

Racialised Groups and Health Status:

A Literature Review Exploring Poverty, Housing, Race-Based Discrimination and Access to Health Care as Determinants of Health for Racialised Groups

INTRODUCTION

Racialised groups living in Toronto experience disproportionate levels of poverty, homelessness and inadequate housing, discrimination, and barriers to health care (Ornstein, 2000). Emerging research shows that the main determinants of health are neither medical nor behavioural but rather social and economic (Raphael, 2004), suggesting that these structural inequalities have serious health implications. Despite this evidence, little research addresses the impact of social determinants on the health of racialised groups in Canada.

Access Alliance Multicultural Community Health Centre (AAMCHC) and its partners received a one-year research development grant from the Canadian Institutes of Health Research to develop a long-term program of research to investigate the impact of income, housing, race-based discrimination and access to health care on the health status of racialised groups in Toronto; and to increase the capacity of community organisations, academics and other stakeholders to work collaboratively to develop proposals.

What has been particularly exciting about the “Racialised Groups and Health Status” initiative is that the research agenda has been in the hands of community organisations. It has been led by AAMCHC, which is a non-profit organisation that serves immigrants and refugees in the City of Toronto, and carried out in partnership with various community organisations, academic researchers, government representatives and other stakeholders who have worked together to develop sound and rigorous research projects that are intended to lead to action and change. The partners were organized into four working groups each addressing one of the following themes: Poverty, Racialisation and Health; Housing, Racialisation and Health; Race-Based Discrimination and Mental Health; and Access to Health Care for Racialised Groups. The approach they have taken is that of Community-Based Research (CBR). CBR aims to have a high degree of relevance to the community and seeks to bring about both understanding and change. Community involvement in the design and implementation of research is a condition for project success rather than an ad hoc research

component. It ensures that the goals, objectives and methods will be grounded in the realities of racialised communities.

As part of the process of setting research priorities, different bodies of literature (corresponding to the areas covered by each working group) were reviewed to gain an understanding of the information that is already available and to identify knowledge gaps that need to be filled. This review was guided by the interests expressed by working group members as well as by community members and service providers who participated in focus groups and popular education activities, including a forum on Community-Based Research, which took place in late 2004. In addition to using the literature review for our own proposal writing, we are pleased to make it available to other service providers, activists, researchers and community members who may want to draw on it to develop their own projects and initiatives to reduce health disparities.

POVERTY, RACIALISATION AND HEALTH

As a result of consultations with peer outreach workers and members of racialised communities, the Poverty, Racialisation and Health Working Group identified issues of contingent work, un- and under-employment as entry points for engaging racialised communities in exploring the relationships between income and health. The following review of the literature reflects this choice and while it starts with a general overview of the significance of income as a determinant of health, it then focuses on the barriers that racialised groups face in the labour market and on the health effects of precarious employment. We also point towards future directions for research.

Income as a Determinant of Health

Poverty is a major factor in people’s health, affecting access to basic needs, limiting the ability to fully participate in society, causing stress and restricting choices people can make (Benzeval, Judge & Whitehead, 1995; Raphael, 2002a; Williamson & Reutter, 1999). Social determinants of health are linked together and income plays an especially important role given its effect on

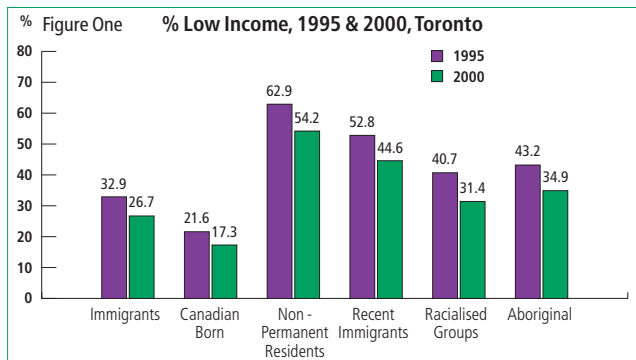
other determinants (Raphael, 2004). Research in both Canada and the United States reveals that there is a link between poverty and a range of health problems. For instance, Wilkins, Adams and Brancker (1989) found that Canadians living within the poorest 20% of urban neighbourhoods were much more likely to die from cardiovascular disease, cancer, diabetes, and respiratory diseases than other Canadians. Indeed, it is estimated that 23% of premature years of life lost to Canadians can be attributed to income differences, with heart disease and stroke being the diseases that are most related to income inequalities, despite widespread beliefs that they are largely caused by lifestyle choices, such as alcohol and tobacco use, diets high in cholesterol and lack of exercise (Raphael, 2001, 2002b & 2004; Dunn, 2002b). This arises because poverty is associated with “material deprivation” (i.e., lack of access to basic needs such as quality food and housing, and exposure to health threatening environmental conditions at home and at work) (Raphael, 2002a&b). When poverty is experienced over the life course (as opposed to occasional episodes), it is a particularly significant factor for health (Benzeval, Dilnot, Judge & Taylor, 2001).

Manifesting as depression, anxiety and other symptoms of psychological stress, low socio-economic status and poverty also negatively affect mental health (Beiser, Hou, Hyrnan, & Tousignant, 2002; Coburn, 2004). American, British, as well as Canadian studies have repeatedly found a positive correlation between low income and experiencing mental health issues (e.g., Beiser, Hou, et al., 2002; Nazroo, 2003; Raphael, 2001; Williams & Collins, 1995). A review of the literature on the influence of race, ethnicity, and poverty on the mental health of children, for example, found that children whose parents are in poverty or who have experienced severe economic losses are more likely to have higher rates of depression, anxiety, and antisocial behaviours (Samaan, 2000). Poverty is, indeed, a major barrier to the healthy development of children and youth. This has serious implications, given that one in six children live in poverty in Canada (Freiler, Rothman & Barata, 2004). The rate is worst for the City of Toronto, where 29% of children live in poverty (Statistics Canada, 2001).

Income inequality, however, does not only impact the health of the lowest income segment of society. Some authors argue that the distribution of wealth in a society affects the health of people at all income levels; higher income adults in more unequal communities or countries will have higher mortality and morbidity rates than those with a comparable income in a community with a more equitable income distribution (Raphael, 2001; Dunn, 2002b). A possible explanation is that income inequality weakens social infrastructure and cohesion (Raphael, 2002b). Following this argument, not only is health a universal right, equality is also in the best interest of society as a whole. Furthermore, Freiler et al. (2004) point to the importance of addressing the structural sources of poverty, as there will otherwise always be a risk of a new vulnerable group replacing others for whom progress is being made.

Racialisation of Poverty

Though there are many low-income White people, the significance of income as a determinant of health puts racialised groups in a particularly vulnerable position as the growing gap between the rich and poor is increasingly being defined along ethno-racial lines (Galabuzi, 2001). Recent studies have found that ethno-racial minorities in urban centres such as Toronto have significantly lower incomes than the general population, due to historical and present-day systemic discrimination, in the labour market for instance (Galabuzi, 2001). Taken as one category for purposes of comparison, racialised groups in Toronto have almost double the rate of low income as the general Canadian-born population – i.e., 31.4% vs. 17.3% (Statistics Canada, 2001). There are substantial differences within racialised groups (including various people of colour having high incomes) but looking at the population as a whole, those who are both racialised and recent immigrants or non-permanent residents are especially likely to fall in the low-income segment of the population (see Figure One). Galabuzi (2001) points out that the levels of poverty are worse for certain sub-groups such as racialised women, lone parents and particular ethno-racial groups.



