7 Ethnicity and racism in the politics of health

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Ethnicity has multiple meanings. While genetics and racism are part of what is encompassed by the term ethnicity, its current meanings are primarily associated with identity and especially aspects of identity which are cultural and where there is some measure of voluntarism in their adoption. Ethnicity is sometimes contrasted with race, with the latter assumed to be a biological category over which the individual has little control. Thus ethnicity is taken to refer to all those aspects of group based identity which do not rest on genetic difference. However, this version of ethnicity as cultural identity is contested by those who suggest that the way the term is used shows that it is simply a euphemism for race. Using ethnicity to avoid the word race is problematic if a belief in a biological and immutable categoric disjuncture in humanity is thereby left unchallenged. Where ethnicity is misused to refer to the effects of racism, that is to say discrimination based on a belief in the reality of biological categories of race, this can imply that inequalities are due to the culture of the minority rather than the way that a minority is treated by others. Euphemisms are unhelpful in any analytic discourse and are particularly problematic here, given that conceptual clarity around the target of a public health intervention is crucial if attempting to make policy to remedy inequalities. Disputes over the status of race as a scientific, sociological and ethical concept have been fraught (Bradby 2003), with some scholars believing that reproducing race as a research variable inscribes oppressive categories. An assimilationist assumption, that once immigrants have lived in the UK for a generation they will take on the ways of the majority and become culturally indistinguishable (Mason 2000), has been combined with a general reluctance to draw attention to racialized divisions in Britain.

Ethnicity as migrant status

In high-income states ethnicity has come to be regarded as a characteristic of minority groups, usually those established as a result of migration motivated either by a search for work or flight from an oppressive regime, or in the case of states with a history of mass slavery, migration that is coerced. The arrival of new groups, distinguished by their language, religion and habits of dress and diet has long been a feature of British life, particularly in big cities which offer employment and trading opportunities, and ports with significant maritime traffic.

Previous waves of migrants from continental Europe and Ireland are sometimes perceived as having been absorbed into the British population with some degree of invisibility in public policy terms. Thus the presumption that migrant populations will take on a British way of life, thereby assuming the health risks and benefits of the general population, tended to remain unchallenged until recently. The labour migration after the Second World War from the Indian subcontinent and the Caribbean gave rise to minorities who were visible and who maintained a distinct cultural life. Whether or not previous waves of migration, such as the Catholic Irish escaping from famine and continental European Jews fleeing anti-Semitism, really did assimilate, any non-assimilation or cultural incompatibility with the majority has tended not to feature recently as a public health problem, although it did so for previous generations (see for example Maglen 2005 and Wray 2006 on the health background to the 1905 Aliens Act in Britain). Of course public perceptions may be very different from the felt experience, as in the case of the Irish in Britain, particularly Irish men, whose health has been poorer than that of the host populations (see for example Bracken *et al.* 1998; Leavey 1999; DoH 2001; Walls and Williams 2004).

A general feature of work on migrant health inequalities has been the excessive attention given to relative risks of specific conditions, rather than assessing absolute risks that might better reflect the overall health of the whole minority population (Smaje 1995: 35). Nonetheless, using mortality as an indicator of health, overall rates in England and Wales, since statistics for Scotland and Northern Ireland being gathered separately, were lower compared with the migrants' place of birth, but higher than for the resident population (Marmot *et al.* 1984; Balarajan and Balusu 1990). Attempts to control for the confounding effect of class among migrants led to the conclusion that differences in the social class distribution of mortality were not the explanation of the different mortality of immigrants from one another and compared to the general population (Marmot *et al.* 1984). A unitary theory of raised levels of mortality for migrants was always unlikely given the enormous contrasts between the cultures and migration histories of migrants from countries showing health penalties, for example, Ireland and Pakistan (Smaje 1995). Smaje regrets the dearth of work considering migrants' general health, and the bias towards studies of the use of particular services, especially reproductive and mental health services, and the experience of particular conditions. Surveys of minority populations across a range of common health conditions showed that coronary heart disease rates were raised for those born in the Indian subcontinent (Balarajan and Balusu 1990; Knight *et al.* 1993) and, in common with people born in Ireland, the gap with the general population was not closing.

