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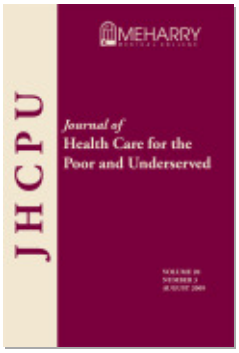

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The Health Status of Black Canadians: Do Aggregated Racial and Ethnic Variables Hide Health Disparities?

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Abstract: This paper examines the importance of collecting and reporting data on race and ethnicity in public health and biomedical research in Canada. Literature and available statistics related to social determinants of health were reviewed and analyzed to illustrate that minority populations in Canada, especially Blacks, are likely to experience poorer health outcomes. Statistics Canada in its commitment to multiculturalism uses broad categories such as *visible minorities* and *racialised groups* as surrogates for race and ethnicity. These categories, when used in health literature may conceal underlying inequities in health between population groups. Blacks and minority groups in Canada have higher rates of unemployment, lower rates of educational attainment, and lower socioeconomic status. Whenever Canadian data based on race and ethnic categories are reported, disparities are observed. The lack of disaggregated data may hide health disparities.

Key words: Canadian, African Americans, racial barriers, ethnic barriers, Black Canadians, visible minorities, health disparities.

Canada is often viewed as a particularly egalitarian society with a genuine commitment to comprehensive, accessible health care for all its citizens. Measured in terms of commonly used health indicators such as life expectancy and infant mortality, Canada ranks among the top three developed countries. Such distinctions have led to a tendency to assume the existence of fewer health disparities and socioeconomic inequities in Canadian society than in the United States.[1] One factor contributing to this supposition is the limited research investigating health issues in Canada within the context of race and ethnicity. The official discourse of multiculturalism makes it difficult to speak of race and racism in Canada. Thus, race and racism have been omitted from major Canadian debates in relation to health. One must consider the fact that under certain circumstances it is unlawful or objectionable in Canada to ask questions about race.[2] Literature also indicates that there are limitations associated with presenting race/ethnicity data in a way that does not stigmatize or imply a dichotomy between

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groups.[3] Despite these limitations, the benefit to the affected populations of collecting such information far outweighs any drawbacks since the existing parameters do not provide an opportunity to investigate health disparities thoroughly.

In the United States, the use of racial and ethnic variables in biomedical and public health research continues to illuminate health disparities between minority and majority populations. An important reason for collecting and presenting federal data on race and ethnicity in the U.S. was to enforce civil rights laws and to promote uniformity and comparability of data on race and ethnicity for different population groups. The U.S. Office of Management and Budget (OMB) sets forth standards for the classification of federal data on race and ethnicity. In its account of why it is important to collect data for populations that have historically experienced differential treatment due to their race or ethnicity, the OMB emphasizes the need to monitor equal assess to social goods such as housing, education, employment and health.[4] In the U.S., these standards are used by agencies such as the Centers for Disease Control and Prevention and the National Institutes of Health in all collection of data at the national level. This paper argues for a similar disaggregation of Canadian health data, since minorities, especially Black Canadians, are likely to suffer health disparities in relation to the majority population, comparable to those experienced by Black Americans. As in the U.S., inequities based on gender, race/ethnicity, and class relations are inextricably linked to the formation of the Canadian state.[5,6]

Though the need for such disaggregated data is important, to ensure that all Canadians equally enjoy the benefits of a well organized universal health care system, several theoretical and conceptual problems exist in the collection of data, which must be resolved. Of primary concern is a preference for the use of broad, intangible terms such as *visible minorities* and *racialised groups*.* The particular manner in which such terms are used may conceal or obscure more underlying systemic and structural problems. These terms, which are the most commonly used surrogates for race categories in health-related literature, must be reevaluated: they are inherently inadequate for analyzing disparities since they tend to merge very heterogeneous groups together (and thus are pejorative). Additionally, these terms ignore the historical and political experiences, and class and racial struggles of the people they designate.[5]

