



Review

Race, ethnicity and health: The costs and benefits of conceptualising racism and ethnicity[☆]

Hannah Bradby

University of Essex, Health and Human Sciences, Wivenhoe Park, Colchester, United Kingdom

Papers that conceptualize ethnicity as an aspect of public health have increased in number over recent years in *Social Science & Medicine*, as elsewhere. This virtual special issue includes a selection of papers, mostly published in the last five years, to highlight recent developments in this area. The question of whether the risks associated with reifying ethnic categories in particular settings, thereby reinforcing racialised models of thinking, is addressed. The wisdom of seeking to construct ethnicity-type variables for the purpose of global cross-cultural comparison is queried.

An unavoidable contradiction of studying ethnicity is the inevitable re-inscription of ethnic and racialised categories. Inequities in health outcome or quality of health service provision and uptake are injustices that have to be measured in order to be addressed. Whether research is qualitative or quantitative and whether or not an investigation finds inequalities, the definition of an ethnic group whether in terms of boundary or content, re-inscribes its existence as a cultural category. Furthermore, the familiar complexities of working with socio-demographic variables that relate to the individual and the population level, applies in the case of studying ethnicity and health.

Ethnic groups exist because we behave as if they do: the social construction of ethnicity occurs as part of the definition of, and the search for, quantitatively and qualitatively significant differences between those groups. In appraising ethnicity, concomitant terms with over-lapping meanings are implied and, in the hope of avoiding terminological obfuscation, are briefly rehearsed below.

Ethnicity – usually seen as a voluntaristic self-identification with a group culture, identified in terms of language, religion, marriage patterns and real or imaginary origins – differs from race. *Race* tends to refer to difference that can be read from physical appearance, and is usually assumed to concern phenotype or physical difference with a biological basis. While race is imaginary in the sense that humanity is not divisible into clear-cut groups on the basis of genetic discontinuities, the idea of race is well-established and persistent. Furthermore *racism* exists and prejudiced beliefs,

attitudes and behaviour towards people who are differentiated from oneself can be articulated through a belief in race or an essentialist view of dimensions of ethnic or cultural variation. So even if race is a powerful fantasy rather than a genetic fact, racism has empirical reality in that it has measurable ill effects on health outcomes (Harris et al., 2006; Kreiger, Smith, Naishadham, Harman, & Barbeau, 2005).

The dominance of American or global English (so-called 'globlish') as a language of commerce, research and the internet, means that the term race has common currency. However, what is meant by race in the US (where the term has an official status) is quite different from other settings where English is an official language, such as the UK (where ethnic, but not racial, terms are used in the national census), Canada (where ethnicity exists as an official category with regard to people from the first nations but not necessarily immigrants) or South Africa where race has a long and divisive history as an official category for local and immigrant groups alike. Where a term equivalent to 'race' is used in another language, conceptual equivalence may pertain, but has to be carefully established. But even restricting consideration to English only, slippage between discussions of race and ethnicity makes it difficult to use the terms as if they were distinct. Even where researchers report that their research is 'race conscious' in an ethical, reflexive and progressive way,

Race stands to be reified as genetic whenever it is used to structure and communicate genomic research and evidence. (Bliss, 2011: 1026)

The slippage goes both ways, so cultural categories acquire a genetic, biological basis while the existence of geographically structured genetic clusters, when reported as mapping onto major self-identified ethnic/racial groups, gain a social as well as a genetic reality. The merging of ethnicity and race as distinct concepts can be seen in the increasing use of the hybrid term 'race/ethnicity'. While some commentators believe that conceptual hygiene can 'save' terms for clear-cut analytic use by only importing them 'from the social sphere' when carefully 'explained and defined' (Bliss, 2011: 1026), this is far from evident. The emergence of new hybrid terminology, such as 'ethnicity/nativity status' (Almeida, Molnar, Kawachi, & Subramanian, 2009), indicates dissatisfaction with the vague nature of 'ethnicity' and of 'race/ethnicity'.

