



# ACTIONS TO ACHIEVE for HEALTH EQUITY ETHNIC/RACIAL GROUPS

REGIONAL WORKSHOP  
ADOPTION AND IMPLEMENTATION  
OF AFFIRMATIVE ACTION POLICIES  
FOR AFRO DESCENDANTS  
IN LATIN AMERICA AND  
THE CARIBBEAN  
MONTEVIDEO, URUGUAY  
MAY 2003



Governance and Policy  
Pan American Health Organization  
*Regional Office of the*  
World Health Organization

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Montevideo, Uruguay  
May 2003



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**World Health Organization**

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# Table of Contents

Health Situation Diagnosis.....	5
Definition.....	9
Background .....	10
Requirements for the Implementation of Affirmative Action Policy .....	11
Typology of Affirmative Action .....	12
Instruments .....	13
Identification and Selection of Beneficiaries.....	15
Definition of Regulatory Standards.....	16
Affirmative Action and Health: Some Examples.....	17
Endnotes .....	23
Bibliography.....	25

## **Graphs**

Gaps in Delivery Care, Guatemala, 1995.....	6
Afro Population living with HIV/AIDS in Canada (in percentages).....	7
HIV prevalence rate in Honduras compared to Garifunas' rate.....	7
Afro-descendants living with HIV in the United States.....	8
Deaths of patients with HIV Brazil in percentages 1990-2001 .....	8
Percentage of Persons with AIDS in the United States, by Ethnicity and Period When Reported ..	9

## **Tables**

1. Instruments for Implementating Affirmative Action.....	12
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# **ACTIONS TO ACHIEVE HEALTH EQUITY FOR ETHNIC/RACIAL GROUPS**

## **Regional Workshop Adoption and Implementation of Affirmative Action Policies for Afro-Descendants in Latin America and the Caribbean**

Montevideo, Uruguay  
May 2003

### **Health Situation Diagnosis**

Forty-three percent of the population of Latin America lives below the poverty line.<sup>[i]</sup> Several studies confirm that a greater proportion of people in specific ethnic/racial groups fall under the category of poor, especially women heads of household and children.

According to data from the 1996 Household Survey of Brazil, an analysis of the segment of the population with the lowest income levels shows that 63.86% of those in quintile I are of African descent and 35.79% of European descent. Afro-Brazilians, accounting for 6 out of every 10 people in Brazil, are overrepresented in the lowest quintile.

Income disparities based on ethnicity are not exclusive to the developing countries, but are also observed in the developed countries of the Region, such as the United States. According to data from the U.S. Census Bureau (1999), the average income per capita in US dollars for African-Americans was US\$14,397, for Hispanics, US\$11,621, and for whites, US\$24,109.

Poverty levels are linked to the complex phenomena of social exclusion, and thus should be addressed using a comprehensive approach that includes education, health, and access to water and sanitation. The traditional forms of social exclusion have been associated with gender, race, and ethnicity.

Some classic indicators will be used to illustrate the foregoing. According to PNAD data for Brazil (Inter-American Dialogue, 2002), although life expectancy has risen, the seven-year gap in life expectancy between whites and Afro-Brazilians that existed in 1950 remains unchanged.

Even in developed countries, ethnic minorities live in situations of vulnerability. In the United States,<sup>[ii]</sup> according to data for 2000, African-Americans have a life expectancy five years lower than that of the general population. (In that country, the life expectancy of the general

population is 76.9 years, while for African-Americans, Native Americans, and whites it is 71.8, 71, and 77.4 years, respectively).

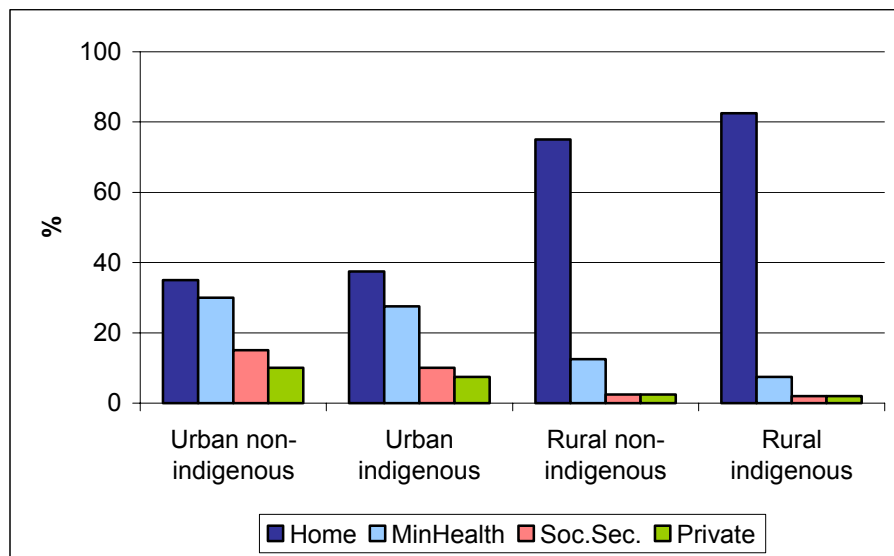
Another indicator that enables us to measure gaps in the health situation is **infant mortality**. In Colombia, for example, infant mortality is between three (for boys) and four (for girls) times greater in the Department of Chocó than in the Department of Antioquia. Male infant mortality is over 90 per 1,000 live births in Chocó, while in Antioquia, it is below the national average of 25. Chocó is a department whose population is principally Afro-Colombian.

Many specialists question whether ethnic origin is a relevant variable or whether the differences in infant mortality are correlated fundamentally with socioeconomic level.

Comparing infant mortality in Brazil with the mother's years of schooling as a proxy for socioeconomic level in each ethnic group, it is observed that the children of women of African descent with the most schooling (eight years or more) have the same infant mortality as the children of illiterate white women.

