

What is affirmative action in tertiary education? An overview of affirmative action policies in health professional programmes, drawing on experience from Aotearoa and overseas

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ABSTRACT

Both the universities of Auckland and Otago have had affirmative selection policies for entry into health profession programmes for a number of decades. These policies have been created and strengthened as a result of the leadership and advocacy of Māori leaders, academics and communities. The aims of this paper are to: 1) define affirmative action and outline the rationale for affirmative policies, 2) give examples of how affirmative action policies have been implemented in Aotearoa, and 3) give examples of legal challenges to affirmative action drawing on international experience. Affirmative action policies for health professional programmes are a strategy for improving equity in health through raising the participation of members of population groups that have been historically excluded or under-represented. There are a range of arguments in favour of affirmative policies: constitutional obligations related to Te Tiriti o Waitangi; health professionals from under-represented communities are more likely to serve their communities; they help address biases in healthcare delivery, thereby improving the quality of care; they contribute to health equity through the impact their careers have on the education of others; they are more likely to focus their research on communities they serve and engage with; and their leadership has the potential to benefit the entire system. Legal challenges to affirmative action have been common in some overseas jurisdictions and have resulted in some instances in weaker, or absent, affirmative action policies. We conclude that strong affirmative action policies in tertiary health profession programme admissions contribute to achieving health equity. While much of the literature focusses on admissions to medical programmes, the principles of affirmative action apply equally to all health profession (and other) programmes in Aotearoa.

For almost six decades now, universities around the world have employed affirmative action policies for entry into health profession programmes in an effort to create health workforces that are representative of the communities they serve.¹ The rationale for supporting these programmes is well articulated—in Aotearoa, constitutional obligations related to Te Tiriti o Waitangi are paramount; health professionals from under-represented communities are more likely to serve their communities; they help address biases in healthcare delivery, thereby improving the quality of care; they contribute to health equity through the impact their careers have on the education of others; they are more likely to focus their research on communities they serve and engage with; and their leadership has the potential to benefit the entire system.¹⁻⁹ Despite evidence in support of the effectiveness

of affirmative action policies, affirmative action has become a controversial topic, even becoming unlawful in some jurisdictions overseas.^{5,10-14} In Aotearoa, while the rationale for affirmative action policies in health profession programme admissions may be well evidenced, there is less experience with legal challenges to affirmative action.¹⁵ The aims of this paper are to: 1) define affirmative action and outline the rationale for affirmative policies, 2) give examples of how affirmative action policies have been implemented in Aotearoa, and 3) give examples of legal challenges to affirmative action drawing on international experience. The paper does not attempt to provide a comprehensive review of all historical and contemporary affirmative action policies in Aotearoa's tertiary education institutions, its local examples being drawn largely from the University of Otago.

Affirmative action: comparing and contrasting its definition and rationale in Aotearoa and overseas

Affirmative action is a term used in public, political and professional forums alike.¹⁶ Much of this discourse assumes understanding of the concept without making explicit what interpretation of affirmative action is being used. For example, several papers define affirmative action as policies that “benefit” particular minoritised groups. The word “minoritised” conveys the idea that people are actively minoritised (or majoritised) by colonial structures, rather than naturally existing as a minority.^{17,18} Other authors have narrowed the scope of affirmative action, defining it as “race-conscious admissions”, while others have broadened the definition to encompass all actions taken to systemically improve the representation of groups in professional cohorts.^{10,19–22} In Aotearoa, for example, affirmative action for entry into health profession programmes applies to a variety of groups including Māori, Pasifika, those from rural areas, refugees, and those from low socio-economic backgrounds. In this usage, affirmative action policies focus on health equity and justice for a number of different groups within society, rather than being focussed solely on ethnicity or race.

