Ethnicity and Health Seminar 8th March 2005
Discussion: Lucinda Platt, discussant.

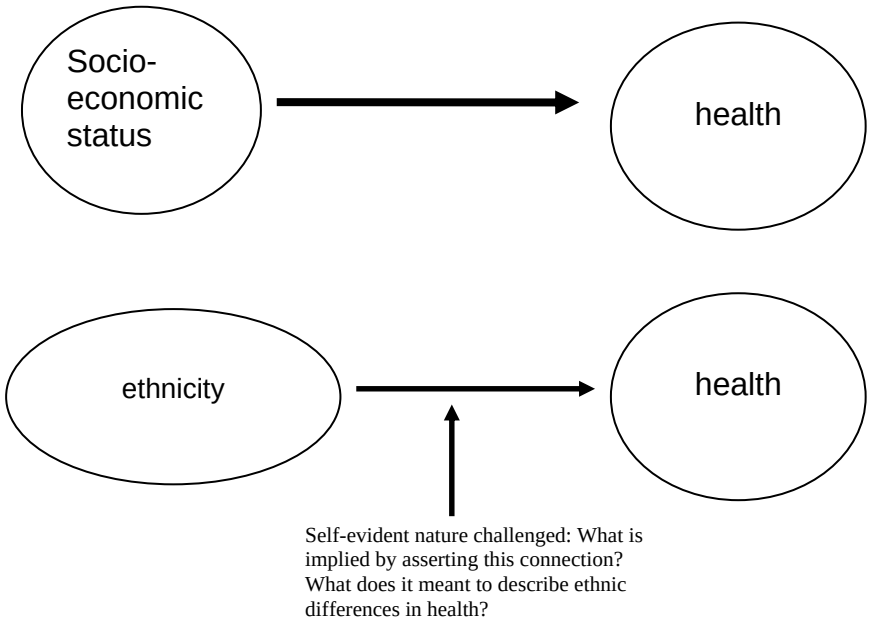
The question considered in small groups was: *If poor socioeconomic conditions largely explain poor health, is ethnicity irrelevant to the task of improving the health of minority groups?*

The feedback from the discussion is summarised here alongside comments from the discussant on the overall topic of the seminar.

In general the answer to the question was 'no' but this was also expressed in the context of concern about the nature of the question – the extent to which you can separate out ethnic minorities and socio-economic disadvantage. It was also felt that the salience of ethnicity might vary for those in different circumstances – for one group it was speculated that ethnic differences in health would become more acute at higher levels of deprivation i.e. that advantage had common health impacts but disadvantage had differential impacts, for another group it was felt that ethnic differences in health would become salient at greater levels of advantage i.e. that disadvantage had common impacts but greater advantage allowed distinct health trajectories to emerge. Before considering the responses further it might be worth discussing how we got to this question, including observations on the presentations today.

In relation to ethnic differences in health – the self-evidentiary base has now been challenged (though still not consistently across health research). The challenge has been to question in what sense it is meaningful to look for differences within the ethnicity of different individuals and groups. It is more fruitful – as James Nazroo has so forcefully argued – to look beyond ethnicity per se as the explanation for health differences / inequalities (with the recourse to genetic or cultural factors that focusing on ethnicity implies) to what might be correlated with ethnicity that itself is known / can be shown to have an impact on health outcomes – namely class or socioeconomic status.

The following diagram crudely illustrates the previous approach and the point of challenge.



This is a powerful and important argument – powerful as it makes sense of a lot of what would otherwise be anomalous (e.g differences between 'Asian' groups); and as it forces the search for understanding and explanation to refocus – what are the groupings we should be considering? – what is ethnicity / ethnic group membership meaning or standing in for?; and important because it has implications for treatment, care and response and challenges the naturalising of ethnic group difference. (Though there is still a lot about the relationship between class and health and the processes involved in the one affecting the other that warrants further disentangling.

Nevertheless, what we have seen in the presentations today has been a 'putting back in' of ethnicity into the relationship between class (or socioeconomic status) and ill-health. James Nazroo's presentation re-emphasised the insight summarised above, and stressed how important it is to look at background to understand ethnic group difference – yet socio-economic status was carrying so much and much that we might otherwise associate with 'ethnic' differences, such as the impact of racism, that I was left perhaps slightly less sure of the distinctiveness of the route between socio-economic status and health: if socio-economic status incorporates so much then it is clear that it will explain health differences and the question thus loses impact. Nilufar Ahmed put ethnicity alongside socio-economic disadvantage (rather than failing to take account of such socio-economic issues as in the traditional approach) as a key aspect of the disadvantage of the Bangladeshi women carers she studied. Her presentation thus raised the question of whether Bangladeshi carers face particular obstacles in caring / accessing services (though language, cultural constraints etc.) with implications for their own health. Saffron Karlsen examined the impact of racism on health status, suggesting that responses directed at minority ethnic groups (rather than characteristics inherent in particular ethnicities, as in the

traditional approach) form an additive factor in influencing health status on top of socio-economic group. Finally, Julia Davis, with her account of the diabetes provision in the innovative (and artistic) Bromley by Bow health centre, made the case that recognition of particular, differential health risks among different communities is only the first step – to actually make a difference means reflecting on and delivering care and advice in ways that patients can respond to. Thus for her, recognising ethnicity was a feature of appropriate care and a factor that mediated the diagnosis and the individual response. It also raised the issue of ethnically sensitive provision within an area that was highly deprived, where the majority experience was disadvantage and where the national majority was in the minority.

