

RACISM AS A DETERMINANT OF IMMIGRANT HEALTH

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RACISM AS A DETERMINANT OF HEALTH POLICY BRIEF

1.0 INTRODUCTION

The right to equal treatment is a fundamental human right, as outlined in the Canadian Human Rights Act (Department of Justice, 1985). Despite this, there has been a failure, both presently and historically, to recognize that racial discrimination persists across all dimensions of Canadian society (Canadian Race Relations Foundation (CRRF), 2008). This is partly due to the fact that racism is typically understood in terms of individual, rather than systemic, acts and attitudes. In other words, while most people may immediately object to direct expressions of racism, they will often condone or overlook the fundamental ways in which society's political, economic and social institutions contribute to health and social inequities among groups marginalized by race, ethnicity, religion, socioeconomic status, dis/ability, gender, sexual orientation and language proficiency.

According to Canada's Population Health framework many broad determinants influence the health of all Canadians, including gender, income and social status, employment and working conditions, health practices, social and physical environments, and culture (Health Canada, 1994). Eleven social determinants of health (SDOH) were identified by Raphael (2004) including: Aboriginal status, early life, education, employment and working conditions, food security, health care services, housing, income and its distribution, social safety net, social exclusion, unemployment and employment security. Racism is considered to be a prominent form of social exclusion. The recent WHO commission on the SDOH (WHO, 2007) explicitly recognized racism as a contributor to socio-economic position, a key structural determinant of health. In the arena of health, Weber and Fore (2007) argue that racism may be considered a matter of life and death. This policy brief proposes adding racism to the Canadian Population Health framework as an additional determinant of health (DOH).

This paper begins with definitions of racism, recognizing that terminologies and concepts in discourses on race and racism have changed and evolved over time. We next present evidence of the major health and health access inequities that exist for racialized people in Canada and elsewhere, and, for racism as a determinant of health. Finally, policy and research actions that address racism and reduce health inequities are presented.

2.0 UNDERSTANDING RACE, RACISM, AND RACIALIZATION: DEFINITIONS AND CONCEPTS

Race and racism are sensitive topics for many people, and while controversy should not be allowed to discourage explicit and frank discussion on serious social issues, defining these key terms and concepts clearly at the outset is of critical importance.

- *Racism* is defined as a belief that race is the primary determinant of human traits and capacities and that racial differences produce an inherent superiority of a particular race (Merriam-Webster Dictionary, 2008). The CRRF defines *racism* not only as an attitude, but as the specific actions that result from this attitude which impact upon, marginalize and oppress some people (Abella, 1984).

- Racism affects people not only at an interpersonal level, but also through the broader structures of society, most notably in the systems of education, justice, media, policing, immigration, and employment, as well as through hate activity and government policies (CRRF, 2008).
- Racism takes many forms, although it is usually understood in the interpersonal sense – that is, discriminatory interactions, both conscious and unconscious, between individuals (Karlsen & Nazroo, 2002). Systemic or institutional racism, by contrast, refers to “the collective failure of an organization or social structure to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin”. This form of racism is less directly visible, though it “can be seen or detected in processes, attitudes, and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantages people in ethnic minority groups” (Macpherson, 1999). Institutional racism also occurs in organizations where the policies, practices and procedures (e.g. job requirements, hiring practices, promotion procedures, etc.) exclude and/or act as barriers for racialized groups (CRRF, 2008).
- As with racism, *race* is understood here as a social construct. Too often, definitions and discussions of racism take for granted the concept of race, leaving the impression that its specific labels – ‘Caucasian,’ ‘Black,’ ‘Asian,’ etc. – reflect innate and genetically discrete categories. However, this view has since been refuted by a growing body of evidence from across the genetic and social sciences, which demonstrates instead that race, while making reference to real biological traits, is nevertheless a categorization scheme that is social in both its origin and maintenance.
- Linking this understanding of race to the reality of racism is the concept of “racialization,” which refers to the social *process* whereby certain groups come to be designated as different and consequently subjected to differential and unequal treatment (Galabuzi, 2004; 2006). Lack of access to opportunities, marginalization, and exclusion among these groups suggest that their perceived racial membership plays a significant role in shaping their collective experience – that is, they are *racialized*, rather than “merely” *racial*, groups. Unlike the term “visible minorities,” which Canada’s *Employment Equity Act* defines as “non-Caucasian in race or non-white in colour,” “racialized groups” makes clear that race is not an objective biological fact, but rather a social and cultural construct that potentially exposes individuals to racism.

