
COMMITMENT

The Commitment to Minority Recruitment Programs

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SUMMARY. A myriad of programs have been mounted to increase access for the underrepresented into health career programs, some being more successful than others. Commitment is the theme of this paper and is linked to success through discussions of: the background to the health care problem in which race, income and related socioeconomic variables play dominant roles; the issue of minority access to college; the minority manpower shortages/maldistribution controversy; and, the need to secure and commit financial resources which, as an expression for diversity, would lead to the improvement of the delivery of pharmaceutical care for all the citizens of this country.

WE THE PEOPLE . . . with these words the Preamble to the Constitution of the United States eloquently set forth a new national ethos designed to guide a fledgling political experiment.

That unity of purpose, dedication to principle, and commitment to equal opportunity and progress which were to characterize the American

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people often seems elusive and contradictory. In its stead we too frequently see an increase in the polarization and fracturing of our society, where angry individuals are pitted against each other on all fronts . . . social, economic, and political. And the phenomena is as evident in health professions education as it is in most other examples to be placed before an audience as sophisticated as pharmacy educators and practitioners.

Although the *Constitution* may guarantee that all men are created equal, it does not assure that they are treated equally. It seems to me that one of the reasons for this is that our society embraces the Horatio Alger ethic that those who truly and sincerely want to make it in our society most assuredly will. According to this formula, the poor, the uneducated, the disabled, the ill, and the unsuccessful are that way because they choose to be. It follows, therefore, that social deprivation, bad housing, malnutrition, and a host of other adversities, are not societal priorities because these conditions are self-inflicted by those who are poor, uneducated, disabled, ill, and unsuccessful. Unfortunately, the compassion of this administration for overcoming these conditions rates somewhere between its affection for Saddam Hussein and its affection for your average welfare mother, and is a nonexample of commitment.

Unlike machines and computers, the society of man is riddled with contradiction, inconsistency and conflict. For example, at a time when many scientists are striving to increase the quality and span of life, others are devising more efficient ways of taking lives, scorching the earth, and polluting the environment. The tragedy is that the contradictions, inconsistencies, and conflicts are all so unnecessary. Life is so dear and the quality of life so inexpensive that our society should be able to provide access to self-improvement for those who want to achieve. But it has not and will not for as long as it refuses to cope with the changes that have taken place and the changes that will continue to occur at an ever-accelerating pace. For example, tomorrow's world will be crowded and ways will have to be found to cope with the masses. Shifting demographics, increasing numbers of the elderly and the minorities, for example, will have a profound impact on society at large. Its priorities will shift and its democratic voice will increasingly respond to the demands of the elderly and the new majority of today's minorities. Our challenge is to persuade our institutions, whether public or private, and their decision makers, and all the other segments of society as well, to address all of the issues relevant to health professions education. We must make certain that access to a health professions education and the delivery of health care

services is available to all segments of our society to ensure that the present double standard of health care will disappear.

BACKGROUND: ACCESS TO HEALTH CARE AND HEALTH PROFESSIONS EDUCATION

Some twenty years ago, November 19, 1971, The Honorable William R. Roy, U.S. House of Representatives stated during a hearing before the Committee on Ways and Means, House of Representatives, 92nd Congress on National Health Insurance Proposals, *"There is no area of human life more important to an individual than his health, and there can be no area of policy of greater importance to a nation than the health of all of its people"*(1). That statement recognized, regardless of status and position, access to health care is a constitutionally guaranteed inalienable right and that members of the health professions are expected to render health services of acceptable quality to underprivileged patients as well as to advantaged persons.

That the broad diversity of the population of this country is not adequately represented in those who graduate from high school, and fewer of those are academically eligible for entrance into college, has been the focus of educators for many years. We in pharmacy education know that many of the reasons for low minority enrollment in health professions schools include inadequate preprofessional preparation, high educational costs combined with limited financial aid, cultural barriers, lack of role models, and motivation. It is also apparent that many communities in our nation are comprised of persons who, for economic, social, and cultural reasons have not enjoyed the normal privileges, rights, and opportunities inherent in an affluent society. Regardless of status and position, however, the Constitution guarantees certain inalienable rights, and access to health care is one of those rights. Yet, health statistics of the minorities and the poor confirm that the delivery of health services of acceptable quality and quantity has not been delivered to the underprivileged.

Studies made in the 1960s and 70s concluded that there was either a shortage or maldistribution of health care personnel, thereby creating a problem with access to quality health care. These academic exercises are necessary and deeply immerse us in the evolution of change, but they provide little comfort or relief for the poor, hungry, malnourished, crippled and diseased. Other studies identified that approximately one-fourth of those within this nation's social fabric of poor, hungry and malnour-

ished were the ethnically and culturally different socioeconomically disadvantaged.