Is ethnicity then important after all in relation to understanding and improving the health of ethnic minorities – can an understanding of ethnically related issues provide greater health gains than 'simply' a focus on class differentials?

As I've indicated, the overall view from the groups was that it could and did. The point was made that to ignore ethnicity also ignores the structural disadvantage that exacerbates health risks. Moreover, the issue was raised that there were important power issues to be considered. There was discussion across the groups about who makes the decision about ethnicity and appropriate responses to those from different ethnic groups: there was felt to be a danger that if ethnicity were not made explicit as a potential component of health status –or at least service delivery, then practitioners might be making silent judgements anyway. On the other hand only some minorities might become 'visible' to service providers, through explicit recognition of the role of ethnicity; but in such cases the groups and categories would at least be open to challenge. It was also important to recognise, it was argued, that self-definition might vary from others' definition of oneself It was also pointed out that ethnicity is not a property of minorities – it is part of all individuals' identity and to that extent is part of any encounter – including any health-related relationship.

While, then, there was general support for sensitively delivered services – sensitive to cultural, linguistic and religious difference – and to a holistic approach to health care, there were anxieties both that group-specific interventions needed to be justified by research and that within-group variation should be fully allowed for – including gender differences and generational differences, but also individual differences.

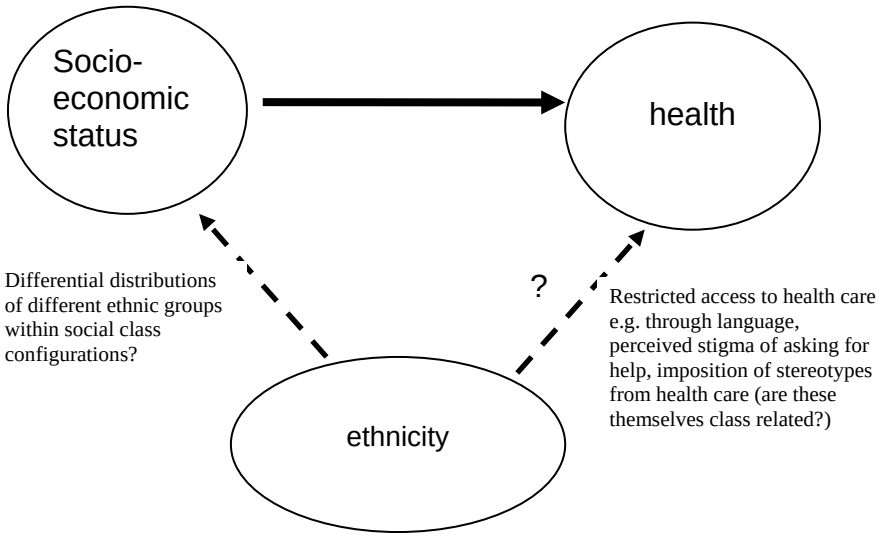
It was also pointed out that class is not necessarily a self-contained concept and can be blurred by processes of migration, for example.

Overall, then, the groups highlighted the problems of dealing with fixed categories – or ones that might be treated as fixed, such as ethnicity or class, and that there were potentially great dangers in particularism. On the other hand, it was argued that a recognition of ethnicity was crucial to appropriate service delivery and that it offered the potential for investigation of dominant groups are paradigms as well as leading to minority-specific research.

Many of these comments seemed both telling and accorded with where I had arrived at during the seminar.
These further thoughts are ones that I would wish to add as reflections on what had been discussed and some additional potential problematisation of the 'putting ethnicity back in', that I have identified in the presentations today.

Firstly it is not a new one – but when looking at what is left when class has been accounted for we need to consider that socio-economic groups are themselves broad distinctions and potentially clumsy. Stratification within classes may be very important with certain ethnic groups lower down within any given class than others. Moreover the very nature of categorical class categories – and the reason, perhaps that they explain health differentials better than straight income, is that they reflect something about wider position – which (without wanting to get into class versus status debates) is bound up with / cross-cut by ethnic group. I don't think this is a reason necessarily for attempting to incorporate all forms of difference within the notion of socio-economic status, I would fear that that would become tautological, I would stick to the notion of class, but be clear about its limitations. This would be particularly so since, as researchers, we are restricted by the measures and variables that are available to us and we both want to exploit them as fully as possible but also be aware of what they are not telling us (the manual, non-manual, unemployed division used, for example, by Karlsen is revealing but is also incorporating huge diversity within the different categories).