[☆] This review also serves as the Introduction for the *Social Science & Medicine* Virtual Special Issue on Race, Ethnicity and Health, available online at: <http://www.journals.elsevier.com/social-science-and-medicine/virtual-special-issues/race-ethnicity-health/>.

E-mail address: hbradby@essex.ac.uk.

Acculturation offers another avenue for conceptualizing the complexities of health outcomes among minority populations (Lopez-Class, Castro, & Ramirez, 2011), but its purview is restricted to social formations arising from migration. Acculturation has been seen as a positive process accompanying assimilation and likely to be associated with improving health outcomes (e.g. Greenblum, 1974). Acculturation has persisted as a term despite warnings to abandon its use due to the flawed and sometimes stereotyped conceptualizations on which it draws (Hunt, Schneider, & Comer, 2004). Furthermore empirical work has discredited as simplistic those linear acculturation models which suggest improved socio-economic status always ameliorates migrants' health outcomes (Jayaweera & Quigley, 2010). *Acculturation* can only be used for minority–majority ethnic group encounters established through a recent migration whereas the language of ethnicity allows for a wider range of encounters between dominant and non-dominant groups. Thus adopting ethnicity as a term of reference may allow the most complex conceptualizations to emerge. The question of whether such complexity can actually emerge from reductionist racialised thinking is worth posing.

Research which looks at 'structured genetic clusters', 'cultural' and/or 'ethnic groups' can all be interpreted in racialised terms because of the long history of constructing the complexities of human variation as races. During the 1930s and 1940s discrete populations were named and logged in international atlases and databases, permitting their use in large-scale population genetic studies and subsequently in the more recent reinvigoration of the search for measurable difference (Braun & Hammonds, 2008). While racialised population groupings could usefully be referred to as geographic or continental ancestry groups (rather than races or populations), it is not clear that this would impede the ongoing essentialist interpretation of complex diversity. Evidence of health differentials between ethnic or cultural groups can, all too easily, be interpreted in racialised terms, that is, the cause of any difference is assumed to lie with some inherent or essential aspect of that group's culture, biology or genetics. By conceptualizing ethnic (cultural/geographic/tribal/racial) groups, even the most progressive and enlightened of research reinforces the idea of these categories and thereby compounds a view of humanity as fundamentally divided.

Avoiding such essentialist implications when discussing variety within the human population is not simply a matter of adopting the language of ethnicity (or diversity) rather than race (or population). Dutch research into how minority groups are constructed in epidemiological research on sexually transmitted infections, shows that differentiation is not only a matter of terminology (Proctor, Kurmeich, & Meershoek, 2011). Minorities' health behaviours are constructed as fundamentally different from that of the majority, with ethnic minorities represented as sexually promiscuous, unsafe and, crucially, *different* from the general population of the Netherlands (Proctor et al., 2011). What is referred to as 'the explanatory dominance of ethnicity' (Proctor et al., 2011: 1845) means that any differences found between the minority and majority are explained in terms of minority ethnic status. The vague and multiple conceptions of both ethnicity and migrant-status in research reports facilitate this explanatory dominance. The differentiation of minorities' health problems from those of the majority can lead to fundamentally different solutions being proposed, and inequities being compounded. When differential HIV treatment (for instance) is undertaken by a statutory agency, such as an institute for public health, the construction of difference is powerful and feeds into 'common knowledge' regarding minority ethnic groups (Proctor et al., 2011).

As (Proctor et al., 2011), power operates structurally and not just via individual actions. As overt racism has become less and less

socially acceptable, the need to understand the institutional operation of racism and forms of discrimination that operate in terms of culture and ethnicity, has become more urgent (Bradby, 2010). Conceptualizing individuals as passive participants whose environment accounts for everything fails to account for the ways that racism has been resisted and accommodated and is as unfortunate as holding the individual entirely accountable for his or her circumstances. Factor and colleagues (Factor, Kawachi, & Williams, 2011) have developed a framework in which both structural inequalities and individual agency figure, which features what are termed 'resistance practices' as well as unhealthy behaviours. 'Non-dominant' minorities can be distinguished from dominant groups across a huge range of contexts, from New Zealand to Taiwan to Israel (Factor et al., 2011: 1292) and the term successfully sheds implications of race by explicitly referring to power. Time will tell whether this framework is adopted and whether it generates testable hypotheses that permit the theory to be refined without picking up the baggage of racialised categories.

