Disparities and social determinants of health among three key populations in Canada

Research in collaboration with Canadian Network for Equity and Racial Justice (CNERJ)

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Office of Health Equity, Centre for Addiction and Mental Health (CAMH)

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Contents

Executive summary

Improving health equity for racialized populations in Canada is a persistent challenge across our health and social systems. To address this, the Office of Health Equity at the Centre for Addiction and Mental Health (CAMH), in partnership with the Canadian Network for Equity and Racial Justice (CNERJ), launched this research project. The project examines how key social determinants of health—employment and working conditions, housing and built environment, and access to health services—impact Black, East Asian (Chinese, Japanese, Korean, Taiwanese) and South Asian populations in Canada. The goal is to identify issues and propose actionable solutions to improve health equity, contributing to the broader objectives of the CNERJ.

We conducted an environmental scan of Canadian academic and grey literature from the past 15 years, targeting studies of adults and young adults as defined per Statistics Canada and Canadian Institute for Health Information (CIHI) standards. Using Statistics Canada's Labour Force Survey, we measured employment and working conditions by unionization rates and access to paid sick leave. Housing indicators include home ownership, core housing need and affordability, while built environment was determined by dwelling types and geographic concentration. We assessed access to health care services using rates of unmet physical and mental health needs and identified barriers to care.

Drawing from the environmental scan and national data sources, this report finds that key social determinants of health are direct drivers of health disparities among the three populations. For example:

- Employment and working conditions – These determinants profoundly affect health, specifically for Black populations where the unemployment rate of 10.3% is nearly double the national average. Moreover, the absence of paid sick leave delays medical consultations across all populations, allowing conditions to progress and increasing reliance on emergency departments.
- Housing quality and the built environment – These determinants also shape well-being, with affordability challenges pervading every populations. Home ownership among Black populations stands at 45.2 %, lower than the 71.9 % national average. Core housing need affects 13.2 % of Black populations and 18.7 % of Korean populations, more than twice the rate experienced by non-racialized Canadians.
- Access to health services – Data on unmet health needs across the three populations remains limited. Available evidence shows that a higher

proportion of Black populations in Canada rate their health as fair/poor compared to other racialized populations. Persistent barriers include, cost, language, cultural stigma and insufficient culturally relevant services, all of which continue to hinder equitable care.

Our report further highlights the relationship between social determinants of health and health. The World Health Organization's framework helps illustrate how structural determinants (such as race, class and political context) intersect with intermediary factors (like income, housing and stress) to shape health. This interplay reinforces longstanding inequities, such as higher chronic disease burden, unmet mental health needs and lower life expectancy in racialized communities. Across all three populations, racialized Canadians face disproportionate barriers in securing stable employment, affordable housing and timely, culturally appropriate health care. These challenges are compounded by systemic racism, which embeds discrimination in institutions and limits access to critical resources across generations. To address these disparities, this report offers actionable recommendations, calling for collective action at provincial/territorial and federal levels, along with meaningful engagement from communities. These include paid sick leave mandates, equity-focused rent supports, race-based data collection and anti-racism training for health and social service providers. Together, these strategies aim to dismantle systemic barriers and advance health equity.

Introduction

This report examines Canadian published literature on three social determinants of health—employment and working conditions, housing and built environment, and access to health services—among Black, East Asian and South Asian populations. Methodology, findings and key recommendations to improve these determinants are presented, along with specific best practices.

The social determinants of health are the conditions in which people are born, grow, work, live and age. They include the wider set of forces and systems shaping the conditions of daily life (World Health Organization. n.d). Many are deeply rooted in systems of oppression such as racism, classism and homophobia (McGibbon 2021).

The social determinants of health affect mental health and well-being. It is these factors that drive health inequity and impact health (World Health Organization. 2024). Social determinants of health can increase or decrease a person's risk of developing a mental health problem or illness, as well as affect access to appropriate and adequate mental health care (McKenzie et al. 2016). These factors are also fundamental to health equity. Understanding the complex relationship between social determinants of health and health is essential to address health equity (Solar and Irwin 2010). The World Health Organization's Commission on the Social Determinants of Health explains the relationship between social determinants and health by dividing the social determinants of health into two categories:

- *structural determinants*, such as socioeconomic and political context, social class, gender, race and ethnicity that may result in structural inequities
- *intermediary determinants*, such as material circumstances, psychosocial circumstances and behavioural and biological factors

Social, economic and political mechanisms contribute to socioeconomic position, characterized by employment and income, education, gender, race and ethnicity, and other factors that reflect social hierarchy and status. These factors can influence an individual's exposure and vulnerability to health conditions. Those structural determinants shape the intermediary determinants that underlie health: material conditions (e.g., living and working conditions, food security), behaviours and biological factors (e.g., alcohol use, physical activity), and psychosocial factors (e.g., social support, psychosocial stressors) (Solar and Irwin 2010).

All these factors impact health, and in turn health can also feed into the structural determinants. For example, poor health can impact an individual's employment opportunities, which in turn can constrain income. Low income reduces access to suitable housing, nutritious food and health care, and increases hardship (National Academies of Sciences, Engineering, and Medicine 2021).

The health care system acts as an intermediary determinant. By improving equitable access to health care and addressing social determinants of health—such as access to healthy food, housing, education, employment and income, transportation and linking to other social services as needed—the health care system can address disparities in health (Solar and Irwin 2010).

The recent report on social determinants of health equity by the World Health Organization highlights that the underlying causes of poor health often stem from factors beyond the health sector, such as lack of quality housing, education and job opportunities (World Health Organization. 2025). Social determinants of health can also be responsible for a dramatic reduction in healthy life expectancy—sometimes by decades. For example, the relationship between employment and income and health outcomes is well established: low income is associated with increased health risks, such as not having enough nutritious food. Further, those with low income are also less likely to access important health services, more likely to have multiple chronic conditions that can lead to further health problems (such as diabetes and heart disease), and more likely to die younger (National Academies of Sciences, Engineering, and Medicine 2021).

Data shows that the poorest people in Ontario are nearly twice more likely to report having multiple chronic conditions compared with the richest people (23.5% compared with 12.4%, and 16.2% for Ontario overall) (Health Quality Ontario 2016). In Ontario, just over half (54.3%) of women living in the poorest urban neighbourhoods (neighbourhood income assessed based on census data and average household income of individuals within that area) have had cervical cancer screening in the last three years, compared with two-thirds (66.7%) of women living in the richest urban neighbourhoods, and 61.8% of all women in the province (Health Quality Ontario 2016). In addition, nearly half (49.7%) of people living in the poorest urban neighbourhoods are overdue for colorectal cancer screening, compared with just over one-third (34.9%) of people living in the richest urban neighbourhoods, and 41.5% for Ontario overall. With regards to life expectancy rates, women living in poorer neighbourhoods in Ontario die, on average, two years earlier than women living in richer neighbourhoods; men living in poor neighbourhoods die, on

average, five years earlier than men living in richer neighbourhoods (Health Quality Ontario 2016).

The World Health Organization Commission on Social Determinants of Health states that interventions focusing on social determinants are the most successful means of enhancing well-being and reducing inequality. This requires action by all sectors and civil society. To this end, the Office of Health Equity at the Centre for Addiction and Mental Health (CAMH) is dedicated to improving patient, family and community well-being by reducing disparities in mental health.

Our foundational work includes the following:

Dismantling Anti-Black Racism – Provides a strategy, including 22 actions, and a framework designed to reduce anti-Black racism at CAMH by addressing systemic barriers and advancing health equity.

The Case for Diversity report – Developed in collaboration with the Wellesley Institute for the Mental Health Commission of Canada (MHCC). This report builds a case for investing in culturally and linguistically appropriate and diverse mental health services for immigrant, refugee, ethnocultural and racialized populations in Canada.

Issues and Options for Improving Mental Health Services for Immigrant, Refugee, Ethno-Cultural and Racialized Groups – Developed in collaboration with the MHCC, this report outlines issues and options for service improvement.

Building on our previous work, this current research study focuses on social determinants of health and health disparities among Black, East Asian and South Asian populations in Canada. It explores three critical social determinants of health: employment and working conditions, housing and built environment, and access to health services. The goal is to identify issues and propose actionable solutions to improve health equity, contributing to the broader objectives of the CNERJ.

Terminology

Some of the common terminology used in this report are defined here.

Racialized: As indicated by the Ontario Human Rights Code (2005), “racialized person” or “racialized group” is preferred over “racial minority," "visible minority," “person of colour” and/or “non-white,” as it recognizes race as a social construct as opposed to a biological trait. In this report we use “racialized group” or “racialized person,” except where the research or report referred to uses terminology like “visible minority,” “Black,” “South Asian,” or “white.” The Canadian census defines visible minorities as persons, other than Indigenous people, who are not Caucasian or white in race.

East Asian population: We use the CIHI definition of East Asian population that focuses on individuals of Chinese, Japanese, Korean and/or Taiwanese descent (Canadian Institute for Health Information 2022).

Immigrant: Refers to a person who is born outside Canada and is a landed immigrant or permanent resident. Immigration authorities have granted immigrants the right to live in Canada permanently (Statistics Canada 2022c).

Ethnic or cultural group: Refers to the ethnic or cultural origin of the person’s ancestors or ancestral “roots.” It does not refer to a person’s citizenship, nationality, language or place of birth (Statistics Canada 2022a).

Core housing need: Measures households whose housing fails to meet standards of adequacy, suitability or affordability, requiring at least 30% of income to secure an acceptable alternative (Statistics Canada 2021c).

Housing affordability: A measure derived using the shelter-cost-to-income ratio, which refers to the proportion of average total income households spend on shelter costs. A household is said to have affordable housing if it spends less than 30% of its total income on shelter costs (Randle, Zheren, and Zachary 2021a).

Core housing needs and housing affordability are distinct concepts with affordability solely focusing on the cost of household while core housing needs include a broader concept measuring suitability, adequacy and cost of housing. Examining both the concepts together provides a holistic view of housing challenges by identifying who is most deprived (e.g., families in unaffordable, overcrowded homes) and why are they deprived (e.g., high rent compared to income)

Unmet needs for health care: Measures the proportion of the population reporting having unmet needs for health care (i.e., there was a need for health care but they did not receive the care at the time they needed it). This indicator is measured in a number of Statistics Canada surveys, including the Canadian Income Survey (CIS) (Statistics Canada n.d).

