

# Racial inequality in access to health care services

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**(Please note:** The views and opinions expressed by the author are their own and do not necessarily reflect those of the Ontario Human Rights Commission.)

**by Sana Halwani**

Sana recently completed her law degree at the Faculty of Law, University of Toronto and is currently articling at Gilbert's LLP, a litigation boutique in Toronto. She will be clerking for Justice Abella, Supreme Court of Canada, in 2005. Sana originally produced this paper for the Ontario Human Rights Commission in 2002 as part of a Pro Bono Students Canada placement.

## **Abstract**

Racial inequality in the health care context is most often indirect and systemic. This paper attempts to give a brief overview of a number of facets of this problem, including the role of socio-economic factors, the under-representation of racialised groups in the medical profession, the importance of communication in the health context, the delivery of culturally sensitive care, and the evidence of discrimination in clinical-decision making and health outcomes.

## **I. Introduction**

Immanuel Kant wrote: "We do not see things as they are, but as we are." His words are especially apt when evaluating access to health care services in Canada. To a Canadian-born, white, middle class individual, the health care system, though admittedly imperfect, provides appropriate services in an appropriate context. To a member of a visible minority, to a person who speaks neither official language or to a recent immigrant, the health system can be an incredible obstacle course.

Discrimination in the health care context is most often indirect and systemic. Indirect discrimination occurs when "exactly the same services are provided to everybody (so that they appear fair) but when for cultural, religious, linguistic or other reasons it is not possible for members of one or more black and minority ethnic groups to benefit equally from them."<sup>[1]</sup> Thus, what might appear to be perfectly equitable access (a small town doctor who sees everyone who needs to be seen) may not be (the doctor is male and Muslim women can therefore not be examined by him). By such examples we see that adopting the usually well-meant "colour-blind approach" and treating all people the same does not result in equal access.

With this in the background, this paper is divided into five sections: (1) the role of socio-economic factors, (2) the under-representation of racialised groups in the medical profession, (3) the importance of communication, (4) the delivery of culturally sensitive care, and (5) clinical-decision making and health outcomes.

## II. The Role of Socio-Economic Factors

Though not directly related to the issue of racial discrimination, as a number of studies have shown, socio-economic status plays an important role as a determinant of health and so should not be overlooked when analysing access to health care. Race, ethnicity or origin is not necessarily the root cause of inequality and resulting poorer health.

The impact of socio-economic status is apparent in a statistic generated by the Advisory Committee on Population Health (ACPH): when questioned about their health, only 47% of Canadians in the lowest income bracket rated their health as very good or excellent, compared to 73% of Canadians in the highest income group.<sup>[2]</sup> Furthermore, it appears that socio-economic status affects the perception that physicians have of their patients: "research has documented difficulties in communication about cardiac testing between physicians and patients of lower socioeconomic status, and physicians report lower perceptions of less affluent or less well educated patients that are more negative than their perceptions of other patients."<sup>[3]</sup> These negative perceptions will likely have an impact on doctor-patient communication.

Part of the life experiences of individuals with lower socio-economic status is a decrease in societal power. "[T]he degree of control people have over life circumstances, especially stressful situations, and their discretion to act are the key influences" in making the health determinant of income and social status significant.<sup>[4]</sup> Furthermore, social status can impact on health *even* within sections of the population with a good standard of living and job security.<sup>[5]</sup> Thus, stresses such as racism or discrimination may also prevent empowerment and such stresses may be further compounded by feelings of helplessness that may arise when individuals are faced with systemic, unacknowledged discrimination.

Both influencing and being influenced by experiences of social power, education and employment play important roles as determinants of health. "Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy."<sup>[6]</sup> In addition, "[u]nemployed people have reduced life expectancy and suffer significantly more health problems than people who have a job."<sup>[7]</sup>

Finally, the relationship between socio-economic status and health can be seen as cyclical. Ill health has emerged as one of the main reasons cited by individuals as the cause of their household's poverty."<sup>[8]</sup> Thus low socio-economic status leads to ill health which may further lower that status.

