

Colour Coded Health Care

The Impact of Race and Racism on Canadians' Health

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Scope and Purpose of the Review

Canada is home to a much-admired system of universal health care, understood as a central pillar of this nation's overall commitment to principles of social equity and social justice. Such an understanding makes it difficult to raise the issue of racial inequities¹ within the context of the Canadian health-care system. Indeed, as a number of Canadian health scholars have argued, with the exception of the substantial data on First Nations health², very little research has been conducted in Canada on racial inequality in health and health care (Health Canada, 2001; Johnson, Bottorff, Hilton, & Grewell, 2002; O'Neill & O'Neill, 2007; Rodney & Copeland, 2009). This literature review attempts to bring together data published between 1990 and 2011 on racial inequities in the health of non-Aboriginal racialized³ people in Canada. The decision not to include data on Aboriginal people in this review is by no means intended to obscure or minimize the appalling health conditions among Aboriginal people and the central role of colonialism and racism in their creation and perpetuation. It is clear, as Kelm (2005) has argued, that "social and economic deprivation, physical, sexual, cultural and spiritual abuse" (p. 397) underlie inexcusable inequities in Aboriginal health. Aboriginal health inequities were not included in this review because we chose not to subsume under an umbrella of racial inequities in health the unique history and continuing injustice of Aboriginal health conditions.

We begin our review with a discussion of the concept of race and its relationship to health outcomes and then move to a discussion of the significance of racial inequities in health and the relationship of these inequities to other forms of social inequality. We also examine mortality and morbidity data for various racialized groups in Canada and explore evidence of the role of bias, discrimination, and stereotyping in health-care delivery. Unequal access to medical screening, lack of adequate resources such as translation services, and new and important research on the physiological impact of a racist environment are also explored. This review concludes with a discussion of the limitations of available data on racial inequities in health and health care in Canada. It also surveys the challenges faced by other jurisdictions, such as the United States and Great Britain, in collecting racial data to monitor the extent of such inequities, understand their causes, and address the consequences of unequal access to health care. Finally, it offers recommendations related to the collection of racial data.

Methodology

Searches were conducted in the following electronic databases: ProQuest, ProQuest Digital Dissertations, Scholar's Portal, Medline, the Statistics Canada Website (www.statcan.gc.ca), Google, and Google Scholar utilizing the key terms "race health inequities," "racism health Canada," and "race health inequities Canada." Searches were confined to the years 1990 to

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- ¹ This review utilizes the term "inequities" rather than "disparities" to describe unequal health outcomes for racialized people. We concur with Patychuk (2011), who demonstrates that numerous sources support the use of the term "inequity" as referring to "differences in health that result from unjust social structures," including a "focus on injustice rooted in the structural determinants of health inequities such as racism, classism, and gender discrimination embedded in society's structure and institutions and how power and resources are distributed" (p. 10).
 - ² The health status of Aboriginal people in Canada falls far below that of other marginalized groups. Life expectancies are significantly lower and infant mortality rates much greater than in the Canadian population as a whole. Chronic illness, obesity, and disease-related health behaviours are twice as frequent in Aboriginal populations as they are in the general population (Frohlich, Ross, & Richmond, 2006). Death from poisoning, diabetes, and injuries is higher for First Nations people, and the suicide rates of Aboriginal youth far exceed those of other residents of Canada (Veenstra, 2009).
 - ³ The term "racialized" is intended to emphasize the socially constructed nature of racial categories by indicating that an individual or group has had an identity conferred upon them that references racial categorizations which have historically ranked human groups hierarchically.

2011. Internal searches within relevant journals were conducted using the key terms “Canada” and “race.” In addition, many references were extracted from the articles found in the searches. A total of 170 journal articles, books, and book chapters were examined in the course of preparing this review.

THE CONCEPT OF RACE AND ITS RELATIONSHIP TO HEALTH OUTCOMES

How we understand race plays a key role in shaping research questions related to health inequities (Williams & Collins, 1995). Scientific racism had its beginnings in Enlightenment thought, a central tenet of which was the categorization of natural phenomena, including human beings. Nineteenth- and 20th-century notions of race consequently posited that a range of immutable biological differences and race-specific diseases inhered in different population groups and that these groups could be sorted into a racial taxonomy that reflected gradations of human worth (Fredrickson, 2002). Such notions provided the ideological underpinnings for campaigns of conquest outside of Europe and for the eugenicist and anti-Semitic doctrines that culminated in the Holocaust. Following World War II, in recognition of the horrific genocidal consequences that such ideologies had wrought, and in light of the lack of scientific evidence of genetic hierarchies among human groups, prominent scientists signed a UNESCO declaration repudiating eugenic racism (Fredrickson, 2002, p. 128). Despite evidence discrediting the biological view of race, some researchers continue to adhere to the notion that biological differences among racialized groups are responsible for racial variations in health status (Bowser, 2001; Krieger, 2003; Williams & Collins, 1995). While seemingly outdated, such notions have been re-energized in this era of global migrations: concerns with the health of migrants and fears that they carry disease echo earlier fears of “aliens as a source of disease” (Skinner, 2006, p. 463). The purported links between racialized immigrants and contagious diseases were made evident in the public response to reports of the arrival of the Ebola virus in Canada as well as to the recent SARS epidemic (Leung, 2008; Murdocca, 2003). However, as Williams and Collins (1995) have argued, “race is a proxy for specific historical experiences and a powerful marker of current social and economic conditions that determine exposure to pathogenic factors” (p. 370). If, indeed, “racial” differences have little relationship to genetic differences, then perhaps the role of the medical sciences should be “to define the array of possible physiologic responses to the social, economic and environmental conditions associated with the increased risk of morbidity and mortality” (Hayward, Miles, Crimmins, & Yang, 2000, p. 913).

TERMINOLOGY: “RACE,” “ETHNICITY,” AND “RACE/ETHNICITY”

The term “ethnicity” was first used in the 1940s when biological notions of race were discredited in the immediate post-Holocaust era (Johnston, Gregory, Pratt, & Watts, 2000). “Ethnicity” is often used interchangeably with “race” or else compounded as “race/ethnicity” in ways that obscure or narrow the meanings of each individual term (Varcoe, Browne, Wong, & Smye, 2009). Some scholars define “ethnicity” as a self-chosen category reflecting ancestry, culture, religion, language, and geographic location relevant to a particular time (O’Loughlin, 1999). “Race,” on the other hand, often refers to conferred identities based on an imagined hierarchy of human value related to phenotypes, skin colour, and other supposed biological expressions of group inferiority. The term “race” also carries with it histories of stereotyping, exclusion, and other forms of social injustice (Karlsen & Nazroo, 2006). However, the differentiation between the two terms has not gone unchallenged, and it has been posited that rather than oppositional, “the relationship between ethnicity and race is intersectional: racial diversity occurs within ethnically defined groups; ethnic diversity occurs within racial and ethnic groups” (Ford & Harawa, 2010, p. 253).

What is important to note for this review is that many Canadian studies utilize the terms “race,” “ethnicity,” “immigration,” and “culture” imprecisely, using one term instead of another or using terms interchangeably (Ng, Wilkins, Francois, & Berthelot, 2005). As Veenstra (2011b) has noted, this mixed approach to terminology has occurred because the National Population Health Survey and the Canadian Community Health Survey (two large national health surveys conducted by Statistics Canada on which much of the research on health inequity is based) collect data on what they term “racial/cultural” identity, thus conflating these incommensurate concepts. Veenstra’s elaboration of racial identities that “feature in dominant racial typologies in contemporary society” (2011a, p. 1153) offers a useful template for future research and allows consideration of the numerous ethnicities subsumed under categories of racialized difference

The term “immigrant” is a particularly problematic identifier in the context of health inequities. While more than 75% of immigrants who have arrived in Canada since 2001 are considered by Statistics Canada to be “visible minorities”⁴ (Statistics Canada, 2010), few studies distinguish between White/European immigrants and immigrants of colour. Moreover, De Maio and Kemp (2010) consider the use of the term “visible minority” by Statistics Canada to be “controversial” and “fraught with methodological pitfalls” (p. 466). They argue that the term “includes a wide range of heterogeneous groups, ... aggregate groups whose experiences in Canada have been historically different and who currently hold different positions in the economic system as gauged by average incomes. The designation also confounds race, ethnicity and nationality” (p. 466).

