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6

Health, Ethnicity, and Race

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This chapter explores the relationship between ethnicity, race, and health, drawing on sociological evidence from the UK and the US. Insights from quantitative traditions of research into health inequalities and from qualitative work on meanings and experience are used to consider how understandings have developed over the past two decades.

The chapter falls into seven sections. We start with a consideration of what *race* and *ethnicity* mean in US and UK contexts and interrogate the role of *slavery* and *empire* in *migration*; we then discuss how *culture* became a key issue in debates on the ways in which ethnicity and race relate to health and health experiences. Second, we consider the ways in which ethnic and racial categories are used in official data in the US and UK, which leads into the third section summarizing the patterns of stratification of health outcomes from UK and US published sources. Fourth, we assess what these data tell us about inequalities in health and critique the development of crude explanatory models. Fifth, we evaluate the evidence on how ethnicity influences the use and experience of health services, including the role that culture plays. Sixth, we touch on the relationship between migration, ethnicity, and health work, considering how the transglobal processes that brought about the creation of ethnic minority groups in Anglophone countries have also staffed the health care industry. Finally, we return to the theoretical treatment of this topic to consider whether, given our critique of existing data, the sociological problematic has been adequately described.

DEFINING THE TERMS OF THE DISCUSSION: WHAT DO "ETHNICITY" AND "RACE" MEAN?

Ethnicity and race are difficult concepts to discuss with precision, since their meanings are highly charged politically, have been subject to change over recent history, and, like many sociological concepts, have a scientific as well as popular usage, and the two do not always coincide. Furthermore, there are subtle but significant differences in the uses of these terms in different social settings; thus, discussing ethnicity or race in the US can have different implications compared with their discussion in the UK. Some of the contrasts between the UK and the US can be understood in terms of the history of empire and colonization, the role of institutionalized slavery, migration, and their implications for the construction of the social problem of ethnic and racial difference in contemporary society.

Slavery and migration

Britain was involved in the Atlantic slave trade and benefited economically from it. While some migration from overseas colonies occurred as a result, the UK was not a major destination for slave labor and slavery was not institutionalized in the UK. Although slavery has been illegal in the US since the second half of the nineteenth century, its influence persists in terms of the current meaning of race and it has played an important role in determining current lines of social stratification. Much of the early press interest in Barack Obama's presidential campaign focused on his Black father being a Kenyan national (rather than an African American descended from slaves) and the identification of slave owners among his White mother's ancestors. The lack of slave ancestors had been identified as potentially reducing Obama's ability to attract Black votes on which Democrat candidates rely, although post-election celebrations indicate how he has become identified as a symbol of "Black America."

The system of indentured and slave labor was responsible for the transport of large numbers of people from West Africa to the US – estimates vary from 9 to 20 million – as well as smaller numbers from Scotland, Ireland, England, and Germany. The majority of Black slaves were used in agricultural work in the Southern States, a fact that is reflected in the greater proportion of African Americans in the South compared with the North that persists today. Migration over the past four centuries accounts for the presence of almost all of the US population, with the exception of about 2 percent who are descendants of indigent populations. The US is a land of migrants where old historical allegiances were abandoned in the construction and celebration of the "new world," yet "melting pot" multiculturalism has tended to include European, and especially Protestant, immigrants and exclude Africans and Native Americans. Indeed, while migrant status is a central symbol of US national character, the extent to which the most recent immigrants from Asia and Latin America will be assimilated remains to be seen.

Empire and migration

While the British Isles have long received immigrants, particularly in urban, maritime centers, mass migration of non-White groups to the UK occurred after World War II (1939–45) when British colonials were invited to make good the labor shortage in the "mother country." The character of migration to the UK has been shaped by the legacy of its empire, a massive global power in the nineteenth century, which transmitted cultural and linguistic influence overseas so that labor migrants were familiar with the English language and aspects of British culture. While racist attitudes and practices shaped the experience of many immigrants to the UK, discrimination was neither ensured nor prevented through legal statute. The White British ethnic majority sees itself as non-immigrant, or assumes origins traceable to Norman immigration ten centuries ago. The attitude to immigrants, particularly in the 1950s and 1960s, was "assimilationist"; where immigrants were welcomed or tolerated, there was an assumption that they would wish to become "British" and integrate into the ethnic majority population. Imperial British history has contributed to an assumption that "Britishness," with its particular blend of individualism, establishment Christianity, and phlegmatism, would be embraced as a superior way of life by immigrants and their descendants. The rejection of, or exclusion from, aspects of British life by immigrants was interpreted as the failure of minorities to assimilate. Multicultural social and educational policies that acknowledged, celebrated, and maintained features of a range of different ethnic and religious identities were introduced in the 1990s to promote integration, if not assimilation. Ongoing marginalization of ethnic minority groups, interpreted as a form of separatism and hence at the root of racial tensions, has raised serious questions about the "failure" of multiculturalism and the place of minorities in the British population. Minority culture has thus been regularly pathologized as problematic in preventing assimilation, and culture (like ethnicity) has been identified as something that minorities have, but the mainstream majority does not.