The enormous range of mechanisms potentially at work in the genesis of health outcomes patterned by ethnic group are illustrated in the pages of *Social Science & Medicine*. Qualitative work in Spain – a country subject to significant levels of immigration over the last few years – offers individual migrants' understandings of the role of discrimination on their health (Agudelo-Suárez et al., 2009). Individually gathered material on self-rated health and other characteristics, combined with neighbourhood-level data from the census and other survey data assesses the relationship between trust and self-related health among Mexican–Americans in poor localities (Franzini, 2008). Intermediary variables operating at the level of neighbourhoods (Mair et al., 2010) or schools (Walsemann, Bell, & Maitra, 2011) have been investigated and are either an important test of the usefulness of thinking in terms of race/ethnicity or further effort in an unwarranted reification of an idea that has outlived its usefulness. How can this judgement be made?

A general bias against publishing negative findings might mean an over-representation of work that finds clear differentiation between ethnic groups. And if so, we find exceptions to prove the rule in *Social Science & Medicine*. Krieger et al. (2008) seek models of discrimination and cultural difference that can be associated with a health outcome in an appropriate context. Using blood pressure as a health outcome, the study sought to account for the accumulation of health hazards in low-income workers from Black, White and Latino groups. In contrast to earlier work with the same cohort (Krieger et al., 2005), the later analysis found no significant associations between social hazards (other than sexual harassment which was relatively rare) and elevated systolic blood pressure. The authors explain the lack of association between racism and raised blood pressure in terms of differential aetiologic patterns for different exposures and the high prevalence of adverse exposures for this whole cohort (Krieger et al., 2008: 1979).

Focussing on the 'mental health paradox' whereby Black Americans have a decreased risk of depression and an increased risk of physical illnesses, as compared with White Americans, Keyes and colleagues' (Keyes, Barnes, & Bates, 2011) analysis further illustrates the difficulties of building up theoretical insights across a field. Previous research had suggested that the consumption of alcohol and nicotine and excessive eating represented coping mechanisms that mitigated the effects of stress among Black (but not White), Americans. This was disconfirmed by analysis of nationally representative data showing that the impact of both stress and coping mechanisms operates similarly in Black and White groups (Keyes et al., 2011). Some of the difficulties of employing epidemiological methods to research ethnic or racialised differences have been rehearsed in this journal already (Exner & Cohn, 2008; Frank, 2008; Kaufman, 2008a, b).

Explaining health disparities between ethnic or racialised groups without recourse to crude biological essentialism or stereotyped cultural generalizations is difficult enough. But then we come to consider whether the epidemiological models, often developed in urban US settings, can be applied across the vast range of settings where the language of ethnicity is employed. Is there enough in common across aboriginal groups, urban migrants' descendants and longstanding diasporas to justify a common terminology, let alone universal theories? While the Canadian first nations, Native Americans, indigenous Brazilians and Guyanese, Aboriginal Australians and New Zealand Maoris have a range of health issues that may have common roots in historical colonialism and current marginalization, should such disparities with the local majority population be compared with the Black–White health disparities in present-day South Africa? Or the position of Jews, Bedouin or Gypsies in various settings? Does the complexity in the local manifestation of racialised power render any attempt to compare across cultures meaningless? Diasporic comparisons of migrants offer possibilities for unravelling the effects of social and economic variation on health by comparing the health outcomes of migrants in two or more different settings. However, this is not the same as saying that ethnicity is a useful concept that should be developed for use in health research. Indeed using terminology that is apparently universal, potentially masks the diversity. This is not only a question of developing a terminology that is sufficiently complex to reflect the social world but also a question of shaping that social world through our interpretations.

