Social Science & Medicine 69 (2009) 538–542

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Short report

Racialized identity and health in Canada: Results from a nationally representative survey☆

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ARTICLE INFO

Article history:
Available online 25 June 2009

Keywords:
Canada
Race
Racialized identity
Socioeconomic status (SES)
Residential locale
Healthy immigrant effect
Diabetes
Hypertension
Self-rated health

ABSTRACT

This article uses survey data to investigate health effects of racialization in Canada. The operative sample was comprised of 91,123 Canadians aged 25 and older who completed the 2003 Canadian Community Health Survey. A "racial and cultural background" survey question contributed a variable that differentiated respondents who identified with Aboriginal, Black, Chinese, Filipino, Latin American, South Asian, White, or jointly Aboriginal *and* White racial/cultural backgrounds. Indicators of diabetes, hypertension and self-rated health were used to assess health. The healthy immigrant effect suppressed some disparity in risk for diabetes by racial/cultural identification. In logistic regression models also containing gender, age, and immigrant status, no racial/cultural identifications corresponded with significantly better health outcomes than those reported by survey respondents identifying as White. Subsequent models indicated that residential locale did little to explain the associations between racial/cultural background and health and that socioeconomic status was only implicated in relatively poor health outcomes for respondents identifying as Aboriginal or Aboriginal/White. Sizable and statistically significant relative risks for poor health for respondents identifying as Aboriginal, Aboriginal/White, Black, Chinese, or South Asian remained unexplained by the models, suggesting that other explanations for health disparities by racialized identity in Canada – perhaps pertaining to experiences with institutional racism and/or the wear and tear of experiences of racism and discrimination in everyday life – also deserve empirical investigation in this context.

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Introduction

Although the scientific idea of race – that the human species consists of a prescribed number of genetically distinguishable subgroupings – finds little purchase nowadays in scientific circles, many scholars argue that race remains a meaningful concept in the social sciences due to widespread belief in the scientific idea of race that gives it social reality (Better, 2007). "The social import of race has to do with society giving significance to people according to selective phenotypic characteristics, and treating the resulting groupings as though they are naturally constituted in and of themselves" (Li, 2008: 21). Racialized identities are identifications with "groups of people that have been socially and politically constructed as "racially" distinct… [They] have notable cultural dimensions, but they are primarily a manifestation of unequal power between groups" (Baum, 2006: 11). They are not synonymous with ethnic identities, the latter referring explicitly to groups that consider themselves to be culturally distinctive (Eriksen, 2002), because racialized identities are imputed to people who need not necessarily acknowledge or profess them as such. However, like ethnic identities, racialized identities are historically and contextually specific, characterized by "malleability, flexibility, and situationality" (Ahmad & Bradby, 2007: 796), and to the degree that racialized identities have cultural dimensions – or ethnic identities are shaped by relations of power (Eriksen, 2002) – they cannot always be readily disentangled from one another.

If a nation's approach to measuring "race" in its census of the population reflects the manifestation of racialized identities in that society, it could be argued that Asian, Black, North American Indian, and White are some of the more prominent racialized identities in the United States (King, 2000) and that Aboriginal, Black, Chinese, South Asian, and White (among others) are widely recognized racialized identities in Canada. But census questions are political

☆ The author is financially supported by a Senior Scholar personnel award from the Michael Smith Foundation for Health Research (2007–2012). Access to the master file of the Canadian Community Health Survey 2.1 was facilitated by the Canadian Initiative on Social Statistics which is jointly administered by the Social Sciences and Humanities Research Council of Canada, the Canadian Institutes of Health Research, and Statistics Canada. Cheryl Hon helped to review and summarize the health determinants literature on race, ethnicity, and health in Canada and Wendy Roth and four anonymous reviewers provided extremely helpful comments on earlier drafts of the article.

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doi:10.1016/j.socscimed.2009.06.009

constructions by the state and cannot be trusted in this regard (Kertzer & Arel, 2002). An identity may be racialized but not included in that nation's census race question, identities that are racialized in some intra-national contexts may not be racialized in others, and over time some racialized identities may split into several identities or merge with others. These factors make the identification of a contemporary suite of salient racialized identities in multicultural nations like the United States or Canada an inherently problematic endeavour.

Because processes of racialization are fundamentally processes of power and inequality, they likely have repercussions for health and well-being and, therefore, deserve attention from population health researchers, despite the difficulties inherent to operationalizing racialized identities in quantitative survey research. Institutional racism "denotes those pattern, procedures, practices, and policies that operate within social institutions so as to consistently penalize, disadvantage, and exploit individuals who are members of nonwhite racial/ethnic groups" (Better, 2007: 11). Embedded in social institutions, social structures, and bureaucracies, systemic forms of racism can limit opportunities for higher education, prestigious jobs with high salaries (or any jobs at all), health insurance and quality care and so forth for people of certain racialized identities, with repercussions for health and well-being. It can concentrate some groups of people in economically impoverished regions possessing relatively few health and social services or in segregated urban residential areas that suffer inordinately from a lack of amenities or the presence of environmental toxins, with implications for the health of area residents. In addition, discrimination on the basis of racialized identity can affect health directly via the negative psychological and physiological effects of regularly experiencing it in everyday life.