Source: Canadian Council on Social Development, Statistics Canada Census Custom Tabulation, 1996 & 2001.

These disparities have been echoed in other data sources. The 2004 Report Card on Poverty in Ontario reports that children of visible minorities are among those hit disproportionately hard by poverty: while 23% of Ontario’s children are visible minorities, visible minority children make up 43% of children living in poverty (Ontario Campaign 2000, 2004). Children of recent immigrants are particularly affected with a child poverty rate of 47% as compared to 17% for all children in Ontario (Statistics Canada, 2001).

Michael Ornstein (2000) also documents very high levels of poverty among several ethno-racial groups from Africa, South Asia and Southeast Asia. He notes that ethno-racial inequalities found in the analysis do not derive from “essential” differences among cultures, but reflect particular historical processes including the period in which non-Aboriginal groups came to Canada and the circumstances of their migration.

Barriers in the Labour Market

The structure of the labour market is a major influence on people's income security. Contrary to popular belief, the *Report Card on Child Poverty in Canada* (Campaign 2000, 2004) points out that the majority of children who live in poverty have parents who actually participate in the labour market but in jobs that do not provide adequate pay, sufficient hours or benefits. For racialised groups, the labour market experience is often one of barriers; even with comparable education, they often face **limited mobility** and **discrimination** in the workplace, and they are over-represented in **low paid, low end occupations**, especially in the service sector and in precarious and **unregulated temporary** or **contingent work**, and under-represented in high paying occupations and sectors (Galabuzi, 2001; Lewchuck, de Wolff, King, & Polanyi, 2003; Ornstein, 2000). In addition, **unemployment rates** are higher among racialised communities - in 1996, overall rates were 13.2% for men and 15.3% for women in racialised communities compared to 9.9% and 9.4% in other communities (Galabuzi, 2001).

An Action Research project involving low income women of colour in Toronto found that the most important concerns for the women were poverty, low wages, unemployment and associated difficulties with social assistance (Khosla, 2003). They identified **lack of childcare, language barriers, and racism** as key obstacles to employment (Khosla, 2003).

Changes in the **structure of the labour market** impact immigrants in particular ways. In a knowledge economy, more importance is attached to professional credentials (Reitz, 2005). Higher educational attainment, however, does not guarantee a corresponding income. Indeed, immigrants, particularly those who are foreign-trained, face increasing barriers in trying to access the better paid knowledge occupations and managerial positions (Reitz, 2005). The unemployment rate is three times higher for university educated recent immigrants than the rate for Canadian-born people with a similar education. When they get a job, six out of 10 immigrants end up in work that is **not related to their qualifications**. As a result, one in four new male immigrants with a university degree are in low-wage, low education jobs. The rate is even worse for women, at almost 40% (Toronto Star, 12/03/2005).

The most cited barrier for immigrants getting work in their field is the lack of recognition of **foreign credentials** (e.g., Alboim, Finnie & Meng, 2005). The situation is complicated by **accreditation** and **licensing** bodies that work independently of each other (Reitz, 2005). Someone who has obtained the educational equivalency would not necessarily qualify for a license in his or her field because of such factors as perceived gaps in training or experience. The requirement from employers for Canadian experience, even when educational credentials and licensing have been attained, constitutes an additional

obstacle. It creates a vicious circle whereby one needs Canadian experience to get Canadian experience (Brouwer, 1999).

In addition, there is a concern that the Canadian experience requirement is a smokescreen for discrimination (Reitz, 2005). It is indeed possible that ethnic and racial stereotypes affect perceptions of immigrant qualifications (Reitz, 2005), even after requirements have been met. Furthermore, when they do gain access to professional fields, **glass-ceiling barriers** make it difficult for minorities to be promoted to more lucrative senior positions (Beck, Reitz & Weiner, 2002).

The barriers cited-above result in differential earnings. Though the net earnings are 12% to 16% lower for university educated men in the knowledge occupations than for those who are Canadian-born, the picture in the fields outside the knowledge sector is actually worse. In all other occupations, the gap is 25% to 34% lower. **Unequal earnings and job distribution** contribute to the overall **downward trend in immigrant earnings** (Reitz, 2003 & 2005) and compound the **income disparity** between dominant and non-dominant ethno-racial groups.

Furthermore, the labour market in Canada has been increasingly characterized by contract, temporary, insecure, and "flexible" employment – referred to as "**precarious**" or "**contingent**" work (de Wolff, 2000, p.4). Just over half (54.2%) of Canadian workers were employed in full-time jobs in 1998. The other 45.8% were employed in more precarious kinds of work arrangements: self-employment, part-time (in one or more jobs), and temporary (de Wolff, 2000). The research conducted by Alice de Wolff and her colleagues provides evidence that these forms of employment play a key role in "the creation and maintenance of ethno-racial segmentation in the city's workforce and an ethno-racial polarization in income" (de Wolff, 2000, p. i). Notably, most of the people relegated to unstable, part-time, and low wage work are new immigrants and racialised individuals, particularly women (Khosla, 2003).

A study on contingent workers in Toronto indicated that low wages were of highest concern to respondents as 69.4% of them earned less than \$1,500 per month, or a maximum of \$18,000 a year (de Wolff, 2000).

Health Effects of Precarious Employment, Unemployment and Underemployment

Galabuzi (2001) points out that precarious work leads to higher health risks from workplace injuries and lack of protection from hazards, resulting in such ailments as chronic pain and exposure to toxic substances. Research carried out in Canada by Wayne Lewchuk and his colleagues (2003) demonstrates that the health impacts of employment are in fact not limited to specific physical conditions in particular workplaces. Rather, there are a number of stresses associated with precarious work itself.

I have worked for these people since I came to this country but I am still so behind in my rent that I can't sleep at night. (A domestic worker in a suburb of Toronto, as quoted in Galabuzi, 2001, p. 98.)

In addition to being exposed to work hazards, contingent workers deal with ongoing insecurity, which leads to a great deal of mental stress: they “face high levels of uncertainty regarding access to work, the terms and conditions of that work, and future earnings. They engage in additional effort searching for work and balancing the demands of multiple employers.” (Lewchuk et al., 2003, p.34). In addition, the pay is often based on completed tasks rather than hours or salary and the workers often have to provide their equipment and training at their own expense. The overall low earnings, coupled with the scarce benefits, add to the stress of workers’ ability to pay for family necessities (Lewchuk et al., 2003). Not surprisingly, the study notes that people in contingent working situations rated their health at lower levels in the National Population Health Survey than those in other work and that **stress related tension and exhaustion** emerge as their most serious health issues (Lewchuk et al., 2003). The issue of stress also figured as the most significant factor in a study of contingent workers by Alice de Wolff (2000), which also found that only 30% of participants received sick pay, two thirds were not covered by the Workers’ Safety Insurance Board, and most worried that they did not receive adequate health and safety training or equipment when they went into a new workplace. Furthermore, participants spoke of workplace discrimination and harassment based on race, gender and age. As the study notes, contingent workers are particularly vulnerable because they have little to no legal or union protection, as well as little access to workplace complaints processes (de Wolff, 2000).