As a consequence of the imprecise use of these terms, much Canadian research on immigrant health has been less than useful. Some researchers have called for the collection of racially and ethnically disaggregated vital statistics and health-care-use data in order to “accurately identify target populations, effectively recruit research participants and responsibly describe surveyed samples” (Rummens, 2003, p. 93). Until such time as this recommendation is implemented, research utilizing aggregated data needs to be interpreted with caution.

In the Canadian literature on health reviewed, there is a recurring call for an investigation of health inequity within an interlocking or intersectional framework that sees categories of difference as produced in and through one another (Anderson, 2000; Anderson, 2006; Anderson et al., 2010). Some nursing scholars have struggled to apply Black feminist, post-colonial, anti-racist, and post-structuralist understandings and methodologies to questions of difference in nursing scholarship and practice. As Anderson (2000) has argued, “we need nursing scholarship that conceptualizes the intersection of class, racialization, gender relations, and other social relations because we experience our lives not solely as gendered persons but as classed and racialized persons” (p. 226). Borrowing from critical race studies, this literature calls on nursing researchers to push the boundaries of the social determinants of health model and address processes of racialization rather than assign people to static racial categories (Anderson, 2006, p. 10). However, as Veenstra (2011b) has recently pointed out, “only a few quantitative studies have explicitly studied illness states associated with complex social positions ... none of them Canadian (p. 3),” which indicates that intersectionality has not yet been widely adopted in studies of health inequality in Canada. The lack of intersectional literature on health inequities represents a significant gap in the health equity literature and renders social researchers at risk of producing data that are as “misleading as they are incomplete” (Veenstra, 2011b, p. 8).

4 Statistics Canada identifies “visible minorities” as “persons, other than Aboriginal persons, who are non-Caucasian in race and non-white in colour” (Statistics Canada, 2010, p. 11). The groups included in this category are: “Chinese, South Asians, Blacks, Arabs, West Asians, Filipinos, Southeast Asians, Latin Americans, Japanese, Koreans and other visible minority groups, such as Pacific Islanders” (p. 11).

WHAT CONSTITUTES RACIAL INEQUITIES IN HEALTH AND HEALTH CARE?

According to Braveman (2006), health inequities can be defined as

systematic, potentially avoidable differences in health—or in the major socially determined influences on health—between groups of people who have different relative positions in social hierarchies according to wealth, power or prestige. Because these differences adversely affect the health or health risks (construed here as exposures and vulnerabilities increasing the likelihood of ill health or adverse social consequences of health) of groups already at a disadvantage by virtue of their underlying social positions, they are particularly unfair. (p. 181)

Braveman goes on to define “health” as “not only morbidity and mortality but functional status or disability, suffering and quality of life; it refers to physical health (including dental as well as medical conditions) and mental health” (p. 182). A critically important study, *Unequal Treatment: Confronting Racial and Ethnic Inequities in Health Care*, published in 2003 by the U.S. Institute of Medicine, broke new ground in the area of health equity by focusing on complexities in the causation of inequities. The study suggested that racism in institutional practices, as well as caregiver bias and stereotyping, is a significant cause of racial and ethnic inequities in health and health care in the United States (Physicians for Human Rights, 2003). What differentiates *Unequal Treatment* from other surveys is its shift from a focus on race as a source of health inequities to an understanding of racism as a major contributing force in the production of these inequities (Smedley, Stith, & Nelson, 2003). While the nature of racial inequities in health and health care in Canada and the United States is different, the methodology suggested by *Unequal Treatment* is relevant beyond the American context.

Researchers have identified numerous pathways to health inequities related to racism, including the following: the psychological stress of living in a racist environment; unequal economic opportunities; inequitable access to education and other social resources; lack of adequate housing; exposure to environmental toxins; engagement in risky health behaviours; victimization through social trauma such as spousal and sexual abuse, and other forms of violence; mistrust of the health-care system; and under-utilization of screening programs (Brondolo, Gallo, & Myers, 2009; Krieger, 2003). While many of these pathways are directly related to poverty, even economically well-off members of racialized groups may be exposed to psychological stress and other non-economic forces endemic to racially unequal societies (Hoyt D’Anna, Ponce, & Siegel, 2010). The impact of racism on the health of racialized people will be discussed further below.

A focus on the role of racism in the production of racial inequities in health has, by necessity, led to an examination of institutional factors and health-care provider behaviours as pathways to race-based health inequities. Language barriers, lack of cultural competence, unconscious racial bias, inaccessible/culturally inappropriate screening services, and inappropriate or unfounded beliefs in race-based biological differences all produce racial inequities in the delivery of health care and in health outcomes (Physicians for Human Rights, 2003). While there are numerous pathways to health inequities, health-care provider bias has recently come under scrutiny by health equity researchers and advocates. Physicians for Human Rights notes that the “question of bias is central to human rights concerns” and that bias in health is a “double violation: of the egalitarian commitments and ethics of medicine and of the democratic principles of the larger society” (p. 2).

SOCIAL DETERMINANTS OF HEALTH AND RACIAL INEQUITIES: DO MATERIALIST APPROACHES ADEQUATELY CAPTURE RACIAL INEQUITIES IN HEALTH?

In Canada, a social determinants of health (SDH) approach to health inequities has had

a powerful influence over attempts to understand how social inequality produces disparate health outcomes for disadvantaged populations. Dennis Raphael, a central contributor to SDH theory in Canada, defines the social determinants of health as

the economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole. Social determinants of health determine whether individuals stay healthy or become ill ... Social determinants of health also determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment. ... Social determinants of health are about the quantity and quality of a variety of resources ... Since a social determinants of health approach sees mainsprings of health as being how a society organises and distributes economic and social resources, it directs attention to economic and social policies as a means of improving it. (Raphael, 2004, p. 1)

Social determinants of health approaches have made important contributions to the contextualization of health inequities arguing that their origins must be understood beyond the framework of individual health behaviours. However, theories that foreground the link between inequitable distribution of social resources and unfair exposure to health-reducing conditions have recently been criticized for ignoring “non-economic”—that is, interpersonal and structural—manifestations of racism that are part of the larger picture of health inequities (Karlsen & Nazroo, 2006; Krieger, 2000; Wu, Noh, Kaspar, & Schimmele, 2003). A social determinants of health approach, however well-meaning, conveys the impression that

across ethnic groups, across countries, and across outcomes, socioeconomic factors contribute to ethnic inequalities in health. However, these data also raise the possibility that socioeconomic inequalities cannot fully explain ethnic inequalities in health. For most groups and for most outcomes, differences remain once the adjustment for the socioeconomic indicator has been made. (Nazroo, 2003, p. 278)

Recently, a strong case has been made that socio-economic explanations of health inequities fail to capture all of the pathways to negative health effects. Hoyt D’Anna et al. (2010) have argued that racialized individuals who belong to higher socio-economic groups may even experience more profound negative health impacts from certain types of discrimination than members of lower socio-economic groups. A significant cohort of researchers in the area of health inequities has argued that while race and socio-economic status are indeed correlated, they nonetheless constitute discrete predictors of health status (Chae, Nuru-Jeter, Lincoln, & Francis, 2011; Galabuzi & Labonte, 2002; Karlsen & Nazroo, 2006; LaVeist, 2005; Nazroo, 1998; Ng, Wilkins, Francois, et al., 2005; Wu et al., 2003; Wu & Schimmele, 2005). There is a consensus among this group of researchers that any study of the pathways to health inequities must incorporate a specific focus on racial and/or ethnic group membership in order to devise targeted remedies to this problem. As noted U.S. epidemiologist Nancy Krieger (2000) has argued, “Despite good intentions ... the suggestion to omit ‘race’ and rely solely on ‘class’ ignores not only the persistence of racism but also a growing body of evidence that interpersonal and structural discrimination, including but not restricted to their economic repercussions, harms health across the life course” (p. 213).

