“Immigrants Can Be Deadly”: Critical Discourse Analysis of Racialization of Immigrant Health in the Canadian Press and Public Health Policies

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ABSTRACT By examining the role of the Canadian press in framing health and social issues of immigrants, the authors highlight the issues of power and social injustice in which immigrant health is constructed and handled by Canada’s health policies. Critical discourse analysis of 273 articles from 10 major Canadian dailies over one decade showed that pre-existing racializing discourses, which treat the immigrant body both as a disease breeder and an irresponsible health fraudster, continue to materialize in contemporary Canadian press coverage. A more balanced and fair media coverage of immigrant health will require deracialization of immigrant health issues as well as the transformation of the Canadian press toward greater inclusivity.

KEYWORDS Discourse analysis; Mass media effects; Policy; Immigrants; Health

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Introduction

Although news media coverage is an important source of health information and can potentially affect public and policy agendas regarding important health and medical issues, studies show that media coverage of health news is often inadequate, incomplete, inaccurate, and contradictory (MacDonald & Hoffman-Goetz, 2002; Rosales & Stallones, 2008). It is in this context that we need to understand how a news story is framed by “select[ing] some aspects of a perceived reality and mak[ing] them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described” (Entman, 1993, p. 52).

Framing as a theory of media effects (Scheufele, 2006) allows us to move beyond a review of which health stories are covered by news media and to a deeper understanding of how news media cover, construct, and represent certain stories (McCombs, 2004). This means analyzing news reports for “the presence or absence of certain keywords, stock phrases, stereotyped images, sources of information and sentences that provide thematically reinforcing clusters of facts or judgments” (Entman, 1993, p. 52). The nature of news coverage and the degree of prominence a news story receives (e.g., placement as front-page lead story, the headline size, the length of the story, the time spent on the story, repetition of a story, broadcast placement of the story) communicate the importance that news media accords to a news topic (McCombs, 2004). In this way, journalists and editors play a role in framing health news stories (Castelló, 2010; Hinnant, Oh, Caburnay, & Kreuter, 2011).

The news media are a leading source of health and medical information for the general public (Atkin, Smith, McFeters, & Ferguson, 2008; Barry, Jarlenski, Grob, Schlesinger, & Gollust, 2011; Cho, 2006; Holton, Weberling, Clarke, & Smith, 2012). Studies show that news media can influence and shape public opinion and perception of health issues (Brodie, Hamel, Altman, Blendon, & Benson, 2003), public health behaviour (Smith Clegg, Wakefield, Terry-McElrath, Chaloupka, Flay, Johnston, et al., 2008), and public health policy and healthcare decisions (Viswanath, Blake, Meissner, Saiontz, Mull, Freeman, et al., 2008). In this way, as McCombs (2004) argues, “the news media set the public agenda” (p. 2). Yet important questions arise: how do news media construct, report, and cover health news? What is the quality of health information reported by news media?

Although there has been some attention paid to how immigrant health is framed in newspapers, there is very little critique of the health policy consequences of how the Canadian press frames immigrant health issues. The lack of research in this area motivated our critical examination of the Canadian daily news coverage of one significant immigrant health concern over the past decade. This article focuses specifically on the press coverage of immigrant tuberculosis (TB) and identifies and analyzes the discourses of immigrant health status and behaviours underlying the coverage.

Racism, media, and immigrant health

Negative representations of immigrants in the Canadian press persist despite compelling evidence that these emotionally charged ethnic stereotypes have no basis in scientific fact. The racist ideologies on which these representations are based are both
morally wrong and resistant to change. According to van Dijk (1991), the negative categorization of non-white persons continues to be widely reflected in a variety of public discourses that “state or imply the belief in the moral, political, cultural, or technological superiority of white, western ‘civilization’” (p. 26). Importantly, the negative representations of immigrants demonstrate that the language born out of racist ideologies serves as a tool of sociocultural production through which people formulate, (re)produce, and re(construct) their knowledge of the world (van Dijk, 1995). The press by and large does not oppose the discourses generated by other sources of sociocultural production, such as people’s everyday conversation, textbooks, government publications, laws, advertisements, and the entertainment industry, because they all share fundamentally similar ideological positions. These ideological sociocultural discourses are “jointly produced, each acting within its own sphere of influence and control, but each also dependent on the other” (van Dijk, 1995, p. 29).