In all of these definitions there are some core concepts that are shared. The first concept is the representation of communities in different programmes: the rationale of affirmative action policies is to increase the representation of under-represented groups, rather than maintaining the privileged status of groups that are disproportionately over-represented.²³ The second concept is that those groups that are under-represented in the health system have consistently suffered from social and institutional discrimination, both historically and contemporarily, and it is just to correct these marginalising processes. This latter concept is important because it recognises the presence of social structures and processes that create privilege for some groups and disadvantage for others.^{24,25} A definition by Guan (2005) best encapsulates both of these concepts, defining affirmative action as “*introducing measures to raise the participation and representation of members of population groups... where they have been historically excluded or underrepresented*”.²⁶ This definition provides an overview of the purpose of affirmative action policies, and centres these two important concepts. In

highlighting these two central concepts, it is clear that the aims of affirmative action policies are to increase equity and to help correct historical and ongoing injustices.^{2,3,7,15,27}

There are a number of benefits to affirmative action. Based on overseas evidence, health professionals from under-represented groups are more likely to return to their communities after study compared to other students.² They are also more likely to provide culturally and medically appropriate care for patients from those communities for a number of reasons, including sharing a worldview and being able to offer appropriate advice, as well as creating deeper trust and rapport with patients.^{3,6,11,13,28} A representative workforce is also key for diversifying the research agenda for institutions and, as a result, accelerating advances in research and care.²⁹ Diverse worldviews and “lenses”—the set of beliefs, biases and experiences that shape how people see, react and think about different situations and experiences—help to contribute to research agendas that address the needs of diverse communities.^{2,30} As a result, affirmative action policies can be thought of as one tool in an institution’s toolbox, working towards equity for the whole of society, particularly in health.

While the international literature considers the benefits that students from under-represented communities can provide to tertiary institutions, in an Aotearoa context it is important to also consider the responsibility these institutions have in creating equitable representation and a health workforce that can best serve society. A rights-based interpretation of affirmative action has as its foundation Te Tiriti o Waitangi, the foundational, constitutional document of Aotearoa, which defines the rights of Māori and the rights and obligations of the Crown in relation to Māori. In Aotearoa, the obligation to correct injustices arising from colonisation and institutional racism derives from the Crown’s responsibility to rectify breaches to Te Tiriti o Waitangi. As agents of the Crown, tertiary education institutions have an obligation to strive to create equitable outcomes for Māori,^{31,32} including in health professional programmes. Affirmative action is one method by which both educational and health equity can be achieved.

Strong and weak policies with international and national examples

Affirmative action policies have been categorised by some authors as “strong” or “weak”, based on

the extent to which institutions commit to the goal of educational and workforce equity.^{22,33,34} Affirmative action policies are considered strong when they focus and commit fully to the goal of affirmative action: creating a representative workforce that contributes to improving health equity. Strong affirmative action policies are direct, and are not watered down in order to ensure “equality”. Instead, fairness is achieved through creating a student cohort that is representative of the communities they will one day serve. For example, these policies may accept all applicants from a particular group who achieve the requirements for a programme.

Weak affirmative action policies, on the other hand, have been defined as policies that “dilute” affirmative action.^{22,34} These policies include, in some contexts, quotas, an avoidance of “race-based” policies in favour of purely income-based pathways and, in some situations, the preference for “preparatory support” before application to programmes as opposed to policies directly impacting admission.^{16,22,34} These are considered weak policies because they are limited in their scope and effect in regards to achieving equitable representation. An example of a weak affirmative action policy in practice is accepting applicants only when candidates are from an under-represented group and are equal (in performance or “merit”) to over-represented applicants. Some authors argue that quotas are not necessarily indicative of weak policies, and that they can form a part of strong policies.³⁵

“Weak” affirmative action policies are utilised in many countries such as the United States (US), Canada, the United Kingdom (UK) and Australia, albeit with different approaches and varying results. Australia has affirmative action pathways across all sectors, mandated by the *Reconciliation Act 1991*. This includes affirmative action in health profession programme entry.^{8,36–38} Affirmative action policies for admission into health profession programmes have been implemented in some, but not all, Australian universities since 1999.³⁹ The affirmative action policies that have been implemented predominately focus on recruiting students from Aboriginal and Torres Strait Islander communities, as well as rural backgrounds, using methods such as establishing a quota for students from these backgrounds, and introducing an interview to the selection process.³⁹ In Canada, medical schools also have inconsistent approaches to affirma-

tive action policies—those that do employ policies often do so by way of questionnaires that ask students a range of questions including their ethnicity, the socio-economic status of their parents, their gender identity and their rural background if applicable.^{40,41} These characteristics are used to generate a score that is considered as a part of the student’s overall application. Some Canadian medical schools also offer specific affirmative action pathways for Indigenous, Black and rural students.^{40,41} The UK has a strong focus on equity in relation to social class: while support is offered to students through social equity pathways, there is less focus on Black, refugee and immigrant students’ entry into health profession programmes.^{42,43}