## III. The Under-representation of Racialised Groups in the Medical Profession

The services provided by the public health care system and the models of delivery employed are defined and shaped by health professionals and administrators within that system. When treatments are to be listed or de-listed, when regulations are drawn up or information pamphlets produced, it is these individuals who are most likely to draw attention *and* resources to inequalities of access. However, problems are unlikely to be addressed or even identified when racialised groups are under-represented in the profession.

Though not a major part of this paper, this aspect of inequality is worth further exploration, and the following provides two starting points for such an inquiry. First, the *Canada (Canadian Human Rights Tribunal) v. Canada (Department of National Health and Welfare) (re Chopra)*<sup>[9]</sup> case provides

an indication of the magnitude of employment discrimination in the health care profession. That case dealt with a Canadian Human Rights Tribunal decision in 1997 that Health Canada had discriminated against racial minorities in scientific and professional jobs by denying them promotions to senior management. Second, immigrants face major obstacles when they attempt to enter the health professions because of the difficulties they face in transferring qualifications.

#### **IV. The Importance of Communication**

The issue of communication is central to any discussion of access to health care. Without good communication between health care professionals and their patients, mistakes may be made, proper care may not be administered, and trust may not be established. Two aspects of communication are explored here: (1) language and (2) conveying information and gaining informed consent.

##### **A. Language**

The lack of services in minority languages has been repeatedly found to be a barrier to access of various social services, including health services.<sup>[10]</sup> For example, language barriers were identified by both physicians and focus groups as a barrier to breast cancer screening for Tamil immigrants and refugees.<sup>[11]</sup> In addition, Arab community focus groups identified a lack of Arabic-speaking health care providers and a lack of interpreters in Arabic as major concerns in their access to health care.<sup>[12]</sup>

As Pask and Yoshida have argued, "if the patient and health professional speak different languages, a competent interpreter should be brought into the dialogue. To proceed without one is less than respectful of the patient and is not in any way in his or her best interests."<sup>[13]</sup> Unfortunately, there has not been a strong statement from the judiciary on whether interpreters must be provided to those who speak neither French nor English. Although the Supreme Court of Canada had an opportunity to rule on this issue in *Eldridge v. British Columbia (Attorney General)*<sup>[14]</sup>, it declined to do so saying only that it was purely speculative to argue that the government would be required to provide minority language interpreters because the court was declaring interpreters for the deaf to be a "reasonable accommodation". We will have to wait and see whether a minority language challenge will succeed.

##### **B. Conveying Information and Obtaining Informed Consent**

As Hyman describes, "cross-cultural differences in information-seeking patterns, communication styles, perceptions of health risk, and ideas about prevention of disease [have] an impact on health."<sup>[15]</sup> Furthermore, effective communication can be impaired by barriers created by differences in status and culture between doctor and patient. Such a problem is obviously compounded by language barriers.<sup>[16]</sup> In addition, since individuals have been taught the nuances of how to behave when ill or suffering, or when healthy, by previous generations,<sup>[17]</sup> if the health professional is not a member of that culture or community, he or she may not understand the patient's symptoms. This situation raises the issue of "explanatory models".

The patient's explanatory model (or EM) is described in Helman's *Culture Health and Illness: An Introduction for Health Professionals* as:

used by individuals to explain, organize and manage particular episodes of impaired well-being. Consultations with a doctor are actually transactions between lay and medical EMs

of a particular illness. ... The context of an EM may include the social and economic organization, and dominant ideology (or religion), of the society in which the individual got ill.<sup>[18]</sup>

In communicating their suffering to others, different cultural groups use different "languages of distress". If a doctor is unable to decipher this verbal or non-verbal language, he or she will be in danger of making the wrong diagnosis.<sup>[19]</sup> Such communication problems can be compounded by the power differential between patients and clinicians. Helman explains: "The *power* invested in the clinician by virtue of his background and training may allow him to mould the patient's EM to make it fit into the medical model of disease, rather than allowing the patient's own perspective on illness to emerge."<sup>[20]</sup> This issue is intimately related to the delivery of culturally sensitive care described in the next section.

