Despite the fact that most Americans are generally satisfied with the health care they receive in the United States through either their employers or the government run programs, the United States health care system is indisputably a failing “system” that is highly fragmented and provides a quality of health care that is incongruent with the skyrocketing cost. Not only is health care becoming a larger slice of the budget pie and crowding out other pertinent items on the agenda such as education, the nation also sees an expanding medically underserved population with many more uninsured and underinsured individuals. In 2003, the exacerbating health disparities in ethnic minority groups were given appropriate recognition in the book Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care published by the Institute of Medicine (IOM). The burden of disease, especially chronic illness, is disproportionately borne by these groups as a result of a lack of access to quality health care and information. Although significant research was conducted to raise awareness of health disparities in the United States, little has been done at the policy level to target the crisis that is the foundation of the health care system as the burden of disease is shifting toward chronic illness. In the U.S., there are numerous disjointed community-based efforts to reduce health disparities in underserved minority communities, but it is markedly difficult to achieve health equity without sufficient funding and institutionalized effort nationwide. This paper focuses on the viability and cost-effectiveness of integrating trained community health workers into the health care delivery system as a solution to reduce health disparities in ethnic minority populations.

Racial and Ethnic Health Disparities

Health disparities in the United States are generally defined as “differences in the incidence, prevalence, mortality, burden of diseases and other adverse health conditions or outcomes that exist among specific population groups” (National Association of Chronic Disease Directors). Gender, age, ethnicity, socioeconomic status, geography, sexual orientation, disability or special health care needs can all be predictors of health disparities that compel certain disadvantaged groups to systematically experience worse health or greater health risks. The focus will be on health disparities caused by ethnic differences in this discussion, which are interrelated with disparities caused by geographic location and socioeconomic status. African American, Hispanic, American Indian and Alaskan Natives, and Asian and Pacific Islander populations are well documented to receive less prenatal care, lower vaccination rates, less cancer screening, have worse control of hypertension and diabetes and are more vulnerable to environmental health hazards. It’s a popular assumption that health disparities exist solely because there is a shortage of physicians or because people are too poor to afford health insurance. This is true to a certain extent until people realize that having health insurance is not the ticket to receiving quality care. The IOM report established that differing socioeconomic statuses is not the only causes of
discrepancies in access to care (30). There is increasing evidence that disparities remain in racial and ethnic populations even after these differences are accounted for.

![Diagram of healthcare quality and disparities](image)

**Figure 1. Differences, disparities, and discrimination: Populations with equal access to healthcare. Source: Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.**

Even if the person of color has the same kind of health insurance coverage as a white person, other obstacles such as language barriers, geographic isolation, lack of regular source of care, lack of trust for providers and cultural competency still prevent the minority from receiving the care they need. The 2006 annual National Healthcare Disparities Report by the Agency for Healthcare Research and Quality documented that racial and ethnic minorities receive poorer quality of care than whites in 22 essential quality of care measures. In addition, Figure 1 illustrates how legal, regulatory, and policy environments that the health care system functions in can create major barriers for minorities to have access to care (IOM 32). Accordingly, the unequal distribution of care reflects fundamental social and political disadvantages ethnic minorities face and result not only from the patient’s own reluctance to seek care, but also from the bureaucratic nature of the health care system such as utilization control as well as stereotyping, biases and uncertainty on behalf of the health care providers. Therefore, reducing health disparities requires the institution of health care to seek out providers who are culturally competent and create an environment that is accessible and welcoming for ethnic minorities.

