

RACISM, POVERTY AND INNER CITY HEALTH: CURRENT KNOWLEDGE AND PRACTICES

A RESEARCH REVIEW FOR THE INNER CITY HEALTH STRATEGY
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Urban issues are emerging more centre-stage within national Canadian politics and with it discussions about sustainable cities with a focus on housing, employment, education and health within inner cities. Inner city health in particular is a subject of concern for frontline health providers and policy-makers alike who advocate reforms to the urban health care system. As this review illustrates, poverty and racism are critical factors that need to be carefully considered and incorporated into urban health strategies and policy interventions that aim to address current inner city health issues. These efforts need to acknowledge poverty and racism as social co-determinants of health which affect health in various direct and indirect ways.

Canadian inner cities are characterised by high rates of unemployment, inadequate housing, full-time workers with low pay, single parent households, people with disabilities and chronic illnesses (Wasylenki, 2001). Inner city residents are faced with growing health risks which are associated with rising homelessness, access to illicit drugs,

HIV infection and tuberculosis, and a concentration of carbon monoxide, moulds, and other pollutants (Wasylenki, 2001). What places inner city populations, and in particular 'the urban poor' at even higher health risks are public policies such as cutbacks in welfare payments and social services, and lack of proper social housing (Ahmed et al., 2007; Wasylenki, 2001).

Not surprisingly then, the Canadian International Development Agency proposes poverty reduction strategies and access to health care along with access to education, family planning, sanitation and shelter as solutions to combat the key problems of Canadian inner cities: poverty and pollution (Wasylenki, 2001).

While it may have been traditionally difficult to document health problems as directly resulting from racism and poverty, recent literature and reports provide empirical support for the analytical concept of racism and poverty as co-determinants of health, particularly for racialised and disadvantaged populations in the inner city. This review makes the linkages between racism, poverty and health clear. It highlights how racism looks like in the every-day lives of racialised individuals and how it contributes to their health. It also identifies what role racism plays in poverty and thereby contributes to the determinants of health via unemployment, low income, homelessness and social exclusion.

Racism and Poverty as Social Determinants of Health

Life expectancy is shorter and most diseases are more common further down the social ladder in each society. Health policy must tackle the social and economic determinants of health. (WHO, 2003)

That social and contextual elements can have a serious impact on health, including the mental health of individuals is hardly new knowledge as the abundance of international literature on social determinants of health shows. Particularly the United States and the United Kingdom contribute a large portion of related findings to the body of existing literature. There seems to be an assumption that Canada experiences fewer health inequities and inequalities that are related to poverty or socioeconomic status when compared to the United States or the United Kingdom (Wasylenki, 2001). But, as Wasylenki (2001) points out and this report supports, emerging study findings are proving contrary.

Poverty - often measured through the low-income cut-off (LICO) - and economic hardship tend to be the key concepts and foci among the majority of available reports. Some of these reports demonstrate that poverty can have detrimental consequences for the health and development of children from low income households (e.g. Aneshensel & Sucoff, 1996; Anisef & Kilbride, 2000; Nazroo, 2003; Samaan, 2000; Walker, 2005; Waughfield, 2002). Particularly the American literature looks at environmental aspects of living in poverty including poor neighbourhoods, and its correlation to poorer health

outcomes (Aneshensel & Sucoff, 1996; Ross & Mirowsky, 2001; Walker, 2005; Waughfield, 2002). Regardless of ethnicity, for example, a strong correlation between low income and high mortality rates has been identified (Wasylenki, 2001). Other studies have shown that income inequalities have adverse effects for good health regardless of income, such that income distribution becomes a predictor of health status (Wasylenki, 2001).

Waughfield (2002) states that being poor is a mental health risk because people who live in poverty face difficulties in relation to finances, employment, isolation and many more stressors which can in turn become barriers to health care access. Waughfield (2002) concludes that low socioeconomic level results in poor nutrition, crowded living conditions, material deprivation, as well as harmful self-esteem issues. Samaan's (2000) literature review on the impact of race, ethnicity, and poverty on children's mental health in the United States, found that anxiety, depression, and antisocial behaviours are more likely to be reported by children of parents who experience poverty or extreme economic losses. Overall, Wasylenki (2001) reports that American and British literature has linked poverty to a greater likelihood of experiencing violence, producing high child abuse rates, and causing family and community breakdown in the inner cities. In 1997, the American College of Physicians referred to the social, economic, and health disadvantages of inner city populations as the 'urban health penalty' (Wasylenki, 2001). Associated with this 'urban health penalty' in the United States are higher rates of violence, teenage pregnancy, drug abuse, HIV

infections, chronic illnesses such as tuberculosis, asthma and diabetes in inner cities (Wasylenki, 2001).