Culture

The role allocated to culture as a marker and a cause of ethnic or racial difference can be contrasted between the US and UK. In the US, residential segregation underpins many other aspects of racialized inequality (Massey and Denton 1993), whereas in the UK, the extent to which inequality can be characterized as segregation continues to be debated (McCulloch 2007) and cultural difference carries more weight as both explanation and cause.

The plurality of a melting pot of culture as a rhetorical ideal (if not a lived norm) in the US, the Atlantic slave trade, and the internal movement of slaves west during the "second passage" effectively destroyed the cultural patterns of the enslaved. Discrimination against people of African origin in the US has not focused on the content of minority culture, but rather has relied on biologically justified racism. This discrimination resembles divisions of class in the British context, where an assumption about the inherent nature of difference between groups is deep-seated and difficult to challenge. The UK pattern of cultural difference justifying discrimination assumes, as described, that minorities could and should change their culture in favor of the majority. This ignores the important role that culture may play in people's identity. Although it cannot be assumed, elements of culture, such as religion and/or marriage practices, can have overwhelming importance for people's sense of themselves.

Unfortunately, in the analysis of inequality, rather than informing an appropriately complex view of cultural identity, a focus on culture has regularly diverted attention from structural inequalities. When culture comes to be seen as a feature of the minority rather than the majority, it can be used as a euphemism for referring to a problematic deviation from the majority, such that culture becomes no more than "a tool for blaming black people within popular ideology and in research" (Donovan 1986: 45). As a result, minorities are seen as the authors of their own disadvantage and culture comes to be identified as a cause.

Much of the evidence for inequalities in health within and between ethnic groups comes from official data sets and large-scale surveys in the US and the UK. Using a "complicated view of culture" as part of a definition of ethnicity in social surveys presents particular challenges (Bradby 2003), which means that simplified proxies are inevitably employed. We discuss these proxies and the data that they have generated next.

Official Data on Ethnic and Racial Categories

The use of ethnic and racial categories in official data in the US and the UK and the changes in usage over time have been described elsewhere (Nazroo and Williams 2005). Racialized categories have been deployed in the US since the first census in 1790, whereas ethnic categories have only been used in the last two UK censuses (1991 and 2001). In both the US and the UK, the classification system has changed from census to census to reflect both changing patterns of migration and the development of ideas about racialized difference. In the US, alterations to the legal status of racialized groups have been key, as for instance with the disappearance of slave as a category of enumeration between the censuses of 1860 and 1870, following the abolition of slavery in the intervening years.

The terms *ethnic* and *racial* are sometimes used as synonyms, but they are used in distinct ways in official data. UK data only report on ethnicity and there are no racial classifications, whereas US data use both racial and ethnic classifications. The distinction between race and ethnicity is based on convention rather than theoretical or empirical data and cannot be justified except through the historical development of categories.

US official data

Racial classifications were crucial for administering the system of slavery and, subsequently, racial segregation, including the prohibition on interracial marriage. Historically, the legal distinction between the free and the slave, and then between subjugated Black and subordinating White, distinguished unambiguously between Black and White, preserving privileged White access to property, education, employment, housing, and other resources. The illegality of intermarriage coexisted with sexual unions (often exploitative of the enslaved) producing a substantial mixed population, while White privilege created a strong incentive for light-skinned people of mixed origins to pass as White. First documented in the 1850 census, people with Black and White parents were formally treated as Black according to the "one drop rule," whereby membership of the White race was limited to those without any Black ancestors. The Black–White line was thus preserved in law, in race theory, and in popular culture, but not in the genealogical legacies of the population (Perlmann and Waters 2002: 5).

