

Research paper

The impact of inequality on health in Canada: a multi-dimensional framework

Ingrid RG Waldron PhD

Assistant Professor, School of Occupational Therapy, Faculty of Health Professions, Dalhousie University, Canada

What is known on this subject

- Independent analyses of inequality and discrimination that separate institutional, structural and everyday inequality do not go far enough in understanding the impact of inequality on the health of racialised communities in Canada.
- Health disparities between white and racialised groups in Canada are due primarily to the refusal by the Canadian healthcare system to challenge the privileging of Euro-Western ideology and epistemology.
- Inter-professional practice (IPP) can be a particularly useful approach for reducing and eliminating social and environmental determinants that have a negative impact on the health of racialised communities.

What this paper adds

- It contributes to the Canadian literature, offering a more inclusive framework for understanding the impact of inequality and discrimination on health.
- It recognises the significance of racism in producing poor health outcomes in Canada.
- It highlights the importance of IPP for healthcare delivery to racialised communities in Canada.

ABSTRACT

This paper argues that a truly critical understanding of health inequality requires an analytical approach that acknowledges the interactional and interdependent relationships between structural, institutional and everyday inequalities, and how these inequalities are informed by the intersecting relationships between race, culture, gender, citizenship status, socio-economic status and other social factors to determine health outcomes, health access and quality of care. The influences of macro-structural forces and micro-situational events on health outcomes are issues that have largely been analysed independently in the literature. This paper presents a Canadian perspective on these issues. It argues for an analysis that characterises inequality in its circuitous, contextual, multi-layered and multi-dimensional forms by articulating health outcomes for racialised and other marginalised groups as the product of the convergence between the macro-structural forces of

discrimination that often occur within societal institutions and structures, and the micro-situational discriminatory events that occur between individuals in everyday life. Finally, the paper suggests that reducing and eliminating poor health outcomes for racialised groups requires inter-professional partnerships between physicians, psychiatrists and other mental health professionals, nurses, social workers, community and settlement workers and other professionals, which would enable professionals in diverse fields to share different skills at various levels to help clients at different points in their lives within diverse clinical and non-clinical settings.

Keywords: everyday inequality, health outcomes, institutional inequality, macro-analysis of inequality, micro-analysis of inequality, racialised groups, structural inequality

Introduction

In Canada, racialised, immigrant and refugee groups are most at risk of the negative health effects that result from persistent health disparities, arising from race, socio-economic status, poverty, citizenship status and other social determinants, that expose them to macro-structural and micro-situational inequalities. (The term *racialised* is a sociological term that is often used to describe non-white and non-European heritage communities that lack social, economic and political power in white dominant societies.) Several Canadian studies have shown that the main determinants of health are not rooted in medical or behavioural factors, but rather in a host of social, economic and environmental factors that expose individuals to various health risks and barriers and produce health disparities between more and less advantaged groups (Raphael, 2004, 2007; Access Alliance Multicultural Community Health Centre, 2007). This paper uses a *social determinants of health* approach to examine how inequality and discrimination expose individuals to various social, environmental, economic and political factors that compromise the health status and well-being of marginalised groups, communities and jurisdictions. Raphael (2007) has identified the following main social determinants of health:

- health status and health services
- early life
- education
- employment and working conditions
- food security
- income and income distribution
- social exclusion
- social safety net
- unemployment
- employment insecurity
- poor quality housing.

Racial discrimination is one of the most important health and mental health issues affecting the lives of racialised groups. It occurs when ideologies of superiority and inferiority are put into practice in ways that exclude perceived inferior groups from accessing resources and participating in the social, economic and political processes in any given society. When we look at its implications for health, we find that discrimination often produces the psychosocial stressors that lead to health problems, and is a major barrier to access or utilisation of health services. Discriminatory practices are key factors in producing health disparities and poor health outcomes for racialised groups, in determining the place where members of these groups receive diagnosis and treatment, and in determining the quality of clinical services.