Applying the concept of racialization to the field of public health helps to clarify a number of salient questions, chiefly, “If racial categories are a social product rather than a biological fact, then how might one explain the very real differences in health outcome observed among ethno-racial groups?” According to Krieger (2003), observed health disparities between different groups (discussed below) come to be understood not as reflecting underlying and static differences in biology but rather as dynamic “biological expressions of race relations”.

The purpose of defining race, racism, and racialization is not to reject the use of racialized group categories in public health research and practice as these labels offer strategic parameters for identifying certain population groups in, for example, epidemiological surveys and targeted interventions. But understanding the central role of racialization in creating what may appear

to be “natural” racial groupings helps to remind us that these groupings are not “natural” at all, but rather are the product of a social process.

3.0 RACISM AND RACIALISATION IN CANADA

Consider, for example, the following facts about the experiences of racialized groups in Canada:

- Ethnoracial groups comprise over 13% of Canada’s population. By 2017, this proportion will increase to 20% (Statistics Canada, 2005). It has been estimated that 75% of recent immigrants to Canada belong to racialized groups, and this is likely an underestimate due to an under-reporting of visible minority status in government surveys.
- In Canadian urban centres, racialized people are two or three times as likely to be poor than other Canadians. This disproportionate and persistent exposure to poverty among racialized groups has been termed the racialization of poverty (Galabuzi, 2006).
- Despite higher levels of education, racialized groups in Canada are more likely to be unemployed or employed in precarious work (defined as atypical employment contracts, limited social benefits, poor statutory entitlements, job insecurity, short tenure and low wages) than non-racialized Canadians (Galabuzi, 2006).
- The 2001 unemployment rates for the total labour force, at 6.7%, in comparison to 12.1% for recent immigrants and 12.6% for visible minorities, indicates a clear differential in access to the labour market (Teelucksingh & Galabuzi, 2005). It is taking much longer for racialized immigrants to catch up with other Canadians, in comparison to past European immigrants. Poverty rates among recent immigrants have increased substantially since 1980 (Statistics Canada, 2003; Picot & Hou, 2003).
- According to the 2002 Canadian Ethnic Diversity Survey, approximately 20% of visible minorities, compared with 5% of non-visible minorities, reported having sometimes or often experienced discrimination or unfair treatment in the previous five years preceding the survey (Canadian Ethnic Diversity Survey, 2003).

4.0 RACIALIZED INEQUITIES IN HEALTH STATUS

The last decade has seen a marked increase in research focused on health disparities. A large body of published research suggests that health disparities based on immigrant status, race and ethnicity persist, even after adjusting for age, gender, education level, income, severity of disease, and other variables (American College of Physicians, 2004; Lasser, 2006; Smedley, Stith, and Nelson, 2003; Karlsen & Nazroo, 2002). These and other health disparities have also been documented in countries (such as Canada) that have a ‘universal health care’ system (Ali et al., 2004; Chen, Ng and Wilkins, 1996; Dunn and Dyck, 1998; Hyman, 2001, 2007; Wu and Schimmele, 2005).

In Canada, racialized group status does not automatically translate into poorer health status (Wu et al., 2003) and may in fact represent a health advantage for certain groups (Prus & Lin, 2005; Wu & Schimmele, 2005; Kopec et al., 2001). A recent review of Canadian census mortality

1991-2001 found that 'visible minority groups' experienced lower age-standardized mortality rates than their non-visible minority counterparts (Wilkins et al., 2008).

There are exceptions, however, suggesting important intersections between race, immigration, gender, poverty and health. Enang's (2001) comprehensive literature review of the health needs of Black women in Nova Scotia identified diabetes, cardiovascular disease, HIV/AIDS and mental health as prominent concerns. Refugees continue to experience an increased risk of mortality and mental health problems (Beiser, 2006; Rousseau & Drapeau, 2004; Beiser et al., 2002). Racial and ethnic health inequities are increasingly being documented in recent cohorts of racialized immigrants. Immigrants from non-European countries, primarily Asian, are twice as likely to report declining health as those from European countries. Low-income and recent immigrants who are members of a racialized group are at increased risk of transitioning to poor health over time (Ng et al., 2005).

