



## Moving beyond description: Closing the health equity gap by redressing racism impacting Indigenous populations



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In liberal democratic societies such as Canada, ideologies of egalitarianism and multiculturalism paint a picture of the state and its institutions as free from racism and other forms of discrimination. Egalitarianism is a particularly appealing, pervasive and powerful discourse in health care, which perpetuates the assumption that people are treated the same regardless of their social, ethnocultural or gendered locations (Henry et al., 2010). Intersecting with the rhetoric of fairness, tolerance and respect for diversity, these discourses tend to render 'talk' of racism and other types of injustices as socially taboo (Henry et al., 2010; Tang and Browne, 2008; Tator and Henry, 2006). In this context, critical discussions of racism and racialization as key determinants of health and social inequities are often viewed as unnecessary or unwarranted. As Paul Gilroy (2005) reminds us,

... [T]he signs of 'race' do not speak for themselves and ... the difficult work of interpreting the system of meaning they create is always likely to appear illegitimate, 'politically incorrect,' sometimes treasonable and usually speculative in the most dismissive sense of that term (Gilroy, 2005) (p. 31).

At the same time, there is a burgeoning body of research that continues to demonstrate how 'race' as a social category and racism as a social process have profound negative impacts on health, access to health care, and quality of life (e.g., Allan and Smylie, 2015; Krieger, 2014; Paradies et al., 2015; Stuber et al., 2008; Wyatt et al., 2016). Given these contexts, it is imperative to generate rigorous

analyses of the complex and often obfuscated processes by which racialization operates to sustain and exacerbate health and social inequities.

The health status of Indigenous<sup>1</sup> peoples in Canada and globally represents an important case in point as emphasized by Goodman and colleagues (Goodman et al., 2017), the authors of a recently published paper in *Social Science and Medicine*. Although Indigenous peoples have thrived in the face of ongoing colonial policies and structures, Indigenous populations experience significantly higher morbidity and mortality rates compared to non-Indigenous populations. In Canada, the health status of Indigenous peoples falls significantly behind that of other Canadians on virtually every measure (Greenwood et al., 2015). In Australia, life expectancy at birth for Indigenous peoples is estimated to be 19–21 years lower than for non-Indigenous Australians (United Nations, 2015). These morbidity and mortality patterns are strongly connected to histories of colonization, the dispossession of lands and economic resources, and the ongoing lack of access to the social determinants of health. As emphasized in the report of the United Nations Special Rapporteur, compounding these health status disparities are the persistent and multifaceted forms of racism and discrimination experienced by Indigenous peoples globally: "such discrimination is intimately interconnected and mutually reinforcing with the

<sup>1</sup> Consistent with accepted terminology used in landmark international reports, the term Indigenous peoples is used to refer to the diversity of populations throughout the world. In Canada, over 1.4 million people of the total population of ~32.9 million (4.3%) identify as Indigenous (Statistics Canada, 2013), including First Nations, Métis, and Inuit people. The term Aboriginal is also commonly used, and the colonial term 'Indian' is still used in federal government policy documents (e.g., The Indian Act).

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spectrum of violations experienced by Indigenous peoples” (Tauli-Corpuz, 2014, p. 10) (p. 10). For example, the disproportionate rates of HIV infection among Indigenous women in Canada (Public Health Agency of Canada, 2012), and the high rates of violence against Indigenous women and girls are explained by the distinctive experiences of colonization stemming from ongoing racism and discrimination (Anaya, 2014; Brownridge, 2008; Parliament of Canada, 2014; Royal Canadian Mounted Police, 2014; The Special Committee on Violence Against Indigenous Women, 2014). These health status inequities cannot be attributed to lifestyle, behavioural or cultural factors: rather, they are embodied manifestations of the complex interplay of socio-historical, political and economic determinants of health. Racism and intersecting forms of discrimination therefore must be considered determinants of health for Indigenous peoples, and strategies are required to mitigate their negative impacts on health (Allan and Smylie, 2015; Browne et al., 2016; Senese and Wilson, 2013; Tauli-Corpuz, 2014; United Nations, 2015). In this regard, Goodman et al. (2017) tackle a critically important issue: Indigenous peoples’ experiences of racism in health care settings.