Background and context

Canada's racial diversity

Canada has undergone significant demographic changes since the 1960s, when Canadian immigration policy was reformed to include immigration regardless of national origin. In 2021, 9.6 million Canadians (26.5%) identified themselves part of 10 racialized groups, an increase from 22.3% in 2016. In 2021, South Asian (7.1%), Chinese (4.7%) and Black (4.3%) people together represented around one-sixth of Canada's total population (Statistics Canada 2022b).

The following provides a brief history and snapshot of the demographics and diversity of three key populations in Canada:

1. Black populations
2. East Asian populations (Chinese, Japanese, Korean, Taiwanese)
3. South Asian populations

Please note: All research reported aggregate data for Black and South Asian populations. For example, the 2021 census data grouped all people who identified their origins from India, Pakistan, Sri Lanka, Bangladesh and Nepal as South Asian population (Statistics Canada 2022d). There was a discrepancy in the way East Asian populations are defined. The 2021 census grouped East and Southeast Asian populations together, with some reports providing data separately for different East Asian communities. However, according to the CIHI, East Asian populations include individuals of Chinese, Japanese, Korean and Taiwanese descent (Canadian Institute for Health Information 2022). As mentioned earlier, people of Chinese, Japanese, Korean and Taiwanese descent constitute the East Asian populations for this report (Canadian Institute for Health Information 2022).

1. Black populations in Canada

As of 2021, Canada's Black population was 1.5 million, making up 4.3% of the total population, and it is projected to more than double by 2041 (Statistics Canada 2025a). Many of those identifying as being part of the Black population live in urban areas, with significant concentrations in cities including Toronto, Montreal and Ottawa. The identity of Black people of African and/or Caribbean descent has evolved over the past centuries both in terms of imposed names and self-defined groups. Civil and human rights struggles led to the emergence of Black or African Canadian as preferred terminology. The term Black refers to individuals of African heritage who may also self-identify as Black, African or Caribbean. As per the 2021 census, the Black population are incredibly diverse, with 25.6% of people reporting more than one ethnic or cultural origin. The most commonly reported origins include African (15.7%), Jamaican (13.0%), Haitian (10.8%) and Canadian (5.9%) (Statistics Canada 2025a).

Black populations have played a vital role in shaping Canada's heritage and identity and have been an integral part of the nation's development. Many Black Loyalists who arrived after the American Revolution helped build communities in the Maritimes, while soldiers of African descent made significant sacrifices in wars such as the War of 1812 (Government of Canada n.d). These contributions were pivotal in creating the diverse and inclusive society that Canada celebrates today.

In 2021, 40.9% of the Black population were Canadian born, including individuals with multi-generational Canadian roots as well as children of immigrants. Almost one-third (32.6%) of the Black populations were born in Africa, including Nigeria (7.1%), Ethiopia (2.8%) and the Democratic Republic of the Congo (2.4%), while 21% were born in the Caribbean, mostly in Jamaica (8.8%), Haiti (7.2%) and Bermuda (Statistics Canada 2022c)

2. East Asian populations in Canada

East Asian populations in Canada are steadily increasing. Although most East Asian people first arrived and settled in British Columbia, today they are

concentrated in the urban areas of Southern Ontario, Southwestern British Columbia and Central Alberta.

2.1 Chinese population

The first Chinese people arrived in Canada in 1788, helping to build a trading post (Government of Canada 2024b). According to the 2021 census, 1,713,870 people (4.7%) identified themselves as Chinese, making them the largest East Asian population group in Canada (Statistics Canada 2024a).

> Between 1881 and 1884, over 17,000 Chinese immigrants, constituting 75% of the workforce, worked to build the Canadian Pacific Railway. They were paid lower wages than white workers and lived in inadequate conditions, resulting in untimely deaths.

Over the years, Chinese people arriving in Canada have settled mostly in Ontario, British Columbia and Central Alberta.

2.2 Japanese population

People of Japanese origin arrived in Canada between 1877 and 1928, settling in British Columbia. Following Japan's entry into World War II in 1942, the *War Measures Act* forcibly removed Japanese people from the West Coast to inland areas. Families were separated and held in camps and livestock barns in Ontario and on the British Columbia/Alberta border. Those who resisted arrest were incarcerated in prisoner-of-war camps in Ontario. Despite the government's promises, the property confiscated from people of Japanese origin was sold. With the end of World War II, people of Japanese origin had to relocate to Alberta, Ontario, the Prairies and Quebec. About 4,000 of this population, half of whom were Canadian-born and one-third of whom were dependent children under the age of 16, were exiled to Japan in 1946 (Government of Canada n.d). According to the most recent census, about 129,425 people identified themselves as Japanese (Statistics Canada 2024a).

2.3 Korean population

Korean people first arrived in Canada on temporary basis in the 1890s to train as missionaries. In 1963, Canada formally established diplomatic relations with South Korea. In 1973, when the Canadian embassy opened in South Korea, many Korean people started coming to Canada on a temporary basis for education and work opportunities. Since then, Korean immigrants have continued to arrive in Canada as skilled workers and/or professionals, settling in urban centres including Toronto, Vancouver, Montreal, Edmonton and Calgary (Government of Canada 2024b). The 2021 census recorded 217,650 people of Korean origin in Canada (Statistics Canada 2024a).

2.4 Taiwanese population

The first people from Taiwan arrived in Canada in the 1960s. Subsequently, people from Taiwan arrived in Canada in the 1980s and 1990s. Those arriving in the 1980s settled in Ontario; after 1980, Vancouver became home to the largest Taiwanese communities in Canada. Taiwanese Canadian identity continues to evolve in Canada. Until early the 2000s, the Taiwanese population was viewed as being part of the Chinese diaspora. But now, the Taiwanese population is seen as a distinct community. According to the 2021 Canadian census, an estimated 65,000 people of Taiwanese origin live in Canada, representing 0.2% of the population (Peng 2024).

3. South Asian population in Canada

South Asian people have a long and vibrant history in Canada. The first South Asian people to arrive in Canada were men from India who settled in Vancouver in 1896. They worked as labourers in the lumber, railway and farming industries (Asian Heritage Society of New Brunswick n.d).

The South Asian population is diverse in terms of their geographical demographics, languages, dialects, religions and immigration status. The South Asian population traces their origins to South Asia, which includes India, Pakistan, Bangladesh, Afghanistan, Nepal, Bhutan and Sri Lanka. Most South Asian people in Canada are immigrants or descendants of immigrants from these countries.

Among the South Asian population in Canada, 44.3% were born in India, 28.7% in Canada, 9.2% in Pakistan, 5.4% in Sri Lanka and 3% in Bangladesh (Statistics Canada 2022c). Most South Asian people live in Ontario, British Columbia and Alberta, with Ontario being home to more than one million South Asian people. British Columbia is home to Canada's second-largest South Asian population. According to the 2021 census, over 2.3 million people identified as being of South Asian origin, making them the largest racialized population group in Canada, making up about 7.1% of the total population (Statistics Canada 2024a).

Methods

The objective of this research is to examine the health disparities among three key populations in Canada—Black, East Asian and South Asian populations—focusing on three critical social determinants of health:

1. Employment and working conditions
2. Housing and built environment
3. Access to health care services

The availability of data drove the decision to focus on these three racialized groups. According to 2021 census, 26.5% of Canada's total population identified themselves as racialized; of these, 18% identified as South Asian, Black or East Asian people (Statistics Canada 2021b).

This research aims to answer the following questions:

- What are the economic, housing and health disparities among the key populations in Canada?
- What is the impact of these disparities on the health of people?
- What are the recommendations to improve economic, housing and health equity?

For this research report, we use the following definitions of the social determinants of health.

Employment and working conditions:

Employment, as defined by the Labour Force Survey of Statistics Canada, includes both paid jobs and self-employment. To better understand the working conditions of each population group, we use following indicators:

- Proportion of people in unionized roles
- Proportion of people with paid sick days

These two indicators signify better working conditions as unionized roles offer increased job security and protection, while paid sick leave can support workers through periods of illnesses, promote better health outcomes, boost worker productivity and help increase overall labour force participation (Statistics Canada 2024c).

Housing and built environment:

Housing is assessed on indicators such as (1) housing ownership, (2) core housing needs as defined by Statistics Canada and (3) housing affordability. Built environment is examined using the following indicators:

- Types of dwellings
- Geographical concentration of population

These indicators help us better understand housing needs in terms of affordability, accessibility and socioeconomic disparities. While types of dwellings throw light on housing affordability (rent vs home ownership) and whether housing meets basic needs (i.e., suitability, safety, overcrowding), geographical location may help better understand accessibility issues (e.g., availability of services).

Access to health care services:

Access to health care services is assessed using two criteria: (1) unmet health care needs of populations, and (2) barriers to accessing health care.

This work includes an environmental scan of academic and grey literature published in the last 15 years focusing on issues and solutions/recommendations relevant to the three populations and their associated social determinants of health. We have also included some foundational work on the social determinants of health and health equity that

dates back beyond 15 years to frame our narrative. The scope of the search focuses on Canadian studies/papers that included young adults and adults. Population groups are defined using Statistics Canada and/or CIHI definitions.

Findings

1. Employment and working conditions among three key populations in Canada

Employment and unemployment rate

The employment statistics highlight the unequal distribution of opportunities for certain populations. In December 2024, the employment rate of the Black population was 78.2%, lower than the general population's average employment rate of 83.5% (Statistics Canada 2025b). Comparatively, in December 2024, the South Asian populations had a comparable employment rate of 82.1%. Among East Asian populations, the employment rate of Chinese people was 80.1%, that of Korean people was 78.8% and that of Japanese people was 75.5% (Statistics Canada 2025b). Data for the Taiwanese population was not available.

Conversely, the unemployment rate of the Black population was highest when compared to South Asian, Chinese and Korean populations (see Table 1).

Table 1: Unemployment rates of key populations in December 2024

Population Groups	Unemployment rate (percentage)
Total population	5.4
Visible minority population	7.6
Black population	10.3
South Asian population	7.3
Chinese population	5.8

Korean population	5.9
Taiwanese population	-
Japanese population	-

Data source: (Statistics Canada 2025b)

Educational attainment and occupational outcomes

Black and South Asian populations disproportionally face underemployment and overqualification. Research shows that Canadian-born Black workers hold lower-level positions relative to their qualifications and are less likely to secure full-time, year-round employment (Wall and Wood 2023). In 2021, 16% of Black workers with a Canadian bachelor's degree or higher were employed in roles requiring only a high school diploma or less, compared to 11.1% of the general Canadian-educated population. This overqualification rate is the highest among Canadian-educated racialized groups, surpassing South Asian workers (14.2%) and the general population.