Additionally, there is a mutually reinforcing relationship between the content of news reports and the public health policies that control the health of immigrants, as media provide “a feedback loop to bureaucrats and policymakers as to the legitimacy and ‘correctness’ of what they are saying” (Danso & McDonald, 2001, p. 132). Moreover, the opinions and decisions of health policymakers are often informed by various mass media (Seale, 2003). As we will show in the following paragraphs, the negative discourses about immigrants’ presumably unhealthy and infectious bodies disseminated by the press, in fact, historically contributed to the development and entrenchment of many discriminatory public health policies to control immigrants (Mawani, 2003; Ward, 2002). Some of these policies remain in place today (Reitmanova & Gustafson, 2012a).

The negative stereotypes of racialized people are deeply rooted in Enlightenment pseudo-scientific ideologies about human race (later supported by Darwin’s theory of evolution and Mendel’s inheritance laws), according to which the white race was presumably naturally and inherently superior to all other races. In accordance with this hierarchy of races, allegedly ugly and odorous bodies of members of non-white races were regarded as degenerate and “potentially contaminating to those who came into contact with [them]” (Lupton, 1999, p. 131). With the popularization of lay knowledge, these negative representations of racialized people proliferated quickly from the realm of science labs and experiments to the public realm (Headrick, 2000). Scientific academies and learned societies were eager to share their findings and discoveries with the public in coffeehouses, lectures, and public demonstrations. More importantly, the advent of print media facilitated the penetration of scientifically justified discourses of racial hierarchy into the popular culture on a colossal scale (Anderson, 1991). Consequently, the readily available language of health and disease, which considered some groups of people as clean and pure and labelled others as dirty and unhealthy, “has often been implicated in the creation of [racializing] boundaries” (Bashford, 1998, p. 390). Unfortunately, the divide along racial lines facilitated the oppression and marginalization of racialized people in all spheres of life throughout the colonial history of many Western countries (Miles & Brown, 2003; Ward, 2002).

In Canada, many distinct groups of immigrants were subject to racialization of their physical characteristics and differences in health status and behaviours (McLaren, 1990).
Racialized immigrants from southern and eastern Europe, as well as Jews and the Irish, were deemed mentally and physically weak but able to assimilate with proper education and moral upbringing (Avery, 1995). The negative representation of these specific immigrant groups changed in the socio-political and economic milieu of the second half of the twentieth century. At that time, these immigrants slowly and successfully penetrated social institutions, acquiring power, prestige, and privileges previously attributed only to the white Protestant middle class (Avery, 1995; Brodkin, 2007).

At other moments in Canadian history, the so-named Orientals (Chinese, Japanese, and Hindus), Arabs, and Levantines were negatively represented as inherently uncivilized, dirty, and diseased (Woodsworth, 1972). It was often presumed that infectious diseases were one of the reasons these immigrants felt forced to leave their homelands (Beiser, 2005). They were presumed to pose a serious health threat to white Canadian settlers because it was believed that their geographic origin, known as the Orient, “was ravaged by virulent, disgusting diseases” (Ward, 2002, p. 7). The poor dwellings these immigrants occupied in the Canadian cities of the late nineteenth century were often regarded as “nests of disease” (Sellar, 2006) where, allegedly, they slept three or four to a bed out of stinginess or degeneracy (Ward, 2002). These households were described in the newspapers as the sources of worrisome epidemics of pestilence, smallpox, cholera, and leprosy. This negative representation contributed to the acts of racial discrimination against these non-white immigrants. For instance, after the Colonist (1892) condemned Vancouver’s Chinatown as “a reeking mass of filth” (Ward, 2002, p. 44), several of these dwellings were destroyed on the order of the city sanitary officer. The city council authorized the vaccination of all local Chinese immigrants (often against their will) and strict disinfection procedures to rid the city of contagions presumably associated with these persons. Since the mid-1890s, Vancouver’s Chinatown was subjected to special sanitary interventions in the same manner as were sewerage, slaughterhouses, and pig ranches (Leung & Guan, 2004).

These racialized discourses about immigrant health effectively (re)produced by print media further contributed to boycotting of and physical attacks on immigrants and their businesses in Canada (Mawani, 2003; Sellar, 2006; Ward, 2002). A strict control policy that led to forced isolation of some immigrants was enacted after an 1891 Toronto Mail news report claiming that Chinese immigrants in British Columbia had spread leprosy in the Aboriginal community (Mawani, 2003). Although the federal Department of Indian Affairs found no cases of leprosy among the Aboriginals, and physicians testified before the Royal Commission on Chinese Immigration that leprosy among the Chinese was very rare, the Canadian press continued to file reports about leprosy, known as the “Chinese disease” (Mawani, 2003). After years of reports fanning fears, the city of Vancouver built a lazaretto on D’Arcy Island where 43 Chinese men who were believed to be lepers were confined in dreadful living conditions.

