

Ethnic inequalities in health: social class, racism and identity.

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Work on ethnicity and health has mainly focussed on specific illnesses or has been based in specific locations. Nationally representative information on the health of ethnic minority people in Britain is scarce and until recently has largely relied on immigrant mortality statistics. While these show important differences in health between ethnic groups, they have a number of drawbacks, including using country of birth as a crude surrogate for ethnicity and using overarching and misleading ethnic groupings. The *Fourth National Survey of Ethnic Minorities* (FNS) presented the first opportunity to use nationally representative data that did not have these problems and that allowed the concept of ethnicity to be unpacked across a variety of dimensions.

There are two principle limitations with existing research exploring ethnic inequalities in health:

- firstly, the use of one-dimensional definitions of ethnicity means studies have been unable to take account of the range of meanings of 'ethnicity', including recognising the importance of ethnic identities and that these identities are diverse and neither stable nor pure;
- secondly, many studies fail to account for the role of social structure in the relationship between ethnicity and health, namely the role of socioeconomic position and the impact of racism.

Previous attempts to explore the relationship between socioeconomic position and ethnicity and their association with health have met with limited success. Findings from our multivariate analysis suggest, however, that these negative findings are a result of an overly crude assessment of ethnicity and the use of socioeconomic indicators that inadequately reflect the position of ethnic minority groups. The use of more sensitive measures show that difference in socioeconomic position make a major contribution to the relationship between ethnicity and health.

However, health differences across ethnic groups may not be reducible to socioeconomic position. The relative deprivation faced by ethnic minority people, in other words, is likely to involve more than material disadvantage. For example, ethnic minority people also face alienation and racial harassment. Our findings suggest that racial harassment and perceptions of discrimination have a considerable health impact, which must be taken into account when investigating ethnic inequalities in health.

We also sought to assess underlying dimensions of ethnic identity and how they might be related to health. This suggested dimensions of ethnic identity that were related to self-description, being 'traditional', participating in the 'ethnic community', and the extent to which someone sees themselves as being a member of a racialised group. These dimensions of ethnic identity were consistently identified across the different ethnic minority groups included in the analysis, but they appeared unrelated to health.

Our findings supported the hypotheses that inequalities in social position have a substantial impact on the health experience of ethnic minority groups, both in terms of socioeconomic disadvantage and racial harassment and discrimination. These findings would suggest that the use of traditional definitions of ethnicity is shortsighted as they ignore the complexity of the relationship between ethnicity and health. To fully understand the mechanisms that lead to ethnic inequalities in health, we need measures that can take account of the effects of the other, more structural, factors that underlie them.

Background

This study was concerned with improving understanding of the complex relationship between ethnicity and health. Although there has been considerable interest in ethnicity and health, research in this field has often been conducted quite separately from wider work on inequalities in health. So, we set out to apply this wider work to understanding ethnic differences in health.

While a number of studies have shown important differences in health between ethnic groups, exploration of these differences has been limited. This is largely a consequence of the over-simplistic assumptions made about the role of ethnicity in relation to health experience. These assumptions have led to the use of one-dimensional assessments of ethnicity (usually based on country of family origin), overarching and misleading ethnic groupings which are unable to account for the complex relationship between ethnicity and health (such as a South Asian category that, in fact, involves many diverse ethnic groups), and a failure to assess the role of more structural influences on this relationship, particularly the role of socioeconomic position and racial harassment and discrimination.

An assessment of ethnicity that includes additional dimensions, such as religion or language, allows the relationship to be explored further (Nazroo 1997, 1998a). What is clear is that assigning individuals into a heterogeneous one-dimensional ethnic category, such as 'Black' or 'Asian', results in a failure to recognise the importance of ethnic diversity within minority groups. In terms of understanding this diversity and possible links with health, it is crucial to consider ethnic identity and how this is related to both the cultural traditions of an ethnic group and their experiences in Britain.

Given the relationship between socioeconomic position and health and the relatively poor socioeconomic position of many of Britain's ethnic minorities, the failure to explore the impact of socioeconomic position on ethnic inequalities in health would seem to be an oversight. While attempts to explore the interaction between socioeconomic position and ethnicity and their association with health have met with limited success,

analyses of the FNS data suggest that this too is a result of the use of overly crude assessments of ethnicity and the use of socioeconomic indicators that inadequately reflect the position of ethnic minority groups (Nazroo 1997, 1998a). For example, these analyses have shown that within particular 'social class' bands ethnic minority people have lower incomes, within particular tenure bands they have poorer quality housing, and among the unemployed they have been unemployed longer, compared with white people (Nazroo 1997).