While some attention has been paid to the health effects of precarious employment and to a lesser extent unemployment (e.g. Price, Choi, Nam & Amiram, 2002; Rodriguez, Allen, Frongillo & Chandra, 1999), we still know very little about the effects of underemployment (as largely caused by systemic barriers such as the lack of recognition of foreign credentials and experience) on the mental health of immigrants and other racialised groups and their families.

Income as a Determinant of Health for Racialised Groups

Despite the evidence that suggests that poverty is becoming increasingly racialised in Toronto and Canada and that income inequalities are bad for health, there is a dearth of research that addresses the impact of socio-economic determinants on the health of racialised groups in this country. The mediating factors between race/ethnicity, social class and health status are not well understood (Nickens, 1995). Ethno-racial health disparities have been documented in the U.S. and the U.K but they have mostly been explained by cultural and genetic factors without recognizing the significance of socio-economic

inequalities (Nazroo, 2003). In particular, little research has addressed the health consequences of the barriers that racialised people experience in the labour market.

Future Research Directions

The relationship between income, racism and health is certainly an area that requires research as no studies have actually been conducted in Canada looking at the interaction between these three variables. Of particular need is community-based research (CBR), through which racialised people, who have been socially excluded, can be recognized as knowledge producers and contribute to building richer understandings of health inequalities and to finding solutions to address poverty and improve health. The following are suggested areas for future research. To ensure the quality of the research, participation by racialised groups is required in all steps of any of these research ideas.

- Qualitative research about the lived experience of specific low-income racialised groups and documentation of the ways in which income insecurity directly and indirectly affects their health;
- Longitudinal studies of the impact of income-related issues upon the health of racialised groups across the life-span;
- Research on the health effects of racism and **racialisation** and analysis of the role of intersecting oppressions (e.g. sexism, racism, etc.) in creating ethno-racial health inequalities;
- Exploration of the links between the characteristics of precarious work, unemployment, underemployment and health outcomes for racialised groups and their families;
- Focus on knowledge needed for individual and collective action to avoid preventable illness, injury and premature death and to remove barriers to health;
- Research on the links between income inequalities and mental health;
- Tracking of indicators related to ethno-racial health disparities and documentation and dissemination of evidence of ethno-racial health disparities in order to advocate for greater resources to address the health priorities of racialised non-dominant groups;
- Development of data collection tools and strategies that are explicitly anti-racist;
- Identification of the most important determinants of health on which to act to effect changes that will reduce infection, stress and illness; and
- Examination of effective policy interventions to reduce poverty and income inequality.

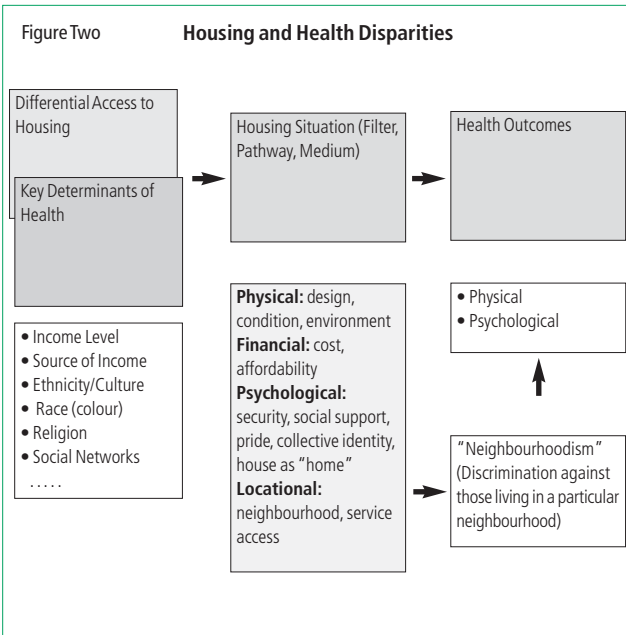
Key Resources

- Galabuzi, G.-E. (2001). *Canada's Creeping Economic Apartheid: The Economic Segregation and Social Marginalisation of Racialised Groups*, Toronto, ON: CSJ Foundation for Research and Education. Available at: http://www.atkinson.yorku.ca/ace/ace_publications.html
- Raphael, D. (ed.) (2004). *Social Determinants of Health: Canadian Perspectives*. Toronto, ON: Canadian Scholars Press Inc.

- Reitz, J. G. (2005). Tapping Immigrants' Skills: New Directions for Canadian Immigration Policy in the Knowledge Economy. *Choices*, Institute for Research on Public Policy (IRPP), 11 (1).

HOUSING, RACIALISED GROUPS AND HEALTH STATUS

While there is a growing body of research that explores the relationship between **housing and health** in Canadian cities, and a similarly growing body of research on the **housing experiences of immigrants, refugees and racialised groups**, there is limited research that explores housing as a social determinant of health of racialised groups. This working group's review of the literature has led to the development of a diagram, which provides a perspective on the relationship between housing and health disparities (see Figure Two). Rather than providing a comprehensive review of existing research, we present this diagram, indicating how it has been informed by the literature. We then follow by pointing to some of the gaps in our understanding of the interactions of racialisation and housing and their impact on the health of racialised groups.



The ultimate objective of the diagram, as indicated by the box in the upper right corner, is to determine the way in which health outcomes, both physical and psychological, are affected by a person's housing situation. The initial argument is that a number of aspects of an individual's housing situation may affect health and general well being. These include a) the physical characteristics of the house (e.g., design, condition, space, air quality, and immediate environment), b) the financial situation (e.g., cost, affordability), c) psychological well being (e.g., safety/security, social support, collective identity, house as 'home', refuge, etc.) and d) locational issues (e.g., neighbourhood and broader social and community context, availability of and access to social and health services and educational opportunities, exposure to environmental hazards, etc.).

Housing Dimensions

The physical and financial characteristics of housing are related to Canada Mortgage and Housing Corporation's three components of appropriate housing, as identified in its Core Housing Need Model: adequacy, suitability and affordability (Canada Mortgage and Housing Corporation, 2004). Adequacy refers to the physical quality of the dwelling, suitability to the appropriateness of the dwelling for accommodating a particular size and type of household, and affordability to the relation between shelter cost and income. The way in which these characteristics affect health and well-being is not always clear. However, there is strong causal evidence in the housing and health literature between **physical**, biological and chemical exposures (e.g. lead, radon, asbestos, cockroaches, and extreme temperatures) and health status (Wilkinson, 1999). For instance, it is apparent that dampness and mold can exacerbate allergies and other respiratory conditions, and that overcrowding can have negative impacts on both physical and mental health (e.g., Dunn, 2002a; Hwang, Fuller-Thomson, Hulchanski, Bryant, Habib & Regoeczi, 1999). Indeed, while housing density has implications on physical health contributing to the spread of infectious disease, some studies also explore the mental health implications of housing density and crowding (Moloughney, 2004).