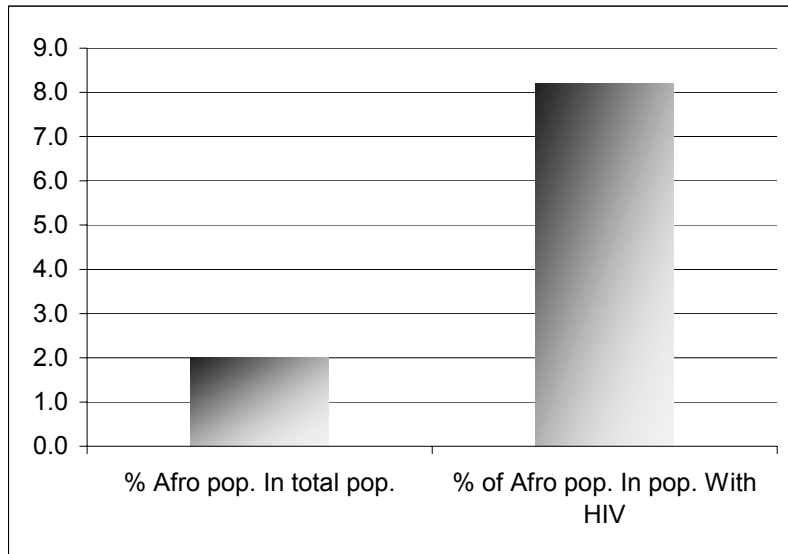
This demonstrates that the variable of ethnic origin is independent of people's socioeconomic level as measured by their level of schooling.

### Gaps in Delivery Care, Guatemala, 1995

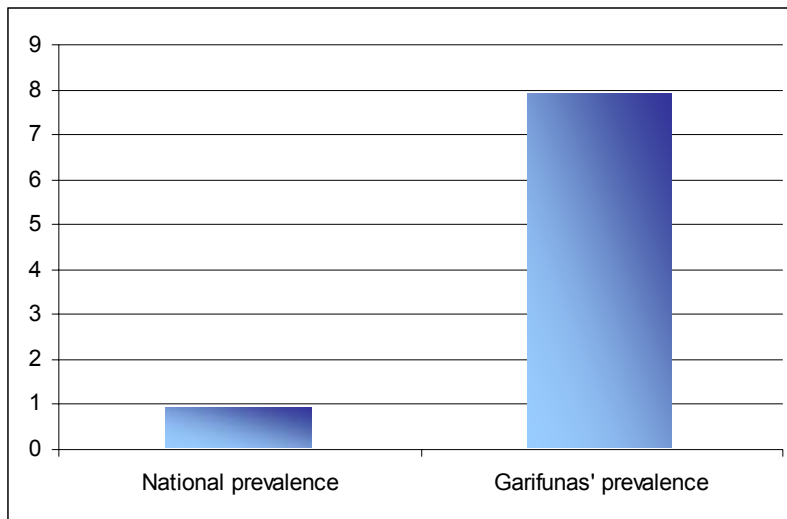


One of the most pressing issues in health is the HIV/AIDS pandemic, which has had a devastating effect on ethnic groups. The disease's prevalence rate among the population of African-descent is much higher than among other population groups in Latin America, Canada, and the United States. Some data on the subject is presented below.

**Afro Population living with HIV/AIDS in Canada (in percentages)**

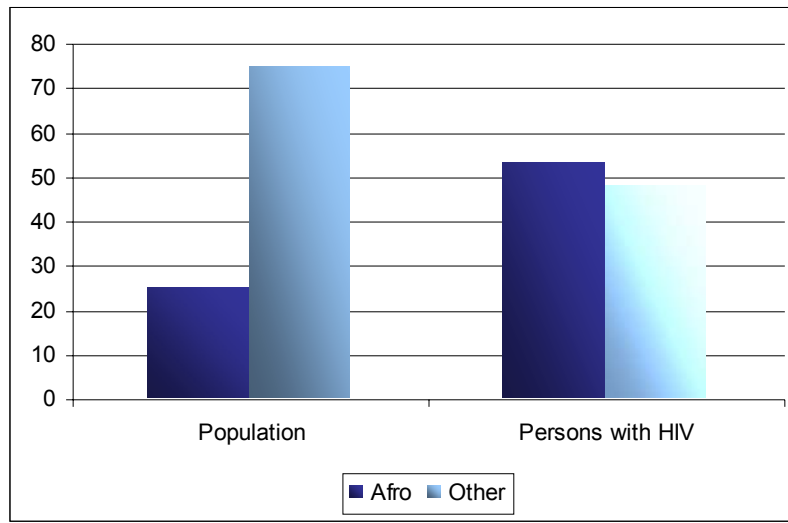


**HIV prevalence rate in Honduras compared to Garifunas' rate**



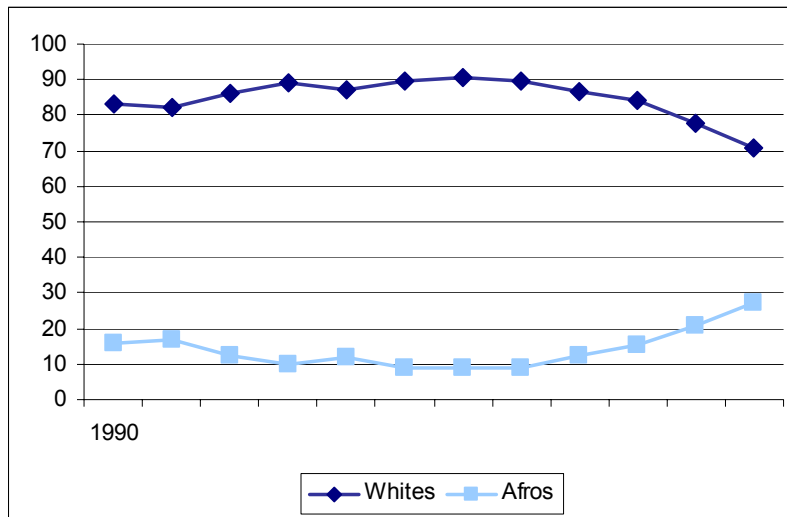
**Source:** World Bank 2002.