EVIDENCE OF RACIAL INEQUITIES IN CANADA

Evidence of racial inequities in Canada is substantial. An examination of these inequities can be helpful in thinking about the extent to which racial inequality manifests itself institutionally and within everyday social interactions in Canadian society. To begin with, Canada is becoming an increasingly multiracial/multicultural society. Data from the 2006 Canadian

census indicate that nearly 5,068,100 people surveyed belong to what Statistics Canada calls a “visible minority” group, accounting for nearly 16.2% of the total population (Statistics Canada, 2010, p. 5). The census indicates a 2.2% increase in “visible minorities” since 2001, and a 5% increase since 1996 (p. 1/1). These numbers also reflect a dramatic change in Canada’s demographic composition since 1971, when the percentage of people of European heritage in Canada constituted a definitive majority.

South Asians are Canada’s largest “visible minority” group, with Chinese and Blacks, respectively, constituting the second- and third-largest groups. Nearly 96% of all “visible minority” people live in a Census Metropolitan Area as compared with 68.1% of the general Canadian population (Statistics Canada, 2008, p. 5). It is important to note that not all “visible minority” group members are immigrants. Indeed, three out of ten racialized individuals were born in Canada, including 44.3% of Blacks and one-third of all South Asians (p. 13).

Socio-economic inequality between White/European residents of Canada and racialized Canadians has been the focus of significant research attention in the last decade. Pendakur and Pendakur (2011) have argued that not only male and female immigrants of “visible minority” status face substantial wage disparities; Canadian-born racialized individuals do as well (p. 6). Moreover, those of South Asian and Black/Caribbean/African origin appear to be the most disadvantaged in the labour market (Pendakur & Pendakur, 2011, p. 6). Indeed, in comparison to the previous census period, data from the 2006 census indicate a significant decline in earnings for all racialized people in comparison to those of (White) British origin. Men of Chinese origin whose employment status was on a par with their British-origin counterparts faced an earnings penalty of 8%, while Arab and West Asian–origin men earned 13% less and men of Southeast Asian origin earned 30% less (Pendakur & Pendakur, 2011, p. 23). Overall, a Canadian-born racialized man earned 18% less than a Canadian-born White man, while racialized women earned just 3% less than their White Canadian-born counterparts (Friesen, 2011). While it might be assumed that these discrepancies arise because of an educational deficit, in fact, the percentage of university-educated immigrants is more than five times that of individuals born in Canada (Galabuzi, 2001, p. 71).

Employment and wage inequities represent only one aspect of racial inequities in Canada. Researchers have documented evidence of racist discourse in Canada’s English-language press (Tator & Henry, 2002), racial inequities in Canadian education and jurisprudence (Razack, 1998, 2002), racially unjust immigration policies (Calliste, 1993, 2000; Stasiulis & Bakan, 2003), racial profiling and racist policing (Tator & Henry, 2006), and other indications of racial injustice too numerous to mention. Galabuzi (2001), in an important survey of racial inequality in Canada, characterized the context as follows:

While Canada embraces globalization and romanticizes cultural diversity, there are persistent expressions of xenophobia and racial marginalization that suggest a continuing political and cultural attachment to the concept of a white settler society. This unresolved tension is reflected not only in a racially segregated labour market and the subsequent unequal outcomes detailed in this report, but also in the quality of citizenship to which racialized group members can aspire. In recent years, racial and other forms of inequality have been exacerbated by the shift away from an activist role for governments, and towards a free market approach to social problems. This development raises questions about Canada’s commitment to the liberal democratic notion of equal citizenship as enshrined in the Canadian Charter of Rights and Freedoms, and to the international obligations under the various United Nations rights covenants and conventions. (p. 3)

Racial Inequities in Health in Canada: What's the Evidence?

As previously noted, reliable health-related research on racialized populations in Canada is relatively rare (Clarke, Colantonio, & Rhodes, 2008; Veenstra, 2009). One of the reasons for the lack of such research is that care registry data in Canada do not regularly record race or ethnicity statistics (Hyman, 2001; Kobayashi, Prus, & Lin, 2008; Varcoe et al., 2009). Nonetheless, some studies do examine non-Aboriginal health inequities within the Canadian health-care system.

Our review of these studies begins with a discussion of the “healthy immigrant effect,” a concept that belies outdated notions linking immigrants and disease and at the same time reveals the deterioration, over time, of new immigrants’ health status. The healthy immigrant effect refers to “an observed time path in which the health of immigrants just after migration is substantially better than that of comparable native-born people but worsens with additional years in the new country” (McDonald & Kennedy, 2004, p. 1613). As Hyman (2007) has pointed out, to some degree this effect is due to the fact that the more able among potential immigrants are more likely to immigrate and that the immigration system itself excludes those whose health is poor (p. 1).

Some research uses the term “immigrant” as a proxy term for racialized individuals, which is highly problematic; this term should be interpreted with caution. As noted above, more than 75% of immigrants who have arrived in Canada since 2001 belong to “visible minority” groups, but the approximately 25% remaining are of White/European descent (Statistics Canada, 2008). Some researchers have, however, begun to disaggregate immigration data by race. Ali, McDermott, and Gravel (2004) have shown that the healthy immigrant effect is strongest among non-European and recent immigrants (p. 19) and that non-European immigrants have survival rates that surpass those of the Canadian-born population, with 41% of male and 58% of female non-European immigrants expected to live until age 85 as opposed to 23% and 45%, respectively, for males and females born in Canada (Chen, Wilkins, & Ng, 1996, p. 32). However, utilizing data from five cycles of the National Population Health Survey (1994/95 to 2002/3), Ng, Wilkins, Genderon, and Berthelot (2005) found that immigrants from non-European countries were twice as likely as Canadian-born individuals to report a deterioration in health over the period under study (p. 3), a deterioration mirrored in the increased number of visits to doctors (at least six contacts a year) (p. 4). De Maio and Kemp’s (2010) recent study has confirmed earlier research demonstrating that immigrant health begins to decline soon after immigration to Canada. Their data show that even after controlling for experiences of discrimination and for socio-economic status, “visible minority” status was a statistically significant factor in the decline of immigrant health (p. 470).

Ng et al. (2005) have shown that non-European immigrants are more likely than Canadian born individuals to become physically inactive over time and more likely to increase their body mass index, which might explain the deterioration of their health over time (p. 17). Utilizing data drawn from the longitudinal components of the 1994/95, 1996/97, 1998/99, and 2000/01 cycles of the National Population Health Survey, an on-going longitudinal survey administered by Statistics Canada, Newbold (2005) found that native-born Canadians were much less likely to report a decline in health over time than were immigrants. The study reported that Black immigrants were found to be 76% more likely to assess themselves as “unhealthy” than were other racialized groups (p. 1365). However, Wu and Schimmele (2005), in an investigation of whether socio-economic status explains racial/ethnic health inequities in Canada, reported that while 22% of Black Canadians fell within the lowest income quartile compared with 11% of White Canadians, they nonetheless had “superior functional and self-reported health” (p. 715). This statistic seems to challenge analytical frames that focus on low socio-economic status as the key determinant of population health.

Racialized Immigrants and Specific Health Conditions

CARDIOVASCULAR DISEASE

Some diseases are linked to specific racial/ethnic profiles. South Asian people have some of the highest rates of cardiovascular disease in Canada and in the world (Gupta et al., 2002). It is well documented, for example, that South Asian populations in Canada have the highest rate of ischemic heart disease. Defined as the lack of blood flow and oxygen to the heart muscle, this condition is caused by the narrowing of arteries causing less blood and oxygen to reach the heart muscle. This condition is also called “coronary artery disease” and “coronary heart disease,” and it can ultimately lead to a heart attack.⁵ Deaths from cardiovascular disease are significantly more frequent in Canadians of South Asian origin than in Canadians of European origin, with 42% of South Asian men and 29% of South Asian women diagnosed with the disease as compared with 29% of European origin men and 19% of European origin women (Gupta et al., 2002, p. 718). These dramatic statistics have prompted much speculation as to the origins of this phenomenon, which includes theories centred on the genetic makeup of South Asians. But as Hayward et al. (2000) have convincingly argued:

... racial differences in the vast majority of chronic health conditions have little to do with genetic differences. Biology’s major role is to define the array of possible physiologic responses to the social, economic and environmental conditions associated with the increased risk of morbidity and mortality ... Adverse social conditions also evoke physiological responses in the allostatic system as physiology seeks to maintain all systems in equilibrium ... The price that is exacted by responding to adverse social or environmental conditions over the life cycle has been termed allostatic load, or the wear and tear on the body that occurs from chronic overactivity or underactivity of the allostatic system The prolonged activation of the allostatic system, in turn, predisposes persons to chronic (as well as infectious) diseases. (p. 913)

Anand et al. (2000) have argued that the discrepancy between European and South Asian Canadians’ incidence of cardiovascular disease has implications for how medical data are collected. As well, they have indicated that inasmuch as data from European populations cannot be extrapolated to other ethnic groups, the collection of data disaggregated for race/ethnicity has important clinical implications (p. 283).