In the 1990s questions of how to measure ethnicity, rather than simply migrant status, became more urgent as third and fourth generations of descendants of migrants could no longer be identified using country of birth or parents' country of birth. The question of whether country of birth constituted a suitable proxy for a broader, more complex notion of ethnicity had remained largely unexplored. But with researchers seeking to define health outcomes among the grandchildren and great grandchildren of migrants, the discussion reopened and the contested nature of ethnicity became apparent (Bradby 1995; Nazroo 1998).

Ethnicity as genetics

The difficulties in defining ethnicity correspond to the problems in measuring it. Throughout the twentieth century assumed phenotypically based concepts of race were being challenged. After the Second World War the ghastly implications of Nazi racist policies became clear and gradually the relegation of people to a subservient class based on ethnic group or race has become more difficult to maintain in countries that claimed to be democratic: segregation became illegal in the USA during the 1950s and minority white rule with apartheid was dismantled in South Africa during the 1990s. The idea that humanity could be divided up into distinct groups and hierarchically ordered has been shown to be an oppressive ideology rather than an empirically observed scientific truth. The assumption that health differences between culture groups can be attributed to underlying genetic differences between populations has been demonstrated to be fallacious.

Variation within ethnic groups

It was with the publication of the results from the *Fourth National Survey of Ethnic Minorities*, conducted by the Policy Studies Institute, that the debate really matured in the UK. This survey included, for the first time, an extensive section on health, health-related behaviours and the use of health services, and was able to explore the complex relationship between health and ethnicity using a sample that was fully representative of the ethnic groups included (Modood *et al.* 1997). The recorded detail on the lives of members of different ethnic groups also meant that factors that might explain the relationship between ethnicity and health could be directly considered. The report challenged current assumptions about the uniform pattern of ill health across broadly defined ethnic groups, such as South Asian. It also illustrated the importance of socioeconomic factors to ethnic differences in health, both within particular ethnic groups and when making comparisons across ethnic groups (Nazroo 1997).

Statutory data-gathering requirements

Problems of measuring ethnicity, especially in statutory statistics, have been the focus of much discussion (Aspinall 2000). The 2001 UK census question set on ethnicity included a substantially revised ethnic group question and a new question on religion which addressed some of the shortcomings in the 1991 census question on ethnicity. However, Aspinall (2000) argues that there remain problems with the lack of detail on the ethnic origins of the 'white' group, including those of Irish and Scottish origin, as well as the use of Indian subcontinent groups, that ignores important differences between religious and linguistic communities within the broad categories of Indian, Pakistani and Bangladeshi. Despite these problems in measurement, a proposal has been made to include ethnicity at birth and death registration in England and Wales (Aspinall *et al.* 2003).

Data from the 2001 census shows that 87 per cent of the population of England and 96 per cent of the population of Wales gave their ethnic origin as white British with other white categories making up the largest minorities. In Scotland, 88 per cent of the population gave their ethnic origin as white Scottish and a further 10 per cent as some other white origin, including Irish. People who give their origins as Pakistani make up 2.9 per cent of the population of England and Wales and 0.63 per cent of the Scottish population, with people of Indian origin making up 2 per cent of the population of England and Wales and 0.3 per cent of the population in Scotland. In Northern Ireland more than 99 per cent of those responding in the 2001 census gave their ethnic group as white. The total number of people from minority ethnic groups grew from 6 to 9 per cent of the population between 1991 and 2001 according to the census data for England and Wales, partly due to the addition of a 'mixed' category. People from minority groups are clustered in London, which has the highest proportion of all minorities except for people of Pakistani origin, whose greatest concentration is in the West Midlands and Yorkshire and Humber. But even in local areas with the highest concentration of a single minority, they remain minorities. For instance, 33 per cent of people in Tower Hamlets are of Bangladeshi origin and 26 per cent of people in Leicester are of Indian origin.

All public authorities in the UK listed under the Race Relations (Amendment) Act 2000 have a general duty to promote race equality. This includes the standard collection and use of ethnic group and related data on patients, service users and staff of the National Health Service (NHS) and social services. However, data from the Hospital Episode Statistics for England in 2002–3 show that only 68.1 per cent of all hospital episodes had a valid ethnic group coding (Aspinall and Jacobson 2004). In addition to incompleteness, there may also be problems with data quality as some hospital trusts are still using the 1991 census classification to identify ethnic groups and others assign ethnicity on the basis of staff observation rather than patient self identification (Aspinall and Jacobson 2004).

