Ethnicity and Inequalities:
Case 1: Immigrant Health & Inequalit
Case 2: Aboriginal Health & Social Exclusion
Research: Social Inclusion/Exclusion

Sharon Yanicki

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Overview of the Class

Continuation – Gender & Explanations (last class)

Ethnicity, Health & Inequality - Definitions

The Paper – clarifying expectations

Ethnicity & intersecting inequality

Explanations for ethnicity & differences in health

Case Example: Aboriginal Health & Social Exclusion

Intersectionality

Learning Objectives

By the end of this class you will be able to:

- Define and apply terms
  - race, ethnicity, culture, racism, hegemony, social exclusion, racialized poverty
- Describe the social inequalities underlying social exclusion
- Apply social exclusion as a determinant of health to explain health inequities for Aboriginal peoples.
- Describe factors affecting the health of immigrants (intersection)
- Describe several explanations of ethnic differences in health and illness

Sex & Gender-Based Analysis (SGBA)

Review

- Sex = biologically-based differences between males and females
- Gender = socially constructed behaviours, roles and relationships, and relative power between men and women
- SGBA is an analytic approach that integrates sex and gender perspective into health research, policy and program development, decision-making and planning (Health Canada, 2013)

The Paper

- Questions & Answers
- APA format – see template in Moodle

iClicker Question #1

Segall & Fries suggested that gender stratification leads to differences in health due to:

a) inequalities in power and privilege for women and men

b) inequalities in income and education for women and men

c) a and b

d) sex differences in health for females and males

e) sex differences in mortality for females and males

Case 1: Immigrant Health & Inequalities

Segall & Fries, 2011, p. 168

Ethnic differences in health: Explanations

- The Healthy Immigrant Effect
- Differences in perception and understanding of symptoms
- Differences in health care behaviours
- Differences in the social determinants of health
- Differences due to social exclusion

Healthy Immigrant Effect

McDonald & Kennedy, 2004

New immigrants were in relatively better health on arrival in Canada compared to native-born Canadians.

- Dx of a chronic disease by a physician (robust evidence)
- Self-rated health status (weak evidence)

•Over time, immigrant health converges to native-born levels

Possible reasons:

•Acculturation?

•Undiagnosed conditions?

•Access to Health Care Services?

•Social, cultural and language difference?

•Differing rates of diagnosis?

Evidence of the HI Effect:

Base on national surveys, evidence confirms the HI Effect for <u>one group of chronic diseases</u>:

Type A = asthma, back pain, high blood pressure, allergies, migraines, ulcers, bronchitis, and arthritis

Type B = heart disease, cancer, thyroid disease, Chrohn's disease, and diabetes

For both immigrant men and women (McDonald & Kennedy, 2004):

•Rates of Type A diseases were lower but converged with 20 years to native-born rates.

•Rates of Type B disease did not differ on arrival.

Healthy Immigrant Effect

Kennedy et al 2014

The HI Effect in Four Countries

The self-reported health status and health behaviours of new immigrants to Canada, Australia, USA and UK were compared.

- The HI Effect was confirmed in four countries (Kennedy et al, 2014)
  - Comparable access to health care,
  - Similar language and culture

Explanations

- Positive Self-section

New immigrants were more likely to report than native-born:

- Higher educational attainment (university) from both developed and developing countries
- Higher self-reported health status
- Non-smokers

Yet higher education alone did not account for levels of positive health status.

i<Clicker Question

The Healthy Immigrant Effect is best described as follows:

a) New immigrant's health is better than native-born residents of a country upon arrival

b) New immigrants health declines over a period of years (years after migration).

c) Differences in both self-rated health and rates of chronic disease have been measured as part of the healthy immigrant effect.

d) a, b, c

e) New immigrants' health gradually improves over time (years after migration).

Trends in Canadian Immigration

Milestones – Welcoming Syrian Refugees

- **Last government-organized flight arrives in Toronto**

"Welcoming 25,000 refugees in such a short period of time is a shining example of the welcoming spirit of Canadians…"
Hon. Maryann Monsef (2016)

26,176 Syrian refugees arrived in Canada Since Nov. 2015

Welcoming Refugees

From Damascus to Toronto: Mohamed's story

- http://www.cic.gc.ca/english/refugees/welcome/video/mohamed.asp

Lethbridge Family Services

- Mar 4, 2016
- Bringing Syrians home
- How can community members help?

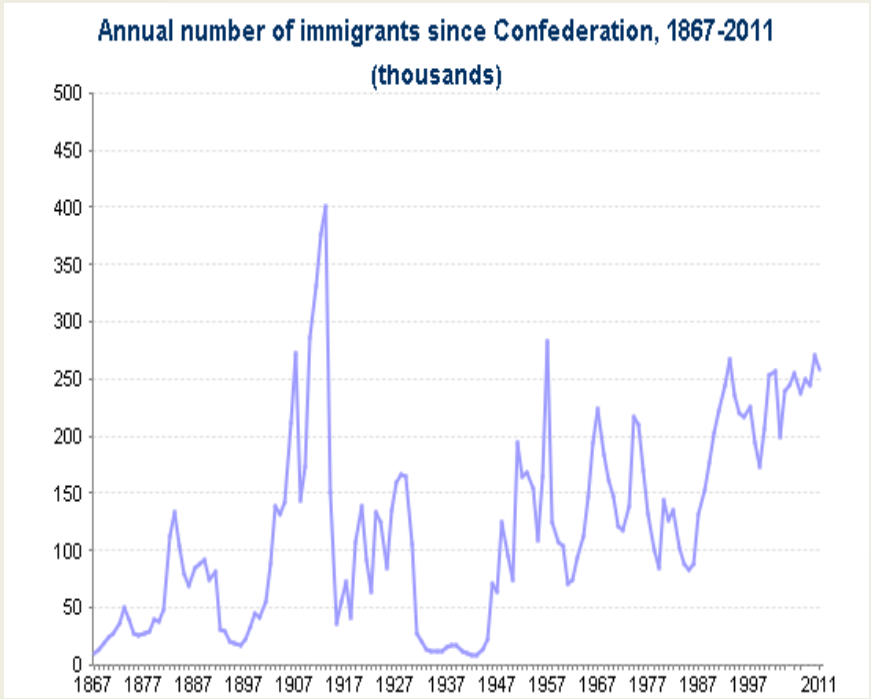
CNN video clip

- Syrian refugees find sanctuary in [Lethbridge] Canada (Mar, 3, 2016)
- http://www.cic.gc.ca/english/refugees/welcome/video/mohamed.asp