Housing **affordability and tenure** are two of the financial characteristics of housing. High rent-to-income ratios, especially for low-income families, can lead to fewer financial resources for other essentials of life such as food, utilities, medication, clothing and transportation, with ultimate consequences for physical and mental health (e.g., Moloughney, 2004; Murdie, 2003). These **'trade-off'** choices have begun to emerge in affordable housing advocacy and public policy campaigns (e.g., Feed the Kids and Pay the Rent Campaign at <http://dawn.thot.net/rent.html>). The stress caused by the obligation to make such trade-off choices still warrants further research. In addition to affordability, some attention has also been paid to tenure patterns. Many studies indicate that homeowners enjoy better health. This could be due to indirect benefits such as less exposure to, or more control over, physical hazards (asbestos, mould, etc.), or psychological advantages such as a sense of ownership and control, or improved access to services due to location (Moloughney 2004). However as homeowners generally have higher socio-economic status, home ownership may be acting as a proxy measure for income and social status. Therefore, the connection between tenure and improved health status is one that needs further investigation.

The other two characteristics of the housing situation are not explicitly identified in the Core Housing Need model. One is characterized by **psychological** considerations, particularly the distinction between house as a roof over one's head and **'home'** as a more abstract notion – a comfortable, cozy, safe and enjoyable place to be. There is less research about this dimension of housing than about its physical aspects, perhaps because it is more difficult to measure. James Dunn (2005), a leading researcher in the housing

and health field, refers to the 'meaning of home as one of the most important sites for the construction of meaning in our lives.' He further explains that the notion of home plays a significant part of one's identity and that social ties are connected to home. For immigrant households, for instance, 'home' can relate to the safety and security associated with a new environment, the availability of social supports, and the pride associated with welcoming guests into their 'home'. Turning a house into a 'home' is also an important measure of immigrant integration and an essential indicator of satisfaction and well being (Murdie, 2004). People who are more satisfied with their housing tend to have a better health status but the relationship between satisfaction and health and the variables that are specifically impacting on housing satisfaction are unclear (Moloughney, 2004).

The final characteristic of housing concerns the **locational** aspects of the dwelling –the extent to which the local **neighbourhood** functions as a 'community' where one feels a sense of belonging and that provides convenient access to good quality services. The latter is also related to the extent to which the neighbourhood is marginalized or stigmatized from the rest of the city, identified in the box in the lower right corner of the diagram as '**neighbourhoodism**', or discrimination against those living in a particular neighbourhood (Novac, Darden, Hulchanski & Séguin, 2002). Some long-term studies have observed that the quality and availability of institutions (e.g., schools and community services), the relationships and networks among members in the neighbourhood, and the community norms, influence the health outcomes of community residents. However, more research is needed to explore the links between housing and neighbourhood conditions on the psychological dimensions of health.

Interaction of Housing with Other Determinants of Health

An individual's housing situation is not the only variable that affects health and well-being. As shown earlier, there is a strong relationship between income and health, leading to lower income people generally having poorer health outcomes. Likewise, as will be indicated in the Access to Health Care section of this literature review, financial, cultural, language, geographic and systemic barriers to the health care system also have an impact on health. In that respect, an individual's housing situation may act as a filter or pathway through which other variables operate, as illustrated by the middle panel of the diagram. The housing situation may impact directly on health outcomes or it can exacerbate the effect of other variables such as income (e.g., if nearly all of a household's income goes to pay the rent, little is left for food, which then leads to health problems) and access to services.

As represented by the left panel in the diagram, access to good quality and affordable housing is affected by several of the variables that also influence health outcomes. For many groups and individual households these characteristics emerge as **barriers in their search for appropriate housing**. New

Canadians, in particular, are likely to experience multiple aspects of disadvantage resulting from these barriers. Examples of barriers that have emerged in studies of the housing experiences of immigrant groups in Toronto include level of income, source of income (e.g., social assistance), ethnicity/culture, race (skin colour) and religion (Dion, 2001). Level of income is important because most landlords require prospective tenants to spend no more than thirty percent of their monthly income on rent. The argument is that if a household spends more than thirty percent of income on shelter there will not be much left for essentials such as food, clothing, and transportation and the probability of default on the rent will increase. If a potential renter cannot provide proof of income from employment, it is quite difficult for them to access decent and affordable housing (Murdie, 2005). In addition to source of income, many landlords have a negative view of persons on social assistance and may also discriminate against persons because of their race or their cultural or religious background. These factors, either alone or in combination, can lead to poorer quality and less affordable housing that in turn can lead to negative health outcomes.

Towards a Better Understanding of Housing as a Determinant of Health for Racialised Groups

Though there is much variation across and within racialised groups, it has been pointed out that the racialised population as a whole is disproportionately represented in lower income classes (Ornstein, 2000; Galabuzi, 2001), leading to a high percentage of racialised groups, most especially recent newcomers, living in Canada's poorest neighbourhoods, often in substandard, marginal and over priced housing (Kazemipur & Halli, 2000; Ley & Smith, 2000). Grace-Edward Galabuzi (2001) argues that members of racialised groups continue to experience residential segregation even when their economic status improves.

It must be pointed out, however, that there is debate over the advantages and disadvantages of residential concentrations of particular ethnic groups (e.g., Germain & Gagnon, 1999; Novac, 1999; Qadeer, 2003, 2004 & 2005). Middle and upper income groups, who have the power to choose where to live, may choose to acquire housing in areas where a high proportion of residents from their ethnic background reside, thereby potentially having access to more support, services in their language, foods from their homeland, etc. Over-representation of racialised groups and immigrants in low-income neighbourhoods, however, might act as a barrier to economic success, hamper children's education opportunities and raise overall health risk (Carter & Poleyvchok, 2004; Galabuzi, 2001). Jasmin Zine (2002) also found that having fewer options in the housing market places people in neighbourhoods characterized by less opportunities and a more limited range of services. While some research has examined the impact of neighbourhoods on the educational, professional and employment prospects of immigrants (e.g., Galster, Metzger & Waite,

1999), no research has examined the health impacts of housing specifically on racialised groups or the interactions of race, housing and health status in the Canadian context.

Most of the Canadian literature that explores the relationship between racialised groups and housing has looked at areas such as housing access (including perceptions of discrimination), processes in acquiring housing, and housing mobility (e.g., Hulchanski, 1997). To a lesser degree, there has also been research on the residential patterns of certain groups (e.g. Lo and Wang, 1997; Owusu, 1999). There is evidence of differential access to housing based on level and source of income, language/accents, race/ethnicity, immigrant and refugee status, religion, household size and gender (e.g., Dion, 2001), affordability being a major problem for various ethnic groups (e.g., Murdie, 2003). The need for a guarantor is also a major obstacle in obtaining housing (Murdie, 2005). In a study she conducted among Latin Americans and Muslims in Toronto, Zine (2002) also found that lack and source of income were the most important factors in housing discrimination followed by language difficulties, number and age of children, lack of knowledge about housing, and race.