The binary framing of affirmative action policies as weak or strong has limitations in the Aotearoa context. Affirmative action policies in Aotearoa should be categorised and evaluated based on how effective they are in creating a representative health workforce and improving health equity in Aotearoa. Some policies considered “weak” by international authors—including bridging courses and support programmes—form an integral part of comprehensive affirmative action programmes in Aotearoa. These programmes help to prepare students for, and support students through, the rigorous, stressful and Western-centric courses that are required for entry to professional programmes. One example of this is the Tū Kahika (TK) programme at the University of Otago. The TK programme is a scholarship for tauira Māori entering tertiary study with an interest in health.⁴⁴ The programme supports tauira through a foundation year, preparing them for Health Sciences First Year, the competitive course required for entry into health profession programmes.⁴⁵ The TK scholarship is a foundational component of the University of Otago’s affirmative admission policy, Te Kauae Parāoa, and has had a direct impact on the number of Māori students in health-related courses, particularly health profession programmes.⁴⁶ A similar programme, Whakapiki Ake, exists at the University of Auckland.^{47,48} This programme provides support for rangatahi in secondary schools as they begin their journeys to tertiary study and careers in health. At both universities these programmes provide crucial support to tauira as they begin thinking about their aspirations for the future and their potential career paths.

Affirmative action: challenges from the past, lessons for the future

Both the universities of Auckland and Otago have had affirmative selection policies for entry into health profession programmes for a number of decades. These policies have been created and strengthened as a result of the leadership and advocacy of Māori leaders, academics and communities.^{15,49–52} Medicine was the first health profession programme to have affirmative policies introduced in both universities, with the first affirmative action programmes being introduced at Otago Medical School in 1951 and in Auckland School of Medicine in 1972. Both universities implemented quota systems, known as the Polynesian Preference Scheme (PPS) at Auckland and the Alternative Pathway at Otago, and both used blood quantum as a measure of Indigeneity up until the 1980s. The PPS at Auckland provided three places to Māori and Pacific students who passed an academic threshold.²¹ In 1987, the Medical Faculty at The University of Auckland acknowledged that the full number of places for Māori and Pacific students had only been filled twice since 1972.⁵³ The number of places available in the scheme was subsequently increased to nine in 1979, to 12 in 1990, and 23 in 1999.^{53,54} In 2020, 77 places were reserved for Māori and Pacific students, with 65 students filling these spaces.⁵⁵

Otago Medical School held two places for Māori or Pacific students from 1951 to 1985. In 1985, the O'Regan report strongly advocated for more “structured” affirmative action policies at the Otago Medical School that would allow for increased numbers of Māori and Pacific matriculants.^{56,57} The report stated that “*the term ‘institutional racism’ is not undeserved*” when considering the operation of the affirmative selection policy at the time.⁵⁶ As a result, the number of places on the alternative pathways rose from two to six students in 1985.⁵⁷

Implemented in 2012, the University of Otago's Mirror on Society policy (re-named as Te Kauae Parāoa in December 2021) aims to create equity in the health workforce in response to Tiriti o Waitangi obligations and to equity objectives.⁵⁸ The policy has no limit on the number of students accepted through the pathways offered (Rural, Equity, Pacific, Refugee background and Māori). 2017 marked the first year that a medical school graduating cohort mirrored the proportion of Māori in Aotearoa. However, it will still be many

decades before this increase translates into proportional representation in the medical workforce, as Aotearoa continues to have an unjust representation of Māori, Pacific, low socio-economic background, refugee background and other minority groups in the health workforce.¹⁴

While there are many practical and legal lessons to learn from affirmative action case studies overseas, an over-arching lesson that the overseas literature provides is that the strength of affirmative action policies, and the extent to which they are protected from weakening, depends on the social and political context of tertiary education institutions.

