Impacts of racial discrimination on people's health and public health systems in multicultural societies

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Abstract

Systemic racism represents a major threat in multicultural societies in which racial biases and framing still play a significant role in the creation of public policies and organizing public systems such as health care. This paper argues that racism and racial framing directly influence negative effects on people's health, especially among minority groups such as African Americans in the United States and Aboriginal people in Canada. These groups of people are more likely to get unsatisfactory or inadequate medical service and suffer from chronic illnesses, such as cardiovascular problems, diabetes, mental health issues, drug abuse and overdose, or HIV infection more/in a higher degree than the white population. Furthermore, racism has a direct impact on inequalities in health care systems due to a lack of diverse health care providers in more urban areas and inaccessible treatment because of geographical reasons or cultural differences. In this paper, we have taken into consideration the concept of race and ethnicity, decades of racial framing in the United States and Canada, and shown the negative impacts on health within different ethnical groups. The paper concludes by emphasizing the need for structural change within health care systems.

Key words

racism, racial framing, health care systems, United States, Canada

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Introduction

Health care systems around the world have experienced exceptional change, restructuring, and downsizing in the last two decades. In the media, we can often hear health policy experts describe health care infrastructure as being in a state of crisis. Health care providers are faced with caring for patients with increasingly complex health challenges. Patients are getting sicker because of the impacts of climate change, hospital stays are shorter due to low income, and medical treatment is becoming more inaccessible because of social, economic, political or geographic determinants. At the same time, communities like those in the United States of America and Canada are becoming increasingly diverse every year. The heterogeneity of one population is also reflected in the health care system.

The health care system, complex as it already is, is even more complicated for people of color, minorities, and "others", as they face different obstacles in getting fair and good treatment because of various forms of discrimination that go way back to the times of racial framing and racism in general. This paper aims to examine the influence of race and ethnicity on health care systems and services, and what kinds of outcomes racism in all its forms has on the health of people of color and ethnic groups, as well as their treatment within the health care system. The main hypothesis of this paper is that people of color (e.g. African Americans) and ethnic minorities (e.g. Indigenous people) are more likely to get worse health service and to suffer from chronic diseases in a higher percentage than the white population.

Decades of systemic racism have left significant consequences on contemporary health systems and on the ways in which these systems fail to provide the same quality of health care to all who need it. In this paper, we will introduce and analyze concepts of race, ethnicity, and racism, and show how racism can be “measured” in health care. Furthermore, along with a descriptive revision of literature, we will give an overview of the different impacts of discrimination (racism) on people's health, and why groups such as black people and Aboriginal people are more likely to suffer from high blood pressure, mental illness, HIV and AIDS or higher infant mortality.

Understanding race and ethnicity

Race and ethnicity are issues of high importance not only in social sciences but also in public health. Public health is the organized effort of society to protect, promote and restore the public's health (Weeramantrhi, 2000:2).

Race is a word frequently used in general conversation and the media. It is enshrined in constitutions and legislations, such as the "racial discrimination acts" (Weeramantrhi, 2000:2). The concept of race is taken to be a result of its extensive use in assembling boundaries that simultaneously include and exclude people and lead to imagined communities (Pettman, 1992). Several features are associated with the use of the term race in scientific literature, especially in the last couple of years (Weeramantrhi, 2000:2). The first feature is the notion that a specific moral character can be imputed to a person based on their physical type; the second feature is the creation of associated hierarchies where the people constructing the hierarchy generally find themselves in the highest stratum with the right to dominate others (Weeramantrhi, 2000:2-3).

However, we cannot talk about race or ethnicity without mentioning culture. Culture is perceived as the process of cumulative adaptation of a social group to a particular environment (Shannon, 1994:33-34). On the other hand, an ethnic or racial group refers to a culturally defined group that may include common geographic origin, language, and faith, as well as shared traditions and values (Polednak, 1989:4-5). Like race, the concept of ethnicity can be mobilized for political purposes, and the expansion of shared political values and traditions can shape ethnic identity.

Before conceptualizing racism, in this case as a determinant of health, it should be acknowledged that racism is only one of several causes of ethno-racial differences in health. Sociocultural and socioeconomic differences between ethno-racial groups also contribute to such disparities (Paradies, 2016:1). So, racism impacts health and wellbeing, and it does so in interaction with other oppressions such as sexism, homophobia, and classism (Bauer, 2014:12). The study of racism as a determinant of health has predominately focused on understanding how discrimination impacts health through several recognized pathways:

„First, reduced access to social outcomes such as employment, housing, education, and increased exposure to risk factors such as racial violence; second, negative cognitive or emotional and related pathopsychological processes such as hypervigilance and anxiety; third, allostatic load and concomitant pathopsychological processes; fourth, diminished participation in healthy behaviors – sleep and exercise and increased engagement in unhealthy behaviors such as drugs, smoking or alcoholism; and fifth, physical injury as a result of racially motivated violence" (Paradies, 2016:2).

To sum up, various socio-economic aspects directly influence racial discrimination towards individuals, which is, ultimately, reflected not only in their health but also in their way of life, education or employment. This is one of the numerous reasons why we are witnessing an increasing number of progressive policies being put on the political agenda to tackle unjust systems and systemic discrimination in different forms.