A few studies have also researched the housing conditions of newcomers in Toronto and found high levels of dissatisfaction with housing conditions (e.g., Murdie, 2002a, 2002b) as well as high levels of overcrowding among certain groups (Alfred & Sinclair 2002). Thirty percent of newcomers who participated in Alfred and Sinclair's community-based study (81% of whom were of Chinese descent) reported that they did not have enough space and 39% reported that they did not have enough privacy. Overall, 79% of the respondents reported that their living conditions were poor or unsatisfactory. The most commonly reported problems were rats and roaches, poor ventilation and shortage of hot water (Alfred & Sinclair, 2002).

A CBR project led by Access Alliance Multicultural Community Health Centre (2002) identified immigrants and refugees in Toronto (most of whom are members of racialised groups) as a high-risk group for **homelessness** because of the multiple barriers they face in accessing housing (i.e., lack of affordable and adequate housing, discriminatory attitudes and practices among landlords, and lack of linguistically appropriate services in the settlement and shelter sectors). Another CBR project that took place in Toronto found that visibly homeless women had higher rates of arthritis/rheumatism, allergies/hay fever, emphysema and chronic bronchitis, hypertension, asthma, heart attacks, epilepsy, head injury, diabetes, and stroke (Kappel Ramji Consulting Group, 2002). The report notes that the health of hidden homeless women is at-risk primarily from poverty; substandard housing (including poor sanitation and poor indoor air quality); sexual harassment and violence; exposure to physical, chemical, and biological hazards; stress; hunger and poor nutrition; and higher

rates of hospitalization. Although the study does not focus specifically on ethno-racial minority women, 67% of the respondents identified their race as other than "white." Most notably, 15% of the women self-identified as Aboriginal, 23% as black, and 13% as South Asian. The study indicates the need for research on the impact of housing status (including homelessness) on the health of racialised groups (Kappel Ramji Consulting Group, 2002).

Future Research Directions

Though there are growing bodies of research about the impact of the different dimensions of housing on health, and about racialised groups', particularly newcomers', access to appropriate housing (and lack thereof), we still know very little about the nature of the relationships between the process of racialisation and housing trajectories and their impact on the health status of racialised groups. In particular, there is a need for the following types of research projects:

- Involving racialised community members in defining the meaning and impact of racialisation in a way that does not further marginalize, homogenise or stigmatize them and the communities they live in;
- Exploring the different levels at which racism and discrimination might operate in relation to housing and health, that is both in getting access to housing and once in housing: e.g., what historical factors and barriers have led to the concentration of racialised groups in particular neighbourhoods (e.g. changes in the housing and labour market, discriminatory attitudes faced when looking for housing, or racism that might act as a structural barrier to obtaining adequately paid employment)? How do ethnic enclaves come about? What compounds people's marginalisation once they are in a particular neighbourhood?;
- Evaluating the **trade-offs** that people have to make to pay for housing (e.g. having less available for food, medicines and education) and the impact these have on their health: How do people allocate their income? Is it less of a trade-off to be in public housing? What policies and services could help alleviate the strain (e.g., budgeting and financial planning workshops, better food access, etc.)?;
- Documenting the impact of adequate housing (or lack thereof) on the **mental health** of racialised groups, taking into consideration the **four dimensions** of housing (physical, financial, home and neighbourhood);
- Making a case for the **benefits of good housing**: What do racialised communities like about their housing? What they would like to see more of? How does improved housing impact overall quality of life?
- Exploring the connections between tenure patterns and health of racialised groups;
- Using a life-course perspective to explore the direct and indirect effects of housing on child and youth development, and on later health (Dunn, 2002a);

- Evaluating the health impact of housing interventions for vulnerable sub-groups of racialised populations, such as newcomers, children, low-income families, and seniors;
- Identifying possible linkages between housing and health policies (Bryant, 2004), providing convincing evidence of the impact of good housing policy on health and showing whether the long-term benefits of housing can balance out its costs: e.g., the alleviation of the strain on the health care system (Carter and Polevychok, 2004);
- Developing a more complex understanding of the advantages and disadvantages of ethnic enclaves: e.g., what opportunities do ethnic enclaves provide in terms of support?
- Paying attention to the positive: e.g., what explains the resilience of racialised families and individuals in the face of adversity?

Key Resources

- Dunn, J. (2002). *A Population Health Approach to Housing: A Framework for Research*. Ottawa, ON: Canada Mortgage and Housing Corporation.
- Moloughney, B. (2004). *Housing and Population Health: The State of Current Research*. Ottawa, ON: Canadian Institute for Health Information & Canadian Mortgage and Housing Corporation.
- Novac, S., J. Darden, D. Hulchanski and A-M. Seguin (2002). *Housing Discrimination in Canada: What do we know about it?* Toronto, ON: Centre for Urban and Community Studies, Research Bulletin #11.
- Zine, J. (2002). *Living on the Ragged Edges: Absolute and Hidden Homelessness Among Latin Americans and Muslims in West Central Toronto*. Toronto, ON: Informal Housing Network.

Recommended Website

Housing New Canadians:
<http://www.hnc.utoronto.ca/intro/index.htm>

RACE-BASED DISCRIMINATION AND MENTAL HEALTH

The close connection between *mental health* and race-based *discrimination* is too often overlooked or inadequately conceptualized in terms of psychopathologies rather than within the context of *racism* and a racist society. Individuals tend to be psychopathologised and therefore blamed for their mental health state while the role and adverse effects of *structural racism* and racial stratification on the mental health of racialised populations remain largely unexplored and neglected in research (as noted by Brown, 2003; Fernando, 2002; Karlsen & Nazroo, 2002a; Krieger, 2000 & 2003). Yet a few existing studies point to a significant relationship between discrimination and mental health issues such as depression, anxiety, and stress for certain individuals and groups (e.g., Canadian Mental Health Association, 2000; Gee, 2002; Harrell, Hall, & Taliaferro, 2003). Lack of access to culturally appropriate services, for example, is one way in which race-based discrimination indirectly contributes to the deteriorating mental health state of some racialised individuals. This review

of the literature points to key findings in the area of race-based discrimination and mental health and to directions for future research.

The Literature's Main Areas of Focus

The number of studies explicitly documenting how discrimination can harm health remains very small (Krieger, 2000). An overview of the literature concerned with discrimination reveals that a number of studies focus on individual-level health outcomes. Some studies approach the link between mental health and discrimination from the angle of perceptions. That is, they concern themselves with the ways in which perceived racism or discrimination impact on health (e.g., Brown, 2001; Noh & Kaspar, 2003).

With the realisation that social structures impact psychological health (Brown, 2003), individual-level mental health problems are increasingly linked to macro-level social processes and structural factors (e.g., Karlsen & Nazroo, 2002a; Williams & Collins, 1995). A few studies therefore challenge individualistic and psychopathologising perspectives on the differences in health for racialised populations by focusing their attention on structural factors such as racism in exploring the relationship between various health indicators and mental health stress (e.g., Gee, 2002; Karlsen & Nazroo, 2002b; Harrell et al., 2003; Khosla, 2003; Nazroo, 2003). Some of them argue that some mental health problems can be conceptualised as coping mechanisms (Fernando, 2002 & 2003; Noh & Kaspar, 2003). In other words, what appears to be a symptom of a mental illness may be a strategy used in the face of structural issues. This confusion of coping strategies with psychopathologies may partly be attributed to "ignorance of cultural contexts" and "racist attitudes that invalidate the authenticity of some form of behaviour or thinking" (Fernando, 2002, p. 69).