The potential harm of collecting data that create ethnic divides is pointed up in Canadian research. Canada does not currently routinely collect data on patients' ethnicity in healthcare contexts. In their research Varcoe, Browne, Wong, and Smye (2009) conducted interviews with staff and patients plus community and healthcare leaders to enquire how people would feel about being asked about their ethnic in a clinical setting. Those people who identified themselves as from minority or marginalised groups consistently identified the potential harm *both* from agencies holding ethnicity data *and* from the processes of having collected it. Varcoe and colleagues call for a demonstration of the benefit of collecting ethnicity data prior to instigating such a policy in Canada.

Perhaps Canada can avoid constructing ethnicity variables in healthcare, even as they have become routine elsewhere. Assuming that ethnic monitoring does not become standard practice in Canadian clinical settings, will some alternative form of scrutiny emerge to ensure equity? Will avoiding the terminology of ethnicity permit another vocabulary to develop?

The language of ethnicity and diversity has been found wanting as an adequate reflection of current socio-economic and legal complexity in migration studies (Vertovec, 2007). Discussions of ethnicity in the context of multi-culturalism are inevitably tightly linked to migration. The figure of the immigrant, with his or her aspirations for asylum, paid work and a better life is closely related to the figure of 'the other' that boundaries of ethnicity demarcate. The doubt underpinning this editorial is whether the complexities of these figures can be adequately and appropriately translated into models of health outcomes so as to build better theories.

Despite terminological inadequacies and ambiguities, the way that ethnicity and racism operate in models of health outcomes among urban populations in the US is being untangled over the life course through the methods of social epidemiology; and the complexity means that no simple health message is appropriate. The global power of American English promotes a tendency to export models as well as language.

Terminology around ethnic and racialised groups is always a short-hand for simplification of a set of social and economic processes that have operated over time and in specific cultural

settings. Ideally, research should seek to interrogate whether its own conceptualisations of health and of ethnicity are valid, in addition to interpreting the world through them. The construction of variables should, of course, always be done in relation to a research question. A certain intolerance of 'ethnic group' as a meaningful variable among reviewers of research protocols and an insistence upon a more precise statement of the aspect of ethnicity or 'race/ethnicity' that is under investigation could tighten the link with those research questions. If researchers were encouraged to specify their interest in particular aspects of ethnicity we might find recourse to the short-hand of 'race/ethnicity' dying out. As we learn more about, for instance, the intersecting effects on health of resisting racial discrimination and the stigma associated with specific neighbourhoods combined with highly restricted employment opportunities and low-income, we may be less willing to put these in the same category as challenges to the health of migrants who are living without social and health insurance. If health effects are hypothesized and tested with greater specificity, then ethnicity might come to be replaced by its constituent parts.