“White supremacy” and racial framing through history

Research on inequality typically focuses on health problems faced by people of color, while neglecting to mention white perpetrators with racist practices and institutions which create the problems. However, Feagin and Bennefield focus throughout their research on the roles, framing, and institutionalized actions of influential white people and problematize them as responsible for many health-related problems (2013). They claim that “[t]he majority-white decisionmakers include public health researchers and policymakers, medical educators and officials, hospital administrators, and insurance and pharmaceutical executives, as well as important medical personnel” (Feagin and Bennefield, 2013:8).

Many researchers who have dealt with the topic of social inequality in every aspect of society have managed to develop concepts such as bias, prejudice, cultural competence or racial hate. The gathered data suggests that the conduct of the majority of white health care and public health personnel is based on white framing, with its pro-white and racist orientation; moreover, this framing includes notions of biologically and culturally distinct racial groups, and links them to discriminatory practices which account for institutionalized inequalities in health care and health (Feagin and Bennefield, 2013:8). Public health communities, with their dominant white leaderships, seem reluctant to examine the current impacts of past racial oppression in U.S. medical and public health institutions. Systemic racism and medical and biological science, including the latter’s medical and public health practices, evolved together in society (Feagin and Bennefield, 2013:9). Medical treatments and public health practices were often matters involving white racial framing. For example, in the 18th and19th centuries prominent white physicians, medical professors, and biological scientists played a central role in creating the concept of “race” at the heart of the still-dominant white racial framing (Feagin, 2010).

„In the 19th century, profit-driven growth of the scientific medical system pressed white physicians and scientists to discover technologies and treatments to serve whites. In the South medical experiments were carried out on black women that no white physician would try on whites. This resulted in death for many enslaved women and set the model for continued use of African Americans as guinea pigs for medical progress, as well as for white physicians’ provision of inadequate care for them. Black women were often denied treatment for real ailments, resulting in excruciatingly painful deaths for many. The racialized abuse endured today by black patients frequently replicates the racialized abuse their ancestors suffered.“ (Feagin and Bennefield, 2013:9)

Furthermore, Washington highlights one important aspect of history, an act of injustice towards black women. Black women were subjected in a higher percentage to “eugenics” in the early 20th century by doctors and scientists. According to Washington, „eugenics was appropriated to label Black women as sexually indiscriminate and as bad mothers whose biology caused them to give birth to defective children. The demonization of Black parents, especially mothers, as medically and behaviourally unfit has a long history, but twentieth-century eugenicists provided the necessary biological foundations to scientifically validate these beliefs” (2006: 191). Feagin and Bennefield also mention Margaret Sanger, birth control pioneer, who helped devise a 1939 “Negro Project,” which sought to reduce the black population through negative eugenics (2013: 9-10). Due to her lobbying, numerous forms of birth control were tested in black communities. Because of high levels of hormones in early pills, black women were exposed to high health risks such as hypertension and stroke.

How to measure racism in health care?

Paradies states that one of the most persistent challenges in operationalizing health effects is the complexity involved in attributing a particular event to racism (2016:2). If we think about it, racism can be subtle, unintentional, and even unconscious. Subjective experiences of racism may be caused by different forms of oppression, while objectively racist experiences may be attributed to other forms of oppression. Moreover, some forms of systemic or internalized racism are frequently not perceived as such and may not be perceivable by those affected. With regard to approaches to operationalizing racism in health research, one can distinguish between indirect inference and direct perception. Concerning indirect inference, Habtegiorgis and Paradies have stated that the relationship between racism and health is inferred by eliminating other possible explanations such as randomization or matching, and by using decomposition or causal inference approaches; any residual or unexplained differences by ethno-race are considered to be due to racism (2013). An indirect approach to studying racism is, generally, the only available option when racism is not perceivable or expressible by individuals or when racism cannot be readily or comprehensively measured – as is the case for some forms of systemic and internalized racisms (Paradies, 2016:3). Direct approaches that involve the self-reporting of internalized, interpersonal, or systemic racism as an endangerment are the ones most regularly utilized in evaluating health impacts. Although the self-reporting of racism is influenced by a range of psychological and sociodemographic factors, in no sense is this kind of racism experienced or perceived; on the other hand, however, it is neither imagined, fabricated, nor illusionary (Paradies, 2016:3).

There are several factors to consider in the understanding, attribution, and reporting of racism, and Paradies highlights three of them: "overestimation due to system blame, external attribution, or aspects of identity or social context that may lead to hypervigilance or hypersensitivity; underestimation due to internalized racism, internal attribution, or aspects of identity or social position, including social norms and pressures, that may preclude recognition or conscious awareness of racism; and cognitive or affective and methodological factors such as domain priming or social desirability bias that can either increase or decrease the perception, attribution, and reporting of racism" (2016:3).

Differences between indirect and direct studies of racism in health care systems

We can agree that most of the effects racism has on health are exercised through institutional mechanisms, which makes them difficult to measure in epidemiological studies. Berard says there is a noteworthy conceptual debate about the nature of systemic racism, including the role of individuals, and whether nonhuman actors such as organizations can perpetrate anything in and of themselves (2008:741-742). For example, residential racial segregation, well known in American history, the physical separation of ethno-races in different residential areas, is an obvious example of such institutional mechanisms at work.

Kramer and Hogue believe that residential segregation adversely affects health in multiple ways, resulting in higher rates of mortality, as well as disparities in certain chronic and infectious diseases (2009:184-188). But if we think about it in a broader context, it can also serve to limit access to education, employment, and participation in socio-political processes. Segregation results in unhealthy physical and social environments for minority ethno-racial groups either through poor quality or high cost of nutritious foods, a lack of appropriate recreational facilities, exposure to toxic environmental substances, increased levels of crime and more retail outlets for alcohol and tobacco (Paradies, 2016:6). Health care service is also of poorer quality in segregated areas, with segregation contributing to racial disparities in preventive, screening, diagnostic, treatment, and rehabilitation services.

