Diversity and Equity in Health Care

Roger Harrison, Ph.D.
Nemours Children's Health
Wilmington, DE
The changing face of America, 1965–2065

% of the total population

Note: Whites, blacks and Asians include only single-race non-Hispanics; Asians include Pacific Islanders. Hispanics can be of any race.

PEW RESEARCH CENTER
Growth by race in US, 2014 to 2060

Non-Hispanic whites are the only group that will see a decline in proportion of the population, from 62.2 percent in 2014 to 43.6 percent in 2060.

Chart: The Conversation, CC-BY-ND • Source: US Census • Get the data
Figure 18. Percentage of all active physicians by race/ethnicity, 2018.

Click on legend item below to add or remove a section from the report.

- American Indian or Alaska Native (2,570)
- Black or African American (45,534)
- Multiple Race, Non-Hispanic (8,932)
- Other (7,571)
- White (516,304)
- Asian (157,025)
- Hispanic (53,526)
- Native Hawaiian or Other Pacific Islander (941)
- Unknown (126,144)

18 shows the percentage of active physicians by race and ethnicity as of July 1, 2019.

Source: Race and ethnicity are obtained from a variety of sources including ERAS, ERAS APP, MCAT, MDREP, GG, MSQ, IMG, FACULTY, CME; STUDENT with priority given to the most recent self-reported source.
ETHNIC AND RACIAL DIVERSITY AMONG DENTISTS DOES NOT MIRROR THAT OF THE U.S. POPULATION

In terms of race and ethnicity, white and Asian dentists are proportionally more represented in the profession when compared to the U.S. population. Hispanic and Black dentists, as well as dentists who identify themselves as another race or ethnicity, are proportionally less represented in the profession when compared to the U.S. population.
### Racial and Ethnic Breakdown of APRNs

<table>
<thead>
<tr>
<th></th>
<th>U.S.</th>
<th>NPS &amp; RNs</th>
<th>CNMS</th>
<th>NAS</th>
</tr>
</thead>
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<tr>
<td>White</td>
<td>73.3%</td>
<td>85.7%</td>
<td>85%</td>
<td>87%</td>
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<tr>
<td>Latinx</td>
<td>17.3%</td>
<td>3.4%**</td>
<td>2.8%</td>
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<tr>
<td>Black</td>
<td>12.6%</td>
<td>6.6%</td>
<td>4.2%</td>
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</tr>
<tr>
<td>Asian</td>
<td>5.2%</td>
<td>5.8%</td>
<td>3.3%</td>
<td>4%</td>
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</tr>
<tr>
<td>Native American</td>
<td>0.8%</td>
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<td>0.3%</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>4.8%</td>
<td>0.6%</td>
<td>-</td>
<td>1%</td>
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</table>
CERTIFIED PHYSICIAN ASSISTANT STATISTICS BY RACE

The most common ethnicity among certified physician assistants is White, which makes up 71.0% of all certified physician assistants. Comparatively, there are 10.9% of the Asian ethnicity and 10.5% of the Hispanic or Latino ethnicity.

- White, 71.0%
- Asian, 10.9%
- Hispanic or Latino, 10.5%
- Black or African American, 5.2%
- Unknown, 1.8%
- American Indian and Alaska Native, 0.6%
On behalf of the Task Force on Black and Minority Health, I am pleased to submit the report and recommendations of the Task Force for your review and consideration. The report consists of an executive summary volume presenting our major findings and recommendations, and additional volumes containing extensive background information and analyses supporting and extending the executive summary. These will be extremely useful to those who wish to become familiar in greater depth with selected aspects of the issues we have analyzed.

I believe this report is a landmark effort in analyzing and synthesizing the present state of knowledge of the major factors that contribute to the health status of Blacks, Hispanics, Asian/Pacific Islanders, and Native Americans. It represents the first time the Department of Health and Human Services (DHHS) has consolidated minority health issues into one report. This report should serve not only as a standard reference for departmentwide strategy, but as the leading force for an accelerated national assault on the persistent health disparities which led you to establish the Task Force a little more than a year ago.

It would be a disservice to the Task Force members, staff and consultants who worked so diligently on this project during the past year, to underestimate the complexity of the task we undertook. The issues identified during our deliberations and presented in this report are of major importance, but must not be regarded as the final word on the subject. Just as individual well-being is not static, the health needs of minority populations are changing. They are influenced by a diverse set of factors of which disease is but one aspect. The report, then, must continue to be updated and revised as new data and information become available.

