Setting the Stage for a Business Case for Leadership Diversity in Healthcare: History, Research, and Leverage

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EXECUTIVE SUMMARY

Leveraging diversity to successfully influence business operations is a business imperative for many healthcare organizations as they look to leadership to help manage a new era of culturally competent, patient-centered care that reduces health and healthcare disparities. This article presents the foundation for a business case in leadership diversity within healthcare organizations and describes the need for research on managerial solutions to health and healthcare disparities. It provides a discussion of clinical, policy, and management implications that will help support a business case for improving the diversity of leadership in healthcare organizations as a way to reduce health and healthcare disparities. Historical contexts introduce aspects of the business case for leveraging leadership diversity based on a desire for a culturally competent care organization.

Little research exists on the impact that the role of leadership plays in addressing health disparities from a healthcare management perspective. This article provides practitioners and researchers with a rationale to invest in leadership diversity. It discusses three strategies that will help set the stage for a business case. First, provide empirical evidence of the link between diversity and performance. Second, link investments in diversity to financial outcomes and organizational metrics of success. Third, make organizational leadership responsible for cultural competence as a performance measure. In order to address health and healthcare disparities, collaborations between researchers and practitioners are necessary to effectively implement these strategies.

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INTRODUCING THE PROBLEM

The healthcare field has been calling for studies to support diversity management as an intervention for racial and ethnic disparities in access, treatment, and outcomes (Dreachslin, Weech-Maldonado, and Dansky 2004; Weech-Maldonado et al. 2002; Brach and Fraser 2000). Previous literature suggests that racially and ethnically diverse business organizations outperform their more homogenous counterparts in both quality and financial outcomes (Richard 2000; Dreachslin and Hunt 1996; Cox 1993). Some authors have noted that the business case would be easier to assess if interventions were implemented with strong evaluation designs that could isolate intervention effects associated with the business case for diversity (Lurie et al. 2008b). This article provides contextual support for a business case in leadership diversity as a strategy for reducing racial and ethnic health and healthcare disparities.

Public health researchers solve problems using a public health approach, which involves defining and measuring the problem, determining the cause or risk factors for the problem, determining how to prevent or ameliorate the problem, implementing effective strategies on a larger scale; and evaluating the impact of those strategies (Satcher and Higginbotham 2008). Racial and ethnic health disparity is a pervasive problem that has been defined and measured both in the research literature and in national reports (AHRQ 2008; IOM 2002, 2001; HHS 2000). It has been suggested that the pervasiveness of the problem is related to the operational drivers of the health system. Two of these drivers are leadership and the presence of culturally competent care. Research has yet to fully address these issues. Important topics related to these drivers, but missing from the literature, are an organizing framework for integrating the factors that promote workplace diversity practices and an understanding of leaders' perspectives on managing diversity (Ng 2008).

So is the absence of cultural competence a system failure? While organizational cultural competence is the preferred outcome, some scholars and practitioners involved in this debate believe that diversity management is the process leading to culturally competent organizations (Betancourt 2006). Others have stated that the commitment of top leaders to change is a fundamental element in the implementation of diversity management initiatives (GAO 2005). To put this issue into a larger context, these drivers are further described as being important factors in the development of a business case for leveraging leadership diversity in healthcare. Adapting a business model framework (Konrad 2003), organizations are urged to become culturally competent and invest in leadership diversity for the following reasons:

- Shifts in the demographic landscape of the healthcare workforce and consumer needs requires organizations to embrace an increasingly diverse labor pool if they want to stay current and compete for the best talent.
- The realities of a global economy require that healthcare organizations respond with a diverse workforce to effectively provide high-quality, culturally competent care to an

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increasingly diverse consumer and patient population.

- Demographic diversity unleashes creativity, innovation, and improved group problem solving, which in turn enhances and leverages the competitiveness of organizational financial and quality outcomes.

These arguments are considered key to an assertion for a business case in leadership diversity. Leveraging diversity is associated with managerial practices and is discussed in terms of sound business management acumen that helps organizations become culturally competent. Current research on the impact of diversity practices on reducing health disparities is varied and has yet to outline the need for a business case for diversity leadership in healthcare. We use literature on culturally competent care and leadership performance to develop a business case for leveraging leadership diversity as a promising solution for addressing health and healthcare disparities.