The system of racial classification operating for Native Americans and Hispanic Americans relies on another logic, since this group was not subject to institutionalized slavery. Tribal membership was defined for official purposes by the proportion of an individual's ancestors who were tribal members (with the proportion required for membership differing between tribes), plus recognition of that individual as a member of the tribe by other tribe members. The rules for Hispanic Americans, descended from very mixed populations in Latin America, differed again and have been constituted as a separate category through the use of a Spanish language question in the US census (Perlmann and Waters 2002: 6).

Racial classification of Black, White, Native, and Hispanic Americans has played a key role in defining the structural and symbolic aspects of the American population. The role that ethnicity has played is of interest because of the way that it has reinforced White advantage. Ethnicity is similar to race in that it is often assigned involuntarily through heredity, although for White minorities its expression is voluntaristic. Thus, for this group there may be a considerable degree of choice both in the ethnic group with which one aligns oneself and how this allegiance is manifest: Italian ancestry, for instance, is popular and regularly claimed, whereas Scottish ancestry is not (Waters 1990: 34). The consumption of special foods and the celebration of particular holidays offer White Americans an ethnic identity and mark belonging to a community, but a highly individualized personal choice over the adoption of these practices is retained (Waters 1990: 151). Ethnicity generally operates as both a resource and a liability (Jenkins 1995), yet for White minorities little effort is put into sustaining group cohesion and if sexist, racist, clannish, and narrow-minded aspects related to ethnicity are encountered, the voluntary nature of participation means that they can abandon their liability. This is the crucial difference between race and ethnicity: for suburban Whites, ethnicity lacks social costs, provides enjoyment, and is chosen voluntarily, none of which is true for non-White Americans (Waters 1990).

Racial minorities cannot exercise choice in the same way as "ethnics" (Waters 1990: 158), particularly White ethnics. If one's ethnicity is a voluntaristic, personal matter it can be difficult to see that other groups are subject to political, societal forces that are not a matter of individual choice. White European immigrants (certain exclusions for Italians and Irish notwithstanding) have never faced the systematic legal and official discrimination experienced by Blacks, Hispanics, and Asians in America (Waters 1990: 164). Ethnic identification for White Americans is so voluntaristic and so unaccompanied by discrimination or prejudice that in due course White groups may no longer exist: As the time since migration extends, and assuming high rates of intermarriage persist, there will no longer be White enclaves where the individuals have a distinct cultural or genetic profile. Paradoxically, Americans who emphasize, for instance, their Italian or Irish ethnicity continue to think of both ethnicity and race as biologically rooted and persistently ascribe identities to others, especially those based on skin color. White minorities can enjoy the voluntary aspects of ethnic traditions, but because ethnic and racialized divisions are thought of as equivalent, the rise of White suburban ethnic identification has had an exacerbating effect on racial tensions (Waters 1990: 167).

UK official data

Until the 1991 census, country of birth was typically used in UK official statistics to identify ethnicity or race, with the clear implication that racial and ethnic minorities were "foreign," despite the majority also being British citizens. As post-World War II migration became more distant, the inadequacies of this approach for identifying growing numbers of UK-born minorities became increasingly obvious, and a question about ethnic identity was introduced in the 1991 census. The question was updated for the 2001 census (and will be updated again for the 2011 census), with respondents asked to select a category that best describes their ethnic identity from a list. The question varied very slightly across the countries of the UK, with the following categories used in England and Wales:

- **White** – British or Irish or Any Other White background (write in)
- **Mixed** – White and Black Caribbean or White and Black African or White and Asian or Any Other Mixed background (write in)
- **Asian** or **Asian British** – Indian or Pakistani or Bangladeshi or Any Other Asian background (write in)
- **Black** or **Black British** – Caribbean or African or Any Other Black background (write in)
- **Chinese** or **other ethnic group** – Chinese or Any Other (write in)

Respondents were expected to select a single main category that applied to them (the first descriptor for each bullet point, shown in bold above), and then to choose a subcategory from the options that follow. This official categorization of a diverse population has no historical legal definition on which to draw and compounds a number of aspects of ethnicity pertinent to UK race relations, including nationality, country of birth, geographical origin, and skin color. Notable here is how the "Mixed" and "White Irish" categories emerged between the 1991 and 2001 censuses in response to both popular and policy concerns. Inevitably, this form of classification contains compromises, for example all individuals from sub-Saharan Africa are covered by a single category, as are all those claiming an Indian identity. Such compromises also reflect the ways in which ethnicity is conceptualized and the dimensions of an ethnic identity that *are* perceived to be of policy importance. For example, a question on religious identity was included in the 2001 England and Wales census for the first time, as religion became increasingly significant on the public policy agenda.