Informed consent, one of the central tenants of medicine, has also been shown to be compromised when language or cultural barriers are present. In a study on the quality of informed consent in cancer clinical trials "[l]ower knowledge scores [the reporting scale of informed consent quality] were associated with absence of college education and use of language other than English in the home."<sup>[21]</sup> They further concluded that efforts are needed to ensure that the consent of non-English speaking patients' is adequately informed and suggested the expansion of the use of interpreters and translated consent forms where needed.

## V. The Delivery of Culturally Sensitive Care

It is worth repeating that equality of access is not ensured by uniformity in a multiracial society. Thus, culturally sensitive delivery of health care is a necessity if equality is to be a serious goal. In evaluating cultural sensitivity, we must first explore if the current delivery of services is equitable, and if not, how it could be made equitable.

Reitz, in his review of Canadian, U.S., British and Australian publications, found that differences in cultural patterns of help-seeking and a lack of culturally-sensitive services or delivery modes were barriers to accessing health care or to gaining full benefits from that care.<sup>[22]</sup> In addition, in discussing culture as a determinant of health, Health Canada stated that in an environment largely determined by dominant cultural values, some groups face health risks stemming in part from a "lack of access to culturally appropriate health care and services."<sup>[23]</sup> These studies clearly demonstrate that current health care delivery does not create equitable access for members of all cultural groups.

A theme that appears repeatedly in the literature is the positive impact that an "ethnic match" between patient and clinician makes in access and utilisation. In the United States, it was found that the greater the proportion of minority staff in a mental health centre, the greater the utilisation rate by that minority.<sup>[24]</sup> In addition, a number of studies have shown that an ethnic match between client and service-provider generally increases service utilisation and reduces drop-out rates.<sup>[25]</sup>

In dealing with such inequality, a number of creative solutions have been proposed. These solutions range from simple and practical to requiring a full overhaul to the system. Sharda notes that improvements in quality of care can begin simply with "multilingual information, link workers, appropriate diets and a multifaith approach in hospital."<sup>[26]</sup> On the other hand, Across Boundaries, an ethnoracial mental health centre, advocates "anti-racism service delivery" which involves "ensuring that providers are reflective of ethno-racial communities and knowledgeable about issues of race,

gender, power and privilege, that people of colour are involved in planning, implementing and evaluating these services and that services are appropriate to the needs of communities of colour."<sup>[27]</sup>

## VI. Clinical Decision Making and Health Outcomes

The NIH *Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities* outlines, in a nutshell, the issues in this section, and in fact in this entire paper:

there is compelling evidence that U.S. minority populations suffer from increasing differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions. These health disparities include shorter overall life expectancy, higher rates of cardiovascular disease, cancer, infant mortality, birth defects, asthma, diabetes, stroke, sexually transmitted diseases, oral diseases and disorders, and mental disorders among others. Contributing factors include reduced access to health care, increased risk of disease and disability due to occupation or exposure, and increased risk of illness due to underlying biological, socioeconomic, ethnic, or familial factors; cultural values, and education.<sup>[28]</sup>

There are a great number of studies showing differential clinical decision-making and even more studies showing differential health outcomes for minorities, particularly visible minorities.

### A. Clinical Decision-Making

A number of studies have shown lower rates of surgeries for racialised groups as compared to non-racialised groups, as well as differences in the provision of basic clinical care.