It is also important to consider how gender intersects with race to expose racialised women to a host of physical and mental health problems. An understanding of health and illness for racialised women must acknowledge their history as a racialised group that has experienced, for example, slavery, genocide or forced relocation, the existence of gender inequalities that accord them secondary status in the social, legal, economic and political institutions of society (e.g. discrimination in employment, housing and society, and unequal protection under the law) and their complex relationships with their own communities that simultaneously buffer them from the hard edge of discrimination and subject them to lingering internal problems due to a legacy of oppression. To give one example, Thomas Bernard (2003) found that, for black women in Nova Scotia, the cumulative effect of systemic racism in their lives puts them at increased risk of a host of chronic diseases and other health problems, including depression and suicide. Fear, mistrust, despair, alienation, loss of control, damaged self-esteem, drug and alcohol abuse, violence, high levels of stress and stress-related diseases, short lifespan, hypertension, cardiovascular disease, high blood pressure, stroke, psychological stress, diabetes, breast cancer and lupus were also noted.

The cultural embeddedness of whiteness and the implications for health

A discussion about discrimination generally, and racism specifically, would not be complete without an acknowledgement of how whiteness, white privilege and the hegemonic character of Euro-Western thought come to be enmeshed within the process and practices of modern-day institutions and manifested in the everyday mistreatment of racialised individuals. Moreover, an analysis of race as a predetermining factor for poor health outcomes and disparities lends itself to a focus on the ways in which Euro-Western ideology shapes conceptualisations of illness, assessments and treatment. Euro-Western ideology can be defined as the belief systems, knowledge, traditions and cultural norms that emanate from the European frame of reference and shape institutions in both Western and non-Western societies. The privileged status of this ideology worldwide allows for its dominance and centrality within various discursive and institutional spaces, including health. This cultural embeddedness of whiteness within discursive spaces and practices means that the dominance of Euro-Western thought remains unconscious, standard, universal, *common-sense* and consequently, the yardstick by

which non-white groups are judged. The *common-sense* knowledge in every society includes those ideologies, beliefs and traditions that constitute the moral fabric of that society, and that are presented and perceived as natural, obvious and normal. The cultural normativity of Euro-Western ideology accords it a kind of invisibility and privilege that allows it to be exercised from a hidden and unmarked space. Consequently, it continues to regenerate within the social structures, institutional practices and ideologies (Waldron, 2010).

Conceptualisations of illness and health are rooted in the *common-sense* knowledge of the society in which they operate, because the actions, beliefs and motives that provide the basis for understanding illness are conceptualised in unique ways. Assessments, diagnoses and treatment within health services are shaped, for the most part, by Euro-Western health belief systems that are often at odds with the health beliefs of culturally and racially diverse groups. When the health system presents Euro-Western health approaches as standard and universal, the consequence is often the denunciation, devaluation and marginalisation of the cultural belief systems and traditions that shape the health ideologies of culturally and racially diverse groups. Consequently, racially and culturally diverse groups are often less satisfied with the quality of care that they receive, or hesitant to access health services. This may result in the under-diagnosis of illness, lack of healthcare and poor health outcomes (Waldron, 2003, 2010; Carlsson and Jacob Johnson, 2004; Bernard and Moriah, 2007; Etowa *et al.*, 2007a; Khanlou, 2008; Kisely *et al.*, 2008). It is the invisibility, privilege and unquestioning of so-called *common-sense* knowledge within healthcare that is of concern in this paper, particularly with regard to how health disparities and outcomes can be traced directly to structural, institutional and everyday inequalities that are premised on race-based privileges. Therefore interrogating the hegemonic and imperial character of Euro-Western thought within medical knowledge is important if we are to understand the health disadvantages that are experienced by racialised groups.

Analyses of inequality: macro- and micro-level interactions

This paper argues that a truly critical analysis of health disparities between more and less advantaged groups in society is one that acknowledges differences in health outcomes and access to health services as a product of the convergence of macro-structural inequalities

and micro-situational inequities. It offers a multi-level analysis of discrimination by drawing connections between micro-situational analyses of everyday inequities and macro-structural analyses of inequality.

A macro-analysis of inequality reveals inequality as a product of historical and present-day processes and practices that are embedded within social structures, that permeate the institutions of modern-day society, and that limit opportunities to access social, economic and political resources. It is important here to acknowledge the subtle distinctions between structural and institutional inequality. *Structural inequality* refers to the policies of institutions which may be race/ethnic/gender/sexuality neutral in intent, but which have a differential and/or harmful effect on marginalised groups. It also refers to the behaviour of the individuals who implement these policies and control these institutions. *Structural inequality* operates through the laws, norms and rules of governance in every society. It is cumulative and persistent. *Institutional inequality* refers to the ways in which inequality is manifested and embedded in the processes, practices and policies within institutions in order to accord privileges to certain groups and subject other groups to disadvantages. It focuses on the availability and quality of societal and institutional resources, such as income, housing, social services, educational resources and health, and how these resources are distributed along race, class and gender lines.