Identifying Cause and Risk Factors

National action toward the idea of organizational cultural competence and the reduction of health disparities have three separate, but equally important, origins that shape history and are central to setting the stage for the business case: (1) the Civil Rights Act of 1964, (2) the Heckler report of 1985, and (3) the Healthy People Initiative of 2010. Each event is historic in its own right, but for cultural competence, the result of action from each provided a managerial building block for making a business case for leadership diversity in the current health system. First, the Civil Rights Act provided legislative enforcement against any organization that discriminates against its citizenry based on race, color, or national origin (Office of Civil Rights 2007). For any organization receiving federal funding, these societal mandates curtailed formal policies of discrimination and raised the costs to organizations that failed to implement fair employment practices (Kochan et al. 2003).

Second, the Heckler report provided the incentive for clinical research focused on reducing health and healthcare disparities. The report recommended increasing federal resources in six areas that would address health disparities: health information and education, health service delivery and financing, development of health professions, cooperative efforts with the nonfederal sector, data development, and creation of a future research agenda (Heckler 1985). These recommendations led to initiatives that resulted in legislative appropriations for the Office of Minority Health and Health Disparities, now the National Institute for Minority Health and Health Disparities. Additionally, these recommendations have been used as the framework for several health and healthcare disparities studies commissioned by the Institute of Medicine.

Finally, our nation used the Healthy People (HP) initiative as a "strategic management tool for the federal government, states, communities, and many private sector partners" (HHS 2000). The top two goals for Healthy People 2010 were to (1) increase quality and

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years of life, and (2) eliminate health disparities (HHS 2010, 2000). There now seems to be a national desire to address health disparities, as evidenced by the Equal Employment Opportunity Commission's robust policies and monitoring, and the HP collaborative recent release of HP2020 with the elimination of health disparities as an overarching goal and measure of progress for the nation's health agenda (HHS 2010).

Healthcare organizations are in difficult management situations as they try to coordinate solution-oriented efforts and maintain a profitable stance in the ever-increasing competitive healthcare environment. As isolated incidents, these historical contexts provided clear strategies toward gaining equality for all. Taken together, they coalesce legal, clinical, and legislative support for the use of leveraging leadership diversity as a business case toward a solution for health and healthcare disparities.

Based on evidence that business solutions can be found in managerial components of organizations, we believe that the presence of health and healthcare disparities indicates, in part, the lack of a culturally competent care perspective at the management level. Because leaders of healthcare organizations are considered the operators of the system, the existing set of business practices used in their managerial roles is directly responsible for the financial and quality outcomes. If one believes the adage that the system is designed to achieve the results that it creates, it can be concluded the healthcare system is designed to create health disparities. The quality of care being delivered in healthcare organizations is directly related to how well leadership and management practices are aligned to understanding the organization's health and healthcare disparities. The knowledge of and the ability to address health disparities in healthcare organizations are leadership qualities required of a sound, culturally competent organization.

EFFECTIVE STRATEGIES TO ADDRESS THE PROBLEM

Today, finding effective strategies that deliver affordable, high-quality healthcare to an increasingly diverse population is a major challenge for the leadership of the American healthcare system. As our nation continues to wrestle with reform, affordable healthcare in a more diverse society will be uniquely tied to addressing the cultural and linguistic barriers present in our delivery system that have perpetuated health disparities. Addressing the barriers includes understanding the potential costs and benefits for patients, families, communities, and healthcare providers and systems and producing the evidence to evaluate the fiscal implications (Goode, Dunne, and Bronheim 2006). Hospitals that fail to make progress on these fronts risk alienating their biggest institutional clients—employers and health plans—and the public sector (Armada and Hubbard 2010). We believe a successful healthcare organization understands the origins of health disparities and competently delivers care using strategies that address the needs of a diverse patient population with the goal of reducing disparities. It is within this context that culturally competent care becomes a business phrase and not simply a healthcare term.