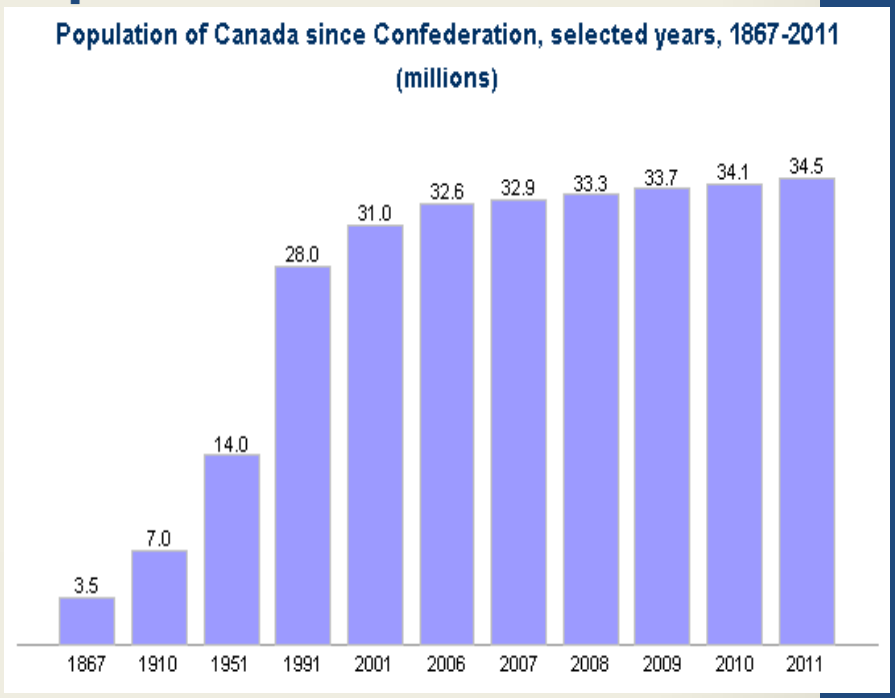
Immigrations & Canadian Population Growth

Statistics Canada, 2011, cited in HRSDC, 2012

HRSDC Canada 2012



Population Size & Growth



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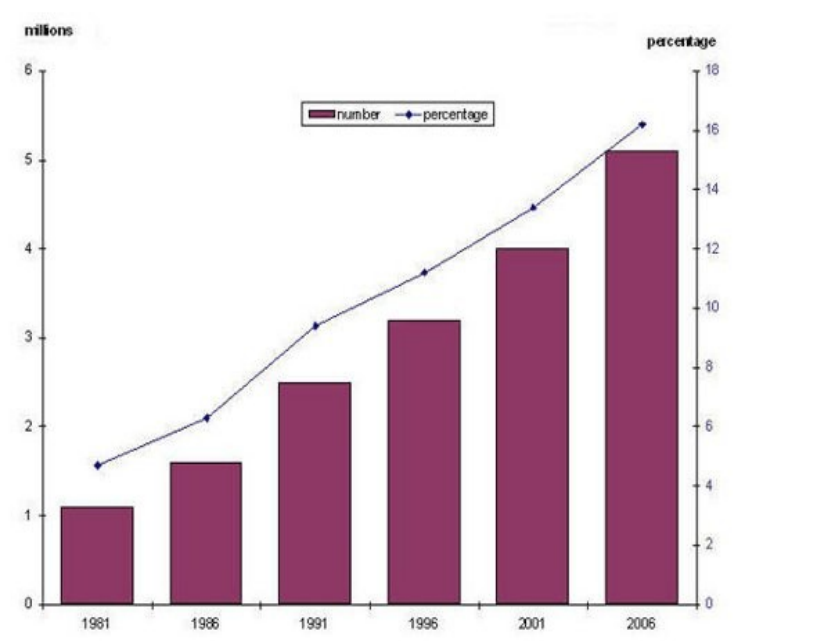
Canada's Ethnocultural Mosaic (Statistics Canada, 2007)

% of Visible Minorities in the Population, Canada 1981-2006



Visible Minorities

"The Employment Equity Act defines visible minorities as 'persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour.' (Source: 2006 Census Dictionary, Statistics Canada.)"

Will 'visible minorities' become the dominant group in some Canadian cities in the future?

In Contrast: Ethnicity & Economic Apartheid in Canada Galabuzi 2006

Changing Population &

- Increased racial diversity
- Above average educational attainment of new immigrants
- Unequal citizenship for racialized groups

Racialized Poverty

- A persistent and double-digit income gap – between racialized groups & other Canadians (1996-2001).
- Social inequalities by income and ethnicity intersect

Ethnic Differences in Health

Segall & Fries, p. 168; Smylie, 2009

Diversity in Aboriginal Peoples

- 300 distinct Indigenous languages
- 50 distinct language groups

10x > linguist diversity than Europe at the time of contact (Goddard, 1999, cited in Smylie, 2009).

Aboriginal Health

- Three major groups of Aboriginal peoples in Canada (FNMI):
  - First Nations
  - Metis
  - Inuit
- Status Indians - registered under the Indian Act (Government of Canada, 1995)
- Aboriginal peoples in Canada have been affected by multiple sources of social exclusion.

Social Inclusion/Exclusion

Social Exclusion

- Barriers to participation result from social inequalities in society (Raphael, 2007)
- Unequal power, opportunities
- Unequal access to resources
- Unequal development
- Unequal recognition and respect

(Yanicki, Kushner & Reutter, 2014)

Inclusion/Exclusion

- Inclusion is an ideal – for social relationships supporting participation, development, & recognition.
- A dynamic multidimensional process & a lived experience (Frieler & Zarneke, 2002)
- Enables/constrains participation
- A determinant of health (Galabuzi & Labonte, 2002)

Definitions of Terms

Segall & Fries p 167-168, 178-181

Base Group Matching Activity

- Ethnicity
- Ethnic Group
- Ethnoculture
- Ethnic ancestry/origin
- Race
- Racialization
- Racism
- Culture
- Ethnic Stratification

Definitions

(see handout)