Two messages emerge from these earlier studies: that measures of socioeconomic position need to be developed that are sensitive to ethnic difference; and that when controlling for socioeconomic position, socioeconomic effects should be shown (rather than footnoted as controlled for). The starting point for this study was to build on the earlier work that illustrated socioeconomic effects (Nazroo 1997).

However, health differences across ethnic groups may not be reducible to socioeconomic position: the relative deprivation faced by ethnic minority people is likely to involve more than material disadvantage. For example, ethnic minority people face alienation and racial harassment and, while there is only limited evidence to support the possibility that the experience of racism is associated with poor health, what evidence there is suggests that this is an avenue worth pursuing.

The specific aims of the study were to:

- describe the extent to which different dimensions of ethnicity, including ethnic identity, are related to health.
- examine the extent to which the relationship between ethnicity and health is mediated by socioeconomic disadvantage and other forms of inequality, such as the experience of racism.

Methods

The FNS was a nationally representative survey of 5196 ethnic minority people (of Caribbean, Indian, Pakistani, Bangladeshi and Chinese origin), with a comparison sample of 2867 white people. The survey questionnaire covered many measures of social and economic disadvantage and also included sections on: family structure,

ethnic identity, experience and perceptions of racism, and health.

To analyse these data, a variety of multivariate analysis techniques were used, including factor analysis and logistic regression. Using these techniques allowed us to explore underlying attitudinal dimensions in the data and to consider a number of explanatory factors at the same time.

Findings

The following will provide a brief summary of key findings that have emerged. To save space, the focus is mainly on one health outcome, reported fair or poor health, although figure 1 uses heart disease as the outcome.

Socioeconomic effects

To illustrate findings in relation to socioeconomic gradients and how far they contribute to ethnic inequalities in health, we have included details of our analysis comparing people of Pakistani and Bangladeshi origin and white people, in terms of risk of heart disease (Figure 1, see also Nazroo 2001). The choice to focus on this outcome for this ethnic group was made because approaches to data analysis have assumed that: South Asian people uniformly have much higher rates of heart disease than white people; that they do not have a class gradient in heart disease; and that socioeconomic effects do not contribute to ethnic differences in this outcome (see Nazroo 1998a and 2001, for a discussion of this).

The first step of the analysis, not shown here, suggested that the assumed higher rates of heart disease among South Asian people is, in fact, concentrated among people of Pakistani and Bangladeshi origin. Consequently, the later analysis concentrated on differences between Pakistani and Bangladeshi and white rates of heart disease. Logistic regression analyses were performed to assess the importance of socioeconomic factors to ethnic differences in heart disease. The first line of figure 1 shows the odds ratio, compared with white people, to have diagnosed heart disease or severe chest pain without taking into account socioeconomic factors, while the following lines show the effect of controlling for occupational class, or standard of living, or both.

The figure shows that Pakistani and Bangladeshi people do have higher rates of heart disease than white people (with an odds ratio of 1.9), and comparing the first and second lines in figure 1 shows that controlling for occupational class had only a marginal effect on this risk (the odds ratio drops from 1.9 to a still significant 1.67). However, comparing the third line in figure 1 with the first shows that controlling for standard of living leads to a big reduction in the odds ratio (from 1.9 to 1.42) and to a level that is no longer statistically significant. The final line in figure 1 confirms that occupational class adds little to the analysis. The problems with using an indicator such as occupational class to *adjust* for socioeconomic effects were described in the background section, and is also discussed in a number of the publications arising from this project (e.g. Nazroo 1997, 1998a,b).

We conclude that:

1. Within ethnic minority groups, socioeconomic position is an important determinant of health outcomes;
2. For comparisons across ethnic groups, we need to carefully develop and evaluate indicators of socioeconomic position;
3. If we use valid indicators of socioeconomic position, they can be shown to make a substantial contribution to ethnic inequalities in health.

