

Colour Coded Health Care

The impact of race and racism on Canadians' Health

Canada's universal health care system is often understood as a central pillar of a national commitment to social equity and social justice. Such an understanding makes it difficult to raise the issue of racial inequalities within the context of the Canadian health care system. Indeed, far too little research has been conducted in Canada on racial inequality in health and health care.

Colour Coded Health Care offers a review of relevant academic and community-based research on racial disparities in the health of Canadians appearing between 1990-2010. In addition to surveying the research on mortality and morbidity by racialized groups in Canada, it surveys the evidence of bias, discrimination and stereotyping in health care delivery. This research shows non-European immigrants are twice as likely as the Canadian-born to report deterioration in health subsequent to immigration. Moreover, Black immigrants were 76 percent more likely to assess themselves as "unhealthy" than other racialized groups. Recent research on the physiological impact of racism suggests that living in a racist environment increases the risk of illness for racialized individuals. Some studies also suggest that racialized people experience racism in their interactions with the health care system, which may have an impact on access to health care and to life-saving screening procedures. This survey concludes by looking at recommendations from other jurisdictions for the collection of data by racialized group including measurement of health care inequities.

UNDERSTANDING RACIALIZATION AND RACE

How we understand race plays a key role in shaping research questions related to health inequities. The term "race" carries with it histories of stereotyping, exclusion and other forms of social injustice. There is a long historical record of sorting populations into racial taxonomies reflecting perceived gradations of human worth. Despite evidence discrediting the biological view of race, some researchers continue to adhere to the notion that biological differences among racial groups are responsible for racial variations in

health status. Though seemingly outdated, these notions have found new life in an era of global migrations.

Because we have determined that racial differences have little relationship to genetic differences, the role of the medical sciences should be to assess the social determinants of health as they relate to race and racism in Canada.

EVIDENCE OF RACIAL DISPARITIES IN HEALTH

Reliable health-related research on racialized populations in Canada is relatively rare. One reason for this is that care registry data in Canada, unlike in the United States, does not regularly record race or ethnicity statistics.

One area that has been investigated is the health of recent immigrants. While the relatively good health of immigrants, known as the "health immigrant effect" was once touted as a unique and positive phenomenon, recent evidence disputes this. 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." Recent studies demonstrate that immigrant health begins to decline soon after immigration to Canada and that "visible minority" status is a statistically significant factor in the decline of immigrant health.

Some diseases, including cardiovascular disease, certain cancers, diabetes, and HIV/AIDS, are linked to specific racial/ethnic profiles. Studies have identified South Asian Canadians as being at a three times greater risk for diabetes mellitus and at greater risk for death from cardiovascular disease than the general population. Plausible explanations for these phenomena have included genetic susceptibility and environmental differences. Higher rates of obesity and transition from rural to urban communities are also emerging as recognizable risk factors. Accessing physician care or other health care resources also impacts the severity and prevalence of these diseases. Inasmuch as South Asian Canadians are a highly diverse group, differentiated by such

factors as country of origin, socioeconomic status and educational status, to name a few, disaggregated data is necessary in order to track the pathways of diseases that appear with greater frequency among various racialized groups.

RACISM AND HEALTH

Recent research has called for a shift in thinking about the link between race and health. Rather than looking for biological factors inherent in race which are responsible for racial inequities in health, some researchers propose that the “problem of racism” must be seen as one of the primary factors in producing inequitable health outcomes in racialized populations regardless of socioeconomic or educational status. Racial inequality in health needs to be situated within an historical context and a contemporary reality shaped by racism in its various forms. While race is often referred to as a social construct with no real material base, racist assumptions continue to shape institutions and social interactions including those related to health and health care.

Epidemiologist Nancy Krieger has suggested that there are six pathways through which racism harms health:

1. economic and social deprivation;
2. toxic substances and hazardous conditions;
3. socially inflicted trauma (mental physical, and sexual, directly experienced or witnessed, from verbal threats to violent acts);
4. targeted marketing of commodities that can harm health such as junk food and psychoactive substances (alcohol, tobacco, and other licit and illicit drugs);
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.

One focus of this review is literature on the impact of racist experiences on racialized people. There are statistically significant associations between self-assessed poor or fair health and the experience or perception of racism. Some researchers have demonstrated the ways in which racism produces physiological responses leading to increased cardiovascular, endocrinal, neurological or immunological diseases within racialized populations.

BIAS IN HEALTH CARE DELIVERY

A crucial area for examination is bias in health care delivery. Racial inequities in health in the United States are longstanding and well documented. These inequities are independent of access to health care insurance, income status, education, and other relevant influences on health care use. That these outcomes are evident, even under con-

ditions of equal access to medical care, should be of concern in countries like Canada with universal health care systems. The research surveyed here suggests that these inequities may be linked to the dynamics of the health care encounter. In Canada, very little research exists that explore this phenomenon. In one study of family medicine physicians in Canada, nearly half of those studied claimed that race raised no tensions in their practices. Other physicians saw these differences as having no social importance. These attitudes, unfortunately, can sometimes lead to a denial of the role that racism plays in accessing health care. However, without empirical evidence, it isn't possible to conclude that inequitable health care outcomes are produced within the clinical encounter. A small body of research provides evidence of patients' perceptions of racism in their encounters with physicians. For example, one study of Canadian South Asian women's experiences of racism in health care analyzes the ways in which the 80 South Asian women were “othered” in their encounters with physicians. The study pairs the women's experiences with interviews with their physicians revealing a major disjuncture between the accounts of the two groups. The researchers found that racist attitudes of health care providers took three forms: essentializing explanations, culturalist explanations, and racializing explanations. There is room for larger studies of health outcomes among (non-Aboriginal) racialized people, including those utilizing ethnographic and other qualitative methodologies, that would provide information on the aspects of the medical encounter which might be linked to the racially unequal health outcomes that are beginning to become evident within the Canadian health care system.

IMPLICATIONS FOR FUTURE RESEARCH

There are 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. Among the questions that are raised here is: 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? The challenge for policy makers and health care providers might be to understand the ways that race, sexuality, culture, class, (dis)ability, immigration status, and gender are interlocked phenomena which in some configurations lead to disparate chances for health, illness and well-being. 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.

The Wellesley Institute is a Toronto-based non-profit and non-partisan research and policy institute. Our focus is on developing research and community-based policy solutions to the problems of urban health and health disparities.