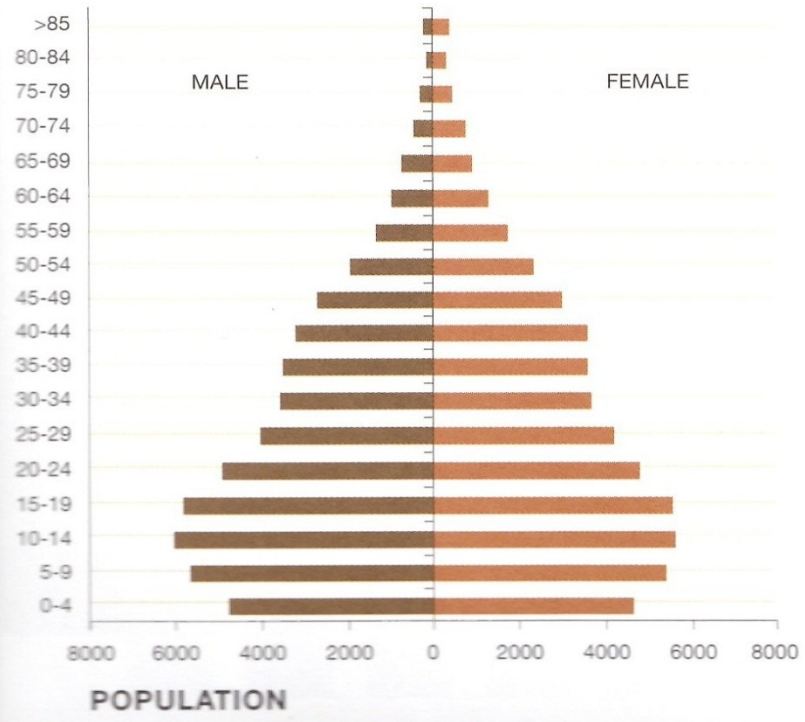
Demographics

- **The 2006 Census:**
  - 3.9% of Canadians reported Aboriginal heritage
    - Status Indians
    - Metis,
    - Inuit
    - Mixed ancestry

- Aboriginal Population by region of Canada (2001):
  - 67.3% the four Western Provinces
  - 19.3% in Ontario (highest absolute #)
  - 8.1% in Quebec
  - 5.4% in Atlantic provinces

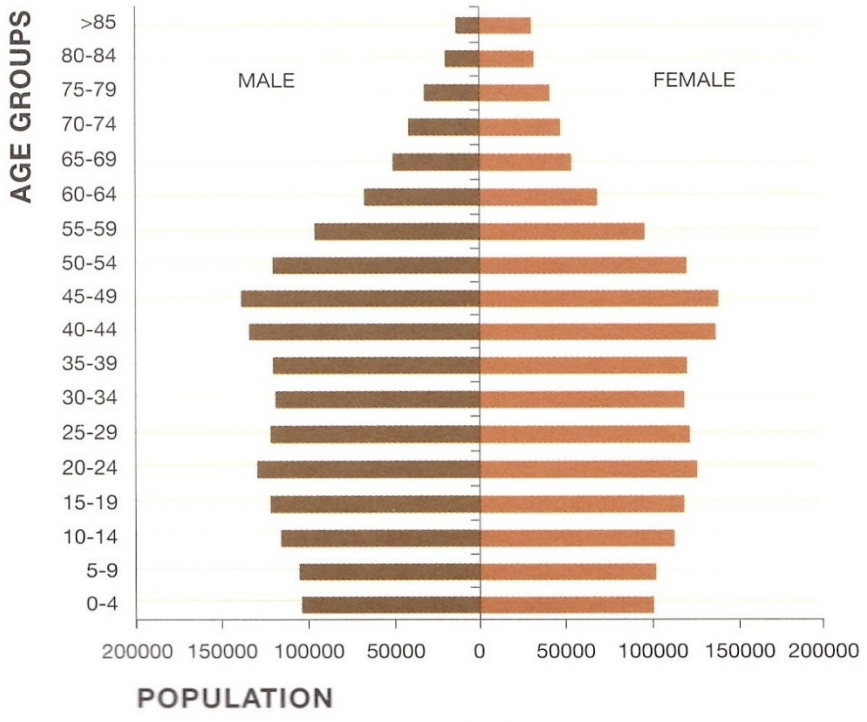
First Nations population pyramid for Alberta 2008 (Health Canada, 2010)

> **Figure 4:** Distribution of the Alberta First Nations Population by Age and Gender (2008)



Source: Indian Registry as of December 31, 2008, Indian and Northern Affairs Canada

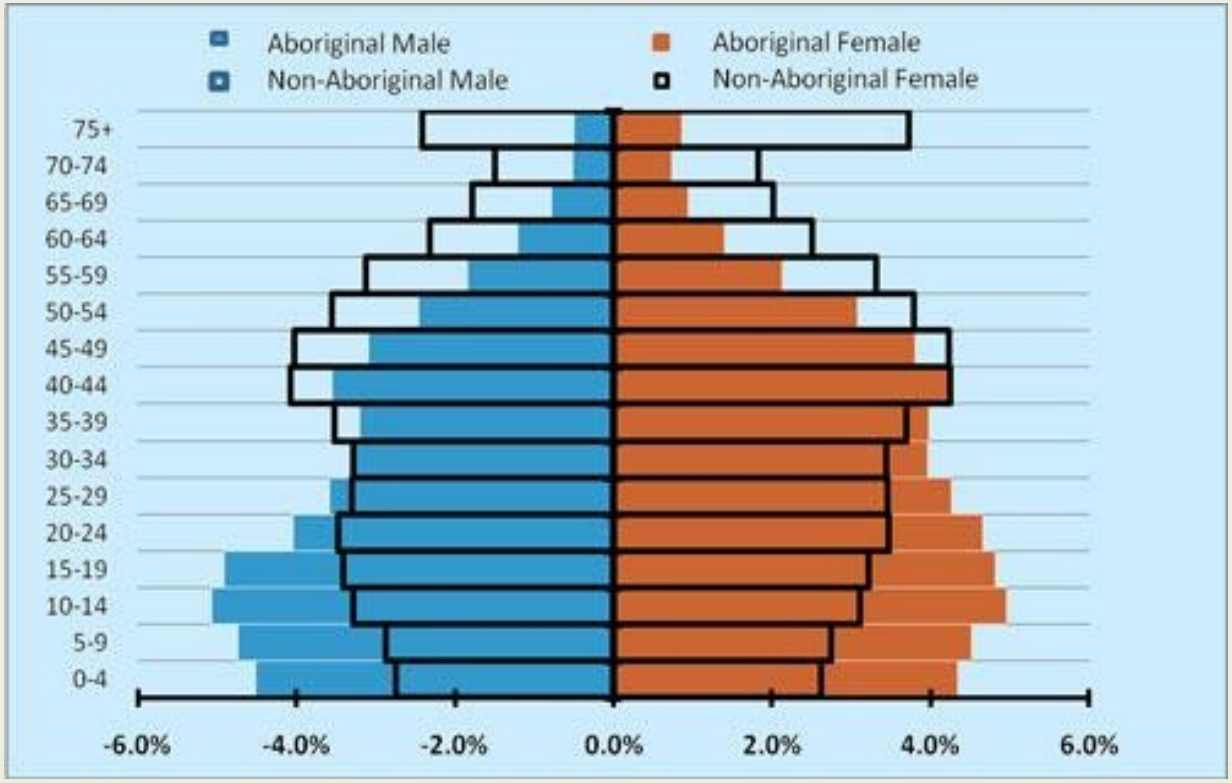
> **Figure 5:** Distribution of the Alberta Population by Age and Gender (2006)



