Ethnicity, Health and the Census: Moving Beyond "Culture-by-Proxy"

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ABSTRACT

The percentage of the current foreign-born Canadian population is at its highest in 70 years. Censuses can help us determine such statistical information. The data they yield can also be analysed with an eye toward identifying the complex interplay between ethnicity, culture and health in such as way as to make our health care system equitable, efficient, and accessible to all Canadians. The author proposes a series of steps to help us obtain meaningful data about the cultural diversity of Canadian citizens, which in turn can help us better serve the ethno-culturally complex makeup of our society.

During the past four decades Canada has undergone a fundamental socio-demographic shift due in large part to changing immigration trends. 2.2 million immigrants and refugees arrived in Canada between 1991-2000, the highest number for any decade since the beginning of the century and close to double the 1.3 million figure for the 1980s (Statistics Canada, 2003: 6). As a result 18.4% of the current Canadian population is foreign-born, representing close to 5.4 million people, the highest level in 70 years (Statistics Canada, 2003: 5). There has also been a major change in primary source countries. Prior to 1961, European-borns made up 90% of all immigrants coming to Canada (Badets 1989); in contrast, the 2001 Census indicates that 58% of the immigrants who arrived during the past decade came from Asia (including the Middle East), 20% from Europe, 11% from the Caribbean, Central and South America, 8% from Africa and 3% from the United States (Statistics Canada, 2003: 6). In addition to enriching the cultural fabric of Canadian society, this shift has contributed to a concomitant increase in the proportion of visible minorities within the overall population with close to 4 million individuals (representing 13.4% of the population) identifing themselves as such in the 2001 Census, up from 3.2 million (11.2%) in 1996 and 1.1 million (4.7%) in 1981 (Statistics Canada, 2003: 10). It is further reflected in the growth in Islam, Hinduism and Buddhism within a predominantly Christian population (Statistics Canada, May 13 2003 Census Release).

Ethnicity and Health

Research into the connections and interplay between ethnicity, culture and health is of growing strategic importance for societies as ethno-culturally diverse as Canada. If our health care system is to equitably, effectively and economically serve all Canadians, it is essential that we be able to accurately identify variations in health status, behaviour and outcomes across salient sub-populations. This knowledge greatly facilitates the development of health initiatives most responsive to actual needs. It is also critical to the identification of socio-cultural barriers to health care services which otherwise remain hidden behind an erroneous assumption that equal *availability of* health care services necessarily translates into *equal access to* or *usage of* available resources. This is significant because obstacles to needed care can in-and-of-themselves constitute a major health risk factor in certain vulnerable populations. It is also fundamental to ensuring that the specific health care needs of marginalized sectors of the client population are fully met. Greater awareness of differences in cultural knowledge, beliefs, values and practices as they relate to health in turn helps to minimize the risk of underutilization of essential services among culturally distinct or 'racially' disadvantaged groups and has direct implications for effective client care. Culturally sensitive, responsive and competent health care service delivery is particularly important for newcomer immigrants and refugees, established ethnic populations, as well as for aboriginal peoples, and simultaneously underwrites increased choice in health promotion and care intervention for all Canadians.

The trend towards a society ever more ethnically complex underscores the pressing need to better understand the various intersections between culture and health, and acutely heightens the demand for accurate and valid data upon which to base health policy, programming and health service decisions. Ironically, despite Canada's tremendous diversity, research into specific cultural factors which impact individual and population health is surprisingly limited. The key

stumbling block is the scientifically valid identification of culturally and/or 'racially' distinct sub-groups existent within the Canadian population. This then readily translates into a relative lack of meaningful, comparable data regarding the impact of variations in culturally-based lifeways within the general population – and concomitant interplay with social factors – on health outcomes. Yet quality evidence-based research regarding the role of cultural beliefs and practices and identifications in health behaviour and concomitant impact on health status is clearly needed to inform policy decisions, programming initiatives and service provision that is fully responsive to the ethno-culturally complex makeup of our society.