In accordance with your charge, we have examined the impact of a broad range of behavioral, social, and health service issues on the current departmental program areas. Our recommendations are consistent with the objectives for the Nation in disease prevention and health promotion for the year 1990. The six topics we have identified as priority areas merit intensive action and study in themselves, as do various issues such as nutrition and development of health professionals that cut across all health problem areas. We encourage the Department to continue to take the lead in implementing such activities.
In January 1984---ten months after becoming Secretary of Health and Human Services---I sent Health, United States, 1983 to the Congress. It was the annual report card on the health status of the American people.

That report---like its predecessors---documented significant progress; Americans were living longer, infant mortality had continued to decline; the overall American health picture showed almost uniform improvement.

But, and that "but" signaled a sad and significant fact; there was a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation's population as a whole.

That disparity has existed ever since accurate federal record keeping began---more than a generation ago. And although our health charts do indicate steady gains in the health status of minority Americans, the stubborn disparity remained---an affront both to our ideals and to the on-going genius of American medicine.

I felt---passionately---that it was time to decipher the message inherent in that disparity. In order to unravel the complex picture provided by our data and experience, I established a Secretary's Task Force whose broad assignment was the comprehensive investigation of the health problems of Blacks, Native Americans, Hispanics, and Asian/Pacific Islanders.

The Task Force under the insightful direction of the distinguished Thomas E. McLane, Ph.D., Deputy Director of the National Institutes of Health and with the invaluable contribution of experts from throughout the department, met its challenge. Brilliantly. First, by a review of departmental programs to determine how the health problems of minorities have been addressed; followed by a careful analysis of the range of health care resources and information available; and then by a critique of the health status of Blacks, Native Americans, Hispanics, and Asian/Pacific Islanders. The Task Force was further charged with finding ways for our department to exert leadership, influence, and initiative to close the existing gap. The report is comprehensive. Its analysis is thoughtful. Its thrust is masterful. It sets the framework for meeting the challenge for improving the health of minorities.

It can----should---mark the beginning of the end of the health disparity that has, for so long, cast a shadow on the otherwise splendid American track record of ever improving health.

[Signature]

Margaret H. Heckler
Secretary
African American Health
Creating equal opportunities for health

African Americans are living longer. The death rate for African Americans has declined about 25% over 17 years, primarily for those aged 55 years and older. Even with these improvements, new analyses show that younger African Americans are living with or dying of many conditions typically found in white Americans at older ages. The difference shows up in African Americans in their 20s, 30s, and 40s for causes of death. When diseases start early, they can lead to death earlier. Chronic diseases and some of their risk factors may be silent or not diagnosed during these early years. Health differences are often due to economic and social conditions that are more common among African Americans than whites. For example, African American adults are more likely to report they cannot see a doctor because of cost. All Americans should have equal opportunities to pursue a healthy lifestyle.

Public health professionals can:
- Use proven programs to reduce disparities and barriers to create opportunities for health.
- Work with other sectors, such as faith and community organizations, education, business, transportation, and housing, to create social and economic conditions that promote health starting in childhood.
- Link more people to doctors, nurses, or community health centers to encourage regular and follow-up medical visits.
- Develop and provide trainings for healthcare professionals to understand cultural differences in how patients interact with providers and the healthcare system.

Want to learn more? viwww.cdc.gov/vitalsigns/africanhealth
Problem:

Young African Americans are living with diseases more common at older ages.

African Americans are more likely to die at early ages from all causes.
National Healthcare Quality and Disparities Reports

Tools for measuring healthcare quality, including the National Healthcare Quality and Disparities Reports, AHRQ Quality Indicators, and ambulatory clinical performance measures.

For the 16th year in a row, the Agency for Healthcare Research and Quality (AHRQ) has reported on healthcare quality and disparities. The National Healthcare Quality and Disparities Report presents trends for measures related to access to care, affordable care, care coordination, effective treatment, healthy living, patient safety, and person-centered care. The report presents, in chart form, the latest available findings on quality of and access to healthcare, as well as disparities related to race and ethnicity, income, and other social determinants of health.
Figure 9. Overall quality of care, by state, 2015-2017

- 4th Quartile (Lowest-Worst)
- 3rd Quartile
- 2nd Quartile
- 1st Quartile (Highest-Best)
- Missing
Figure 10. Average differences in quality of care for Blacks, Hispanics, and Asians compared with Whites, by state, 2015-2017
STRUCTURAL RACISM AND HEALTH INEQUITIES:
Old Issues, New Directions