Racial harassment and discrimination

In much of the work arising from this study (Karlsen and Nazroo, 2000a and 2001a), it has been argued that racism is a central component of ethnic inequalities in health. On the one hand, the consequent discrimination and social exclusion can lead to a disadvantaged socioeconomic position and consequent poorer health. On the other, racism might have a negative impact on health as a result of the psychological processes that might result from either the direct experience of racism, or that perceptions of living in a racist society might set off.

Figure 2, drawn from Karlsen and Nazroo (2000a), summarises a logistic regression model exploring these issues. The model

covers all ethnic minority respondents (excluding Chinese people), because findings were remarkably similar across individual groups. The model suggests that over and above socioeconomic effects, both experience of racial harassment and perceptions of racial discrimination make an independent contribution to health. For example, those who had been verbally harassed had a 50 per cent greater odds of reporting fair or poor health compared with those who reported no harassment, while those who reported racially motivated damage to their property, or physical attacks were more than twice as likely to report fair or poor health. There was also a statistically significant association between perceiving British employers as discriminating against members of ethnic minority groups and self-reported fair or poor health. Those that believed some or most British employers to be discriminating had a 60 per cent greater odds of reporting fair or poor health compared with those who believed no or few employers were.

Ethnic identity

Fuller details of the findings in relation to the investigation of ethnic identity and health among the different ethnic minority groups can be found in Karlsen and Nazroo (2000b and 2001b). In summary, for the factor analysis used to identify dimensions of identity, we concentrated on questionnaire items relating to descriptions of ancestry and ethnic affiliation, lifestyle, experience of racism, and social and community involvement. The factor analysis was initially conducted for each ethnic group separately, but the results were very similar across them. This would suggest that the dimensions which constitute such an identity are consistent across minority groups, and allowed us to use the same model for each group. This contained five factors with working titles of: nationality important for self description; 'ethnicity/race' important for self-description; 'traditional'; community participation; and member of a racialised group.

In order to help us understand the inter-relationships between self-reported fair/poor health, ethnic identity and class, we constructed logistic regression models in three stages, for each group separately: first

with only self-reported health and the dimensions of identity; then with age and gender, and finally with occupational class.

In summary, initially there appeared to be some relationship between these dimensions of ethnic identity and health, but later stages of the analysis indicated that this was fully accounted for by age and class effects. So, while these dimensions of identity can be clearly and consistently identified across ethnic minority groups, they did not predict health. Rather, as the analysis shown in this and the preceding sections suggest, ethnicity as structure - both in terms of perceptions of racial discrimination and harassment and class experience - is a stronger determinant of health risk for ethnic minority people living in Britain.

Conclusions

In conclusion, we have shown that ethnic identity is formed in relation to a number of dimensions: self-description, being 'traditional', participation in the 'ethnic community', and racialisation. So, rather than being something based solely on country of origin, as would be suggested by definitions of ethnicity used in earlier studies, ethnic identity can be seen to be influenced by the wider social structure. Any measure of ethnicity need to allow for this. These analyses suggest that the relationship between ethnicity and health is also mediated by structural factors, explored here in terms of socioeconomic position, and racial harassment and discrimination. This would suggest that while traditional measures of ethnic group can allow us to recognise the existence of ethnic inequalities in health, in order to fully investigate the relationship between ethnicity and health, we require a more sophisticated assessment of ethnicity, which can both adequately account for the different forms of social disadvantage experienced by ethnic minority groups and the various ways in which racism itself can impact on physical and mental health. Racism and its accompanying social disadvantage are important aspects of the lives of people from ethnic minority groups, and this must be incorporated into strategies to address ethnic inequalities in health.

Figure 1: Effect of adjusting for socioeconomic status on odds ratio of reporting diagnosed heart disease or severe chest pain - Pakistani and Bangladeshi people compared with white people, age 40 to 64.