**An Incomplete Workforce**

While the minority groups constitute more than 25% of the nation, they represent less than 9% of nurses, 6% of physicians and 5% of dentists (Wong). A broader range of health care services need to be provided to accommodate the increase in population diversity through migration and higher fertility in minorities as well as the escalating number of low-income families as a result of the economic downturn. Cultural understanding, community health education, and translation services will be increasingly needed for delivering care to the growing families and ethnic communities that have been traditionally underserved and neglected. Even with the visible increase in the ethnic minority populations in the U.S., there has been no improvement in the diversity of the health workforce. It is important to have a diverse workforce, because minority health professionals can understand the cultural context and background of the ethnic
communities the patients come from. Their ability to elicit trust stimulates more patient compliance and produces much better health outcomes. However, there are numerous barriers preventing more minority students from enrolling in health care, including but not limited to lack of access to higher education, financial hardships, family burdens, and the highly competitive admission process. Overcoming these barriers would require making drastic policy changes and increase the diversity of the health workforce in the long run, but it is in consensus that cultural competency in the health workforce is needed presently. Although physicians are crucial to the function of the health care system, they only constitute about 20% of the health workforce worldwide (World Health Report 2006). Nurses, practitioners, physician assistants and other licensed and non-licensed practitioners are the faces of health care and play a much more pertinent role in the health care delivery process than given credit for. The ideal solution that reduces health disparities should address all these barriers that the ethnic groups face, while minimizing the cost and time required to do so. Community health workers (hereafter referred to as CHWs) have been proven to provide effective interventions and serve as timely and cost-effective liaisons between the patients and the established health care providers.

A New Era of Healthcare Providers

The rising cost of health care, shortages of nurses and primary care physicians in medically underserved areas, the burden of disease shifting toward chronic illness and the advent of telemedicine that requires less clinical training have created a shift in training non-medical individuals (HRSA). These individuals are to exhibit strong personal and community skills and could become valuable members of established medical teams for improving access to health care, patient communication and compliance, outreach, prevention, and early diagnoses in underserved communities. A community health worker (also known and recognized as a community health advocate, lay health educator, community health representative, peer health promoter, community health outreach worker and promotora, etc.) is an indigenous member of a community “who applies his or her unique understanding of the experience, language, and/or culture of the populations he or she serves in order to bridge individuals, communities, and health and human services, provide culturally appropriate health education and information, ensure people receive the services they need, provide direct services such as informal counseling and social support, and advocate for individual and community needs” (Ballester). Community health workers (hereafter referred to as CHWs) usually work for pay or as volunteers for the local health care system in urban and rural communities that lack access to adequate health care and information. In the state of California, promotoras that work almost exclusively in Latino communities are of particular importance since 36% of the population is Latino, 50% of the Latinos do not speak English well and 34% of the Latinos are uninsured (Osorio). They are usually identified and respected as the natural leaders and the right messengers of the communities they serve. Not only do they provide culturally and language appropriate care, their knowledge of the living and working situations of the Latino populations allow them to provide time and place-appropriate care. For example, the best time for promotoras to seize an opportunity to speak to a family of farm workers is not at the normal 9am-5pm work schedule, but at 2am in the morning before they leave for work (Osorio). This demonstrates how each ethnic community is unique in the kind of services needed and requires the appropriate method of intervention.
Not only do CHWs require less training, the services they provide tend to be less expensive, more accessible and acceptable to their clients, able to increase coverage and impartiality of health care delivered, to promote self-care and local participation, and most importantly, is population-specific. CHWs are capable of providing services during the course of illness in a clinical setting, but they can also function as patient navigators in the healthcare system and educators of disease prevention and self-management. The versatile nature of CHWs allows them to either integrate both health and social services or focus solely on health issues. They may only service the community or they may be employed in a health care setting. Regardless of the role they play, CHWs can communicate with the ethic minority populations more effectively and “recognize and incorporate cultural buffers, such as cultural identity, spiritual coping, and traditional health practices, to help community members cope with stress and promote health outcomes” (CDC's Division of Diabetes Translation). For example, the Latin American culture has a variety of beliefs related to health that has been passed down for generations, such as the evil eye of envy, or mal de ojo. It is believed to pass on bad luck to the person the envy or dislike is directed to. One traditional cure in rural Mexico involves a curandero (folk healer) sweeping a raw chicken egg on the body of a victim to absorb the power of person with the evil eye. The shape of the yolk can be used to indicate whether the aggressor was a man or a woman (O'Neil). Cultural beliefs such as “mal de ojo” are abundant in all cultures, thus it is very valuable to have members in the health workforce that are familiar with them and able to incorporate the patients into the healing process rather than alienating their beliefs.

