

# Social Inclusion as a Determinant of Health

*This summary is primarily based on a paper and presentation by Grace-Edward Galabuzi, Researcher, Centre for Social Justice and Doctoral Candidate, Department of Political Science, York University, and a presentation by Ronald Labonte, Director, Saskatchewan Population Health and Evaluation Research Unit and Professor, Community Health and Epidemiology, University of Saskatchewan, Professor, Kinesiology and Health Studies, University of Regina. The presentations were prepared for The Social Determinants of Health Across the Life-Span Conference, held in Toronto in November 2002.*

***The opinions expressed in this publication are those of the authors and do not necessarily reflect the views of Health Canada.***

Social exclusion describes the structures and dynamic processes of inequality among groups in society. Social exclusion refers to the inability of certain groups or individuals to participate fully in Canadian life due to structural inequalities in access to social, economic, political and cultural resources. These inequalities arise out of oppression related to race, class, gender, disability, sexual orientation, immigrant status and religion.

Social exclusion is experienced by both individuals and communities in multiple and often reinforcing dimensions. For example, groups of people living in low-income areas are also likely to experience inequities in access to employment, adequate housing and social services, as well as to experience stigmatization, isolation from civil society, higher health risks and lower health status. Such groups include Aboriginal peoples, immigrants and refugees, people with disabilities, single parents, children, youth and women in disadvantaged situations, older people and unpaid caregivers, gays, lesbians, bisexuals, transgendered people, and racialized groups. (Galabuzi, 2002).

There are four aspects of social exclusion:

- **Exclusion from civil society:** disconnection through legal sanctions, institutional mechanisms or systemic discrimination based on race, ethnicity, gender, disability, sexual orientation and religion.
- **Exclusion from social goods:** failure of society to provide for the needs of particular groups, such as housing for the homeless, language services for immigrants, and sanctions to deter discrimination.
- **Exclusion from social production:** denial of opportunities to contribute to and participate actively in society.
- **Economic exclusion:** unequal or lack of access to normal forms of livelihood.

In keeping with the paper and presentation by Grace-Edward Galabuzi, this summary focuses on the experience of racialized groups and new immigrants. The term "racialized group" is used to denote the racial categories imposed on certain groups on the basis of superficial attributes such as skin colour. For the purpose of data collection at the federal level, the term "visible minority" approximates the same category.

## Current Situation

Racialized group members, Aboriginal people and recent immigrants have been identified as among the most marginalized in Canadian society. However, much of Canadian health research and the health system as a whole fail to appreciate the dimensions of social exclusion that these groups face (Galabuzi, 2002). Racialized group members now account for 13.5% of the population and growing; immigrants now account for 18.4% and are projected to make up 25% of the population by 2015. Most visible minority populations live in large urban centres. In 2001, racial minorities accounted for 54% of Toronto's population and over 30% of

people in Vancouver (Statistics Canada, 2003).

Racialized groups face multiple risks to their well-being, including:

- **A double-digit income gap** as high as 30% in 1998, which has not been dented by improvements in the economy in recent years. In 1998, poverty among recent immigrants stood at 27%, double the 13% rate among the rest of the Canadian population. Their annual wages and salaries were one-third less than those of other Canadians. For families, the poverty rate for racialized groups was 19%, compared to 10.4% for other Canadian

families. In 1995, the rate for children under age six living in low income families was 45%—almost twice that for all children living in Canada (26%) (Jackson, 2001).

- **Unemployment** rates two to three times higher than average, combined with **discriminatory practices in the workplace** for those who are employed. Income discrimination against visible minority workers (both immigrant and Canadian-born), gender-based wage discrimination for female immigrants, pay inequities and the under-utilization of the skills of recent immigrants are all significant factors (Abella, 1985; Henry and Ginsburg, 1995; Reitz, 2001).
- **Deepening levels of poverty.** Aboriginal people and racialized groups members are twice as likely as other Canadians to live in poverty. Studies show that poverty levels for all immigrants increased between 1991 and 1996 and that visible minority immigrants are much more at risk for persistent poverty (i.e., 35 years), than immigrants who are not visible minorities (Harvey and Siu, 2001).
- **Differential access to housing leading to neighbourhood segregation.** In Canada's urban areas, the spatial concentration of poverty and residential segregation among racialized group members is intensifying (Galabuzi, 2002).
- **Disproportionate contact with the criminal justice system.** The Ontario Commission on Systemic Racism in the Criminal Justice System reported in 1995 that the increase in the incarceration rate among Black males was over 200% from 1986-1993, compared to 23% for white males. These findings mirror those on the treatment of Aboriginal peoples in reports from Nova Scotia (1989), Manitoba (1991) and Alberta (1991).
- **Higher health risks.** Please see later section "Effects of Social Exclusion on Health".