Patterns of ethnicity and health from the Health Survey for England

Since the Fourth National Survey, there have been two large-scale surveys of adults and children, representative of minority ethnic groups across England: the Health Surveys for England in 1999 (DoH 2001; Erens *et al.* 2001) and in 2004 (DoH 2005; Sproston and Mindell 2006). In addition to self-reported information, objective physical measurements and blood, urine and saliva samples were analysed. Both surveys reveal a complex distribution of these indicators among the major ethnic groups (for further discussion of wellbeing, social capital and health in relation to ethnicity, see Chapter 6).

In 1999, among men, the prevalence of limiting long-standing illness was between 30 and 65 per cent higher for Pakistani, Bangladeshi and Irish men than for men in the general population (DoH 2001). Among women, black Caribbean and South Asian groups were between 20 and 45 per cent more likely to report limiting long-standing illness than women in the general population. Chinese adults in contrast were about 40 per cent less likely than the general population, and less than all other minority ethnic groups, to report limiting long standing illness. By 2004, the levels of long-standing illness and limiting long standing illness were significantly higher for Pakistani women than they were in 1999, whereas for Indian women, the levels in 2004 were significantly lower (DoH 2005).

In 1999, Pakistani and Bangladeshi men and women had significantly higher rates of cardiovascular disease (CVD) than the general population, while Chinese men and women had lower rates (DoH 2001). The prevalence of CVD was also higher among black Caribbean women. By 2004, the prevalence of CVD had doubled among Pakistani men and Indian women (DoH 2005). In 1999 and in 2004, South Asian (Indian, Pakistani and Bangladeshi) men and women had the highest rates of diabetes. Rates of diabetes among the black Caribbean population were also significantly higher than in the general population.

In terms of communicable diseases, tuberculosis and sexually transmitted infections are distributed differentially across ethnic groups. In 2001, the highest tuberculosis rate was found among black Africans (211 per 100,000), followed by Pakistani (145 per 100,000), Indian (104 per 100,000) and Bangladeshi groups (62 per 100,000) (Aspinall and Jacobson 2004). In comparison the tuberculosis rate for white groups is 4 per 100,000 population. HIV and sexually transmitted infections also disproportionately affect black and minority ethnic groups in the UK. Furthermore, undiagnosed HIV infection and late diagnosis is more common among some minority ethnic groups.

Mental health

In 1999, Bangladeshi and Pakistani men and women were more likely than the general population to suffer from minor psychiatric morbidity, measured by the 12-item General Health Questionnaire (GHQ-12), as were black Caribbean and Indian women, while Chinese men and women were far less likely to have minor psychiatric morbidity (DoH 2001). Among black Caribbean and Indian men, and Irish men and women, the prevalence of high GHQ-12 scores did not differ from the general population. The prevalence of minor psychiatric morbidity was lower in 2004 in the general population and among Irish and Bangladeshi men and women, and black Caribbean and Indian women when compared with 1999 data (DoH 2005). For Chinese men, in contrast, the prevalence was higher in 2004 than it had been in 1999.

As the research from the Health Survey for England suggests, there are differences in mental health across ethnic groups. However, these results are not congruent with two key findings in the literature on ethnicity and mental health in the UK, namely the apparently high rates of schizophrenia and other forms of psychosis among African-Caribbean people, and the apparently low rates of mental illness generally among South Asian people (Cochrane and Bal 1989). The literature on ethnic differences in psychotic illnesses suggests that rates of first contact with treatment services for such illnesses are three to five times higher for black Caribbean people than the general population.