Immigrants were also believed to pose a health threat as they allegedly engaged in risky behaviours. For instance, it was presumed that “virtually all Chinese” were infected with syphilis upon entering Canada because of their low sexual morals (Ward, 2002, p. 9). Chinese women were widely regarded as prostitutes and concubines, as this 1876 report in the Colonist illustrates: “Chinese women are in the habit of luring
boys of tender age into their dens after dark, and several fine, promising lads have been ruined for life in consequence” (quoted in Ward, 2002, p. 9). The press also characterized immigrants as gamblers and opiate addicts. Besides corrupting white settlers by teaching them to smoke opium pipes, they were accused of trying “to enslave a white woman with the poppy and then defile her ... or prostitute her” (quoted in Ward, 2002, p. 9), as the Victoria Times of 1908 reported.

These and similar discourses about the health and moral threats posed by immigrants in late-nineteenth-century Canadian society made it easier to enforce quarantine and other public health control policies. Immigrants were required to provide certification that they were free from infectious diseases and vaccinated (de Waal, 2008). Immigrants who were deemed ill or unfit were deported from Canada (Mawani, 2003). Those assessed as “idiots, imbeciles, feeble-minded persons, epileptics, alcoholics, criminals, and anarchists” as well as persons who were “insane, dumb, blind, physically defective, and illiterate” (Government of Canada, 1924, p. 14) became ineligible to immigrate to Canada. Some immigrants who were regarded as mentally or physically weak became subject to sexual sterilization introduced in 1920s, as it was believed that their “feeble” (McCuaig, 1999, p. 15) offspring would have no strength and vitality. These health and immigration policies combine to create “an important technology of nation building, allowing political officials to banish and exile those who were socially, morally, and physically unfit” (Mawani, 2003, p. 13).

The system of quarantine, deportation, and sexual sterilizations of presumably unfit immigrants was eventually abolished in Canada. However, the current federal policy still requires newcomers to comply with strict medical screening before they are allowed to enter the country. Since 1967, all would-be immigrants (with the exception of refugees) are assessed by Canada’s overseas immigration physicians. Those assessed as a potential public health threat (due to an infectious disease, for example) or as an economic burden to the Canadian healthcare system (such as through disability or chronic illness) are deemed inadmissible for immigration purposes. Beiser (2005) asserts that the medical screening system can be credited with producing the healthy immigrant paradigm or the situation in which the health status of the approximately 250,000 newcomers entering Canada each year is better than the health status of those who are Canadian-born. However, within 10 years of settling in this country, the health status of immigrants falls below that of their Canadian-born counterparts because of post-migration unemployment, poverty, lack of access to health and social services, and other factors associated with resettlement stress (Beiser, 2005).

In those cases where immigrants experience ill health, these episodes are typically associated with and explained by the country of their origin, race, ethnicity, or culture rather than the previously mentioned stressors and social conditions that cause a deterioration in the health of immigrant groups (Greenberg, 2000; Leung & Guan, 2004; Murdocca, 2003). According to Greenberg (2000), some immigrant groups are still represented as the “disease-carrying embodiment of danger whose presence poses a significant threat to the moral, physical, and economic being of ‘legitimate’ Canadians” (p. 12). Leung and Guan’s (2004) study of the impact of news coverage of the SARS outbreak in Toronto in 2003 shows that the racialization of the infection in the press
contributed to racism against the Chinese and South Asian communities, who experienced alienation, discrimination, and harassment in schools and workplaces, on public transportation, and in their own homes. They conclude that “the contemporary rhetoric of SARS echo[ed] very clearly the historical discourses [of diseased and contagious immigrants] that attempted to contain, regulate and prevent the inclusion of Chinese Canadians and other racialized bodies in Canada” (Leung & Guan, 2004, p. 7).

Similarly, immigrants have been misrepresented as the embodiment of disease in Canadian news reports on Ebola fever (Murdocca, 2003) and the Chagas disease scare (Kirkey, 2007). In both cases, the diseases were largely blamed on the foreign origin of immigrants (African and South American, respectively). Similarly, the International Gay and Lesbian Human Rights Commission (2000) showed how the Canadian media misrepresented HIV/AIDS as an imported problem that could be addressed only by excluding suspect immigrant groups, rather than by sound and multifaceted disease prevention strategies.