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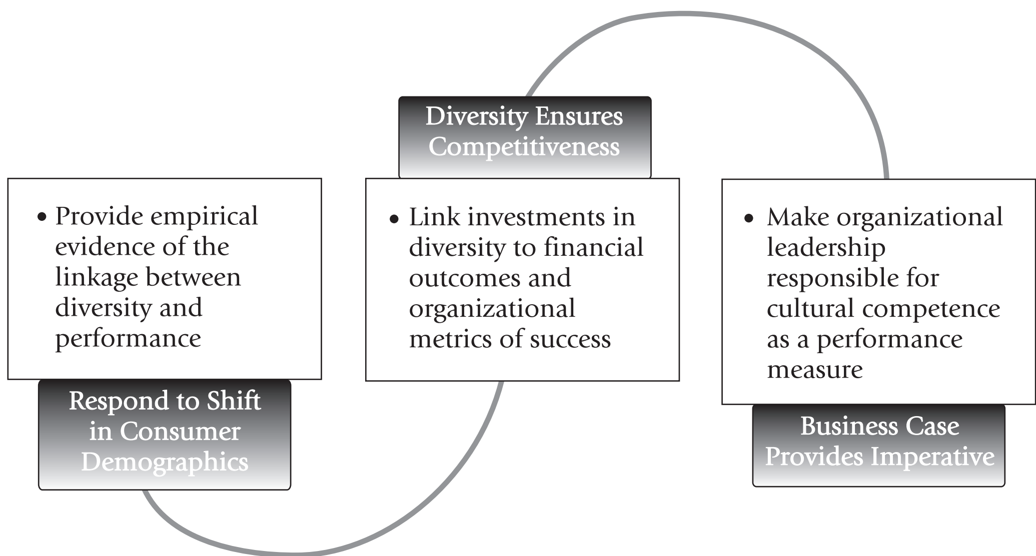
To address the problem of health and healthcare disparities, we identified three effective strategies that will help organizations become culturally competent and effectively leverage a business case for leadership diversity (see Exhibit 1). First, provide empirical evidence of the link between diversity and performance. Second, link investments in diversity to financial outcomes and organizational metrics of success. Third, make organizational leadership responsible for cultural competence as a performance measure. Effective implementation of these strategies will require better collaborations between researchers and practitioners.

Diversity and Performance

If leadership practices are going to change toward the operation of a culturally competent system, tying financial incentives to managerial components of culturally competent care is essential. Embracing culturally competent care as a business imperative will require a paradigm shift that focuses research on the managerial components of the healthcare system. The healthcare field has been slow to embrace this shift in thinking, perhaps because there is little evidence that diversity leads to better performance. Examples relating diversity to performance are hard to find in healthcare, but other industries have found these associations.

Studies have shown an empirical link between diversity and performance. In a firm-level study of the banking industry, racial diversity was positively associated with performance for firms pursing growth strategies and negatively associated with performance for firms engaged in downsizing (Richard 2000). The study concluded that racial diversity interacted with business strategies in

EXHIBIT 1
Strategies to Leverage Leadership Diversity



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determining firm performance measured in three different ways: productivity, return on equity, and market performance. In a comparative analysis of small service firms, more culturally diverse workforces were found to have a greater positive percent change in revenue, net income, and CEO income than small firms with less culturally diverse workforces (Hartenian and Gudmundson 2000). Alternatively, Kochan and colleagues (2003) were not able to deduce whether diversity initiatives affected performance based on readily available measures, but concluded that with the proper research design, diversity can be shown to affect performance (Kochan et al. 2003). The study ultimately found racial diversity to be associated with higher overall performance in banking branches that enacted an integration-and-learning perspective on diversity.

Diversity and Financial Outcomes

Research studies are only beginning to highlight the financial implications that healthcare leaders must contend with in their desire to have culturally competent organizations and the long-term payoff for these initial investments. For example, there is a noticeable absence of a broadly defined framework that includes the cost benefits of cultural and linguistic competence to families, communities, employers, and society (Goode, Dunne, and Bronheim 2006). However, cost and quality are hallmarks of culturally competent care. Furthermore, few studies have directly identified cultural competence as the primary driver of cost reduction or quality enhancement (NBGH 2003).

The link between financial investment and return will be an important driver for change that includes diversity initiatives. Demonstrating this link will provide leaders with leverage when deciding what investments will return the best outcomes. Leaders of organizations will need well-honed capacities to analyze the markets in which they operate and assess the relative advantages and possible actions of major rivals (Shortell and Kaluzny 2005). Researchers have argued for investments in diversity initiatives to be viewed as business decisions that increase one's competitive advantage (Meyers 2007; Dreachslin and Hunt 1996). Quantitative and qualitative performance measures will help organizations translate their diversity aspirations into tangible practice (Catalyst 2002). However, until these topics are better studied and measures adequately tested, support will continue to be sparse.