Although they do not always use racialization vernacular per se, American health researchers have documented sizeable health disparities between people identifying with various racialized identities in the United States, finding, for example, that hypertension (Kurian & Cardarelli, 2007), stroke (Sacco et al., 1998), and poor self-rated health (Borrell & Dallo, 2008) are more prevalent among people identifying with Black than with White and that diabetes is more prevalent among people identifying with Black or Native American than with White (Jovanovic & Harrison, 2004). Experiential racism appears to explain some Black/White disparities in hypertension (Krieger & Sidney, 1996; Krieger, 2000), residential segregation has been implicated in Black/White differences in mortality and other health outcomes (Acevedo-Garcia, Lochner, Osypuk, & Subramanian, 2003), and educational attainment and income are thought to contribute substantially to explaining many health disparities by racial identity in the United States (Nazroo, 2003).

Most of this kind of research in Canada has focused on the plight of Aboriginal peoples in particular, finding, for instance, that Aboriginal life expectancy is substantially lower than the national average, that Aboriginal people are more likely than other members of the Canadian population to die from injuries or poison, that the suicide rate is much higher for Aboriginal youth than for any other group of Canadian youth (Shah, 2004), and that deaths from diabetes are more common among Aboriginal peoples than in the Canadian population (Young, Reading, Elias, & O'Neil, 2000). Socioeconomic factors are clearly implicated in many of these outcomes (Shah, 2004). Research on other racialized identities in Canada is much rarer. One investigation of the health of immigrants to Canada found that immigrants from the Americas and Europe tend to have worse health than immigrants from Asia and Africa (Newbold & Danforth, 2003), while a study of Canadians from European, South Asian, and Chinese backgrounds reported all-cause mortality rates that were highest for Europeans and lowest for Chinese (Sheth, Nair, Nargundkar, Anand, & Yusuf, 1999). Another study reported lower than average scores for self-identified Aboriginal, East Asian, and Southeast Asian Canadians and higher than average scores for self-identified Black, French, and English Canadians on a self-rated health variable, differences that were not explicated by socioeconomic status (Wu & Schimmele, 2005). Canadian health research that incorporates a range of different racialized identities – which are clearly distinguished from ethnic identities – and that investigates a variety of possible explanations for health disparities by racialized identity therefore remains forthcoming.

Using nationally representative Canadian survey data from 2003, this article documents empirical associations between a proxy measure of racialized identity that distinguishes between respondents who identify themselves as Aboriginal, White, Aboriginal *and* White, Black, Chinese, Filipino, Latin American, or South Asian and three morbidity indicators – diabetes, hypertension, and self-rated health – and then attempts to provisionally explicate these health disparities by introducing socioeconomic status (educational attainment and household income) and residential locale (urban/rural locale and national region of residence) to multivariate regression models. Although it is certainly possible that socioeconomic status and residential locale are both influenced by the presence of systemic racism in Canadian society, the health effects of racism and discrimination could not be directly investigated with these data.

Methods

The *Canadian Community Health Survey 2.1* was conducted by Statistics Canada in 2003. A total of 134,072 usable responses were obtained with a national response rate of 80.7%. The survey respondents aged 25 and older ($N = 109{,}967$) are described in Table 1. Younger respondents were excluded in order to produce more stable measures of educational attainment and household income. Statistics Canada recruited interviewers with a wide range of language competencies and translated survey questions into French, Chinese, Punjabi, Inuktitut, and Cree. Because Indian Reserves were not sampled by Statistics Canada none of the results reported here apply to on-reserve Aboriginal people.

Racialized identity was operationalized via the following survey question: "People living in Canada come from many different cultural and racial backgrounds. Are you: White? Chinese? South Asian (e.g., East Indian, Pakistani, Sri Lankan)? Black? Filipino? Latin American? Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)? Arab? West Asian (e.g., Afghan, Iranian)? Japanese? Korean? Aboriginal (North American Indian, Métis, or Inuit)? Other – Specify." Interviewers were instructed to read all of the categories to the respondent and to record all that apply. A racial/cultural identification variable with mutually exclusive categories was derived from this question and is summarized in Table 1. The Southeast Asian, Arab, West Asian, Japanese, and Korean categories were not further considered here because of small representation in the samples used in the multivariate analyses. Finally, those respondents who selected *both* of the Aboriginal and White identities were extracted from the original "multiple origins" category and placed in their own category; this represents the only sizeable "bi-racial" identification in this dataset.

Many different health indicators are available in the CCHS 2.1. Self-rated health was chosen because it is a good measure of overall health and well-being and is predictive of mortality (Idler & Benyamini, 1997). Diabetes and hypertension were chosen because they are both known to be associated with racialized identity in the United States (Jovanovic & Harrison, 2004; Kurian & Cardarelli, 2007). Respondents were asked: "I'll start with a few questions about your health in general. In general, would you say your health

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