CANCERS

A 2011 study of the incidence of cancer among immigrants to Canada offers a relatively comprehensive picture of the status of this disease among racialized immigrants (McDermott et al., 2011). Utilizing four national databases, including the Canadian Human Mortality Database and the Canadian Cancer Database, the study concluded that with the exception of nasopharyngeal and liver cancers, the SIR (Standardized Incidence Ratio) was lower for immigrants than for the Canadian-born population (p. 19). However, among immigrants from Northeast Asia and Southeast Asia, the incidence of liver cancer was significantly elevated. Increased rates of nasopharyngeal cancer were also noted among non-refugees from Northeast Asia. The study’s authors speculate that the high levels of liver cancer may be attributed to the prevalence of viral hepatitis in Northeast and Southeast Asia, to which some immigrants may have been exposed (p. 19). Another possible source of origin for these cancers is the consumption

⁵ Definition retrieved from the American Heart Association website www.americanheart.org on May 17, 2011.

of aflatoxin, a fungus frequently found in Southeast and Northeast Asia, which can be present in cereals, nuts, oils, and spices (p. 19).

Cervical cancer rates among refugee women 45 to 64 were higher than among the Canadian born and may be related to low rates of Pap smear screening among refugee women and possibly to higher rates of Human Papillomavirus, known to be connected to cervical cancer (McDermott et al., 2011, p. 19). Lasser, Himmelstein, and Woolhandler (2006), in their study of access to health care in the United States and Canada, also reported that non-White Canadians were less likely to have received a Pap test within the last three years (p. 1303). Lofters, et al (2007) indicated that most new cases of invasive cervical cancer in Canada are to be found among women who have been under-screened or who have never been screened, a situation more common among immigrant women of colour.

Elevated rates of cancer among some Asian immigrants have clear public health consequences. McDermott et al. (2011), in their review of four national databases, found that more screening is required for carriers of Hepatitis B and C and that more Asian women should be informed about the importance of screening for cervical cancer, a service that appears to be under-accessed in the Asian community (Gee, Kobayashi, & Prus, 2007; Yuan, Permaul-Woods, Barnsley, & Cockerill, 1999). A study by Lofters et al. (2007) found that only 37% of the newest registrants in the Ontario health-care system had been screened for cervical cancer, compared with 61% of those who were not new to the system. The study demonstrated that women with lower income, lower education, a foreign language, and who are not Canadian-born—descriptors that could apply to a significant segment of racialized immigrants—were less likely to undergo screening for cervical cancer (Lofters et al., 2007, p. 538). The number of Chinese Canadian women who undertake screening for breast cancer has also been less than optimal. In a study of Chinese Canadian women living in Vancouver, Jackson et al. (2003) found that more than one-quarter of the study participants had not had a mammogram and that over half did not follow the recommended screening routine of one mammogram every two years. Similar findings emerged from a study of knowledge and practices related to breast cancer among South Asian Women in Toronto. Choudhry, Srivastava, and Fitch (1998) interviewed 57 South Asian women over 40 and found that 47% of participants had never had a mammogram and 54% reported that they had little knowledge of breast cancer.

Recent research has also explored the cultural norms projected through Canadian literature directed at breast cancer patients and their families. Nelson and Macias (2008) investigated the responses of women of colour to informational material on breast cancer and found that a White, middle-class professional image was projected through the visual representations and content of breast cancer pamphlets for patients. The women interviewed for the study were particularly concerned with the absence of alternative representations and, in particular, the lack of racial and cultural diversity in the food choices discussed in the materials. The authors concluded that women of colour were left feeling “guilty and fearful, often unnecessarily” (p. 30). Projection of particular kinds of norms may contribute to a lack of engagement with health-care institutions by racialized women, the consequences of which could have serious health repercussions.

OCCUPATIONAL AND ENVIRONMENTAL ILLNESSES

In one of the first Canadian studies to investigate the occupational health of immigrants and minorities, Premji, Duguay, Messing, and Lippel (2010) used census and workers’ compensation data to look at the relationship between occupational risk and immigrant health. They reported that immigrants and racialized people, particularly women, are three times as likely as non-immigrant women to work as manual labourers in what is considered the highest risk sector (p. 882). They posited that occupational health problems may go under-reported among racialized and linguistic minority groups because of fear of reprisals, inad-

equate language skills, and difficulty obtaining information (p. 882). They also argued that the lack of information on ethnicity, language, and immigrant status in administrative databases makes it difficult to gather relevant data that could help bring attention to occupational health inequities among racialized and immigrant workers. Other researchers have drawn attention to the health risks suffered by low-income immigrants, most of whom live in Canada's urban centres and increasingly in racially segregated urban enclaves (Galabuzi, 2001, p. 7). Much of the housing available to this population is poorly maintained, with residents having to put up with "drafts, leaks, mold, pests, broken appliances and insufficient heat during the winter," all of which can contribute to poor health (Mattu, 2002, p. 7).

DIABETES

Numerous studies have identified South Asian Canadians as being at a much higher risk for diabetes mellitus than the general population (Beiser, 2005; Gupta et al., 2002; O'Loughlin, 1999; Shah, 2008; Sohal, 2008). Leenan, Dumais, and McInnis (2008) reported that South Asians are three times more likely to develop type 2 diabetes than European/White Canadians. Shah (2008) found the overall incidence of diabetes among South Asians to be as high as 12% to 15%, as compared with 3% to 5% among European Canadians (p. 207). South Asian Canadians are also likely to be diagnosed with diabetes 10 years earlier than their White counterparts (Lau, 2010, p. 102). Plausible explanations for this phenomenon have been few, although genetic susceptibility and environmental differences have been included in some medical hypotheses about the high rates of diabetes among South Asians in Canada. Lau (2010) has cited increasing affluence, the transition from rural to urban communities, and higher rates of obesity among South Asian Canadian children as possible risk factors. Some researchers, however, also cite evidence that South Asian Canadians are less likely to access physician care and other health-care resources, which may have an impact on the prevalence and severity of diabetes. Shah, for example, has demonstrated that eye examinations, a key indicator for diabetes care, were less common for all ethnic minority groups than for the White population after adjusting for age, sex, socio-economic status, and duration of diabetic condition (Shah, 2008, p. 329).

Obesity and diabetes are the principle causative factors behind the increasing prevalence of cardiovascular disease and rising rates of cardiovascular-disease-related mortality among South Asians Canadians who, in an Ontario study, evidenced higher cardiovascular risk profiles than Chinese Canadians or European Canadians (Lau, 2010, p. 102). Gupta, Anand, Chow, Harris, Qaadri, and Teoh (2011) have demonstrated that

South Asian Canadians have been found to present to the Hospital later in the course of acute [myocardial infarction] ...; be younger at the first hospitalization for heart failure and at the time of catheterization, ... have poorer outcomes and survival from coronary artery bypass surgery (CABG) ...; be more likely to have diabetes; and be more likely to have evidence of [coronary artery disease], even in the absence of symptoms or clinical findings. (p. 718)

Lau (2010) has argued that health policies and intervention/prevention programs that are "culturally specific and sensitive to South Asians" are "lacking but desperately needed" (p. 103).

The fact that South Asian Canadians are a highly diverse group, differentiated by countries of origin, socio-economic status, educational status, and a variety of other factors makes the statistical picture of diabetes and cardiovascular disease for this group that much more complex. However, the overall increased risk of morbidity and mortality for this sector of the population raises urgent questions about the need for disaggregated health data and for research on the interrelationship between the biophysical and socio-cultural causes of health inequities.