Similarly, research shows that while South Asian populations are more likely to have college and university degrees, they encounter more barriers in obtaining employment and are often earn lower salaries than white Canadians, suggesting they are targets of systemic discrimination (Poolokasingham et al. 2014). This disparity is linked to foreign credentials not being recognized in Canada post-migration. Despite having a higher level of education (i.e., post-secondary education and higher), only 39% have jobs with duties similar in type and complexity to their pre-migration jobs (World Education Services 2019). Reports indicate that the proportion of South Asian populations working in professional, management and education sectors pre-migration decline post-migration, suggesting a change in work sector post-migration in Canada (World Education Services 2019). This is likely because most of these sectors are regulated in Canada and South Asian immigrants encounter difficulties with accreditation of their educational credentials required for these regulated professions (Council of Agencies Serving South Asians, South Asian Legal Clinic of Ontario, and South Asian Women's Rights Organization 2020).

A study by the Council of Agencies Serving South Asians (CASSA) shows that irrespective of their educational level, experience or overall qualification, most South Asian immigrants have to start from scratch when they immigrate to Canada (Council of Agencies Serving South Asians, South Asian Legal Clinic of Ontario, and South Asian Women's Rights Organization 2020). The

study also highlights that systemic racism impacts fair hiring practices, often contributing to discrimination against South Asian people. For example, while screening candidates and resumés for a job, Asian-sounding names have a 30% lower chance of being called for an interview. Likewise, having a "strong accent" is seen as a barrier to getting a job in Canada. Similarly, South Asian people are generally stuck in entry-level, low-paying work and are often passed up for promotions compared to their counterparts due to systemic barriers in promotion and upward mobility (Council of Agencies Serving South Asians, South Asian Legal Clinic of Ontario, and South Asian Women's Rights Organization 2020).

Further examination suggests that unlike South Asian populations, disproportional underemployment among Black populations is not primarily linked to foreign credential recognition, as the rate of overqualification is consistent across first-generation (15.8%), second-generation (16.6%) and third-generation-or-more (15.7%) populations (Statistics Canada 2023a). These findings are consistent with the fact that Black workers are more likely to face racial discrimination and unfair treatment in the workplace (StatsCAN Plus 2022; Foster et al. 2023).

East Asian populations are the only group that have jobs commensurate with their educational qualifications. In 2021, most East Asian populations (60% Korean population, 56.3% Chinese population and 48.2% Japanese population) had a bachelor's degree or higher, well above the national average of 32.9% (Statistics Canada 2023a). Consistent with their high educational qualifications, they each make up a large share of working-age people in occupations typically requiring a bachelor's degree or higher.

- Chinese people make up 5% of the working-age population and are highly represented among engineers (10.2%), computing professionals (12%) and doctors (8%).
- Korean people make up 0.7% of the working-age population but 5.1% of religious leaders and 2.1% of conductors, composers, arrangers, musicians and singers.
- Japanese people make up 0.3% of the working-age population and are also highly represented in the performing arts, making up 0.9% of conductors, composers, arrangers, musicians and singers (Statistics Canada 2023a).

Wide gender gap in employment rate among South Asian population

Specific to the South Asian population, data suggests a wide gap in employment rates among both men and women. In 2021, the employment rate among South Asian men (75.5%) was 15% higher than South Asian women (59.7%)—triple the gap between white men (70.9%) and women (65.7%). Much of this gap can be attributed to the notably lower labour force participation rate of South Asian women with children under the age of six (70.4%) compared with non-visible minority women with children in the same age group (81.0%) (Statistics Canada 2021a). More recent data also shows a similar trend—in December 2024, the employment rate of South Asian men was 88.3% while that of women was 74.9% (Statistics Canada 2025b).

A nation-wide survey (n=2,200) shows that despite being among the most highly educated, South Asian women disproportionately report feeling underused at work (57%), with 82% reporting higher rates of job dissatisfaction (Turner 2022). In addition, 55% report feeling they are treated less fairly than their peers in the workplace, and 60% state they are belittled by their peers or managers. South Asian women are also vastly under-represented in senior roles, such as at the executive and board levels within corporations, due to systemic barriers in career progression (Turner 2022).

A national study of over 3,000 health care leaders in Canada reveals significant underrepresentation of racialized individuals in leadership roles, particularly compared to the racial diversity of the communities they serve (Sergeant et al. 2022). In this study, reasons for this disparity are ascribed to systemic barriers such as limited mentorship, discriminatory hiring practices and a smaller hiring pool (Sergeant et al. 2022).

Barriers in seeking employment

- Language barriers
- Inaccessible resources and information for employment
- Lack of affordable child care, particularly for South Asian women
- Lack of Canadian experience for immigrant workers
- Difficulties in accreditation of skills and education
- Discrimination in hiring process
- Lack of access to transportation

- Lack of network and networking opportunities

Systemic financial challenges and income disparities among Black business owners

Black business ownership is increasing in Canada, but systemic financial challenges and income disparities persist, impacting the sustainability and growth of Black-owned businesses. By 2018, Black business owners accounted for 2.1% of all business owners in the country (Gueye 2023). Between 2005 and 2018, the representation of Black entrepreneurs increased among both incorporated and unincorporated business owners (Gueye 2023). In 2018, the majority of Black business owners were men (70.4%) and immigrants (61.4%) (Gueye 2023). However, there are significant income differences for Black business owners in Canada. Black male business owners have the lowest average income ($56,100), earning $9,500 less than male business owners from other racialized groups and $43,300 less than white male business owners (Gueye 2023). For Black female business owners, the average income ($55,700) is comparable to their racialized counterparts ($54,800) but $16,000 less than white women (Gueye 2023). Black-owned businesses are also smaller than business owned by white or other racialized individuals (Gueye 2023).

Overall, the data indicates that Black-owned businesses may not be realizing their full potential, as they are often smaller and generate less profit compared to other businesses. This is in part because Black-owned businesses face systemic funding challenges that limit their growth and profitability. For example, Black business owners are more likely to be denied loans; when loans are granted, they are charged higher interest rates by financial institutions. A major source of funding for small businesses comes from “dealmakers”—experienced entrepreneurs who reinvest in new ventures. However, these networks are predominantly composed of white individuals, leaving Black entrepreneurs with limited access to this crucial support system (Gueye 2023).

Black entrepreneurs often struggle to secure bank loans and face higher interest rates compared to others.

The persistent employment disparities faced by Black populations in Canada are rooted in systemic racism, which manifests through unequal access to

opportunities, occupational segregation and widespread discrimination. Despite advances in education and entrepreneurial efforts, Black individuals face higher unemployment rates, underemployment, income disparities and limited representation in leadership roles. These challenges are further compounded by financial and structural barriers that undermine economic mobility and workplace equity. Addressing these issues requires systemic changes, including equitable hiring practices, greater access to mentorship and financial resources, and proactive measures to dismantle racism within institutions.

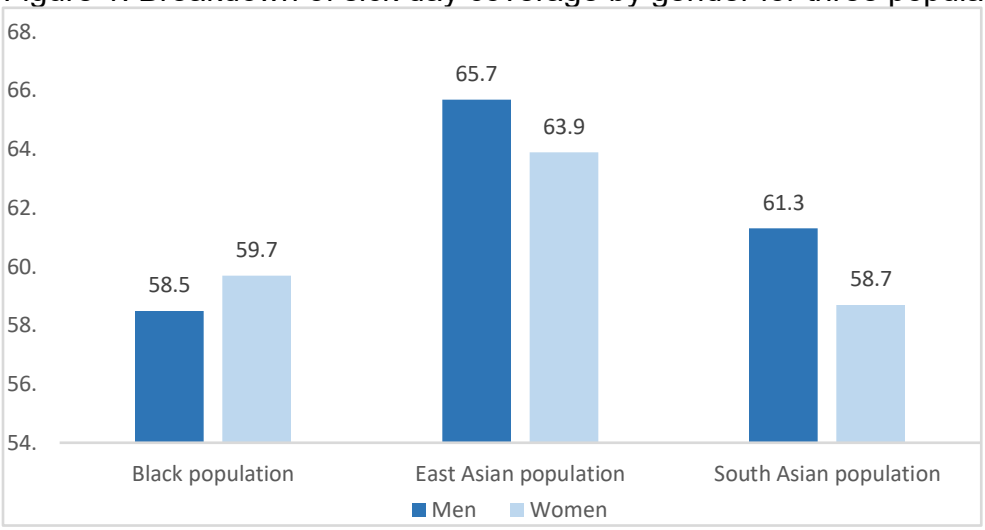
Union coverage and paid sick days

Data indicates that Black workers report the highest union coverage compared with South Asian and East Asian workers, who are the least likely to be union-covered. In 2022, a research paper by the Centre for Future Work (W. Ng, Khan, and Stanford 2024) had the following findings:

- Black workers reported 33.6% union coverage compared to the total population at 30.3%.
- The South Asian population had a union coverage of 19.4% (less than one worker in five).
- East Asian populations had a unionization rate of 22.3%.

In terms of paid sick day coverage, data shows that Chinese workers have the highest rates of paid sick leave coverage compared to other racialized groups (MacIsaac and Morissette 2023). The higher rate of paid sick leave coverage among the Chinese population is likely related in part to their industries of employment. In 2023, just over one in four (26.7%) Chinese employees worked in finance, insurance, real estate, rental and leasing or professional, scientific and technical services, industries with high rates of paid sick leave coverage. Chinese employees are about twice as likely to work in these industries compared to their white and non-Indigenous counterparts (13.4%) (Statistics Canada 2024c). Data for Japanese, Korean and Taiwanese populations is not available. Figure 1 provides a breakdown of paid sick day coverage by gender for all three key populations.