The lack of institutionalized racial categories in the UK means that classifications inevitably reflect powerfully felt racialized folk typologies that both constrain and inform people's identities. Conceiving a classification that usefully captures the experience of identity without promoting the essentializing of difference has proved difficult. Recent critiques of the homogenizing assumptions of pan-ethnic classifications (for example, Zsembik and Fennel 2005) suggest that lessons from previous work have not been learned.

In the next section we describe, in general terms, the patterning of ethnic/racial disparities in health and point to the implications of crude quantitative classificatory schemes for explanatory models. Arguably, the use of broad classifications as proxies for ethnic or cultural group has hindered the development of sophisticated explanatory models for inequalities in health and allowed the persistence of crude stereotyped explanations (Nazroo and Williams 2005: 239).

Inequalities in Health in the US and UK

Differences in health across ethnic groups, in terms of both morbidity (the presence of illness and disease) and mortality, have been repeatedly documented in the UK (Erens, Primatesta, and Prior 2001; Harding and Maxwell 1997; Marmot et al. 1984) and the US (Davey Smith et al. 1998; Sorlie, Backlund, and Keller 1995; Sorlie et al. 1992; Williams 2001). Health is, of course, a multidimensional and complex concept (Blaxter 1990), yet in statistics it is often reduced to death and/or specific disease categories (such as coronary heart disease, hypertension, or diabetes). In the UK, mortality data are not available by ethnic group, but country of birth is recorded on death certificates and mortality rates have been published by country of birth using data around the 1971, 1981, and 1991 censuses and, to a more limited extent, the 2001 census. Given the relatively recent mass migration to the UK, analyses of mortality by country of birth are typically taken to indicate *ethnic* inequalities in health. Analyses around the 1991 census showed marked variation in mortality rates by country of birth and gender (Harding and Maxwell 1997):

- Men born in the Caribbean had low mortality rates overall, and particularly low mortality rates for coronary heart disease, but high rates of mortality from stroke, as did women born in the Caribbean.
- This high mortality rate from stroke and low mortality rate from coronary heart disease was also found among those born in West/South Africa, who also had a high overall mortality rate.
- Men and women born in the Indian subcontinent and East Africa (presumed to be South Asian migrants) had high rates of death from coronary heart disease, with the highest rates found among those born in Bangladesh.
- Those born in the Indian subcontinent also had high mortality rates from stroke.
- Those born in Ireland had high mortality rates for most diseases.
- On the whole, the non-White migrant groups had lower mortality rates from respiratory disease and lung cancer.
- There were very high death rates among non-White migrants for conditions relating to diabetes.

Despite being statistically robust, these findings, based as they are on country of birth, cannot be extrapolated unproblematically to ethnic categories. The most obvious problem is that the experience of UK-born ethnic minority people, which is likely to differ from migrants, is ignored.

Although the UK does not record mortality data by ethnicity, there has been a growth in data on ethnic differences in morbidity over the last two decades. While these contradict the immigrant mortality data in some respects (Nazroo 2001), the patterns are basically similar. For example, findings from the 1999 Health Survey for England (Erens et al. 2001) on ethnic differences in self-reported general health showed considerable heterogeneity in experience, with the non-White groups having a variably increased risk of poor health compared with the White groups. Most notable, perhaps, was the wide variation for the three South Asian groups identified, with Indians having better health than Pakistanis, who had better health than Bangladeshis.

In the US, there is a similar heterogeneity of outcomes across racial groups (Nazroo and Williams 2005; Sorlie et al. 1995). Mortality rates for non-Hispanic Black people are more than twice as high as those for non-Hispanic White people until early old age, when the gap begins to narrow. A similar pattern is found for Native Americans, though differences are smaller at younger ages, and the improvement relative to non-Hispanic White people at older ages is clearer. Mortality rates for Hispanic people are generally lower than those of non-Hispanic Whites, though the differences are small at younger ages. Rates for Asian/Pacific Islanders are uniformly lower than those for non-Hispanic Whites.