The CHWs employed by Allies Against Asthma represents a standard example of CHW intervention. The prevalence of childhood asthma has been associated with poverty levels, which is directly proportional to the rate of incidence and severity in African American and impoverished children (Oakar). This leads to increased asthma related hospitalization in such vulnerable populations. The CHWs in this intervention provided individualized, home-based interactions as well as one-on-one guidance at community settings such as schools with the low-income families that have children with asthma. They expand the services of a physician by providing additional health education in convenient and family-friendly settings. Families in this particular intervention learned about basic asthma self-management education, rationale for daily medication use, recognition of signs and symptoms, appropriate use of inhalers and spacers, and recognition and avoidance of asthma triggers. The services provided by CHWs are essential as they offer the time and support physicians and nurses normally could not (Oakar). It is documented early on that communities where people have poor access to medical care have higher rates of hospitalization for chronic diseases (Bindman, et al.). Subsequently, health education provided by CHWs that focuses on chronic disease prevention and self-care can decrease the number unnecessary trips to the hospital and potentially cut health care costs in the long run. Presently, there are community health workers in all 50 states. According to the National Workforce Study by HRSA, community health workers were first documented in the U.S. in 1966-1972 as attempts to improve health outcomes in poverty stricken communities. There had been major public policy breakthroughs from 1999-2006 addressing community health workers. Their use and their certification was passed in several states and a Patient Navigator bill was signed into law as a major piece of legislation at the Federal level addressing CHW activities. Also, the 2003 Institute of Medicine report on reducing health disparities mentioned earlier also made recommendations regarding CHW roles. However, none of the many state and federal
initiatives in support of CHW activities other than the Patient Navigator bill has passed (HRSA). Since CHWs do not have a specific occupational code, there is no official estimate of the number of community health workers in the U.S. It has been approximated that 86,000 community health workers served in the U.S. in 2000 and the number has increased 41% by 2005 to 121,000. California proudly owns the largest percentage at 9000 CHWs.

The HRSA report documented the main characteristics of the CHW workforce. The largest groups of CHWs are Hispanic and Non-Hispanic White and they serve all ethnic and racial groups, predominantly Hispanic, African American and White. Most of them are female between the ages 30 and 50. Experienced employed community health workers are paid $13/hour or more, while the newly hired are paid less. More than one-third of all employed and volunteer community health workers had a high school education, about one-fifth had completed some college work, and almost one-third had at least a 4-year college degree. About half of employers had educational or training requirements for CHW positions. Most of the employers require post-hire training through either continuing education with classroom instruction or through mentoring and on-site technical assistance. Training time ranged from 9 to 100 hours. These trainings aim to enhance generic skills and competency for specific programs. Addition training was required for medical and social services, home visits, health education and counseling, CPR and first aid.

**Viability and Cost-Effectiveness**

In 2005, a Robert Wood Johnson Foundation program (Finding Answers: Disparities Research for Change) sought to determine the best methods of intervention to reduce racial and ethnic disparities in the care and outcomes of patients with chronic conditions. They evaluated the relative effectiveness of the interventions based on cultural leverage versus the existing pay-for-performance and public reporting of performance measures. The study concluded that multifactorial interventions that target patient, provider, organization and community factors simultaneously and culturally tailored individualized care provided by case managers, CHWs, and counselors show the most promise at reducing health disparities (Chin, et al.).

Figure 2 demonstrates the incredible multiplicity in access to care. The arrows between the
community and health care organization circles show how interventions that create linkages between these two entities could improve health status. Interventions and cultural competency programs that promote enhanced communication between patients and health care providers are essential to positive patient engagement in their care (Chin, et al.). Thus, conceptually, CHWs can be successful at reducing health disparities in community settings as well as clinical settings.