Such racialized press discourses point to a crisis in the immigration system, for they suggest that unhealthy foreigners are able to penetrate a nation of healthy, respectable, and innocent citizens (Hier & Greenberg, 2002; Murdocca, 2003). In response to this unproblematized theme, the press argues that the nation is justified in protecting and securing its borders to ensure “order, control and cleanliness” (Murdocca, 2003, p. 26) against the immigrant health threat.

Deracializing discourses about immigrant health issues and situating them in the framework of social determinants of health is essential for several important reasons. First, the continuous uncritical association of negative health outcomes, choices, and behaviours of immigrants with their presumably “problematic” country of origin, ethnicity, or culture leaves the structural social, economic, and political causes of immigrant health problems unaddressed (Reitmanova & Gustafson 2012b). Second, by racializing and decontextualizing immigrant health problems, the media contribute to preservation of institutionalized racist health policies and practices that are “often evident as inaction in the face of need” (Jones, 2000, p. 1212). Racializing and decontextualizing press reports thus reinforce health disparities and social inequalities that some visible minority immigrant groups already experience (Anderson & Reimer Kirkham, 1998). Third, the negative images of immigrants promote fear and hatred within the native-born population of host countries, such as Canada, and increase the existing social distance between the natives and the non-native-born groups (Eichelberger, 2007; Leung & Guan, 2004). For these reasons, this study can contribute to improving the understanding of how the health of marginalized populations, such as racialized immigrants, is determined by cultural production in the press as well as toward reducing the negative outcomes of racialized news reports on ethnic affairs.

Study methods and limitations
In this article, we restrict our discussion to the critical retrospective exploration of the discourses of immigrant health status and health behaviours, which emerged from the analysis of the newspaper coverage of immigrant TB in Canada between January 1, 1999, and December 31, 2008. (For more detailed discussion of the press coverage of immigrant TB as a racialized and medicalized disease, see Reitmanova
& Gustafson, 2012c). This time frame was characterized by large in-migration of the foreign-born population to Canada. A significant number of visible minority immigrants arrived from countries with a high burden of TB incidence and prevalence. We examined the press coverage of TB because this disease was historically closely associated with concepts such as contagion and moral taint in the racialization and othering of a population perceived to be a threat to health and nation (Littleton, Park, & Bryder, 2010). In addition, the data on incidence of TB in Canada shows that the foreign-born population accounted for approximately 60 to 80 percent of all reported cases of infectious TB between 1999 and 2008 (Public Health Agency of Canada, 2008). For these reasons, we anticipated that the problem of TB would appear frequently in the press coverage.

The data were collected from the news, editorials, columns, and letters to the editor of 10 major Canadian daily newspapers published in the seven cities identified by Kariel and Rosenvall (1995) as the most influential in news production in Canada: Ottawa, Toronto, Montréal, Vancouver, Edmonton, Winnipeg, and Halifax. The selected newspapers included the Ottawa Citizen, Ottawa Sun, Toronto Star, Globe and Mail (Toronto), National Post (Toronto), Gazette (Montréal), Vancouver Sun, Edmonton Journal, Winnipeg Free Press, and Chronicle Herald (Halifax). Because these English newspapers have the highest circulation in the country and cater to a diverse readership, they can reach and influence wide audiences.

Since the main focus of our study was the coverage of immigrant TB, we selected only the articles written about immigrant TB by entering combinations of keywords such as immigrant(s) and tuberculosis, refugee(s) and tuberculosis, or immigration and tuberculosis in the Factiva, LexisNexis, and Newscan.com search engines. The resulting 273 relevant articles were coded in chronological order by source and date of publication. The articles were read for content. We selected the emerging narrative themes supported with direct quotes from the articles. We attended to the ideological assumptions underlying the news framing as a way to better understand the sociocultural and political milieu playing out during the time frame. We linked these framings to the public policies for controlling immigrant health, many of which date to the late nineteenth century. To strengthen our analysis, we also noted outliers or those examples that appeared to contradict emerging themes. In addition, we collected quantitative data on the prevalence and patterns of message occurrence.

We compared our findings with those of similar national and international studies, noting similarities and differences. We acknowledge that some differences across countries may be due to differences in colonial histories, patterns of immigration, and prevalence of immigrant TB. We also recognize that our analysis is limited by the selection of articles that focused exclusively on the coverage of immigrant TB. We admit the possibility that examining general press coverage of immigrant health affairs rather than the specific coverage of immigrant TB could generate discourses different from those we report here. However, our findings are significant since they demonstrate that the coverage of one specific disease that burdens the immigrant population can serve as an attractive hook for the (re)production of other related and non-related racializing discourses about immigrant general health status and health behaviours.
Findings
We found that pre-existing racializing discourses that treat the immigrant body both as a disease breeder and an irresponsible fraudster materialized in the contemporary Canadian press coverage we analyzed.