Use of Ethnic Origin Census Data

In Canada, base-line information regarding ethnicity is collected in the long form of the official census. The Ethnic Origin question reads "To which ethnic or cultural group(s) did your ancestors belong?" It is accompanied by a list of 24 illustrative sample responses including "Canadian;" an open ended response format then allows the respondent to provide up to four responses. Additional instructions specify that "an ancestor is someone from whom a person is descended and is usually more distant than a grandparent," and indicate that most non-aboriginal people can trace their origins to their ancestors "who first came to this continent." They clarify that "ancestry should not be confused with citizenship or nationality" and that information is sought regarding the "ethnic or cultural group or groups to which their ancestors belonged, not the language they spoke." Persons of East Indian or South Asian origins and those with Aboriginal ancestors are furthermore advised to "report a specific group" (www.statcan.ca).

The resulting data constitute a key information source regarding Canada's diversity that helps to inform health research, policy, programming, and service delivery alike. A key anchor for tracking Canada's changing demographic profile over time, this data is most often used in conjunction with other ethno-cultural identity indicators – including place of birth, mother tongue, language usage, religion, citizenship, immigration status and visible minority status – to identify possible areas of need, determine priorities, plan programme initiatives, inform service delivery and evaluate health-related outcomes. The primary challenge in using Ethnic Origin census data by itself is, however, that sophisticated statistical analyses are required before something meaningful can be said or extrapolated regarding the *actual cultural practices* and *current identifications* of a population living in a certain catchment area. Expensive cross-tabulations – for instance of home language by visible minority status – are often needed, as are specially commissioned 'target profiles' of particular ethno-cultural groups and/or ethno-cultural communities. Language knowledge and contextual usage data become helpful indicators of possible cultural practice(s), visible minority status data suggestive of 'racial' diversity, and place of birth and immigration status information jointly indicative of the percentage of newcomer Canadians living within a specific census area. Additional information must then also be gleaned from other available survey databases, ecological analyses, individual research studies, targeted surveys, as well as via 'anecdotal' information provided by health care providers practising within a given geographical area or ethno-specific community. This rather piecemeal approach requires additional resources and effort and is, moreover, duplicated across separate research or policy applications.

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The reason for these existing difficulties lies in the conceptualization of "ethnicity" within the Ethnic Origin Census question itself. The question formulation, format, and accompanying instructions make it clear that information is sought regarding the ethnic or cultural group(s) to which the respondent's *ancestors* belong rather than that of the respondent per se. The illustrative responses provided further suggest that *ethnic ancestry* is meant to refer to *country and/or nation of origin.* What the question really asks about, and what the resulting data can thus only convey, is the respondent's *family background* according to country/nation of origin. This has important implications for the use of the resulting data. Used by itself Ethnic Origin census data does not – and cannot – accurately reflect either past or present *cultural lifeways* either of the ancestors in question or of respondents themselves. Nor can it capture *cultural identifications,* symbolic or otherwise. Any attempt to use ethnic origin data as a "cultural marker" erroneously assumes that the line of descent has been culturally homogeneous for an unspecified number of generations. It also assumes that a statement about ethnic origin is a statement about continuing cultural *practice;* this may or may not be the case. It may also lead to the false, yet surprisingly common, assumption that a response to a question about ethnic ancestry is a statement about current ethnic *identification,* namely continuing affiliation, allegiance or assignment to a particular group based on a shared cultural tradition, language and history. For these reasons epidemiological and cross-cultural health research using Ethnic Origin census data alone is understandably limited to comparative natal, fertility and mortality rates.

As a result of these limitations, estimates of current cultural practice and likely identifications are often made in health research – as in other research – by using a combination of diversity markers. The latter include: ethnic origin; place of birth of respondent; place of birth of

parents; citizenship; immigrant status; generational status; age at immigration; mother tongue; language knowledge, language usage at home and work respectively; as well as age and sex. These indicators are then checked for overlaps or intersections with religious identifications, 'race,' and/or visible minority status in order to identify possible cultural groupings. Such "*culture by proxy*" is helpful in making educated guesses within census areas regarding current ethno-cultural diversity, particularly in the case of newcomer populations. They do need, however, to then be empirically substantiated on the ground via cross-triangulation with additional sources of information, including other survey data or direct supplementary research questions.