Figure 1: Breakdown of sick day coverage by gender for three populations



Source: (MacIsaac and Morissette 2023)

Increased job insecurity during pandemic

During the early phase of the COVID-19 pandemic, South Asian and Black populations faced increased job insecurity. The unemployment rate of South Asian populations between 15–69 years of age was 17.8% higher than the national unemployment rate in Canada (11.3%) (Statistics Canada 2020). Similarly, Labour Force Survey data from January 2020–January 2021 showed that the unemployment rate increased more among the Black populations (+5.3 percentage points) than among white counterparts (+3.7 percentage points) (Statistics Canada 2021d). In addition, Black youth aged 15–24 experienced particularly high unemployment rates during the pandemic, with almost one-third of the labour force for this group (30.6%) being unemployed in January 2021—almost twice the rate of non-visible-minority youth (15.6%) (Statistics Canada 2021d).

Many South Asian immigrants in precarious work or with precarious immigration status were unemployed from the beginning of the pandemic in March 2020 (Council of Agencies Serving South Asians, South Asian Legal Clinic of Ontario, and South Asian Women's Rights Organization 2020). The Canadian Emergency Response Benefit was available through the federal government, but reports suggest that many South Asian people were not eligible for the financial support due to their immigration status (Thobani and Butt 2022). A national survey conducted by the Association for Canadian

Studies (2020) during the initial phase of the COVID-19 outbreak found the following:

- Seventy-five percent of South Asian people surveyed reported that the economic crisis was a threat to their personal finances compared to 52% of white North American individuals surveyed.
- South Asian temporary foreign workers were working in unsafe conditions during the pandemic and many of them were working in essential frontline low-paying jobs, leaving them more susceptible to contracting COVID-19.

While many South Asian men worked from home (40.3% compared to 33.4% women) from the start of the pandemic, others did not have the same experience. South Asian people were twice as likely to live in a household reporting difficulty meeting essential financial needs (29.6%) compared with white Canadians (15.7%) (Statistics Canada 2021a).

We did not find data on job insecurity among East Asian populations during the pandemic, however research suggests heightened workplace discrimination against East Asian populations during that time. Studies show that East Asian populations faced verbal and physical abuse during the pandemic, particularly those who were engaged in public-facing occupations. This made them feel unsafe and socially isolated, and influenced their emotional well-being (Leigh et al. 2022). Another study found similar results, with East Asian populations experiencing more instances of discrimination compared to white Canadians. Specifically, on a 0–5 perceived discrimination index, white Canadians reported a mean score of 0.53, whereas East Asian populations reported about 1.00 (Wu et al. 2020a).

South Asian respondents in British Columbia reported the following:

- They were less likely to be employed in jobs that provided sick leave, with 54% of respondents indicating they did not have paid sick leave.
- Forty-three percent of South Asian respondents reported experiencing discrimination in the workplace.

2. Housing and the built environment among three key populations in Canada

Housing is a cornerstone of community well-being and social inclusion, providing security, access to essential services and opportunities for community connection. Housing is essential for health and well-being. The *National Housing Strategy Act* (2019) states that the right to adequate housing is a fundamental human right affirmed in international law (i.e., housing that provides secure tenure and access to basic infrastructure; is affordable; is habitable; is located close to employment, services and amenities; is accessible for people of all abilities; and is culturally appropriate) (Government of Canada 2019). Nevertheless, we found that some populations face discrimination and disparities in accessing affordable housing.

Home ownership

Home ownership provides financial stability and indicates long-term settlement, but some populations experience disproportionately low levels of home ownership. For instance, Black populations in Canada experience lower ownership rates compared to other groups. In 2021, 84.5% of Chinese, 63.9% of Korean, 69.8% of Japanese populations and 70.3% of South Asian populations lived in owner-occupied dwellings, compared with 71.9% of the total population (Statistics Canada 2023c). Comparatively, only 45.2% of Black individuals lived in owned dwellings, significantly below the national average of 71.9% and lower than all other racialized groups (64.7%) (Statistics Canada 2023c). Limited access to resources and systemic barriers contribute to this disparity among Black populations.

A study investigating ownership patterns among Canadian-born racialized groups (born between 1970–1990) shows that South Asian (80% and more) and Chinese (79% and more) populations have the highest rates of home ownership during their early 20s to early 40s (Stick, Hou, and Schimmele 2023). This greater proportion of home ownership could primarily be due to the tendency for these populations to live in the parental home, with 90% or more of the homes being owned by their families. In comparison, Black populations from their early 20s to early 40s have lower homeownership rates (49% and more), regardless of whether they are living with their parents.

The Canadian Housing Survey data of 2018 suggests that Chinese people are less likely to live in rented dwellings (15%) compared to the total population (27%) and are less likely to live in subsidized rental housing (1%, compared with 3% for the total population) (Randle, Zheren, and Zachary 2021a). When compared with Chinese men, Chinese women were just as

likely to live in owner-occupied dwellings (35% versus 34%) (Randle, Zheren, and Zachary 2021a).

According to the 2016 census, the proportion of Korean people (38.2%) living in rented dwellings was higher than that of the total population (26.6%), with a similar proportion of Korean people (3.0%) living in subsidized rented dwellings as the total population (3.3%) (Randle, Thurston, and Kubwimana 2022b). Japanese people were less likely to live in subsidized rented dwellings (2.4%) than the total population (3.3%) (Randle, Thurston, and Kubwimana 2022a).

Core housing needs

As of 2021, all three key populations experienced core housing need when compared to the overall population average of 7.7% (Statistics Canada 2023c) and 11.3% of racialized Canadians (see Table 2).

Table 2: Core housing need in 2021

Total population	7.7%
Racialized populations	11.3%
Black populations	13.2%
South Asian population	9.1%
Chinese population	12.9%
Korean population	18.7%
Japanese population	9.4%
Taiwanese population	Data unavailable

Data source: (Statistics Canada 2023c)

Housing affordability

In terms of housing affordability, in January 2021, the Black population was almost twice as likely as white Canadians (32.2% versus 16.6%) to have experienced housing unaffordability (Statistics Canada 2021d). In 2018, 32% of the Chinese population experienced housing unaffordability compared to

18% of the total population experiencing housing unaffordability (Randle, Zheren, and Zachary 2021a). Chinese individuals who lived in owner-occupied households (32%) were more likely to experience unaffordable housing compared to the total population in owner-occupied dwellings (15%). For other East Asian communities, 38.8% of Japanese (Randle, Thurston, and Kubwimana 2022a) and 48.5% of Korean people (Randle, Thurston, and Kubwimana 2022b) lived in households that spent more than 30% of their total income on shelter, compared with 20% of the total population. This means that Korean people were more than twice as likely as the total population to encounter housing unaffordability. A high rate of housing unaffordability was seen among Korean people who lived in owner-occupied dwelling (40.4%) as well as those living in rented dwellings (61.6%) compared to national rates (14.7% owner-occupied dwellings and 34.5% rented dwellings). This means that Korean people living in rented dwellings experienced housing unaffordability that was nearly double the rate for the total population living in rented dwellings.

Another study examining the long-term housing affordability trends in the Toronto Census Metropolitan Area from 1991–2016 showed that the rate of unaffordable and severely unaffordable housing is persistently around 10% higher for South Asian, Black and Chinese households compared to non-racialized households (Leon and Iveniuk 2021). One of the contributing factors to high unaffordability could be socioeconomic status due to immigration; reports show that immigrant groups tend to face more housing challenges compared to their non-immigrant counterparts (Statistics Canada 2023c). During the COVID-19 pandemic, a report indicated that 46% of South Asian people surveyed reported having difficulties paying rent or a mortgage compared to 19% of white Canadians (Jedwab 2020).

Among the South Asian populations, 26% live in households that spend 30% or more of their total household income on housing costs, compared with 18% of the total population (Randle, Zheren, and Zachary 2021b). High unaffordability rates for housing among South Asian and East Asian populations may be associated with their increased tendency to live in urban areas such as Vancouver and Toronto where housing costs are expensive (Choi and Ramaj 2024).

> In 2016, while 75% of non-racialized households had housing costs below 30% of their income, only 64% of South Asian-, 65% of Black- and 67% of Chinese-led households had this level of housing affordability (Leon and Iveniuk 2021).

Barriers in accessing affordable housing and housing condition

The Human Rights Code of Ontario states that everyone has the right to equal treatment in housing without discrimination. However, a study by the Canadian Centre for Housing Rights (CCHR) reveals that immigrants report experiencing a high degree of discrimination by housing providers and many barriers to accessing housing in Toronto (Canadian Centre for Housing Rights 2022). Reports suggest that 85–92% of immigrant households experience discrimination when they inquire about available apartments—and this discrimination represents a significant barrier to their ability to access housing (Centre for Equality Rights in Accommodation n.d). For example, a discrimination audit study done by CCHR showed that women who disclose their newcomer status face 62% more discrimination when they had racialized accents compared to women who did not have racialized accents. Men who disclosed a newcomer status faced a 267% increase in discrimination when their accents presented as racialized, compared with male newcomers who did not have racialized accents. Similarly, racialized newcomer women faced a 563% increase in discriminatory treatment when they disclosed that they were caring for a child, compared with when parental status was not disclosed (Canadian Centre for Housing Rights 2022).

Common barriers in accessing affordable housing

- race-based discrimination
- discrimination based on familial structure (e.g., single-parent family)
- lack of familiarity with Toronto and the norms associated with finding housing
- gender-based discrimination
- discrimination based on the receipt of social assistance

Data source: (Canadian Centre for Housing Rights 2022)

A report from the Toronto Community Housing Corporation (TCHC), one of Canada's largest housing providers, highlights how anti-Black racism manifests in housing environments for the Black population. The report acknowledges that systemic inequities faced by the Black population, resulting in disproportionately high poverty rates, make them more likely to rely on subsidized housing (Toronto Community Housing 2021). Within these

settings, Black residents face racism through stigmatization, surveillance, bias in risk assessment, erosion of trust and community development, and policing. Black tenants are often subject to greater scrutiny and stereotyping, and are perceived as risks or troublemakers rather than community members with valid needs. Practices like reporting tenants for “overhousing” force families into overcrowded conditions, exacerbating stress and undermining dignity.

The “risk management” approach of housing providers embeds racial biases, disproportionately affecting Black tenants with assumptions about poverty and criminality, while decisions around resource allocation often marginalize their concerns. Staff behaviour, such as ignoring cultural or religious practices, signals a lack of respect and understanding of tenants ’lived experiences, while community programs that could alleviate social exclusion are often deprioritized, leaving tenants without essential supports. Additionally, the Community Safety Unit (CSU), tasked with ensuring security, enforces policies in ways that alienate Black tenants, perpetuating fear and criminalization and mirroring broader systemic over-policing of Black communities (Toronto Community Housing 2021).

