both sides of the picture to fully understand workforce participation. Jobs that pay well are critical for individuals and families striving to achieve economic security and opportunity. It appears that in the health care workforce, whites have an economic advantage over minorities by working in sub-sectors that pay more. Meanwhile, minorities are at a disadvantage, working in sub-sectors that pay less. This unequal distribution of the workforce has consequences for patients, professionals, and society as a whole.

Figure 4. Minority Workforce - Manchester v. Nashua



What causes these differences? Based on national research, we know that labor market differences are partially explained by education levels, or human capital. Research has also shown that there are other dynamics at play. For example, it is widely recognized in employment that, "*it's not what you know, but who you know.*" Networks and other mechanisms lead people to work in certain occupations and organizational settings. Further research is required to investigate these dynamics in Southern New Hampshire's health care workforce.

In Summary

- Non-Hispanic whites are overrepresented in sectors that tend to have higher paying jobs.
- The patterns presented so far are mirrored at the local levels in both Manchester and Nashua.

Not So Black and White

The data presented so far have painted a broad overview of trends depicting "racial and ethnic minority" as a meaningful category. While this category is useful in geographic areas that are predominantly white and where data on specific racial and ethnic groups are difficult to find, it is also important, when possible, to understand how different racial and ethnic groups are distributed throughout the workforce. Data from Manchester (Table 2) and Nashua (Table 3) illustrate how trends differ between the largest four racial and ethnic groups in each city.

Table 2. Manchester Health Care Workforce - Select Racial and Ethnic Groups

	Total Population	All Industries	Ambulatory Health Care Services	Hospitals	Nursing and Residential Care Facilities
White	86.90%	94.70%	95.40%	96.10%	89.30%
Black and African American	4.50%	1.90%	1.40%	1.30%	6.40%
Asian	3.90%	2.10%	2.30%	1.70%	2.70%
Hispanic or Latino	7.30%	3.80%	2.70%	2.00%	3.90%
Total Racial/Ethnic Minority	**17.90%**	**8.40%**	**6.80%**	**5.50%**	**13.70%**

In Manchester, black and African American workers make up 6.4% of the nursing and residential care workforce compared to only 1.9% of the total workforce. In comparison, Asian and Hispanic/Latino workers are much more evenly distributed across sub-sectors, although all minority groups continue to be underrepresented in the hospital workforce.

Table 3. Nashua Health Care Workforce - Select Racial and Ethnic Groups

	Total Population	All Industries	Ambulatory Health Care Services	Hospitals	Nursing and Residential Care Facilities
White	85.70%	93.20%	93.80%	94.60%	90.40%
Black and African American	2.10%	1.70%	1.50%	2.00%	5.30%
Asian	7.00%	3.70%	3.30%	2.20%	2.70%
Hispanic or Latino	9.70%	4.60%	3.10%	3.70%	5.80%
Total Racial/Ethnic Minority	**20.80%**	**10.50%**	**8.60%**	**8.40%**	**13.90%**

In Nashua, once again the difference across sectors is greatest for black and African American workers. Asians in Nashua are underrepresented in nursing and residential care (2.7% compared to 3.7% in the workforce), which suggests that the overrepresentation of minorities is largely due to disparities for black/African American and Hispanic/Latino workers. Finally, differences within racial or ethnic categories are not reflected here because of a lack of more granular race and ethnicity data and sample size.

To more fully answer the original question about whether New Hampshire is missing certain racial or ethnic groups in the health care workforce, we would need occupational data by race and ethnicity. The broad sub-sector categories presented here do not tell us in detail about the occupations that individuals hold within each sector. The New Hampshire Division of Public Health Services, Rural Health and Primary Care has started a statewide data collection system for this purpose.

In the meantime, the data presented in this brief illustrate some compelling trends, and generate even more compelling questions. Why are minority groups more prevalent in certain occupational locations? To what extent does education account for these differences, and to what extent are other dynamics at play? Although minorities are not "missing" in the health professions, they are

more likely to be found at the lower end of the occupational spectrum. What economic, social and health impacts does this have for the patient population, the workforce, and our communities?