Racial and ethnic inequities in health status have typically been explained using theories of deprivation and privilege since many racialized people live in poverty and/or have been disproportionately exposed to health risks and consequences associated with their economic, physical and social environments (Fine, 2005; Kelaher et al., 2008). However, scholars such as Nancy Krieger (2001) propose that racism contributes to multiple and intersecting pathways that impact on health status. Thus accumulated disadvantage over the life course, differences in exposures and life opportunities by race and psychosocial stresses all need to be considered in research on race and health (Jones, 2003; Weber and Fore, 2007; Nazroo, 2003; Gee et al., 2006). These proposed pathways are further discussed in Sections 8.0 and 9.0.

5.0 RACIALIZED INEQUITIES IN ACCESS TO HEALTH CARE

There is good evidence from the U.S that racialized patients do not have equal access to health care and have more unmet needs (American College of Physicians, 2004; Bhugra, Harding and Lippett, 2004; Haas et al., 2004; Fiscella et al., 2002). Data on health care access by race or ethnic group is not routinely collected in Canada. Still, despite Canada's universal health care policies, evidence indicates that racialized groups do not have equal access to health care and have more unmet health needs than non-racialized groups. One study examining ethnic variations in rates of physician contacts and hospital admissions found that racialized group members were less likely to be admitted to hospital compared to their non-racialized counterparts, although they were more likely to use a GP and equally likely see a specialist (Quan et al., 2006). Likewise, findings from the 2007 Canadian Community Health Survey indicated that recent immigrants were significantly less likely to have a regular medical doctor compared to non-recent immigrants and the Canadian-born population (Statistics Canada, 2008). Several studies suggested that immigrants and racialized group members were less likely to use preventive cancer screening services (Quan et al., 2006) and mental health services (Steele et al., 2006; Gadalla, 2008). The inability to access health services, particularly those designed to maintain and promote health and prevent disease increases health risks and is associated with negative health outcomes, particularly over time.

6.0 RACIALIZED INEQUITIES IN QUALITY OF HEALTH CARE

Evidence from the US and elsewhere corroborates the claim that racialized groups receive and perceive lower quality and intensity of health care compared to non-racialized groups across a wide range of health services (Washington et al., 2008; Gonzales-Espada et al., 2006; Napoles-Springer et al., 2005; Blanchard & Lurie, 2004; Bhugra et al., 2004; Ngo-Metzer et al., 2004; Corbie-Smith et al., 2002; Smedley et al., 2003). For many racialized groups, language barriers strongly contribute to these differential experiences including diagnostic errors, adverse events, excessive or unnecessary tests, prolonged hospital stays and inappropriate use of the ED (Wilson-Stronks et al., 2007; Divi et al., 2007; Gonzales-Espada et al., 2006).

The body of Canadian literature on racial and ethnic disparities in quality of health care is relatively thin. Among individual and structural issues identified that influence quality of care are organizational policies (e.g. lack of interpretation services, lack of representation), financial barriers, and health values that conflict with the dominant ideology of the health system and contribute to misunderstandings over the meaning of illness, its terminology and its appropriate treatment (Shahsiah & Yee, 2006; Oxman-Martinez & Hanley, 2005; Access Alliance, 2005; Whitley et al., 2006; Hrycak & Jacubec, 2006; Benjamin & David, 2003; Enang, 2001).

7.0 RACISM AND HEALTH

While race is sometimes named as a health risk, a large and growing body of research now links racism to poorer health (Paradies 2006). Much of the evidence comes from the US and UK, where negative associations between racism and mental health, physical health (e.g., hypertension, self-reported health, heart disease, pain, respiratory conditions), and health risk behaviours have been well-documented (Kelaheer et al., 2008; Larson et al., 2007; Schultz et al., 2006; Williams et al., 2003; Brondolo et al., 2003; Krieger et al., 2005; Gee et al., 2006; Harris et al., 2006a, 2006b). A recent review of 138 population-based studies showed associations between self-reported racism and health among oppressed racialized groups even after adjusting for confounders such as age, SES, race/ethnic group, health behaviours stress, and social support (Paradies, 2006). The strongest and most consistent findings were for mental health, although relationships with self-assessed health and physical health were also observed. Of particular concern for racialized immigrants are recent studies suggesting that perceptions and experiences of discrimination increase over length of stay due to a greater recognition of discriminatory behaviour, as well as an increased exposure to discrimination over time (Gee et al., 2006). Some research suggests that the relationship between discrimination and mental health is stronger among non-recent compared to recent immigrants (Gee et al., 2007).