Source: 92-591-XWE, 2006 Census, Statistics Canada

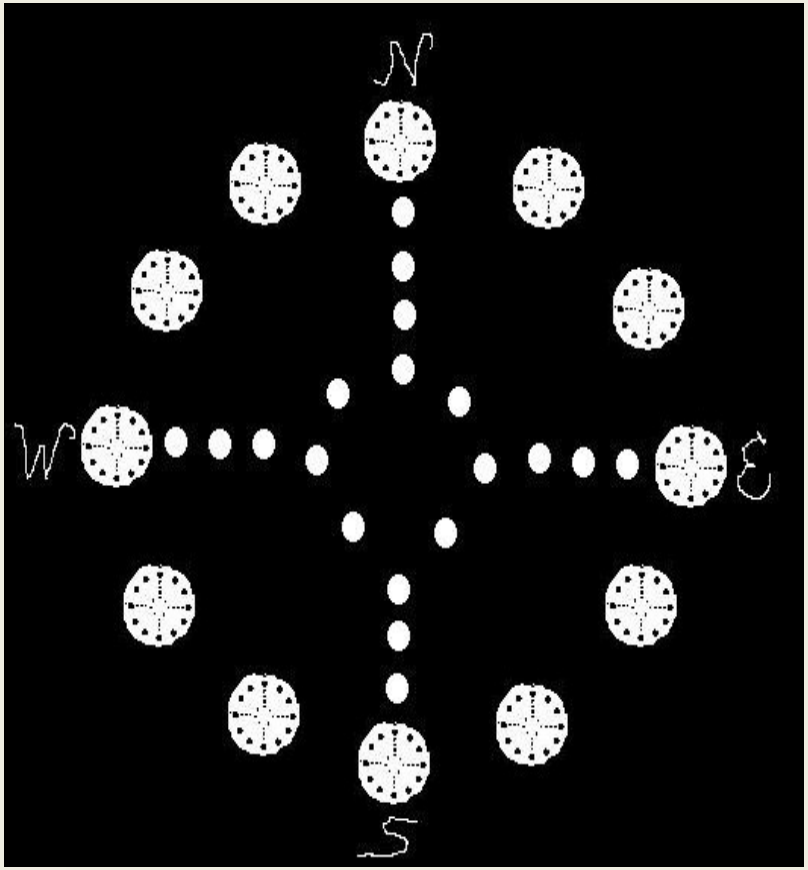
Age & Gender Distribution of the Urban Aboriginal & Non-Aboriginal Populations (%) , Gov. Canada, 2010

Almost 34% (213,945) of the urban Aboriginal population of Canada lived in five cities: Winnipeg, Edmonton, Vancouver, Calgary and Toronto (2006 Census Data)



Concepts of Health & Illness

- Balance
- Harmony
- Holism
- Spirituality



Historical Context

- How did we get to the current state of affairs for First Nations people?
- What is colonialism and how does it continue to affect First Nations people?

Colonialism

Menzies 2004, cited in Curtis, Garbb and Guppy, 2004; Stout, 2005, Smylie, 2009

Canada was built on a colonial system

- lands expropriated
- loss of power & self-governance
- institutions & languages banned
- marginalization
- disadvantages by race, gender and class" (p. 18)

Residential Schools

100 schools operated between 1849-1983

Colonialism

- Established relationships of
  - dependence
  - Subordination
- The results include:
  - Social inequities &
  - Health disparities

United Nations Declaration on the Rights of Indigenous Peoples (UN, 2006) – Canada signed in 2010

Right to:

- full enjoyment of all human rights and fundamental freedoms
- equality with all other peoples.
- self-determination
- autonomy or self-government (internal and local affairs)
- maintain and strength their distinct political, legal, economic, social and cultural institutions

Right to:

- a nationality
- life, physical and mental integrity, liberty and security of person
- freedom, peace and security as distinct peoples
- not to be subjected to forced assimilation
- revitalize, development and transmit their histories, language, oral traditions…
- maintain their language
- Establish and control their educational systems

United Nations Declaration on the Rights of Indigenous Peoples (UN, 2006)

Right to:

- dignity and diversity of cultures, traditions, histories and aspirations
- media in their own languages
- Improvement of their economic and social conditions including:
  - education
  - employment
  - housing
  - Sanitation
  - Health
  - social security
- development
- traditional medicines

Right to:

- highest attainable standard of physical and mental health
- conservation and protection of the environment and productive capacity of their land/resources
- consultations re: their lands and territories
- contact, relations and cooperation across borders
- recognition, observation & enforcement of treaties..
- consultation and cooperation with states
- Financial and technical assistance
- Just and fair procedures…

Types of Social Exclusion

(White, 1998; cited in Galabuzi, 2004, in Raphael, 2009, p.253-254)

