The Leverage Network
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Inequity starts at the top

Healthcare is failing to meet its own goals for leadership diversity

With a global pandemic exposing longstanding racial inequities in access to jobs, housing, nutrition and quality healthcare, this study finds that at least one sector – healthcare – lacks the leadership diversity many experts believe is needed to address disparities.

9

% of Blacks on boards of leading companies across 4 health sectors

Summary

The Leverage Network, the Health Equity Leadership Pipeline Collaborative at the University of Michigan School of Public Health, and the legal and consulting firm McGuireWoods conducted this study of 623 board members at 41 of the largest healthcare organizations in the country across the provider, payer, pharmaceutical and biotech markets from 2016 to 2018.

The team found that the average board was 87% white and 13% people of color. Seventy-two percent of members were male, and only 3% were Black women. Among CEOs, the picture was even bleaker: Blacks held just 8.5% of the top jobs and women only 4%. There was not a single Black female healthcare CEO in the study group.

The data from this research is preliminary and is the first step in developing a more nuanced understanding of board diversity across the healthcare industry, leading to more specific data on how diversity impacts clinical and financial outcomes.

Background

CEO BOARD CHAIRS

8.5% BLACKS

4% WOMEN

0% BLACK WOMEN

Board diversity significantly impacts a health system's level of performance and ability to address the needs of those it serves.[i] Having members with different backgrounds and life experiences ensures that the board maintains an informed perspective, influencing population health and outcomes.

In a survey of 311 healthcare executives across the U.S., 71% of respondents said that having culturally diverse perspectives on healthcare boards leads to successful decision-making.[ii] Minorities and women bring a wealth of differing cultural and professional experiences with them, reflecting the varied backgrounds of the community. These perspectives lead to robust discussions and allow boards to develop a more nuanced understanding of how to provide patient-centered services in accordance with the community's unique needs.

As the late health policy expert Katherine W. Phillips argued, diversity often provokes discomfort, conflict and more challenging interactions, but it has the net positive effect of making people more creative, diligent and hard-working.[iii]

As just one example of the clinical impact of a lack of leadership diversity, a recent cross-sectional study found that just 24% of U.S. hospitals and 16% of physician practices reported screening for food insecurity, housing instability, utility needs, transportation needs, and interpersonal violence.[iv]

Diversity is also an economic opportunity; companies in the top quartile for gender or racial and ethnic diversity are more likely to see financial returns above national industry medians, the consultancy McKinsey & Co. found.[v]

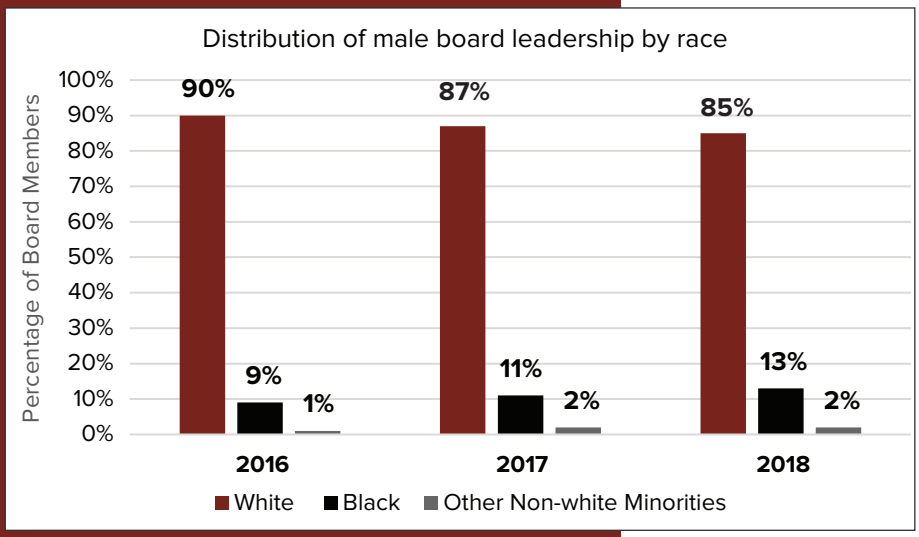
This report mirrors the findings of the American Hospital Association's National Health Care Governance Survey Reports in 2011, 2014 and 2019. Little changed over those years, despite a 2011 call from five national healthcare associations jointly urging hospital and health system leaders to help eliminate health disparities and improve quality of care by, among other changes, increasing diversity in governance and leadership.