### Afro-descendants living with HIV in the United States

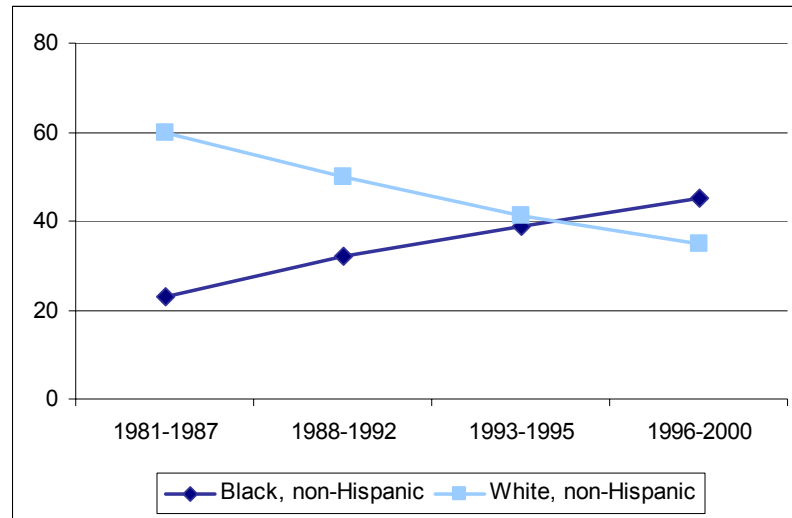


It should be noted that policies have benefited members of society differentially at the expense of Afro groups. The information presented below clearly shows that beginning in the mid-1990s, while deaths of patients with HIV/AIDS in Brazil and the United States decline for whites, they increase for Afro-descendants.

### Deaths of patients with HIV in Brazil, in percentages 1990-2001



**Percentage of Persons with AIDS in the United States, by Ethnicity and Period of Being Reported**



## Definition

Affirmative action is a *public policy expressed through a legal norm, a judicial ruling, or an official decision that seeks to improve opportunities for groups segregated within society due to their disadvantaged position relative to the dominant groups.*

Affirmative action should not be considered an end in itself, but a *temporary mechanism to reduce disparities, thereby increasing opportunities for minorities, especially in terms of their access to education, employment, housing, public funds, and political representation. It is assumed that the human rights of the majority are abridged to restore balance to a situation that also threatens the human rights of ethnic groups.*

In some cases the terms *positive action* or **positive discrimination** are preferred. Regardless of what it is called, affirmative action recognizes the existence of social inequalities. It is conceived as the elimination of discrimination and the promotion of opportunities for all groups in a society. <sup>[iii][iv]</sup> In any case, adopting this type of public policy implies a change in mentality on the part of government and the people and private entities that interact in society.

The majority of Constitutions and legal bodies in the Latin American countries include express statements promoting diversity and the inclusion of all social groups in national development, regardless of their ethnicity or race, economic status, gender, creed, sexual orientation, political connection, or culture. The spirit of the provision is to guarantee that all people enjoy the same opportunities without discrimination. Here, the goal is to ensure the participation of all people in national life by respecting the special characteristics of social groups and their forms of organization.

In Latin America efforts have recently been made to induce governments to implement affirmative action as a means of guaranteeing the access to opportunities and encouraging the participation of ethnic/racial groups in national development. For example, the Declaration of

Afro-Latin American and Caribbean Leaders of San José, Costa Rica achieved during preparations for the III World Conference against Racism, Racial Discrimination, Xenophobia, and Related Intolerance is very explicit about setting quotas to implement affirmative action in the areas of employment, education, and political participation. It furthermore calls for the implementation of a comprehensive affirmative action policy in housing, cultural heritage, and access to justice and health.<sup>[vi]</sup>

Similarly, the Plan of Action of the Forum of the Americas for Diversity and Pluralism, held in Quito, Ecuador in March 2001, states its intention<sup>[vii]</sup>:

*To demand from States the implementation of affirmative action policies for indigenous peoples and peoples of African descent, as part of their public and development policies at the national and regional levels. Among the areas to be covered by such affirmative policies are housing, cultural heritage, access to justice and health care, especially percentage quotas in the executive, legislative and judicial bodies of national governments; percentage quotas in the hiring and promotion of employees in private, communications, and government enterprises; percentage quotas in the educational system, particularly in teaching in primary and secondary schools and higher education.*

## Background

The concept of affirmative action originated in the United States, growing out of the civil rights and social justice movements to achieve the full integration of American society. With the support of Congress, explicit policies were crafted to provide greater opportunities for minorities in employment, education, the awarding of public contracts, and political participation.<sup>[1]</sup>

American society is characterized by its widespread social segmentation. Tensions among ethnic/racial groups date back more than a century; for example, in 1882, Congress passed the Chinese Exclusion Act to limit Chinese immigration. Other immigrant groups were also stigmatized on the basis of prejudices about their cultural and ethnic “inferiority.” A critical point in the struggle for social equality in the United States was the emergence of Nazism, because it forced United States’ authorities to take a firmer stance with regard to discrimination within its own borders.

World War II provided President Franklin D. Roosevelt with a situation conducive to promoting action to reduce discrimination. Thus, he stipulated that defense contractors hire African-American workers. This decision was based more on the war-time needs of the defense industry than on an interest in resolving social inequalities.<sup>[vii]</sup> In any event, this argument bolstered the rhetoric in the fight against Nazism.<sup>[2]</sup>

However, the situation was also favorable for activist groups. Adding minorities to the ranks of the army during World War II was used to demonstrate that the country was united despite its ethnic/racial diversity. In 1955, the boycott against the bus company in Montgomery, Alabama served as a platform for peaceful protests at lunch counters and other private and public establishments. Thus, during the 1963 March on Washington, Martin Luther King stated: “... in spite of the difficulties and frustrations of the moment, I still have a dream... a dream that one day this nation will rise up and live out the true meaning of its creed: ...that all men are created equal.”<sup>[viii]</sup>

The civil rights movement gathered strength, contributing decisively to the passage of the Civil Rights Act (1964) and the Voting Rights Act (1965). As a result, the Equal Employment Opportunity Commission and the Office of Federal Compliance were created to guarantee compliance with the law.<sup>[ix]</sup> These legal instruments were the first official efforts against racial discrimination.