Regarding indirect racism, and research of it, in the last couple of years there has been a growing concern about the impact of racial discrimination and it has resulted in many reviews and findings. For example, mental health or chronic illnesses like HIV diagnoses have been the focus of many reviews, as well as, in some cases, specific population groups such as Asian Americans, Latino Americans and Black Americans, Aboriginal and Indigenous people. Many reviews have found that racism is significantly related to poorer health, most significantly mental health, but also, to a lesser extent, physical ill-health (Paradies, 2016:7). Poor mental health is about twice as strongly related to racism as physical ill-health (Paradies, 2016:7). With regard to mental health, racism most often leads to depression and anxiety. As for physical health, current evidence indicates that racism is not associated with blood pressure or hypertension, but rather with weight gain and obesity (Paradies, 2016).

Measurement of healthcare provider racism

Although considered a key factor in perpetuating racial inequalities in healthcare, comparatively little is known about the degree of interpersonal racism perpetrated by healthcare providers; moreover, there is no consensus on how best to measure such racism. Paradies, Troung and Priest (2013) have, in their research paper "A Systematic Review of the Extant and Measurement of Healthcare Provider Racism," reviewed evidence from all around the world, spanning from 1995 to 2012, concerning racism among healthcare providers. They have compared existing measurement approaches to the emerging risk practice, while focusing on interpersonal racism. What we might find interesting is that they were only able to find research which relates almost exclusively to the United States of America, and some European countries like Denmark and the United Kingdom, while they were unsuccessful in finding research papers regarding healthcare provider racism in Canada or Australia. However, later in the paper, we will present findings for Canada and Australia from other authors.

The existence of racial variations in medical treatment, health service utilization, and patient-provider intercommunication is supported by a wide group of researchers from around the world. Although a study on healthcare provider racism was first conducted over 30 years ago, it was not until the publication of the report "Unequal Treatment" that racism was recognized as a key driver of racial disparities in healthcare (Paradies and others, 2014: 364). Focusing on interpersonal racism rather than internalized or institutional racism, Paradies, Troung, and Priest (2013) have reviewed worldwide evidence concerning racism among health care providers, comparing existing approaches of analysis to the best new practices. Their database consists of studies published between 1995 and 2012, and as the subject of their research, they focus on health care providers such as physicians, nurses, social workers, health assistants, etc. The authors have managed to find a total of 37 studies published between 1995 and 2012 that meet the inclusion criteria.

It is necessary to emphasize that direct measurements of racism happened when the subject in question was asked about it specifically, while indirect measures require inference from congregated data. In their research, self-completed surveys were the most commonly utilized direct measurement approach. Some authors have assessed beliefs about patient abilities and personality characteristics by way of physicians rating a series of semantic differentials: intelligent – unintelligent; self-controlled – lacking self-control; pleasant – unpleasant; educated – uneducated; responsible – irresponsible (Paradies and others, 2013:366). Providers rated patients in terms of how likely they were to lack social support; exaggerate discomfort; fail to comply with medical advice; abuse drugs, including alcohol; desire a physically active lifestyle; participate in cardiac rehabilitation; try to manipulate physicians; initiate a malpractice suit; have major responsibility for the care of a family members; and have significant career demands or responsibilities (Paradies and others, 2013:366).

Vignettes are indirect measures that infer bias in diagnosis, recommended treatment or patient characteristics, practices or behaviors, from differential response to hypothetical situations that are identical except for the race or ethnicity of the patients involved (Paradies and others, 2013:381). Vignettes are primarily based on brief written scenarios but can also include more detailed approaches, such as medical chart abstraction and audio-visual material. For example, some authors have used audio-visual clips of virtually generated characters along with vignettes to examine the influence of contextual information such as sex and race on pain-related decisions among nurses (Paradies and others, 2013:381).

Health care providers’ perception of race

The influence of nonclinical features on the provider’s perception of racial or ethnic minority patients, might also have consequences on the health care received by patients. Physician recommendations and referrals have been shown to contribute to racial inequalities in referrals for kidney transplantation and subjects of some cardiovascular procedures (Shavers and Shavers, 2006:392). An example of how health care providers can intentionally or unintentionally contribute to racism is their potential bias against racial minorities and scepticism in interactions with minority patients (Shavers and Shavers, 2006:392-393). Almost 20% of Asians, 19% of Hispanics and 14% of African American respondents to the Commonwealth Fund 2001 Healthcare Quality Survey reported being treated with disrespect or being looked down upon during a patient-provider encounter (Shavers and Shavers, 2006: 393). In another report, 63% of the 76 participants in a cross-sectional survey indicated that they had experienced discrimination in their interactions with their healthcare provider because of their race or skin-color; 29% of African Americans and more than 10% of Latino/Hispanic, Filipino and Korean people reported that they had experienced discrimination when seeking or obtaining healthcare due to their race and/or ethnicity (Shavers and Shavers, 2006:393).