But as several significant reports and research findings point out: poverty is not the only critical determinant of health (Gee, 2002; Galabuzi, 2001; Ornstein, 2000). In 2002, the National Anti-Racism Council of Canada reported that experiences of discrimination based on 'race' or skin colour are a common reality in Canada. The Council asserts that Canada is stratified and experiences a growing racialised divide (NARCC, 2002). 'Race' indeed matters in people's lives, particularly in terms of structural barriers, access issues, and socioeconomic status (Ahmed et al., 2007; AAMCHC, 2005; Galabuzi, 2001; Gee, 2002; Harrell et al., 2003; Nazroo, 2003). 'Race' or the experiences of racialised individuals due to the consequences of institutional and structural racism often go hand-in-hand with experiences of economic hardship and low socioeconomic status (Galabuzi, 2001; Ornstein, 2000). Galabuzi (2001) calls this the racialisation of poverty, and with it cements the notion that a discussion of poverty can no longer exclude its racialised subjects. Galabuzi (2001) highlights the growing gap between the rich and poor in Canada is increasingly characterized by an ethno-racial divide.

In fact, statistical data provide supporting evidence. According to Statistics Canada's data of 2001, the low income rate of racialised minorities as a

group in Toronto is nearly twice as high as that of the Canadian-born, white population (in AAMCHC, 2005). More recent numbers for Toronto, illustrate that both unemployment and poverty rates are three times higher for racialised populations than for White groups (Lovell & Shahsiah, 2006). Overall, racialised groups as well as new immigrants are earning less in the Canadian labour market today than previous immigrants (Aydemir & Skuterud, 2005; Schellenberg & Hou, 2005). The lack of recognition for their 'foreign' credentials and local work experience, and a scarcity of affordable housing have placed many immigrant households in Canada at the margins, despite being on average more skilled and educated than their Canadian-born counterparts (AAMCHC, 2005; Preston & Murnaghan, 2005). While there are many differences among groups, those who are racialised and recent immigrants are statistically more likely to fall into the lowest income levels in Canada and are disproportionately represented at these levels (Galabuzi, 2001; Ornstein, 2000).

Ornstein (2000) reports that apart from racial discrimination, racialised groups in Toronto experience disproportionate levels of poverty, homelessness, inadequate housing, and access barriers to health care when compared to their White counterparts. Similar disproportionate rates, such as the overrepresentation of racialised families in the child welfare system and of racialised men in the forensic system

and psychiatry, suggest a strong interrelated relationship between structural disadvantage due to racism and factors associated with poverty (Fernando, 2003; Galabuzi, 2001; Kafele, 2004; Nazroo, 2003).

In terms of concrete health outcomes, disparities have been documented for various ethnic or racialised inner city communities in Canada as well as the United States and the United Kingdom. Conceptualizing racial classifications as part of the social structure and hierarchy in Canada, Wu and colleagues (2003) argue that prevailing explanations based on socioeconomic status, social resources and interaction alone cannot adequately account for such health disparities. Others echo the notion that social and economic inequalities are underpinned by racism at multiple levels, and therefore play a fundamental role in health disparities (Ahmed et al., 2007; Gee, 2002; Nazroo, 2003).

While 'race' is sometimes named a health risk factor, a number of studies clearly identify racism as a key social determinant of health (Gee, 2002; Harrell et al., 2003; Karlsen & Nazroo, 2002b; Krieger, 2003; Nazroo, 2003; Peters, 2004; The Calgary Health Region, 2007). The community organisation Women's Health in Women's Hands (2003) found that racial discrimination shapes the health of young women of colour in Toronto and identified racism as a major health risk. Their report explains that racism creates barriers to access to quality

healthcare, health education and information for racialised people. Another Canadian-based report reviewed existing health research and local initiatives in Nova Scotia, and identified that black women in Nova Scotia experience increasing suicide rates, racism, and disproportionately high schizophrenia diagnoses rates (Enang, 2001). Examining 593 cases of breast cancer, Taylor and colleagues (2007) assessed the relationship between perceived experiences of racial discrimination and breast cancer among black women in the United States. Their findings showed that particularly among younger black women, perceived experiences of racism were associated with increased breast cancer incidences (Taylor et al., 2007).