The use of a combination of diversity indicators to construct cultural profiles and subsequent utilization thereof as proxies for lived cultural expression has both advantages and disadvantages. The primary advantage of developing such 'cultural profiles' is that information regarding relevant diversity markers is in fact collected via the Canadian Census and thus readily available. In the absence of a direct question regarding respondent culture and/or identity, such proxies may therefore present the best, and often only, option for many researchers and analysts. The primary disadvantage is that the resulting groupings are by nature *social* identifications regarding respondent culture(s) and identification(s) constructed by analysts and researchers rather than the *personal* identifications provided by respondents themselves (see Rummens 1993, 2000). In short, without the possibility of direct recourse to respondents there is no way of ascertaining the *validity* of cultural identifications made via proxy.

Key Issues

The successful teasing out of cultural factors, their inter-relationships and connections to health inherent in ethnicity and health research is fundamentally dependent upon two things: first, the accurate and reliable identification of distinct cultural groupings; second, the subsequent specification and examination of those specific cultural values, beliefs, knowledge systems and practices thought to have direct or indirect bearing on health outcomes. The latter then needs to be considered within the framework of the particular societal context in question and carefully distinguished from social factors per se.

The accurate identification of culturally and/or 'racially' distinct sub-groups existent within the Canadian population is clearly the primary challenge. In Canada information regarding client 'ethnicity' or 'race' is not collected during hospital admissions or via health care practitioner records; only country of birth is recorded on birth certificates. In order to identify the ethno-cultural or ethno-racial composition of a population living within a given geographical area, researchers, policy makers and programme planners have therefore to consult and then carefully analyse available census tract and vital statistics information. It is largely for these reasons that epidemiological research into ethnicity and health is highly dependent upon the development of separate surveys. Most of these are directly informed by diversity information available in the census, especially at the initial design and participant recruitment stages. Some initiatives are directly linked to census data, while others incorporate alternative sources of base-line diversity information. However, in the end health researchers, policy analysts, programme planners, and service providers alike are left dependent upon triangulation across different information sources, all of which may use different conceptual definitions, question formats, health indicators and measures.

As a result, evidenced-based policy-making in the area of ethnicity and health remains challenged by the relative lack of meaningful, comparable data regarding the impact of variations in culturally-based lifeways within the general population – and concomitant interplay with social factors – on health outcomes. This is critical since limitations in accurate data collection regarding ethno-cultural variation and various minority statuses readily translate into hidden needs, the underutilization of existing services, and non-responsive service provision within certain sectors of the general population. In the final analysis, existing difficulties obtaining accurate, valid information regarding actual cultural practices and identifications within the general population actually contribute to the continued relative 'invisibility' of cultural influences on health outcomes.

Efforts to address these shortcomings remain stymied by an erroneous *conceptual* conflation between ethnic ancestry, lived culture and self-identification. Confusion between these three distinct referents is not unique to this particular field of inquiry. However, in ethnicity and health research it can effectively hamper the search for relevant cultural factors, render data analyses invalid, and result in compromised policy analysis, programme development, and service delivery. Increased conceptual clarity is therefore of fundamental importance, as it so readily translates into improved data validity and research methodology.

Initial failure to accurately identify practitioners of specific cultural lifeways effectively hinders subsequent identification and isolation of specific cultural factors thought to have either direct or indirect impact on health behaviours and health status outcomes. This effectively obscuring a long list of potential protective and risk factors relevant to both individual and population health, including a variety of lifestyle factors, (eg. diet, exercise, leisure activities), values (eg. regarding work/family balance), ideologies (eg. gender role divisions) and practices (eg. family networks; social activities) that help to inform health and wellbeing. The end result is often what has been called 'black box epidemiology' (Bohpal, 1997), a type of research in which the "how" is hidden and the cultural link simply assumed through the mere inclusion of various ethno-cultural populations in the study sampling frame.