Systemic racism in the American public health system

The United States of America are a multi-ethnic society that is becoming more diverse every year. The 2000 U.S. Census already indicated that 34.6 million Americans identified as Black or African American, 10.2 million people as Asian or Asian-American, and 35.3 million people as Hispanic or Latino (Brondolo, Gallo and Myers, 2009:1). By 2050, demographers estimate that 14.6% of Americans are going to be Black, 8% Asian, and almost one in four (24.4%) Latino or Latina (Brondolo, Gallo and Myers, 2009:1). Looking at the present situation, immigrants and their descendants across all ethnic groups will likely become the most numerous populations in the United States of America, increasing the heterogeneity of the U.S. population both across and within ethnic groups.

Decades of witnessing police brutality towards African Americans, segregation in public schools, discrimination in the workplace and much more, indicate the presence of racism in American society even nowadays. Moreover, many researchers have found that (the) public health (system) involves systemic racism and has negative effects and outcomes on the physical and mental health of all racial or ethnic groups, especially Americans of color. The systemic racism theory is firmly grounded in race-critical literature which first appeared during the 1960s black civil rights movement and which argued that racism involves a proclamation of decisions and policies by which a dominant race subordinates a racial group (Feagin and Bennefield, 2013:7). Feagin has pointed out that racism theory within the American society has five dimensions: 1. dominant racial hierarchy; 2. comprehensive white racial framing; 3. individual and collective discrimination; 4. social reproduction of racial-material inequalities; and 5. racist institutions integral to white domination of Americans of color (2010).

A lot of research claims negative health outcomes are not equally common among various ethnic groups. For example, rates of hypertension and related complications are significantly higher in African Americans than in non-Hispanic Whites or Asians; and even within broad groupings, there is substantial heterogeneity in health outcomes (Brondolo, Gallo and Myers, 2009:2). Among Latino(a)s, Puerto Ricans demonstrate particularly poor health – for example, relatively high rates of premature mortality, whereas Cubans show better health when compared to other Latino(a) subgroups (Brondolo, Gallo and Myers, 2009).

Racial treatments today

Feagin and Bennfield have pointed out that numerous reports demonstrate that Americans of color continue to suffer from greater health problems than their white counterparts – African-American women are more likely to die of breast cancer than women of any other racial or ethnic group; American Indians are nearly three times as likely to be diagnosed with diabetes as White Americans; 82% of pediatric AIDS cases consisted of African-American and Latino children (2014:12). These kinds of social inequalities are nothing less than health outcomes of systemic racism's pathways of negative impact. Many public health experts have found obstacles for black people and low-income people in getting kidney transplants, and that black patients are less likely to receive transplants than whites; the reasons suggested by one group of experts include a physician’s subconscious bias and financial disincentives (Feagin and Bennfield, 2014:10).

Moreover, a lot of analyses have found that for decades, African Americans have regularly been misdiagnosed by mostly white mental health professionals. Back in the 1960s, black men were seen by white doctors as anti-establishment protestors, and then commonly diagnosed as “schizophrenic” or otherwise mentally ill; moreover, African Americans in some areas are even today at a greater risk of being recruited into health care research without giving their consent than white people, because black people are more likely to receive their health care from emergency rooms (Feagin and Bennefield, 2014:10).

Distribution of primary care physicians in the United States

Racism within the health system is not only evident in the form of producing poor medical service to members of a racial or ethnic minority group, but it's also evident in the availability of life-saving medicines and in the workforce, where, for example, doctors who are African-American have lower representation in certain medical specialties, as well as the fact that they have a much lower chance of getting a job in urban hospitals or clinics where white people are a majority. Primary care physicians are the first stop for every patient in case of illness or health problems. However, in recent years, there has been a growing number of African American physicians who are staying in primary care without getting specialization in other fields of public health service, and mostly, their place of employment is often in more rural areas – smaller cities or villages.

Some authors have researched this subject and compared representations of different ethnic and racial groups within individual medical (public health) specialization or geographical areas. The geographic distribution of the health care workforce is a long-term problem in many countries. The long-time existence of U.S. communities without satisfactory physician services is an ongoing challenge to medical and public health systems in the United States. Racial and ethnic minority physicians are more likely to practice primary care and serve in underserved communities. Some research implies that medically underrepresented minority physicians are important for the delivery of primary care, provide care to indigent and minority populations, and improve access to health care services in underserved communities (Xierali and Nivet, 2018: 1-2). The racial and ethnic diversity of the U.S. population is increasing constantly, but the physician workforce is expanding at a much slower rate. Reports of a general lack of diversity in several medical and surgical specialties, such as radiology, oncology, emergency medicine, orthopedic surgery, obstetrics and gynecology, and ophthalmology document the continuing lack of diversity in certain specialties (Xierali and Nivet, 2018:2).

Xierali and Nivet conducted the cohort study. The study cohort are primary care physicians who graduated from medical school in or after 1980. They excluded international medical graduates in this study, as U.S. medical schools' diversity efforts are mostly relevant for U.S. medical graduates; moreover, there is a lack of race or ethnicity data for a solid proportion of international medical graduates in their data sources. The term primary care physician refers to physicians whose self-declared primary care specialties are in family medicine, general practice, general internal medicine, and general pediatrics (Xierali and Nivet, 2018:3). In their study, they examined the differences in the racial and ethnic diversity of primary care physicians from a national perspective and studied the correlation between a physician's race or ethnicity and their geographic distribution. The other goal of their research was to portray the regional distribution of areas most affected by the presence of primary care physicians who were from backgrounds underrepresented in medicine.