In a U.S. study on the use of cardiovascular procedures, tapes of actors portraying patients in scripted interviews about their symptoms were shown to physicians to eliminate confounding variables, and researchers found that the race and sex of a patient independently influenced how physicians managed chest pain.<sup>[29]</sup> Such disparities extend beyond surgical procedures to basic care. In addition, Hargreaves found that "[b]lack people, women, and the poor are less likely to receive inexpensive and proven therapies for treatment of acute myocardial infarction than other patients."<sup>[30]</sup> Although an American study, these results show that physicians were less likely to administer cheap, proven therapies, even when Medicare covered the cost of treatments. However, as Geiger notes, in nearly all cases of documented disparity, the differences in treatment do not reflect conscious bias.<sup>[31]</sup>

Differences in diagnosis and treatment may also come from a lack of experience with individuals from minority groups. Recognising clinical signs in skin (jaundice, cyanosis, pallor, rashes, inflammation, bruising), for example, can be very difficult if the patient is dark skinned and the doctor has never been trained to recognise these signs in anything but light skin.<sup>[32]</sup>

### B. Health Outcomes

The ACPH report, *Toward a Health Future*, outlines a number of health disparities with respect to First Nations people. For example, the infant mortality rate for First Nations is twice as high as that for the Canadian population, and the prevalence of major chronic diseases including diabetes and heart disease is significantly higher in Aboriginal communities.<sup>[33]</sup>

The Morehouse study on *Racial and Ethnic Differences in Access to Medical Care* summarised racial and ethnic inequalities for a number of different diseases even after controlling for confounding variables. For example, African Americans are between 41 and 73 percent less likely than whites to receive particular drug agents for the treatment of HIV/AIDS, even after adjusting for age, sex, mode of HIV transmission, insurance, residence, income and education.<sup>[34]</sup>

The NIH too, outlines some startling statistics. For example, they note that, even when controlling for socio-economic factors, the infant mortality rate is twice as high among African Americans as among Caucasians.<sup>[35]</sup> As with the Morehouse study, a variety of diseases and conditions are addressed in the NIH study, but are not outlined here. Although both of these studies are American, given that such inequalities often exist regardless of insurance or income level, we may infer that Canadian statistics will be similar.

## VII. Conclusion

The evidence of inequality in the health sector is generally very subtle. The challenge, then, is to distinguish between all the factors at play in ethnocultural health differences.

Though access to health care poses subtle discrimination problems, such problems can often be more difficult to remedy than overt discrimination. As Mock and Laufer have stated: "Racism is systemic. The individual need not personally or consciously do anything to maintain institutional racism but if nothing is done to actively oppose racism, nothing will change."<sup>[36]</sup>

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<sup>[1]</sup> A. Henley & J. Schott, *Culture, Religion and Patient Care in a Multi-Ethnic Society: A Handbook for Professionals* (London: Age Concern England, 1999) at 47.

<sup>[2]</sup> Advisory Committee on Population Health (ACPH), *Toward a Healthy Future: Second Report on the Health of Canadians* (Ottawa: Minister of Public Works and Government Services Canada, 1999) at ix.

<sup>[3]</sup> A.M. Epstein & J.Z. Ayanian, "Racial disparities in medical care" (2001) 344:19 *New England Journal of Medicine* 1471-1472 at 1472.

<sup>[4]</sup> Health Canada, *What Determines Health?* (2001) online: Health Canada <http://www.hc-sc.gc.ca/hppb/phdd/determinants/>.

<sup>[5]</sup> *Ibid.*

<sup>[6]</sup> ACPH, *supra* note 2 at x.

<sup>[7]</sup> Health Canada, *supra* note 4 .

<sup>[8]</sup> G.-E. Galabuzi, *Canada's Creeping Economic Apartheid: The economic segregation and social marginalisation of racialised groups* (Toronto: CSJ Foundation, 2001) at 70.

<sup>[9]</sup> [1998] F.C.J. No. 432 (T.D.).

<sup>[10]</sup> J.G. Reitz, *A Review of the Literature on Aspects of Ethno-Racial Access Utilization and Delivery of Social Services* (1995) online: CERIS [http://ceris.metropolis.net/frameset\\_e.html](http://ceris.metropolis.net/frameset_e.html) at 6.

<sup>[11]</sup> M. Meana et al., *Report on CERIS-funded Study: Identifying Barriers and Incentives to Breast Cancer Screening in Tamil Immigrant Women 50 Years and Over* (2000) online: CERIS

[http://ceris.metropolis.net/frameset\\_e.html](http://ceris.metropolis.net/frameset_e.html).