There is a well-established body of research and evidence conducted in a range of contexts confirming that Indigenous peoples frequently experience individual and systemic racism when interfacing with the health care system (e.g., Allan and Smylie, 2015; Browne et al., 2011a,b; Browne et al., 2016; Herring et al., 2013; Howse and Dwyer, 2016; Peiris et al., 2008; Razack, 2015; Tang and Browne, 2008). There is also an important body of evidence-based literature that shows the extent to which racialized assumptions about Indigenous peoples actually *organize* health care providers’ practices, and organizational and institutional policies, practices, discourses and norms (e.g., Dion Stout and Downey, 2006; Fiske and Browne, 2006; Greenwood et al., 2015; Kelm, 1998; Kirmayer et al., 2014; Maxwell, 2014; O’Neil et al., 1998; Razack, 2015). For example, one of the most ubiquitous and harmful stereotypes pervading Canadian social consciousness is founded on colonizing images of Indigenous peoples as being more prone to alcohol use than other Canadians, despite the body of evidence refuting this myth (Razack, 2015; Tait, 2009). Today, stereotypes about Indigenous peoples “getting everything for free” continue to fuel resentments in the health care sector about Indigenous peoples as being undeserving recipients of care. Similarly, enduring colonizing images and discourses about Indigenous women as irresponsible and incompetent parents continue to underpin the state’s widespread removal of Indigenous children from their families and communities (Anaya, 2014; Fiske and Browne, 2006; Maxwell, 2014). Thus, the findings described by Goodman et al. (2017) are not only distressing: they are disturbingly prevalent.

The paper by Goodman et al. (2017) features the perspectives of peoples’ lived experiences of racism, and these are essential to understanding the profoundly detrimental impacts of racism on health and access to care, the harms of being viewed as discredited medical subjects, and the negative impacts on peoples’ overall sense of well-being. Other studies have similarly demonstrated the extent to which patients who identify as Indigenous describe how attuned they are to staff members’ potentially dismissive attitudes and behaviors, given their negative past experiences with people in positions of power and authority (Allan and Smylie, 2015; Browne, 2007; Browne et al., 2011a,b; Browne et al., 2016; Dell et al., 2015; Gerlach et al., 2016; Herring et al., 2013; O’Neil, 1989; Pauly et al., 2015; Peiris et al., 2008; Tang et al., 2015; Tang and Browne, 2008; Varcoe et al., 2009). The points I raise in this commentary are in no way intended to diminish the importance of learning about peoples’ experiences of racism as a route to taking action to redress the harms of racism. Moreover, when exploring peoples’ experiences of racism, the aim is not to question the accuracy or

‘validity’ of those experiences. Rather, counteracting racism and other forms of discrimination in organizations and institutions requires that all claims be considered seriously, regardless of intention, and that action be taken to mitigate their adverse impacts. This is particularly important given the unequal power relations operating in health care; even if staff members do not intend to act in a ‘power over’ or discriminatory manner, their social location as representatives of the health care system can be interpreted by patients to imply that power inequities will be maintained and will shape how they are treated (Browne et al., 2016). Responsibility for shifting these deeply engrained power relations must lie with health care institutions, and the practices and policies that sustain or disrupt discriminatory practices.

Goodman et al. (2017) could go further in analyzing individual experiences of racism as imbricated with systemic racism and with the structural determinants of Indigenous peoples’ health. The authors’ focus on describing individual experiences of racism is important in terms of revealing the damaging impacts, particularly to audiences who may downplay or minimize the significance of peoples’ experiences of racism. However, describing these experiences without adequate attention to the ways in which racism is bound up with myriad dimensions of systemic inequities – including for example, high levels of poverty, ongoing economic marginalization, and the lack of adequate housing on reserves and in urban settings – draws attention away from the strategies and actions needed at multiple levels to counteract the deleterious effects of racism.