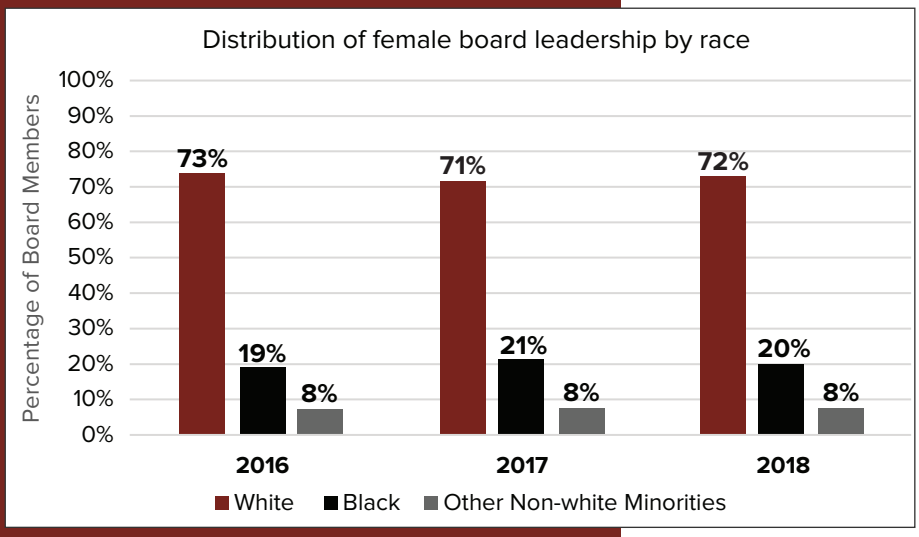
Although this study reflects the circumstances of a period before COVID-19, its findings still challenge any notion of proportional Black or other minority representation in the boardroom, raising questions about whether the healthcare industry is really invested in solving health inequities that are limiting access to quality care and better outcomes among people of color.

What's behind this report

The Leverage Network, Inc. (TLN) is dedicated to the advancement of Blacks in governance roles in healthcare. It initiated this preliminary research to assess the correlation between board diversity and the prevalence of health disparities. TLN is partnering in this research with the Health Equity Leadership Pipeline Collaborative at the University of Michigan School of Public Health, and McGuireWoods, LLP, a firm providing legal and public affairs solutions to corporate, individual and nonprofit clients worldwide.

Upcoming research will allow for further nuance within the categorization of ethnicity and race. TLN is hard at work developing partnerships through which organizations can self-report data, minimizing room for error and allowing for a greater depth of information.





Methodology

On average, the study cohort boards included 15 members, ranging from 8 members to 25. Board members were assessed on gender, race, ethnicity, and position. Within the provider category, the research was expanded to include five additional not-for-profit or privately held hospital and healthcare systems.

The dataset was developed from institutional and publicly available data. For each publicly traded company researched, the number and names of the CEO, board chair, and board members in 2016, 2017, and 2018 were identified using information from the U.S. Securities and Exchange Commission (including 10Ks). For each nonprofit or privately held company, these data were drawn directly from websites and reputable business media.

Individual-level data were identified using a triage procedure that included photo identification, social media confirmation, and social network analysis. Photo identification for each board member provided the initial gender and racial and ethnic categorization. The company website and at least two other forms of social media hits were used to confirm the board member's name, gender, race, and ethnicity. The categorizations were sent to a separate individual in the network to confirm each board member's demographic information. To further validate individual-level data, each company was sent a listing of the gender, race, and ethnicity categorizations of its board members for verification.

The research team then developed a dataset that included race, gender, company, sector, duration of board membership, and position for each member. The data were analyzed using SAS (9.4) statistical software, with all missing data and repeated variables checked for accuracy. Descriptive statistics regarding board diversity were obtained using standard PROC FREQ coding. Frequency distributions were calculated by race and gender. Trends in race and gender were examined across the three-year period studied, and results were further stratified by sector and board leadership. Term limits for board members were not taken into account, and each member could serve on multiple boards across the different sectors. It should be noted that a few individuals held a board seat across more than one company and sector.

Results

Board diversity was found to be consistently low across all four healthcare sectors (pharmaceutical companies, providers, payers, and biotech organizations) studied. On average, 87% of board members were white and 13% were minorities; 9% were Black. Seventy-two percent of all board members and 33 individuals from the sample population (N=623) across the combined healthcare sectors were men. Black women made up just 3% of board positions.

Among CEO board chairs, only 3 were women and 3 were Black men.

Providers

On average, white men occupied 87% of board seats among providers from 2016 to 2018, a trend that decreased over that period from 90% in 2016 to 85% in 2018. In 2016 most of these male board members were white (90%). Blacks only held 9% of seats. However, the distribution of Black board members increased to 11% in 2017 and 13% in 2018.

In 2016, 73% of women board members were white, 19% were Black, and other minorities held 8% of seats. In 2017, there was a 2% increase in the number of Black women who held board seats.

AVERAGE DISTRIBUTION OF PROVIDER BOARD MEMBERSHIP BY RACE AND GENDER, 2016-18

	MEN	WOMEN
WHITE	87%	72%
BLACK	11%	20%
OTHER MINORITY	2%	8%

Pharma

White men occupied 85% of board seats within pharma from 2016 to 2018, a trend that increased over that period. This percentage was lowest in 2016 (84%) and highest in 2018 (86%).