Many other relevant studies confirm that mental health is an aspect of health which is especially affected by experiences of racism. Krieger's (2000) review of 20 American public health studies, for example, illustrates that some of the most common health outcomes from self-reported experiences of racism are depression, psychological distress, and high blood pressure. Similarly, a wide range of studies provide evidence that the material deprivation associated with low income, socioeconomic status and/or poverty significantly impacts on mental health (AAMCHC, 2005). Based on a wide-ranging review of relevant literature on various determinants of health for racialised groups, the Access Alliance Multicultural Community

Health Centre (2005) in Toronto reports that low socioeconomic status and poverty manifests often as depression, anxiety, and other forms of psychological distress and mental health issues. Overall, the negative effects on health caused by factors related to poverty are particularly exacerbated when poverty is experienced over a life-span rather than episodically (in AAMCHC, 2005).

Based on data from the Fourth National Survey of Ethnic Minorities, Karlsen and Nazroo (2002b) assert that experiences of racism - and not ethnic identity as traditionally assumed - are directly related to health outcomes, regardless of the health indicators that were used. Other reports highlight that racism and experiences of racial discrimination are closely tied to socioeconomic status, low income, and poverty (Ahmed et al., 2007; Gee, 2002; Nazroo, 2003; Ornstein, 2000; Wu et al., 2003). Reviewing empirical evidence in available American literature, Ahmed and colleagues (2007) highlight how institutional racial discrimination shapes socioeconomic status and ultimately affects the health of racialised populations, and in particular African Americans. They establish a clear relationship between the consequences of institutional racism and poverty and health. Key in their overview is residential segregation.

Residential segregation has historically shaped the residential distribution of whites and blacks in the United States

and can today be witnessed in predominantly poor black urban neighbourhoods (Ahmed et al., 2007). American Census data from 2000 not only shows that residential segregation of African Americans continues to exist today in the United States, but also that these neighbourhoods are characterized by high levels of economic hardship and lower socioeconomic levels (Ahmed et al., 2007).

Unfortunately, there are few Canadian studies that examine the implications of housing and neighbourhood segregation. But it is known that income segregation is rampant in Canadian cities and that this segregation is highly racialised in many urban areas (Dunn, 2002; Galabuzi, 2001; Ornstein, 2000). Galabuzi (2001) points out that racialised groups experience residential segregation even when they experience an improvement in their economic status. Indeed, a significantly high proportion of racialised people in Canada live in poor neighbourhoods with poor quality, over priced and marginal housing conditions (AAMCHC, 2005; Dunn, 2000; Novac, 1999). Poor housing in Canada is related to low income, which is in turn related to poor health outcomes. On average, households pay around thirty percent of their income on rent, leaving very little for food, clothing, transportation and other necessary expenses (AAMCHC, 2005). The resulting material deprivation can lead to poor health outcomes through poor nutrition and

financial barriers to accessing necessary services.

Level of income, however, is not the only determining factor in quality of housing and residential segregation. The source of income such as from social assistance as well as the tenant's ethnic and cultural background, 'race' or skin colour, citizenship status, language and accent, gender, and religion play also important roles (Dion, 2001; Murdie, 2003; Novac, 1999; Novac et al., 2002). Prejudices against people on social assistance and racist views about people of colour in general prevent many individuals and families from accessing quality housing in good neighbourhoods. In other words, differential access to decent and affordable housing exists due to discrimination based on these factors, in addition to affordability for racialised groups.

The reviewed reports emphasize that for analysis and action purposes around health, racism and poverty can no longer be treated as separate variables with independent outcomes for affected populations. Poverty and racism are co-determinants of health.

Pathways of Racism and Poverty as Social Determinants of Health

Despite the small but growing number of reports on racism and poverty as social determinants of health, there is no clear agreement about how exactly they are linked to health. Many report on

differential health outcomes but cannot explicitly illustrate the causal link between racism and/or poverty and health.

Among those which attempt to present an explanatory theory are a range of plausible pathways. For example, the World Health Organisation's (2003) major report on social determinants of health does not conceptualize poverty or racism as key determinants, but categorizes these within and under other social determinants. As a result, racism and poverty are mentioned in their discussions of health and social exclusion, social support and food as determinants of health.

This review of available literature on recent findings about racism and poverty as co-determinants of health generates an overview of the most common and supported plausible pathways. These are grouped together for analytical purposes. This overview illustrates that empirical data remains limited, and that multiple pathways must be considered even if they appear often overlapping and interrelated.