The term *affirmative action* appeared officially for the first time in an Executive Order signed by President John F. Kennedy in 1961, in which he urged the Federal agencies to take “affirmative action” to end discrimination against African-Americans in the hiring of personnel. Then, in 1964, the Civil Rights Act once again used the term in the remedy section of Title VII on discrimination in employment.

In 1965, President Lyndon B. Johnson signed Executive Order 11246, requiring companies contracted with federal funds to comply fully with affirmative action. Actually, the goal of the civil rights movement was to obtain laws that were “colorblind.” Ending discrimination did not appear to be enough, and thus it was necessary, where applicable, to promote action to improve equality. In this tenor, in a speech delivered at Howard University, President Johnson declared: “You do not take a person who, for years, has been hobbled by chains and liberate him, bring him up to the starting line of a race and then say: ‘you are free to compete with all the others,’ and still justly believe that you have been completely fair”....<sup>[x]</sup> In that way, impetus was given to the implementation of *affirmative action* to favor the hiring of workers from minority groups.

Four decades later, the beginning of the 21st century has been marked by a rise in educational levels, a reduction in poverty, an increase in home ownership, and an improvement in the job status of the African-American population, although inequities persist. In 1999, according to Census Bureau data, the average income of African-Americans was approximately 40% below that of whites (\$14,397 and \$24,109, respectively). Another example is access by the population to health care. The percentage of uninsured Afro-Americans (20%)<sup>[xi]</sup> is double that of the white population.

However, it should be noted that the actual implementation of affirmative action has generated growing tensions and debate about the legitimacy of maintaining it as a permanent fixture.

## Requirements for the Implementation of Affirmative Action Policy

Like all policies, affirmative action has stages of development that begin with the definition of plans and the identification of objectives, goals, financing sources, and deadlines by which to achieve the objectives (timetable), a monitoring system, and impact assessment.<sup>[xii]</sup><sup>[3]</sup>

Initially intended to regulate the job market, affirmative action policies have been heavily influenced by the legal perspective. García Añón proposes that the following elements be considered in the implementation of affirmative action:

- The context in which the nature of one group’s disadvantage relative to another’s is determined in a society.

- The objectivity of assumptions; that is, determine the existence of *de facto* equality in the competition for employment. In addition, determine whether less or unequal representation occurs for other reasons (historical, social, economic).
- Objectivity in selecting beneficiaries. To this end all criteria relating to an individual's personal or professional aptitude and competence should be considered. Thus, the preference allowed by the standard should be ignored when the criteria tilt the balance in favor of better-skilled people. This does not mean discriminating against minorities.

## Typology of Affirmative Action

*Affirmative action* can be implemented in response to different problems and is substantiated through different approaches, namely:

- **Compensatory** (intended to remedy harm caused in the past. Basically, its implementation results in a lawsuit subject to a ruling by a civil court. It has been utilized in lawsuits on land titling or employment discrimination and is settled through monetary compensation and/or restitution of the lost property or right).
- **Corrective** (utilized to ensure the end of discriminatory practices. This affects the future. Basically, it is applied in matters related to education, employment, and health).
- **Redistributive** (the objective is to put an end to the unequal distribution of opportunity <sup>[xiii]</sup>).

These approaches allow for a better understanding of the different types of *affirmative action*, areas of implementation, and instruments utilized in each case.

In principle, instruments that facilitate implementation of the standard to ensure equal opportunity and the integration of minorities into the social dynamic without adversely affecting majorities will be termed *soft*, while those that impose the standard without sufficient consideration of the essence of equal opportunity will be classified as *hard*.

The following table shows the relationships between the aforementioned approaches and the types of instruments used to implement **affirmative action**.

**Table 1. Instruments for Implementing Affirmative Action**

Approach	Type of Instrument	
	Hard	Soft
Compensatory	Law Ruling, decree	-----
Corrective	Quotas	Preferential selection Targeting Specific programs; subsidies Risk approach
Redistributive	Selective targeting Quotas	Targeting Specific programs; subsidies

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## Instruments

In the category of hard instruments, we find judicial rulings, quotas, and selective targeting. **Quotas** are percentages imposed by law to ensure that a segment of the neglected group has access to social participation. They are usually used in the labor market, in regulations of the political system, and in the standards that regulate access to education.

There is some controversy over the use of quotas.<sup>[4]</sup> Although the law cannot mandate their use as a specific instrument of affirmative policy, quotas were adopted in practice by some private and public entities, for example in the United States, because they give high visibility to faithful compliance with the law and also serve to neutralize the pressures of organized minority groups. Nevertheless, this practice has generated opposition, since the constitutional right to equality under the law is violated and the practice of discriminating against people in the present to compensate for the exclusion of minorities in the past is debatable.

In fact, it is pointed out that quotas establish a mechanism for reverse discrimination that militates against skilled people merely because they belong to a group considered “dominant.”<sup>[xiv][5]</sup>

Higher education has been a fertile field for lawsuits against affirmative action practices, especially utilizing the argument of reverse discrimination. In recent years, lawsuits have been brought against the Universities of Georgia, Michigan, Texas, and Washington, among others.<sup>[6]</sup>

In contrast, **soft** instruments (preferential selection, targeting, specific programs) have achieved greater acceptance.

Among the soft instruments, the most important is **preferential selection** (also known as tiebreak).<sup>[7]</sup> This soft instrument is used when applicants are equal in ability; that is, if there are two candidates for an opening, whether in education or employment, who present similar profiles and comparable merits, the one belonging to a minority is chosen. Preferential selection is less questioned because it does not exclude majorities automatically as in the case of quotas. If, objectively, inequality exists in favor of a candidate regardless of whether he or she belongs to the minority or the majority, and that person has more merit than the others, there is no reason to apply equalizing measures,<sup>[xv]</sup> but rather he or she should be given priority.