Towards a Solution

What is needed at the conceptual level is greater clarity regarding the difference between ethnic origin, current cultural practice and actual identification, and at the methodological level clearer identification of specific cultural (and social) factors that inform health behaviour and thereby help to determine health status. The key question thus becomes: How might we best obtain and use meaningful data regarding cultural diversity across

time and space in Canada with which to better inform health policy decisions, programming initiatives and actual service provision?

Three steps are suggested. First, the simplistic assumption that a survey response regarding ethnic origin is necessarily equivalent to a statement about current cultural practices and/or identifications must be abandoned. Second, it is important to recognize the limitations of attempts to determine "culture by proxy," as it essentially represents a default position. Third, it is suggested that a series of standardized questions regarding ethnic origin, actual cultural practice, and identification respectively be developed for use within and across the Canadian Census and/or other studies and surveys. The use of three separate standardized questions would better tap variations across cultural, ethno-cultural and ethno-racial groups, effectively increase the scope of research inquiry, and greatly facilitate direct linkages and comparisons across different surveys, databases and applications. They would greatly enhance data validity, improve comparability across population groups, and in the area of health research, help to more clearly identify and clarify possible links with relevant health indicators and measures.

The **first** of these standardized questions consists of the existing Ethnic Origin census question. The data it provides are essential to the description of Canada's social composition through time, and critically important for the analysis of changing immigration trends, settlement trajectories, intermarriage patterns, ethnic references, linguistic and cultural shifts. Modest changes to the current formulation would strengthen the existing question by helping to ensure even greater consistency within and utility of the data collected. First, the question' referent might be clarified. Since the question is meant to only capture *family background* rather than tap the respondents' current cultural practices and/or identitifcation(s), it would be clearer for respondent and analyst alike to simply rename the question accordingly. An accompanying explanatory note might then specify that this information is being collected *according to country or nation of ancestral origin.* Second, the responses provided might be further qualified by asking ask respondents to specify the generational distance involved in each response; this information is currently only available in derived form for first and second generation immigrant respondents. Third, greater conceptual consistency in the sample responses provided would enhance internal comparability as well as facilitate data linkages with 'current cultural practices' and 'identification' responses in relevant surveys.

Second, it would be extremely useful to develop a separate standardized question regarding *current cultural practice(s)* for use in – or with – the Census and other surveys. The increased conceptual clarity provided by a separate question would translate into more valid representation of existing cultural diversity and fundamentally transform investigations into the respective roles of cultural and social factors in health processes. Such a question would serve as a model for – and link between – various quantitative and qualitative research initiatives. The information collected via would be particularly helpful in ethnicity and health research, where 'culture by proxy' clearly has its limits. The effective linkage it would provide between data sources would also prove cost effective for comparative cross-cultural research both in the area of health and elsewhere.

Third, a standardized question focusing on *self-identification(s)* might also be developed for use across various surveys, research initiatives, and study designs. Such a question would help to tap into salient cultural, 'racial,' 'ethnic,' religious, and minority status identifications, facilitate distinctions between historical, contextual, cultural and social factors, and tease out existing relationships between various permutations of origin, practice and identification. It would also permit meaningful analysis of, and comparisons cross, data regarding family background(s), current cultural practice(s), and actual identification(s). Such self-reporting would help researchers and analysts avoid the temptation to deduce salient cultural identifications without recourse to the independent verification necessary for data validation.

Used separately or in combination, across different surveys or within individual studies, the introduction of three separate, standardized research questions regarding family background, respondent cultural practice, and self-identification respectively would raise our understanding of the interplay between culture, ethnicity and health to an entirely new level. It would permit the accurate identification, description and location of relevant targeted populations. Used in conjunction with relevant health indicators and measures would underwrite attempts to accurately identify various culturally-based protective and risk factors in the area of health. More importantly, the enhanced conceptual clarity would translate directly into improved specificity of the resulting data and thus increase the validity of subsequent analyses. The use of identical questions across individual population health surveys and research initiatives would, moreover, maximize comparability both across research initiatives and among population groups; such combined and/or linked data would in turn permit more varied analyses and create more application possibilities. Together, these three questions would yield valuable additional data at all levels with which to better inform evidence-based health policy, planning and service delivery that is more truly responsive to the increasingly diverse, rapidly globalizing society that is Canada.

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