The HRSA report comprised of 45 research studies nationwide. The assortment of research studies demonstrates how CHWs have a very diverse range of health targets. The list includes, but is not limited to, cardio vascular disease, diabetes, asthma, maternal/child health, cancer screening, immunization, environmental health risks, and general health promotion. Not only do they focus on health risks and conditions most likely to affect medically underserved communities, such as cardio vascular disease, diabetes and asthma, they also provide general preventive services that are not sufficiently delivered in these communities, such as prenatal care, maternal/child health, cancer screening, immunization and general health promotion. CHWs also have very diverse roles and responsibilities as members of the care delivery system, navigators, screening and health education providers, outreach-enrolling information agents, and organizers (HRSA).

While CHWs have very diverse roles and responsibilities, they all function as patient advocates and mediums for information delivery. Health disparities exist not only because of differences in the access to and the quality of care delivered, they also exist due to disparities in knowledge and health education. Rather than measuring impact effectiveness of CHWs with mortality and morbidity rates like most literature on the subject, qualitative measures such as client satisfaction, constructive changes in client behavior and community mobilization are used to indicate degrees of impact effectiveness. Most of the research studies indicated the changes in clients’ knowledge or behavior as a result of the CHW intervention to be statistically significant. Diabetes, heart disease, asthma and hypertension interventions are particularly effective. According to Professor Ed O’Neil, director of The Center for Health Professions, the shift of disease burden to chronic conditions requires the practice model of health care delivery to change from acute and inpatient care oriented to focusing on chronic prevention and management (O’Neil). As the kind of health information CHWs provide promote self-care and allows the patient to monitor their chronic conditions, CHWs could become very valuable members of the new system of health care delivery. Not only do CHWs function as patient navigators and link them to health or support services, they also connect the patients to other service systems. That is, CHWs can teach about HIV, but they also connect their clients with lawyers and other people to service their need (Osorio). Many people from ethnic groups are barred from the health care system due to legal barriers.

The cost-effectiveness of CHWs has continuously been a subject of debate and people question just exactly how CHW can increase the efficiency of the system and help lower health care costs. Efficiency is defined in economic terms as the use of resources in such a way as to maximize the production of goods and services (Sullivan and Sheffrin). In order for the health care system to become more efficient, three questions need to be considered: which locations have the greatest need, which providers improve outcomes the most and how should a health care organization staff its facility to maximize outcome (Spetz). An equal distribution of the workforce may not improve health. Thus, it is important to identify the locations with the greatest need of health
care providers, i.e. the “Medically Underserved Areas” and “Health Professional Shortage Areas” designated by HRSA. These “Medically Underserved Areas”, most likely to be populated by ethnic minorities, have too few primary care providers, high infant mortality rates, high poverty and/or high elderly populations. The Health Professional Shortage Areas have shortages of primary medical care, dental or mental providers and can be based on geographic location (county or service area), demographics (low-income) and the kind of institution (Federally Qualified Health Centers). For example, the Border States such as Texas, New Mexico, Arizona, and California grew by 20% during the 90’s, which was 50% higher than the national growth rate. The border region population is projected to be 19.4 million in 2020 (EPA). On the U.S. side of the border, the Hispanic population at the state and county level is projected to double in 25 years (United States-Mexico Border Health Association). Relatively, it would take the nation as a whole 90 years to double its population. Accompanying the increase in population in these states is increasing diversity that causes immense health disparities, including “lack of language skills, inadequate education, a poor understanding of values, political agendas, and a non-global commitment to health care” (Forster-Cox, et al).