[12] L. Yuan et al., *Health Status and Health Care Access for the Arab Community in Toronto: A Pilot Study to Assess Health Needs* (2000) online: CERIS [http://ceris.metropolis.net/frameset\\_e.html](http://ceris.metropolis.net/frameset_e.html).

[13] E.G. Pask & M. Yoshida, "General Health Issues throughout the Life Span" in R. Masi, L. Menash, & K. A. McLeod, eds., *Health and Cultures: Exploring the Relationships*, vol. 2 (Oakville, ON: Mosaic Press, 1993) 25 at 37.

[14] [1997] 3 S.C.R. 624.

[15] I. Hyman, "Immigration and Health" Health Policy Working Paper Series (Ottawa: Minister of Public Works and Government Services Canada, 2001) at 111.

[16] R. Jayaratnam, "The Need for Cultural Awareness" in *Access to Health Care for People from Black and Ethnic Minorities*, (London: Royal College of Physicians of London, 1993) 11 at 13.

[17] Pask & Yoshida, *supra* note 13 at 36.

[18] C.G. Helman, *Culture Health and Illness: An Introduction for Health Professionals*, 3rd ed. (London: Butterworth-Heinemann, 1994) at 111.

[19] *Ibid.* at 135.

[20] *Ibid.* at 112.

[21] S. Joffe, et al., "Quality of informed consent in cancer clinical trials: a cross-sectional survey" (2001) 358 (24 November) *The Lancet* 1 at 9.

[22] Reitz, *supra* note 10 at 6.

[23] Health Canada, *supra* note 4 .

[24] Reitz, *supra* note 10 at 19; see also Hyman, *supra* note 15 at 46.

[25] *Ibid.*

[26] A. Sharda, "Purchasing for the health of black and ethnic minority people: some theoretical considerations" in *Access to Health Care for People from Black and Ethnic Minorities* (London: Royal College of Physicians of London, 1993) 21 at 25.

[27] Across Boundaries, "Values and Beliefs" (2002) online: Across Boundaries Home Page <http://www.acrossboundaries.ca/content.php?ID=49>.

[28] National Institutes of Health (NIH), *Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities (Draft)* (Washington, D.C.: U.S. Department of Health and Human Services, 2000), online: NIH [www.nih.gov/about/hd/strategicplan.pdf](http://www.nih.gov/about/hd/strategicplan.pdf) at 4.

[29] K.A. Schulman, et al., "The effect of race and sex on physicians' recommendations for cardiac catheterization" (1999) 340:8 *New England Journal of Medicine* 618 at 618.

[30] S. Hargreaves, "Inequalities in clinical decision making for low-cost treatments" (2000) 356 (12 August) *The Lancet* 1 at 1.

[31] H.J. Geiger, "Racial stereotyping and medicine: the need for cultural competence" (2001) 164:12 *Canadian Medical Association Journal* 1699 at 1700.

[32] Henley & Schott, *supra* note 1 at 129-130.

[33] ACPH, *supra* note 2 at xiv.

[34] Morehouse Medical Treatment and Effectiveness Center (MMEDTEC), *A Synthesis of the Literature: Racial and Ethnic Differences in Access to Medical Care* (Menlo Park, California: Henry J. Kaiser Family Foundation, 1999), online: Kaiser Family Foundation <http://www.kff.org/minorityhealth/loader.cfm?url=/commonspot/security/ge...> at 2.

[35] NIH, *supra* note 28 at 5.

[36] K.R. Mock & A.S. Laufer, *Race Relations Training in Canada: Toward the Development of Professional Standards* (Toronto: Canadian Race Relations Foundation, 2001) online: Canadian Race Relations Foundation [http://www.crr.ca/EN/Publications/ResearchReports/pdf/ePub\\_BnaiBrithRpt...](http://www.crr.ca/EN/Publications/ResearchReports/pdf/ePub_BnaiBrithRpt...) at 10