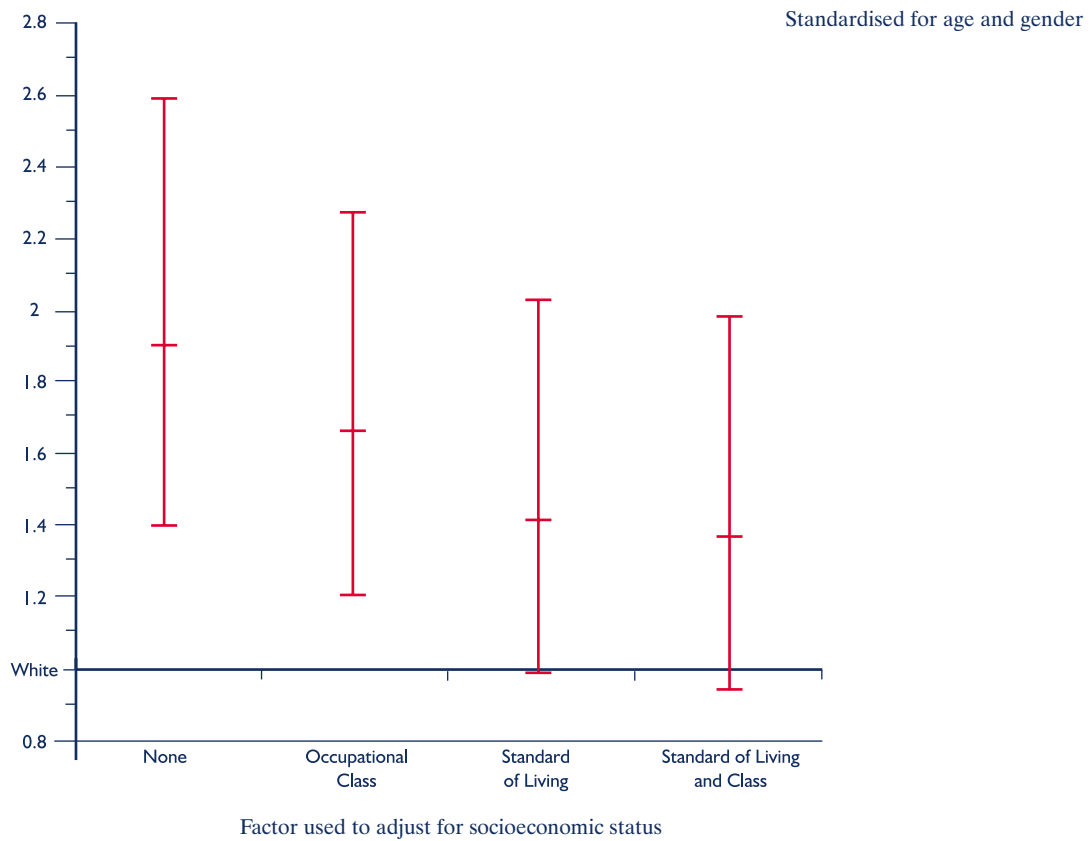
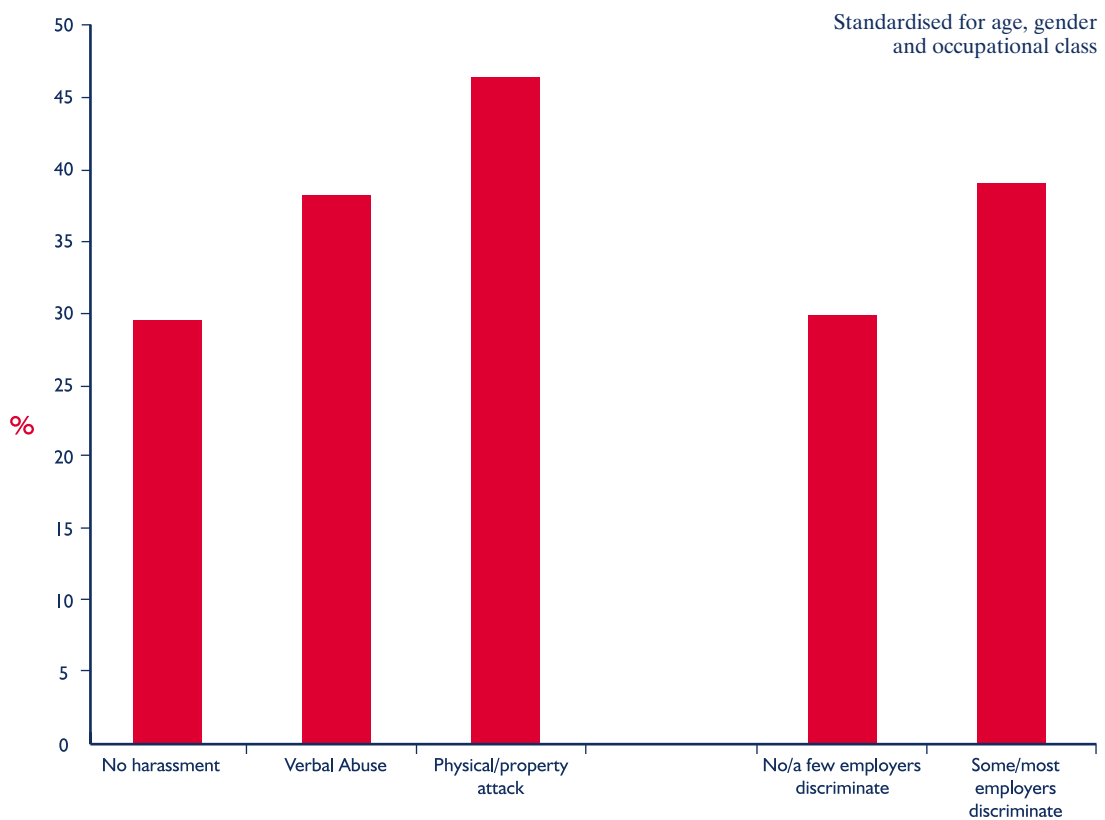