Gilbert C. Gee and
School of Public Health, University of California, Los Angeles

Chandra L. Ford
School of Public Health, University of California, Los Angeles

Abstract
Racial minorities bear a disproportionate burden of morbidity and mortality. These inequities might be explained by racism, given the fact that racism has restricted the lives of racial minorities and immigrants throughout history. Recent studies have documented that individuals who report experiencing racism have greater rates of illnesses. While this body of research has been invaluable in advancing knowledge on health inequities, it still locates the experiences of racism at the individual level. Yet, the health of social groups is likely most strongly affected by structural, rather than individual, phenomena. The structural forms of racism and their relationship to health inequities remain understudied. This article reviews several ways of conceptualizing structural racism, with a focus on social segregation, immigration policy, and intergenerational effects. Studies of disparities should more seriously consider the multiple dimensions of structural racism as fundamental causes of health disparities.

Keywords
Racism; Discrimination; Health Disparity; Race; Ethnicity; Immigrant; Social Determinants; Inequality

INTRODUCTION
Health inequities among racial minorities are pronounced, persistent, and pervasive (Sendik et al., 2010). Racism may be one cause of these inequities. Studies find that individuals who report experiencing racism exhibit worse health than people who do not report it (Williams and Mohammed, 2009). While this line of research has been invaluable in shifting the discussion from innate differences in biology or culture to social exposures, it is limited by inadequate attention to the multiple dimensions of racism, particularly structural racism. The

\footnote{The authors thank Karen Fujishiro, the guest editors, and several anonymous reviewers for invaluable comments on an earlier draft of this manuscript. The authors acknowledge support from the California Center for Population Research at the University of California at Los Angeles. © 2011 W.E.B. Du Bois Institute for African and African American Research. Corresponding author: Gilbert C. Gee, Department of Community Health Sciences, UCLA School of Public Health, 659 Charles E. Young Drive South, Los Angeles, CA 90095-1777. Tel: 310-825-2361. Email: ggee@ucla.edu.}
Diagnosing and Treating Systemic Racism

Michele K. Evans, M.D., Lisa Rosenbaum, M.D., Debra Malina, Ph.D., Stephen Morrissey, Ph.D., and Eric J. Rubin, M.D., Ph.D.

For physicians, the words "I can’t breathe" are a primal cry for help. As many physicians have left their comfort zones to care for patients with Covid-19-associated respiratory failure, the role of the medical profession in addressing this life-defining need has rarely been clearer. But as George Floyd’s reported cry of "I can’t breathe" while he was being murdered by a Minneapolis police officer has resounded through the country, the physician’s role has seemed less clear. Police brutality against black people, and the systemic racism of which it is but one lethal manifestation, is a festering public health crisis. Can the medical profession use the tools in its armamentarium to address this deep-rooted disease?

The role of the physician in times of social injustice and societal distress is difficult to navigate. Since the importation of enslaved Africans as chattel to provide the labor that built this country began, Americans have functioned within the intricate injustices that are the vestiges of that institution. Slavery has produced a legacy of racism, injustice, and brutality that runs from 1619 to the present, and that legacy infects medicine as it does all societal institutions. Slaves provided economic security for physicians and clinical material that permitted the expansion of medical research, empowerment of medical care, and enhancement of medical training. This long and troubled history has permeated the physician-patient relationship with insidious, reducing the potency of one of medicine’s most powerful tools for healing and changing behavior.

In an effort to engender trust in what they would like to see as a "post-racial" society, some U.S. clinicians proclaim that they "don’t see color." But color must be seen. By looking through a racially impervious lens, clinicians neglect the life experiences and historical inequities that shape patients and disease processes. At times, we fail to make even the simplest efforts: for instance, even though Covid-19 disproportionately afflicts black Americans, when physicians describing its manifestations have presented images of dermatologic effects, black skin has not been included. The "Covid toes" have all been pink and white.

In the review of x-rays, we query patients about exposure to xenobiotics, but we never ask about one of the most dangerous xenobiotics: racism. The work of David Williams details the morbidity and risk of death related to perceived discrimination. Discrimination and racism as social determinants of health act through biologic transduction pathways to promote subclinical cardiovascular disease, accelerate aging, and impede vascular and renal function, producing disproportionate burden of disease on black Americans and other minority populations.

