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The Racialisation of Ethnic Inequalities in Health

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Ethnicity does not reflect presumed genetic or cultural attributes

Introduction

Class inequalities have been at the centre of health research for some time, despite attempts to ignore their existence. Their importance was firmly established by the Black Report (Townsend and Davidson 1982), which came to the conclusion that they were primarily a consequence of material differences in living standards. Since then researchers have, on the whole, concentrated on providing additional evidence for a material explanation of class inequalities in health and unpacking the mechanisms that might link material disadvantage with a greater risk of poor health (e.g. Macintyre, 1997; Vågerö and Illsley, 1995; Davey Smith *et al.*, 1994; Lundeberg, 1991, and *see also* Chapters 20, 27 and 28).

There is also a burgeoning interest in the health of ethnic minority groups. Within the UK a large amount of research has been funded. Some examples include national surveys – the Health Education Authority's Black and Minority Ethnic Groups: Health and Lifestyles surveys (Rudat, 1994) and the Fourth National Survey of Ethnic Minorities (Nazroo, 1997a,b). This growing body of research reflects, at least in part, a public policy concern with the health of, and quality of health care provided for, ethnic minority groups. In theory, research should lead to policy developments that improve both of these, but in practice this may not be the case. This is not only because research can be poorly disseminated, or because it may provide unpalatable messages to those concerned with public finance, but also because the research itself may contribute to the racialisation of health issues. It does this by identifying the health disadvantage of ethnic minority groups as inherent to their ethnicity, a consequence of their cultural and genetic 'weaknesses', rather than a result of the disadvantages they face because of the ways in which their ethnicity or race is perceived by others.

Given the pattern of socio-economic deprivation faced by some ethnic minority groups in Britain (shown in Table 25.1), and the clearly established relationship between socio-economic factors and health described above, it would be expected that once their younger age profile had been taken into account, ethnic minority people would generally have poorer health as a result of their poorer class position.

Table 25.1 Ethnic differences in socio-economic position: percentages by class for each ethnic group

Registrar-General's class	*White*	*Caribbean*	*Indian*	*Pakistani*	*Bangladeshi*
I/II	35	22	32	20	11
IIIn	15	18	20	15	18
IIIm	31	30	22	32	32
IV/V	20	30	26	33	40
Unemployed	11	24	15	38	42

Source: Fourth National Survey of Ethnic Minorities (Nazroo, 1997a)
Note: 'Registrar-General's class' is based on the occupation, or most recent occupation, of the head of the household (where known)

However, in the UK, with one or two notable exceptions (Ahmad *et al.*, 1989; Fenton *et al.*, 1995; Smaje, 1995; Nazroo, 1997a, *see also* Chapter 16), class has disappeared from investigations into the relationship between ethnicity and health. Instead, work in this field has largely followed a trend set by the now classic work of Marmot *et al.* (1984) shortly after the Black Report was published. This used a combination of death certificate and census data to show how mortality rates varied by country of birth. The findings indicated that class and, consequently, material explanations were unrelated to mortality rates for most migrant groups, and made no contribution to the higher mortality rates found among those who had migrated to Britain (Marmot *et al.*, 1984). Indeed, for one group, those born in the 'Caribbean Commonwealth', the relationship between class and overall mortality rates was the opposite of that for the general population. The authors concluded:

> (a) that differences in social class distribution are not the explanation of the overall different mortality of migrants; and (b) the relation of social class (as usually defined) to mortality is different among immigrant groups from the England and Wales pattern (Marmot *et al.*, 1984, p. 21)

Rather than puzzling over why such an important explanation for inequalities in health among the general population did not apply to ethnic minorities, researchers have simply accepted that different sets of explanations for poor health applied to ethnic minority and majority populations and, of course, that for the minority population, explanations were related to cultural and genetic differences.