Micro-analysis of inequality focuses on the everyday inequalities that characterise those unjust actions (conscious and unconscious) that are created and reinforced through everyday practices. These link *structural inequalities* with routine situations in everyday life and interactions. These everyday injustices (intentional and unintentional) occur in interpersonal relationships and daily interactions between individuals through verbal communication, gestures and behaviours that are experienced in negative ways by the victims.

Despite an increasing interest in multi-level analyses, few researchers have examined health as a product of the simultaneous and interactional effects of the macro-structural forces of structural and institutional inequality and the micro-situational inequities inherent in everyday discrimination. This paper addresses these limitations by arguing for an analysis that characterises inequality in its circuitous, contextual and multi-dimensional form, and by examining health outcomes and disparities as the product of the convergence between the two forms of inequity.

An interactional analysis for understanding health disparities and health outcomes for racialised groups

Independent analyses of macro-structural forces and micro-situational events

The influence of macro-structural forces and micro-situational events on health outcomes and disparities between various racial groups are issues that have largely been analysed independently in the literature. Many studies have largely failed to examine how poor health among racialised groups and health disparities between dominant and subordinate groups result from the convergence of structural, institutional and everyday inequalities and inequities. For example, several Canadian studies (Hyman, 2003, 2007; Ali *et al*, 2004; Gee *et al*, 2004; Women's Health Surveillance Report, 2004; Halli and Anchan, 2005; Haws, 2005; Wu and Schimmele, 2005; Newbold and Filice, 2006) have examined the *healthy immigrant effect* and provide evidence for the negative health effects of structural and institutional inequalities experienced by immigrant and refugee groups. According to Gee *et al* (2004), the *healthy immigrant effect* characterises the phenomenon whereby immigrants are found to be healthier than Canadian-born individuals upon arrival, but this effect tends to diminish over time, as the health of immigrants converges to the Canadian norm due to the development of chronic diseases and other health problems, over several generations among immigrant and refugee communities. Explanations given for the diminished health of immigrants include marginalisation, social inequality and discrimination, the migrant experience and poverty.

Several studies have shown that duration of residence in Canada and age can be used to predict health outcomes for immigrants. For example, the results of the 2000–2001 Canadian Community Health Survey, which were reported in the Women's Health Surveillance Report (2004), indicate that the health advantage that is experienced by recently arrived immigrants and refugee groups, compared with longer-term residents and Canadian-born people, gradually erodes over successive generations. Within the first two years of their arrival, immigrant women were less likely to report poor health than Canadian-born women, but after they had lived in Canada for 10 or more years, immigrant women were more likely to report poor health. Ali *et al* (2004) found that the rates of depression among immigrants who arrived 10–14 years ago and those who arrived 20–29 years ago were similar to those for the Canadian-born population.

Long-term residents who had lived in Canada for over 30 years have similar rates of alcohol dependence to the Canadian-born population. In addition, this study found that region of origin was significant, with immigrants from Asia having the lowest rates of depression and immigrants from Europe and North America experiencing rates similar to that found in the Canadian-born population.

Wu and Schimmele (2005) have questioned the health advantage of new immigrants, given that the migration experience may increase the risk of depression and other mood disorders. They found that age at the time of arrival in Canada has a significant effect on mental health status. Immigrants who arrived in Canada when under 18 years of age experienced poorer mental health than all of the other immigrants, due to the many difficulties that they faced in fitting into a new social environment, as well as the pressures arising from conflicts between values in their home environment and those in the school environment. In addition, since long-term immigrants who have lived in Canada for more than 10 years tend to be older than the average member of the Canadian-born population, it is not surprising that their health status is poorer.