Such research is part of a growing body of literature on health and health care disparities and their manifestations at every level of care. The recent study, for instance, found racial bias has bled into a commercial algorithm used to predict the needs of patients with uncontrolled illnesses. Using health spending as a proxy for gravity of illness, the algorithm ignored the fact that disparities in access result in lower spending on black patients and thus failed to identify...
The Impact of Racism on Child and Adolescent Health

Marie Trent, MD, MPH, FAAP, FSPR, DaCruce C. Dusley, MD, MPH, FAAP, Joceline Bougatsa, MD, MPH, FAAP, SECTION ON ADOLESCENT HEALTH, COUNCIL ON COMMUNITY, PEDIATRICS COMMITTEE ON ADOLESCENT HEALTH

The American Academy of Pediatrics is committed to addressing the factors that affect child and adolescent health with a focus on issues that may leave some children more vulnerable than others. Racism is a social determinant of health that has a profound impact on the health status of children, adolescents, emerging adults, and their families. Although progress has been made toward racial equity and justice, the evidence continues to highlight the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships.

The objective of this policy statement is to provide an evidence-based document focused on the role of racism in child and adolescent development and health outcomes. This policy statement will allow pediatricians to implement recommendations in practice that will better address the factors that make some children more vulnerable than others. The statement also addresses new AAP policy recommendations associated with other social determinants of health, such as poverty, housing insecurity, child health equity, immaturity, and early childhood adversity.

RACISM AS A CORE DETERMINANT OF CHILD HEALTH

Racism is a core determinant of child health that is a factor in almost all health inequities.1-2 The World Health Organization defines social determinants of health as "the conditions in which people are born, live, work, and age." The determinants are influenced by economic, political, and social factors linked to health inequities (available through World Health Organization.

This statement highlights the significance of childhood experiences and the influence of early social determinants on health outcomes. The statement also provides recommendations for addressing the impact of racism on child and adolescent health and well-being.

The statement is available at www.aap.org/policy/2018/equity-racism-objective-policy-statement.html.}

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Pediatrics 146, 2 (2020): 333-342

PEDIATRICS Volume 146, Number 2, August 2020.

PEDIATRICS Volume 146, Number 2, August 2020.
I'M NOT RACIST!!!
Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review

William J. Hall, PhD, Milmil V. Chapman, PhD, Kent M. Lee, MS, Yesenia M. Merino, MPH, Tahsah W. Thomas, MPH, B. Keith Payne, PhD, Eugenia Eng, DrPH, Steven H. Day, MCP, and Taimera Cooney-Beasley, MD

Background. In the United States, people of color face disparities in access to health care, the quality of care received, and health outcomes. The attitudes and behaviors of health care providers have been identified as one of many factors that contribute to health disparities. Implicit attitudes are thoughts and feelings that often exist outside of conscious awareness, and thus are difficult to consciously acknowledge and control. These attitudes are often automatically activated and can influence human behavior without conscious volition.

Objectives. We investigated the extent to which implicit racial/ethnic bias exists among health care professionals and examined the relationships between health care professionals’ implicit attitudes about racial/ethnic groups and health care outcomes.

Search Methods. To identify relevant studies, we searched 10 computerized bibliographic databases and used a reference harvesting technique.

Selection Criteria. We assessed eligibility using double independent screening based on a priori inclusion criteria. We included studies if they sampled existing health care providers or those in training to become health care providers, measured and reported results on implicit racial/ethnic bias, and were written in English.

Data Collection and Analysis. We included a total of 15 studies for review and then subjected them to double independent data extraction. Information extracted included the citation, purpose of the study, use of theory, study design, study site and location, sampling strategy, response rate, sample size and characteristics, measurement of relevant variables, analyses performed, and results and findings. We summarized study design characteristics, and categorized and then synthesized substantive findings.

Main Results. Almost all studies used cross-sectional designs, convenience sampling, US participants, and the Implicit Association Test to assess implicit bias. Low to moderate levels of implicit racial/ethnic bias were found among health care professionals in all but 1 study. These implicit bias scores are similar to those in the general population. Levels of implicit bias against Black, Hispanic/Latino/Latina, and dark-skinned people were relatively similar across these groups. Although some associations between implicit bias and health care outcomes were not significant, results also showed that implicit bias was significantly related to patient–provider interactions, treatment decisions, treatment adherence, and patient health outcomes. Implicit attitudes were more often significantly related to patient–provider interactions and health outcomes than treatment processes.