On discrimination and misdiagnosis in psychiatry:

"Second generation black people were given the schizophrenia label at high rates. An immunological/virus theory was proposed as an explanation for this "high incidence" of schizophrenia among black people, rather than looking at issues of racism that were brought forward by critical psychiatry advocates" (Fernando, 2003, p. 54).

The area of research concerned with racism and health is one that is filled with much debate. Lack of consensus exists with respect to the extent and severity of adverse effects on mental health; inter- and intra-group differences; the role of gender as opposed to 'race'; the influence of 'class' versus 'race' or racism; the causal link between racism and health; the conceptualisation of racism; the measurement of racism and its manifestations; and the specific processes whereby race-based discrimination exerts detrimental effects on health (Anand, Yusuf, et al., 2000; Blank, Dabady, & Citro, 2004; Coburn, 2004; Krieger, 1996; Krieger, 2003; Meyer, 2003; Nickens, 1995).

"[T]he rationale for studying health consequences of discrimination is to enable full accounting of what drives population patterns of health, disease, and well-being, so as to produce knowledge useful for guiding policies and actions to reduce social inequalities in health and promote social well-being." (Krieger, 1999, p.297)

Key Findings from the Literature

There is evidence to believe that racism, and the different ways in which it manifests itself in society, has various independent detrimental effects on health (Gee, 2002; Harrell et al., 2003; Karlsen & Nazroo, 2002b; Krieger, 2003; Nazroo, 2003). That is, social and economic inequalities, underpinned by racism, play a fundamental role in ethno-racial inequalities in health (Nazroo, 2003). Using data from the Fourth National Survey of Ethnic Minorities, Karlsen and Nazroo (2002b), for example, found that experiences of racism - as opposed to ethnic identity - are directly related to health outcomes, regardless of which health indicators were employed. Mental health is an aspect of health that is particularly impacted. In fact, a review of 20 studies in the American public health literature has found that the most common outcome of self-reported racism is depression and psychological distress, with the second most common outcome consisting of hypertension or high blood pressure (Krieger, 2000).

An adolescent woman of colour comments on the impact of racism on health during a focus group discussion:

"It affects your emotional and mental health. If someone calls you a nigger, it would affect you emotionally and cause you to have low self-esteem. Once emotions are affected, it affects your mental health. It's a chain reaction. Once your mental health is affected, so is your physical health." (WHWHCHC, 2003, p.29)

While the mediating factors between race/ethnicity, social class and health status are not well understood (Beiser, Hou, et al., 2002; Harrell et al., 2003; Nickens, 1995), 'race' matters in that racialised persons tend to be at a greater health and mental health risk due to experiences of discrimination (Harrell et al., 2003; Karlsen & Nazroo, 2002a; Nazroo, 2003; Noh & Kaspar, 2003; Schoenbaum & Waidmann, 1997; Wu, Noh, Kaspar & Schimmele, 2003). An American study on the effects of individual and institutional racial discrimination confirms that discrimination at multiple levels negatively impacts the health status of visible minority group members (Gee, 2002). This has major implications for immigrants who tend to immigrate from racialised, so-called developing countries, as well as for Canadian-born individuals who are considered visible minorities (Beiser, Devins, Dion, Hyman & Lin, 1997; Beiser, Hou, et al., 2002; Canadian Mental Health Association, 2000; Hyman, 2004). New immigrants to Canada experience significantly high levels of psychological stress and associated physiological symptoms and mental health problems

(Beiser et al., 1997; Beiser, Feng, Kaspar, & Noh, 2002; Beiser, Hou, et al., 2002; Canadian Mental Health Association, 2000). Depression and anxiety are particularly linked to the dramatic decrease in their economic and social status, feelings of isolation, racism, and traumatic experiences before migration (Hyman, 2001).

Not all racialised groups experience necessarily the same mental health issues to the same degree (Anand et al., 2000; Nickens, 1995; Wu et al., 2003). Nickens' study (1995) suggests that racial or ethnic groups differ greatly both among and within themselves with regard to health status and a large number of other indices. While some studies emphasize that disadvantaged populations, including racialised people, experience a variety of psychological stressors and are therefore at a higher mental health risk, other studies have found that ethno-racial minorities do not necessarily experience mental health problems such as depression any more than the general, or, dominant ethno-racial population. An analysis of a Canadian health survey, for example, found that East and Southeast Asian, Chinese, South Asian, and black Canadians in fact enjoy better mental health than English Canadians, who in turn have better mental health than Jewish Canadians (Wu et al., 2003). This leads to interesting questions regarding how mental health is defined, how problems are identified, whether and how care is obtained, and the supports, personal characteristics and resistance strategies that act as protective factors.

Future Research Directions

The literature concerned with race-based discrimination and mental health reveals that studies are primarily preoccupied with the resulting micro-level impact and outcomes for implicated individuals, and increasingly with the structural ways in which racism creates health inequalities. However, aside from exceptions such as writing by Fernando (2002 & 2003), the literature rarely focuses on institutional racism in the mental health care system itself.

Another major gap in the literature pertains to conceptual and methodological inconsistencies. One of the persistent methodological difficulties is the challenge of measuring discrimination within empirical studies (Blank, Dabady, & Citro, 2004; Brown, 2001; Meyer, 2003). Stress, for example, has been traditionally treated as a variable that is to be measured and examined at the level of analysis of an individual (Meyer, 2003). Given recent findings about the impact of racism and race-based discrimination, however, analysis needs to be expanded and indeed pushed beyond individual levels to account for structural forces and systemic realities.

A related issue is the challenge of capturing the experience and impact of racism when key concepts such as racism and discrimination are variously defined in the literature. These need to be clearly conceptualized and defined to address some of the gaps in the literature on mental health and race-based

discrimination. According to Krieger (2003), for instance, evaluating the consequences of racism based on social as opposed to self-classification of racial identity will change the outcome of a given study. Similarly, Brown (2001) found that the prevalence of perceived discrimination as well as mental health consequences differed depending on how the research questions had been framed. The lack of conceptual clarity only exacerbates previously mentioned measurement issues.

In addition, tools could be developed to help mental health practitioners assess the situation of the consumer-survivors with whom they work. As argued earlier, mental health practitioners operating from a medical model tend to give individual diagnoses to problems that are social in nature (e.g. discrimination). The ways in which practitioners define and interpret problems in the assessment phase actually largely dictate the manner in which they deal with them; thus the failure to conceptualize so-called personal problems as predominantly structurally based or as fundamentally connected to systemic realities runs the risk of further perpetuating inequalities and racism (Fook, 1993). For practitioners to be able to work from an anti-racist framework, there needs to be institutional support. The strengthening of anti-racism practice will thus require the overcoming of institutional resistance and the development and sharing of institutional change strategies. Action Research is a potentially useful approach for enabling this type of change.