Gee *et al* (2004), Newbold and Filice (2006) and Ali *et al* (2004) have also pointed to structural and institutional factors as health determinants for Canadian immigrants, namely age, duration of residence in Canada, self-selection in the immigration process and socio-economic factors (educational and occupational opportunities). For example, Gee *et al* (2004) examined the *healthy immigrant effect* among those in mid- and later life, aged 45–64 years and 65 years or over, respectively. They found strong evidence of a healthy immigrant effect among the younger age group, particularly recent arrivals. However, although the health of recent older immigrants was similar to that of the Canadian-born population, older immigrants generally were disadvantaged because of limited access to resources and facilities. Moreover, although recent mid-life immigrants, who had entered the country less than 10 years ago, reported better health than both those who arrived 10 or more years ago and Canadian-born individuals, those aged 65 years or over had poorer health than longer-term residents and Canadian-born individuals.

Newbold and Filice (2006) compared the health status of immigrants aged 55 years or over with that of Canadian-born seniors and found that although the crude prevalence rates for all health outcomes were similar for immigrant seniors and Canadian-born seniors, female immigrants experienced poorer health for all outcomes compared with the Canadian-born group. Moreover, although reported rates of chronic conditions were similar for immigrants and Canadian-born individuals, there were differences in reported

rates of specific conditions. For example, immigrants reported less asthma, cataracts, emphysema and heart disease than the Canadian-born group.

Research into micro-situational events also obscures and negates the interactional relationships between everyday discrimination and structural and institutional discrimination (Browne and Fiske, 2001; Samuel, 2004). Although there has been some attempt to address these limitations in research conducted in the UK and the USA (Schulz *et al*, 2000; Karlsen *et al*, 2005), the Canadian research has largely failed to articulate the interactional relationship between these multiple forms of discrimination. However, important gains are being made in the investigation of the interactional effects of institutional inequalities and everyday inequities. A study conducted by Noh *et al* (2007) is notable because it is one of few in Canada that offer a framework for future research on the interactional effects of macro-structural inequalities and micro-situational inequities. In this study, the authors argued that in Canada, both overt, everyday and subtle, structural and institutional discrimination have an impact on mental health through different intra-individual processes. They found that overt discrimination resulted in erosion of positive affect, independent of emotional or cognitive mediators, and that subtle bias resulted in more complex emotional and cognitive appraisal of experiences that produce distress. The authors' attempts to distinguish between the specific experiences of subtle and overt discrimination are promising, and speak to a need to examine the multiple levels at which health is negatively affected.

In this context, an interactional analysis must be characterised in five main ways, namely inclusive, interdependent, multi-level, multi-directional and contextual. Inclusivity is essential because it acknowledges the multiple social factors that determine health outcomes and disparities, such as race, culture, gender, sexual orientation, disability, language and citizenship status. Interdependence acknowledges health as a product of the intersections of multiple social factors (race, gender, social class, etc.) operating interdependently and simultaneously. The multi-level approach is necessary because both the macro- and micro-level events affect health. Interactional analysis also demonstrates the multi-directional character of discrimination and its impact on health, because it acknowledges how structural and institutional forms of discrimination produce and are produced by one another. Similarly, everyday discrimination produces and is produced by structural and institutional discrimination. This characterisation speaks to the circuitous nature of discrimination and suggests a kind of ongoing refuelling of discrimination that allows for its production, generation and regeneration in each historical moment. Finally, interactional analysis has a contextual nature because the determinants of health are constituted and manifested differently within and across multiple spatial, geographical, temporal and socio-cultural situations.

Initiatives geared towards reducing and eliminating health disparities and poor health outcomes for racialised groups must acknowledge how these factors are implicated in decisions to access health services, healthcare treatment that is meted out to racialised groups, follow-up care and health outcomes for these groups.

A multi-level interactional analysis

In proposing a multi-level interactional analysis for understanding the determinants of health, it is recognised that health disparities and poor health outcomes for racialised groups are produced from the interaction between structural and institutional inequalities and discrimination. These limit opportunities and restrict access to resources for racialised groups *and* give rise to the everyday forms of mistreatment that victimise racialised individuals (micro-situational events). It is also recognised that neither discriminatory macro-structural forces nor micro-situational discriminatory events operate independently or in isolation. Rather, they operate *together* and interdependently to determine health outcomes, health disparities, access to and utilisation of health services and quality of care with regard to clinical assessments, diagnoses, treatment and follow-up care.