In order to address this controversial area, the Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) study was conducted. It comprised a quantitative survey of rates of mental illness among different ethnic groups in England and a qualitative study investigating ethnic and cultural differences in the context, experience and expression of mental distress (Joint Health Surveys Unit 2002). This report highlighted a major weakness of most work on ethnicity and mental illness, which tends to rely on data based on contact with treatment services. Contact with services, even when access is universal, as in the NHS, reflects illness behaviour rather than illness per se (Blane *et al.* 1996). This makes interpreting differences in treatment rates across ethnic groups difficult, particularly as illness behaviour is likely to be influenced by a number of factors that are influenced by ethnicity, such as socioeconomic position, health beliefs, expectations of the sick role and lay referral systems. In contrast to studies on rates of contact with services, the EMPIRIC study indicated a twofold higher rate for black Caribbean people compared with the white group. This difference was not significant for men or the total black Caribbean population and was not significant at the level of estimated rates of psychosis. Even if black Caribbean people are more vulnerable to psychotic illnesses, the discrepancy between the data from psychiatric services and the general population suggests that they are also treated differently in the UK. Possible explanations suggested by EMPIRIC are racism by psychiatrists and in the community, misunderstanding of cultural expressions of distress, differential responses by police, social and treatment services, and social inequality. However, why such factors should operate for black Caribbean people as opposed to other ethnic minorities is not clear.

Factors associated with ethnic differences in health

The Fourth National Survey illustrated the importance of socioeconomic factors in understanding the pattern of ethnic differences in health (Nazroo 1997). This pattern of socioeconomic disadvantage is often multidimensional, reflecting the poorer living conditions of many ethnic minorities in terms of housing or neighbourhood conditions, underemployment and unemployment (Chandola 2001). In addition, other factors such as differences in health behaviours, access to health services and the experience of racial discrimination have also been highlighted as contributing towards this pattern.

Behavioural risk factors

The distribution of health behaviours among different ethnic groups is complex. Some of these differences may be affected by cultural patterns of traditional diet and lifestyle; others may arise due to the differential rate of change in the behavioural patterns of the general population compared to ethnic minority groups. So for example, chewing tobacco products such as *paan* mixed with tobacco is common to some of the South Asian groups. In 1999, Bangladeshi and Irish men reported using tobacco products much more than the general population (DoH 2001). Although Bangladeshi women were similar to the general population in terms of self-reported tobacco use, they had a much higher risk of a saliva cotinine level of 15 ng/ml or over than any other group of women. Saliva cotinine levels are an indicator of actual tobacco use. Black Caribbean, Bangladeshi and Irish men in 1999 had a higher proportion of smokers compared with the general population. By 2001, the prevalence of cigarette smoking was highest among Bangladeshi, Irish and Pakistani men (DoH 2001). While the smoking rates of Irish men had fallen considerably, the higher prevalence for Bangladeshi and Pakistani men and the high use of tobacco products among Bangladeshi women is a matter of some public health concern.

Obesity, a major risk factor for cardiovascular disease, is increasing worldwide and the causes of this increase are much debated (for further discussion, see Chapter 3). Some of the explanations look at the imbalance between physical activity or energy output and diet or energy intake. The distribution of obesity among ethnic groups in England is different depending on the measurement of obesity chosen. In terms of body mass index, black African, Pakistani and black Caribbean women tend to be more overweight than the general female population, while in terms of raised waist-hip ratio, Pakistani and Bangladeshi men have a higher risk than the general male population (DoH 2005). Explanations for the raised risk of obesity for some ethnic minorities are probably not found in differences in dietary behaviour, as most ethnic minorities report healthier diets compared to the general population, whether in terms of consuming five or more portions of fruit and vegetables, or in terms of lower fat intake. Except for the Irish, whose behaviour replicates that of the general population, men and women from all minority ethnic groups report less alcohol consumption than is normal. This pattern has changed little between 1999 and 2004. However, in terms of physical activity, Indian, Pakistani, Bangladeshi and Chinese men and women are less likely to meet current recommended levels of activity compared with the general population. Between 1999 and 2004, this gap in physical activity increased for Indian, Pakistani and Bangladeshi men, and for Pakistani, Bangladeshi and Chinese women (DoH 2005).

Cigarette smoking, the use of tobacco products and lower physical activity levels are important risk factors for a range of health problems later on in life. Their higher prevalence, particularly in Bangladeshi and Pakistani groups, suggests that ethnic differences in health may continue to widen as men and women in these groups age (for more on the connection between smoking and ethnicity, see Chapters 10 and 17).

Racial discrimination

There are two main types of racial discrimination, interpersonal and institutional (Karlsen and Nazroo 2002). Interpersonal discrimination refers to discriminatory interactions between individuals, which usually can be directly perceived. Interpersonal discrimination has been shown to be associated with poorer health outcomes in the UK and USA, including physical and mental health outcomes, such as raised blood pressure, increased psychological distress, depression and poorer self-rated health (reviewed in Karlsen and Nazroo 2002). Reporting experiences of racial discrimination is also associated with increased prevalence of cigarette smoking.