The Impact of Stress: Racism and Poverty

Stressful circumstances, making people feel worried, anxious and unable to cope, are damaging to health and may lead to premature death. (WHO, 2003)

One of the recurring explanations in the literature illustrates how racism and/or poverty are more directly linked to

Besides their association with social and economic determinants of poor health, inner cities may also present residents with health hazards related to pollution and environmental degradation. Over the last thirty years, considerable research mainly done in the U.S. has documented that the most disadvantaged groups, the poor, racialised groups, immigrant and refugee populations, often experience the worst of urban pollution. This work has introduced the term *environmental racism* in order to related the fact that racialised groups are more likely to be exposed to air-born pollutants related to traffic, heavy industry and other noxious substances with the political decisions that determination the location of urban environmental hazards. While the issue of unequal exposure to pollution in Canadian cities has not yet received substantial attention, there are signs that some Canadian cities may exhibit unequal exposure of residents to environmental hazards based on socio-economic inequalities. For example, in Hamilton, Ontario, the site of the country's two largest steel producers, studies have found that low-income inner city residents are considerably more likely to be exposed to pollution from heavy industry compared with wealthier suburban residents (Buzzelli et al, 2004).

adverse health outcomes and in particular mental health problems. When Wu and colleagues (2003), for example, explored the relationship between socioeconomic status and mental health, they found that a prevailing theory among existing literature treats low socioeconomic status as a stressor because it is associated with situations that expose families to psychosocial and environmental health risks. Another explanation is that the accumulated stress related to low socioeconomic status over the life span often results in despair and powerlessness, and finally depression (Wu et al., 2003).

The daily experience of living in lower socioeconomic levels as a racialised individual causes chronic psychological distress which in turn can manifest as other health problems such as migraines or back aches. When stress is experienced over a long period of time it can have detrimental effects on cardiovascular and immune systems increasing a person's vulnerability to infections, diabetes, high blood pressure, heart attack, stroke, depression and aggression (WHO, 2003). Racism and poverty act here as chronic stressors which directly shape

health due to their immediate and long-term effects.

Ross and Mirowsky (2001) found that residents of disadvantaged neighbourhoods where levels of crime were high experienced daily stress. This daily stress developed into chronic health problems like asthma, arthritis, and high blood pressure. Similarly, a study by Aneshensel and Sucoff (1996) explored how the mental health of youth in a Los Angeles neighbourhood in the United States was affected by neighbourhood characteristics and parents' socioeconomic status. Findings showed that mental health problems were more pronounced and prevalent among youth who lived in areas which were residentially stratified based on socioeconomic status and 'race' or ethnicity, than youth who lived in other social strata (Aneshensel & Sucoff, 1996). They also found that the more a neighbourhood was perceived as dangerous or threatening, the more common were symptoms of anxiety, depression, conduct disorder and 'oppositional defiant disorder' among the youth.

Racism can also affect health in a more indirect way. Studies on youth in inner cities illustrate that drugs and alcohol are often chosen as a means to cope with the daily experiences of discrimination and life-long stress from racism (Borrell et al., 2007; Lovell & Shahsiah, 2006). Assessing the association between racial discrimination and substance abuse among young adults in the United States, Borrell and colleagues (2007) suggest that substance use is an unhealthy coping response to perceived discrimination. Several studies confirm that these coping strategies are not only harmful physically but also mentally, exacerbating existing mental health problems and causing potentially more (Borell et al., 2007; Fernando, 2002, 2003; Noh & Kaspar, 2003; Lovell & Shahsiah, 2006).

Ahmed and colleagues (2007) add an additional explanation of how racism affects health. They point out that prevailing racial stereotypes and prejudices can be internalised. While research is very limited in this area, internalised racism has been found to contribute to poor health (Ahmed et al., 2007). Similarly, a study on substance use and mental health among young people in a Torontonion inner city found that racism or the experience of being racialised impacted on the identities of some youth (Lovell & Shahsiah, 2006). Apart from internalising racial stereotypes, some of the youth spoke about low self-esteem and even self-harming behaviours with regards to

their own bodies (Lovell & Shahsiah, 2006).

Given the biological and psychological basis of stress-related causal explanations, the onus is often placed on subjectivity and the individual rather than structural factors. Personal resilience is often highlighted as a mediating factor in health outcomes and structural disadvantage take a back seat. Instead, the perception of the individual becomes a central factor in the pathway of how racism or racial discrimination can affect health. Thus, the majority of this literature remains 'raceless' despite its initial attempt to account for disparities in health along racial lines.

Racism and poverty creating barriers to access

Apart from the more immediate, direct causal pathways, racism and poverty also affect health in less visible, indirect ways by shaping and creating structural disadvantage. Disadvantages created through institutional racism and poverty can decrease and prevent access to quality health care and to other variables that promote good health.