3. Access to health services among three key populations in Canada

Unmet health care needs

In 2022, close to 3 million Canadians aged 15 and older reported unmet health care needs (9.2%), which is an increase from 2021 (7.9%) (Statistics Canada 2023b). In 2022, unmet needs varied across the country, with proportionally more people in the Atlantic provinces (12.6%) and British Columbia (10.9%) reporting unmet health care needs, compared with the Canadian average (9.2%). The rate of unmet health needs in Ontario was 8.5%. When broken down in terms of age, unmet health needs were highest among the 25–54 years age group (see Table 3). Gender differences in unmet needs for health care were also observed, with more women (10.4%) than men (8.0%) reporting a need (Statistics Canada 2023b).

Table 3: Unmet needs for health care (in per centage) across age groups

15–24 years	7.4%

25–54 years	10.9%
55–64 years	9.3%
65 years and older	6.5%

Data source: (Statistics Canada 2023b)

Unmet health care needs are intimately associated with access issues. A report suggests that in 2023, a smaller proportion of racialized adults had a regular health care provider compared to white Canadians wherein compared with white adults (83.8%), only 72.3% of Black, 70.7% of Korean, and 80.4% of Chinese adults reported having a regular provider (Statistics Canada 2023b).

Although data on the variation of unmet mental health needs across these three key populations remains limited, a 2018 Ontario study found that service use was markedly lower among Chinese, South Asian and Black populations. For example, only 19.8% of the Chinese population with fair/poor mental health sought professional help compared with 53.2% of the white population. Similarly, 51.4% of South Asian and 43.6% of Black individuals reporting suicidal thoughts sought care, highlighting persistent disparities in access and use of mental health services (Chiu et al. 2018).

Racialized populations in Canada experience significant disparities in physical health outcomes compared to white adults, particularly in relation to chronic conditions such as diabetes. According to data from the Government of Canada (2022), the prevalence of diabetes is substantially higher among certain racialized groups. South Asian adults are 2.3 times more likely to have diabetes than white adults, while the rates are 1.9 times higher among Black adults. These disparities are especially pronounced among men, suggesting that gender may interact with race and ethnicity to compound this health risk (Government of Canada 2022). A nationwide Canadian Community Health Survey (CCHS) analysis suggests the racial gap in unmet mental health needs may be narrowing. Between 2012 and 2022, the rate of reported unmet mental health needs for racialized individuals was 8.1% lower than that reported by white individuals (Government of Canada 2024a).

With regards to self-reported health and mental health, data suggests that a higher proportion of Black populations report their health to be fair/poor compared to non-visible-minority counterparts. Between 2010 and 2013, 14.2% of Black individuals reported their health as fair/poor, compared with 11.3% of non-visible minority people. In addition, 15% of Black women

reporting their health as fair/poor (Government of Canada 2020). In terms of perceived mental health in 2023 (Q3), 20% of Black, 18.6% of South Asian and 23.9% of Chinese populations reported their perceived mental health as fair/poor as compared to 19.2% of non-visible-minority groups (Statistics Canada 2024b). Data for Korean, Japanese and Taiwanese populations is not available.

Barriers to access to health services

Populations who are exposed to stressful life events and social stress, low incomes, poor support networks and poor societal safety-nets may be more likely to have poorer health and mental health, resulting in greater need for health care services. Racialized populations are more likely to be exposed to social determinants that promote health problems. However, research shows that many do not get the care they need. Studies show reduced access to primary health care among immigrant populations in Canada (Dahal et al. 2024). In the next section, we identify the barriers to accessing health care among the three key populations in Canada. Since we found many similarities in terms of the barriers faced by all the three populations when accessing health care services, we report the findings under three broad categories (Sanford, Yin, and Sheppard 2024): intrapersonal, interpersonal and systemic.

Barriers in accessing health care

Intrapersonal	Interpersonal	Systemic
• Health system-related knowledge • Stigma	• Experiences of discrimination • Language barriers • Cultural differences	• Economic barriers • Access to regular health care provider • Lack of services • Systemic racism and discrimination • Lack of culturally relevant care

Intrapersonal barriers

Health system-related knowledge

Knowledge about the health care system and access to information play crucial roles in enabling immigrants to effectively use health services. Lack of knowledge about the Canadian health care system and difficulty navigating the system are significant barriers to accessing health services (Black Health Alliance 2020; Devlin 2023; Turin et al. 2020b; Dahal et al. 2024). People who are new to Canada are unaware of the available health care services and may not know how the Canadian health care system works. Reports suggest that immigrants often learn about available health care services through friends or colleagues. For immigrant populations, lack of social support impedes access to care (Turin, Rashid, Ferdous, Naeem, et al. 2020; Richter et al. 2020). Poor social connectedness often impacts their ability to navigate the health care system. Research shows that Chinese immigrant women who lack knowledge about the Canadian health care system are more likely to rely on informal sources for health information (such as discussion with family member) rather than reliable sources. This limits their exposure to comprehensive health information and decreases their engagement in preventive health behaviours, such as cancer screening (Zhu et al. 2024). Further, the fact that in Canada, people have to wait to be accepted by a doctor also influences access to care. New migrants therefore often have to rely on walk-in clinics rather than a regular family physician, which hinders continuity in care (Dahal et al. 2024; Richter et al. 2020).

Stigma

When accessing mental health care, stigma associated with mental illness acts as a strong barrier (Black Health Alliance, 2020; Islam et al. 2017). Mental illness continues to be stigmatized in many populations, including the Black, South Asian and East Asian populations. Mental illness stigma refers to the negative perceptions people have about mental health problems and illness. It remains one of the biggest challenges to accessing mental health care. Among all the three populations, fear of being judged and the family's reluctance to seek mental health care are some of the barriers to accessing mental health care (Tiyondah Fante-Coleman and Jackson-Best 2020; Naeem et al. 2024; Islam et al. 2017; Faruquzzaman 2020; Sanford, Yin, and Sheppard 2024; Chiu Maria 2017). Self-stigma and feelings of shame among East Asian and South Asian populations and their families is compounded by cultural differences in the perception of mental illness. For example, the view

that mental illness should be managed within the family may result in delays in seeking help (Chiu Maria 2017).

Interpersonal barriers

Discrimination

Experiences of discrimination within the health care system result in disparities in accessing quality health services. A report by Black Health Alliance (Tiyondah Fante-Coleman, Booker, et al. 2022) shows that the Black populations in Ontario are overlooked, misunderstood or treated poorly when trying to access care. Additionally, mistrust, lack of effective communication and information sharing, not listening to the client, disrespectful treatment and too-short consultations are some factors impacting the quality of care (Pederson Aderonke Bamgbose 2023; Majid et al. 2016; Dahal et al. 2024).

Language barriers

Language is another barrier to accessing care. Research shows that for South Asian and East Asian populations, language barriers and lack of interpretation services also impact quality of care (Wang and Kwak 2015; Turin, Rashid, Ferdous, Naeem, et al. 2020). According to the 2021 census, 4.6 million people (12.7%) in Canada speak a language other than English or French. Interpreter services within health care settings thus become crucial to receiving quality care. However, interpretation services are inconsistent across Canada and very little progress has been made to reduce language-related barriers to care (Arya et al. 2024). Among South Asian and East Asian populations, lack of English language proficiency, coupled with the unavailability of interpreters speaking their preferred language, result in an inability to understand what doctors and receptionists say. This perceived misunderstanding, in turn, hinders access to health care (Turin, Rashid, Ferdous, Naeem, et al. 2020; Dahal et al. 2024; Wang and Kwak 2015). Research suggests that language barriers often lead to missed appointments and underuse of specialized services such as cancer screening and mental health services among Chinese immigrants (Zhu et al. 2024; Wang and Kwak 2015).

Cultural differences

Cultural orientation and cultural differences also affect access to care. Research shows that health care seeking practices of immigrant populations and their expectations while accessing health care are often influenced by cultural differences between their country of origin and Canada. They often tend to compare the health care system between the two countries, and this difference poses another barrier to accessing health care (Turin, Rashid, Ferdous, Chowdhury, et al. 2020; Wang and Kwak 2015; Richter et al. 2020; Dahal et al. 2024). For example, immigrants from China hold different beliefs and attitudes toward health and health care compared to the Canadian population. They may also exhibit distinct cultural values that differ from those of Canadian culture, resulting in a greater likelihood of reporting obstacles to accessing services (Zhu et al. 2024). Further, reliance on traditional and cultural medicine as opposed to the heavy dependence on clinical and biomedical approach to care in the Canadian health care system often impact access to health care (Wang and Kwak 2015; Richter et al. 2020; Naeem et al. 2024). As a result, many East Asian immigrants rely on alternative medicine like acupuncturists and herbalists, which are culturally relevant and easily understood (Zhu et al. 2024).

Systemic barriers

Economic barriers

One of the well-documented systemic barriers to accessing care is economic factors. Low income negatively impacts access to and use of health care services. Economic barriers in terms of paying for services that are not covered by public health care system, along with lack of private health insurance, often hinder access to health care and treatment. Lack of funds can also prevent people from buying necessary medications. In addition, new immigrants report financial barriers in accessing primary health care. These barriers to access to care include the struggle to find a meaningful job, working more than one job, increased working hours, low pay and an overall struggle to maintain their day-to-day financial needs (Bajgain et al. 2020). Further, the three-month wait time after arrival to Canada to receive public funded health insurance poses challenges to accessing care for some populations. Additionally, transportation costs and/or lack of transportation can also impact service use (Turin, Rashid, Ferdous, Chowdhury, et al. 2020; Dahal et al. 2024; Turin, Rashid, Ferdous, Naeem, et al. 2020; Zhu et al. 2024).

Access to regular health care provider

A regular health care provider is a health professional (i.e., a family doctor or general practitioner) or a nurse practitioner that a person sees or talks to when they need care or advice about their health. They are usually the first contact in primary care in Canada. In 2021, 14.4% Canadians did not have access to a regular health care provider (Statistics Canada 2023b). Compared with white adults, there are large disparities in accessing health care provider among racialized adults. For example, the Black populations in Canada are less likely to have access to a family physician and is more likely to rely on drop-in clinics (Anderson, Flora, et al. 2015). In another study of access to mental health services, Canadians of Black-Caribbean descent waited an average of 16 months for care, compared to half that for white counterparts (Anderson, Cheng, et al. 2015). Among South Asian adults, there are 6% fewer adults with access to a regular health care provider compared to white adults (Public Health Agency of Canada 2022).