Figure 1. Racial-ethnic composition of primary care physicians in the study cohort. Source: Author according to Xierali and Nivet (2018) The Racial and Ethnic Composition and Distribution of Primary Care Physicians

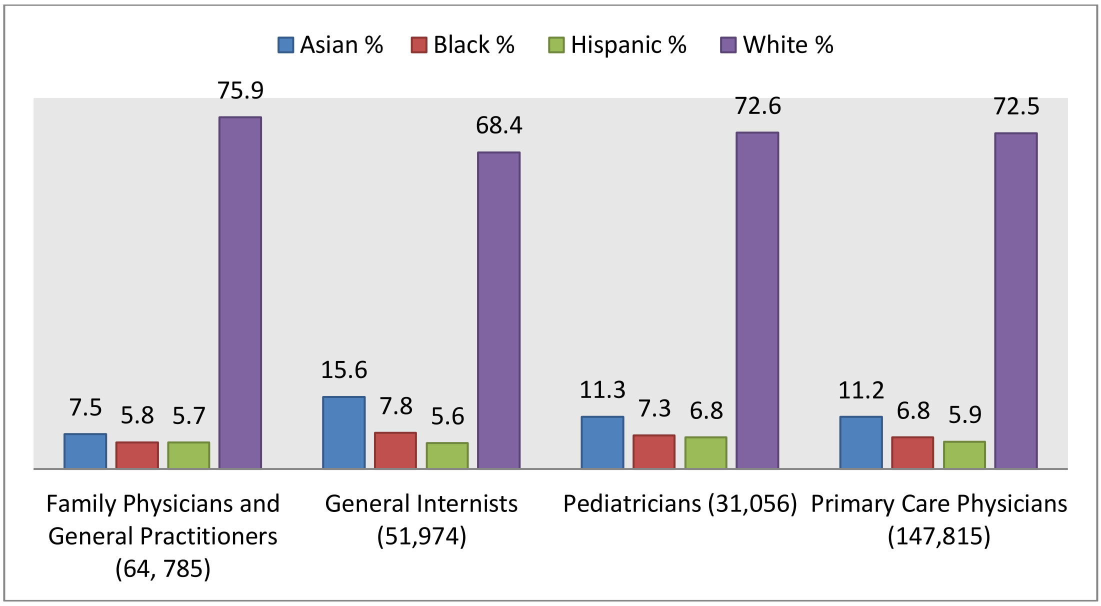


Figure 2. Variations in practice location by primary care physician race ethnicity and specialty: rural areas.
Source: Author according to Xierali and Nivet (2018) The Racial and Ethnic Composition and Distribution of Primary Care Physicians

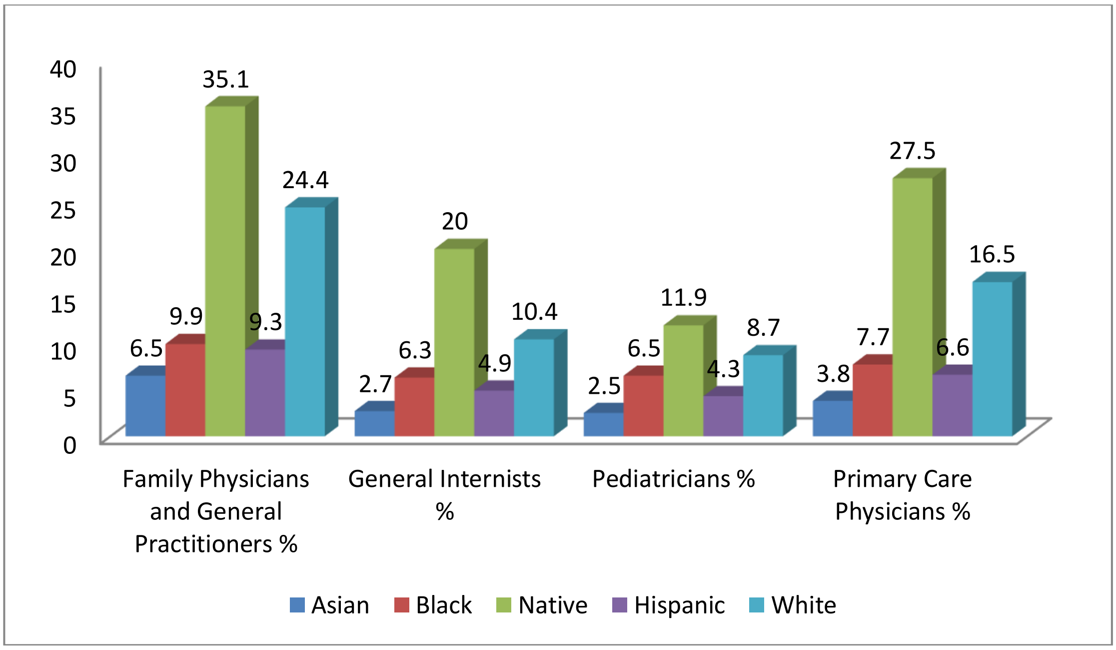
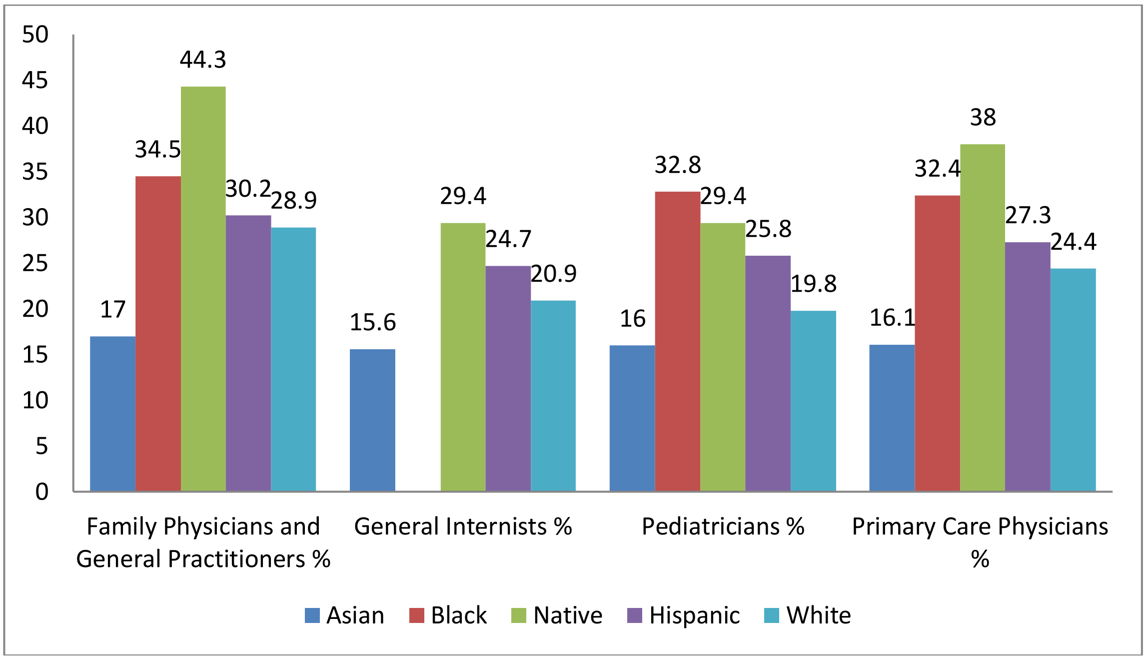