The literature on access issues to health care has increased significantly particularly in the context of low income populations and recent immigrant populations in recent years. In Canada, health care services also include community-level services which serve various preventative and health promotion functions. And yet studies on

Studies conducted throughout North America and in increasing numbers elsewhere are finding that not only do poorer populations in cities experience a greater difficulty in meeting basic food needs but accessing nutritious food, that is food that contributes to physical and emotional well-being, is increasingly limited to a suburban white upper class. This is known as the *food desert*, a region of the city where it is difficult to access affordable and nutritious food. For inner city residents, food deserts include high concentrations of cheap and unhealthy fast food outlets and have contributed to residents' greater risk of acquiring serious chronic illnesses, such as diabetes. In the U.S., a proliferation of junk food outlets and the closing of grocery and other stores with better food options have been found to especially affect inner city African-American and Hispanic communities (e.g. Morland and Filomena, 2007). In Canada, studies done in Vancouver (Rideout et al, 2007) and Hamilton (Latham and Moffat, 2007) have found that junk foods are widely available in the inner city and especially in close proximity to elementary and intermediate schools. Furthermore, food costs are much higher in the small variety stores that dominate food retail in low-income residential neighbourhoods, yet there is a very low availability of fresh foods in these stores. The food divide in cities has become a key marker of the health divide in cities and a stark reminder of close links between health inequalities related to class and racial divisions and the neighbourhood environment.

access issues tend to focus on mainstream services rather than community health centres and other organisations, and on variables such as language and citizenship status as opposed to 'race' or racism.

As discussed previously, a kind of racialisation of poverty exists in Canada, which suggests that racism and poverty act as co-determinants of health via pathways that reach beyond the more obvious language and citizenship status barriers. The most commonly documented pathway is that low income or poverty means individuals and families simply cannot afford needed services. In other words, racism and poverty manifest as low socioeconomic status, creating financial barriers which in turn prevent access and harm health indirectly. This is particularly true for inner city populations in the United States, but also in Canada (AAMCHC, 2005; Ahmed et al., 2007). Eye care, dentistry, prescription medications, and

mental health counselling are no longer covered by Canada's national health care system. Accessing these services depends increasingly on benefits extended by employers and level of income. An inability to access needed services due to financial barriers leaves health needs unmet, and therefore worsens health status (Kafele, 2004; Waughfield, 2002). Financial barriers affect particularly racialised communities which are more likely than their non-racialised counterparts to experience financial insecurities (Galabuzi, 2001; Ornstein, 2000).

Discussions about access to services also point out that help-seeking behaviours further affect health when services are not sought and impeding health needs are left unmet. For example, Kafele (2004) argues that the combined experiences of racial discrimination, social exclusion, and poverty can produce a sense of mistrust and fear within racialised and Aboriginal

communities in Canada. These feelings and perceptions may in turn prevent individuals from accessing services that they may need, as suggested by a number of reports on the underutilisation of services by specific minority groups (Kafele, 2004).

Quality and availability of appropriate services

Inaccessibility of services is not the only pathway via which racism and poverty become co-determinants of health. The content, that is the quality and availability of appropriate services, is also challenged in the reviewed literature. For many, the issues here are that the most funded and available services are often incapable of responding adequately to the health needs of racialised populations (AAMCHC, 2005; Bowen, 2000; Kafele, 2004; Women's Health Matters, 2007). Eurocentric views and practice models dominate mainstream services and reproduce - whether consciously or unknowingly - institutional disadvantages and differential health outcomes. Critical health advocates consider these inappropriate or inadequate unless they change. Different reports highlight different angles and problems of available health services and the provision of such services to racialised populations.

Misdiagnosis and false diagnostic labelling by mental health and health care professionals is one of the ways by which racialised people experience

institutional and individual-level discrimination (AAMCHC, 2005; Fernando, 2002 & 2003; Kafele, 2004). Misdiagnoses of racialised groups can be traced back to dominant medical practices and psychiatric care during and after slavery when black people were assigned a range of diagnostic labels which deemed them genetically, biologically, psychologically and culturally inferior (Arredondo & Toporek, 2004; Desai, 2003). But the prevalence of misdiagnosis remains and can be identified in various reports that illustrate that blacks continue to be disproportionately represented in certain psychiatric and forensic diagnostic categories (Arredondo & Toporek, 2004; Desai, 2003; Kafele, 2004). It is argued that rather than dealing with the root cause of the health problem - such as issues related to racism and poverty - practitioners extend diagnostic labels which pathologize the problem and ultimately blame and even stigmatize the individual (AAMCHC, 2005; Desai, 2003; Fernando, 2002; Kafele, 2004).