There are also other more diffuse modalities implemented through **grant programs** specifically for minorities that range from vocational activities to credits for housing and business. In general, these *ad hoc* programs aimed at minorities have mixed financing (federal, state, and private).

Another group of instruments are common to those utilized in **targeting**. In its broadest sense, targeting means *channeling public resources or subsidies toward specific population groups to achieve certain policy objectives*.<sup>[xvi]</sup> The fundamental purpose of targeting is to utilize public resources efficiently and not to promote the equalization of ethnic minorities. Several studies have demonstrated that subsidies often benefit population groups that do not need them, generating inefficiency and inequity in public spending.

For example, there are subsidized programs for the distribution of food to the poor that are taken advantage of by the non-poor with power and lobbying resources.<sup>[xvii] [xviii]</sup> In this case,

the action was ineffective because it included the non-poor; that is, there was an error in allocating the subsidy (type I error). But leakage to the non-poor could exclude legitimate beneficiaries from the program. These errors are classified as type II.

Thus, governments generally use targeting—understood as policy—to deliver subsidies to the poor. However, targeting introduces tools that are valid for orienting programs and resources to other population groups based on ethnic/racial, gender, age, geographical, and other criteria.

Some studies on the channeling of public spending to the social sectors reveal that in terms of equity, it is more advantageous to target programs and services to priority groups than to make them universal. Nevertheless, in developing countries, the political risk and vested interests have encouraged governments to adopt policies for the universal delivery of services such as education, nutrition, and health. It is common to observe the targeting of subsidies as part of the structural adjustment and macroeconomic reform programs. However, targeting should not be used solely to compensate for the effects of an economic policy that exacerbates social inequalities and results in a less equitable distribution of income. The targeting of social programs and services in Latin America has been cautious, notwithstanding the benefits it could provide in terms of efficiency, effectiveness, and equity.

Targeting can be a soft or hard instrument depending on the size of the target group. *Selective targeting* is directed to a specific group defined by very strict and selective criteria.<sup>[xix]</sup>

Based on this definition, it is evident that **selective targeting** would become a hard instrument for affirmative action, while the remainder of the targeting—universalization continuum— would be compatible with the definition of a soft instrument (see table above).

An example of selective targeting is the provision of iron supplements to low-income pregnant women.

In short, targeting has its origin in a context other than affirmative action. However, it can help to reduce discrimination and be a useful instrument for the identification and selection of beneficiaries, as well as a mechanism for the delivery of services and subsidies.

Finally, another soft instrument has its origin in the epidemiological approach: the **risk approach**. This instrument has been utilized **in health** to direct appropriate actions to populations with characteristics or behaviors associated with a high risk of becoming ill or of dying.<sup>[xx]</sup>

In this case, a specific condition is targeted and used as the basis for curing or preventing deterioration in people's health—for example, malnourished mothers and children given access to feeding and nutritional supplementation programs. Up to now, however, neither the economic nor the ethnic/racial characteristics of the population have been considered when targeting actions using the risk approach.

This approach is especially useful in targeting actions and health programs to population groups that are more vulnerable because of their race or ethnicity.

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## Identification and Selection of Beneficiaries

Identifying who the beneficiaries should be is one of the most complex tasks in *affirmative action*. The guidelines for identifying beneficiaries vary:

They can be identified as a group of people within a territory, or belonging to a community—a very pertinent practice for indigenous populations, *marrons*, *palenques*. Criteria can also be established for the identification of individuals, being careful to take membership in the ethnic group as a self-ascribed cultural factor and not as a characteristic of phenotype.

The criteria can be established by a team of experts, with the participation of members of the community of the **beneficiary group**; this has the advantage of easy implementation and lower administrative costs. To apply affirmative action to a group, it is sufficient to identify the minority group that is the object of affirmative action to deliver the intended benefits. One characteristic that should be considered is that membership can be established rather precisely by utilizing a simple administrative procedure. Statistical data from the population census or periodic household surveys is required for this purpose. This mechanism is useful for different types of programs—i.e., feeding, education, and health programs—based on the identification of groups of school-age children, construction workers, and the poor, respectively.

**Geographical location** is one modality of this way of identifying beneficiary groups. Benefits are provided to the entire population identified as the target. Aside from the advantages indicated, this has a positive impact on social integration when used to apply affirmative action to guarantee equal opportunity for the entire group. Its main disadvantage is leakage to unintended beneficiaries and thus, a certain degree of inefficiency.

The identification of **individual beneficiaries** is based on personal characteristics: membership in an ethnic group, geographical location, income level, level of education, place of birth, age, sex. It requires more information, and it is costly, since the selection is made for each beneficiary. Some of the tools used to compile the pertinent information are surveys on economic resources; income assessments performed by social workers; indirect indicators of income, such as gender of the head of household, housing conditions, possession of certain goods (television, vehicle) and services (telephone, electric power); and indicators of nutritional and health risks. This mechanism certainly permits greater precision, but it is not always more efficient. The typical case in which this targeting mechanism is used is the awarding of scholarships for minorities. Exhaustive research is justified in the case of scholarships for higher education, for which the amounts can be substantial.

In the case of scholarships that provide nothing more than money for books, the administrative cost to ascertain whether the beneficiary qualifies can be greater than the amount of the scholarship. In these cases, it is preferable to opt for group targeting criteria that guarantee a substantial degree of homogeneity among the members of the target group, although individually some may not qualify. Thus, the criteria of efficiency should be taken into account when choosing the modality for selecting beneficiaries.

**Self-selection** is more limited but more precise. However, reverse discrimination could occur particularly because of the stigma, opportunity costs, and difficulties in access associated with this mechanism. Unlike the previous mechanisms, the administrative burden of self-selection

is almost nonexistent, but its disadvantage lies in that it does not completely eliminate leakage. The cost is transferred to the user, who must spend time and money to obtain the benefits.