The favorable position of Hispanic people, given their relatively poor socioeconomic position, has generated considerable research interest. It has been suggested that these findings reflect: a "protective" Hispanic culture; health selection, whereby only the healthiest migrate to the US; and/or poor data quality, with undercoverage of denominators and inaccuracies in the reporting of numerators (see Nazroo and Williams 2005 for a review). Indeed, there are important limitations linked to the quality of these mortality data for all groups. The numerator for the officially reported death rates in the United States comes from death certificates, and it is estimated that officials who record racial and ethnic status on the death certificate misclassify as many as 26 percent of self-identified American Indians, 18 percent of Asians and Pacific Islanders, and 10 percent of Hispanics, with misclassifications largely allocated to White/non-Hispanic categories (Sorlie et al. 1992). This undercount in the numerator suppresses the death rates for the minority groups and slightly inflates the death rates for non-Hispanic Whites.

In both the US and the UK, problems with the denominator can also affect the quality of mortality statistics. Census data are used to calculate the denominators for mortality rates and a denominator that has an undercount inflates the obtained rate in exact proportion to the undercount. Although the overall undercount for the US and UK populations is relatively small, it is much higher for non-Whites. For example, in the US, an evaluation based on demographic analysis suggests that there is a net census undercount of 11–13 percent for Black males between the ages of 25 and 64 (National Center for Health Statistics 1994). Thus, all of the officially reported morbidity and mortality rates for African American males in these age groups are potentially 11–13 percent too high.

The heterogeneity found in mortality and morbidity rates parallels the heterogeneity in migration, settlement, and socioeconomic experiences. There is a need to reflect the diversity of experience in data collection, making efforts to contact an appropriate range of people, while remaining aware of, and sensitive to, potential ethnic differences within groups since we cannot assume that all Pacific Islanders, or all Hispanics, or all South Asians are equivalent.

EXPLAINING ETHNIC/RACIAL INEQUALITIES IN HEALTH

How can we make sense of the data showing differences in health across these broad race/ethnic groups? There is a strong temptation to read meaning directly into the categories the statistical data provide. Just as we might say that Pakistani men have high rates of unemployment, or Black American families are more likely to be headed by a single parent, so we might say that Bangladeshi people have poor health. It is then straightforward to go from this simple assertion to seeking an explanation for poor health in the nature of what it is to be (in this example) Bangladeshi. The impulse to resort to explanation based on an understanding of a reified category, stripped of contextual meaning and stereotyped, is strong. Just as we might seek explanations for higher rates of single parenthood in Black cultures, we can seek explanations for high rates of illness or disease in the cultures of the ethnic categories associated with these higher rates. Culture and genetics become all the more compelling as an explanatory variable for minority group difference when we see a diversity of outcomes across ethnic groups or across disease categories. So, if Pakistani people have high rates of heart disease, but Caribbean people do not, how can this be explained on the basis of an ethnic socioeconomic disadvantage? And if the low rates of respiratory illness and lung cancer among Pakistani people can be explained as a consequence of low rates of smoking, cannot "their" high rates of cardiovascular disease be similarly explained as a consequence of cultural traits?

If we are to develop adequate explanatory models for ethnic differences in health, we have to consider how the categories we use reflect heterogeneous social identities and how they relate to wider social and economic inequalities. In the UK, there has been a long tradition of investigating inequalities in health associated with factors such as class, residential area (for example, see the collection in Gordon et al. 1999), and gender (Annandale and Hunt 1999), producing strong evidence that these health disparities are a consequence of socioeconomic inequalities (Marmot and Wilkinson 2005). In the main, this work has not informed investigations of ethnic inequalities in health. This disjunction in the conceptual development of explanations of health inequalities is perhaps due to the impact of Marmot and colleagues' (1984) study of immigrant mortality rates. Published shortly after the Black Report had put socioeconomic inequalities in health on the research agenda (Townsend and Davidson 1982), this study used the combination of British census and death certificate data to explore the relationship between country of birth and mortality rates (Marmot et al. 1984). A central finding was that there was no relationship between occupational class and mortality for immigrant groups, even though there was a clear relationship for those born in the UK. It was concluded that differences in socioeconomic position could not explain the higher mortality rates found in some migrant groups in the UK (Marmot et al. 1984).

From 1984, it took more than a decade for socioeconomic position to reappear in published UK data exploring the relationship between ethnicity and health. Conclusions drawn from analysis of immigrant mortality data did not appear to support a socioeconomic explanation for the different rates of mortality across immigrant and non-immigrant groups (Harding and Maxwell 1997). However, work on morbidity suggested that socioeconomic factors made a major contribution to ethnic differences in health (Nazroo 1997). Some continued to claim that socioeconomic inequalities make a minimal, or nonexistent, contribution to ethnic inequalities in health (Wild and McKeigue 1997). Such denials of the relevance of socioeconomic inequalities to ethnic inequalities in health can be interrogated first by considering the limitations of quantitative empirical models. The sociological significance of ethnicity, ethnic relations, and ethnic identity cannot be captured in ethnic classifications. The role played by local and historical context, generation and period since migration, and so forth, is difficult to encapsulate in the proxies used, and is easily ignored when using crudely quantified categories that result in ethnicity being operationalized in fixed and reified terms. Furthermore, there is a lamentable lack of good, or often any, data on economic position in health studies, let alone data that can deal with other elements of social disadvantage faced by ethnic minority groups, such as inequalities related to geography and experiences of racial discrimination and harassment.