## Factors that Affect the Issue

Poverty is a key cause and product of social exclusion. Its impacts on health status are well established (Wilkins et al, 1989; Wilkinson, 1996; Wilkinson and Marmot, 1998; Kawachi, Wilkinson and Kennedy, 1999; 2000; Raphael, 1999; 2001). Racial

differences in health status tend to reflect differences in social and economic conditions (Wilkinson, 1996).

However, Galabuzi suggests that a social determinants of health approach must go beyond class inequalities, to account for the health impacts of being shut out of the social, economic, political and cultural systems that determine access to society's resources, and by extension, health status. Of particular interest is how processes of social marginalization such as racial and gender discrimination and xenophobia mediate the experiences of poverty, income inequality, unemployment, neighbourhood selection and health service utilization, to produce differential health outcomes for affected groups.

In industrialized capitalist societies, social exclusion is largely a byproduct of a focus on production, wealth and consumption that validates and intensifies inequalities. Market-driven political ideologies tend to see marginalization as the failure of an individual to use their opportunities in the marketplace. In addition, certain ethnocultural norms are established in societies that lead to economic, political and social privilege. Historically in Canada, Eurocentric culture has marginalized first Aboriginal cultures, and later other cultures. As the state retreats from its regulatory role and the market gains prominence in social regulation, privilege and discrimination become more entrenched. This inequality helps explain the growing gap between rich and poor, as well as the "racialization" of that gap (Kunz et al, 2001; Galabuzi, 2001; Lee, 2000).

Processes of social exclusion intensified in the late twentieth century. This can be traced to the restructuring of global and national economies that emphasized the deregulation of markets, the decline of the welfare state, the commoditization of public goods, increased global migration, and changes in workplaces towards flexible deployment, longer hours, work fragmentation, multiple jobs and non-standardized work. These developments have intensified exploitation in workplaces and increased urban segregation including the gendered and racialized concentrations of poverty in certain neighbourhoods (Galabuzi, 2002).

The Canadian economy and labour market are increasingly stratified along racial lines. Racialized group members are over-represented in industries dominated by non-

standard forms of work such as textiles, clothing, hospitality and retailing, and in low-income jobs and low-end occupations. On the other hand, they are under-represented in such high-income sectors as the public service, automobile making, and metal working, which are also highly unionized (de Wolff, 2000; Galabuzi, 2001).

Most employed members of racialized groups work in low-skilled, low paying jobs where the working conditions are often unsafe. A recent Toronto survey estimated that over 1.2 million workers in the Toronto City-region were contingent workers, the majority racialized women. Some 69% of these workers earn less than \$1,500 a month (or \$18,000 annually). Clearly, the impacts of the changing economy have not been evenly distributed, and many racial and gender inequalities have become structural (de Wolff, 2000).

The dismissal of the pervasiveness of racial discrimination in mainstream discourse and by those in power makes it difficult for racialized group members to confront the problem. Employers that take advantage of immigrant workers disempower these workers and rob them of a voice.

A key explanation for residential segregation is the out migration of middle class European-descendant families from core urban and traditional low-income neighbourhoods, combined with the inward migration by racialized group members. Increasingly, these geographical areas represent low-income enclaves subject to the distresses of substandard, often over-priced housing. While some residential segregation can be explained by new immigrants voluntarily seeking familiar environments, persistent discrimination in housing is also clear. For example, a study by the Canadian Civil Liberties Association in the 1980s showed that in Montreal, race was a key determinant in acquiring housing in certain parts of the city (Henry et al, 2000). This phenomenon continues to exist in the rental market in Canada's urban centres (Rees, 1991; Mwarigha, 2000; CCLA, 1990).

Racial profiling and targeted policing can lead to disproportionate criminalization and incarceration of racialized groups, especially young men who are Black or of Aboriginal descent. The effect of incarceration on health is largely negative. When people leave jail their life chances are further limited, creating a situation wherein they are vulnerable to the

allure of crime, which then becomes a self-fulfilling prophecy.