This mechanism probably prevents people who do not qualify from obtaining benefits, but it can also exclude others who truly need them. For example, food programs that require people to demonstrate a lack of economic resources and the long waits required to receive the food can dissuade legitimate beneficiaries from participating. This mechanism, however, is useful in the recruitment of personnel, since it clearly establishes the requirements to fill a vacancy and allows applicants who do not possess the necessary knowledge and experience to decide on their own not to apply.

Then, beyond the effectiveness and precision of targeting mechanisms, a key issue for the implementation of affirmative action is the recognition and explicit identification of people in a particular population group. The identification with and sense of belonging to an ethnic/racial group is particularly important. If whoever makes the identification also directs a benefit program, the degree of subjectivity involved in such a decision can become controversial because it is based on the observer's assessment criteria rather than those of the object of the affirmative action (individual targeting).

In principle, it should be the subject of affirmative action the one who identifies himself or herself as a member of such-and-such an ethnic/racial group (self-selection); although this does not eliminate subjective judgment, it does reduce it. In an extreme situation, people could unscrupulously self-identify with a certain ethnic/racial group in order to become beneficiaries, producing a leakage. To diminish this type of error, an appeal could be made to the beneficiary community for its *de facto* or legally-appointed leaders and its members in general to corroborate the individual identification, thus strengthening program transparency and reinforcing the social audit.

In practice, a combination of mechanisms is used for selecting beneficiaries, but **community participation** in the monitoring of the beneficiary population, in particular, can guarantee greater effectiveness, efficiency, and equity in affirmative action policies.

## Definition of Regulatory Standards

Affirmative action programs must be regulated to prevent the leakages and abuses that can occur. A major argument for regulation is economics, since resources are always limited and it is therefore necessary to preserve their good use, with good use understood as production of the expected results in a transparent, predefined process.

Regulation would also help to soften opposition to affirmative action by offering authoritative evidence of the benefits of social integration. This opposition is based on the argument that affirmative action erodes the concept of equal rights under the law, which holds that the person most qualified for a job or program of study should be chosen regardless of ethnicity/race, gender, or any characteristic that offers him or her advantage. It is argued that affirmative action programs offer a perverse incentive by allocating funds based on the achievement of specific goals (quotas), thus reducing efficiency and effectiveness in the workplace and in education. Well-crafted regulations would improve the participation of ethnic/racial minorities and thus reduce the controversy over affirmative action.

In contrast, *affirmative action* can become a tool for discrimination when its beneficiaries erect barriers to participation by people with different ethnic/racial characteristics—for example, refusal to hire a person with expertise in financial management from an ethnic/racial group other than the predominant group in the company.

## Affirmative Action and Health: Some Examples

The United Nations considers the human race to be one, with individual differences being cultural and symbolic in nature.<sup>[8]</sup>

To expand this analysis to health, it is worth noting that health is a good with distinctive characteristics. Basically, government actions cannot “guarantee health,” but rather access to services and to information, prevention, and health promotion.

Health, unlike education, is a good that is more vulnerable and subject to variation, depending on the risks to which people are exposed during the different life cycles.

At this point, it is appropriate to analyze the concept of “opportunity goods,” which served as the basis for arguments favoring the passage of the Civil Rights Act. Opportunity goods are those that affect an individual’s basic chances in life and are especially important from the standpoint of justice.

Without these goods, people have few or very limited chances of leading a productive life. Education and health are opportunity goods, without which the chances of leading a full and productive life are considerably lower.<sup>[xxi]</sup>

For example, in today’s world, where the labor market is increasingly specialized and competitive, education plays a key role in allowing people to become productive agents.

Likewise, although people may have access to education, poor health radically diminishes their capacity to learn and grow, limiting their chances of leading a productive life.

The prevailing economic model today is the free market, which operates according to the supply and demand for goods and services. However, it does not guarantee the uniform distribution of wealth and opportunities, as can be seen in the section on diagnosis.

In practice, the people who make up a society become economic agents who choose the patterns of consumption they desire. However, the decisions are not so simple, because members of a society generally cannot meet their own consumption needs in education and health.

This requires complex systems of interaction between people and institutions and significant resources that exceed individual capacity. In Latin America up through the 1990s, the model of “universal access to basic health services” had generally been utilized to achieve equity.

Traditionally, most of the countries in the Region have allocated resources in the health sector by subsidizing health services supply. The beneficiary population receives the subsidy indirectly, because the resources go to the service providers.

This modality of resource allocation is administratively simple but prone to inefficiency because it lacks incentives to improve productivity and the quality of services. Providers deliver services universally without considering the needs of users, who cannot choose either, and performance is not linked to financing.

During the health sector reform process, the effectiveness of these mechanisms was reconsidered. Programs that seek universal coverage are not successful in reaching the entire population. For example, vaccination programs are universal in nature, but in practice, their coverage is far from the entire target population. In the early 1990s coverage with the third dose of DPT in Bolivia, El Salvador, and Venezuela did not exceed 60% of the infant population.<sup>[xxii]</sup> Similarly, in Guatemala in mid-1996, tetanus vaccination coverage for the indigenous population declined.<sup>[xxiii]</sup>

The example of HIV in Brazil described earlier in this document is eloquent in the same sense. A regressive trend can also be observed in universal programs because they are of most benefit to those who require them least. An evaluation of thirty social programs in Latin America performed by Grosh in the mid-1990s concluded that: (a) targeted programs reach the target populations more effectively than untargeted ones; (b) the different targeting mechanisms achieve similar results in terms of the proportion of legitimate beneficiaries; (c) the administrative cost of targeting is not excessive; and (d) there seems to be no relationship between the results of targeting and its administrative costs.<sup>[xxiv]</sup>

It was noted that when resources are channeled to the user and a demand subsidy is granted, a targeting mechanism should be established and the beneficiaries identified before the subsidy is disbursed. Demand subsidies favor the users of services, because it gives them greater freedom of choice and encourages quality and efficiency among providers. The disadvantage lies in that it is administratively more expensive to finance demand because of the need to identify beneficiaries.