Despite the limitations of the data, there is an emerging consensus that a socioeconomic patterning of health is present within ethnic groups in developed countries. Analysis of the US Multiple Risk Factor Intervention Trial (MRFIT) data showed that all causes of mortality rates over its 16-year follow-up period had a very clear relationship to median income in the area of residence of respondents for both Black and White men. Mortality rates increased with decreasing income, resulting in a twofold difference in mortality rates between those in the top ($27,500 or higher) and those in the bottom (less than $10,000) annual income bands for both Black and White men (Davey Smith et al. 1998). Similarly, in data from England, rates of reporting fair or bad general health by household income show a clear relationship between reported general health and income for each of several ethnic groups included (Nazroo 2003). These analyses point to heterogeneity within broad ethnic groupings in health: for example, Black Americans in better socioeconomic positions have better health. There is nothing inevitable, or inherent, in the link between being Black American or being British Bangladeshi and a greater risk of mortality and morbidity. There is an urgent need to move beyond explanations that appeal to, and further cement, assumptions of essentialized and fixed ethnic or race effects.

If socioeconomic position is related to health within groups, it seems probable that inequalities in socioeconomic position across ethnic groups might be related to ethnic inequalities in health. Here the interpretation of data becomes more contentious. In most analyses, once adjustments for socioeconomic position have been made, there is a clear and often large reduction in risk for ethnic/racial minority groups. For example, analysis of the US MRFIT data showed that standardizing for mean household income in area of residence greatly reduced the relative risk for all causes of mortality of Black compared with White men – it dropped from 1.47 to 1.19, thereby statistically explaining about two thirds of the elevated mortality risk among Black men with this income measure (Davey Smith et al. 1998). Nevertheless, in such analyses, for most groups and for most health outcomes, differences remain once the adjustment for the socioeconomic indicator has been made. Here again, it is important to recognize the limitations of such quantitative models. The process of standardizing for socioeconomic position when making comparisons across groups assumes that all necessary factors are accounted for by the measures

available (Kaufman, Cooper, and McGee 1997; Kaufman et al. 1998). Evidence from the UK indicates this assumption may be fallacious. An analysis of ethnic differences in income within class groups showed that, within each class group, ethnic minority people had a smaller income than White people (Nazroo 2001). Indeed, for the poorest group – Pakistani and Bangladeshi people – differences were twofold and equivalent in size to the difference between the richest and poorest class groups in the White population. Similar findings have been reported in the US. For example, within occupational groups, White people have higher incomes than Black people; once below the poverty line, Black people are more likely to remain in this situation than White people, and, within income strata, Black people have considerably lower wealth levels than White people and are less likely to be home owners (Oliver and Shapiro 1995). The implication of this is clear: Using either single or crude indicators of socioeconomic position does not "control out" the impact of socioeconomic position. Within any given level of a particular socioeconomic measure, the circumstances of minority people are less favorable than those of White people. Nevertheless, research typically presents data that are "standardized" for socioeconomic position, allowing both the author and reader to mistakenly assume that all that is left is an ethnic/race effect, often attributed to "cultural" or "genetic" difference.

In addition, these kinds of analyses reflect current socioeconomic position only, since data assessing the effect of the life course and other forms of social disadvantage are not included. In fact, in the US, research on the links between health and experiences of racism and discrimination (crucial as a form of social disadvantage) has shown a relationship between self-reported experiences of racial harassment and a greater likelihood of reporting various measures of ill health, including hypertension, psychological distress, poorer self-rated health, and days spent unwell in bed (Krieger 2000; Krieger and Sidney 1996; Williams, Neighbors, and Jackson 2003). In the UK, analyses have shown a relationship between reports of experiences of racial harassment, perceptions of racial discrimination, and being fearful of racism and a range of physical and mental health outcomes across ethnic groups (Karlsen and Nazroo 2002a, 2002b, 2004; Karlsen et al. 2005).