Though each minority group is counted in the Canadian census based on self-reported categories, the term *visible minority* continues to be used by Statistics Canada at the national level to report census data. According to Statistics Canada, *visible minority* is used to refer to people classified by the Employment Equity Act as being non-Caucasian or non-White. According to this Act, Aboriginal people are not considered to be visible minorities.[7] By amalgamating heterogeneous minorities of South Asian, East Asian, Middle Eastern, Latin American, and African descent into one group, data may be skewed and gaps between groups may be hidden. It is important for researchers to have accurate health profiles of groups that historically have endured inequities. For

* The term *visible minorities* is used specifically by Statistics Canada and Health Canada in the presentation of various data about minority populations.[7] The term *racialised groups* refers to the same populations as *visible minority* and is commonly used throughout Canadian literature that addresses race and ethnicity.[20]

this type of analysis, groupings such as *visible minority* or *racialised group* are inadequate and need further disaggregation by racial/ethnic categories to capture important differences in health outcomes. This disaggregation would give health professionals the tools needed to provide better service to these diverse populations.

Social Determinants

Generally, health research has been influenced by theories regarding non-medical determinants of health. Research indicates that circumstances other than the provision of health care—such as employment, income levels, and educational attainment—affect health outcomes.[8] These findings indicate that the establishment of universal insurance coverage for necessary medical health care services alone is neither enough to improve population health nor enough to prevent disparities. However, these social determinants of health continue to be ignored in the formulation of current health policy because the main emphasis is placed on medical determinants and curative treatment. The effects of racism, sexism, patriarchy, gender, and economic exploitation on marginalized populations are also important social health determinants that affect health outcomes. The combined effects of these relationships remain to a large extent ignored in the Canadian context.

In Canada, the term *social exclusion* has emerged and gained currency in the Canadian literature addressing these social determinants of health.[9] There remains strong evidence of social exclusion and discrimination based on race in the fields of education, employment, and housing.[10] Although the notion of social exclusion may be useful in sociological terms, it is rather sanitized and conceals deeper relations of exploitation, institutional racism, and gender bias in the delivery of health services. The term refers to the dynamic processes that lead to structural inequalities in access to social, economic, and political resources. More centrally, it refers to the inability of some individuals, households, and communities to enjoy the benefits of full participation in society, and facilitates a deeper analysis of deprivation and disparity. Marginalized access to employment, adequate housing, educational attainment, political processes, and social goods and services lead to various risk conditions and behaviors associated with negative health outcomes, such as illness and chronic disease.[9,11]

Globally, the positive correlation between socioeconomic status (SES) and negative health outcomes has been well documented. Numerous studies conducted among various populations confirm this link.[12–14] Socio-economic factors have an even greater impact on health outcomes than factors such as access to health care services and behavior modification.[15] The higher the level of economic inequality existing within a society, the lower the health status and the higher the death rates among its population.[16,17] These associations, together with observed socioeconomic disparity, raise questions about the actual health status of visible minorities, in particular Black Canadians.

Black Canadians, Visible Minorities, and Vulnerable Groups

Using the categories that are available in Canada, differences between the majority White population and other groups are evident. Visible minorities and other vulnerable

groups experience higher rates of poverty, low education, poor living conditions, and poor working conditions, which often result in chronic diseases such as hypertension and obesity, excessive smoking and alcohol consumption, substance abuse, physical inactivity, poor diet, depression, and prolonged stress due to racism and exploitation. Poverty levels among these populations are twice as high (19%) as those of White Canadians (10.4%).[18] In 1995, racialised groups experienced twice the rate of poverty; 35.6% lived below the poverty line, compared with 17.6% in the rest of the Canadian population (i.e., White Canadians, Non-visible minorities, and Aborigines).[19] The rate of poverty among racialised groups in Canada's urban centers was 37.6%, compared with 20.9% for the rest of the population.[20] Though various studies have confirmed that visible minorities suffer disadvantages within the Canadian labor market[21,22,23] which may indicate persisting discriminatory practices, data on associated health disparities are limited. Beyond documenting that people living in poverty experience worse health status, there has been little consideration of the relationship between inequality and health in Canada.[24]