Little Canadian research has examined racism and health, although a recent federal report recognized that mental health is associated with social issues such as racism and discrimination (Government of Canada, 2006). Data from the Korean Health Study in Toronto demonstrated that 85% of respondents had experienced racial discrimination and that, after controlling for other variables, perceived discrimination was associated with depressive symptoms (Noh and Kaspar 2003). This was shown to be true for both overt and subtle forms of discrimination (Noh et al., 2007). Using data from the Southeast Asian Refugee Project, Beiser (2006) identified racial discrimination as a predictor of depression among Southeast Asian refugees in Canada; however, early integration mitigated against both discrimination and depression. Participants

in Etowa's (2007) qualitative study of Black women's health in Nova Scotia described racism as a major source of stress as well as a major health issue affecting their families and communities. The consistency of findings across diverse ethnic minority groups underscores the importance of racial discrimination to the health of racialized groups (Landrine et al., 2006).

One of the few identified Canadian studies examining the impact of racism on quality of care was conducted by Women's Health in Women's Hands Community Health Centre (Women's Health in Women's Hands, 2003). Almost 1 in 5 of the study participants reported that they experienced racism in the health care system, including being subjected to name-calling and racial slurs; 8.6% found doctors to be culturally insensitive or ignorant; and 6.2% reported receiving an inferior quality of care. As cited by a study participant,

"They were coming from a completely different culture... They didn't understand my culture and it didn't seem like they made an effort either. It was more just like, 'Well, it shouldn't be that way,' and it's almost like my own culture was being put down."
(WHIWH, 2003, p. 28)

Other Canadian researchers identified policies, processes and practices (i.e., institutional racism) that deter racialized Canadians from accessing and receiving quality health care. These included for example, lack of recognition of non-status immigrants, lack of racial-ethnic concordant staff and stakeholders, lack of staff training and skills in the provision of culturally sensitive care. In addition, perceptions of racism, in terms of being treated unfairly or inequitably, not feeling comfortable and accepted, not being treated with respect and dignity and insensitivity to historical or cultural backgrounds and/or alternative health value systems were frequently reported. The provision of professional interpretation services is central to providing 'high quality' health care (Shahsiah & Yee, 2006; Etowa et al., 2007; Hyman, forthcoming; AAMCHC, 2005; Benjamin & Este, 2003).

8.0 RACISM AND ITS DIRECT IMPACTS ON HEALTH

It has been hypothesized that racism influences health and health behaviours *directly* through the increased and prolonged stimulation of the human body's physiological stress response (Williams et al., 2003; Harris et al., 2006a; Harris et al., 2006b; Brondolo et al., 2003). The literature on stress and health posits that stressors influence physical health primarily by causing negative emotional states such as anxiety, depression, and lowered self-esteem/identity which can in turn have direct effects on biological processes such as the immune system or patterns of behaviour that affect disease risk and mortality (Kubzansky & Kawachi, 2000; Williams et al., 2003; Harris, 2006a). The direct impact of racism on health behaviours includes resorting to high risk health behaviours, such as substance abuse and self-harm and other negative coping responses, as well as delays in seeking healthcare.

Although there are interactions between racism and poverty, research on the synergetic effects of these variables on stress is still quite limited. According to the WHO (2003), the daily experience of living as a racialized individual in poverty causes chronic psychological distress which can lead to ill health, either through biological pathways (for example, by affecting the endocrine or immune system) or through behavioural pathways (for example, by inducing risk

taking behaviour). When this stress is experienced over a long period of time it can have detrimental effects on cardiovascular and immune systems increasing a person's vulnerability to infections, diabetes, high blood pressure, heart attack, stroke, depression and aggression.

9.0 RACISM AND ITS INDIRECT IMPACTS ON HEALTH

Racism influences health indirectly through differential exposures and opportunities related to other determinants of health, for example, education and employment. Krieger (2001) proposed multi-level and intersecting pathways linking racism to health outcomes across the lifecourse including economic and social deprivation, exposures to toxic substances and hazardous conditions, socially inflicted trauma, targeted marketing of commodities to racialized communities, inadequate health care and community awareness and action to counter racism. It is well-documented that racialized individuals in Canada experience disproportionate levels of poverty, inadequate housing, exposure to hazardous substances, barriers to or poor quality health care and social exclusion, another important social determinant of health (Hyman, 2001; Galabuzi, 2004; Kazemipur & Halli, 2003; Ornstein, 2001; Colour of Poverty, 2008).