Qualitative reports suggest that additional issues associated with mainstream or traditional health services include inappropriate treatments as a result of erroneous diagnoses, deferred interventions, and culturally inappropriate service (Bowen, 2000; Desai, 2003; Fernando, 2003; Snowden, 2003; Women's Health Matters, 2007). While lack of cultural competency by service providers has received considerable attention and

prompted calls for linguistic and cultural representation among service providers (AAMCHC, 2005), racism and racial discrimination as underlying factors remain less explored and dealt with.

In the participatory Women's Health in Women's Hands (2003) research project one in five young women who participated in the study reported experiencing racism in the Canadian health care system. Among their self-reported negative experiences with health care services were ignorance, cultural insensitivity, name-calling or racial slurs, and inferior quality of care from health care professionals (WHiWH, 2003). The report argues that the current health care system in Canada may be incapable of meeting the needs of young, black women because it perceives and treats them as abnormal because it is based on a monocultural, and typically Eurocentric, medical model.

Based on a number of reviewed reports on access to mental health services, the Access Alliance Multicultural Community Centre (2005) also suggests that the context within which services are provided is moulded by dominant cultural values. As a result, a kind of cultural barrier persists where service providers are perceived as prejudiced or not understanding of ethno-racial minorities (AAMCHC, 2005). Biases and prejudiced attitudes of service providers during the assessment as well as treatment stage then lead to erroneous diagnosis and discriminatory practices,

and likely prevent the individual from seeking their service a next time (Kafele, 2004; Snowden, 2003).

Current policies and practices

Some Canadian reports point out that certain populations in Canada are not well served by current health services because of racism, discrimination, language and cultural barriers, and lack of cultural sensitivity and competency (Bowen, 2000; HereToHelp, 2006; Kafele, 2004; WHiWH, 2003). But innovative responses are emerging in the inner city that attempt to address racism and poverty as co-determinants of health.

After reviewing several existing models of health care, Bowen (2000) identifies that the most innovative programs are those which combine responses to specific health needs with responses to barriers to access for individuals. Such initiatives focus on building community partnerships and have the potential for initiating organizational change even though they may not be able to necessarily promote structural or policy changes (Bowen, 2000). Kafele (2004) suggests adapting a community development approach to enable the development of appropriate mental health care for racialised communities. Within such a community development model health promotion occurs alongside efforts to strengthen resilience and capacity, mental health advocacy, local leadership and equitable partnerships (Kafele, 2004).

Across Ontario, Community Health Centres provide primary health care through interdisciplinary teams which are often made up of professionals who represent the cultural and linguistic diversity of the community served (Bowen, 2000). As such, they attempt to boost cultural competency efforts to make services more appropriate and effective for ethno-racial minorities in Canada. They are officially committed to equitable access and community accountability (Bowen, 2000), and have the potential to get involved in the community as a whole to address racism- and poverty-related factors that shape individual's health status.

In a commentary on inner city health, Wasylenki (2001) states that the Inner City Health Program established by St. Michael's Hospital in Toronto is one of Canada's innovative initiatives that addresses poverty as a key determinant of health within inner cities. With a mandate to provide compassionate and effective care to disadvantaged populations, St. Michael's Hospital runs out of one of Toronto's poor inner cities. The Program brings various medical subspecialty divisions, women's health departments and psychiatry together to focus on identified needs of specific inner city populations. Some of these groups are homeless individuals, people with HIV infection, people with severe and persistent mental illnesses, women whose health are at risk because of social isolation, poverty, working in the sex trade or the stresses of single parenthood, and people with addictions.

The Program has developed a clinical program, active outreach, and a research unit with the mission to improve health and health care for inner city populations. Wasylenki (2001) further praises Canada's national commitment regarding sustainable cities but argues that this commitment must be applied to inner city health problems in Canada as well.

GAP ANALYSIS: Needed Responses to Racism and Poverty in Inner City Health

The number of studies explicitly documenting how racism or racial discrimination can harm and affect health remains relatively small (Kafele, 2004; Krieger, 2000; Women's Health Matters, 2007). Even less exists that looks at racism and poverty as co-determinants of health. Even among existing literature on social determinants of health is much debate. There are disagreements about the extent and severity of adverse effects on health, inter- and intra-group differences in terms of differential health outcomes, the role of gender or class or other dimensions are primary as opposed to 'race' or socioeconomic status, the causal link between racism or poverty and health, the conceptualization and measurement of racism, the manifestations of poverty versus racism, and the specific processes or pathways whereby racism and/or poverty have negative effects on health (Anand et al., 2000; Blank, Dabady, &

Citro, 2004; Coburn, 2004; Krieger, 2003; Meyer, 2003).