Figure 2: Predicted per cent of ethnic minority respondents reporting fair or poor health.



Selected papers drawn on for these Findings

- Karlsen, S. and Nazroo, J. (2000a) 'The relationship between racism, social class and health among ethnic minority groups', *Health Variations: Official newsletter of the ESRC Health Variations Programme*, Issue 5, pp. 8-9
- Karlsen, S. and Nazroo, J. (2000b) 'Identity and Structure: rethinking ethnic inequalities in health' in H. Graham (ed.) *Understanding Health Inequalities* Buckingham : Open University Press.
- Karlsen, S. and Nazroo, J. (2001a) 'The relationship between racial discrimination, social class and health among ethnic minority groups' *American Journal of Public Health* (in press).
- Karlsen, S. and Nazroo, J. (2001b) 'Agency and structure: the impact of ethnic identity and racism on the health of ethnic minority people', *Sociology of Health and Illness* (in press).
- Nazroo, J. Y. (1997) *The health of Britain's ethnic minorities: findings from a national survey*, London: Policy Studies Institute.
- Nazroo, J. Y. (1998a) 'Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health', *Sociology of Health and Illness*, 20, 5, 710-730 and in M. Bartley, D. Blane, and G. Davey Smith, (eds.) *The Sociology of Health and Inequalities* Oxford : Blackwell
- Nazroo, J. Y. (1998b) 'The racialisation of ethnic inequalities in health' in D. Dorling and L. Simpson (eds.) *Statistics in Society: The arithmetic of politics* London : Arnold
- Nazroo, J. Y. (2001) 'South Asians and Heart Disease: An assessment of the importance of socioeconomic position', *Ethnicity and Disease* (in press).

Forthcoming

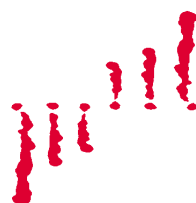
We are currently preparing for publication our work on gender, ethnicity and health, and that on the impact of area of residence on the relationship between ethnicity and health.

Information about Programme

The Health Variations Programme was established by the Economic and Social Research Council in 1996 to focus on the causes of health inequalities in Britain. Over the last two decades, Britain has got healthier and richer, but inequalities in health and income have increased. Death rates have fallen but mortality differences between social classes I and V have widened; real incomes have risen but so has the proportion of the population living in poverty. The Programme aims to:

- advance understanding of the social processes which underlie and mediate socioeconomic inequalities in health;
- advance the methodology of health inequalities research;
- contribute to the development of policy and practice to reduce the health gap between socioeconomic groups.

There are 26 projects in the Programme, based in university departments and research units across the UK. The projects have been established in two phases: in 1996/7 and in 1998/9. They address questions at the cutting-edge of health inequalities research, including the influence of material and psycho-social factors across the lifecourse, the influence of gender and ethnicity and whether and how areas have an effect on the socioeconomic gradient over and above the influence of individual socioeconomic status. The potential contribution of policy, at national and local level, is also addressed.



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