Key Resources

- Brown, T. N. (2003). Critical race theory speaks to the sociology of mental health: Mental health problems produced by racial stratification. *Journal of Health and Social Behavior*, 44(3), 292-301.
- Krieger, N. (1999). Embodying inequality: A review of concepts, measures and methods for studying health consequences of discrimination. *International Journal of Health Services*, 29(2), 295-352.
- Krieger, N. (2003). Does racism harm health? Did child abuse exist before 1962? On explicit questions, critical science, and current controversies: An ecosocial perspective. *American Journal of Public Health*, 93(2), 194-199.
- Nazroo, J. (2003). The structuring of ethnic inequalities in health: Economic position, racial discrimination, and racism. *American Journal of Public Health*, 93(2), 277-284.

ACCESS TO HEALTH CARE FOR RACIALISED GROUPS

Health services, particularly those designed to maintain and promote health, prevent disease, and restore health are among the determinants of population health identified by Health Canada (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). Although Canada's health care system consists of many points of delivery (e.g. hospitals, public health, community health centres) and provides different types of care (e.g., perinatal, mental health, cancer care), little research has examined all of these diverse forms of access by racialised people.

Most of the research in this area has focused on access to health care for immigrants, rather than racialised groups. Studies suggest that as a whole, immigrants show similar patterns of medical service utilisation to the Canadian-born population (e.g., Globerman, 1998). However differences exist within the immigrant population and for different types of health services. For example, Reitz (1995) and various studies reviewed by Hyman (2001) show that that recent immigrants experience significant underutilization of preventive (e.g. cancer screening) and mental health services, despite evidence of significant need. These findings help refute concerns that immigrants and refugees constitute a financial burden to the taxpayer-funded health care system.

It is also important to note that there is evidence of a "healthy immigrant effect" in Canada. This refers to the observation that the health of recent immigrants is substantially better than that of the native-born population but declines overtime and begins to converge with that of the Canadian-born population (Chen, Ng & Wilkins, 1996; McDonald & Kennedy, 2004). Hyman (2001) attempted to explain this phenomenon using acculturation theory (i.e. newcomers adopting unhealthy Canadian health behaviours, and negative changes in income and social support over time). However, whether access barriers contribute to declining immigrant health has not been examined.

Barriers to Health Care

Again, most of the literature in this area has examined access issues related to immigrants and newcomers, rather than racialised groups (e.g. Capps, Hagan, Kabiri & Rodriguez, 2003; Edwards, 1994; Jenkins, Le & McPhee, 1996; Meana, Bunston et al., 1999; Weerasinghe, Mitchell, Hamilton & Ragheb, 2000). The most common access barriers identified in the literature can be categorised as follows: financial, cultural, linguistic, geographic, discrimination and lack of status. Each is discussed.

1. Financial Barriers - Even though Canada's health care system provides access to universal coverage for 'medically necessary' health care services, other essential services such as eye care, dentistry, mental health counselling, and prescription drugs are not covered (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). Financial barriers are key for members of racialised communities who are more likely than their non-racialised counterparts to experience financial insecurity (Ornstein, 2000; Galabuzi, 2001).

2. Cultural Barriers - Immigrants and refugees face various challenges accessing health care due to a socio-economic environment, which is largely determined by dominant cultural values. Kirmayer, Galbaud du Fort, Young, Weinfeld & Lasry (1996) investigated health service utilisation among three immigrant groups (i.e., Vietnamese, Caribbean and Filipino) and found these groups experienced significantly more barriers

to care than their Canadian-born counterparts. Although the majority of their study respondents tended to minimize, normalize or self-manage problems, barriers included perceptions that health professionals would not understand, or be prejudiced against, the respondent's culture, the lack of health professionals of similar cultural backgrounds and ethnic mismatch (Hyman, 2001).

The most commonly cited barriers to access include lack of cultural competency, a Euro-centric orientation of mainstream services, stigmatization, loss or devaluation of language and culture, and the lack of culturally appropriate health care and services (Bannerman, Hoa, & Male, 2003; Fernando, 1991; Reitz 1995; Hyman, 2001; Betancourt, Green & Carrillo, 2002).

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

3. Linguistic Barriers - Linguistic and communication barriers frequently hinder equitable access to health care (e.g., Bowen, 2001). Particularly affected are individuals who do not speak one of Canada's official languages fluently. For example, several studies have found an association between length of stay in Canada (less than 10 years) and/or speaking a language in the home other than English or French, and the underuse of preventive health services (Hyman, 2002; Goel, 1994; Goel & Mercer, 1999). Linguistic barriers are also evident when interpretation services are not available (Bannerman et al., 2003) and/or when health information is not translated into multiple languages (Brown, Li and Pinder, 2003). For example, 22 out of the 38 participants in a study on people living with HIV/AIDS reported a lack of information of Canada's health care system as a significant barrier to accessing health care (CAAT, 2001, p. 6).

Bowen (2001) points out that little research has focused on the impact of language barriers on health outcomes, service utilisation and overall costs to the health care system or society in Canada. Research in that field is still in development, with issues of definition and measurement having to be taken into account (Bowen, 2001; Bowen & Kaufert, 2000). There is, however, enough evidence of negative effects to warrant the development of standard practices and appropriate models of service.

4. Geographic Barriers - Lack of availability of services in certain neighbourhoods means that racialised groups living in underserved areas, and who are already disadvantaged by other barriers, cannot qualify for appropriate services or cannot travel the large distances required to access health care. Reitz (1995) highlights the need to bring health resources and care centres to areas where marginalized populations are highly concentrated. Bannerman et al. (2003) also report that many

non-insured people experience difficulties accessing services outside of their catchment areas due to transportation costs.

5. Discrimination - Some studies have found discrimination to be a critical barrier for racialised immigrants, possibly impacting on the quality of care provided (Beiser et al., 1993 cited in Hyman, 2001). One study notes the presence of neglect in pain treatment for ethno-racial minorities by alternatively placing emphasis on identifying the different responses to pain, resulting in minorities not receiving the same quality of care as Caucasians (Gallagher, Green, & Tait, 2005). As indicated in the Discrimination and Mental Health section, it has been argued that "eurocentrism" encourages practitioners to identify responses and coping strategies of minority groups as symptoms of medical problems and/or abnormal behaviour (Fernando, 1991).

A participatory research project led by Women's Health in Women's Hands (2003) investigated the effects of racism on access to health care for young women of colour in Toronto. Many of the 81 women interviewed qualified their experiences with the health care system as negative (29.6%). In addition to citing personal discomfort (8.6%), poor doctor-patient communication (6.2%), and doctors lacking sufficient skill or knowledge as some of the reasons, almost one in five said they had experienced **racism** in the health care system. These experiences ranged from cultural insensitivity or ignorance from their doctors, to name-calling or racial slurs, and also the receipt of inferior care (Women's Health in Women's Hands, 2003).

6. Lack of Legal Status - Although this has not been widely discussed in the literature, *people living with less than full status* in Canada face particular challenges. Community-based reports suggest that lack of status and/or health insurance are major barriers to health care. Bannerman et al. (2003) discuss the **fear** of the health care system and health care professionals that marginalized groups experience. As a result, many individuals might not seek medical attention until it is absolutely necessary. Also noted is the "run around" that **uninsured** people typically experience when trying to access services. In some cases, individuals experience long waiting lists, racism or offensive treatment, rude staff members, or are denied service altogether. Frustration over these factors combined with a lack of information in general about services can lead to eventually giving up and not receiving the much needed health care (Bannerman et al., 2003).