EXPERIENCE AND USE OF HEALTH SERVICES

The quality of experience when using health services is a matter of social justice, regardless of resultant health outcomes. In addition to offering an equitable service, health professionals should play a role in ameliorating existing inequalities, whereas in practice, existing ethnic/racial inequalities in health may be aggravated by inequity in access to good quality services. In the US, ethnic/racial inequalities in access to and quality of health care have been repeatedly documented, with inequalities that are consistent across a range of outcomes and types of providers. An Institute of Medicine (IOM) study, requested by Congress, identified ethnic/racial differences in health care insurance status as a key determinant of these inequalities (Smedley, Stith, and Nelson 2003). However, the primary focus of the IOM study was on non-access-related factors and the authors noted that while inequalities diminish significantly when insurance status and socioeconomic factors are controlled, some typically remain. Suggested explanations for the remaining inequalities included:

characteristics of institutions (such as language barriers and time pressures on physicians); behaviors of practitioners (such as prejudice against or uncertainty with ethnic/racial minorities); and behaviors of patients (such as non-compliance and delay in seeking care) (Smedley et al. 2003).

The IOM report also noted that the studies of ethnic/racial inequalities in health care that controlled for insurance status had only done so at a crude level, without accounting for the ethnic/racial differences in the extent of coverage provided (Smedley et al. 2003). Thus, minorities are likely to have less comprehensive coverage than White Americans and, consequently, to have a more limited choice of providers, health care settings, and types of services. This confirms the point that ethnic inequalities in health are driven by socioeconomic inequalities. One way of testing whether differences in health care insurance coverage explain inequalities in health care is to examine the extent of ethnic/racial inequalities in health care systems with more comprehensive access. Studies of health care provided by the US military do support the possibility that universal access to health care eliminates the inequalities found in other systems (Smedley et al. 2003).

The publicly funded British National Health Service (NHS) provides (almost) free and universal access to health care, so one might expect ethnic inequalities in access to quality health care to be minimal, or at least smaller than those in the US. However, the benefits of universal access may be offset by the existence of widespread institutional racism in UK public services. Insofar as there is evidence from the UK, it supports the possibility that inequalities in access to health care are not present, but there are inequalities in the quality of care received, supportive of an institutional racism hypothesis. So, UK studies have shown that ethnic minority people on the whole make greater use of primary health care services than White people (with Chinese people being the exception) (Erens et al. 2001), even when adjustments are made for self-reported morbidity (Nazroo 1997). However, this does not appear to be reflected in greater use of secondary care services (Nazroo 1997), and there are suggestions that the quality of service received by ethnic minorities is poorer. For example, in primary care, ethnic minorities are more likely to be dissatisfied with various aspects of the care received, to wait longer for an appointment, and to face language barriers during the consultation (Nazroo 1997).

The evidence from the UK does, then, support the possibility of institutional racism, indicating that regardless of individual professionals' intentions, health services have discriminatory effects. The concept of institutional racism remains contested, not least by medical professionals, and the mechanisms through which organizational processes discriminate are difficult to describe and therefore to reform. Health services operate in the context of broader social and economic processes and understanding institutional racism is a crucial element of tackling persistent inequalities at a time when overt racism in public services is proscribed and relatively rare.

These issues have perhaps been most intensively debated in the mental health field, where symptomatic expression is core to diagnostic processes and where there is a large literature querying the cross-cultural validity of psychiatric diagnostic practices. The concern is that members of different ethnic groups will have different symptomatic experiences when mentally ill, because of cultural differences in the idioms used to express mental distress. For example, it has been suggested that South Asian people in the UK may experience particular "culture-bound" syndromes: that is, a cluster of symptoms that is restricted to a particular culture, such as *sinking heart* (Krause 1989), which consequently may not be identified as mentally ill by standard diagnostic practices and research instruments. Kleinman (1987) argues that the different idioms for expressing mental distress in different cultures allows for a "category fallacy," where the use of a category of illness that was developed in one cultural group fails to identify ill people in another cultural group, because it lacks coherence in that culture. While the Western category of depression is treated as if it were universal, the idioms of mental distress in a non-Western group may be sufficiently different for Western diagnostic practices to fail. Indeed, it has been argued that Western depression amounts to a culturally specific diagnosis (Jadhav 1996).