Institutional discrimination typically refers to discriminatory policies or practices embedded in organizational structures and tends to be more invisible than interpersonal discrimination (Karlsen and Nazroo 2002). However, although people from ethnic minority groups have lower incomes and are concentrated in environmentally and economically poorer geographic areas, in poorer quality and more overcrowded accommodation, in less desirable occupations, and in longer periods of unemployment than their ethnic majority counterparts, there is little direct evidence on the extent to which the health disadvantage of ethnic minority groups is a product of institutional racism (for the effectiveness on health policies directed at locality, see Chapters 12 and 14; for a discussion of data on ethnicity and wellbeing, see Chapter 6).

Access to services

Access to health services is a key issue for marginalized minority ethnic groups, given the 'inverse care law' that those who need healthcare most are least likely to get it (Tudor-Hart 1971). However, as mentioned above, statistics on ethnicity are not always collected routinely by health service providers, and are often questionable in terms of accuracy of measurement.

The evidence suggests that differences in access to primary care may not be as important as access to secondary and community health services, and referrals to hospital services and treatments (Aspinall and Jacobson 2004). Survey evidence suggests that minority ethnic groups see their general practitioner as often or more than the general population. However, this does not translate into higher outpatient hospital attendance rates, which are lower for some minority ethnic groups. In terms of ethnic differences in hospital treatments, there is some evidence of inequity in specialist cardiac investigation services, especially for South Asian groups. Compared to the white population, South Asians with chronic chest pain may be less likely to be referred for exercise testing and wait longer to see a cardiologist or to have angiography (Lear *et al.* 1994). Feder *et al.* (2002) concluded that among patients deemed appropriate for coronary revascularization, South Asian patients are less likely to receive treatment compared with white patients. They also concluded that physician bias and socioeconomic factors did not explain these differences. A possible explanation could lie in the difference in the patient experiences of minority ethnic groups when negotiating health services.

The third National Survey of NHS patients (Airey *et al.* 1999) found that black and South Asian patients are more likely to report poorer patient experiences. They are more likely to report their appointment for their first treatment has been postponed or cancelled and longer waiting times for hospital treatment. South Asian groups, in particular, report poorer communication with health service providers, and often felt they were not always treated with dignity and respect. Non-insulin-dependent diabetes remains undiagnosed in up to 40 per cent of Asian diabetics. Several studies report inadequate quality of healthcare for Asian and African-Caribbean diabetics and poor compliance arising from patients' lack of knowledge about the disease and its management through inappropriate health information (Aspinall and Jacobson 2004).

There are a number of political and practical difficulties associated with the public health issues of minority ethnic groups. The range of ideas that the concept of ethnicity encompasses, including those of identity, origins and culture, means that its use in research and policy inevitably prioritizes some of these. In contemporary Britain self-assigned ethnicity has become the rule, although in some routine data collection ethnicity is still attributed by observation.

Research based on representative samples, including data on country of birth, religion, self-assigned ethnicity and experience of racism, has made it impossible to maintain any illusion that generalizations can be made about the health status of broadly defined ethnic groups. Variations by gender, between minorities and through time, have been documented which suggest that the challenge of documenting, let along remedying, health inequalities influenced by ethnicity, has only just begun. Poor health outcomes documented for particular minority ethnic groups cannot be attributed to a single factor such as gender, locality, racism or poverty, but stem from their interaction. The ill effects of poverty, racism and locality can compound one another. Given the complexity of these factors, the scope and utility for internationally recognized and shared categories of ethnicity remains in doubt.

Commentators have consistently pointed to the way that ethnicity is assumed to pertain to minorities rather than majorities. If ethnicity is a sociologically useful concept it should, logically, be equally applicable to evaluating the causes of the patterns of health of majorities. Logical analysis notwithstanding, ethnicity looks set to remain a means of describing minority culture, context and circumstance, with alternative variables being sought to explain the circumstances of general populations. The dynamic, contingent nature of cultural groupings means that even populations that show stable patterns of ethnicity should not be essentialized. Given that the fastest-growing ethnic group in Britain is made up of those who describe themselves as of mixed origins, the future picture is likely to differ from our current understanding.

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