To provide leaders with support for investment in leadership diversity, we believe evidence-based practices linked to financial outcomes should be the process leaders use to support or back any investments toward organizational change in the healthcare market. In practice, leaders devote resources to diversity initiatives because they believe diversity is a business imperative and good for the bottom line (Jayne and Dipboye 2004). Unfortunately, there is a lack of widely accepted measures for factors such as diversity or leadership in healthcare organizations, and to that end, specific metrics that identify the influence of leadership diversity on reducing health disparities (Dogra et al. 2009). The top 20 percent of American

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hospitals rigorously collect patient race and ethnicity data and tie it to patient outcomes (Armada and Hubbard 2010), which suggests that the overwhelming majority of hospitals may not buy into the idea of diversity's connection to financial success. More directed research that incorporates measures of leveraging leadership diversity, as a healthcare practice and imperative, will enable organizations to better define these issues.

Cultural Competence and Performance

Only in the past few years has the idea of culturally competent care gained attention from healthcare policymakers, providers, insurers, and educators as a strategy to improve quality and eliminate racial and ethnic disparities in healthcare (Betancourt et al. 2005). Initially, leaders of healthcare organizations were reluctant to enact this type of change. Over time, regulatory power moved more healthcare organizations toward becoming more culturally competent as a condition of federal funding, particularly in the areas of language access for limited English speakers. For example, initial estimates suggested that organizations would spend an estimated $268 million to address language compliance as set forth by Culturally and Linguistically Appropriate Service (CLAS) standards or risk cuts in essential funding (Office of Management and Budget 2002).

Organizational change in response to varying cultural needs is not easy but must be part of the equation to eliminate health and healthcare disparities. The current situation calls for constant surveillance; renewed efforts to increase awareness of health disparities among medical professionals, the public, and legislators; and the design and implementation of effective interventions to reverse these problems (Bonow, Grant, and Jacobs 2005). Research on the integration of culturally competent care with culturally competent management is a strong step toward a better business case for organizational investment in leadership diversity as a way to reduce and eliminate health and healthcare disparities.

IMPACT OF CHANGE

From the literature, we see that leaders themselves agree that diversity matters, but they are torn over how to address the lack of diversity in management. Leveraging diversity alone does not guarantee immediate, tangible improvements in organizational, group, or individual performance. However, achieving a diverse workforce and effectively managing this workforce can yield huge benefits (Jayne and Dipboye 2004). To respond to the demographic shifts of the workforce and patient population, and address racial and ethnic disparities in access and outcomes of care, healthcare organizations will need to become culturally competent (Weech-Maldonado et al. 2002). Understanding the implications of the roles of leaders toward this end is the first step towards change.

For example, Kalev, Dobbin, and Kelley (2006) reported that race and gender composition on top management teams predicted race and gender composition of the management workforce in general, suggesting that CEOs who are members of a racial minority group are more likely to be committed to diversity.

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Another example is the National Health Plan Collaborative (NHPC), in which leaders of the 12 top health plans have combined efforts to develop recommendations and resources to encourage and guide primary racial and ethnic data collection (Lurie et al. 2008a). The NHPC is working to assist researchers with ways to identify and address disparities, develop tools and guidelines to improve language access, make a business case for addressing disparities and calculating the return on investment of disparities-related initiatives, and improve knowledge management and dissemination of disparities-related information.

Historical context provided clear strategies and legal foundations toward gaining health equality. However, healthcare systems have yet to fully appreciate the link between health equality and the financial success of healthcare organizations. Further, research has not provided the evidence base to support such strategies. Although disadvantaged groups have gained legal access to services such as healthcare and education, and workforces of many organizations have become more diverse, organizations with historically entrenched cultures of discrimination have not been given the managerial rationale to actively take part in reducing health disparities. Evidenced over the past 40 years, during which advancements in technology and management practices have led to increased quality and years of life for people in the United States (Arias 2006), the current levels of cultural competency in our healthcare organizations have not produced better quality healthcare for everyone.

Other industries are able to show the positive impact of diversity on performance, but in healthcare, executives have not embraced the importance of culturally competent care as a managerial practice to increase organizational performance. As a result, health disparities have been left outside the context of the operation of the system and remain a clinically focused provider issue. If the goal is to eliminate health disparities, culturally appropriate health promotion is as valid a strategy for healthcare systems and practitioners as healthcare is, and the goal will be better achieved when organizations are armed with evidence-based approaches (Tolsma et al. 2009). To improve the quality of care and reduce health and healthcare disparities, organizations will need culturally competent leaders who are able to identify with, relate to, and accommodate the cultural background of the patient (Satcher and Higginbotham 2008).