In 2016, Black men occupied only 9% of board seats within pharma, compared to white board members, who made up 84%. The trends remained constant in 2017 and 2018. For women in 2016, only 6% of board members were Black and there were no Asians, while white women comprised 95% of the board members in this sector. In 2018, there was a decrease in board seats held by Black women.

AVERAGE DISTRIBUTION OF PHARMA BOARD MEMBERSHIP BY RACE AND GENDER, 2016-18

	MEN	WOMEN
WHITE	85%	94%
BLACK	9%	5%
OTHER MINORITY	6%	1%

Payers

White men occupied 89% of board seats within payer organizations from 2016 to 2018, a trend which decreased over that period. This percentage was highest in 2016 (90%) and lowest in 2018 (89%).

From 2016 to 2018, there was a 1% increase in Black board membership. In 2018, Black men occupied 10% of board seats within this sector. White men accounted for 89% of seats. The number of Black female board members decreased over time from 24% to 17%. The number of board seats held by white women remained high (74%-76%) among all women within this sector across 2016-2018.

AVERAGE DISTRIBUTION OF PAYER BOARD MEMBERSHIP BY RACE AND GENDER, 2016-18

	MEN	WOMEN
WHITE	89%	74%
BLACK	9%	21%
OTHER MINORITY	1%	5%

Biotech

White men held 93% of board seats within biotech from 2016 to 2018, a trend that decreased over that period. This percentage was highest in 2016 (95%) and lowest in 2018 (91%).

In 2016, Black men occupied only 1% of board seats within biotech, compared to white men who made up 95%. In 2018, there was a minimal increase (2%) in board seats held by Black men. In this sector, there was an average increase of 7% for Black women holding board seats across 2016-2018. For women in 2018, a combined 23% of board seats belonged to women of color, with whites comprising the remaining 77% of board membership.

AVERAGE DISTRIBUTION OF PROVIDER BOARD MEMBERSHIP BY RACE AND GENDER, 2016-18

	MEN	WOMEN
WHITE	93%	78%
BLACK	2%	7%
OTHER MINORITY	5%	15%

Board diversity was found to be consistently low across all four healthcare sectors (pharmaceutical companies, providers, payers, and biotech organizations) studied.

Discussion

The boards studied in this report are not reflective of the demographics of their service areas or of the U.S. Many of these organizations are headquartered in metropolitan areas with large minority populations, but their boards are mostly white and male. For example, Vertex Pharmaceuticals, a global biotechnology company headquartered in Boston, did not have a single Black board member during the study period. Centene Corp., based in St. Louis, which focuses on managed care for uninsured, underinsured, and low-income individuals, had just one Black board member.

The lack of progress for women across company boards in the pharmaceutical sector is alarming, particularly given the impact of gender diversity on board performance. The International Monetary Fund (IMF) found that adding one more woman to a company's board or senior management team, while keeping the size of the board relatively unchanged, positively influences company performance.[vi]

The provider sector has seen only marginal progress in board diversity, despite years of reports and numerous industry pledges to improve. Even though diverse boards have been proven to generate increased revenue for products and services compared to homogenous boards, research shows that the provider sector still struggles to improve minority representation in governance.[vii]

Similarly, across the payer sector, companies have failed to consistently promote Black men and women into the company's highest levels. In fact, there was a decrease in the percentage of women across payers. Biotech showed notable improvement in its gender diversity, but no improvement in the racial diversity of women.

Conclusion

While the findings from this research don't include attitudinal surveys or responses as to causation, they do demonstrate a clear lack of board diversity among the four core healthcare sectors analyzed. These sectors saw varying degrees of improvement in board diversity over the three years studied, from modest to no improvement at all.

Organizations that figure out how to field leadership and governance teams that represent the communities they serve are more likely to win growth opportunities. By ensuring equitable representation of Blacks on healthcare boards and in senior leadership roles, organizations can work to eliminate health inequities in communities of color.

References

[i] Totten, M. "How and Why to Increase Board Diversity." *Trustee Insights*. Accessed online at https://bit.ly/347vNr1

[ii] "Closing the Gap in Healthcare Leadership Diversity: A Witt/Kieffer Study." 2015. Accessed at https://bit.ly/3jaVPxO

[iii] Phillips, K. "How Diversity Makes Us Smarter." *Scientific American*. Oct. 1, 2014

[iv] Fraze, T.K., et al. "Prevalence of Screening for Food Insecurity, Housing Instability, Utility Needs, Transportation Needs, and Interpersonal Violence by US Physician Practices and Hospitals." *JAMA Network Open*. Sept. 18, 2019

[v] Hunt, V., et al. "Why diversity matters." January 2015. Accessed online at https://mck.co/3dF60tp

[vi] LaGarde, C. "A global imperative: empowering Women is critical for the world's economy and people." *Finance and Development*. March 2019

[viii] Krentz, M., et al. "Diverse Boards Haven't Led to Diverse Leadership Teams (Yet)." April 2020. Boston Consulting Group. Accessed at bcg.com/en-us/publications/2020/diverse-leadership-teams

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