Locating the disadvantaged areas is the first step, while the next steps require identifying and implementing measures to improve the efficiency of the localized health care delivery systems. A very recent study, “Productive Efficiency of Health Clinics in San Joaquin Valley, California: Can Use of Non-Licensed Providers Improve Efficiency”\(^1\), conducted by the California Valley Health Policy Institute strives to quantify how best health clinics in the San Joaquin Valley can convert their production factors into outputs (Rahman and Capitman). All eight counties of San Joaquin Valley have medically underserved areas/populations designations and have shortage designations for primary care, dental and mental health services (Riordan). As a result of the provider shortages, the community health clinics in San Joaquin Valley generally have a higher other provider (non-physician) vs. physician ratio. The community health centers surveyed in the study play a vital role in providing medical, dental and related health and support services to low-income and medically underserved persons. Data Envelopment Analysis (DEA) was used to analyze the efficiency of the community health centers. Consistent reporting of data was ensured as all of the clinics are reimbursed by the same payment mechanism and deal with the same incentive structures. The inputs for the DEA included all of the licensed and non-licensed (outreach workers, medical assistants, dental assistants, system analysts) health care providers and the cost of running the clinic and instruments. The outputs produced included the total number of encounters and the total number of Medicare/Medi-Cal and free care provided (which captures the majority of the outputs of the clinics). The results of the study show that the more non-licensed practitioners, compared to licensed practitioners, a clinic employed the more efficient the clinic was likely to be. One should keep in mind, however, that the results of this particular study are limited to rural community clinics in San Joaquin Valley serving the medically underserved populations. Nevertheless, the conclusions made can easily be applied to other MUAs and HSPs where there is a shortage of licensed providers. This study has many important implications for both clinic managers and policy makers as they need to become aware of the need and changing nature of the primary care practice settings in the rural clinics that have provider shortages. The results encourage clinic managers to hire more non-licensed providers as they may be more instrumental in bringing and treating the patients compared to licensed providers. Although licensed providers are vital to the wellbeing of a clinic, the study conjectures

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\(^1\) The study is still in draft form and has not yet been published.
that non-licensed providers may be more effective at informing patients about their health conditions and motivate them to seek care (Rahman and Capitman). The results also provide direction to policy makers in resource allocation and provide more sustained funding to train non-licensed providers such as CHWs. Nonetheless, CHWs are well suited to work with licensed nurses, who are more cost-effective than physicians, patient-centered, and also familiar and comfortable with working in teams. Together, CHWs and nurses can better facilitate the transition from hospital to home for vulnerable patients with chronic conditions and improve access and adherence between clinic visits. In addition, CHWs can gain more currency in the healthcare system if the mechanism of task-shifting, or the process of delegating tasks to be performed by the lowest qualified constituent of the health workforce, is utilized without violating scope of practice. The shortages of primary care physicians and nurses in rural and underserved communities can very well be supplemented by hiring more CHWs. Therefore, incorporating more CHWs into the health care system can potentially reduce the cost of care and the patients’ shared costs. However, the cost-effectiveness of CHW cannot be correctly measured by purely economic analyses alone. Volunteerism and altruism are important aspects of the services CHWs provide. Cost-effective analyses often miss the social benefits of using CHWs such as community mobilization and empowerment (WHO). As they are indigenous to the communities they serve, CHWs can also strengthen community network ties through the services they provide. Therefore, the effectiveness of CHWs and the impact they have on the communities they serve could very well be greater than what statistics can measure.

Barriers to Overcome

Currently, there is an underutilization of CHWs in clinical settings because the hierarchy of the health workforce does not allow for easy introduction of CHWs. There is still a preference for the formal established health services provided by nurses and doctors, who have established scopes of practice. While the heterogeneity in the roles and responsibilities of CHWs can be lauded as an advantage in providing care to a wider range of clients, it also causes it to be extremely difficult to develop a standard role for CHWs in order for them to be included in the established health care system. Another problem is that the retention rate for CHWs is generally low, because there is no stable governance and management to provide funding and practice critical selection.