In-depth analyses of the relationships among economic inequities, interpersonal and structural violence, mental health and problematic substance use are warranted (Marshall, 2015; Nelson and Wilson, 2017; Shannon et al., 2008; Smye et al., 2011). The process of racialization does not tend to operate in isolation; for example, being subject to racism compounds poverty and experiences of social exclusion – and classism and gendered inequities compound the consequences of racism and racialization (Browne et al., 2011a,b). Thus, the consequences of racialization, historical injustices, and gendered inequities are inextricably interrelated, particularly as they influence health and mental health. Without an analysis of these complexities, the risk will be that peoples’ experiences of racism may be dismissed (or misunderstood) as resulting from the personal opinions of particular research participants or patients, or as reflecting purely individual, overly-sensitive, potentially biased, or idiosyncratic points of view.

One of the problems inherent in analyzing the process of racism and racialization in the absence of a broader theoretical or conceptual framework, is in developing dichotomized and over-generalized views of health care providers as potential oppressors, or of Indigenous patients’ as inclined to interpret their experiences as shaped by racism (Tang and Browne, 2008). Holding out this caution does not in any way diminish the importance of making visible the impacts of peoples’ experiences of racism. However, what is urgently needed are research and analyses that problematize the institutional practices, discourses and taken-for-granted norms that permit racism and other forms of discrimination to be enacted in health care contexts. Such research is needed to develop effective interventions for disrupting these processes – particularly in relation to care for people with stigmatizing health conditions, substance use or mental health issues, or for patients who are considered to be ‘drug-seeking’ or who are viewed as overusing or inappropriately using the system, etc.

Drawing attention to these complexities could help Goodman et al. (2017) extend the depth and scope of their analysis. This could be accomplished by drawing on theoretical constructs or perspectives that would guide more nuanced analyses of the intersections between micro-level experiences operating at the level

of clinical practice and the wider social and historical contexts that shape health care relations and access to services – with a view to identifying strategies to interrupt institutional and individual level practices that sustain racism. For example, ‘structural competency’ (Metzl and Hansen, 2014) has been put forward as an approach that can infuse analyses of clinical-level issues with a structural focus aimed at prompting actions to interrupt racism and stigma as the root causes of inequitable treatment of Indigenous peoples. This would aid in highlighting how systemic racism and other forms of discrimination – as manifestations of structural violence (Farmer, 2013) – contribute to the high levels of poverty, violence and trauma experienced by some Indigenous peoples, with associated negative impacts on chronic health and mental health issues.

Revisiting the critical theoretical perspectives reflected in the concept of ‘cultural safety’ could also help Goodman et al. (2017) deepen their analysis. Cultural safety was initially developed in New Zealand by Māori nurse leaders in consultation with Māori communities as a pragmatic tool for moving health care practices and policies beyond the notion of cultural sensitivity to more actively address inequitable power relations, racism and stigma, and the ongoing effects of historical injustices on health and health care (Ramsden, 2002). The analytical leverage of cultural safety lies in its potential to shift attention away from patients’ presumed cultural ‘differences’ as the source of the problem, and to refocus attention on the culture of health care as the site for transformation (Browne et al., 2016). Increasingly in Canada, the USA and Australia, cultural safety is mandated as an essential element of health care involving Indigenous peoples (Aboriginal Nurses Association of Canada, 2009; Indigenous Physicians Association of Canada & The Royal College of Physicians and Surgeons of Canada, 2009a, 2009b). In New Zealand, cultural safety is legislated as a basic requirement of nursing and medical professional education (Vernon and Papps, 2015).

To conclude, it is critically important to understand experiences of racism described by Indigenous peoples as reflecting broader racist discourses, policies and practices, which are firmly entrenched in organizations and institutions, and in the dominant society through media, public conversations, and everyday practices. Situating these experiences in the wider socio-political landscape may preempt the denial of racism that might otherwise occur when the ‘problem’ of racism is constructed primarily as reflecting individual-level reactions or opinions. What is needed in future studies of racism as it pertains to Indigenous peoples’ health will be strategies, accountability mechanisms, and interventions that can be maximally disruptive of: the deep-seated patterns of power and paternalism operating in health care; the racist and stigmatizing discourses about Indigenous peoples that remain pervasive; and the dismissive, unwelcoming and often demeaning practices and policies that so profoundly impact peoples’ experiences. These are the areas where the problems must be located, and the research agenda advanced, if racism and other forms of discrimination are to be tackled and dismantled in the context of health care delivery.

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