In 2001, the Committee for Accessible AIDS Treatment (CAAT) conducted interviews with immigrants, refugees and non-status people living with HIV/AIDS (PHAs) in Canada. Those who were uninsured could access services at community health centres (CHCs) but experienced multiple barriers due to stretched CHC resources, a continuous fear of deportation and a lack of awareness about services (CAAT, 2001). Many uninsured PHAs, were often forced underground and only accessed health care resources when very ill, or close to death.

The impacts of this included delayed diagnosis, increased severity of the illness, and increased viral resistance. Moreover, several PHAs also reported being turned away from hospitals, even though they were seriously ill. 55% of study participants reported a fear of disclosing their HIV status or immigration status as a barrier to accessing health care (CAAT, 2001, p. 10).

"I have been in Canada for 10 years [applying to get refugee status]. Not having the proper papers made life a living hell. I was sick many times and didn't have anywhere to go because I had no OHIP. I was pregnant with my baby boy, was in labour, taken to the hospital. I was left in the hallway. I was sent home the same day I had the baby. It was terrible." (Anonymous PHA, CAAT, 2001, p.4)

7. Additional Obstacles that have been found in studies of health care services include:

- The three-month waiting period before newcomers can receive public health care benefits (Nerad & Janczur, 2000; CAAT, 2001);
- Fear of stigmatization (CAAT, 2001, Kirmayer et al., 1996);
- Mistrust of the health care system (Kirmayer et al., 1996);
- Practical obstacles, including getting time off work (Kirmayer et al., 1996);
- Underfunding and understaffing of parallel/alternative services provided by ethno-specific organisations (and inability to provide specialized services such as mental health) (Hyman, Peters & Allen, 2000);
- Inappropriateness and fragmentation of services (Boyer, Ku, & Shakir, 1997; Betancourt et al., 2002).

Future Research Directions

The literature reviewed confirms that racialised groups experience multiple access barriers to health care. However several research gaps remain. These include:

- Access to specific health care services (e.g., community health care, long-term care, disease screening, mental health counselling, prevention and health promotion programs, perinatal care, rehabilitation);
- Barriers experienced by specific racialised groups and sub-groups (e.g., women, children, elderly) (Dunn & Dyke, 2000);
- Preferred modes of service delivery (i.e., which types of services are best provided by mainstream and/or community-based agencies);
- The development and testing of strategies to address existing barriers;
- The impact of changes in the Canadian health care system on and as experienced by racialised groups (e.g., Ontario Health Insurance Plan deregulation, primary health care reform, creation of Local Health Integrated Networks in Ontario, etc.);
- The effects of racism/discrimination on access to health care;
- Accountability in the health care system and use of complaint mechanisms;

- Personal and social resources used by racialised groups who experience difficulties in accessing the mainstream system;
- Promising models of providing health education and promotion to racialised groups.

Key Resources

Committee for Accessible AIDS Treatment (CAAT) (2001). *Improving Access to Legal Services and Health Care for People Living with HIV/AIDS who are Immigrants, Refugees or without Status*. Action Research Report. Toronto, ON: Regent Park Community Health Centre.

Hyman, I. (2001). *Immigration and Health*. Health Policy Working Paper Series. Ottawa, ON: Health Canada.

Women's Health in Women's Hands Community Health Centre (2003). *Racial Discrimination as a Health Risk for Female Youth: Implications for Policy and Healthcare Delivery in Canada*. Toronto, ON: Canadian Race Relations Foundation.

CONCLUSION

This literature review provides ample evidence of the impact of income, housing, discrimination and access to health care as determinants of health. These determinants interact together and reinforce each other. The literature review has also demonstrated that poverty in Toronto is becoming increasingly defined along ethno-racial lines and that there are systemic barriers that impact racialised people in particular ways. Nevertheless, there is still very little research that addresses the specific impacts of social determinants on the health of racialised people. Likewise, we know little about the assets that allow racialised people to thrive in the face of adversity. Thus there is a need for Community-Based Research, through which racialised people, can be recognised as knowledge producers and contribute to developing understandings of health inequalities that are reflective of their experiences and to finding solutions to address poverty and improve health.

This literature review came out of a collaborative process through which issues were explored and relationships built among diverse stakeholders, including community researchers, academics, residents, service providers, representatives of a public health agency and others. We are sharing it in the hope that it will move the dialogue forward and spark new initiatives to reduce health disparities.

GLOSSARY

Discrimination: “The denial of equal treatment and opportunities to individuals or groups with respect to education, accommodation, health care, employment, services, goods and facilities. Discrimination may occur on the basis of race, nationality, gender, age, religion, political affiliation, marital or family status, physical or psychiatric disability or sexual orientation” (Henry, Tator, Mattis & Rees, 2000, p. 409).

Mental health: The World Health Organisation defines mental health as the “state wherein the person is well adjusted” (http://www.who.int/topics/mental_health/en/) whereby health is conceptualized as a “state of complete physical, mental and social well-being not merely the absence of disease or infirmity” (<http://www.who.int/about/definition/en/>).

People living with less than full status: “Non-status immigrants are people who do not have the legal status what would allow them to live permanently in Canada. People can become ‘non-status’ when their refugee claim has been rejected, if they don’t have official identity documents, or because their student visa, visitor’s visa, or work permit has expired” (Khandor, McDonald, Nyers & Wright, 2004, p.5).

Racialisation: The process by which racial categories are constructed as different and unequal in ways that lead to social, economic and political impacts (Galabuzi, 2001) and health inequalities.

Racialised groups: Non-dominant ethnoracial communities who, through the process of racialisation, experience race as a key factor in their identity (Galabuzi 2001).

Racism: “A system in which one group of people exercises power over another group on the basis of skin colour; an implicit or explicit set of beliefs, erroneous assumptions, and actions based on an ideology of the inherent superiority of one racial group over another, and evident in organisational or institutional structures and programs as well as in individual thought or behaviour patterns” (Henry et al., 2000, p. 410).

Systemic racism: “Systemic racism consists of policies and practices, entrenched in established institutions, that result in the exclusion or advancement of specific groups of people. It manifests itself in two ways: (1) institutional racism: racism discrimination that derives from individuals carrying out the dictates of others who are prejudiced or of a prejudiced society; and (2) structural racism: inequalities rooted in the system-wide operation of a society that exclude substantial numbers of members of particular groups from significant participation in major social institutions” (Henry et al., 2000, p. 410).

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Funding for the "Racialised Groups and Health Status" project was provided by the following institutes of the Canadian Institutes for Health Research (CIHR): Population and Public Health; Health Services and Policy Research; Gender and Health. This document does not necessarily reflect the views of the funder.

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Access Alliance works to promote access to health and increase access to services for Toronto's multicultural community. We do this by addressing the social, health, education, legal and cultural needs of the community; by removing barriers to service access and by promoting full and equitable participation in Canadian society.