Dangerous disease breeders
Of the 273 selected articles covering the problem of immigrant TB in Canada, 20 articles (7.3%) reported on the immigrants’ general health status. Nine articles (3.3%) informed readers that the overall health status of immigrants arriving in Canada is good, since they undergo medical screening prior to immigration and only healthy persons are awarded immigration visas. These articles accurately reflected public health research into the healthy immigrant paradigm that indicates that immigrants’ health deteriorates only after immigration due to stress, the loss of traditional supports, and the development of poor eating and fitness habits.

At the other end of the spectrum, 11 articles (4.0%) reported that “refugees and immigrants can be deadly” (Francis, 1999, p. D03) and “the tally of immigrant and refugee health problems is long” (Heinrich, 1999a, p. A2). Newspaper articles blamed immigrants for bringing in deadly contagious diseases such as TB, AIDS, malaria, hepatitis, syphilis, and leprosy, and for arriving in Canada sick and unvaccinated for diseases as rubella, hepatitis B, measles, influenza, bacterial pneumonia, and diphtheria. For these reasons, immigrants were described as health threats to people walking on the streets, visiting shops, or using subways, streetcars, and buses.

The threat of infectious diseases was the problem most frequently mentioned in the newspapers. Several articles referred to a new computerized system that quantifies the risk of transmission of 47 different infectious diseases. As a result of this risk assessment, Health Canada makes recommendations about the diseases immigrants should be screened for (“Medical testing …,” 1997). One Canadian public health official reportedly said, “[I]f we cut off the infected [immigrants], just about everybody would be excluded. Canada’s immigration would be reduced to a trickle” (quoted in Hurst, 2000, n.p.). The implication of this statement is that the vast majority of immigrants harbour infectious diseases from which native-born Canadians must be protected. This contradicts the purpose of immigration medical screening, which allows only healthy persons to immigrate to Canada, and the findings on the healthy immigrant paradigm explained above.

Another article typifies the racialization of the sick immigrant discourse, suggesting that sick immigrants come to Canada from places other than the USA and Western Europe. The opening paragraph reads: “They might be tougher than the rest. But are they sicker, too? For people who immigrate to Canada from outside North America or Western Europe, or come here as refugees, the answer is often yes” (Heinrich, 1999b, p. A1). This statement suggests that health problems are associated only with immigrants from outside western geographic space, the space predominantly populated by peoples of colour. This suggestion again contradicts evidence that the health of visible minority immigrants deteriorates several years after their arrival in Canada or the previously mentioned healthy immigrant paradigm (de Maio & Kemp, 2009).
Another claim reported in the news is that immigrants arrive in Canada unvaccinated for a number of diseases, such as rubella, hepatitis B, measles, influenza, bacterial pneumonia, and diphtheria. What makes this claim curious is that the majority of native-born Canadians are also not vaccinated against three of these diseases. Hepatitis B and bacterial pneumonia vaccinations were introduced to the Canadian public only in recent years, and influenza shots are voluntary (Public Health Agency of Canada, n.d.). More importantly, an unpublished study of the risk factors for positive or incomplete infection screening conducted with 1,520 foreign-born women in Toronto in 1999 revealed that 90.3 percent of them were effectively vaccinated for these infectious diseases. Of the remaining 9.7 percent of women who showed susceptibility to rubella, hepatitis B, and/or syphilis, the researchers concluded that they were likely not vaccinated or their vaccination was ineffective (Ford-Jones, Kelly, Wilk, Lamba, Bentsi-Enchill, Hannah, 1999). This study calls into question the claim that “most immigrant women have not been vaccinated” prior to coming to Canada (Heinrich, 1999b, p. A1). However, we recognize that we cannot generalize the findings of this small study to all immigrant women in Canada, and this issue would require further investigation.

According to the same article in *The Gazette*, immigrants also fail to have their newborns screened for thyroid and other screenable diseases, and to protect the health of their children by vaccination and appropriate utilization of health services. Effectively, not only were immigrant women accused of failing to protect their own health (and by extension, the public health), but they were simultaneously being constructed as incompetent mothers for failing to protect the health of their children. This discourse occurs frequently in the Western press (Villenas, 2001).