Demarcating 'race' and ethnic groups in health research

Part of the problem lies in the 'untheorised' ways in which ethnic groups are identified in the research process. There is, of course, a wider sociological literature on ethnicity and 'race', which can be broadly defined as concerned with understanding how ethnic and racial groups become social realities, and the relationships between them. Within this work there appears to be complete agreement that 'race' is a concept without scientific validity. For example, in a recent edited volume most authors started from the position that the notion that people can be divided into races on the basis of genetic differences had been shown to be false

(Barot, 1996). From this position, the term 'race' becomes an artificial construct, used to order groups of people hierarchically and to justify the exploitation of 'inferior races'. In contrast, many of these writers give credence to a notion of ethnicity. Crudely, ethnicity can be said to reflect self-identification with cultural traditions from which individuals can draw strength and meaning. Importantly, these cultural traditions are seen as historically located; that is, they are seen as occurring within particular contexts and as changing over time, place and person. And it is recognised that ethnicity is only one element of identity, whose significance would depend on the context within which the individual finds him/herself. For example, gender and class are also important, and in certain contexts may be more important.

Some elements of this message have been adopted by research on ethnicity and health. Within the UK 'race' is never explicitly measured and ethnicity is clearly the term favoured for describing these minority groups. However, the nature of research, with the need for easily used and repeatable measures, often results in the concepts of ethnicity and race being merged (despite the exclusive use of the term 'ethnicity') and the dynamic and contextual nature of ethnicity being ignored. So, the term 'ethnic' is frequently used to refer to genetic and cultural features that are undesirable (from a health perspective) and inherent to the minority groups under investigation.

Consequences of 'untheorised' research

Before we go on to explore why research on ethnicity and health tends to be reduced to genetic and cultural explanations, and how this can be avoided, it is worth illustrating this point with two examples. The first concerns the well-publicised greater risk of 'South Asians' in the UK of coronary heart disease (CHD). A *British Medical Journal* editorial (Gupta *et al.*, 1995) used research findings to attribute this problem to a combination of genetic (i.e. race) and cultural (i.e. ethnicity) factors that are apparently associated with being 'South Asian'. Concerning genetics, the suggestion was that 'South Asians' have a shared evolutionary history that involved adaptation 'to survive under conditions of periodic famine and low energy intake'. This resulted in the development of 'insulin resistance syndrome', which apparently underlies the greater risk of CHD affecting 'South Asians'. From this perspective, 'South Asians' can be viewed as a genetically distinct group with a unique evolutionary history – a race. In terms of cultural factors, the use of ghee in cooking, a lack of physical exercise and a reluctance to use health services were all mentioned – even though ghee is not used by all the ethnic groups that comprise 'South Asians', and evidence suggests that 'South Asians' do understand the importance of exercise (Beishon and Nazroo, 1997) and do use medical services (Nazroo, 1997a; Rudat 1994). It is important to note how the policy recommendations flowing from such an approach underline the extent to which the issue has become racialised. The authors of the editorial recommend that 'community leaders' and 'survivors' of heart attacks should spread the message among their communities and that 'South Asians' should be encouraged to undertake healthier lifestyles (Gupta *et al.*, 1995). The problem is, apparently, viewed as something inherent to being 'South Asian' – nothing to do with the context of the lives of 'South Asians' and as solvable only if 'South

Asians' are encouraged to modify their behaviours to address their genetic and cultural weaknesses.

The second example involves the high mortality rates from suicide among young women living in the UK who were born on the Indian subcontinent. Attempts to explain this have focused on cultural explanations, particularly on a notion of culture conflict, where the young woman is apparently in disagreement with her parents', or husband's, traditional or religious expectations. For example, despite an almost complete lack of evidence, Soni Raleigh and Balarajan (1992, p. 367) state:

> Most immigrant Asian communities have maintained their cultural identity and traditions even after generations of overseas residence. This tradition incorporates a premium on academic and economic success, a stigma attached to failure, the overriding authority of elders (especially parents and in-laws) and expected unquestioning compliance from younger family members. . . . These pressures are intensified in young Indian women, given their rigidly defined roles in Indian society. Submission and deference to males and elders, arranged marriages, the financial pressures imposed by dowries, and ensuing marital and family conflicts have been cited as contributory factors to suicide and attempted suicide in young Indian women in several of the studies reviewed here.

Again such research has led to the racialisation of the issue. The problem is located within a relatively permanent and pathological culture, and one that needs to adopt the 'freedoms' allowed to young white women.