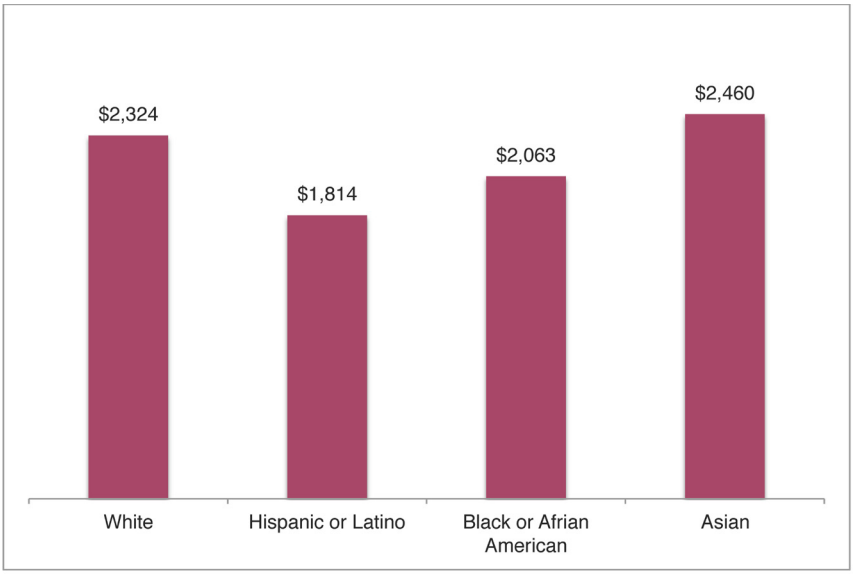
In Summary

- The greatest differences across sectors in both Manchester and Nashua are for black and African American health professionals, when compared with Asian and Hispanic/Latino health professionals.
- More detailed occupational data is required to tell if minorities are "missing" in certain types of jobs in health care.

Conclusion: Missing Out?

New Hampshire's growing diversity is reflected in the health care sector, especially in Southern New Hampshire, where overall, it would be inaccurate to say that minorities are "missing" in health care. Without occupational data by race and ethnicity, we also cannot say for sure if there are certain types of jobs in which minorities are underrepresented. However, within-sector wage differences (see Figure 5 below) suggest that on average, Hispanic/Latino and black/African American health professionals may be working in lower-paying jobs with fewer career advancement opportunities.

Figure 5. Average Monthly Earnings in Nursing and Residential Care - Hillsborough County (2012)



"Any economist will tell you that diversification is the key to a secure portfolio. Any geneticist will tell you that diversification is key to maintaining hardy species of plants and animals. But somehow, when it comes to racial politics, the virtues of diversity are lost. ***Diversity in health care is not about fair representation—it is about saving lives."***

– Commissioner George Strait
Associate Vice Chancellor
for Public Affairs
University of California, Berkeley

This issue brief also illustrates a different type of disparity. By comparing the proportion of individuals employed in three sub-sectors of health care—ambulatory care, hospitals, and nursing and residential care—it appears that when compared to non-Hispanic whites, racial and ethnic minorities are proportionately more likely to be employed in the nursing and residential care sector, which pays the least and offers the fewest opportunities for stability and advancement. This suggests that minorities may be "missing out" on job opportunities that offer the highest pay, and the greatest chance at economic stability and opportunity. Further research is required to understand why this is the case, and to generate recommendations to ensure that everyone has an opportunity to participate in good jobs, achieve their highest potential, and experience well-being. New Hampshire has a unique opportunity to understand and close this workforce gap now—at a critical time before health and workforce disparities further impact the productivity and well-being of our state.

End Notes

[1]Sullivan, Louis W (2004) *Missing Persons: Minorities in the Health Professions, A Report of the Sullivan Commission on Diversity in the Healthcare Workforce*. http://www.aacn.nche.edu/media-relations/SullivanReport.pdf

[2]Smedley, B. D., Stith, A. Y., Nelson, A. R., & Institute of Medicine (U.S.). Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2003). *Unequal treatment: confronting racial and ethnic disparities in health care*. Washington, D.C.: National Academy Press

[3]*The Rationale for Diversity in the Health Professions: A Review of the Evidence*, U.S. DHHS Health Resources and Services Administration (2006).

[4]*Health and Equity in New Hampshire: 2013 Report Card*, NH Center for Public Policy (2013).

[5]*Perspectives and Practices of New Hampshire Health Care Employers* (November 2013). Institute on Assets and Social Policy: Brandeis University.

[6]Johnson, K. (2012). *New Hampshire Demographic Trends in the Twenty-first Century*. University of New Hampshire Carsey Institute: Durham, NH.

[7]ibid.

[8]Karsh, B, Sainfort, F, & Booske, B C. (2005). *Job and organizational determinants of nursing home employee commitment, job satisfaction and intent to turnover*. Ergonomics, 48(10), 1260-81.

[9]Kaye, H S, Chapman, S, Newcomer, R J, et al. (2006). *The personal assistance workforce: Trends in supply and demand*. Health affairs, 25(4), 1113-20.

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This brief contributes to the work of the New Hampshire Health and Equity Partnership, www.equitynh.org. For more information on New Hampshire Health and Equity Partnership, please contact Rebecca Sky at rsky@healthynh.com.

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