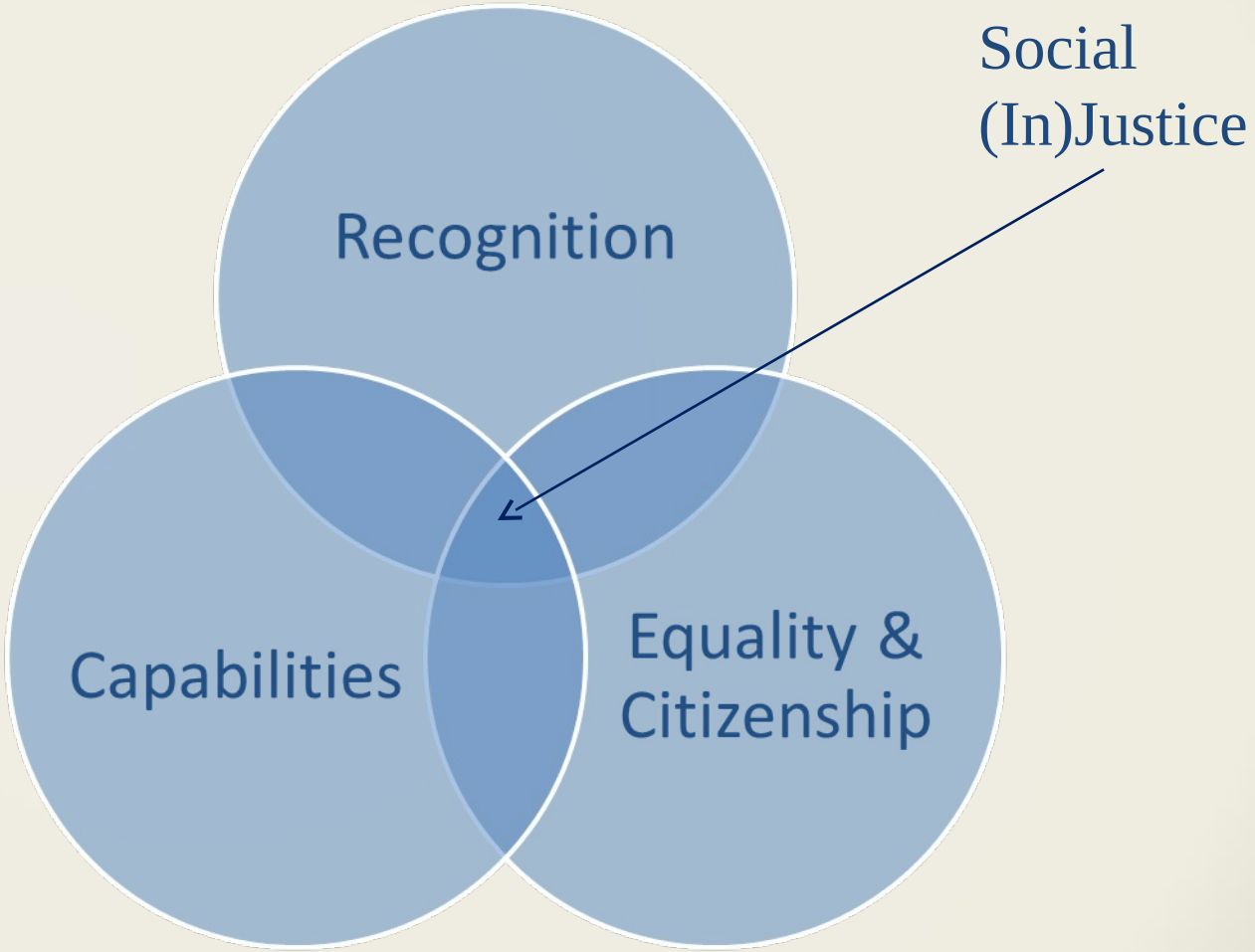
1. **Exclusion from civil society**
   - Legal sanction,
   - Institutional mechanisms,
   - Social isolation

2. **Exclusion by failure to provide for the needs of particular groups**
   - Denial of access to social goods
   - Failure to accommodate for the needs of groups with special needs

3. Exclusion from social production
   - Lack of opportunities to contribute to society
   - Barriers to participate in social/cultural activities

4. **Economic exclusion from social consumption**
   - Economic exclusion/
   - Material deprivation, Barriers to employment
   - Denial of a shared standard of living

Three ways of thinking about Social Inclusion/Exclusion in the literature



(Yanicki, Kushner & Reutter, 2014)

Review of Socio-demographic and Risk Factors for First Nations Peoples in Canada

- Keep track of the differing types of exclusion in the next section
- Population growth: Aboriginal identify population”
  - the fastest-growing segment of the Canadian population

Structural Determinants & Inequities

Shah, 2004; Smylie, 2009

- **Location:**
- How does rural or remote location affect health?

Rural vs Urban

2,284 reserves in Canada

> # of urban Aboriginal peoples versus those on reserve

How does rural & remote locations impact exclusion?

Structural Determinants & Inequities

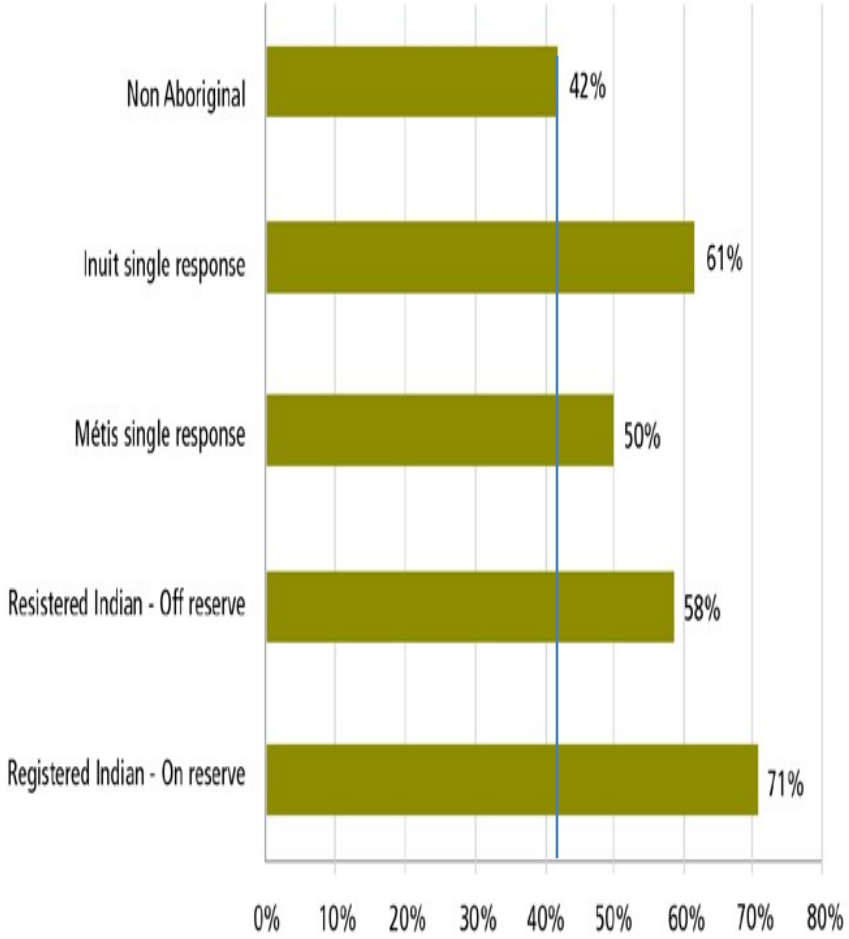
(Shah, 2004, in Raphael, 2004, p. 268-269)