References

- Agudelo-Suárez, A., Gil-González, D., Ronda-Pérez, E., Porthé, V., Paramio-Pérez, G., García, A. M., et al. (2009). Discrimination, work and health in immigrant populations in Spain. *Social Science & Medicine*, 68(10), 1866–1874.
- Almeida, J., Molnar, B. E., Kawachi, I., & Subramanian, S. V. (2009). Ethnicity and nativity status as determinants of perceived social support: testing the concept of familism. *Social Science & Medicine*, 68(10), 1852–1858.
- Bliss, C. (2011). Racial taxonomy in genomics. *Social Science & Medicine*, 73(7), 1019–1027.
- Bradby, H. (2010). What do we mean by 'racism'? Conceptualising the range of what we call racism in health care settings: a commentary on Peek et al. *Social Science & Medicine*, 71(1), 10–12.
- Braun, L., & Hammonds, E. (2008). Race, populations, and genomics: Africa as laboratory. *Social Science & Medicine*, 67(10), 1580–1588.
- Exner, D. V., & Cohn, J. N. (2008). Arguments prove nothing unless verified. A commentary on Kaufman's "Epidemiologic analysis of racial/ethnic disparities: some fundamental issues and a cautionary example". *Social Science & Medicine*, 66(8), 1675–1677.
- Factor, R., Kawachi, I., & Williams, D. R. (2011). Understanding high-risk behavior among non-dominant minorities: a social resistance framework. *Social Science & Medicine*, 73(9), 1292–1301.
- Frank, R. (2008). Functional or futile?: the (in)utility of methodological critiques of genetic research on racial disparities in health. A commentary on Kaufman's "Epidemiologic analysis of racial/ethnic disparities: some fundamental issues and a cautionary example". *Social Science & Medicine*, 66(8), 1670–1674.
- Franzini, L. (2008). Self-rated health and trust in low-income Mexican-origin individuals in Texas. *Social Science & Medicine*, 67(12), 1959–1969.
- Greenblum, J. (1974). Medical and health orientations of American Jews: a case of diminishing distinctiveness. *Social Science & Medicine*, 8(3), 127–134.
- Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Racism and health: the relationship between experience of racial discrimination and health in New Zealand. *Social Science & Medicine*, 63(6), 1428–1441.
- Hunt, L. M., Schneider, S., & Comer, B. (2004). Should "acculturation" be a variable in health research? A critical review of research on US Hispanics. *Social Science & Medicine*, 59(5), 973–986.
- Jayaweera, H., & Quigley, M. A. (2010). Health status, health behaviour and healthcare use among migrants in the UK: evidence from mothers in the Millennium Cohort Study. *Social Science & Medicine*, 71(5), 1002–1010.
- Kaufman, J. S. (2008). Epidemiologic analysis of racial/ethnic disparities: some fundamental issues and a cautionary example. *Social Science & Medicine*, 66(8), 1659–1669.
- Kaufman, J. S. (2008). Epidemiologic analysis of racial/ethnic disparities: a rejoinder to Frank and Exner. *Social Science & Medicine*, 66(8), 1678–1680.
- Keyes, K. M., Barnes, D. M., & Bates, L. M. (2011). Stress, coping and depression: testing a new hypothesis in a prospectively studied general population sample of U.S.-born Whites and Blacks. *Social Science & Medicine*, 72(5), 650–659.
- Krieger, N., Chen, J. T., Waterman, P. D., Hartman, C., Stoddard, A. M., Quinn, M. M., et al. (2008). The inverse hazard law: blood pressure, sexual harassment, racial discrimination, workplace abuse and occupational exposures in US low-income black, white and Latino workers. *Social Science & Medicine*, 67(12), 1970–1981.
- Krieger, N., Smith, K., Naishadham, D., Harman, C., & Barbeau, E. M. (2005). Experiences of discrimination: validity and reliability of a self-report measure for population health research on racism and health. *Social Science & Medicine*, 61(7), 1576–1596.
- Lopez-Class, M., Castro, F. G., & Ramirez, A. G. (2011). Conceptions of acculturation: a review and statement of critical issues. *Social Science & Medicine*, 72(9), 1555–1562.

- Mair, C., Diez Rouz, A. V., Osypuk, T. L., Rapp, S. R., Seeman, T., & Watson, K. E. (2010). Is neighborhood racial/ethnic composition associated with depressive symptoms? The multi-ethnic study of atherosclerosis. *Social Science & Medicine*, 71(3), 541–550.
- Proctor, A., Kurmeich, A., & Meershoek, A. (2011). Making a difference: the construction of ethnicity in HIV and STI epidemiological research by the Dutch national institute for public health and the environment (RIVM). *Social Science & Medicine*, 72(11), 1838–1845.
- Varcoe, C., Browne, A. J., Wong, S., & Smye, V. L. (2009). Harms and benefits: collecting ethnicity data in a clinical context. *Social Science & Medicine*, 68(9), 1659–1666.
- Vertovec, S. (2007). Super-diversity and its implications. *Ethnic and Racial Studies*, 29(6), 1024–1054.
- Walsemann, K. M., Bell, A. B., & Maitra, D. (2011). The intersection of school racial composition and student racial/ethnicity on adolescent depressive and somatic symptoms. *Social Science & Medicine*, 72(11), 1873–1883.