Other articles focused on infectious health threats posed by refugees since they are medically screened only after their arrival to Canada. Only a few newspaper articles reported that the health status of some refugees in Canada may be negatively impacted by traumas from escaping rape and murder (Morrison, 2002). This is consistent with Randall’s (2003) finding that the media are more likely to present information about the assumed health risks posed by immigrants rather than about the trauma, torture, malnutrition, and physical violence they could have experienced prior to settling in their host countries. However, we recognize that we report the findings from the articles restricted by our search terms on refugees and TB. Search terms such as refugees and war, rape, or murder could elicit different results.

We also acknowledge that refugees may carry some burden of illness since their medical screening is required only upon their arrival and because they may have resided for varying amounts of time in refugee camps where crowding, poor nutrition, and insufficient sanitation increase the risk of infectious disease. However, refugees account for less than 10 percent of all immigrants admitted annually to Canada (Citizenship & Immigration Canada, 2009). In addition, refugees receive necessary treatment for identified illnesses upon their arrival in Canada.

The discourse of threat, supposedly posed by immigrants, was accentuated in news reports about Canadians who were exposed to the infectious form of TB when they came in contact with immigrants in refugee camps, hospitals, border offices, or on flights. These soldiers, civilian volunteers, healthcare workers, border officers, and flight
attendants were portrayed in the news either as innocent, unsuspecting victims or heroes who put themselves in harm's way while caring for immigrants. These reports informed readers about the anxiety and stress that these victims and heroes experienced while waiting for the results of their medical tests and the measures they had to undertake, such as preventative medications and (in some instances forced) work leave. Some filed work compensation claims that were not accepted, as it was difficult to prove that they had been exposed to TB at work; others considered suing the government for failing to inform them about the risks of contracting TB while working with refugees. Some expressed the fear of losing their jobs, infecting their families, or being “treated as a leper” (Small, 1999, n.p.). The newspapers did not report that any of these victims developed infectious TB over time, however, one Canadian woman was quoted as calling the situation a “Canadian tragedy” (Oziwicz, 1999, p. A3).

Although the risk of TB transmission from immigrants to Canadians is very low (Hyman, 2001) and only nine separate incidents of TB exposure were reported by the newspapers in 10 years, a reference to these victim stories appeared in 37.4 percent \((n=102)\) of all articles. These stories usually sparked negative reactions from the readers who, in their letters to the editor, demanded a deportation of sick immigrants (“Carrier should …,” 2001). By contrast, the stories depicting the difficulties of immigrants living with TB that had re-activated in their bodies years after their arrival to Canada were found in only 3.7 percent \((n=10)\) of all articles. This is consistent with van Dijk’s (1991) finding that visible minorities living in the West are rarely depicted in the news as victims.

Irresponsible health fraudsters

One reason why immigrants were represented in the press as dangerous disease breeders was the notion that immigrants engage in risky behaviours that negatively impact their health status. Sixteen articles (5.9%) suggested that immigrants commit health fraud in order to obtain immigration visas to Canada. It was alleged that unhealthy immigrants provide the government with false results of their medical examination, which they obtain either by bribing or threatening overseas immigration physicians, or by buying clean health records in foreign black markets. This problem would presumably be solved if would-be immigrants were examined only by Canadian physicians using Canadian equipment. One article recommended that any Canadian doctor caring for immigrants should assume “that nothing has been undertaken” with respect to the medical examination of his/her clients abroad and therefore should re-evaluate their health status (Heinrich, 1999b, p. A1). This article employed a typical discourse of othering by using polarizing opposites: deceiving and untrustworthy foreigners versus honest and trustworthy Canadians. Sometime after these articles appeared in the press, Citizenship & Immigration Canada introduced a more thorough monitoring of overseas physicians who, when appointed, must now work jointly for the immigration services of Canada, the USA, and Australia. If convicted of any fraud, these physicians lose their right to work for all three countries (Health Management Branch, 2009).

The underutilization of Canadian healthcare services by immigrants is a recognized public health issue. There is considerable evidence that underutilization of health services is linked to a variety of systemic, organizational, and socio-economic barriers (McKenzie, Hansson, Tuck, Lam, & Jackson, 2009; Miedema, Hamilton, & Easley, 2008).
It is not surprising then that thirty-four articles (12.5%) reported that the majority of immigrants do not participate in screening for cancers or cardiovascular diseases, make routine preventative health checks in medical clinics, and comply with prescribed therapy. However, the articles inadequately contextualized these health behaviours when immigrants' difficulties were typically linked to their lifestyle choices, lack of knowledge about the disease, or difficulties with the English language. Only a few articles made note of the broader socio-environmental circumstances that might limit some immigrants' health choices and behaviours.