Galabuzi (2004) further argues that there is a need to take into account the health impacts of institutional racism i.e., not having equal access to social, economic, political, and cultural systems that determine the distribution of society's resources due to racial or ethnic characteristics. For example, racially discriminatory systemic practices, such as, differential treatment in recruitment, hiring and promotion, extensive reliance on non-transparent forms of recruitment, such as word of mouth, which reproduce and reinforce existing networks, differential valuation or effective devaluation of internationally obtained credentials and use of immigrant status as a proxy for lower quality of human capital, contribute to differential outcomes in the labour force (Galabuzi & Teelucksingh, forthcoming). Addressing institutional racism in the health care sector requires a commitment to anti-racism, diversity and cultural competency including the elimination of financial, cultural and linguistic barriers to care and strengthening community capacity. These are discussed in greater detail in Section 11.0.

10.0 SUMMARY OF MAIN POINTS

- Racial and ethnic inequities in health status, access to health care and quality of health care exist in Canada and elsewhere.
- Race and racism are social constructs that contribute to health inequities.
- Racism directly impacts on health, primarily through the body's physiological stress response.
- Racism indirectly impacts on health through differential exposures and opportunities related to other determinants of health.
- Institutional policies and practices act to perpetuate racial and ethnic health inequities and impede access to and quality of health care.

11.0 RECOMMENDED POLICY ACTIONS

Racism influences the environment in which racialized Canadians live and proximate pathways influencing health including health behaviours, stress, material deprivation, and access to quality health care. Recognizing racism as a DOH is an important first step to eliminating racism and reducing health disparities between racialized and non-racialized groups. It broadens discussions beyond health care system access and health recruitment towards prevention and the impact of societal structures on health (McKenzie, 2003).

The ensuing six policy actions address the key factors identified in this policy brief that contribute to ethnic and racial health disparities in Canada. These policy actions echo and expand upon recommendations made in other reports such as the, Commission on the Future of Health Care in Canada (2001), Policy Forum on Multicultural Health (2005) and National Transcultural Health Conference (2007).

Working to design and implement strategies to address these policy initiatives will require intersectoral action across all levels of government. Some examples of recommended policy and program initiatives are provided here.

- 1. Increase public awareness of racism and its impacts on health, access to health care and quality of health care.**
 - Reframe health as a human rights issue
 - Work towards structural solutions and social change i.e. “social policy is health policy”
 - Foster professional and community partnerships, alliances and coalitions to name, understand and dismantle racism
 - Support local and regional policies and programs that address racism
- 2. Implement and enforce policies and procedures to eliminate institutional racism in all sectors.**
 - Increase representation of racialized groups throughout the organization
 - Ensure decision making processes do not exclude or marginalize certain groups
- 3. Undo institutional racism in health policy, administration and practice.**
 - Aim to recruit and retain professional staff that reflect the diversity of Canadian society and understand the ethnic and cultural backgrounds of the populations they serve
 - Integrate cultural competence and anti-racism perspectives into governance, organizational policy and staff recruitment
 - Support training for health professionals in the provision of inclusive and anti-discriminatory health care
 - Ensure the availability of professional linguistic and cultural interpretation services in all health care facilities
 - Translate health promotion materials in more than the two official languages
 - Implement monitoring systems to collect data on access and quality of care received by racialized and non-racialized health care consumers
- 4. Reduce the negative impact of racism on health**
 - Advocate for reforms in government policies that adversely affect the health of racialized Canadians

- Increase the capacity of health care consumers to their exercise rights to complain and to respond pro-actively to racism
 - Increase capacity of health care consumers to participate in knowledge transfer and exchange activities aimed at improving health care practice and promoting institutional change
 - Support anti-racism programs and programs aimed at social inclusion in schools and communities
 - Support school-based and community programs that enhance ethnic identity and community cohesion
5. **Allocate funding for research and monitoring activities**
- Develop indicators of discrimination for use in provincial and national health surveys
 - Initiate discussions with government and community stakeholders regarding the inclusion of immigration and racial/ethnicity-related variables in health databases for health planning and monitoring purposes.
 - Support research on racism, to understand and document the multiple and complex ways in which racialised groups experience racism and its impacts on health, access to health care and quality of care
 - Establish national, regional and local systems to monitor health disparities and evaluate policies and procedures designed to eliminate racism and reduce health disparities
6. **Consider the formation of a Standing Committee, similar to the Commission for Racial Equality in the UK.**

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