Some states in the US, for example, have backtracked on their efforts to create a representative student body since the introduction of affirmative action policies in 1964. Some now have weaker affirmative action policies following years of legal challenges against the policies that existed in the 1960s and 70s. Affirmative action policies in the US are generally now characterised as weak, and in eight states there exists a complete ban on affirmative action policies altogether after legal challenges to the policy.^{13,11} These rulings have argued that affirmative action is inherently discriminatory and therefore unlawful (under the *Civil Rights Act 1964*) and that race should only be used as an “additional characteristic” when two otherwise equal applications reach an admissions committee.^{3,11,59} The theme of discrimination is common among many of the legal challenges in other jurisdictions.^{43,60} It is because of the political valuing of “equality” in the US that affirmative action policies have been weakened dramatically over the last 30–50 years.

An important theme in the literature is the equity/equality dichotomy: the belief that affirmative policies give unwarranted advantages to certain groups, and undermine the hard work of other applicants.^{11,37,61} This argument focusses on “equality” (the same selection policies applied to all applicants) at the expense of equity (fairness of representation that takes into account social and historical injustices).^{11,13} Approaches based on “equality” tend to maintain the status quo in terms of health workforce representation, for example, marked under-representation of Black and Native Americans in the US and of Māori and Pacific people in Aotearoa.^{10,11,24,62,63}

Equity approaches, on the other hand, tend to focus on fairness of outcome and opportunity at the level of entire communities and in terms of participation in institutions such as universities. For example, given that only 3% of university

academic staff in Aotearoa are Māori, equity-based approaches would seek to proactively increase this proportion using affirmative policies.⁶⁴ Beltran (2001) frames this as “*providing communities with an equal opportunity to contribute, versus an equal opportunity to get in*”.²⁸ In order to be upholding strong policies, the focus needs to be on achieving health equity in our communities, rather than equality for individuals at the point of admission.

The consequences of weakening or banning affirmative action policies have been quantified.¹⁰ One study followed the number of Black, Indigenous and Hispanic students who applied and were admitted to medical schools in eight US states, before and after an affirmative action ban was implemented.¹⁰ While the number of applications received from Black, Indigenous and Hispanic students did not significantly decrease, the number of these students admitted to medical school the year after a ban was implemented dropped by 4.3% and, over a 4-year period, there was an almost 20% drop in the number of Black, Indigenous and Hispanic students admitted to medicine.¹⁰ Cohen (2003) identified four possible impacts of this decrease: a drop in the quality of medical education that is normally enhanced with a diverse and representative cohort of students, a decrease in access to care that comes with a more representative health workforce, a culturally biased research agenda within institutions and a lack of representative leaders in the health workforce.²

Where affirmative action policies have been banned, medical schools have sometimes adopted covert strategies to maintain similar levels of diverse matriculants in their health professional cohorts.¹⁰ For example, a number of medical admissions committees in Texas, Michigan and California, where affirmative action was banned, adopted an unofficial preference scheme for applicants from minoritised communities. This

approach allowed medical schools to continue taking higher numbers of students from these communities in the absence of an official policy.^{10,63,65} While this approach may circumvent the issue of illegality, it presents other challenges. For example, covert affirmative action strategies rely on committees that are in support of affirmative action, and are therefore reliant on the individual opinions of leaders—which can change (along with their goals and opinions of affirmative action) year by year.⁶⁶ Examples like these demonstrate why countries that intend to hold strongly to affirmative action need to clearly articulate the values that are important to society. The public reaction to the threat of weakening the Mirror on Society policy at the University of Otago in 2020 demonstrated how much these values matter. In order to achieve health equity and uphold the articles of Te Tiriti o Waitangi, affirmative action in Aotearoa deserves to be strong and protected for future generations, until equity is achieved.

Conclusion

In summary, using strong affirmative action policies in tertiary health profession programme admissions contributes to achieving the Crown’s Tiriti o Waitangi obligation to health equity by creating a health workforce that better represents the communities it serves, health-care that is culturally safe and a health research agenda that is more focussed on achieving equity. Tertiary institutions have a responsibility to meet the needs of all communities, not just those that have traditionally been the primary beneficiaries of tertiary education. We look forward to the time when affirmative action policies are no longer required. However, if health equity is to be achieved in Aotearoa then—for the time being—such policies have an essential role to play.

COMPETING INTERESTS

There was no external funding source for preparing this article. The views, opinions, findings and conclusions or recommendations expressed in this paper are strictly those of the authors. They do not necessarily reflect the views of the institutions where the authors currently work. The paper is presented not as policy, but with a view to inform and stimulate wider debate.

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