The case of a Peruvian refugee who was threatened with jail for non-compliance with his therapy for drug-resistant TB is particularly instructive. This man's non-compliance was blamed largely on his lifestyle as an irresponsible “drunk” who forgot or was too busy to follow the regimen (Kalogerakis, 2000). Two articles alluded to the challenge of adhering to this type of therapy by noting that this man was required to take 24 pills at day for at least eight months. While negative side effects are frequently the reason why many people refuse drug therapy, only one article indicated this to be a reason for immigrants. In addition, rather than naming the many and more serious side effects, such as permanent liver damage, the article mentioned lesser (but still troublesome) side effects as skin rash and upset stomach. Thus, immigrants' non-compliance with TB drug therapy was linked to what some people may regard as trivial excuses advanced by the irresponsible racialized body. Such a notion reinforces a discourse that holds that presumably deficient immigrants’ personalities or cultures fully account for their health behaviours and choices, in isolation from the influence of their socio-economic or personal circumstances.

This case received considerable negative press coverage. By contrast, only one article indicated that “most refugees comply” with treatment in Canada (“Most refugees …,” 2000, n.p.). It is also worth noting that only a few articles mentioned that the Peruvian refugee later agreed to follow the prescribed therapy, and only one article noted that he completed his treatment and was proclaimed non-infectious. This is consistent with van Dijk’s (1991) assertion that when some minorities “are accused or jailed they are described as ‘blacks,’ whereas when they are cleared of an accusation, they suddenly lose colour” (p. 64) and disappear from the news. Similarly, once the refugee complied with and underwent the long and difficult therapy, his story (and successful treatment) was no longer newsworthy.

When examining newspaper articles, we found a curious contradiction. While, on the one hand, some reporters stated that immigrants avoid seeking medical help, refuse therapy, and escape from the medical surveillance system, on the other hand, others reported that immigrants burden the Canadian healthcare system by draining its precious resources (Heinrich, 1999b, p. A1). Immigrants were blamed for abusing health benefits available to them in Canada and taking hospital and nursing home beds away from Canadians. One article, for instance, quoted a Canadian physician saying that immigrants use “hideously expensive” dialysis without paying taxes (Francis, 1999, p. D03). This is patently untrue. Immigrants residing in Canada (whether they have applied for and received citizenship or not) are required to pay taxes on income, utilities, and goods and services just like other Canadians. These taxes support the healthcare system.
Moreover, immigrants by law have the right to access therapeutic procedures, such as dialysis. However, the article in question did not address this point, a failure that may have further misinformed readers about immigrants’ health behaviours.

Conclusions
In this study, we found that the contemporary Canadian press continues to (re)produce the long-standing ideological discourses that racialize immigrants’ health status and health-related behaviours. This is in concert with the findings of numerous discursive media representation studies that supported the notion that the racist ideological discourses about immigrants from non-Western countries continue to be recycled in the Western press (Bell, Brown, & Faire, 2006; Eichelberger, 2007; Greenberg, 2000; Henry & Tator, 2002; Hier & Greenberg, 2002; Leung & Guan, 2004; Murdocca, 2003; van Dijk, 1991, 1995, 1999, 2001; Washer, 2004). Similar to the findings of these studies, immigrants were depicted as a health threat to the host population as well as an economic burden on healthcare.

Depicting immigrants as health fraudsters who abuse health benefits and forge their health records resembles the coverage in which immigrants were found to be variously described as “imposters” or “scroungers” and often associated with “specific forms of ‘ethnic’ crime, such as aggression, mugging, rioting, theft, prostitution, and especially drugs” (van Dijk, 2001, p. 309; see also Henry & Tator, 2002). In response to this coverage, the press ran stories calling for tightening borders and immigration policies, and improving medical screening and surveillance of immigrants to protect the health of Canadian-born citizens.

Our findings are also in agreement with Hayes, Ross, Gasher, Gutstein, Dunn, and Hackett’s study (2007), in which the authors examined 4,732 health stories from 13 of the largest Canadian newspapers over a period of eight years. In their analysis of these stories, the authors noted an overwhelming overemphasis of “the roles of health care system and personal health habits in the production of Canadians’ health” and an underemphasis of “the role of social determinants” (p. 557) by Canadian health reporters. Similarly, our study found that news stories were seldom situated in the context of powerful social factors, such as poor-quality housing, malnourishment, unemployment, and discrimination that negatively impact immigrants’ health. The coverage of organizational barriers that prevent immigrants from utilizing health services was also minimal. This lack of contextualization of immigrants’ health problems was noted by discourse analysts in other countries as well (Bell et al., 2006; Lawrence, Kearns, Park, Bryder, & Worth, 2008; Littleton et al., 2010).