MENTAL HEALTH

A number of studies in recent years have dealt with the mental health status of racialized communities in Canada. A 2006 study of substance abuse among youth of colour was conducted by Across Boundaries, a mental health centre catering to the needs of people of colour in Toronto (Lovell & Shahsiah, 2006). The study took place in the Jane and Finch neighbourhood, considered to be a high-risk area for youth due to their exclusion from employment, education, and other social and economic resources. The study was based on questionnaires administered to 300 youth, 20 focus groups conducted with “gender-specific” and “ethno-specific” groups, and 16 discussion groups held with youth workers and mental health-care providers. Among the economic factors found to negatively affect the mental health of area youth were income deprivation, underemployment/unemployment, homelessness, and overcrowding. Among the social factors affecting mental health were racism, the stigma attached to place of residence, internalized feelings of low self-worth, feelings of inadequacy and social exclusion, and disempowering and traumatizing relationships with those in power (teachers, police, etc.). Among the cultural factors found to negatively affect the mental health of area youth were disregard for youth culture, generational gaps between children and parents/family, and ethnic community pressures (p. 8). Nearly half of all the young women surveyed always or often felt sad, while 15% of the young men often felt this way (p. 9). Overall, 30% of those surveyed considered suicide, with the number twice as high for young women as for young men (p. 9). Nearly 20% of young men reported being bullied at least once a week (p. 9). Over 19% used drugs or alcohol to deal with stress (p. 10). While over half reported having generational difficulties at home, almost none had used help lines or other mental health services (p. 10).

Another study conducted with Afghan immigrants to Canada surveyed young people between the ages of 12 and 18. A total of 211 youth filled out questionnaires about settlement stress, war trauma, racism, and difficulties at school (Soroor & Popal, 2005). One-third of respondents reported experiencing anxiety, while 15% reported symptoms of depression (p. 8). One-quarter reported suicidal thoughts. Ninety percent of those surveyed reported being exposed to violence either as a victim/survivor, witness, or perpetrator. Fifty-five percent of those who were in Canada for three years or less reported feelings of low self-esteem and anxiety (p. 8). Fifteen percent of youth surveyed reported experiencing racism and Islamophobia on a regular basis (p. 9). Service providers working with Afghan Canadian youth reported the “stigma and fear” associated with accessing mental health services and underlined an urgent need for “culturally and linguistically appropriate mental health and settlement services in the Afghan Canadian community” (p. 9).

Another study compared the health and well-being of older Chinese Canadians with data on the health of all older Canadians derived from the Canadian Multicentre Osteoporosis Study (Lai, 2004). While older Chinese Canadians were found to enjoy better health overall than other older Canadians, they reported poorer mental health status, with women reporting significantly lower levels of mental health than men (Lai, 2000; Lai, 2004, p. 195). Lai (2000) reported that 9.4% of elderly Chinese Canadians were mildly depressed, while 11.5% were moderately or severely depressed. Several studies have indicated that Chinese Canadians underutilize mental health services, although women had higher rates of mental health visits to professionals than men. Chinese Canadian men were seven times less likely to visit a mental health professional and ten times less likely to visit a psychiatrist compared with men in the general Canadian population (Chen & Kazanjian, 2005).

A 2005 study looked at the role that “Afro-Canadian” status plays in police or ambulance referral to emergency psychiatric services (Jarvis, Kirmayer, Jarvis, & Whiteley, 2005). The study found that African Canadian patients admitted to hospital with psychosis are more likely than others to be brought there by police or ambulance. Suspicion of the medical and justice systems may cause African Canadians to delay seeking help from these institutions, thus caus-

ing a worsening of symptoms that may result in the need for emergency care. The authors cite “complex webs of disadvantage arising from life in societies that devalue individuals on the basis of skin color” that predispose African Canadians to “undesirable modes of referral to emergency services” (p. 708).

A 2007 study of postnatal depression in Quebec utilized baseline data from the Quebec Longitudinal Study of Child Development, which followed the state of 2,223 babies and their mothers annually since 1998 (Tahiri, Zunzunegui, & Seguin, 2007). The study revealed that the incidence of postnatal depression was higher among immigrants from racialized groups than among immigrants from racial majority (European) groups or among Canadian-born mothers. Disaggregation by racial group of data from Canadian-born mothers, however, was not in evidence in the study. The incidence of postnatal depression among racialized immigrant mothers was 24.7%, more than twice as high as the rate for the other two groups surveyed (p. 2). The study revealed that racialized mothers were older, poorer, and had more children than White European immigrant or Canadian-born mothers and were less likely to have a partner. They also smoked less and breastfed for longer than those in the other two cohorts (p. 8).

A 2003 study of Tamil immigrants and refugees in Toronto revealed that one-third of those studied had experienced traumatic events and that 12% of the Tamil population in Toronto qualified for a diagnosis of post-traumatic stress disorder (PTSD) (Beiser, Simich, & Pandalangat, 2003, p. 240). This rate is considerably higher than the overall incidence of 1% in the general population but is consistent with rates found in other refugee populations. However, only 10% of those whose symptoms qualified them for a diagnosis of PTSD had sought or received treatment (p. 240). This study is one of the few that offers information about inequities in clinical encounters in the Canadian health-care system. One-third of those interviewed reported that they faced language problems when visiting hospitals, with seniors and women most likely to be affected by linguistic barriers (p. 240). Older persons were more likely to be dependent on their children to visit a doctor’s office. One in five of those surveyed reported that previous medical visits had been “unproductive,” and many felt that their culture would be misunderstood by health-care providers (p. 241). More than one in ten of the sample reported that they had experienced racial discrimination when accessing health care in Canada (p. 241). The implications of these findings are significant and verify other studies that speculate that racialized immigrants in Canada may defer access to health-care resources for fear of unequal treatment.

The studies cited above appear to validate evidence that self-reported racism has a negative impact on mental health. Paradies (2006) undertook a review of 138 empirical qualitative, population-based studies on racism and health (which included a direct measure of self-reported racism and a direct measure of a health-related factor as an outcome) and found that nearly half of the studies related primarily to mental health. Moreover, the studies revealed that more self-reported racism correlated with worse mental health outcomes (p. 891).

HIV/AIDS

By the end of 2005, approximately 58,000 people in Canada were living with HIV and AIDS (Public Health Agency of Canada [PHAC], 2009, p. 1). Approximately 7,050 of these infections were among individuals from countries considered to be “HIV-endemic.” HIV-endemic countries have a prevalence rate of 1% or greater in the adult population and either a male to female ratio of 2:1 or less, a prevalence rate greater than or equal to 2% among women in prenatal care, or a prevalence rate of 50% or more of cases attributed to heterosexual transmission (p. 1). Black people of Caribbean and African descent in Canada—a demographically, religiously, linguistically, and culturally complex and diverse group—have been significantly affected by the HIV/AIDS epidemic. More than 95% of recent Black immigrants have come from sub-Saharan Africa and the Caribbean, areas considered to be HIV-endemic locales (p. 2).

Of the estimated 2,300 to 4,500 new cases of HIV infection reported in 2005, 400 to 700 were

among individuals from HIV-endemic countries (PHAC, 2009, p. 16). These data represent an infection rate that is 12.6 times higher than in the general Canadian population. Among the 396 HIV positive cases in the HIV-endemic subcategory reported by the National HIV and AIDS Surveillance System for 1998 to 2006 (which included information on ethnicity), more than 90% of cases were among individuals identifying as Black. In contrast, 3.8% of cases were among those who self-identified as Asian, 3% who identified as “other,” and 2.1% who identified as White (PHAC, 2009, p. 20). Overall, between 1998 and 2006, individuals identifying as Black accounted for 88% of those cases attributed to the HIV-endemic subcategory. Of the total number of AIDS cases reported between 1979 and 2006 for which ethnicity information is available, Blacks accounted for 9.4% of all cases (PHAC, 2009, p. 20). The incidence of HIV infection among Blacks in Canada is not limited to those belonging to the HIV-endemic country category. Data from Ontario indicate that while 58.3% of all AIDS cases reported for those who identified as Black were in the HIV-endemic category, 26.3% were from the “men who have sex with men” (MSM) category and approximately 2% were from the “intravenous drug use” (IDU) category (PHAC, 2009, p. 21). It is important to note that data from Ontario may not fully represent the impact of HIV/AIDS among Blacks in Canada. While Ontario is home to 62.1% of Canada’s Black population, it only has 36.1% of the nation’s HIV/AIDS cases. Quebec, on the other hand, has 23% of the Black population but more than half of the nation’s HIV/AIDS cases (PHAC, 2009, p. 19).