Most studies explore concrete individual-level health outcomes, while others approach the link between health and racism or discrimination by exploring personal attitudes and perceptions. They concern themselves with the ways in which *perceived* racism or discrimination affects health, and thereby emphasize the notion of 'risk' and subjectivity as mediating factors (e.g. Brown, 2001; Noh & Kaspar, 2003). Another portion of current literature explores the relationship between racial discrimination and specific mental health issues such as depression, anxiety, and stress. In other words, there is much to be explored and given the conceptual and measurement variations it is difficult to synthesize available knowledge 'out there'.

1. *Lack of data on Canadian inner cities*

A recurrent message by Canadian authors is that there is not enough Canadian research in this area and as a result a dearth of relevant data. The available empirical data on Canadian inner cities is very limited. Even though it is informative and important, American data on inner city health problems and populations cannot be readily extended to the Canadian context because the elements that characterize American inner cities are not representative of the Canadian urban landscape. There are differences

with respect to the historical and socio-political contexts, the form of racism, the extent and manifestations of poverty, the social welfare system and its public policies, and the history of racism and poverty in the United States.

However, as several reports such as Galabuzi's (2001) and Ornstein's (2000 & 2006) suggest, there are inner city health problems within Canadian inner cities which need to be taken seriously and addressed. To address these issues, empirical evidence which is recent and local is needed to generate responsive policies and services for inner city populations.

2. *Limited literature on racialised populations*

Despite growing awareness about the racialisation of poverty in Canada, the body of literature on racialised populations in Canada remains very small. As with the body of literature on inner city problems and populations, there are more research reports on racialised populations and poverty and/or racism from the United States and the United Kingdom than from Canada.

Among the Canadian literature, the focus has been traditionally on 'ethnic minorities' and more recently on various immigrant populations but even these often avoid naming and exploring the role of racism and poverty in connection to these populations. They may discuss disparities in health for minority or

immigrant populations, yet fall short of a critical analysis that can account for the influences of racism and poverty.

Henry and Tator (2000) argue that part of the problem is that a discourse of democratic racism pervades Canadian research. Because of its focus on multiculturalism and ethnicities as opposed to 'race' and racism, the discourse remains uncritical and 'raceless' (Henry and Tator, 2000). As a result, the majority of the literature does not identify how 'race' or the experience of being racialised plays a central role in people's day-to-day lives and thereby determines health. Instead, there is a tendency to confuse and combine immigrant and visible minority health issues even though there are additional as well as different risk factors for poor health for immigrants and refugees despite common experiences tied to being racialised (Bowen, 2000; Kafele, 2004).

Part of the issue seems to be that collecting and generating quantitative data on racialised populations has become controversial. Contrary to the United States and the United Kingdom, such data are not collected in Canadian national health surveys (Bowen, 2000; The Calgary Health Region, Women's Health Matters, 2007). Health advocates argue that the Canadian government's failure to collect and provide such specific information prevents from meeting the needs of certain populations (Lovell & Shahsiah, 2006). Opponents fear that 'hard' data may be taken out of

context and even reproduce racist stereotypes. Reports on inequities in health and mental health in Canada remain therefore largely qualitative in nature and community-based. While they are invaluable, they are few in numbers and, combined with the absence of quantitative data on 'race' or even ethnicity, arguably limited in terms of influencing policy and services.

3. Lack of conceptual clarity and consensus

Core concepts such as 'race', racism, discrimination, being poor, and health are variously defined among the literature reviewed. For example, most studies that set out to explore 'racism' as a factor in shaping health, treat 'racism' as the experience of individual-level encounters, such as racial slurs or violence. Particularly studies which explore racism and poverty in association with stress, frames stress as a variable that is measurable on the level of the individual (Meyer, 2003). More covert forms of racism are less critically explored, if at all. They remain limited in their usefulness of identifying the effects of structural and institutional racism and poverty on health, because they are limited in their conceptualisation of these factors. When racism is treated first and foremost as an interpersonal phenomenon, it is not possible to account for the racialisation of poverty, and fully address the effects of racism and poverty as co-determinants of health.