Both examples provide us with notions of groups that are (from a health point of view) genetically and culturally inferior to the white population. There are a number of reasons why such racialisation has occurred and continues to be present in epidemiological work. Important here is the belief that comparative epidemiology can provide clues to aetiology and that ethnicity is a useful and easy tool for demarcating groups to provide the basis for comparison. There have been numerous critiques of the crudeness with which ethnicity is measured in such work (e.g. Sheldon and Parker, 1992; Senior and Bhopal, 1994; Ahmad, 1995), and work has shown that a more sensitive measurement of ethnicity can lead to quite different conclusions (Nazroo, 1997a). Figure 25.1 shows that although South Asians as a group had a greater risk of indicators of CHD than whites, once the group was broken down into constituent parts this applied only to Pakistanis and Bangladeshis; Indians and African Asians had the same rate as whites. In addition, using religion to provide a more detailed 'ethnic' breakdown in these data showed that within the Indian and African Asian groups Muslins had a high rate of CHD, while Hindus and Sikhs had low rates (Nazroo, 1997a). This approach was useful in uncovering the extent to which convenient assumptions of ethnic similarity within obviously heterogeneous groups could lead to the racialisation of health issues.

However, using more refined ethnic categorisations still allows differences in health to be racialised. For example, it could be suggested that the findings just described mean we can use the term 'Muslim heart disease', or 'Pakistani and Bangladeshi heart disease' – rather than 'South Asian heart disease' – to describe the situation, and explanations can be sought in assumptions about Muslim, Pakistani and Bangladeshi cultural practices or their shared evolutionary history. This

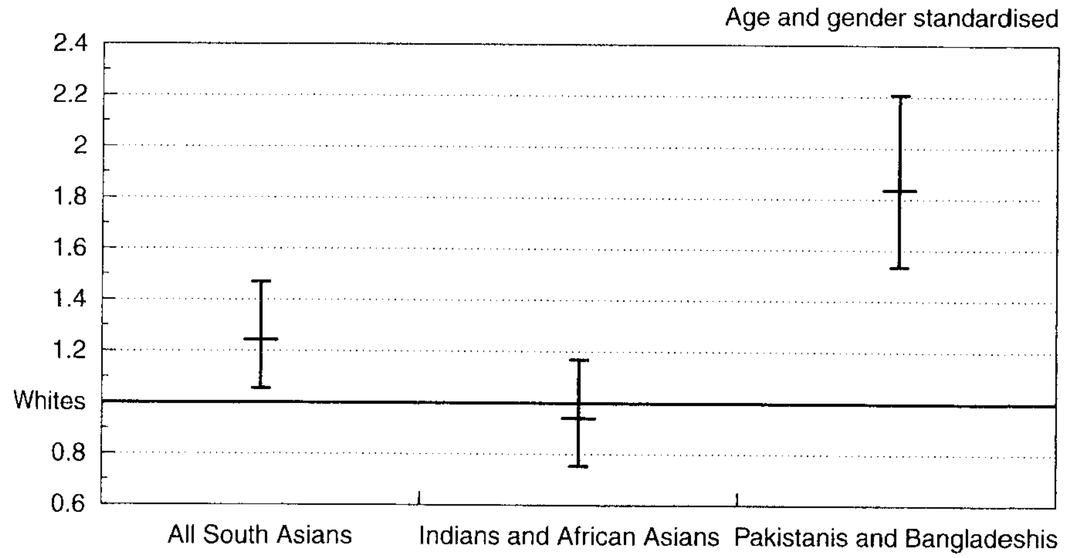

Figure 25.1 Relative risk of reporting indicators of heart disease for 'South Asians' in the UK as compared with whites. ('Relative risk' is simply the chance of being in a particular category compared with a reference group.) Each bar represents 95 per cent confidence limits: that is, the range within which there is a 95 per cent statistical probability of the true value lying. If this range does not cross the range representing whites, differences can be considered to be statistically significant
Source: Nazroo (1997a)

is because of another problem with work on ethnicity and health: the crudeness with which ethnicity is assessed in nearly all this work allows the status of ethnicity as an explanatory variable to be assumed. The view of ethnicity as a *natural* division between social groups allows the *description* of ethnic variations in health to become their *explanation* (Sheldon and Parker, 1992; *see also* Chapters 16 and 17). So, explanations are based on cultural stereotypes or suppositions about genetic differences, rather than attempting to assess directly the nature and importance of such factors. Here, it is worth emphasising the different status of explanations used for ethnic minority groups compared with the ethnic majority. While a lack of interest in exercise, or restrictive family practices, are a consequence of a pathological (minority) culture, high rates of smoking are not viewed as a problem arising from white ethnicity that should be ameliorated by a modification of white culture(s).