The role of discrimination in healthcare access, utilisation and quality of care: macro-structural and micro-situational implications

Health disparities between more and less advantaged groups are often attributed to the multiple inequalities that have a negative impact on health, that deter or prevent individuals from accessing health services, and that result in the mistreatment of racialised groups by healthcare professionals. Clients may be unaware of the often subtle and seemingly benign institutional processes within healthcare that jeopardise their health. However, they are often acutely aware of how ideologies about difference influence the treatment that they receive from healthcare professionals, in the form

of misunderstandings, insensitivity, bias, disrespect and discrimination. Moreover, mistreatment is also manifested in clinical care, including diagnosis, treatment and follow-up care (Etowa *et al*, 2007b; Weerasinghe, 2007; Kisely *et al*, 2008).

Access to and utilisation of health services

Several Canadian studies have documented that race, ethnicity, gender, level of education, immigrant status and level of income act as barriers to health services and health services utilisation (Across Boundaries, 1997; Austin *et al*, 2002; Ahmad and Stewart, 2004; Sadavoy *et al*, 2004; Whitley *et al*, 2006). A study conducted by Across Boundaries (1997) in Canada suggests that many racialised individuals do not access health services because they are wary of receiving services which operate within a Euro-Western framework that they perceive as culturally at odds with their values, traditions and practices. More recent Canadian studies have examined access to health services by South Asian women (Ahmad and Stewart, 2004), Hispanic women (Austin *et al*, 2002), Tamil and Chinese seniors (Sadavoy *et al*, 2004) and West Indians (Whitley *et al*, 2006). These have identified lower levels of access to healthcare among members of these groups, which may be attributed to physicians' propensity to prescribe drugs, a desire for treatment and care that was premised on more holistic approaches, negative past experiences with health services, language barriers, healthcare that was at odds with cultural beliefs and traditions, and racism.

However, Fenta *et al* (2007) argue that there are inconsistencies in the research with regard to the extent to which immigrants utilise healthcare services. Several studies show that immigrants under-utilise health services compared with Canadian-born residents, whereas other studies indicate that they use these services more than the Canadian-born population. Various explanations have been offered for the under-utilisation of health services by immigrants, including language barriers, cultural distance between health providers and clients, unfamiliarity with the health system, and racism. To give an example, Fenta *et al* (2007) found that 85% of immigrants used at least one type of health service, and that a family physician was most frequently used. Few (12.5%) of these participants attended formal health services for mental disorders, but when they did so, they were most likely to see their family physician. The study also found that female participants were more likely than male participants to seek out health services from

mainstream healthcare providers, particularly family physicians and hospital inpatient services.

Other Canadian studies (Glazier *et al*, 2004; Quan *et al*, 2006; Gadalla, 2008) found that differences in the rates of health services utilisation can be attributed to a number of factors, including the number of years that immigrants have been resident in the new country, ethnicity, and the type of health service available or required. However, these studies contend that it is not clear whether the differences in rates are due to barriers to accessing services, lack of awareness of the services available, a health advantage that immigrants have upon arrival in a new country, or all of these factors.

Quality of care

The reluctance of, or refusal by, healthcare professionals to use complementary and/or alternative health approaches is one of the main reasons why culturally and racially diverse groups are often hesitant to access health services in Canada (Waldron, 2003, 2010; Whitley *et al*, 2006; Weerasinghe, 2007). One of the main tensions between Euro-Western medical approaches and others is that the former is premised on scientific approaches that, for the most part, perceive the mind and body as separate, whereas the latter are rooted in more holistic ideologies that conceptualise health as an outcome of physical, mental, emotional and spiritual imbalances. For example, Waldron (2003, 2010) has noted that many African-Canadian women often heal their mental health problems by combining Western psychiatric approaches with the more traditional practices that are indigenous to their cultures. This includes one or more of any combination of psychiatry, psychoanalysis, a family doctor, meditation, yoga, herbal remedies, solitude, regulation of diet, relaxation, social support networks, divination, spirituality and prayers. Moreover, these women's choice of treatment is determined by their personal beliefs about how mental illness is manifested. If they are struggling with relationship problems, their response will typically be medical and they will go to a family doctor or psychiatrist. However, if they believe the cause to be spiritual, they may go to an indigenous healer or engage in prayer or meditation.