- **Income & Poverty**
  - *Mean income from employment* (1997-98) was **50%** less than Canadian average
  - **44%** have incomes below LICO (more than double the Canadian rate)
- **Unemployment**
  - **29%** (1997-98) for on reserve (3x Canadian average)
- **Education** (1996)
- **54%** *had not completed high school* versus 34% of non-Aboriginal people

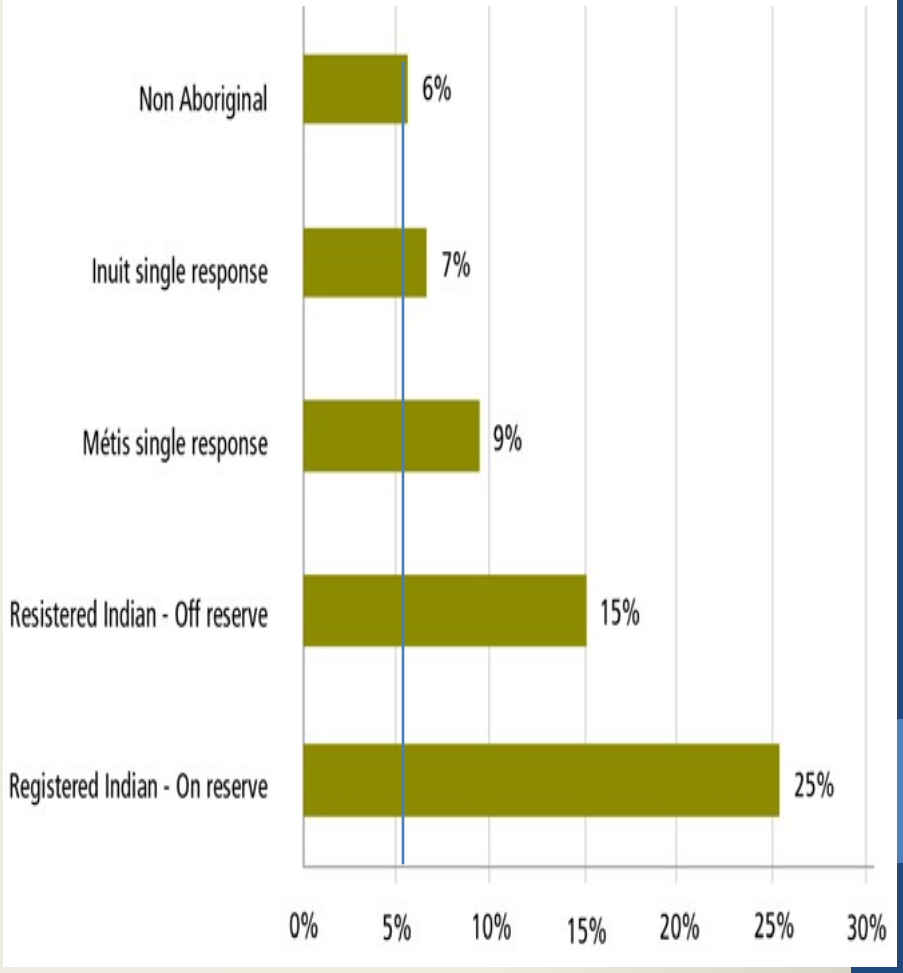
How do low educational attainment and low income influence exclusion?

Employment versus Unemployment
(Smylie, 2013)

Percent of Labour Force Earning <$20,000
(Statistics Canada, 2006)