It is also important to acknowledge the gendered nature of HIV/AIDS infection in Canada. In 2005, 63.9% of those diagnosed with HIV in the HIV-endemic category were women. Moreover, 50.8% of new HIV diagnoses among women were among women from HIV-endemic countries (PHAC, 2009, p. 22). In Quebec, data from 2006 show that 41.3% of women newly diagnosed with HIV were from HIV-endemic countries (PHAC, 2009, p. 22). Of enormous significance is the fact that only an estimated 56% of people in the HIV-endemic cohort who are currently infected have actually been diagnosed (Shimeles, 2011).

It is critically important that the multiple pathways leading to disease always be understood in their social, historical, and biological contexts. Consequently, the spread of HIV/AIDS among African Canadians and other marginalized groups must be traced to forms of structural violence (e.g., poverty, inadequate housing, environmental degradation, lack of access to fresh food, targeted marketing of addictive substances) and social trauma (e.g., racism, domestic violence) that intersect with gendered inequities to increase unprotected sex, sexual violence, intravenous drug use, and other factors that increase the likelihood of contracting the disease.

INTIMATE PARTNER VIOLENCE AND DOMESTIC ABUSE

Physical and emotional abuse have an extremely significant impact on health status. Women abused by partners have been shown to be three times more likely to be killed, twice as likely to be injured, and six times as likely to need medical care as those who are not abused. Women who are repeatedly victimized are more likely to suffer chronic ill health including depression, attempted suicides, addiction, and poor pregnancy outcomes (Ahmad, Driver, McNally, & Stewart, 2009, p. 613). Research on immigrant women has shown that the incidence of “intimate partner” or “domestic” violence among Canadian-born and immigrant women is likely similar but that recently arrived immigrants are more likely to report domestic violence to police but less likely to utilize social services than longer term residents (Campbell, 2009). While some research has looked at the “immigrant women’s” experiences of domestic violence, very little research exists that specifically explores the scope and nature of racialized women’s experience of physical and emotional abuse in Canada.

Ahmad et al.’s 2009 study looked at South Asian Canadian immigrant women’s experience of partner abuse. The authors found that 67% of participants who were administered the Wife Abuse Screening Tool demonstrated stress in intimate relationships. Of these, 34.5% suffered

emotional abuse, 24% endured physical abuse, and 17% were threatened with hitting by their domestic partners (Ahmad et al., 2009, p. 614). All of the women surveyed agreed that they had delayed seeking professional help for a number of reasons, including social stigma, gender roles, concern for children, lack of social support, and lack of knowledge of available social and medical resources (Ahmad et al., p. 616). Additional reasons for delaying or not seeking help include fear of jeopardizing their own Canadian immigration status and/or sponsorship of family members, and fear and distrust of police (Cross-Sectoral Violence Against Women Strategy Group, 2009).

Jiwani's 2001 study of immigrant women of colour, violence, and health care provides one of the only glimpses into the experiences of women of colour seeking help from health-care professionals in the wake of domestic abuse. Jiwani noted that the women interviewed for the study found that physicians often attributed reported violence to the women's culture, presuming that violent behaviour was inherent in the cultural group (p. x). Such beliefs, Jiwani argued, can lead physicians to avoid broaching the topic of domestic violence. Among the other barriers to health care endemic to an abusive relationship were the women's dependence on spouses to select a health-care provider, transport them to the visit, interpret during the visit, and get any prescriptions needed (p. 42). As Jiwani noted, having an abusive partner interpret for the woman can lead to a violation of her rights (p. 42). Jiwani concluded that systemic racism, sexism, and classism intersect, creating a precarious health-care environment for women of colour in abusive relationships.

OTHER HEALTH CONDITIONS AND OUTCOMES

Other health conditions have been linked to racialized/immigrant communities in Canada. Beiser reported that 60% of tuberculosis cases occur among immigrants with active infection occurring five to seven years after settlement (Beiser, 2005). Yeates (2010) reported poor access to liver transplantation among East Asian, Indo Asian, and African Canadians, speculating that this finding may reflect a low access to specialist care among racialized groups (p. 16). Female genital cutting (FGC), sometimes referred to as "female genital mutilation," has recently been raised as a human rights issue, but it carries significant health-care implications as well. Women have immigrated to Canada from regions where this practice is common and who have undergone FGC face numerous reproductive health-care issues. Studies from Australia and the United Kingdom have demonstrated that women who have undergone this procedure in their home countries are likely to encounter discrimination in the health-care setting (Allotey, Manderson, & Grover, 2001; Harper & McCourt, 2002). Language barriers constituted the most intractable problem for many of these women. Most found it impossible to both convey and receive information about complex medical needs during maternity care. Women in these studies reported mismanagement of labour and delivery including severe perineal tears and inadequate pain management (Harper & McCourt, 2002). Caregiver ignorance of this issue combined with racist stereotypes have led to poor health outcomes for child-bearing women who have undergone FGC in their countries of origin.

Racism and Health

THE HEALTH IMPACT OF A RACIST ENVIRONMENT

Recent research has called for a shift in thinking about the link between race and health. Rather than looking for factors inherent in race that are responsible for racial inequities in health, researchers have proposed that the "problem of racism" be seen as a primary factor in producing inequitable health outcomes in racialized populations (Brondolo et al., 2009; Chae et al., 2011).

Chae et al. (2011) recommended a “socio-psychobiological” approach to understanding health inequities. Such an approach “highlights the importance of social processes in generating psychological, behavioral, and biological vulnerabilities involved in processes of embodiment” (p. 65). Moreover, they argued, “present day social forces driving racial inequities in health are conceptualized as being the result of historical legacies of social oppression” (p. 65). This approach critiques “materialist” social production of disease theories which posit that socio-economic position is the most important variable in understanding health inequities. They also argued that race persists as a meaningful predictor of health, even after controlling for socio-economic position. According to Chae et al., the link between race and health lies in racism:

perpetuated by institutions, and manifested in the set of assumptions, stereotypes, and biases that are attached to race ... positioning groups of people into relative positions of power and deprivation ... this framework encourages transdisciplinary methods for studying racial inequities in health, emphasizing interactions between determinants of health at multiple ecological levels and the need to understand how psychological, behavioural, and biological risk factors are shaped by racism (p. 73).

Epidemiologist Nancy Krieger (2011) has suggested six pathways through which racism harms health:

(1) economic and social deprivation; (2) toxic substances and hazardous conditions; (3) discrimination and other forms of socially inflicted trauma (mental physical, and sexual, directly experienced or witnessed, from verbal threats to violent acts; (4) targeted marketing of harmful commodities (e.g., “junk” food and psychoactive substances such as , tobacco, alcohol and other licit and illicit drugs); and (5) inadequate or degrading medical care; and, (6) degradation of ecosystems, including as linked to systematic alienation of Indigenous populations from their lands and corresponding traditional economies (p. 223).

Having dealt with some of these pathways above, this section of the review focuses on socially inflicted trauma (3 above) and the physiological and psychological impact of racist experiences as well as on inadequate or degrading medical care (5 above) and racism in the clinical encounter.

Several researchers have examined the impact that racist experiences have had on the health of racialized people. Paradies’ (2006) review of 138 empirical qualitative, population-based studies of self-reported racism and health found that 72% of the examined (negative) health outcomes were related to self-reported racism (p. 891). As was noted above, nearly half of these studies were related to mental health. However, recent research has dealt with physiological responses to racist experiences.

Utilizing a representative sample of 5,196 people of Caribbean South Asian and Chinese origin, Karlsen and Nazroo (2002) explored the relationship between experienced or perceived racism and indicators of health. They found statistically significant associations between self-assessed poor or fair health and the experience or perception of racism. Those who had experienced verbal abuse were 50% more likely to describe their health as poor or fair than those with no experience of verbal abuse (Karlsen & Nazroo, 2002, p. 627). Karlsen and Nazroo, like other researchers, postulated that experiences of racism produce physiological responses that can be cardiovascular, endocrinal, neurological, or immunological in nature and can lead to ill health (Karlsen & Nazroo, 2002, p. 629). Similarly, Harrell, Hall, and Taliaferro (2003) posited that external stressors such as racism can have a permanent impact on physiological functioning by producing the physical arousal that is a key component of stress-related disease (p. 247).