Figure 3. Variations in practice location by a primary care physician's race, ethnicity and specialty: Percent in Primary Care Health Professional Shortage Areas.
Source: Author according to Xierali and Nivet (2018) The Racial and Ethnic Composition and Distribution of Primary Care Physicians



There were 147,815 primary care physicians in the study cohort. In the cohort, 6.8% (or 10,064) were Black, 5.9% (or 8,697) Hispanic, 0.7% (or (1,014) Asian, 72.5% (107,222) White, 2.9% (or 4,314) with other or unknown race/ethnicity (see Figure 1). Race and ethnicity data of 97.2% of the physicians were based on self-reported data sources and 0.5% were based on secondary, not self-reported data sources (Xierali and Nivet, 2018).

Additionally, there is a significant distinction in geographic distribution across primary care specialties with family physicians and general practitioners overall having higher proportion practicing in primary care health professional shortage areas (HPSA), medically underserved areas (MUA), and rural areas in the study cohort (see Figures 2. and 3.). Among primary care physicians, visible racial and ethnic differences exist in how they spread geographically. In this regard, Black, Native American, and Hispanic groups have a higher number of practices in areas where there is not a sufficient number of primary health care professionals. Within each primary care specialty, significant differences by race and ethnicity also exist in the spatial context (Xierali and Nivet, 2018:3). Black people, Native Americans, and Hispanic groups have higher proportions practicing in HPSA and MUA than their white peers in all three primary care specialties; Native American primary care physicians have the highest proportion practicing in rural areas, whereas white primary care physicians have higher proportions practicing in rural areas compared to Black or Hispanic primary care physicians (Xierali and Nivet, 2018:3). Furthermore, there is a high percentage of Native American primary care physicians in all three underserved areas. The Asian primary care physicians also have a solid number practicing in these areas, but their percentage in these areas is much smaller compared to any other racial or ethnic group.

Impact of racism on indigenous people's health

Indigenous people face systemic racism and prejudice in the Canadian health care system. The health care system is set up to ignore Canada's colonial history, during which its Indigenous people. especially women, greatly suffered. Systemic racism in health care is not unique to Canada. It is also present in other countries. In New Zealand and Australia, for example, Indigenous nationalities are unlikely to get timely access to coronary angiography or revascularization following acute myocardial infarction in spite of high rates of cardiovascular disease (Boyer, 2017:1408). Boyer says that in Canada, Indigenous people carry the intergenerational trauma of the residential school system and its myriad tentacles of physical and sexual abuse; and that such policies are rooted in racism and colonial perspectives of superiority and wardship beliefs (2017:1409). Even today, a firm power asymmetry still exists between non-Indigenous health care providers and Indigenous communities, which underpins many of their unacceptable experiences in the health care system.

However, it is important to emphasize that Aboriginal women in Canada suffer the most and succumb to illnesses more often than other social groups. For example, they have a lower life expectancy, elevated morbidity rates, and elevated suicide rates in comparison to non-Aboriginal women, mostly white women. Bourassa and others have said that epidemiologists suggest that many of these chronic health conditions are a result of the forced acculturation imposed on Aboriginal peoples; and yet, for Aboriginal women, low income, low social status, and exposure to violence also contribute to poor health (2004:23). Also, conceptual distinctions between definitions of ethnicity and race in population health research suggest that race is used to describe natural units or populations that share distinct biological characteristics; whereas ethnic groups are seen as being culturally distinct (Bourassa and others, 2004:23). In fact, racism is a stressor that has real and serious negative health effects on individuals, in this case, on Aboriginal women. Sexism, racism, and colonialism are dynamic processes, measurable determinants of health; they began historically and continue to cumulatively and negatively impact the health status of Aboriginal women (Bourassa and others, 2004).