To appreciate the effects of non-clinical determinants of the health status of Black Canadians in particular, it is important to evaluate the historical underpinnings which contributed to their marginalization. The size of the Black population in Canada has long been in doubt due to gaps in official counts, and because precise reporting of such data was not a priority for researchers with respect to statistical gathering since the numbers were relatively small. This was not corrected until the 1966 census. In the 2001 census, 662,215 Canadians identified themselves as Black (approximately 2% of the entire Canadian population). The majority of Black Canadians (approximately 78.4%) live in five Canadian cities: Toronto, Montreal, Ottawa, Vancouver, and Halifax. Blacks constitute the third largest visible minority group in Toronto, after Chinese and South Asians, respectively. In Montreal, the Black population is half that of Toronto, and constitutes the largest visible minority group.[6]

It has been documented that Black Canadians earn less money on average than the Canadian population as a whole.[19,23] Additionally, research indicates that Black Canadians have the lowest relative earnings (67.6%) of any racial group in the country. The unadjusted relative earnings of native-born Blacks were found to be 29.8% less than those of White Canadian-born paid workers.[23] The most pronounced evidence of socioeconomic disparity between Canadian citizens is the statistically significant gap in wages experienced by Blacks, particularly Black men. Among native-born visible minorities, a significant wage disadvantage is only found among Black men. A wage differential of 19% is evident between Black men and men who are not members of a visible minority group, even after the effects of variables such as current labor market activity, immigration, language, location, aboriginal status, marital status, self-employment status, and occupational level are controlled.[22] Hum and Simpson cite the 1996 census, which reveals that Black Canadian men and women in the Toronto area earned respectively 70.8% and 80.8% of the average income of White Canadian men and women. In addition, the unemployment rate for Blacks in Toronto was 32%, twice as high as that of the general population. The impact of income inequality on health status has been well established;[12,16,23,25] countries with wider income differences have poorer health outcomes.[15]

Whenever data are collected in Canada based on race, disparities are observed. One study that did disaggregate data based on specific racial variables in five cities across Canada found that, among visible minority populations, Blacks were most likely to report having experienced racial discrimination in the labor market and workplace.[26] Other studies have confirmed this relationship between skin color and social exclusion.[27–30] Discrimination based on race has been identified as a common reason for marginalization, yet much of the health research and the health system fail to appreciate the dimensions of social exclusion encountered by these marginalized groups, as noted earlier.

Commentary

The social landscapes for Blacks and other minority groups in Canada are extremely varied, and broad generalizations are inevitably flawed. Ethnically distinct groupings are important to targeting research efforts and interventions to specific populations. Lumping such groups together by using a single label ignores rich diversity that we should seek to understand. Priority consideration in health policy, health planning, and health research is warranted for these vulnerable populations, which are known to have higher disease risks.[31]

Despite the undeniable overall quality of the Canadian health care system, gaps in various sociological areas could foretell the existence of health disparities. The documented disparities that exist between Whites and visible minorities in income and socioeconomic status suggest the possibility of negative effects on health outcomes. In the past, Canada's focus was not on addressing these determinants of health which are not directly related to the health care system. Although the health sector has recently begun to integrate these social determinants into health policy, other sectors such as finance, labor, and social services—which directly influence income, employment opportunities, and social supports to segments of this population—lag behind.[32]

Though universal health care has positioned the country well for addressing inequities in access to health services, the system is not structured for surveillance or elimination of disparities that may exist. The development of a research agenda that disaggregates conventional racial and ethnic categories is critical for the exposure of such disparities in health risks and outcomes.[33] Without access to credible, disaggregated health data, there are unanswered questions about the distribution of health benefits and the resultant health outcomes to minority groups within the society. The health statistics that are available may be skewed and reflect only an appropriate representation of the health of the White majority population, leaving doubt as to the health status of minority groups such as Black Canadians.

Understanding health disparities has long been a major component of public health research in the United States, yet little progress has been made toward narrowing or eliminating the disparities.[34] However in the U.S., unlike Canada, access to services remains a problem, since the U.S. lacks universal health care and health insurance is tied to employment. Beyond giving prominence to research documenting disparities, Canada, with its commitment to universal health care, may be better positioned than other countries to implement policy measures toward the exposure and elimination of

disparities. Efforts must now be made to collect data that will lead to a better understanding of differences in morbidity and mortality among racial and ethnic groups and to develop adequate explanatory models based on these disaggregated data. Given its global reputation as a model multicultural society, Canada should seek to remove any stigma of inequity from its robust health care system.

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