In a review of 53 studies related to discrimination and health, Brown (2003) found that evidence of long-term health consequences resulting from experiences of discrimination were

consistent with other research on the effects of stress. Importantly, Brown discovered that perceptions of discrimination were associated with poorer health across socially disadvantaged groups as well as across social contexts (p. 206).

In another review, Williams and Mohammed (2009) verified the effects of stress resulting from racism, arguing that stress “appears to accelerate cellular aging and the chronic stressors triggered by multiple environmental assaults can lead to wear and tear on the body that can deregulate multiple biological systems and lead to premature illness and mortality” (p. 21). They also argued that as evidence accumulates about the detrimental physiological effects of racism, attention to racism must become an important component of improving health outcomes in racialized societies (p. 40).

Similarly, Brondolo et al. (2009) consider racism to be “a substantial public health threat” (p. 4). Experiences of racism, they have argued, can have serious effects on “cognition, affect, behaviour and psychophysiological responses,” even changing individuals’ interactions with others and increasing the risk of other stress-related illnesses (p. 4). Moreover, they indicated, these outcomes can affect entire communities and may impact future generations’ behavioural and psychological health (p. 4). In addition, they reported that links between racism and risky health behaviours such as smoking and substance abuse have been demonstrated in the medical literature (p. 4).

Williams, Neighbors, and Jackson (2008) confirmed that discrimination can produce long-term consequences for health and encouraged the development of this area of study so that researchers can “evaluate causal directionality in the discrimination-health association” (p. 13).

BIAS, DISCRIMINATION, AND STEREOTYPING IN HEALTH-CARE DELIVERY

Racial inequities in health in the United States are well documented and long standing (Jackson & Williams, 2006). Data on these inequities are readily available for analysis as the U.S. government, unlike the Canadian government, reports health statistics by race.

A recent study undertaken by the U.S. Institute of Medicine of the National Academies sought to account for the conditions under which Black men have higher death rates than White men for 11 of the 15 leading causes of mortality and those under which Black women have higher death rates than White women for 12 of the 15 leading causes of mortality (Jackson & Williams, 2006, p. 132). Entitled *Unequal Treatment: Confronting Racial and Ethnic Inequities in Health Care*, the 764-page report assesses how race and ethnicity affect a variety of health conditions and services independent of access to health-care insurance, income status, education, and other socio-economic influences on health-care utilization (available for free download at www.nap.edu/catalog/12875.html). The authors concluded that persistent racial and ethnic discrimination in American life affects the clinical encounter and leads directly to increased morbidity and mortality for racialized patients (Smedley et al., 2003). According to Francis (2001), the myriad examples of racial inequities in health, not only in access to care, but also in life expectancy, mortality, morbidity, health status, disease prevalence and incidence, utilization of services, clinical outcomes, process of care, adequacy of pain management, do-not-resuscitate orders, and end of life care, are evidence of society’s tacit support of the notion of the “existence of hierarchies of human worth.” (p. 29)

That these outcomes are evident, even under conditions of equal access to medical care, should be of concern to countries with a universal health-care system such as Canada. Indeed, Klonoff (2009) has described inequities in the provision of medical care as “an outcome in search of an explanation” (p. 48). While this review has provided evidence of racial health inequities in Canada, very little research exists that attempts to explain this phenomenon.

There is evidence, however, that Canadian physicians believe that they are immune from the kinds of racial bias exhibited by their colleagues to the south. For example, a study of Canadian resident physicians’ attitudes toward cross-cultural communication by Lingard, Tallett, and

Rosenfield (2002) found that residents believed that “cross cultural misunderstandings did not affect their encounters and that in Canada people were more progressive and less judgemental” (p. 334). In general, the researchers found that residents were willing to admit that prejudice existed but denied that it was a factor in their own clinical encounters with patients (p. 335). The residents viewed medicine as “culture-free” and were unwilling to consider the cultural frameworks that underlie medicine. In the researchers’ estimate, the residents saw themselves as “bearers of fact” and the patients and their families as “bearers of belief” (p. 334). The residents failed to see this hierarchy of knowledge as the locus of power relations in the clinical encounter.

Beagan and Kumas-Tan (2009), in a study of Canadian family medicine physicians, found that nearly half of participants claimed that race, class, sexual orientation, and other socio-cultural differences raised no tensions in their practices (p. 24). Other physicians saw these differences as relevant only to genetics or physiology but as having no social importance. Beagan and Kumas-Tan noted that this individualist approach to patient care is reflective of the dominant approach to diversity in Canada. They argued that

in seeking not to discriminate, physicians aim to neither see sociocultural difference nor apply generalizations at all and inevitably fail to acknowledge generalized social patterns in experiences, life chances and influences in health. (p. 27)

Such attitudes, while well intentioned, can lead to “a denial of the role that racism and cultural variation play in shaping differential patterns of help seeking and access to treatment as well as the experience and outcome of these processes” (p. 27).

Both the Lingard et al. (2002) and Beagan and Kumas-Tan (2009) studies concluded that without empirical evidence, there is no way to know how inequitable health-care outcomes are produced in the clinical encounter. There is, however, a small body of research that provides evidence of patients’ perceptions of racism in their encounters with health-care providers.

A study by Johnson et al. (2004) of Canadian South Asian women’s experiences of racism in health care analyzed the ways in which the 80 South Asian women interviewed were “othered” in their encounters with health-care providers. The study paired the women’s experiences with those of their health-care providers and revealed a major disjuncture between the accounts of the two groups (Johnson et al., 2004). While the women’s stories about their encounters with the health-care providers frequently mentioned “race” and “racism,” the health-care providers’ stories about their encounters with the South Asian women mentioned “equal treatment” and “cultural appropriateness” (p. 258). The researchers found that racist attitudes of health-care providers took three forms: essentializing explanations, culturalist explanations, and racializing explanations. The essentializing explanations, for example, involved overgeneralizing about the women’s culture, race, and social background. The physicians explained South Asian women’s underutilization of the health-care system by their “lack of ability to follow instructions, take responsibility for their health, be proactive in their use of services and be ‘good patients’” (p. 260). The “culturalist explanations involved treating culture as static and frozen in time, while the racializing explanations involved “veiled references to culture, ethnicity and women’s personal characteristics (p. 263). Among the policies that impacted negatively on South Asian women were “restrictions on the number of visitors, rigid appointments or treatment schedules, lack of translation services, and limited time spent with patients. These practices were interpreted by the South Asian women as exclusionary, while the practitioners’ response was to construct the women as difficult and as a burden on the already overstretched health care system” (p. 266).

A study conducted by Women’s Health in Women’s Hands, a health-care clinic that serves women of colour in Toronto, also found evidence of racial discrimination as a health risk among young women of colour. The study included focus groups with 14 women, individual

interviews with 81 women, and 9 interviews with self-defined “anti-racist” health-care practitioners. It found that 29% of the women interviewed described their experience in the health-care system as quite negative (Women’s Health in Women’s Hands, 2003). One in five women surveyed reported encountering racism in the health-care system, including “cultural insensitivity or ignorance from doctors, name calling or racial slurs, receiving an inferior quality of care and being overcharged for services” (p. 31).

With the exception of research on Aboriginal people, empirical data about racial inequities in clinical encounters are scant in Canada. The evidence that exists comes largely from research that was conducted by community-based groups who provide important information on the experience of racialized people in the health-care system (Patyckuk, 2011). However, there is clearly room for larger studies, including those utilizing ethnographic and other qualitative methodologies, that would provide information on the aspects of the medical encounter that might be linked to the racially unequal health outcomes that are becoming evident in the Canadian health-care system.

INEQUITABLE ACCESS TO SCREENING AND SPECIALIST CARE

Newbold (2005) has suggested that there are “unseen barriers” to access to health care for immigrants in Canada. While Newbold does not separate out racialized immigrants in his analysis, the high percentage of racialized people among recent Canadian immigrants means that racialized immigrants are largely affected by the barriers that he describes. Among these unseen barriers are “discrimination based on race or ethnicity ... inability to navigate past a physician and/or to communicate adequately the need for care to their physician” (p. 1368).