Deracialization and contextualization of immigrant health issues in the press can be achieved when the content of mediated messages focuses on potent social determinants of health, such as poverty and discrimination. The reviews of numerous studies showed that poverty and discrimination have a negative impact on people’s health outcomes due to poor-quality housing, malnourishment, unhealthy lifestyle, and chronic stress caused by both material deprivation and unequal treatment (Hyman, 2009). Immigrants’ health status, choices, and behaviours must be understood in this framework for two reasons. First, in the past decade, the poverty rates among recent immigrants (those who came to Canada after 1990) were twice as high as those of non-
immigrants, with almost 30 percent of immigrant families and 42 percent of unattached immigrants living in poverty (National Council on Welfare Reports, 2006). Second, according to the findings of research done by the Canadian Race Relations Foundation, racial discrimination of immigrants “persists across all dimensions of Canadian society” (Hyman, 2009, p. 4). In our opinion, providing more contextualized understanding of immigrant health issues would lead toward the provision of a more balanced and fair coverage of ethnic affairs.

We agree that the steps van Dijk (1999) suggested may be useful for the transformation of the Canadian press toward greater inclusivity. These steps may include the establishment of critical monitoring by researchers and independent groups who would encourage media professionals to “to adopt or enact recognized professional standards of quality, balance, fairness and social responsibility” (van Dijk, 1999, p. 312). The transformation of press could be further achieved by increasing the education of newsmakers in theoretical concepts underlying cultural safety, and also anti-oppressive and anti-racist practices. It would require a more critical choice and utilization of information sources, as well as enforcing ethical codes in newsrooms. Employing immigrants with appropriate levels of decision-making power in newsrooms would also be required. Creating more room for immigrant communities to define their situation in their own voice and from their own standpoint would have the potential of providing news with greater context and deracialization of immigrant health affairs.

The numerous examples provided in the introduction of this article demonstrated that there is a complex, mutually reinforcing relationship between mediated messages and health policies. Therefore, we assume that the focus on social determinants of immigrant health issues in press reports could greatly contribute to deracialization of public health policies, which often overlook the fact that immigrant health is embedded in larger sociocultural, economic, and political forces (Littleton, Park, Thornley, Anderson, & Lawrence, 2008; Reitmanova & Gustafson, 2012b). We call upon other researchers to contribute to an ongoing open discussion on racism, the media, and health (Estacio, 2009). Such a discussion can improve the current understanding of how the health of immigrants is framed by the institutional ideological powers of media and healthcare systems that “have been developed during many centuries of political, economic, and cultural western dominance of non-western people” (van Dijk, 1991, p. 39).

References


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Many studies failed to distinguish between immigrants and Canadian-born visible minorities, thus conflating effects of racial status with those of immigrant status on health. In these studies, the healthy immigrant effect may mask racial health inequities. There were just two studies that compared the health of Canadian-born and foreign-born visible minorities. Visible minorities are often treated as a monolithic category, ignoring the diversity within this growing population, for example, differences by nativity, ethnic origin, and other characteristics. Still, Canada’s health care system is not the comprehensive program focused on keeping people well, rather than just patching them up when they get sick that Douglas once envisioned. Budget cuts and austerity policies under consecutive Conservative and Liberal governments through the 1990s and 2000s further destabilized medicare, hitting First Nations and Inuit communities, front-line health care workers, refugees, and working-class people hardest. Prescription drugs play big role in health care: Around half of all Canadian adults now take a prescription medicine regularly, and up to two-thirds of Canadians aged 65 and up are prescribed five or more daily medications. Recent Research on Immigrant Health from Stats Canada’s Population Surveys. Ali et al., 2004. Diverse social determinants of health have been implicated in immigrant mental health in Canada. Studies worldwide point to increased risk of mental health problems and illnesses in immigrant groups (Abebe et al., 2014; Bourque, an der Ven, & Malla, 2011; Cantor-Graae, Zolkowska, & Mcneil, 2005; Levecque, Lodewyck, & Vranken, 2007). Research Gap. Secondary data analyses of the Canadian Health Measures Survey. Data collection for Cycle 1 occurred from 2007 to 2009; Cycle 2 from 2009 to 2011; and Cycle 3 from 2012 to 2013. There are around 17,800 participants across these three cycles.