through the current administration but beyond. □

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Topics for Our Times: Affirmative Action and Women's Health

This past November, the California Civil Rights Initiative, Proposition 209, was approved by California voters. Although its proponents describe it as antidiscriminatory, the text of the measure explicitly bans outreach and remedial and recruitment efforts to help minority and female students with math, science, and entry to higher education. It also threatens to bar women from a range of occupations in ways that hark back to the era prior to passage of the Civil Rights Act of 1964.

Despite its equally threatening assaults on opportunity for both women and minorities, advocates of Proposition 209 tried to enlist women (implicitly as Whites) and to depict the opposition as minority (implicitly as males). Such dichotomies are not only politically divisive but also spurious; the categories are neither mutually exclusive nor homogenous—a woman may also be a member of a minority group. The term "minority woman," in turn, comprises a range of experiences. Too often, even the proponents of affirmative action restrict advocacy primarily to one group. It is necessary to understand the diversity and specificity of both gender and ethnic status to assess the implications of affirmative action for women's health.

Broadly speaking, affirmative action has two general goals—social justice and efficacy. The former assumes that because of past and present experiences of discrimination the playing field is not level for

today's players and that action is required to widen access to educational and economic opportunities for those previously excluded. The latter focuses on the practical benefits of such inclusion. In the case of health, both aspiring professionals and diverse groups of patients are affected.

Organized medicine formally adopted affirmative action as policy in 1968.[1] Shortly thereafter, Allan Bakke, a white male who unsuccessfully applied to the Medical School at the University of California at Davis, sued, claiming that he had been denied admission because of a race-based quota. In 1978 the Supreme Court ruled such a quota system to be unconstitutional but affirmed that minority status could be a factor in admissions decisions.[2]

Is the playing field now level in terms of opportunity to practice in the field of health? Most available data refer specifically to medical education, and here we see that affirmative action has had a significant impact—for some groups. In the late 1960s, the Association of American Medical Colleges endorsed affirmative action; this rapidly led to increases in female and minority enrollment in medical school.[3] The Bakke decision, however, had a chilling effect that particularly affected minority group applicants. The proportion of minority students enrolling in medical school from the mid-1970s to 1990 did not keep pace with their proportional growth in the population. The result was a degree of underrepresentation of minorities greater in 1990 than it had been in 1975,[4] although minority enrollment has increased somewhat since 1990.[5]

On the other hand, the proportion of women entering medical school increased fairly steadily, and in 1995 women constituted 43% of the entering class compared to 26% in 1978. Closer scrutiny reveals that women in medical school are predominantly White, and secondarily Asian. The proportion of Black women has increased only slightly (for Black men there has been a decline—12% fewer Black male medical students in 1995 than in 1971).[5] The proportion of Hispanic women who are medical school enrollees has not changed at all and still hovers just over 2%.[6] Academic hiring in medical schools presents a similar picture. In 1995 approximately one quarter of faculty members in US medical schools were women; approximately 75% of these were White, 10% Asian, 4% Black, and 3% Hispanic.[5]

The information available about other health professions is rarely organized to examine race and gender simultaneously. These more limited data suggest similarly uneven progress towards proportional and thus more equitable representation.

Minority women have been entering dentistry at a faster rate than minority men, and Hispanic and Native American representation in dental school comes closer to population parity than does that of African Americans. All minority groups remain significantly underrepresented in nursing programs, while minority enrollment in schools of pharmacy has risen steadily.[7]

Hispanics represent only 5% of medical and health professionals, with a disproportionate representation in allied health professions, and Hispanic women represent less than 2% of those in health professions that require an advanced degree.[6] However, Hispanic completion of graduate degrees in public health has quadrupled from the mid-1970s to the early 1990s; Hispanics now make up approximately 8% of such graduates, although only 3% are public health students at the doctorate level. The proportion of Asians in public health schools has doubled, so that they now represent approximately 6% respectively of masters and doctoral level public health students. Black, American Indian, and White proportional enrollments have stayed steady over these 2 decades, and Whites continue to constitute the overwhelming majority (> 80%) of doctoral level students. During this same time period, a pronounced shift in the gender distribution of public health students has occurred. The proportion of women has increased from 40% to more than 60%, although more men than women are pursuing public health doctorates.[8]

Affirmative action is traditionally understood to refer to education and employment, including contracting, but it has important implications for health research as well. Interestingly, the National Institutes of Health (NIH) have adopted what might be considered an affirmative action stance towards health research—one that manages to keep gender and race/ethnicity in the frame simultaneously. Pushed by the women's health movement, in 1985 the NIH formally urged the inclusion of women in clinical research and, in 1987, expanded this to encourage the inclusion of minorities.[9] The NIH Revitalization Act of 1993 legislatively mandated that women and minority group members be included in NIH-supported research and, in that same year, the US Food and Drug Administration stipulated that gender analysis be incorporated into new drug applications.[10]