Small-scale empirical work with British Pakistanis has identified an expression of mental distress described as "thinking too much in my heart" (Fenton and Sadiq-Sangster 1996). While this was found to correlate strongly with the expression of most of the standard Western symptoms of depression, some of these standard symptoms were not present (those relating to a loss of meaning in life and self-worth), suggesting that the form that the disease took was different. Fenton and Sadiq-Sangster point out that "thinking too much in my heart" was not only a symptom but the core experience of the illness, raising the possibility that there were more fundamental differences between this illness and depression. Nazroo and O'Connor (2002) found similar differences, but also important commonalities, indicating that cultural differences may not lie in broader constructs of mental illness but in the detail of the idioms used to express distress. Qualitative analysis of accounts of mental distress demonstrates that people of Pakistani origin living in the UK show considerable fluency across different symbolic domains and refutes the suggestion that culture-bound metaphors or similes might determine patterns of help-seeking and health care use (Mallinson and Popay 2007).

Ethnic minority cultural practices and religious beliefs can prompt particular health behaviors but, as with the ethnic majority, minorities' non-medical practices tend to be used alongside medical advice which is attributed considerable respect (Bradby 1997). In considering the effect of culture on health service use by ethnic minorities, the culture of the health service providers and the organizational culture should be considered. A major barrier to getting access to good quality health care is the lack of common language between patient and staff. Greenhalgh, Voisey, and Robb (2007) show how organizational features of a sample of general practices in London influenced whether interpretation services were available.

MIGRANT AND MINORITY STAFF IN THE HEALTH SERVICES

In both the US and the UK, migrants have filled crucial labor shortages, thereby maintaining health services. For those migrants who are also from a minority, the experience of discrimination is routine and this is true of low-paid staff doing cleaning or catering work as well as skilled medical migrants. From the US, there is evidence that White patients treated by White doctors are less likely to report medical errors than White patients treated by non-White doctors. In a nationally representative data set, the likelihood of reporting medical error does not vary among non-White patients according to their ethnic or racial concordance with the physician (Stepanikova 2006: 3065). The systematically lower status of non-White doctors compared with White doctors is the explanation offered for White patients' greater preparedness to report medical error. This echoes the suggestion that the class position of the skilled migrant doctors who have maintained the NHS in the UK has been mediated by discrimination, leaving them in a "pariah" position compared with other doctors (Kyriakides and Virdee 2003: 296).

Wealthy nations continue to attract qualified, skilled medical practitioners from poorer countries, who can ill afford to lose them. The ethics of global medical migration are fraught, involving as they do issues around the freedom of movement, equal opportunities to employment, and the regulation of health care markets, but the injustice of wealthy populations profiting from the education provided by poor populations is inescapable.

CONCLUSION

The conditions leading to health and to illness, the experience of illness, and the seeking of health care are all, in a sociological analysis, best understood as a dimension and a product of social relations. The ways in which ethnicity and racism play out in the social relations of health, illness, and health care are both complex and, at times, subtle. As an identity which is both self-ascribed and imposed by others, ethnicity or race comes into play differentially according to actors' own choices, and is dependent on the context in which those choices are exercised. Individual identities reflect structural dimensions of society, with individuals' range of choices being differentially constrained. Both structural and identity aspects of ethnicity and race develop over time, so being a Muslim or Polish carry different meanings now compared with 50 years ago, in the US as well as the UK. Slavery is identified as being an important context for understanding racial categories in the US and the resonance of empire is highly relevant to ethnicity in the UK.

The terminology of quantitative analysis can give the misleading impression that the effects of race or ethnicity on health can be controlled for. Understanding social relations to be racialized implies that structure and identity are inflected by race and there is no means of stepping outside or beyond this process: There is no "un-raced" body, just as there is no body free of gender. The demonstrably false assumption that socioeconomic status can be controlled for in statistical models has led to interpretations that attribute health disparities to the racial or ethnic character of the minority population. *Culture*, particularly in the UK context, has become a euphemism for "problematic difference," which in its usage is difficult to distinguish from biologically determined race talk. Thus, the health deficits of minority ethnic or racial groups have all too frequently been understood as the direct effect of the content of the minority culture, and the effects of racism, poverty, and other exclusions are lost from view.

Despite its abuse, culture needs to be retained as an analytic term, given its immense importance for identity, but, as has been noted, it needs to be adequately complicated (Bradby 2003; Hillier and Kelleher 1996). Culture should be understood as a property of organizations, as well as of individuals, if the effects of institutional racism are to be mapped, and the interactions of minority and majority practices must be given equal consideration in an effort to understand culture through the life course.

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