Among those who have a health care provider, 58.3% wait three days or less for an appointment (Statistics Canada 2023b). Research documents the difficulty in finding a family doctor, long wait times, and the slow referral process as barriers to accessing care (Olukotun et al. 2024; Wang and Kwak 2015; Ou et al. 2017; Devlin 2023; Turin, Rashid, Ferdous, Naeem, et al. 2020; Turin, Rashid, Ferdous, Chowdhury, et al. 2020; Dahal et al. 2024; Bajgain et al. 2020). Research shows long wait times not only in accessing a health care provider but also in diagnosis and treatment. For example, a delay in treatment often results in increased use of transnational care among East Asian populations. People from Korean populations travel to South Korea to access medical care, most often dental care (Wang and Kwak 2015).

Lack of services

Systemic barriers in terms of lack of urgent care, after-hour clinics, interpretation services and health resources can also impact access to health care and health outcomes. A study shows that lack of health resources and services in Black-dominated communities are major barriers to accessing primary care (Olukotun et al. 2024). Another report from Toronto shows lack of basic community infrastructure, including health services and programs (e.g., mental health services specific for Black young people) impacts health outcomes for Black populations (Black Health Alliance n.d). Research conducted with South Asian populations shows that overlapping clinic hours with work hours and lack of after-hours services largely impede access to

timely care. In this situation, visiting a doctor during the day may mean taking time off from work, resulting in financial loss. This results in a reliance on emergency care visits for less critical but nonetheless distressing conditions (Turin, Rashid, Ferdous, Naeem, et al. 2020; Turin, Rashid, Ferdous, Chowdhury, et al. 2020). Lack of interpreter services often deepen the communication gap between health care providers and the client, which in turn impacts the doctor-client relationship (Turin, Rashid, Ferdous, Naeem, et al. 2020).

Systemic racism and discrimination

Systemic racism impacts the quality of care for all three populations. For example, systemic racism in the form of unconscious bias (e.g., believing that Black populations have a higher pain threshold, racist stereotypes about drug-seeking intentions, myths about non-adherence to self-care regimes or assumptions about a lack of understanding of treatment) and discrimination are some of the barriers in accessing primary care (Olukotun et al. 2024). A growing body of research suggests a positive correlation between racial discrimination and declining mental health (D. R. Williams et al. 2019). Intergenerational trauma, systemic anti-Black racism and lack of access to care all contribute to lower self-reported mental health outcomes among the Black populations (Government of Canada 2020). A recent study examining the association of racial discrimination within the health care system and COVID-19 vaccination found that 32.5% of total participants (n=2,002) experienced racial discrimination within the health care system as measured by the Major Racial Discrimination Scale (MRDS) and were more likely to be unvaccinated (Cénat 2024). Participants who experienced racial discrimination within health care system also scored high on vaccine mistrust, depression, anxiety and stress scales.

A study from Toronto reveals that South Asian people experience racial and class discrimination as they are looked down upon because of their language and appearance. Health care providers often assume they cannot speak English and lack knowledge about South Asian cultural and religious practices (Mahabir et al. 2021). It is perhaps due to these reasons that South Asian populations are 2.99 times more likely to present to emergency departments involuntarily as compared to white North American individuals (Rotenberg et al. 2017).

Lack of culturally relevant care

Lack of cultural competence, lack of culturally appropriate therapy and therapists, and lack of representation of people from the same racial background in health promotion also impact the quality of care (Tiyondah Fante-Coleman, Wilson, et al. 2022; Salami et al. 2021; Naeem et al. 2024; Sanford et al. 2022; Islam et al. 2017; Faruquzzaman 2020; Wang and Kwak 2015; Tiyondah Fante-Coleman, Booker, et al. 2022). There is evidence that culturally adapted CBT is effective for different ethnic groups (Phiri et al. 2023), yet it is not widely used. Additionally, specific to young adults, reports show that lack of mental health services exclusively for young adults and lack of representation of mental health providers from the community are also barriers (Tiyondah Fante-Coleman, Booker, et al. 2022; Islam et al. 2017; Faruquzzaman 2020).

Impact of social determinants on health

Social factors increase the risk of illness and impact access and quality of care received. Because of this they have a profound impact on rates of illness and life expectancy. The Canadian Medical Association has calculated that 85% of your risk of illness is linked to social factors(Canadian Medical Association, n.d.). Social determinants of health are the most important issues that drive disparities in health. There are a variety of lists of which factors can be considered evidence based social determinants of health. The WHO defines these as:

“The circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics”(World Health Organization. n.d)

People’s lifestyle and the conditions in which they live and work strongly influence their health.

Income, wealth and employment are three of the most commonly researched social determinants. Poorer economic circumstances affect health throughout life. People from poorer economic conditions have a greater risk of serious illness and premature death compared to those who are financially well off. The economic gradient in health runs throughout, whereby people who are from economic conditions have worse health outcomes and at times shorter lives than those who are from better economic positions.

A classic example of this phenomenon is the Whitehall study of British civil servants that began in 1967. The study showed a steep inverse association between social class, as assessed by grade of employment, and mortality from a wide range of diseases. Self-perceived health status and symptoms were also worse in subjects in lower grade jobs; men in the lowest grade, such as messengers and doorkeepers, had a three-fold higher mortality rate than men in the highest grade (administrators). Grade of employment was also linked with some specific causes of death. For instance, low grade jobs were associated with obesity, smoking, less leisure time and physical activity, more baseline illness and higher blood pressure (Marmot et al. 1991). Both the phases of Whitehall study showed that people in the highest grade live longer and have better health than those in the grade just below them who, in turn, live longer than those just below them and so on in a downward gradient until the bottom of the social ladder is reached (Donkin 2014).

Poverty arising from unemployment and/or job instability puts health at risk. The health effects of unemployment are linked to both financial and psychological stress. Further unemployment and economic instability compounds with inadequate access to quality public services in areas such as health, education, social protection, transport and housing, which are major drivers of health inequities (Wilkinson and Marmot 2003). Data from Ontario shows that those from lower income levels have inadequate access to nutritious food (65.2%) compared with those with higher income levels (Health Quality Ontario 2016). In 2023–2024, Toronto food banks served 3.49 million clients—almost 1 million more than the previous year—accounting for a 38% increase compared to 2022–2023. Of those who rely on food banks, 80% are racialized, 92% live in unaffordable housing and 70% are precariously employed (Daily Bread Food Bank 2024). Evidence also shows that as income increases, health risks decrease, while access to high quality health care and health outcomes, such as life expectancy, improve (Health Quality Ontario 2016).

Such complexity and interactions between social factors is common amongst social factors linked to health. For instance, historic discrimination has left some populations with fewer resources and diminished fulfillment of human rights, perpetuating ongoing intergenerational inequity, which manifests as health inequities. Racism, sexism, classism and ableism, for instance, often intersect and compound, acting across the life course and between generations to undermine health and people’s agency to lead flourishing lives.

The public health agency of Canada has prepared a list of social determinants of health ((Government of Canada 2022). These include

1. Income and social status
2. Employment and working conditions
3. Education and literacy
4. Childhood experiences
5. Physical environments
6. Social supports and coping skills
7. Healthy behaviours
8. Access to health services
9. Biology and genetic endowment
10. Gender
11. Culture
12. Race / Racism

The mechanisms through which social factors lead to poorer health include exposure to increased risk factors, inequitable social and health policy and the psychological impacts of inequality.

Social and psychological circumstances can cause long-term stress. Continuing anxiety, insecurity and lack of control over life can have detrimental effects on health. When accumulated over time, such psychosocial risks increase the chances of poor health (e.g., infections, diabetes, high blood pressure, heart attack, and stroke), mental health problems (e.g., depression, anxiety) and premature death. Long periods of stress, anxiety and insecurity, coupled with lack of support systems, are damaging to health and mental health. Research shows that people from lower socioeconomic circumstances with unstable jobs and poor housing are at increased risk of stress, leading to mental health problems (Wilkinson and Marmot 2003).

Across Canada, racialized populations typically experience higher exposure to life stressors; however, mental health inequalities vary.. This may be due to different cultural perceptions of mental health and mental illness, experiences of stigma, barriers to mental health services and resilience (Government of Canada 2022).

Mental health problems and illnesses have a profound effect on the daily lives of individuals. People living with mental health problems often face barriers in accessing suitable housing, educational opportunities, employment and health care. In Canada, people with poorer mental health are more likely (15.8%) to live in inadequate housing than those reporting good mental health (10.1%). Likewise, in Canada, 46.1% people with mental health conditions are employed, while the rest depend on income supports that keep them in poverty (Lowe et al. 2024). These inequities cause stress and may lead to mental health conditions. People with the lowest incomes report having 2.4 times more anxiety than those with the highest incomes. Likewise, a report suggests that 57% of young adults (aged 18–24) who had early signs of a mental illness reported that cost was an obstacle to getting mental health services (Lowe et al. 2024).

Research indicates that immigrant populations have lower or similar rates of mental health problems and illnesses when compared to the Canadian-born population (Ng and Zhang 2020). A large body of evidence suggests that new immigrants are healthier, both physically and mentally, than the native-born population upon initial arrival to their new country (Ng and Zhang 2020).This phenomenon is known as the “healthy immigrant effect.” These findings are perhaps a result of how immigrants are selected for entry into the host country. This initial health advantage has been found to fade the longer an individual remains in the host country, and eventually the health of immigrants converges to similar levels observed in the Canadian-born population (Mason et al. 2024). Some immigrant populations—in particular, immigrants from racialized groups and low-income immigrants—are at a higher risk of deteriorating health soon after arrival in Canada (Ng and Zhang 2020). It is common for immigrant populations to experience a decline in socioeconomic situation due to stressors such as limited access to jobs and education, limited recognition of education and certification, discrimination, poor housing, language difficulty and low social support. All of these factors are linked to an increased risk for mental health problems and illnesses.