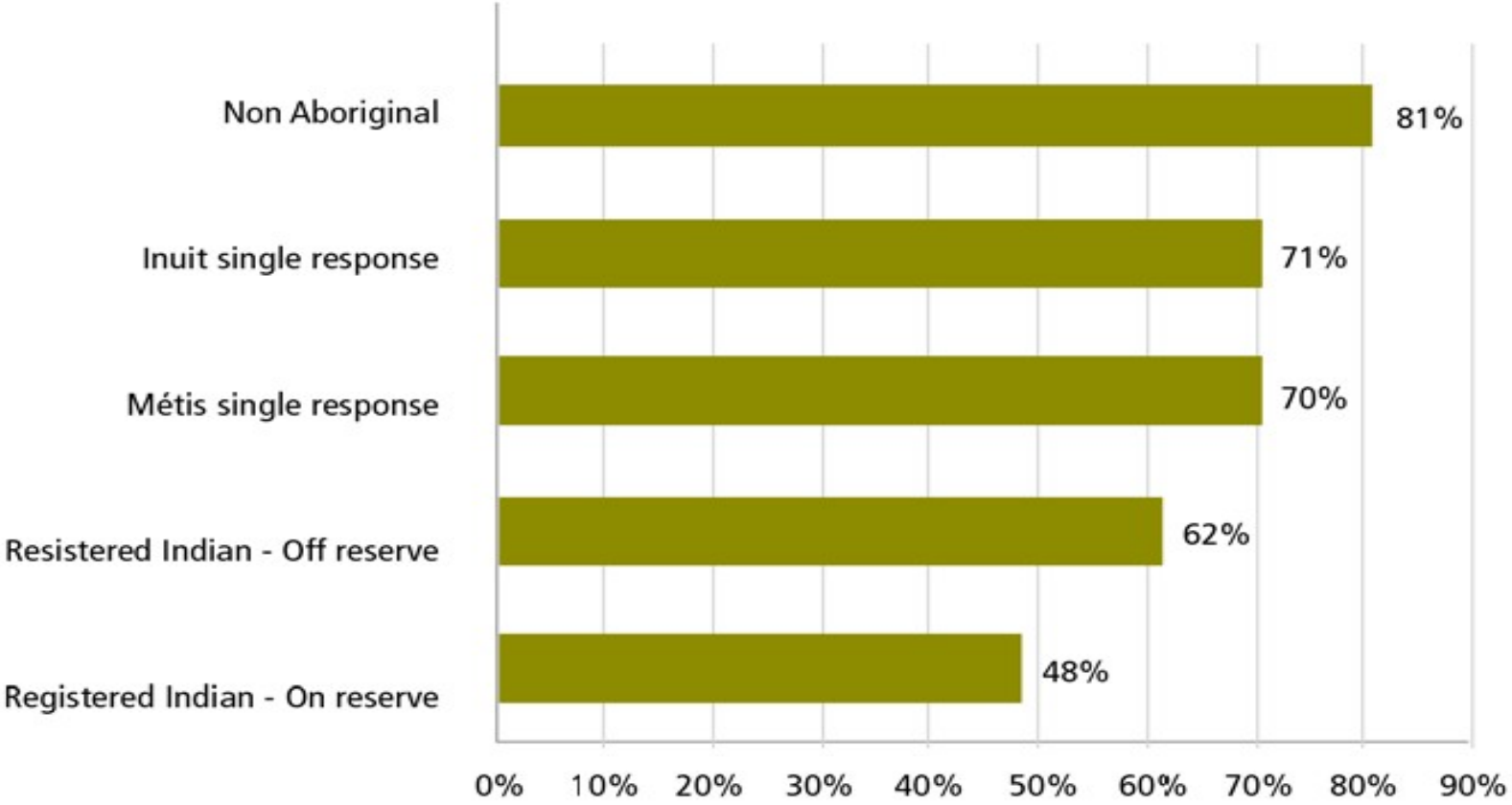


Unemployment rates
(Statistics Canada, 2006)



Education (Smylie, 2013)

Earned a certificate, diploma or degree (Statistics



Structural Determinants & Inequities

Shah, 2004; Smylie, 2009

- **Housing**
  - Four x > crowded living conditions for Aboriginal peoples
    - Inuit = 38%
    - Total Aboriginal = 11%
    - Non-Aboriginal = 3%
  - 50% homes in need of major repairs

= *Inuit children* have some of the highest rates of respiratory tract infection in the world (Kovesi et al, 2007)

- **Environment**

Differential exposure to contaminants can accumulate in fish and marine mammals

  - PCBs & mercury
  - *Inuit mothers* had higher rates of mercury & PCBs than the Canadian average

  - **Drinking Water**

¾ of the water systems were at significant risk to the quality of drinking water (Auditor General of Canada, 2005)

Social Environmental Context

- **Violence**

Shah, 2004, in Raphael, 2

  - **75%** of Aboriginal women are victims versus
  - 7% of Canadian women

  - **40%** of Aboriginal children in some northern First Nations communities have been abused

- **Children**
  - **Twice** as many Aboriginal children lived in lone-parent families & low-income families
- **Suicide Rates**
  - 2.5 x > for all age groups
  - up to 8 x higher for youth

Exclusion: Poor living conditions, loss of traditional lifestyle and loss of traditional cultural traditions, linked to low self-esteem, hopelessness and increased violence.

Community Well-being Index: First Nations verses other communities in Alberta

Well-being in First Nations Communities: Alberta 2006

- Community Well-Being Index, 2006

- 22 First Nations communities in Alberta reported scores of <50.

Local CWB scores:

- Lethbridge = 83
- Fort Macleod = 78
- Cardston = 80

- Piikani Band 147 = 54
- Kainai Band 148 = 53

i>clicker question # 2

Segall & Fries suggested that ethnic stratification leads to differences in health due to the following except:

a) differing racial characteristics such as skin color or eye colour

b) the unequal distribution of income and wealth

c) the unequal distribution of power and privilege

d) unequal opportunities for employment

e) unequal treatment of ethnic groups in society

Aboriginal Women

(Stout, 2005, Women's Health Research Bulletin)

- "*National Aboriginal Health Organization* (NAHO) critiqued health & social policies that focus on changing *individual lifestyle behaviours* rather than dealing with *historically determined power relations that have adversely affected the health of Aboriginal peoples*" (p. 19).

- NAHO closed Dec. 22, 2012 due to funding cuts by the federal government (web resources available to 2017)

Personal Health Practices & Risk

(Shah, 2004, in Raphael, 2004, p. 270-272)

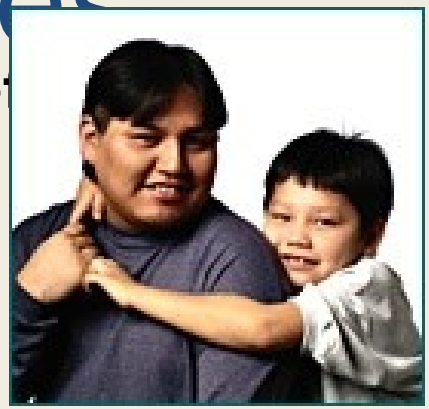
- **Smoking**
- > 2 x higher

- **Alcohol & substance abuse**
  - 2 - 6 x higher for youth
  - Aboriginal men are more likely to abuse alcohol and women are more likely to abuse other drugs alone.

- **Physical activity**
  - Loss of traditional lifestyles
- **Gambling**
  - among youth & adults
  - 15% severe pathological gamblers

Aboriginal Health Inequities

- **Higher rates of**
  - Obesity
  - Diabetes
  - Heart problems
  - Hypertension
  - Arthritis



