Racism as a Public Health Issue

To:	Chair and Members of the Board of Health	
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Recommendations

It is recommended that the Board of Health:

1. Receive this report for information.

2. Acknowledge that racism is a public health issue.

3. Engage with local leaders and individuals in indigenous and racialized communities to better understand the local experience of racism as a Public Health issue and how it can be addressed.

4. Continue to analyze and use surveillance data to assess and report on racial health inequities in Wellington, Dufferin and Guelph. Where there are gaps in data, enhance public health surveillance systems by collecting and analyzing race-based data at the individual and structural levels.

Key Points

- WDGPH is mandated through the Ontario Public Health Standards to address health equity, which includes addressing health disadvantages caused by race.
- Racism is a public health issue because it impacts individuals' opportunities for health and wellbeing. Groups that experience racism are at a higher risk of negative health outcomes.
- While racism can be observed in the thoughts, beliefs, and actions of individuals or groups, it can also be embedded into societal institutions in ways that may be less visible. Systemic racism has a profound impact on racialized groups.

Discussion

Background

The COVID-19 Pandemic has brought the issue of racial health inequities to the forefront as we see the disproportionate impact that COVID-19 is having on indigenous and racialized communities in Ontario.[1] For example, In Wellington, Dufferin and Guelph (WDG), 35% of people who tested positive for COVID-19 and provided information about their race were visible minorities even though visible minorities account for only 11% of the WDG population.[2]

This report provides a definition of racism and its importance as a public health issue and recommends initial actions that Wellington-Dufferin-Guelph Public Health (WDGPH) can take to engage with indigenous and racialized communities to understand the local situation and how to move forward.

What is systemic racism and why is it a Public Health issue?

Racism can be defined as a "cultural and structural system that assigns value and grants opportunities and privileges based on race".[3] The cultural aspect refers to values and beliefs that maintain a racial hierarchy (i.e. narratives, unconscious/conscious ideas, cultural images, etc.), while the structural aspect refers to systems that create and reinforce racial inequities (i.e. history, public policies, institutional practices, etc.).[3] Society attaches racial meaning to different groups (through **racialization**) that affirms racist ideas and produces inequities.[3]

Racism exists in all aspects of society and functions on multiple levels:

1) **Internalized racism** refers to attitudes, beliefs and actions that reflect ideas of racial supremacy.[3]
2) **Interpersonal racism** refers to racism expressed between people, such as assaults on dignity and social status, racial slurs, verbal or physical assaults, or individual discriminatory behavior.[3]
3) **Systemic racism** refers to institutional policies and practices (such as racialized and colour blind norms and standard ways of operating) that lead to racially biased outcomes and experiences.[3]

While racism can be observed in the thoughts, beliefs, and actions of individuals or groups, it can also be embedded into societal institutions in ways that may be less visible. For example, racism is visible in institutions through racial profiling and racist hiring and promotion practices.[4] At the system level, racist banking practices have made it more difficult for certain groups of people to access financial capital.[4] At the community level, these two factors have affected where people can afford to live, resulting in residential segregation, a root cause of racial disparity in health today.[4]

Individuals may experience multiple forms of systemic racism due to the overlap of multiple social identifiers (race, gender, sexuality, class, etc.).[5] Multiple systems of oppression can work together to produce compounding inequalities that differentially affect an individual's material resources, health, and power.[5] For example, a Black gay man living with HIV could experience discrimination related to being racialized, identifying as gay, and living with HIV, that combined, produce poorer health outcomes.[6]

Systemic racism informs societal norms about which groups hold power and how that power is exercised. A group is said to be **privileged** when it "has something of value that is denied to others simply because of the groups they belong to, rather than because of anything they've done or failed to do."[7] The power that privileged groups exercise over non-privileged groups can be seen in discriminatory laws, residential segregation, inferior health care or education, unequal economic opportunity, and exclusion from cultural institutions.[8]