One example of inadequate social and health policy is the hospitalization rate for ambulatory-care-sensitive conditions (ACSCs) among people living in the poorest neighbourhoods (neighbourhood income assessed based on census data and average household income of individuals within that area). This is almost 2.5 times the rate of people living in the richest neighbourhoods, 368 per 100,000 compared with 150 per 100,000. The overall Ontario rate is 233 per 100,000 people (Health Quality Ontario 2016). Ambulatory care sensitive conditions are illnesses such as diabetes and asthma that can usually be

treated in primary care. Admission to hospital occurs when control of diseases in primary care happens, or if people do not have access to good care or if the social factors which are making the illness worse are not balanced by the impact of healthcare. Higher rates of hospital admission demonstrate the differential ability of primary care to support people with ACSC but also the lack of social policy to counter the impacts of factors. For instance, access to good food choices can decrease the rate of diabetes complications and outpatient programs based on the cultural needs of racialized populations improve outcomes.

Social determinants of health such as employment, housing and access to health care, coupled with systemic racism, drive inequitable health outcomes for racialized populations. In the following sections, we take a deeper dive into how the interwoven disparities in employment, housing and health care access contribute to health inequities among each of the three key populations in Canada.

Impact of disparities on health – Black populations

Black populations face health inequities, primarily driven and compounded by systemic barriers such as anti-Black racism, resulting in limited access to employment and educational opportunities and health care. Discrimination against Black populations is deeply entrenched in Canadian institutions, policies and practices and is often invisible to those who do not feel its effects. This form of discrimination has a long history, uniquely rooted in European colonization (Government of Canada 2020). These experiences negatively impact the mental and physical health of Black populations.

> Black communities are disproportionately impacted by chronic diseases such as heart disease, stroke, and diabetes, exacerbated by risk factors like hypertension, chronic stress and obesity (Tjepkema et al. 2023).

Social determinants of health, such as limited access to health care, financial resources and educational opportunities, along with chronic stress caused by racism, exacerbate these disparities (Public Health Agency of Canada 2020). For example, the prevalence of food insecurity among Black adults is the highest across all racialized groups, with a rate 2.8 times higher than white adults. This translates into 13 more Black adults experiencing food insecurity

per 100 people. These inequalities are more pronounced among women, with Black women representing the highest proportion of adults experiencing food insecurity (Government of Canada 2022). Black populations in Canada are also disproportionately impacted by inequities in safe and stable housing. As reported earlier, the proportion of those living in core housing need is highest among Black populations (13.2%), with a national average of 7.7%. These inequities impact health outcomes.

In Canada, Black men have an increased risk of dying from four causes—HIV/AIDS, prostate cancer, diabetes mellitus or cerebrovascular disease—compared with their white counterparts. Similarly, Black women are at an increased risk for six causes of death—HIV/AIDS, stomach cancer, corpus uteri cancer, lymphomas and multiple myeloma, diabetes mellitus and endocrine disorders—out of the 27 causes of death examined (Tjepkema et al. 2023). Another study shows that while the incidence of diagnosis of uterine cancer is lower among Black women, the uterine cancer mortality among this population is relatively high. Specifically, Black women are 15% less likely to be diagnosed with uterine cancer compared with white women, but are two times more likely to die due to uterine cancer compared to white women. Delayed diagnosis and poor access to screening contribute to a higher proportion of differential uterine cancer mortality among Black women (14.9%) compared with white women (8.9%) (Olaniyan et al. 2025).

A report from the 2016 Canadian Census Health data examining hospitalization rates among people aged 10–74 from 2016–2022 shows that avoidable hospitalizations are significantly higher among Black individuals and significantly lower among people of Chinese origin. This finding suggests that inequities such as poor access to primary care and discrimination stemming from systemic racism may be contributing factors (Brobbey, Sharma, and Mazereeuw 2025).

Black Ontarians experience a higher level of aversive pathways to care (e.g., via emergency room, ambulance or police) when compared to those of white European descent (Tiyondah Fante-Coleman and Jackson-Best 2020). These entry points to the health “system” are not desirable for anyone. For Black young adults needing mental health supports, transitioning between systems is also compounded by anti-Black racism and discrimination at multiple levels of society. In Ontario, immigrants of Caribbean descent have a 60% higher risk of psychosis and refugees from East Africa have a 95% higher risk of psychosis (Anderson, Cheng, et al. 2015). These rates do not reflect the rates of psychosis in their countries of origin, which suggests that social factors associated with migration may contribute to the risk of psychotic disorder (Anderson, Cheng, et al. 2015). Black Ontarians of Caribbean descent also

experience a longer delay in receiving evidence-based services for psychosis than people of white European descent (Anderson, Flora, et al. 2015). These gaps foster systemic racism, distrust in the health and mental health care system, and significant barriers to access.

Impact of disparities on health – East Asian populations

In Canada, systemic racism toward East Asian populations is present through historical and ongoing discriminatory governmental policies and practices that date back to the 18th century (Yao 2021). More recently during the SARS outbreak and COVID-19 pandemic, anti-Asian sentiments heightened, leading to exclusion of East Asian communities (University of Waterloo 2024).

> Anti-Asian hate crimes that peaked during the early phases of COVID-19 pandemic impacted the mental health of many East Asian Canadians.

East Asian populations also experience discrimination while accessing affordable housing and health care. A survey of 516 Chinese Canadians (44% of whom were born in Canada) revealed that the experience of discriminatory behaviours significantly impacted their sense of self and belonging. Sixty-one percent of respondents said they had to change their routines to avoid microaggressions, and over 50% expressed concern that Asian children would be subjected to bullying (Angus Reid Institute & University of Alberta 2020).

> One in four Chinese Canadians reported they feel like outsiders living in Canada (Angus Reid Institute & University of Alberta 2020).

These experiences of racism impact mental health. For instance, studies show that East Asian populations (Chinese, Japanese and Korean populations) have poorer mental health (mean score of 11.49 on Center for Epidemiologic Studies Depression Scale) when compared to white Canadians (mean score of 9.51) (Wu et al. 2020b). Research also shows that experiences of racism during the pandemic resulted in feelings of loneliness and anger, and a decreased sense of self-worth (I. Ng, Hilario, and Salma 2024). Many second-generation Chinese young adults reported that their

sense of isolation was compounded by the racism that heightened during the pandemic (M. T. Williams et al. 2022; I. Ng, Hilario, and Salma 2024). Despite these experiences of racial discrimination during the COVID-19 pandemic, research shows that East Asian populations had low COVID-19 vaccine mistrust, leading to high vaccine uptake compared to those identifying as white (Mahmood et al. 2024).

Impact of disparities on health – South Asian populations

South Asian populations experience disproportionate rates of chronic conditions and mental health issues, often exacerbated by cultural factors such as intergenerational conflicts and stigma, as well as barriers to care (Islam, Khanlou, and Tamim 2014; Islam et al. 2017; Council of Agencies Serving South Asians, South Asian Legal Clinic of Ontario, and South Asian Women's Rights Organization 2020). While migration and acculturation may contribute to the stressors experienced by South Asian population in Canada, negative health outcomes in this population are predominantly the resulting effects of systemic racism and discrimination (Muralitharan 2021).

South Asian population face specific health challenges, reporting a high prevalence of type 2 diabetes, cardiovascular problems and asthma (Quay et al. 2017). The prevalence of diabetes among South Asian adults is highest (15.3%) compared to white adults (6.8%), Black populations (12.9%) and all racialized populations (10.8%) (Public Health Agency of Canada 2022). Research shows that race, gender (being male) and immigrant status contribute to health inequities among South Asian population. Further, as discussed in an earlier section, racialized populations such as Black, South Asian and East Asian populations are less likely to have access to quality health care (and thus are more likely to experience unnecessary treatments, inaccurate diagnoses and medication errors), and more commonly face structural and individual discrimination within the health care system.

Research in Canada reports that 48% of South Asian populations with major depressive disorder do not receive necessary mental health care, and 33% perceive barriers to accessing care (Islam, Khanlou, and Tamim 2014). Factors such as declining socioeconomic status, food security status (post migration) were found to contribute to mental health concerns present among South Asian individuals (Islam, Khanlou, and Tamim 2014). South Asian populations in Canada with major depression are also 85% less likely to seek treatment than other Canadians who experience the same illness (CAMH 2019). Similar trends are seen among South Asian young adults. In addition,

this population is under-represented in health care research, resulting in health care practices based on research with limited validity for South Asian context (Quay et al. 2017).

> Systemic racism shaped a heightened risk of exposure and poorer protection from COVID-19 among Canada's workforce, with 65% of South Asian population either experiencing unemployment or anticipating the risk of unemployment.

During the COVID-19 pandemic, many South Asian people working as essential workers were more prone to exposure to the infection (Council of Agencies Serving South Asians, South Asian Legal Clinic of Ontario, and South Asian Women's Rights Organization 2020). Studies found that COVID-19 mistrust was low in this population, resulting in high vaccine uptake (Mahmood et al. 2024). A study from British Columbia showed that vaccine trust played the least important role in vaccine receipt among those who identified as South Asian. Only 8.2% of those identifying as South Asian reported mistrust, and despite that, vaccine receipt among South Asian was still the highest (50.6%) compared with 40.5% among those who identified as Chinese and 26.9% among the white population (Mahmood et al. 2024). Another study from British Columbia highlighted that culturally tailored outreach among South Asian populations was one of the enablers of high vaccine uptake among this group (Kandasamy et al. 2023).

The three populations discussed here all face disparities due to systemic racism and discrimination, the ultimate impact of which is associated with deleterious health outcomes. These health disparities are not isolated but are linked to broader socioeconomic challenges, including unemployment and underemployment, housing insecurity and inadequate access to culturally relevant health services. Recognizing and addressing these factors through systemic interventions can lead to equitable interventions and systems. In the following section, we discuss recommendations to improve equity.

Recommendations

The World Health Organization (World Health Organization. n.d) states that

“There are challenges to overcome in implementing action to address health inequities through the social determinants of health. The social determinants of health equity is a complex and multifaceted field. It involves a wide range of stakeholders within and beyond the health sector and all levels of government. In addition, social determinants of health data can be difficult to collect and share”.

While the evidence base on the social determinants of health has strengthened during the past decade, the evidence base on what works needs to also be strengthened and good practices disseminated effectively.