I believe it is safe to say that during the era being described Americans were shocked to learn that approximately one-fourth of the nation's population was poor. The poor had become an invisible group (if they were white) whose poverty was hidden beneath their apparent similarity to other Americans. They appeared to be healthy, they betrayed few of the signs of despair and desperation that characterize the poor in other parts of the world, and they wore much the same clothes as do we of the nonpoor classification. And, unless they were easily identified as *minorities* they were alluded to as "The other America."

But black, brown, red and yellow America was something else. It was there; everyone knew it, but it had become a phantom population in public housing, segregated middle-class neighborhoods, migrant farm workers housing, federally supported reservation domiciles or remote marginal farms in the deep south. However, as a result of the 1950s and 60s civil rights movement the poor were no longer invisible. They constituted a revolutionary force in American society for their condition was inextricably woven with other than economic issues, such as civil rights, civil dissent and the morality of war. Thus, it was no longer possible to deal with the poor solely in terms of living standards. (Author's note: Because of the economic progress minorities have made since the civil rights activities of the 1960s, it may be difficult for the reader to envision that prior to the civil rights movement a major segment of the minority population fit into the economic definition of poor.)

Eliot L. Richardson, then Secretary, Department of Health, Education, and Welfare, in a presentation on The National Health Insurance Partnership Act before the House Committee on Ways and Means (October 19, 1971) stated that lower income groups and racial minorities have far poorer health, but at the same time receive far less health service than other groups. Those gross measures masked large disparities in health status among subpopulations in the U.S. On nearly every index, the poor and the racial minorities fared worse than their opposites, e.g., shorter life spans; more chronic and debilitating illnesses; higher infant and maternal death rate, etc. (2). And, they also had far less access to health services.

Accordingly, it was recognized that awareness of these differences among our citizens . . . the denial to some of a life span as long and as relatively free of disabilities and illnesses as that which others enjoy . . . accompanied by a sense of injustices that denial entails, and by experiences that denial and its effects can and should be obviated, would be a major step in eliminating what was then known as a "health care crisis."

The above was generally accepted as an adequate description of part of the health care problem in which race, income and related socio-economic variables played dominant roles. What followed was the consideration of the variables to eliminate this problem. The result was an agreement that reforms in education, which meant access to an education in pharmacy in particular, was to be embraced. This meant that changes in basic commitments and attitudes, as well as the commitment of financial resources to assist the poor in obtaining an education in pharmacy, were necessary and must be made available.

MINORITY ACCESS TO HIGHER EDUCATION/PHARMACEUTICAL EDUCATION

The issue of minority access to college was one of the dominant issues of the 1970s and, 20 years later, still is. Around that issue revolved a host of questions and problems related to the gravity of racial and ethnic conflicts, and the answers to delivery of health care to those not receiving is partially tied, if not significantly interwoven, into *access* to higher education. Access for the poor is mostly economically controlled. Lack of ability, for example, is not a barrier to entry into the first grade of elementary school, but it is at the point of entry to college. If society were to decide that everyone must go to college, just as it decided years ago that all must attend elementary school, the ability barrier would disappear because it would be irrelevant.

The same observation could be made about barriers caused by lack of money. If it were to be decided that all the direct and indirect costs of higher education were to be charged against society at large and that the individual consumer of education would be charged nothing, the cost barrier would disappear. The point is that barriers came into being and now continue to operate because society either permitted them to evolve or consciously created them.

Some 55 years have elapsed since Lee and Jones first concluded that there was a shortage of physicians in the United States (3). Those conclusions were then extrapolated to indicate that there may also be a *shortage of pharmacists*. Thus, on the basis of more refined data, and prognostications somewhat less refined, it became fashionable to blame the insufficiencies of the health care delivery system on maldistribution. Those academic exercises were necessary, and deeply immersed us in the evolution of change, but they provided little comfort or relief for the poor,

hungry, malnourished, crippled and diseased. For these were (are) the victims of either *professional manpower shortages* and/or *maldistribution*.