Improving access to quality healthcare services for racialised groups requires the involvement of all levels of the healthcare system from the health services administrators, healthcare professionals and key policy makers. It also requires that these individuals take seriously the significance of race, racism and other differences in producing health disparities and poor health outcomes for racialised groups. Although the health system has been keen, to some extent, to look at

how cultural differences create barriers to healthcare, it has been less willing to acknowledge how race, racism and white privilege in society and within healthcare disadvantage, exclude and oppress racialised groups.

Improving access to health services for racialised groups: challenges and opportunities

Decreasing health disparities and increasing health access for racialised groups require a multi-pronged approach that acknowledges how health outcomes and disparities arise from the interactional relationship between macro-structural forces and micro-situational events. This approach must also address the social, health, educational, economic, political and environmental inequalities that exist in modern-day societies. Although it is beyond the scope of the health system to eliminate inequalities generally, it can play a role in helping racialised clients to cope with the contradictions, tensions and challenges of living in an unequal society. Therefore it is important that scholars, healthcare professionals and policy makers who are working in the area of health equity reconsider how equitable health outcomes and equitable relationships within healthcare agencies can be produced through a more critical analysis of inequality.

Increasing access to health services for racialised groups requires that health policy, health services and healthcare professionals work together to identify how ideological representations of race and other differences are manifested both in the healthcare system and in everyday interactions with clients. In doing so, it is critical that they question how bias, exclusion and discrimination become embedded and reproduced through unquestioned and common-sense ideologies and practices. Too often the focus is on changing the values, traditions and health behaviours of culturally and racially diverse individuals, rather than on addressing the policies, processes, systems and practices that need to be modified. Questioning the taken-for-granted and common-sense assumptions that are inherent to the health system should involve a consideration of how the infrastructure and physical environment of the clinical setting may be insensitive, intimidating and demeaning to racialised and other marginalised groups.

Several issues require attention with regard to the provision of equitable care. It is crucial that issues of race and racism are explicitly addressed. The visibility of race in white dominant societies and, as a result, the powerful currency that race and racial hierarchies hold in these societies suggest that racism is one of the more

salient issues facing racialised peoples. Moreover, race offers an intellectual, ideological and political entry point from which to challenge the hegemonic nature of Euro-Western knowledge and values within health.

There must be an appreciation of how multiple social identities operate in the lives of racialised peoples, and a willingness to challenge monolithic conceptions of communities (Gazso and Waldron, 2009). Such an appreciation requires an understanding of the complex relationality of these multiple identities and how they frame individuals' social, economic and political lives. Moreover, individual/personal factors and institutional/structural processes are assumed to intersect, interact and converge in multi-directional and fluid ever-changing relationships to produce diverse experiences of individuals and communities. Consequently, an intersectional analysis can be particularly useful when grappling with diversity, because it articulates how various disparate elements intersect and interact simultaneously. It also demonstrates how structures and processes influence social relationships and human interaction, and how individuals and groups are positioned differently within hierarchies of power. An intersectional analysis requires attention to the historical, material and structural contexts and conditions that produce societal inequality and the meanings assigned to it, as well as an interrogation of white privilege and patriarchy, and their accompanying ideological rationales for dominance. Such an analysis reveals the processes through which inequalities are produced and reproduced within institutional structures, and questions the power, privilege and dominance that result from unequal relationships. With regard to health, an intersectional analysis is useful for examining how multiple social identities intertwine and are expressed. It offers an alternative to biomedical frameworks that tend to homogenise difference or complexity by separating race from socio-economic status and gender as discrete rather than mutually constitutive concepts. It also challenges biomedical research paradigms that present race, gender and other social identities merely as characteristics of individuals, rather than as social relationships that are shaped by hierarchies of power, and that consequently disconnect those social identities from the historical, social and political processes from which they emerge.