There are three areas for critical action identified in the Global Commission on Social Determinants of Health report which reflect their importance in tackling inequities in health. These include:

1. Improve daily living conditions: These include the circumstances in which people are born, grow, live, work and age;
2. Tackle the inequitable distribution of power, money and resources including the structural drivers of those conditions of daily life (for example, macroeconomic and urbanization policies and governance);
3. Measure and understand the problem and assess the impact of action: this would include expanding the knowledge base, developing a workforce that is trained in the social determinants of health, and raising public awareness about the social determinants of health. Scaled up and systematic action is required that is universal but proportionate to the disadvantage across the social gradient. This is necessary for effective delivery to addressing inequities in health and promoting healthier populations.

With this is in mind some specific recommendations have been made.

Recommendations to improve employment and working conditions

Employment equity is a proactive approach to achieving and sustaining substantive equality in the workplace that will foster inclusive workplaces for everyone in Canada. The Employment Equity Act Review Task Force suggested a transformative framework comprising of three pillars necessary to achieve and sustain employment equity (Government of Canada 2023).

1. Implementation through barrier removal

- Provide specialized funding programs aimed at supporting Black entrepreneurs, like the federal Black Entrepreneurship Loan Fund (Innovation, Science and Economic Development Canada n.d).
- Expand access to mentorship and foster connections beyond traditional networks to open doors to resources, funding and collaborative opportunities that are often less accessible to these groups (Turner 2022). This approach not only broadens opportunities but also helps challenge systemic inequities within professional networks.
- Focus on providing resources and training in business fundamentals to help aspiring entrepreneurs overcome gaps in knowledge and navigate the complexities of running and growing a business. Education and skill-building are crucial.
- Recognize international credentials of immigrant workers and offer professional opportunities.
- Implement policies that ensure equal pay for racialized populations that commensurate with their educational qualification and skillsets.

2. Meaningful consultations

- Plan and fulfill commitments to equality and inclusion in consultation with racialized communities, such as building pipelines for Black leadership (KPMG 2024).
- Raise awareness about racial privilege and the unique barriers faced by Black and South Asian employees, which is critical in addressing workplace racism.

3. Regulatory oversight

- Make Employers ’Equity Diversity Inclusion (EDI) training mandatory for management supervisory and general staff. Ensure this training integrates education on eliminating systemic racism and microaggressions and prescribe it at regular intervals.
- Integrate trauma-informed approaches to HR practices in response to historical and aggravated anti-Black inequality in employment practices and work environments.
- Develop tools to collect disaggregated race-based data on labour market trends that are coordinated with immigration data to better understand

those impacted and make appropriate changes to labour market program and legislation (Turner 2022; Dhiman, Wong, and Yvonne 2020; Council of Agencies Serving South Asians, South Asian Legal Clinic of Ontario, and South Asian Women's Rights Organization 2020).

Recommendations to improve housing and built environment

A research report from Wellesley institute (Leon and Iveniuk 2021) highlights some policy directions to improve housing equity. These include:

1. Introduce an equity-based approach to housing policy at all levels of government. This could include:

- reconsidering policies that widen disparity (e.g., tax subsidies that benefit high-income households over low-income ones)
- measuring and monitoring disparities and then evaluating the impact these policies and programs have on disparities
- introducing policies and programs that will aim to reduce and ultimately remove equity gaps in housing affordability
- strengthening the collection and public reporting of disaggregated race-based data on housing affordability to monitor progress on disparity reduction efforts

2. Increase the supply of social, affordable and market housing:

- investing in social and affordable housing through the construction, acquisition, and retrofit of existing housing
- reducing barriers to housing construction

3. Improve housing affordability

- expanding rent benefits to low-income families
- increasing income supports and social assistance to allow housing affordability
- introducing rent stabilizing policies that will limit rent increases and improve housing affordability

In addition, there is a need to strengthen legislation to address discriminatory landlord practices and prevent racial discrimination in housing is a crucial step towards ensuring fair and equitable access to housing. This includes measures to protect tenants' rights, hold landlords accountable for discriminatory behavior, and prevent systemic biases in the rental market.

Some recommendations for legislative improvement also include (Canadian Centre for Housing Rights 2025):

- Strengthening tenant rights
- Prohibiting discriminatory practices
- Holding landlords accountable
- Addressing systemic bias
- Promoting inclusive design to ensure accessibility and inclusivity

The Ontario Human Rights Code (2009) also stresses that government-subsidized social housing should be an essential component of Canada's strategy to provide adequate housing to Canadians and advocates for removal of barriers in accessing social housing. Additionally, addressing systemic racism at all levels is necessary to reduce discrimination in accessing affordable housing.

Recommendations to improve access to health services

The Institute for Healthcare Improvement (IHI) framework (Wyatt et al. 2016) for achieving health equity includes the following key elements.

1. Make health equity a strategic priority.

a. Mandate race-based data collection and its application across the health care system. This must be done in partnership with the communities to truly understand the depth and breadth of these outcomes.

2. Develop structure and processes to support health equity work.

a. Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact.

3. Decrease institutional racism within the organization.

4. Standardize and mandate anti-racism, anti-oppression and decolonization training for health care providers, professionals, leaders and health system planners.

5. Develop partnerships with community organizations to improve health and equity.

6. Develop legislation to ensure health and mental health services are equitable in both access and outcomes.

Steps to improve health care access and equity among Black populations (Black Health Alliance n/d)

- Support Black representation in leadership.
- Develop strategies to decrease the effects of adverse childhood experiences on mental health.
- Focus on inter-sectoral partnerships to build a better health and social service infrastructure.
- Prioritize protective interventions that improve well-being, such as early childhood intervention.
- Invest in culturally responsive interventions in
    - mental health
    - chronic disease management
    - screening and prevention

The Canadian Institute of Health Research (CIHR) emphasizes the need to improve outcomes through evaluation, building evidence and implementing evidence-based position changes. For example, to support transitions in care (TiC) for Black youth experiencing mental health issues, the CIHR-Institute of Neurosciences, Mental Health and Addiction (INMHA) is funding research projects in addition to consulting with national initiatives like the Mental Health of Black Canadians Fund to mobilize new knowledge. The Black youth funding pool in the TiC Initiative is one step toward reducing inequities in

health research and knowledge and improving mental health care for racialized communities in Canada. The Mental Health Strategy for Canada (2012) emphasizes the need for evidence-based culturally appropriate mental health interventions and supports to respond to the diverse needs of all people.

> Particularly for young adults, there is a need to create more services that offer long-term care, culturally responsive crisis support centres (such as Toronto Community Crisis Service) and services for 2SLGBTQ+ youth (T Fante-Coleman, Booker, et al. 2022).

Limitations

Some of the limitations of this work include:

- There is very limited data available for Taiwanese population. This is possibly because Taiwanese populations are often considered part of the Chinese diaspora, resulting in a lack of disaggregated data for that community. This report therefore fails to capture the disparities that Taiwanese populations face in terms of employment, housing and health care access.
- In many reports and in much academic research, immigrant and racialized groups are often combined, which does not offer accurate pictures of the disparities.
- There is limited research on racialized groups born in Canada. Particularly, most of the research pertaining to South Asian populations include those who are recent immigrants to Canada, thereby offering little information about Canadian second- or third-generation South Asian populations.

Conclusion

Addressing the social determinants of health equity is fundamental for improving health and reducing longstanding inequities in health care. This descriptive study highlights the disparities in employment, housing and access to health care services and their impact on health outcomes for three key populations in Canada. There continue to be research gaps in both South

Asian and East Asian populations specifically on social determinants that drive health inequities. The recommendations highlight the need for collective action at the provincial/territorial and federal levels, along with engagement from the community. One of the key takeaways of this research is the need for the collection of sociodemographic data to create equity-based interventions. Addressing systemic racism and introducing equity-based approaches to employment, housing and health care services can help reduce the disparities and ultimately improve access to services and housing, employment and health outcomes of racialized populations in Canada.

Appendix

Snapshot: Promising practices in Canada

Programs providing culturally appropriate care and therapy

- CAMH has developed culturally adapted Cognitive Behavioural Therapy (CA-CBT) for each of the South Asian and Black populations. Developed in partnership with community-based organizations working with South Asian communities, CA-CBT for South Asian populations in Canada has been found to be effective (Naeem et al. 2023).
- Resources on Culturally Adapted Cognitive Behavioural Therapy (CA-CBT) for Black populations include a CA-CBT manual for Black populations for health care providers, an online CA-CBT course, a community of practice to enable health care providers to develop skills, and a website for CA-CBT resources and support.
- AMANI Mental Health & Substance Use Program (formerly known as SAPACCY) in Ontario offers culturally responsive mental health services to Black youth.
- Hong Fook Mental Health Association provides culturally appropriate services to East Asian communities in the Greater Toronto Area.

Health promotion and prevention

- South Asian Health Institute (SAHI) Fraser Health at British Columbia is working toward fostering culturally appropriate health promotion and prevention activities among South Asian populations.
- Women's Health In Women's Hands Community Health Centre offers holistic culturally appropriate health services to racialized women in the Greater Toronto Area, including mental health services, community health promotion and primary health care.
- TAIBU community health centre in Ontario offers health promotion through culturally designed primary health care services and strategies.

Language Interpreter services

- CAMH offers interpreter services to all its clients and their families through qualified contract interpreters who are skilled in interpreting for mental health care. In addition, CAMH often uses Remote Interpretation Ontario (RIO).
- Access Languages Services offers interpretation services in all hospitals in Nova Scotia, both in-person and virtually.
- The Provincial Language Service provides interpretation and translation services to provincial British Columbia Health Authorities.

Tools to improve service

- The Health Equity Impact Assessment (HEIA) tool helps identify unintended potential health impacts of a policy, program or initiative on vulnerable or marginalized populations. The Ontario Ministry of Health and Long-Term Care developed the tool to advance health equity and reduce avoidable health disparities between population groups.
- Collection of race-based data through public health units was critical in informing the creation of equity-based COVID-19 interventions that reduced infection rates and hospitalizations.
- The CIHI has developed standardized guidelines around the collection of race-based data and health reporting in Canada.
- The Health Inequality Data Tool is a measure to identify disparities in health outcomes and determinants between subgroups of Canadians at the national and provincial/territorial level. The tool contains 175 indicators of health outcomes and health determinants, grouped within 14 domains and stratified by a range of social and economic characteristics that are meaningful to health equity.
- The Engagement, Governance, Access, and Protection (EGAP) Framework, developed by the Black Health Alliance in consultation with communities, sets out the guidelines for collection and use of race-based data to address structural racism.

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