Is it reasonable, then, to ask whether affirmative action is possible in the field of health?

Although affirmative action has not been described using the parlance of “health policy”, many of the instruments utilized can be identified as common to both. The use of targeting, risk groups, demand subsidies, and supply subsidies to improve access to services and the provision of monetary compensation in response to legal action have been common practices used by health authorities in the definition and implementation of health policies.

Perhaps the mechanism most utilized in health is targeting by *specific geographical region or certain administrative district, focusing on particular demographic groups (such as mothers with preschool children), high-risk groups (HIV-positive people), or certain economic groups (landless farmers, small businessmen)*.<sup>[xxv]</sup> Therefore, the ethnic/racial characteristic can be utilized to target policies, programs, or actions, but it is not a deciding factor.

In other words, ethnic/racial groups are the object of health program targeting if there is an identifiable gap between their health and that of the rest of society. In this regard, the economic aspect of targeting seeks to improve equity by emphasizing action in vulnerable groups.

An example of the **risk approach** in ethnic populations would be programs that identify the carriers of hemoglobin S, so that appropriate steps can be taken for people with sickle cell anemia. In this regard, the Latin American Center for Perinatology (CLAP) has updated its perinatal care form to include questions on the ethnic/racial origin of the mother and her interest in having her newborn screened.

Early detection using a simple laboratory test involves screening to identify carriers and people who will develop the disease. Thus, the latter can be given the chance to lead a more normal life and develop like other members of society.

Another example in health care is the **targeting** of educational activities to promote health and prevent the spread of HIV infection and the development of acquired immunodeficiency syndrome (AIDS). At present, the groups at greatest risk are known, and efforts have been made to change the behavior of the population. However, success has been limited in certain groups, perhaps because the messages have not always been delivered with the social and cultural nuance they require to be accepted and put into practice.

In many countries of the Region, the use of condoms during sexual intercourse has been promoted through elaborate messages with adequate technical content but without the social sensitivity required to reach the target group. To illustrate the foregoing, it should be noted that one of the most frequent methods for transmitting the message is through posters; however, illiteracy is prevalent in certain areas and among certain ethnic/racial groups in the countries of the Region. Furthermore, even where the target group is capable of reading the messages, they are not always adapted to the cultural characteristics of the group so that they can be understood and assimilated.

It is even more important to see into the day in day out life of the group. To accomplish this, it is necessary that its leaders assimilate the message so that they will influence other members of the community. This situation is common in indigenous communities where the approval of the chief or prince is decisive to the acceptance of the message and to fostering changes in the behavior of the target population.

**Health promotion** is another important area of personal health care. Here, targeting is useful in directing communication campaign messages to the target groups. The subject of these messages can range from healthy lifestyles to dengue prevention. However, as noted earlier, the emphasis should be on the need to deliver messages with appropriate content and language understandable to the target groups. In this regard, the messages should be developed through a participatory process to incorporate the cultural elements characteristic of the target group.

In particular, ethnic/racial groups have communication codes and their own cultural elements that should be included in the content of the message to ensure its effectiveness. The way in which messages are transmitted is also important for these groups and should be appropriate to their particular situation; for example, in the indigenous communities with a high degree of illiteracy, methods such as socio-drama and the group's indigenous language should be utilized. Thus, health promotion will have the appropriate cultural content to ensure that the message is understood, rather than focusing solely on the image.

Ensuring **access to health services** is a key element to guaranteeing care for people of minority or disadvantaged ethnic/racial groups. In principle, in most countries of the Region, the State in theory guarantees all citizens access to health. However, in practice, there is empirical evidence showing that gaps and exclusions persist. The first level of analysis is access to social security services, basically associated with the quality of employment. For example, in Brazil, 64% of whites between 10 and 64 years of age are covered by the Social Security system versus 34.76% of Afro-Brazilians (Institute of Social Welfare) (PNAD, 1996).

According to the household survey of Brazil (PNAD, 1998), the behavior of population groups with the greatest economic capacity is very different from that of other groups; thus, those who consider themselves white consult a private physician one and a half times more often than Afro-descendants. A similar pattern is observed in the United States for these same ethnic/racial groups, indicating a gap in behaviors related to health, with the latter group accessing treatments that are less effective or more costly to the individual, such as amputations.

Some governments in the Region (Argentina, Bolivia, Brazil, Canada, Colombia, Chile, Ecuador, El Salvador, the United States, Guatemala, Honduras, and Panama) have launched **special health programs** for their indigenous populations. This is encouraging, opening up the prospect of future expansion of the programs to other ethnic/racial groups.

In fact, the United States has gone further by creating a sort of ministry of health specifically for Native American groups, with financial and administrative autonomy. Known as the Indian Health Services (IHS), this agency is responsible for providing health services to Native American populations. Canada also tends to the health care of its indigenous peoples, including the Inuit population, devoting resources of over Can\$ 1 million at the federal level, complemented with budgetary allocations at the provincial and local levels.

Another **successful activity** within the framework of special programs is the **dual reference program**, which combines traditional medicine with orthodox health practices. Bolivia, Colombia, Ecuador, and Mexico have pilot activities underway in this area.

This category should include the introduction of mechanisms to overcome cultural or linguistic barriers that often prevent health care facilities from being prepared to receive contingents of peoples of specific ethnic/racial origin.

The most obvious area for the implementation of *affirmative action* is in **training and the job market**. Gaps in vocational training negatively affect ethnic populations. In Brazil (PNAD, 1996), for example, health professionals (physicians, dentists, and other specialists) are distributed as follows when the statistical information is disaggregated by race: whites, 82.93%; mixed race 11.84%; and blacks 1.01%.