Furthermore, significant gaps exist between material, social, and health outcomes for Aboriginal men and women. Racist underpinnings of colonialism have also produced gaps between Aboriginal women. For example, Métis women in Saskatchewan are more likely to be employed than status Indian women but less likely to be employed than non-Aboriginal women (Bourassa and others, 2004:24). Therefore, it is evident that even cultural identity has implications for the status that women have in the world and this has also an impact on their health. Additionally, Aboriginal women acknowledged that many factors shaped their health and well-being including poverty, housing, violence, and addictive behaviors. However, cultural identity served as a potential anchor to help them deal with these issues and promote health (Bourassa and others, 2004:25). It is good to stress that they have made recommendations for health practices to introduce more holistic solutions that include more traditional cultural practices and take into account their health and wellbeing more respectfully.

Detailed research among experts of the post-contact history of indigenous peoples in Canada demonstrates that direct practices of genocide have transformed into legislated control of Aboriginal identity and colonization-based economic, social and political disadvantage that disproportionately affects Aboriginal women (Bourassa and others, 2004). The government's definition of who can be called Indian, who cannot and who must exist in liminal spaces where they are outsiders both on and off reserve lands has implications for citizenship, but it also has implications for access to health services and ability to maintain health and well-being (Bourassa and others, 2004:27). With this knowledge, data must be re-examined in light of how colonization and postcolonial processes have conferred risks to the health of Aboriginal women, and barriers to accessing quality health care, with special focus on the fact that Aboriginal women are excessively vulnerable to cerebrovascular disease, coronary heart disease, diabetes, suicide cancer, depression, substance use, HIV or AIDS, and violence abuse (Bourassa and others, 2004:27).

Health and (in)equity among Canadian Aboriginal people

In the Canadian context, the consistent growth of Aboriginal health and social inequity signals that the Canadian (political) society is in a public health policy crisis; and current policy reflects a historic relationship between Aboriginal people and Canada that neglects the up-to-date health needs of Canada’s Aboriginal peoples (Richmond and Cook, 2016). Even though Canada is perceived as a country with a universal health care system where every person has affordable health care insurance, unfortunately, there is a distinct absence of Canadian public policy supporting the health of Aboriginal peoples and well-being at the national and provincial levels. Even today, the only active national-level legislation specific to the First Nations people in Canada remains the Indian Act of

1876, which gave the responsibility of health and health care for First Nations to the federal government, while for the general population, health was primarily a provincial responsibility (Richmond and Cook, 2016:2).

At the very beginning, the Indian Act was generated and implemented under the presumption that the Aboriginal population was inferior, unequal, and uncivilized. Canada's Aboriginal population is growing faster than the general population, having increased by 20.1% from 2006 to 2011. At the same time, the non-Aboriginal population growth has been 5.2% (Richmond and Cook, 2016: 4). Why is that happening? Richmond and Cook found out in their research that the fertility rate is higher is higher among Aboriginal women than other Canadian women, mostly white ones. The First Nations women are having babies at a significantly younger age; over half of the First Nations women who gave birth in 1999 were less than 25 years old; and secondly, while life expectancy is increasing across all Aboriginal groups, it is still lower than the non-Aboriginal population (68.9 for Aboriginal males and 76.6 for Aboriginal women versus 78 among non-Aboriginal males and 81 for non-Aboriginal women) (2016:4).

The overall leading causes of Aboriginal mortality are injury and poisoning, circulatory disease, cancer, and respiratory disease; chronic diseases also disproportionately affect Aboriginal populations in Canada, the most significant one of which is diabetes (Richmond and Cook, 2016:5) In terms of morbidity, Aboriginal people also experience an excessive burden of infectious disease, including pertussis, chlamydia, hepatitis A, and tuberculosis; HIV/AIDS diagnoses in the Aboriginal population are also on the rise, and in 2011, Aboriginal peoples accounted for 12.2% of new HIV infections and 18.8% of reported AIDS cases (Richmond and Cook, 2016:5).

According to the Aboriginal Peoples Survey (APS), only 13% of the overall Aboriginal population described their health status to be either "fair" or "poor" whereas 26% indicated that they considered their health status to be "excellent" (Adelson, 2005: 53). These figures are significant, and even more so in contrast to the overall percentage of people with disability (30%) or people who saw either a general practitioner (67%) or health-care professional (73%) (Adelson, 2005:53). What is perhaps even more shocking is that 23.1% of those living off-reserve rated their health as either fair or poor and in the same population 60% reported at least one chronic condition such as arthritis, high blood pressure or diabetes, while 16.2% reported a long-term activity restriction, which is more than 1.6 times higher than non-Aboriginal population; moreover, 13.2% of those living off-reserve had experienced a major depressive episode in the year before the survey (Adelson, 2005:52-53).

The health and social inequities suffered by Aboriginal Canada are rooted radically in their historical position within the Canadian social system. In spite of treaty and other Aboriginal rights preserved in the Canadian Constitution, including access to health care, the present Aboriginal policy endures, characterized by jurisdictional uncertainty, inasmuch as it lacks clarity about both the federal and provincial government's level of health service delivery and financial responsibilities to the First Nations and Inuit communities (Richmond and Cook, 2016:6). Furthermore, Richmond and Cook have pointed one very crucial fact about the current situation, saying:

„Aboriginal health policy also demonstrates widespread neglect, and a distinctly lacking political will to improve access to health and health care. For example, the Auditor Generals' Report on Access to Health Services in Remote Communities identified substantial concerns about the quality of care in remote First Nation communities, citing a number of critical issues that compromise both provision and management of health care including: the inability or unwillingness of government to ensure the competency of service providers; low perceived safety of health care facilities, untimely record keeping with respect to non-insured health benefits, and poor community consultation" (2016:6).

