

Equal Employment Opportunity in Managed Care Organizations

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American history challenges us to forge political and economic equality from a rich mosaic of cultural diversity. This is no less true of those in the most privileged professions—law and medicine—than of those living in poor urban neighborhoods, rural communities, or even our prisons. From the descendants of this land's original inhabitants and its earliest European, African, and Asian arrivals to its most recent immigrants, we all must accept this American challenge to work together to form and reform a more perfect union.

The issue of equality is central to our American identity, yet we sometimes avoid the painful questions it raises by insulating ourselves in the comfort of our own ethnic identities, social mores, and folkways. It takes vigilant leadership to keep us mindful of our social responsibility to improve upon “business as usual.” Fortunately, leaders do step forward to challenge us, reminding us how far we have come and how far we have yet to go.

One such leader was the late Herbert W. Nickens, MD, Vice President for Community and Minority Programs at the Association of American Medical Colleges (AAMC), who died unexpectedly of a heart attack in May of this year. The AAMC annual report on minorities in medical education and the program to increase minority medical school enrollment to “3000 by 2000” are but 2 examples of his positive influence on medical education.^{1,2}

A survey of our social progress reveals a positive course in minority participation in the medical pro-

fession over the past several decades.³ There is, however, a continued need for medical professionals to fully reflect the make-up of our population. In its twelfth report to Congress, the Council on Graduate Medical Education noted that “if the AAMC were to meet its objective to achieve 3000 matriculants by 2000, which doubles its 1990 number of matriculants, then perhaps this growth rate could be sustained for several more decades to achieve 4500 matriculants by 2010 and 6000 by 2020.”⁴

Yet, even if educational equality is improved, equal employment opportunity must be afforded to graduating professionals to realize complete equality and diversity in the United States. Managed care organizations (MCOs) are expected to deliver a growing share of health services to members of ethnic minority groups that comprise an increasingly greater share of our population.⁵

The focus of healthcare research on access, cost, quality, and outcomes has provided the industry with tools to manage services effectively. Research in medical sociology will help account for, and correct, disparities in health status and outcomes among various minority populations. Knowledge that improves the fit between process, patient, and improve satisfaction with and public opinion of managed care.

An example of this type of research is the article by Mackenzie and colleagues in this issue of the *Journal*, which addresses the subject of equal employment opportunity for health professionals in the managed care environment.⁶ Performing secondary analyses of telephone survey data for 1032 primary care physicians, the authors constructed scales to determine the difficulty of physicians' obtaining managed care contracts; the rates of contract termination, patient attrition, and physician satisfaction; quality of care; and limitations on care. Their multiple regression analyses revealed few sig-

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nificant differences between physicians of different racial or ethnic groups. This can be interpreted as a failure to reject the null hypothesis of equal employment opportunity.

An analysis of bivariate associations between ethnicity and MCO affiliation revealed that Latino physicians have significantly fewer MCO affiliations than non-Latino physicians and the lowest board certification rates. Since MCOs typically use board certification as a quality assurance measure, it is likely that the lower board certification rates of Latino physicians may account for their lower MCO participation. Although not shown in their article, a 3-way analysis of MCO affiliation by ethnicity controlling for board-certification rates revealed that Latino physicians have lower-than-expected affiliation rates even after accounting for their lower certification rates. The reasons for Latino physicians' lower board certification rates and lower MCO affiliation rates are 2 issues that clearly require further research.

Failure to reject the null hypothesis may be a positive sign that gross, overt discrimination is not widespread in MCO contracts with physicians. This fact offers evidence that the institution is fair and open to all, as it should be. However, a single piece of reassuring evidence should not excuse complacency. As the authors point out, their research with ethnically diverse physician focus groups indicates that more subtle problems exist.⁷ Perhaps the survey instrument was insufficiently sensitive to measure the types of problems that physicians

encounter or perceive. Further development and refinement of instruments and surveys designed to evaluate minority participation in healthcare and to measure subtle problems associated with it will prove invaluable to MCOs as they operate in a society where cultural competence increasingly counts toward the bottom line.

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