CONCLUSION

The salient point throughout this article is that if a business case can be made to show that operational returns on investments in diversity leadership are associated with a culturally competent care organization and the reduction of health disparities, leadership will make these investments. Although empirical data to support this claim are sparse in healthcare, a synthesis of these disparate literatures draws a blueprint from which to engage in a discussion of how to leverage leadership and diversity in our healthcare organizations. This article provides a contextual pathway toward a business case that invests in leadership

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diversity as a managerial solution to helping eliminate health disparities.

Will a business model that aligns healthcare's organizational business practice with our national healthcare agenda (by focusing on culturally competent care) help to eliminate health disparities in a better way than the attempts made over the past 40 years? To answer this question, researchers must evaluate racial, ethnic, and cultural competency factors along the same compendium as the clinical care experience. Healthcare leaders are making the case that as the population becomes more diverse, clinicians will increasingly see patients with a broad range of perspectives regarding health, often influenced by their social or cultural backgrounds (Betancourt 2006). Hence, a culturally competent care organization is needed; so is a diverse workforce to operate it.

If researchers and practitioners plan to eliminate health disparities, they must move beyond testing race and ethnicity for the sole purpose of assessing clinical outcomes for patients. The inclusion of appropriate exposure and outcome variables should help generate future research that tests whether favorable financial or quality outcomes accrue from leadership diversity. This article contributes a model and rationale for future researchers to use to help test the implication of managerial practices such as leadership diversity on measures of organizational performance as better solutions for reducing health disparities are sought.

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PRACTITIONER APPLICATION

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Leadership diversity in healthcare deserves additional research to confirm the theory that it adds value. Dotson and Nuru-Jeter suggest that for a business case for investment in leadership diversity to be established, organizations must provide evidence of how diversity links to performance, financial goals, and organizational goals and require organizational leadership to be accountable for cultural competency. I agree with the authors' perspective. Diversity in leadership is a valuable strategy that can advance the efforts to eliminate inequities and disparities in care.

Recently the American Hospital Association, along with several other major healthcare associations, launched the Equity in Care initiative—and one of the key strategies the initiative suggests to address health inequities is leadership diversity (AHA 2011). A model to allow for the study and validation of why diversity matters is long overdue and would provide support for organizations seeking to show a return on their investment.

In my own experiences, I have found leadership diversity to be a valuable strategy in addressing healthcare inequities and delivering culturally competent care. I agree with the authors that a focused strategy aimed at responding to the needs of the community combined with a leadership strategy focused on diversity will yield positive outcomes. I have observed a positive impact on organizations when efforts to recruit leaders with diverse backgrounds were successful and in alignment with the needs of the community. I believe that having leaders who are broadly focused on delivering care, with an emphasis on eliminating disparities and understanding inequities, yields positive outcomes. Further, diverse leaders who reflect the communities they serve have an enhanced impact.

The linkage between diversity and performance, as suggested by the authors, is an area to be further explored. In my executive role, I have seen the benefit of having a leadership goal focused on diversity as a strategy to successfully build a more culturally competent organization. The authors share insight from other industries that a more diverse team has been shown to yield productivity and increased financial success. The financial health and quality of care in an organization is another area where I have seen positive potential. When an investment is made to address health disparities, the quality of care for the diverse groups most affected has the potential to improve. As care delivery is focused on the affected population, there is great potential for better financial outcomes for the organization. A practical example is focusing on hypertension on a community. Data (Keenan and Rosendorf 2011) support that African Americans are more likely than Mexican Americans or non-Hispanic whites to have uncontrolled hypertension and thus to experience progressive disease and higher healthcare costs. In a previous organization I developed a community outreach program where a diverse team of lay health workers partnered

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in a multicultural community to educate and screen for hypertension. This diverse and culturally competent approach greatly helped identify those unaware of their hypertension and provided them valuable tools. While the immediate savings were not evident, the management of the disease should yield better outcomes, higher quality, and overall lower costs.

My long-term commitment, through the National Association of Health Services Executives, to the mentoring and the development of diverse future healthcare leaders has centered on the belief that building a culturally competent organization requires a diverse workforce. My personal experience has shown that diversity in thought and experiences creates a strong platform for developing a unique strategy to address healthcare disparities and inequities.

The authors make a strong and valid point that people have sought to eliminate health disparities for the past 40 years. These efforts have yielded many strategies, one being an investment in leadership diversity. The authors present a compelling argument for further research to form a business case that a culturally competent organization can be successful in eliminating health disparities. A leadership team that reflects the community served, in my experience, is a first step in the path to health equity.

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