Therefore, it can be concurred that the combination of non-effective coordination of health care services, difficult access to quality health care, and significant geographic variation of communities have reduced the ability of the First Nations, as well as Inuit people, to access the basic human right that is health care.

Suicide and chronic illness among Aboriginal population

Suicide is the most distinct indicator of the cruelty of social disruption in Aboriginal Canada and the rates are tellingly high by any standard. Suicides are the result of a toxic mix of poverty, powerlessness, depression, bad living conditions, and so on. The strongest risk factors for suicide attempts are male gender, having a friend who had attempted suicide, the experience of physical abuse, a history of solvent abuse, and having a parent with an alcohol or drug problem (Adelson, 2005: 56). And one of the reasons why this is happening in such a high percentage among Aboriginal people in Canada is the lack of effective and proactive public health care administration. Adelson mentions the limitations on an individual's mobility either from or to a remote community, inadequate family and child services that are replete with jurisdictional disputes between prevention and protection services, and the absence of appropriate counseling (2005:56).

In the last decade, the proportion of Canada's total HIV and AIDS cases contracted by Aboriginal people has risen sharply from 1.0% in 1990 to 7.2% in 2001 (Adelson, 2005: 57). Like many other health issues among Aboriginal people in Canada, HIV and AIDS are also a result of poverty, sexual and domestic abuse, drug abuse, unstable access to health care services, and so on. Furthermore, many studies have found that when Aboriginal people test positive for HIV infection, they often do not access the available services; as a consequence of multiple stigmas associated with HIV and AIDS, both within the Aboriginal and non-Aboriginal communities, most Aboriginal people living with HIV or AIDS prefer to remain invisible, silent and anonymous (Adelson, 2005:57). What is even more concerning is that the majority of Aboriginal people, both men, and women, in most cases, will not seek out care, treatment or support from their families or friends upon HIV diagnosis.

Conclusion

The study of racism and health has gained traction significantly in the last couple of years, what with the rise of socially aware young politicians and activists across the world, and it is becoming one of the key areas of study in public health. Even though many studies have proved that racism acts as a negative determinant of health and well-being, and is a contributor to racial disparities in healthcare, the public health infrastructure with long-term racial framing has not changed yet. This paper has provided a comprehensive literature and data overview, emphasizing the importance of condemning racism within current health care systems that are being disproportionality equitable to different populations. Racism in health care and public health institutions is systemic, and it has been present for decades. Generations of white privileged systems and white-imposed racism has completely reconstructed the way health care institutions function and provide health services to people. Of course, white-imposed racism contributes not only to racial inequalities in health but also in employment, education, political representation, and other aspects of everyday life.

This paper has put the focus on systemic racism in health systems and highlighted both the racial character of and the impact of health care institutions and health practitioners on health inequalities. Inequalities in health care are produced by the direct and indirect discriminatory behaviours of dominantly white men, and women in a much lesser percentage, who operate out of racial framing, which has produced institutionalized health care inequalities for racial and ethnic minorities such as African Americans in the United States and Indigenous people in

Canada. The initial hypothesis of this paper was that people of color (e.g. African Americans) and ethnic minorities (e.g. Indigenous people) are more likely to get unsatisfactory or inadequate health service and to suffer in a higher percentage of chronic illnesses than the white population. Descriptive research and data analysis have shown that racism has negative impacts and outcomes on people's health, even though it is not something that is often recognized in public discourse when it comes to the topic of the quality of health care system and services.

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Utjecaji rasne diskriminacije na zdravlje ljudi i sustave javnog zdravlja u multikulturnim društvima

Dino Galinović

Sažetak

Sustavni rasizam predstavlja veliku prijetnju u multikulturalnim društvima u kojima rasna pristranost i dalje igra značajnu ulogu u kreiranju javnih politika i organiziranju javnih sustava poput zdravstvene zaštite. Ovaj rad tvrdi da rasizam i rasni framing izravno utječu na negativne ishode zdravlja ljudi, osobito među manjinskim skupinama poput Afroamerikanaca u Sjedinjenim Američkim Državama i Aboridžina u Kanadi. Navedene će skupine ljudi vrlo vjerovatno dobiti nezadovoljavajuće ili neadekvatne zdravstvene usluge i u većem će postotku bolovati od kroničnih bolesti, poput kardiovaskularnih problema, dijabetesa, problema mentalnog zdravlja, zlouporabe lijekova i predoziranja ili HIV infekcije u odnosu na bijelu populaciju. Nadalje, rasizam ima izravan utjecaj na nejednakosti u zdravstvenim sustavima u vidu nedostatka različitih pružatelja zdravstvenih usluga u urbaniziranijim sredinama ili nepristupačnog liječenja zbog geografskih udaljenosti ili kulturnih razlika. Kroz ovaj rad uzeli smo u obzir koncept rase i etničke pripadnosti, desetljeća rasnog framinga u društvu Sjedinjenih Država i Kanade, pokazali negativne utjecaje na zdravlje unutar različitih etničkih grupa te uspješno naglasili potrebu strukturnih promjena zdravstvenih sustava.

Ključne riječi

rasizam, rasni framing, zdravstveni sustavi, Sjedinjene Države, Kanada