EDITORIAL

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Voice: the importance of diversity in healthcare

We know that 'voice' matters in healthcare. We undertake patient opinion surveys for humanistic and medical reasons, as measures of outcome and quality improvement, as well as efficiency and even for marketing purposes (1). At our hospitals and health authorities we seek public engagement and participation because it helps inform decision-making and provides legitimacy, credibility, transparency, accountability to the process and promotes partnership and trust (2). We also expect our leadership to reflect this ethos of good governance through consultation and collaborative efforts. For example, we know that when confronted with difficult resource allocation or disinvestment decisions, broad participation from managers and clinicians at all levels is often the most effective approach.

Healthcare organizations ought to reflect the diversity of the communities they serve

But what of those who are intended to listen directly to 'voice' and then interpret and transmit information? Are the right people in place? For example, although most observers would agree that the ability to create and maintain an effective, efficient and motivated workforce is central to good outcomes (3), not all would assign equal value to a diverse healthcare workforce. For some organizations diversity means in-groups and out-groups, stereotyping, polarization, conflict and performance loss and, in reality, a challenge to be dealt with the best way possible while for many others, putting in place a well-thought out diversity strategy that seeks to develop a workforce that is reflective of the communities they serve, is one way to achieve better outputs, outcomes and ultimately, to improve population health (4).

These improvements might be realized through multiple pathways (5). First, minority healthcare workers are more likely than other healthcare workers to reach out to provide services to minorities in the community and to advocate on their behalf; second, where there is commonality between patient and practitioner communications, decision-making and adherence improve; third, improving the diversity of the workforce also augments the pool of medically trained personnel that can take leadership positions; and fourth, a diverse healthcare workforce provides role models for young people in minority communities.

The most important of these pathways as well as the most relevant to clinicians is racial, ethnic, and language concordance. Increasing the under-represented minorities (URM) helps improve the probability that minority patients will see a clinician from their own racial or ethnic group or who speaks their primary language. Concordance 'may improve the quality of communication, comfort level, or trust in patient-practitioner relationships and thereby improve partnership and decision making. This may in turn increase adherence to effective programs or regimens, ultimately resulting in improved health outcomes' (6). Evidence also suggests that racial concordance may influence disparities in health and mortality (7).

For similar types of reasons, many argue that where taxpayer dollars are involved, health authority or hospital boards ought to reflect the diversity of the communities they serve – to offer voice for those groups that might otherwise be overlooked, to articulate their needs and desires, strengthen the relationship between public and provider, to educate and be educated and to authenticate diversity and plurality in the community.

Participation, engagement and inclusion imply a redistribution of power. It is for this reason that most organizations stress the business case for a 'diversity and inclusion' strategy rather than a humanistic reason. For example, the Institute of Medicine's(8) diversity document *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce* strikes a similar chord to its position paper on global health entitled 'America's Vital Interest in Global Health: Protecting Our people, Enhancing Our Economy and Advancing Our International Interests' in that the emphasis is on self-interest – perhaps a more a dependable motivator and more likely to achieve stakeholder 'buy in' than the more volatile humanistic approach. Yet, organizations using this approach alone run the risk of appearing shallow if it is somehow implied that an injustice would be overlooked or let stand if the business case could not be made.

What is perhaps more striking than the evidence that diversity and inclusion strategies lead to better outcomes, is the evidence showing that failure to implement or to implement in a half-hearted manner usually has an accumulative and detrimental effect on institutional legitimacy, credibility and morale. In instances where this failure occurs without apparent consequences may actually suggest total occlusion and suppression of underrepresented groups. The following paragraphs look briefly at a local example

of this, the black diaspora in Nova Scotia, the largest and most troubled in Canada (9).

Black Nova Scotians, descended from African American former slaves or freemen, first arrived in the province in the 18th and 19th centuries and settled in separate and distinct communities, at the geographic, economic and social margins of society. One indicator of this marginalization is that about half of blacks come from families who live or have lived within 5 km of landfill projects. Although the last geographically segregated school was closed in 1983, ghettoization still defines the indigenous black community and for most, particularly young people, prospects are dismal. Research shows that blacks have higher morbidity and mortality rates than the general population; one study reports that the incidence rate ratios for blacks were significantly elevated for the three diseases: circulatory disease (1.19, 95% CI 1.08–1.29), diabetes (1.43, 95% CI 1.21–1.64) and psychiatric disorders (1.13, 95% CI 1.06–1.20) (10). A core theme in a multitude of equity studies is that black Nova Scotians 'have limited access to appropriate social, economic, and health services; and they are under-represented in healthcare delivery, in health research, and in the design and implementation of health policies' (11). Although we have universal health care, black Nova Scotians are often disinclined to access services, programs or facilities that they perceive as culturally incompetent.

Although one would expect some sort of accumulation of black Nova Scotians in the healthcare workforce, there is little evidence of this – perhaps one physician. The local medical school which has a fine international reputation yet has only produced one physician from the local black community in its 100 year history. Furthermore, there is no representation of blacks on hospitals boards which tend to be made up of influential professionals from affluent neighborhoods. As might be imagined, the story does not end there. Anger and frustration turns to drugs and violence and some of those disinclined to utilize health facilities often find their way by ambulance or police escort. Unhappily, other sectors of civil society that are mandated with creating and applying laws are sometimes perceived as weakened by institutionalized racism.

Most local health institutions have in place some sort of cultural competence training initiative based on the government's all-inclusive version of what constitutes diversity. Yet, consistent with the literature (12), these training initiatives have yielded few measurable results. Instead what is called for is a more direct approach – increased concordance between clinician and patient. This unfortunately, requires actually acknowledging the severity of the problem and the will and resources to do something about it. Political leadership at both the provincial and local level seems to lack the metacognitive ability to recognize existing failures and oversights; leaders not only don't know what it is they ought to be doing, they don't know that they don't know. This of course is consistent with the view of black Nova Scotians – that it's not simply that they have not been listened to but rather they have no voice to be heard.

A few bright lights are showing a way forward: for example, consistent with research that suggests that the best means to improve levels of URM in the health sector is to start early (4), the School of Nursing has been running annual summer camps to reach out to junior and senior high school students with mentorship and some financial aid to help bring then into the health professions. Key decision-makers, who are otherwise well-intentioned and competent, could learn from the grit and determination of the handful of students now enrolled in nursing; it's time to deal with this shameful situation that is the black diaspora in Nova Scotia and give voice to those who yearn for it.

Disclosures

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