The differential conceptualizations and lack of conceptual clarity among the health literature and racialised populations in Canada means that racism, discrimination and other related variables are also measured variously. Existing studies are not only conceptually but also methodologically inconsistent, and thus hamper the development and use of accurate measurement instruments. One of the documented methodological difficulties is measuring racial discrimination within empirical studies (e.g. Blank et al., 2004; Brown, 2001; Meyer, 2003). It has been a challenge for researchers as there is no consensus currently. That means when consequences of racism are evaluated based on socially versus self-identified variables, the outcome of a given study changes (Krieger, 2003).

As mentioned previously, explanatory theories on processes whereby racism and poverty affect health are quite varied. As with the conceptual clarity and measurement issues, there is no consensus with regards to causal pathways. Proposed pathways are contested and rarely substantiated with strong empirical data. In addition, despite the growing evidence about the racialisation of poverty, racism and poverty are rarely connected as co-determinants of health. Poverty and its manifestations are mostly treated as the key social determinant of health, whereas racism and its various forms are mainly associated with barriers to health care access. These analytical linkages need to be further fleshed out in

order to arrive at adequate responses and strategies.

4. Where are Canada`s innovative practices?

Within Canadian literature, most of the discussion on racialised populations and health is about cross cultural mental health services, ethnic minorities and cultural competence, integrated models of care, and to a lesser degree community development models and anti-racist practices. Many studies challenge what constitutes accessible services, equitable services, and culturally competent or appropriate services as well as how such services can be achieved and sustained on a community-level. Virtually all call for more research in this area in order to redress inequities in health for racialised communities.

Community-based research studies and reports are scarce and often limited, and yet insightful in the absence of 'hard facts'. But even though they exist, too few innovative community initiatives and projects from Canada are documented and accessible. This creates a knowledge gap and limits knowledge sharing.

NEXT STEPS

A major step that is required across the board entails developing and implementing services and policy interventions that address the impact of racism and poverty for inner city

racialised populations in Canada. To achieve this there is a need to:

→ **acknowledge** racism and poverty as interlaced social determinants of health. This process requires an analytical "lens" that is able to come to terms with and tackle such concepts. With a critical framework based on anti-racism or anti-oppression, for example, it would then be possible to identify underlying causal pathways that may lead to ill health and adequately address them.

→ **achieve** conceptual and methodological clarity. Capturing the experience and impact of racism depends on key concepts such as racism and discrimination which are currently variously defined. Conceptual and operational inconsistencies in health research create further challenges in terms of arriving at a consensus on the impact and connection between racism and poverty as co-determinants of health. Consistent measurement instruments will also clear up some of the conceptual confusion and allow for a critical analysis in health research.

→ **move beyond** individual-level analyses. To enable current knowledge to move beyond this level and account for structural and systemic sources of disadvantage that affect health, Canadian research needs to move beyond its 'race'-less

discourse of multiculturalism to one that has the capacity to speak to issues of racism and poverty and generate proper responses as opposed to band-aid solutions.

→ **train** practitioners in anti-racism practice and integrate this knowledge into their curriculum to enable prospective practitioners to be able to assess how racism and poverty are linked to the health needs of service users. Proper training has the potential to extend analytical tools to trainees and challenge discriminatory practices.

→ develop and support **holistic services** through adequate funding and partnership work. Addressing immediate health concerns must also include efforts to address other needs and the overall socioeconomic situation of the service user. Identifying the far-reaching impact of racism and poverty on health is difficult when health problems are isolated and treated in a vacuum.

→ **engage** with and gauge the input of racialised communities through awareness-raising, lobbying, and community events. Given the legacy of psychiatry and Eurocentric medical practice models, and important factor in addressing inner city health problems is the trust and involvement of residents. As the rationale behind CHCs demonstrates, service provision must be community-level and able to

regain the trust of communities in order to encourage service utilization. In addition, combating racism and poverty requires a degree of political involvement to challenge inequalities and structural disadvantage.

- develop appropriate **measurement tools** in health research to enable comparisons of research findings across studies. These tools are also required to much needed data on racialised populations to address racial differences in health outcomes and inequities in health.
- develop **assessment tools** for service providers. How health problems are identified and defined in the assessment phase usually dictate how they are dealt with. Thus, the failure to conceptualize so-called personal problems as predominantly structurally based or as fundamentally connected to experiences of racism and poverty results in inadequate responses to a person's health needs. To develop tools that can help health practitioners account for structurally-based 'problems', such as racism or experiences of racial discrimination, then assessment tools must reflect the conceptualization of racism and poverty as co-determinants of health.
- develop an overarching **knowledge-sharing** network or system to enable and encourage the sharing of

practitioners' knowledge about innovative projects and programs. The exchange of ideas and know-how is important for practical purposes but also for challenging the controversy that seems to linger with respect to racism as a determinant of health.

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