In addition, the published studies on CHWs in the HRSA report rarely provided information on the participatory processes that are central to the success of the programs. Only 41% of the studies included information on CHW selection and they are generally lists of desired qualities such as interest in the subject material, willingness to learn, compassion and leadership abilities (O’Brien, et al.). Even though racial and ethic concordance with the communities served was seldom listed as a selection criterion, it is usually the case with the selected CHWs. The lack of coherent reporting of CHW selection and training processes prevent
better interpretation of the study findings. For example, there is a wide array of training approaches from state certificate programs to on-the-job training and from 9 hours to 100 hours training. Research has shown that the CHWs trained under standardized curricula developed by national programs serving populations with diabetes and hypertension tend to have better health outcomes.

Careful selection of CHWs and continuous training and support are critical to the well-being of CHW programs. CHWs do not have a clear role definition, unlike the established healthcare workforce of doctors, nurses and other medical professionals, and it may compromise the quality of care provided. Therefore what the CHWs need in order to be recognized, is an established role definition that they can be identified with, and this requires the government to first identify the location of need, determine a set of selection criteria based on education, community involvement and specific training requirements, establish guidelines to monitor performance and an evaluation process to uphold quality care (O'Brien, et al.).

Most of the current funding for CHWs came from the federal and state governments (HRSA). It is a key determinant in the future of community health workers, as well as the recognition of CHW as a career option and the establishment of a central organizing power. However, many employers are optimistic about potentially integrating community health workers in clinical settings, emergency rooms and other geographical areas (HRSA). Although numerous state and federal initiatives to establish CHWs as an essential aspect of the health workforce have failed in the past, progress has been made in the health reform bill passed in the House, H.R. 3962, the America’s Affordable Health Care Act. Within the bill is a provision that grants $30,000,000 per year for four consecutive years to support community health worker programs in medically underserved communities. In addition, H.R. 3962 includes an provision under Medical Home Pilot Program that requires the Community-Based Medical Home to employ community health workers, including nurses or other non-physician practitioners, lay health workers, or other persons…that assist the primary or principal care physician, nurse practitioner, or physician assistant in chronic care management activities such as teaching self-care skills for managing chronic illnesses, transitional care services, care plan setting, medication therapy management services for patients with multiple chronic diseases, or help beneficiaries access the health care and community-based resources in their local geographic area (Dingell).

Despite the progress in the House bill, what is currently on the policy agenda for CHWs is insufficient to established a new health workforce that is crucial to addressing the problems of cultural incompetency in the workforce, the rising cost of care and the narrow range of services provided to minority populations who are the backbone of this country. CHWs do not have advocates to lobby for them at the policy level like the doctors, nurses and physician assistants, so their position is fragile among political vagaries. What they need is an influential voice or a unity of voices in the political battlefield to give them proper representation.

Recommendations

The utilization of community health workers as agents to improve health is a global phenomenon that ranges from large scale national programs such as the Brazilian Family Health Program to small community-based programs like in the United States. There is substantial evidence that CHWs can improve health outcomes in ethnic minority populations by increasing the quality of
care, access to care, insurance coverage and reducing language, cultural, legal and regulatory barriers. Yet, the many limitations and disincentives that CHWs face at present do not allow CHWs to be the sole panacea or a cheaper option to provide all necessary care for the underserved communities. To be successful at reducing health disparities at a national level, CHWs programs require centralized leadership, thorough planning and professional recognition, stable source of long term funding, active government involvement and community support. There is no centralized supervision of CHWs in the United States. It can be argued that the lack of management, selection and training guidelines not only affect the number and efficacy of CHWs as whole, they are also not being recognized as essential members of the health workforce. What the U.S. needs is a large-scale political transformation, like what happened in Brazil and China, and the most challenging aspect of sustaining CHW programs is institutionalizing and mainstreaming community participation. Both the government and private sectors can influence the organization of health care through payment mechanisms for CHWs and the creation of standards that can greatly affect provision of care and reduce health disparities. It’s important to include the payers and decision makers in the policy realm to partake in the planning and implementing of CHWs programs.