People that experience systemic racism are more likely to also experience higher rates of poverty, precarious and under employment, and systemic disadvantages within housing, education, and public health systems.[3] People who experience racism are also more likely to have negative mental health outcomes, negative physical health outcomes (i.e. hypertension, low birth weight, heart disease and diabetes) and negative health-related behaviours (i.e. cigarette smoking, alcohol and substance use).[5]

It is important to note that race alone does not put individuals at higher risk for certain negative health outcomes. Race is "an idea developed by societies to create and categorize differences among groups of people based on physical features like skin colour and hair texture and sometimes culture and religion. Race is used to create and maintain a social hierarchy with human value assigned based on how close one is to Whiteness."[3] It is the socioeconomic and political context attached to race, the social hierarchies assigned to different races, and the racism faced by different groups that impact individuals' opportunities for health and wellbeing.

How does systemic racism impact the health of the population?

Following are several Canadian, Provincial and local examples that illustrate the impact that racism has on the health of the population:

- **COVID-19:** The most ethno-culturally diverse neighbourhoods in Ontario are experiencing COVID-19 infection rates that are three times (3x) higher than the rates in the least diverse neighbourhoods after adjusting for the age structure of the neighbourhoods. Ethnoculturally diverse neighbourhoods have COVID-19 hospitalization and ICU admission rates that are four times (4x) as high, and death rates that are twice (2x) as high as the least diverse neighbourhoods.[1] In WDG, 35% of people who tested positive for COVID-19 and provided information about their race were visible minorities even though visible minorities account for only 11% of the WDG population.[2]
- **Diabetes:** African, Caribbean, Black Canadian, and South Asian adults are more than two times (2x) as likely to live with diabetes than White adults.[9]
- **Dementia:** Dementia rates in Canada are rising more rapidly among First Nations populations compared to the general Canadian population, and onset of disease is earlier.[6]
- **Intergenerational Trauma:** Intergenerational trauma or historical trauma is the transmission of historical oppression and its negative consequences across generations. Cumulative effects of trauma (colonialism, the loss of culture and land, the forced removal of children) are passed down along generations and cause other unpredictable impacts including impacting the trajectory of obesity and related complications throughout the lifecycle. [10]
- **Poverty:** While visible minorities and non-visible minorities in WDG are equally likely to have a secondary school diploma, visible minorities are more likely to experience poverty (14%) than non-visible minorities (9%).[11]

As next steps, it is recommended that WDGPH conduct a situational assessment to comprehensively understand the local situation and the impact of racism on the health of individuals living in WDG. This process will involve engagement with local leaders and individuals in indigenous and racialized communities to understand the local experience of racism as a public health issue and how it can be addressed. In addition, WDGPH will analyze and use surveillance data to assess and report on racial health inequities within WDG.

Conclusion

Anti-racism work is an ongoing commitment to learning and action. To advance our understanding and initial actions to address racism as a public health issue, the following first steps related to local engagement and surveillance are recommended:

Local Engagement: Engage with local leaders and individuals in indigenous and racialized communities to understand the local experience of racism as a public health issue and how it can be addressed. Engage with other local organizations involved in anti-racism work to learn from their experiences and find opportunities for alignment and collaboration.

Surveillance: Analyze and use surveillance data to assess and report on racial health inequities in WDG. Where there are gaps in data, enhance public health surveillance systems by collecting and analyzing race-based data at the individual and structural levels. [3,5]

Ontario Public Health Standard

WDGPH is mandated through the Ontario Public Health Standards (OPHS) to address health equity. “Health equity means that all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance.”[12] The requirements of this standard that relate to anti-racism work include:

1) The board of health shall assess and report on the health of local populations describing the existence and impact of health inequities and identifying effective local strategies that decrease health inequities in accordance with the Health

Equity Guideline, 2018 (or as current) and the Population Health Assessment and Surveillance Protocol, 2018 (or as current).