Conclusions. Most health care providers appear to have implicit bias in terms of positive attitudes toward Whites and negative attitudes toward people of color. Future studies need to employ more rigorous methods to examine the relationships between implicit bias and health care outcomes. Interventions targeting implicit attitudes among health care professionals are needed because implicit bias may contribute to health disparities for people of color. (Am J Public Health. 2015;105:660–e75. doi:10.2105/AJPH.2015.302560)
Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review

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Implicit bias in healthcare professionals: a systematic review

Chloé FitzGerald and Samia Hurst

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Background: Implicit biases involve associations outside conscious awareness that lead to a negative evaluation of a person on the basis of irrelevant characteristics such as race or gender. This review examines the evidence that healthcare professionals display implicit biases towards patients.

Methods: PubMed, PsycINFO, PsycARTICLE and CINAHL were searched for peer-reviewed articles published between 1st March 2003 and 31st March 2013. Two reviewers assessed the eligibility of the identified papers based on precise content and quality criteria. The references of eligible papers were examined to identify further eligible studies.

Results: Forty-two articles were identified as eligible. Seventeen used an implicit measure (Implicit Association Test in fifteen and subliminal priming in two) to test the biases of healthcare professionals. Twenty-five articles employed a between-subjects design, using vignettes to examine the influence of patient characteristics on healthcare professionals’ attitudes, diagnoses, and treatment decisions. The second method was included although it does not isolate implicit attitudes because it is recognised by psychologists who specialise in implicit cognition as a way of detecting the possible presence of implicit bias. Twenty-seven studies examined racial/ethnic biases; ten other biases were investigated, including gender, age and weight. Thirty-five articles found evidence of implicit bias in healthcare professionals; all the studies that investigated correlations found a significant positive relationship between level of implicit bias and lower quality of care.

Discussion: The evidence indicates that healthcare professionals exhibit the same levels of implicit bias as the wider population. The interactions between multiple patient characteristics and between healthcare professional and patient characteristics reveal the complexity of the phenomenon of implicit bias and its influence on clinician-patient interaction. The most convincing studies from our review are those that combine the IAT and a method measuring the quality of treatment in the actual world. Correlational evidence indicates that biases are likely to influence diagnosis and treatment decisions and levels of care in some circumstances and need to be further investigated. Our review also indicates that there may sometimes be a gap between the norm of impartiality and the extent to which it is embraced by healthcare professionals for some of the tested characteristics.

Conclusions: Our findings highlight the need for the healthcare profession to address the role of implicit biases in disparities in healthcare. More research in actual care settings and a greater homogeneity in methods employed to test implicit biases in healthcare is needed.

Keywords: Implicit bias, Prejudice, Stereotyping, Attitudes of health personnel, Healthcare disparities
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Want to learn more about implicit bias and implicit association tests?

Project Implicit

www.implicit.harvard.edu
Reducing Implicit Bias on your Care Team

Prevent
Implicit bias is difficult to undo. Rather than trying to become “bias free,” implement practices and policies to prevent implicit bias from operating.

Diversify
Work to diversify your care team and your leadership team. Diversifying does not simply mean adding people who are different, it means creating an inclusive environment where their perspectives are held with equal value.

Train
Does your team know the difference between cultural awareness, cultural sensitivity, cultural competence, and cultural humility? Increase personal cultural humility through dedicated training, supported by leadership.
Reducing Implicit Bias on your Care Team

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<thead>
<tr>
<th>Examine Access</th>
<th>Who accesses your services? Who does not? Do you collect meaningful patient information to assess disparities? What does that mean and what do you need to do?</th>
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<td>Examine Engagement</td>
<td>Use patient engagement and satisfaction measures. Examine the data by important cultural variables (e.g., race/ethnicity, language/national origin status, gender and sex identity). Find other ways to examine engagement.</td>
</tr>
</tbody>
</table>
The Nemours Behavioral Health Strategy

- Acknowledge
- Train
- Plan
- Assess
- Incorporate into mission and vision
- Execute
## The Nemours Behavioral Health Strategy Outcome

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<tr>
<th>Year</th>
<th># positions</th>
<th>% applicants of color ranked in highest tier (unique applicants)</th>
<th>% interns of color in class</th>
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<tr>
<td>2021-22</td>
<td>10</td>
<td>90%</td>
<td>70%</td>
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Diversity and Equity: What’s required?

- **Will**
- **Leadership**
- **Data**
  - We measure what we value and value what we measure
- **Inclusion**
- **Accountability**
- **Policy**