Mechanisms must be established to achieve a balance in university admissions of students from different ethnic/racial groups, not only because affirmative action policy requires it, but because it has been found that ethnic/racial diversity in the health sector work force is a key element to the delivery of culturally adequate health services for minority groups. Promoting diversity in human resources for health also helps to improve the coverage of minority groups, research in neglected areas, and the hiring of more ethnically and racially sensitive leaders in health who can serve as mentors to future generations.<sup>[xxvii]</sup> While the long-term solution lies in modifying the secondary education system, affirmative action is useful in the short term to achieve diversity in the health work force.<sup>[xxviii]</sup>

To reduce the potential bias of affirmative action in using ethnicity/race as a criterion to influence the selection of medical students, it has been proposed that the socioeconomic factor or social class also be considered in weighing the decision and promoting greater opportunity. Elimination of the ethnic/racial criterion is not intended, however, because in the case of medical faculties and schools, affirmative action goes beyond the objective of reducing discrimination. Rather, it is used to increase student diversity and improve the health service delivery.<sup>[xxviii]</sup>

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## Final Considerations

The use of **affirmative action** has been questioned because it can produce biases in selection that may violate human rights and undermine equal opportunity, excluding people with greater knowledge and skills solely because they do not belong to a minority or disadvantaged group. Although the existence of shortcomings in the implementation of affirmative action has been proven, the arguments partly rest on prejudices and perceptions of the groups involved. Several studies conducted in educational institutions and the workplace conclude that perceptions of affirmative action are more favorable and prejudices against it reduced when preferential selection is applied.<sup>[xxxix]</sup> On the other hand, the use of hard instruments, such as quotas, generates a negative perception and inflames racial prejudices.<sup>[xxx]</sup>

Furthermore, the ideology of group supremacy associated with racist behavior objects to affirmative action on the basis that it is unfair to assign quotas or give preferential treatment to people by virtue of their membership in a specific social group rather than for reasons of ability.<sup>[xxxii]</sup> Similarly, people who have suffered discrimination in the past tend to take better advantage of education and training opportunities for minorities as a strategy to improve their level of employment.<sup>[xxxiii]</sup> Likewise, those who support selection based on personal merit oppose affirmative action because they adduce that benefits should come to those who earn them.

Resistance to affirmative action wanes when it is perceived as a measure to fight discrimination.<sup>[xxxiiii]</sup> A study of 360 health employees in South Africa concluded that evaluating employee perceptions about affirmative action was critical in identifying problems and taking action to improve the situation. Furthermore, the group studied associated effective implementation of affirmative action with higher productivity, supported the appointment of personnel to implement affirmative action, and believed that affirmative action would fail if its objectives were not adequately and effectively communicated to all employees.<sup>[xxxiv]</sup>

In the field of health, some areas such as staff training and the job market are likely to use some hard instruments such as quotas in countries with a high percentage of minority or disadvantaged ethnic population. In other areas, such as health promotion, medical care, and access to services, a series of mechanisms have already been adopted in other contexts that could be adapted to improve the situation of specific ethnic/racial populations.



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## Endnotes

<sup>[1]</sup> The term *ethnic/racial minority* refers to low representation in specific situations that favor inequality of opportunity.

<sup>[2]</sup> The contradiction in fighting Nazism without having resolved discrimination in the United States served as the basis for Gunnar Myrdal to pose the problem of white supremacy, supported by much of the population, over the inferiority of African-Americans and the public policies that, at that time, promoted racial segregation.<sup>[2]</sup> In 1944, he published the book *An American Dilemma: The Negro Problem and Modern Democracy*, in which he proposed that the United States demonstrate to the world its position as a tolerant, diverse society that accepted racial equality.

<sup>[3]</sup> Executive Order 11246 of 1965 of the United States and its subsequent amendments establish requirements for its implementation: the presentation of reports on annualized and total compensation, with information disaggregated by degree/rank/level of the total number of employees distributed by gender and ethnicity/race. Furthermore, it required annual affirmative action plans that include goals, deadlines, and methods for disseminating information on recruitment processes. Compliance with these procedures can be confirmed at any time by the Labor Department.<sup>[3]</sup>

<sup>[4]</sup> Richard Nixon was the first President to establish federal policies that guaranteed the hiring of minorities. The Philadelphia Plan was implemented in 1969 to require federal contractors to set specific goals (quotas) in the hiring of minorities.

<sup>[5]</sup> To illustrate the foregoing, it is worth noting that lawsuits have been brought before the Supreme Court—for example, the case of Alan Bakke (1978), who sued the University of California - Davis for setting quotas in the admission of medical students from minority groups, thereby impeding his admission. The decision was in Bakke's favor, establishing that numerical quotas based on ethnicity/race violated the 14th Amendment of the Constitution and the Civil Rights Act; however, it concluded that ethnicity/race can be utilized legitimately in certain circumstances, provided that it is not the only factor used in selection.<sup>[5]</sup><sup>[5]</sup>

<sup>[6]</sup> Opposition to quotas reached its highest level some weeks ago, when President George W. Bush declared himself against the admissions program of the University of Michigan that favors minority applicants with additional points on their applications to that university. Bush argued that these types of programs amount to racial quotas and are a form of discrimination that is unconstitutional.<sup>[6]</sup> Mary Sue Coleman, President of the University of Michigan, stated that the institution does not use a quota system, but recognized that ethnicity/race is a factor that is considered in the admissions process as established in jurisprudence.<sup>[6]</sup>

<sup>[7]</sup> By way of illustration, it can be utilized when there is little allocation of federal funds to companies owned by ethnic/racial minorities. The federal government is obligated to invite these companies to participate in bidding for its contracts. Something similar occurs with educational institutions that try to diversify their student population, or public entities and Armed Forces that try to keep a proportion of their rosters filled by representatives of minorities.

<sup>[8]</sup> Publication of the results on the human genome sequence was a milestone not only from the standpoint of genetic engineering, but also in the debate on racism. The human genome sequence proves that the genetic foundation is the same for all human beings.

The myth of large genetic differences among the races vanished; however, the social and cultural construct that establishes racial stereotypes and prejudices persists.

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