Quan et al. (2006), utilizing data from the 2001 Canadian Community Health Survey, found that “visible minorities” were less likely than Whites to have had contact with specialist physicians or to be admitted to hospital (p. 789). Inequities between racialized people and Whites with regard to visits with a specialist, admission to hospital, and undergoing cancer screening tests were consistent across racialized subgroups when controlled for sex, income, language, and length of residence in Canada (p. 789). However, after adjustment for socio-demographic characteristics and health status, racialized people were more likely than White people to have had contact with a general practitioner, equally likely to have visited a specialist, less likely to have been admitted to hospital, and less likely to have undergone any of the three cancer screening tests investigated (p. 789). Quan et al. (2006) have indicated that the racial inequities in hospital admission and cancer screening require further investigation.

THE COLLECTION OF EVIDENCE OF RACIAL INEQUITIES

Numerous researchers have pointed out the inadequacy of data on racial inequities in health in Canada (Beiser, 2005; Clarke et al., 2008; Hyman, 2009; Kobayashi et al., 2008; Lofters, Shakkardass, Kirst, & Quinonez, 2011; Parsons, 2005; Premji et al., 2010; Rummens, 2003; Varcoe et al., 2009). Beiser (2005), for example, argued that immigrants are underrepresented in the National Population Health Survey and that this absence mitigates the ability to analyze health status by race/ethnicity, among other variables. Parsons (2005) noted that there is a “profound lack of routine collection of race/ethnicity relevant data in Canada” (p. 34) and that race is not coded in the Canadian cancer registries, making it “impossible to even begin to ascertain the effect of race on breast cancer survival (p. 34). Randall (2007) argued that the lack of uniform data collection impedes researchers’ ability to accurately describe racial discrimination in health care. “Disaggregating data based on race,” she argued, “is important because it helps make the impact of racism and racial discrimination visible and thus allows us to address the root problem” (pp. 9, 18).

There are clearly pros and cons in relation to the collection of race data in relation to health, but these have not been widely discussed in Canada. As noted, many scholars see the benefits

of collecting race statistics which, they argue, “enable identification of and provide a basis for rectifying inequities in order to achieve more equitable and culturally competent care” (Varcoe et al., 2009, p. 1659). Varcoe et al. (2009) found that for some patients, the collection of race data became a “racializing process with potentially harmful effects” (p. 1664). Their study indicated that asking questions about race and ethnicity evoked anxieties about racism and racist classification, particularly among people who had experienced racism in the health-care system (p. 1664). In a study of patients, community leaders, and health-care workers, Varcoe et al. (2009) were able to identify the advantages of collecting data on race/ethnicity as contributing to reducing barriers to health care for racialized patients. However, the primary benefit identified by all those interviewed was that data on race/ethnicity would ensure that risk factors related to race, were taken into consideration in clinical care. Those interviewed also were concerned that the process of asking about racial identities might indicate that inequities were endemic to the health-care system. A recent study by Lofters et al. (2011) also reflected anxieties about the collection of race statistics in Canadian health-care settings. The researchers found that of the more than 1,000 study participants 48% did not believe that it was important for hospitals to collect personal information from patients (p. 195). There was an overall concern among participants that this data would be used to discriminate against patients, with this concern higher among those from racialized groups. This response echoes results from similar studies carried out in the United States.

Collecting race data in health-care settings has the potential to provide needed data about racial health inequities, but clearly such an undertaking is complex. There is evidence from the United States that despite the routine collection of race data in that country’s health-care system, “research has not shown that knowledge about health inequities leads to better health-care services at the individual level (Varcoe et al., 2009, p. 1660). In more than one study, researchers called for both evidence of the benefits of collecting race data in a given health-care setting before implementing data collection and for the evidence to be clearly articulated to health-care providers and patients. This evidence must be accompanied, they argued, by a commitment to act on any evidence of racism or discrimination revealed by the collection of such data. Such a commitment might serve to reduce anxieties among racialized patients.

THE COLLECTION OF DATA ON RACE AND ETHNICITY IN OTHER JURISDICTIONS

There is a broad consensus both in the United Kingdom and the United States about the need to collect standardized data on race, ethnicity, and the primary language of those utilizing the health-care system (Fulton, 2010; Smedley et al., 2003). In the United States, the collection of race data has been endorsed by the Institute of Medicine, Physicians for Human Rights, and The Commonwealth Fund (Varcoe et al., 2009, p. 1660). The U.S. Institute of Medicine’s report *Unequal Treatment: Confronting Racial and Ethnic Inequities in Health Care* argued that

standardized data collection is critically important in the effort to understand and eliminate racial and ethnic inequities in health care. Data on patient and provider race and ethnicity would allow researchers to better disentangle factors that are associated with health care inequities, help health plans to monitor performance, ensure accountability ... improve patient choice, allow for evaluation of intervention programs, and help identify discriminatory practices. (Smedley et al., 2003, p. 21)

The need to track racial inequities in health has also been recognized by the international community. The 2008 report *Closing the Gap in a Generation* by the WHO Commission on the Social Determinants of Health argued for the need to “ensure that routine monitoring systems for health equity and the social determinants of health are in place locally, nationally, and internationally” (Pan-Canadian Public Health Network, 2009, p. 4).

It is widely recognized that while the collection of statistics on race and ethnicity has the

potential to uncover inequities in health-care delivery, implementing this type of data collection represents challenges. Neither the United States nor the United Kingdom has been successful in creating comprehensive monitoring systems that address health-care inequities (Fulton, 2010; Smedley et al., 2003). The challenges involved in routine data collection on race and ethnicity include difficulty in determining racial categories for self-identification, reluctance to request race data from patients because of fear of offending them, lack of incentive to collect data, concerns with how data might be used, concerns with patient privacy, and the cost involved in undertaking the data collection (Fulton, 2010, p. 2; Smedley et al., 2003, p. 22). Dealing with the complexities of racial identity is perhaps the greatest challenge. As Rummens (2003) argues,

The capturing of multiple origins is essential as it more accurately reflects the lived reality of increasing numbers of Canadians and more clearly reveals the rich complexity of Canadian society. At the same time it effectively challenges any notion of a necessary direct correspondence or equivalence between ethnic ancestry, lived culture, and cultural identification. (p. 93)

In the Canadian context, a belief in the absence of racial inequities might be added to this list of challenges that must be faced if racial data are to be collected within the health-care system. While the implementation of racial monitoring may appear to be a difficult task, the social costs of not addressing racial inequities significantly outweigh any burden that task may pose.

The authors of *Unequal Treatment* put forward four recommendations relating to the collection of race statistics:

1. Collect and report data on health care access and utilization by patients' race, ethnicity, socioeconomic status, and where possible, primary language.
2. Include measurements of racial and ethnic disparities in performance measurement.
3. Monitor progress toward the elimination of health care disparities.
4. Report racial and ethnic data by OMB [federally defined] categories, but use subpopulation groups where possible. (Smedley et al., 2003, p. 22)

While these recommendations could take us a long way toward eliminating racial inequities in health, some scholars suggest that addressing race as a stand-alone category may not produce adequate explanations for why some people enjoy better health than others in a theoretically universal health-care system. The challenge for the 21st century may well be “how to understand the ways in which gender, race, and class relations intertwine and are expressed in disparate chances for health, illness and well-being” (Schulz & Mullings, 2006, p. 6).⁶

Final Questions

This review raises many questions about how we might begin to address the unequal health outcomes faced by racialized people in Canada. In many ways, these questions reflect contradictions in Canadians' self-perception as an equitable society. Comparisons with greater health inequities in the U.S. health-care system may be unavoidable but should not be a deterrent to addressing the clear evidence of racial inequality in Canada. Among the questions that are raised here are as follows:

- What kind of monitoring system might accurately and effectively reveal the causes of health inequities, given the unique nature of Canada's health-care system?
- How can we best incorporate the voices of both health-care providers and racialized health-care consumers in an analysis of the causes of health inequities?
- What kinds of interventions are likely to have an impact not only on the level of population health but also on individual experiences of health and illness?

Canadians' belief in their society as one that is just, compassionate, and inclusive can only be sustained if we are able to find answers to these important questions.

⁶ It would be appropriate to add sexuality to Schulz and Mullings' statement, as there is ample evidence of health inequities being linked to sexual minority status.

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