Analyses that rely on a *social determinants of health* approach for articulating health disparities and outcomes for racialised groups are inherently oppositional to traditional health discourse, because they challenge the medicalisation of illness in academic scholarship and health policies and practices. Whereas Western medical discourse, for the most part, is premised on scientific ideologies and methods, a *social determinants of health* approach recognises the multiple systems, processes and phenomena that are external to the individual, and the fact that these influence health and produce

health disparities. Although this approach does not deny that illness may originate within the body independent of external forces, it embraces the notion that illness is a product of multiple, interdependent and multi-layered factors, many of which result from historical and present-day inequalities that are couched within the structures, systems and institutions of society. Studies by Raphael (2004, 2007) and others (Thomas Bernard, 2003; Halli and Anchan, 2005; Access Alliance Multi-cultural Community Health Centre, 2007; Etowa *et al.*, 2007a) have played an important role in bringing attention to the multiple social, economic and environmental factors that have a negative impact on health. However, their analyses lack a forceful and uncompromising argument about the significance and salience of race in producing poor health and mental health outcomes for racialised groups in Canada, and in shaping ideologies within healthcare services that often serve to negate, undermine, exclude and belittle racialised clients.

Consequently, health policies directed towards the development of health services that provide more practical therapeutic approaches, such as talk therapy and peer support, may be better able to respond to the everyday lived realities of vulnerable populations. Health policies and services must also attend to and validate the multiple ways in which racialised individuals seek help for and cope with health problems, many of which may be at odds with Euro-Western medical approaches. These include religion and spirituality, health practices that are indigenous to specific cultures, and complementary medicine that integrates alternative approaches and Western medical approaches. Recognising and validating these approaches may involve opening up opportunities for integration and synthesis between Western and alternative approaches in medical scholarship and professional practice, and nurturing more collaborative relationships between Western and alternative health professionals.

It is also crucial that health services encourage more inter-professional partnerships between diverse health professionals, and also between them and community-based agencies. These partnerships can play a crucial role in supporting individuals in coping with the multiple social, economic and environmental determinants that jeopardise health in both clinical and non-clinical settings. Unfortunately, since many community-based agencies fail to understand that these social, economic and environmental issues are in fact health issues, they lack an awareness of the role that they can play in improving health outcomes for racialised groups.

Collaboration between healthcare professionals in diverse fields, commonly referred to as inter-professional practice (IPP), is becoming increasingly important in the health professions and in the

Canadian healthcare system. IPP is viewed as one way to meet the demands of a healthcare system that is rapidly evolving and costly. Collaborative patient-centred practice is a practice orientation that involves healthcare professionals working together and with their patients. It involves the continuous interaction of two or more professionals or disciplines, in a common effort, to explore or solve issues and achieve the best possible outcome for the patient. Various Canadian reports and studies (Kirby, 2002; Romanow, 2002; Barrett *et al.*, 2007; Interprofessional Care Steering Committee, 2007; Margison and Shore, 2009) have identified IPP as an important requirement for delivering health services. The report by Romanow (2002) draws links between IPP and inter-professional education (IPE) by arguing that changing the way in which healthcare providers are educated is the key to achieving systemic change in the Canadian healthcare system. The report observes that changing trends demand that new models of care be developed, and that healthcare providers be educated and trained to use diverse methods for delivering healthcare services. IPE equips students of the healthcare professions with the knowledge, skills and attitudes necessary for future collaborative IPP. The goal of IPP, to be accomplished through education and training, is to eliminate the tradition of healthcare professionals working in silos and to adopt a system in which they interact in an inter-professional, collaborative fashion. There is a growing belief that IPP is one of the most cost-effective ways to deliver comprehensive and cost-effective health services to patients by multiple healthcare providers who work collaboratively to provide care within and across settings, particularly given that the distinctions and boundaries between individual healthcare professions are becoming increasingly blurred. IPP requires that healthcare professionals value the knowledge, competencies and experiences that their counterparts in fields other than their own can contribute to health service delivery.

However, although the Canadian literature provides strong evidence for the positive impact that IPP can have on healthcare delivery, health programmes and professional collaborations, it has yet to fully explore the impact of IPP on specific population subgroups, particularly under-served groups with limited access to health services. More research is needed in Canada on how IPP can be used to reduce the many barriers that face racialised and immigrant communities in accessing healthcare. IPP could not only help to sanction ways of sharing skills at different levels to help clients, but could also offer more opportunities for professionals to support one another in providing healthcare to clients outside the mainstream healthcare system, particularly since these clients are often hesitant to access these services.

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Ingrid RG Waldron, 1015 Barrington Street, Apartment 204, Halifax, Nova Scotia, Canada B3H 4R4. Tel: 902 405 7679; email: iwaldron@dal.ca

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