## Effects of the Social Exclusion on Health



In addition to the negative health effects of relative deprivation, the actual experience of inequality and the stress associated with dealing with exclusion tend to have pronounced psychological effects and to impact negatively on health status (Wilkinson, 1996; Kawachi and Kennedy, 2002).

The 'racialization of poverty' compounds Inequalities in living conditions and health status. Labour market segregation, high unemployment, low occupation status, living in substandard housing and in dangerous or distressed neighbourhoods, homelessness, working at dangerous work sites, working extended hours and/or multiple jobs, and experience with everyday forms of racism, lead to unequal health service utilization and differential health status.

Children whose health is most at risk tend to live in low-income families, single families, or among racialized group populations, including immigrant and refugee families and Aboriginal families. Among youth, the psychosocial stress of discrimination contributes to such health problems as hypertension, mental health concerns and substance abuse (Galabuzi, 2002).

Increasingly, research has begun to confirm the links between the minority status of ethnic, immigrant and racialized groups and low health status (Adams, 1995; Anderson, 2000; Bolaria and Bolaria, 1994; Wilkinson, 1996; Hyman, 2001; Shaw et al, 1999; Wilkinson and Marmot, 1998). Even recent immigrants, who have historically enjoyed higher health status because of the stringent health selection process, show a loss of ground over time under conditions of social exclusion (Hyman, 2001; Noh et al, 1999). Recent research also shows that the experience of racism and discrimination puts racialized group members and immigrants at higher risk for mental health concerns (Beiser, 1988; OACW, 1990; Dossa, 1999; Noh et al, 1999). This may be exacerbated by extended periods of family separation that erode one's social support network. Research in women's health suggests similar impacts from gender discrimination (Agnew, 2002; Adams, 1995).

Many new immigrants work in unsafe conditions. Racialized women are particularly over-represented in unregulated piecemeal homework. Gendered racism and neo-liberal restructuring have produced what some have called Canada's sweatshops, especially in the garment and clothing industry (Yanz, et al, 1999). This work involves long, low-paid working hours, often in the home. It imposes physical and mental stressors on poor women (many of whom are single parents) who continue to carry a disproportionate bulk of domestic housework.

Most workers from racialized groups have no standard benefits such as sick leave, disability insurance, pension or maternity leave. Many of the agencies that hire these workers exact a premium for the job matching—some taking as much as 50% of the wage the employer pays for their “administrative services”.

Members of minority groups often face institutionalized racism in the health care system, which is characterized by language barriers, stereotypical views held by some health professionals, lack of cultural sensitivity, absence of cultural competencies, barriers to access and utilization, and inadequate funding for community health services (Galabuzi, 2002).

Reports suggest that discrimination against people with HIV/AIDS is compounded by their racial status (ASAP, 1999). In addition, racialized groups, especially Blacks and Aboriginals are disproportionately represented in prisons where infection rates far exceed those in the general population.

## Implications for Policy Practice and Research

What is needed to address inequities in today's society is policy development using a **social inclusion framework** that allows for the reassertion of social rights based on the concept of social protection as the responsibility of society and not the individual. It shifts the focus back to the structural inequalities that determine the intensity and extent of marginalization in society (Galabuzi, 2002). Our concerns should be not with the groups or conditions that are excluded, but with the socioeconomic rules and political powers that create excluded groups and conditions, and

the social groups that *benefit* by this (Labonte, 2002).

The health sector has a direct role to play by:

- increasing access to appropriate health services for immigrants and racialized groups that incorporate culturally sensitive and language specific services for all health needs, including mental health services
- confronting racism in policy and practice and putting legal restrictions on racism in place
- training health workers to be culturally sensitive, and other activities designed to help reverse the process and impact of social exclusion
- hiring health workers from visible minority groups
- helping minority communities build support networks
- protecting racialized workers and new immigrants from unsafe and discriminatory working environments
- undertaking research into the impacts of the multiple dimensions of social exclusion on the health status of the target group
- empowering racialized groups to participate in developing policy and program responses to the multiple dimensions of social exclusion.

As partners with other policy-makers, the health sector can also act as a knowledge broker and advocate in areas such as housing, transportation and urban planning.

Research gaps include our understanding of:

- the mental health of immigrants
- the relationships among race, culture and socio-economic status and health status
- the persistent gap in health care utilization between immigrants and native born Canadians.

Research in these areas can benefit from using a framework that recognizes the impact of racism and immigrant status on the social exclusion and the social determination of health (Beiser et al., 1993).

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