With respect to commitment, the attitudes of professional practitioners, and the lack of leadership from local, state, and national pharmaceutical associations cannot escape indictment. The past had demonstrated that all of the above have, to differing degrees, either neglected or refused to initiate without prodding any activity to increase minority enrollment in pharmacy schools. Back in 1971, during the annual meeting of the American Pharmaceutical Association, the association was sharply criticized by members of its House of Delegates for not delivering on its policy, adopted a year earlier, to make special efforts to recruit disadvantaged ethnic and racial minorities. The point is that the challenge to assist in increasing the number of health professionals from minority groups was accepted only after a confrontation over priorities. Unfortunately, the priorities were related to minority recruitment specifically rather than to improvement in the delivery of pharmaceutical services generally through minority recruitment. By and large, local and state associations made the same kinds of noises but not the commitments necessary to move ahead with minority recruitment.

MINORITY MANPOWER ARGUMENT AND COMMITMENT

To recite forecasts and provide documentation which indicates that pharmacy manpower demands will exceed the supply and to use these forecasts as a basis for committing ourselves to minority recruitment is specious reasoning. It enshrouds the real issue. To design recruitment strategy on the premise that pharmacy manpower requirements dictate tapping of the potential minority manpower is not facing, or refusing to recognize, the real issue of socioeconomic discrimination, whether de facto or otherwise. It is a cop out.

The determination of whether or not to commit ourselves makes the difference between a paper plan to be filed and a commitment to a viable entity. Commitment is the most important aspect to be considered and is tantamount to achievement. The decisions to split the atom and to place a man on the moon are eloquent sagas illustrating this point. And, the speed with which a commitment will be realized depends upon the priority assigned. As a health care issue, it is a serious mistake to assign less than the highest priority to improving health care of the population as a whole through minority recruitment.

AN EXAMPLE OF COMMITMENT FOR CHANGE

In the early 1970s, the University of California, San Francisco School of Pharmacy, recognizing its responsibilities to *all* the citizens of California, devised a successful strategy of minority recruitment and retention to address one formidable barrier of access to quality pharmaceutical care . . . the absence of minority pharmacy professionals. The strategy developed required the commitment of administration, faculty, and students. The rewards were, over a ten year period, that seventeen minority graduates joined the faculties of Schools of Pharmacy across the nation. Subsequently, importantly, and undeniably that commitment by the UCSF School of Pharmacy increased diversity within our pharmacy faculties.

MAKING THE CASE FOR FINANCIAL ASSISTANCE

Commitment includes providing resources for both recruitment and retention. The need for higher education is just as great among racial and ethnic minorities and the poor as it is in the rest of the population. However, colleges and universities were slow to serve even the most able students in this segment of society. Considerable improvement has occurred over the past twenty years despite the fact that efforts were blunted, and continue to be blunted, by inadequate financial aid. The first and most obvious step in any successful recruitment program is the securing of sufficient funds for financial aid. If recruitment programs are to reach into the low income areas, we will then be reaching students whose families are unable to make significant contributions toward their education. Therefore, it is unrealistic to suggest that those students can pay tuition and other fees. In response, some say that there is a long list of government programs and private philanthropic organizations which provide substantial financial support to economically disadvantaged students. The reality is that the financial pressures the state governments are presently suffering is causing a reordering of priorities and, accordingly, diluting past commitments. As of this writing, the financial picture is becoming increasingly bleak. Therefore, it is incumbent upon our professional associations, whether they be local, state or national, to assist our schools in locating and establishing financial assistance for the underprivileged and the underrepresented. That is commitment.

As an example of commitment for local, state, and regional organizations, one approach would be to make *low interest* loans available by negotiating guarantees either through the associations or in concert with

the local bank. The guaranteed federal loans now available are high interest loans, sufficiently high to discourage potential applicants to our schools to pursue an education in pharmacy. One must recognize that most minority students are in the lower incomes strata, usually have little collateral and, therefore, are poor risks for the banking community. Accordingly, evidence of commitment could come in the form of assisting the schools in securing loan funds for high-risk students. Concomitantly, getting involved in an effort to support the negotiation of loan guarantees would aid in the recruitment of the underprivileged and the underrepresented. That, again, would be commitment; an engagement to assume a financial obligation as an expression of support for diversity which, subsequently, would lead to the improvement of the delivery of pharmaceutical care for all the citizens of this country.

Although commitment is the theme of this effort, "Health is our Concern" is, appropriately, the real issue underlying commitment. My concern is whether we will all move forward because more of us will be involved in commitment, or whether our hesitancy in embracing commitment will contribute to the ever-widening gap between the healthy and the ill. We can narrow, even close that gap with the tools we have; education, involvement and commitment.

I trust health care practitioners and educators concur that the opportunity and the responsibility to improve the delivery of health care rests with each of us and also recognize that *commitment* to providing access to an education in pharmacy is part of the equation in solving the problem of the double standard of health care.

REFERENCES

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