Those developments arose from the recognition that clinical care for women was inadequate because research had concentrated on men. The picture regarding women's health is a complicated one. Disparities persist between racial and ethnic groups of women for preterm delivery rates, infant mortality, maternal mortality, hip fractures, and mortality and morbidity from breast and gynecologic cancers.[11–15]

Within racial and ethnic groups, health outcomes vary according both to economic status and to national origin. Both maternal and infant mortality rates are inversely related to socioeconomic status, but a Black–White gap persists across class lines and, furthermore, varies by national origin; for example, Afro-Americans fare worse than Afro-Caribbeans.[16] Differences in birth outcomes have also been demonstrated among low income Hispanics, Asian Americans, and Native Americans in the United States, according to national or tribal descent groupings.[17–21]

Recognition that research focused on men did not produce findings relevant to this diversity of subgroup profiles led both NIH and the US Food and Drug Administration to adopt their affirmative action policies towards health research. They concluded that failure to formulate race- and gender-specific research questions led to gaps in knowledge and, consequently, to compromised care.

Just as excluding some groups from research may compromise their care, so too may limiting their entry to health professional training. Clearly, access to prestigious and remunerative professions matters to the individuals concerned. Does it matter to the public health? The second pragmatic goal of affirmative action in health assumes that inclusion of those with diverse backgrounds as providers will render health care more effective. Some data substantiate this. A study of graduates from medical school in 1975 documented that affirmative action was ameliorating maldistribution of physicians. A larger proportion of minority physicians became primary care practitioners, worked in medically underserved communities, and cared for more indigent patients and for patients of their own racial/ethnic group.[22] A recent study in California confirmed this pattern. Black and Hispanic physicians were more likely

to work in medically underserved areas and to take care of higher proportions of indigent patients and those of their own racial/ethnic group.[23] In 1993 more than one third of minority medical school graduates planned to practice in underserved areas, while less than 10% of other graduates intended to do so.[7]

Extensive evidence shows that, although minorities in general need more health care than the majority population, they have access to fewer providers, use fewer health care services, and receive less aggressive care when they do so.[24–25] Limited research is available regarding a link between the racial/ethnic gender similarities of provider and patient and the use of health care services, but this research offers some suggestion that such congruence has a positive effect.[26] Obviously, it is helpful to have provider and patient speak the same language, and this will be increasingly important as first generation immigrants constitute growing proportions of the population. Even more important than linguistic and cultural congruence is increasing the supply of providers and thus increasing access to care for underserved groups.

The complexities of differential outcomes between women of varied racial and ethnic groups cannot be solved by the provision of health care alone. Health status, of course, derives from complex interrelationships between genetic, socioeconomic, cultural, and societal/institutional factors. Certainly public health interventions, which are often educational and behavioral in nature, and aimed at communities, will be more likely to be effective if designed by those familiar with the culture, language, and circumstances of the targeted group.

We can consider the twin goals of affirmative action—justice and efficacy—in light of three approaches to women's health, which should be added to the necessary parallel approaches to the health of racial/ethnic minorities:

- documentation of the heterogeneous and specific health experiences of diverse groups of women
- inclusion of race/ethnicity and gender as parameters of interest in medical and public health research
- training of women of diverse backgrounds to be health and public health professionals

Demographic projections for the United States suggest that racial/ethnic identification and experiences of Americans will become increasingly complicated as immigrant populations grow, meet, and mix. We will need to figure out ways to thoughtfully acknowledge and respond to this complexity without succumbing to fragmentation or to competition between groups.

Encouraging models emerged in opposition to Proposition 209. Health Professionals for Diversity is a coalition of more than 35 medical and public health organizations of health providers and educators, including the American Public Health Association. "No on CCRI," a California-wide effort, was cosponsored by many national medical organizations, including both those specifically representing women (for example, the American Medical Women's Association) and those specifically advocating for minorities (National Medical Association). The Affirmative Action Education Project is a joint project of the American Medical Student's Association, the Student National Medical Association, the National Network of Latino Medical Students, and the American Medical Women Student's Association.

The public health analyses reveal the complexity behind simplistic categories and underscore the importance of both social justice and efficacy. These coalitions offer an alternative to separating women's and minority interests in affirmative action, a division that serves only to further damage health and human potential and makes neither scientific nor political sense. □

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