The need to measure hypothesised variables – and to be sensitive to class

This does not mean that cultural or genetic factors are of no use in explaining poor health. Rather, cultural practices and genetic differences need to be assessed directly, rather than assumed, and the contexts in which they operate and their association with health outcomes measured. Also, other explanatory factors have to be considered when exploring the relationship between ethnicity and health, in particular those related to socio-economic status. Although initial attempts to take socio-economic factors into account for migrant groups in the UK failed to show

a relationship between class and health (Marmot *et al.*, 1984), there are a number of reasons why the relationship between class and mortality rates might have been suppressed in these data. Most important is that they used occupation as recorded on death certificates to define social class. It is likely that, because of the well-recognised process of inflating occupational status on death certificates (Townsend and Davidson, 1982), where relatives declare the most prestigious occupation held by the deceased, this will have failed to capture the downward social mobility of members of ethnic minority groups on migration to Britain (a process that both Smith (1977) and Heath and Ridge (1983) have documented). So, the occupation recorded on the death certificates of migrants may well be an inaccurate reflection of their experience in Britain prior to death. In addition, given the socio-economic profile of ethnic minority groups in Britain, this inflation of occupational status would need to happen only in relatively few cases for the figures representing the small population in higher classes to be distorted upwards.

More recent analyses of immigrant mortality data around the 1991 census have shown that socio-economic differentials might be an important explanation of inequalities in mortality rates *within* ethnic minority groups, but still have suggested that differences *between* ethnic groups remain unexplained by class effects (Harding and Maxwell, 1997). Again it is tempting to believe that the differences between groups must be a consequence of 'obvious' genetic and cultural factors. However, it is important to recognise that important shortcomings remain in the statistics used. As before, the analysis had to rely on occupation as recorded on death certificates, which has the problems outlined above. And, as the authors point out, this information is not present for all men and missing for a large number of women (who consequently were not included in the analysis). Most important, however, is that the attempt to control for socio-economic factors with an indicator such as occupational class, ignores how crude this measure is and how it may apply differently to different ethnic groups. In fact, there has been an increasing recognition of the limitations of traditional class groupings, which are far from internally homogeneous. A number of studies have drawn attention to variations in income levels and death rates among occupations that comprise particular occupational classes (e.g. Davey Smith *et al.*, 1990, *see also* Chapter 27). And within an occupational group, ethnic minorities may be more likely to be found in lower or less prestigious occupational grades, to have poorer job security, to endure more stressful working conditions and to work unsocial hours. For example, it has been shown that within particular class groups ethnic minority people have a lower income than white people; that among the unemployed, ethnic minority people have been out of work for longer than whites; and that some ethnic minority groups have poorer-quality housing than whites regardless of tenure (*see* table 5.2 in Nazroo, 1997a). The conclusion to be drawn is that, while standard indicators of socio-economic status have some use for making comparisons *within* ethnic groups, they are of little use for 'controlling out' the impact of socio-economic differences when attempting to reveal a pure 'ethnic/race' effect.

Figure 25.2 provides additional support for this conclusion. Using data from the Fourth National Survey (Nazroo, 1997a), it shows changes in the relative risk of reporting fair or poor health for Pakistanis and Bangladeshis (the groups who had the poorest health) compared with whites once the data had been standardised for a variety of indicators of socio-economic status. Comparing the first bar with