2) The board of health shall modify and orient public health interventions to decrease health inequities in accordance with the Health Equity Guideline, 2018 (or as current), and by:
    a. Engaging priority populations in order to understand their unique needs, histories, cultures, and capacities; and
    b. Designing strategies to improve the health of the entire population while decreasing the health inequities experienced by priority populations.
3) The board of health shall engage in multi-sectoral collaboration with municipalities, LHINs, and other relevant stakeholders in decreasing health inequities in accordance with the Health Equity Guideline, 2018 (or as current). Engagement with Indigenous communities and organizations, as well as with First Nation communities striving to reconcile jurisdictional issues, shall include the fostering and creation of meaningful relationships, starting with engagement through to collaborative partnerships, in accordance with the Relationship with Indigenous Communities Guideline, 2018 (or as current).
4) The board of health shall lead, support, and participate with other stakeholders in health equity analysis, policy development, and advancing healthy public policies that decrease health inequities in accordance with the Health Equity Guideline, 2018 (or as current).[12]

2020 WDGPH Strategic Direction(s)

☒ **Service Delivery**: We will provide our programs and services in a flexible, modern and accessible manner, and will ensure they reflect the immediate needs of our Clients and our role in the broader sector.

☐ **System Transformation**: We will equip the Agency for change in all aspects of our work so that we are ready for transformational system change when the time comes.

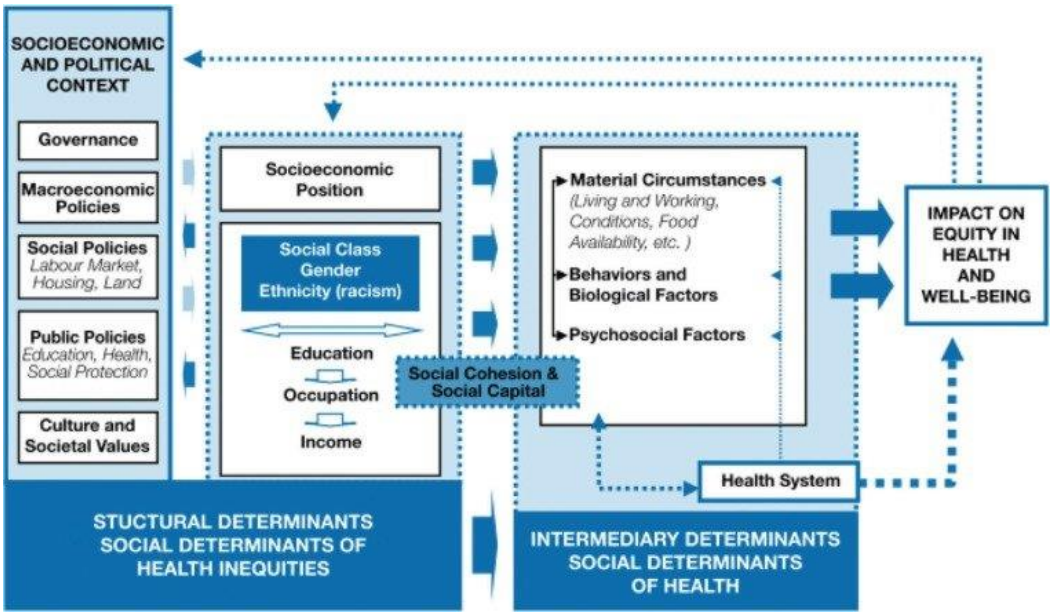
☒ **Knowledge Transfer**: We will ensure that our decision-making and policy development efforts are informed by meaningful health data at all times.

Health Equity

Racism within society and institutions influences how opportunities are distributed. It can result in inequities in social inclusion, economic outcomes, health and wellbeing, and access to quality health and social services.[3,5]

The diagram below from the World Health Organization (Figure 1) explains how structural determinants of health can produce health inequities. It shows that social, economic and political mechanisms influence an individual's socioeconomic position, which is stratified according to income, education, occupation, gender, race/ethnicity, and other factors. An individual's socioeconomic position, including their race, influences intermediary determinants of health, such as food access, living conditions, behaviours, and biological and psychological factors. As a result, individuals in different socioeconomic positions experience differences in their exposure to and vulnerability to different health promoting or health compromising conditions.[13]

Figure 1: Structural Determinants of Health[13]



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Appendices

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