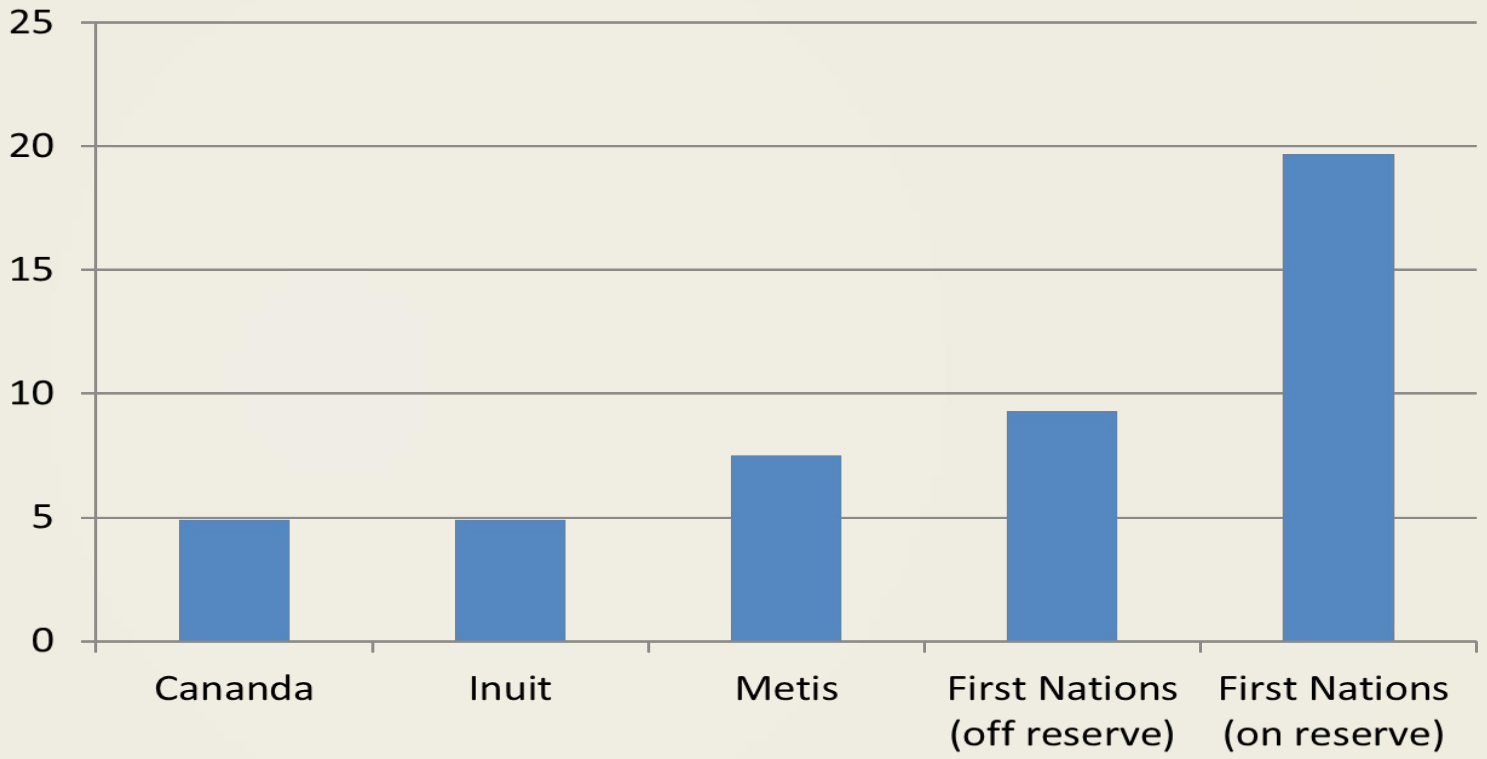
- **Why the differences?**
  - Loss of Traditional Diet
  - Loss of traditional lifestyles/activity
  - Income Inequality
  - Food Insecurity
  - Limited Access
  - Geographic Isolation

The *National Collaborating Centre for Aboriginal Health*, funded by the Public Health Agency of Canada seeks to address the knowledge gap in Aboriginal Health.

•Only 22 Random Control Trials addressing issues of obesity, diabetes, mental health, parenting, child conduct and substance abuse for Aboriginal Peoples in Canada (Saini & Quinn, 2013).

Diabetes: Prevalence

First Nations Centre, 2007 cited in NCCAB, 2013, p. 17



Aboriginal Women (Donner, 2005, p 28)

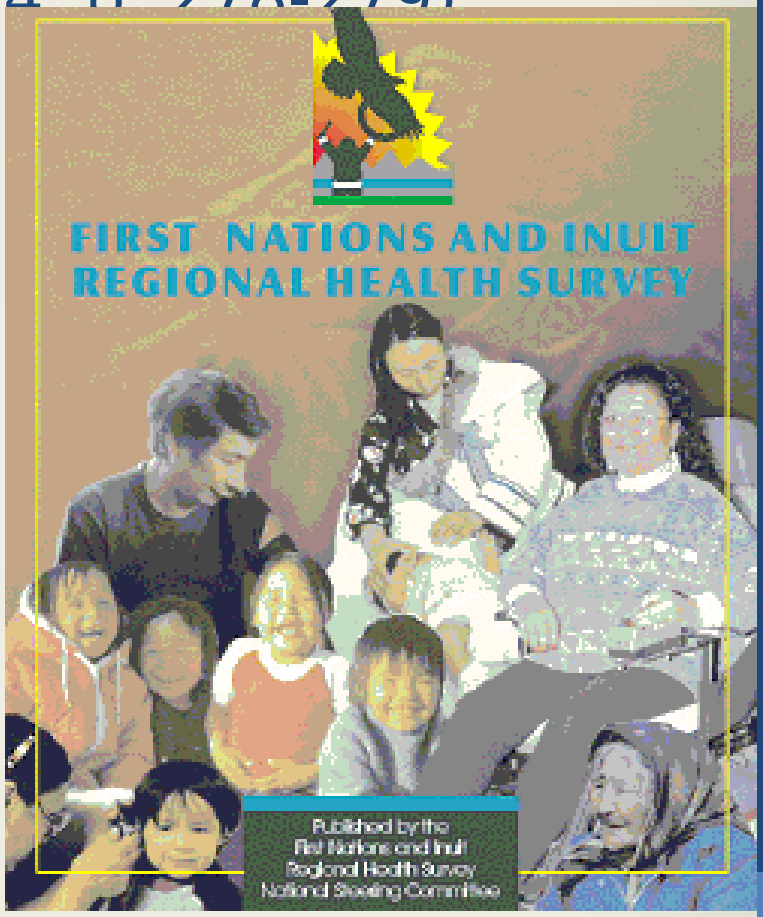
- **Aboriginal women are:**
  - more likely than Aboriginal men to be diagnosed with diabetes from the ages of 15 - 39 years.
- **Aboriginal men are:**
  - more likely to be diagnosed from ages 40 and up.

- **Aboriginal women (versus Canadian women):**
  - 3 x> rate of HIV/AIDs
  - 6 x >rate of Injection drug use
  - 5 x >rate of diabetes
  - 40% have gestational diabetes during pregnancy (vs 4%)

Self-Rated Health

Shah, 2004, in Raphael, 2004, p. 278-279)

- 40% Aboriginal women aged 55 - 64 reported fair to poor health



Recommendations:

Royal Commission on the Health of Aboriginal People (1997)

Principles of Social & Health Equity:

- “Equity in access to health and healing services
- Equity in health status outcomes
- Holism
- Aboriginal authority/self-management
- Renew strong communities, people and economics”

Iclicker question #3

Social exclusion results from inequalities in access to:

a) income, opportunities for economic participation and access to material goods

b) opportunities for cultural participation and recognition

c) opportunities for social and political participation

d) opportunities for personal development (education) and community development

e) all of the above

Class Discussion

- 1. What types of social inequalities underlie ethnic differences in health?

- 2. How could promoting social inclusion and reducing social exclusion influence health inequities among:
  - Aboriginal peoples
  - New immigrants?

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