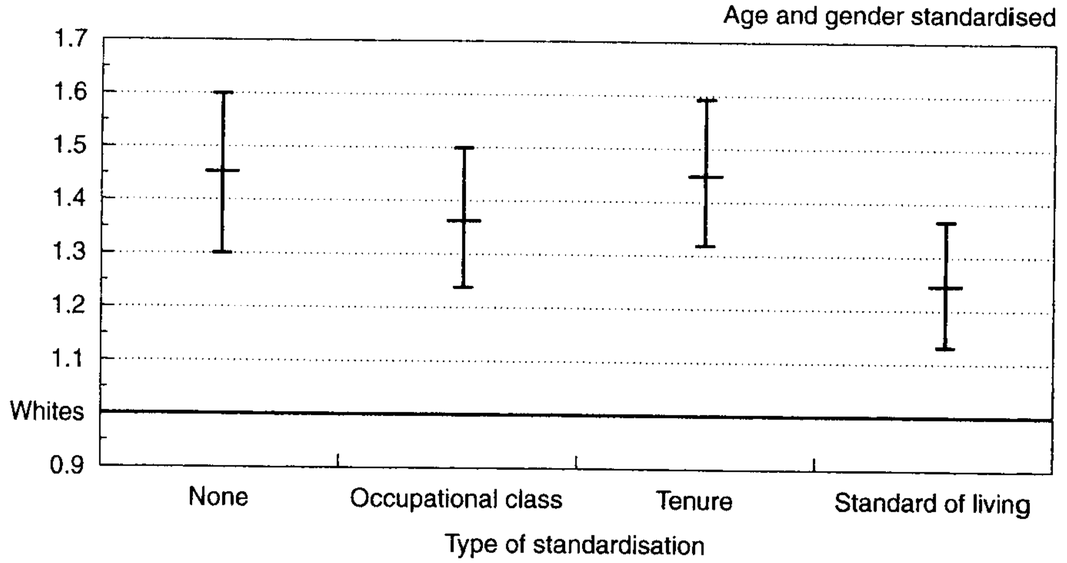

Figure 25.2 Relative risk of fair or poor health standardised for socio-economic factors: Pakistanis and Bangladeshis in the UK compared with whites. (For the meaning of 'relative risk' and the meaning of the bars, *see* the caption to Figure 25.1)
Source: Nazroo (1997a)

the second and third, shows that standardising for occupational class and tenure (the indicators commonly used in epidemiological research) makes no difference. However, taking account of an indicator of 'standard of living' (a more direct reflection of the material circumstances of respondents – *see* Nazroo (1997a) for full details) leads to a large reduction in the relative risk (compare the first and last bars). Given that this indicator is also not perfect for taking account of ethnic differences in socio-economic status (*see* table 5.4 in Nazroo, 1997a), such a finding suggests that socio-economic differences, in fact, make a large and key contribution to ethnic inequalities in health.

Another problem with using data that have been standardised for socio-economic status is worth highlighting. Such an approach to analysis and interpretation regards socio-economic status as a confounding factor that needs to be controlled out, in order to reveal the 'true' relationship between ethnicity and health. This results in the importance of socio-economic factors becoming obscured, and their explanatory role lost. The presentation of 'standardised' data leaves both the author and reader to assume that all that is left is an 'ethnic/race' effect, be that cultural or genetic. This also gives the impression that different types of explanation operate for ethnic minority groups compared with the general population and so leads to racialisation. While for the latter, factors relating to socio-economic status are shown to be crucial, for the former they are not visible. Differences are then assumed to be related to some unmeasured aspect of ethnicity or 'race', even though socio-economic factors are important determinants of health for all groups and cannot be assessed with sufficient accuracy in our statistics for us to be confident that they have really been controlled for (Kaufmann *et al.*, 1997).

Conclusion

If work on ethnicity and health is prone to such problems, how do we avoid them? Most important is to avoid reading off explanatory factors from the ethnic classification that we have imposed on our data without bothering to assess such factors directly. The ethnic classifications we use do not reflect unchangeable and natural divisions between groups. Also, ethnicity does not exist in isolation; it is within a social context that ethnicity achieves its significance, and part of that social context is the ways in which those seen as members of ethnic minority groups are racialised. Indeed, one of the most important purposes for undertaking work on ethnicity and health is to extend our understanding of the nature and extent of the social disadvantage faced by ethnic minority groups. Not only is poorer health potentially part of that disadvantage, it is also a consequence of it. Understanding ethnic inequalities in health raises the need to address them. And if such inequalities are rooted in the wider inequalities faced by ethnic minority groups in the UK, as some evidence suggests (Nazroo, 1997a), the impetus must be to address the wider inequalities.

Here it is also important to acknowledge the limitations of our assessments of socio-economic status and to remember that they do not account for the other forms of disadvantage faced by ethnic minority groups that might play some role in ethnic inequalities in health. For example, both the experience of racial harassment and discrimination, and the geographical location of ethnic minority people in particular locations, may have a direct impact on their health.

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