One way of increasing mainstream participation in CHW programs is through increasing coordination between CHWs networks and the local Public Health Departments through community mobilization and participation. Health Initiatives of America (HIA) is program established in 2001 under the sponsorship of the California Policy Research Center of the University of California, Office of the President. The main objective of the initiative is “to coordinate and optimize the availability of health resources for Mexican immigrants and their families through bilateral training, research, and health promotion activities” (Health Initiatives of the Americas). HIA established the Binational Promotoras Program in 2003 to address specific health problems faced by the migrant population during the different states of the migratory cycle (Osorio). During this year’s Binational Promotoras Conference in Berkeley, 370 participants came from around the U.S. and Mexico to listen in on presentations regarding responses to H1N1 from experts in Mexico and California. Promotoras from this conference exclaimed that they want to be informed and considered key partners of the public health network for outreach activities during public health emergencies. As CHWs such as the promotoras are readily active within their communities’ health networks, the public health system can very well use CHWs as viable means to disseminate health information quickly during emergencies such as a pandemic like H1N1. As H1N1 is a strain of influenza A virus that is more likely to hospitalize populations with chronic conditions, ethnic minority populations are at greater risk. Therefore, it is critical to provide appropriate and timely communication to at-risk populations. CHWs are entirely capable of undertaking the responsibility if they can work in harmony with the public health system.

A Vision

A shift in the organization of health care is essential to accommodate the shift in disease burden. However, it is impractical to suggest a fundamental reform in a health care system that is primarily focused on the downstream model of care. Doctors and nurses in the U.S. have very strong advocacy groups and unions to help them maintain their established statuses in the system, so it is also nearly impossible to change their scopes of practice and payment mechanisms for the
overpaid doctors and nurses in comparison to the rest of the world. All the stakeholders of health care, i.e. tax payers, the elderly, providers, policy makers, uninsured, need to realize what the U.S. needs today are not more doctors and nurses to treat patients who are already inside hospitals and clinics, but more providers who have the ability, time and desire to go out into the communities to practice the upstream model of care. Federal and state dollars shouldn’t be going into building more medical schools in rural areas with the faint hope that the graduates would actually stay there. Medical schools are also not going to suddenly increase the number of minorities they want to accept. Instead, the effort and money should go to the caregivers who are already established in their communities to support existing and very effective programs.

Imagine a perfect health care system where CHWs are recognized as an essential part of the workforce and are present in every mode of health care delivery. The implications for ethnic populations as well as non-ethnic populations are immense. Door-to-door visits by CHWs would eliminate potential health hazards. Community health fairs held by CHWs would be able to disseminate information on how to prevent illness and also diagnose diseases early for timely care and treatment. People who are uninsured would be identified and CHWs could work with them individually to discuss their options. Even before patients go into clinics and hospitals as a last minute resort to get care that can only be provided by a licensed practitioner, they would already have knowledge of their conditions and know what self-care measures to take.

It is a indeed a far-fetching vision for today’s hostile political and social environment, but it is a more feasible solution than most of the other attempts to address the distribution and diversity problem of the workforce such as feeble student loan repayment programs. The quality of the workforce is essential to the wellbeing of the health care system and should be at the top of the health care reform agenda. Rather, just as how the policy makers are frugal with public health/disease prevention efforts, very little money is going to go into increasing diversity of the health workforce. People are more keenly focused on the heated debate of the public option, the individual and employer mandate, Medicare expansion, etc. But when it comes down to the crux of the matter, guaranteeing a type of insurance coverage that is so washed-down from political compromises is not going to be the ticket to quality health care for ethnic groups. Just having an option for coverage at the national level is not enough; a workforce like the CHWs is needed to bridge the existing gaps between ethnic minority patients and the traditional health care providers to fix the problems of access, quality and coverage at the personal level.

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