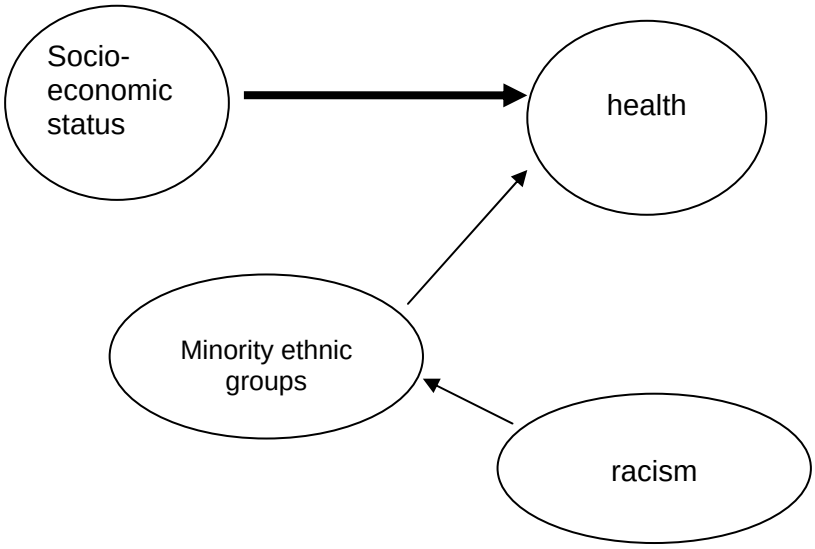
Thus some of the remaining 'ethnic' differences we find after apparently taking account of class could be reflecting extremes of or cumulative class disadvantage. This is pertinent, I think, to Nilufar Ahmed's compelling discussion of carers in Tower Hamlets. The diagram below illustrates that, while the implied effect on the carers' health was via their ethnicity (alongside their socioeconomic status), the actual effect might have been that this particular section of Bangladeshi carers may have been singularly socio-economically disadvantaged, with the impact on their health coming through that disadvantage.



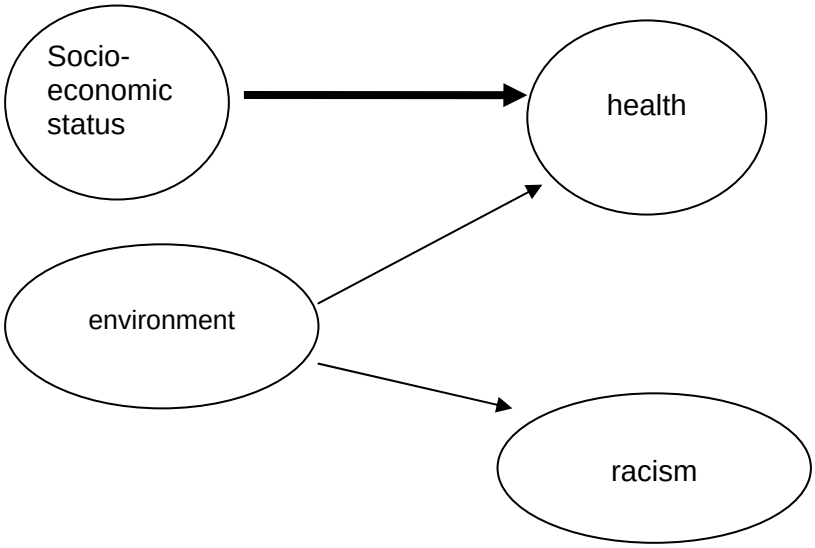
What is the fact of their being Bangladeshi adding in this instance to our understanding of their poor health outcomes? Similarly, one might ask, as one of the participants did earlier on - how much would poor white wives of sick (white) husbands be subject to many of the same things – including the potentially difficult behaviour accompanying the shift from breadwinner to dependant, alongside expectations on wives – and if not wives daughters / daughters in law to care and the health toll of such experiences – and the difficulty of being assertive with services and service providers? The fact that these are Bangladeshi women suggests a particularity of experience, but it is surely worth asking how particular it is.

There is also the question of environment – whether class captures the (admittedly disputed, but nevertheless widely maintained) impact of area effects and environmental impacts that may exacerbate disadvantage over and above a straightforward measure of class based on occupation – and even over and above a measure of worklessness.

Moving on to apply this observation to Saffron Karlsen's study of the impact of racism, if environment has an impact both on health and on exposure to / impact of / recognition of / negative effects of racism, then might we not be seeing an environmental impact in the results of racism that show over and above class? That is rather than an effect of ethnicity stemming from others' responses to it (through racism) illustrated in the diagram below



Might we not instead be seeing an additional (unmeasured) factor contributing to both the higher risks of racism and the poorer health outcomes, in the manner illustrated in the diagram below:



I'm not attempting to deny that racism may be a very significant (and detrimental) factor in the experience of minority ethnic groups, but I think it is important to continue to question the posited processes by which ethnicity is linked to particular outcomes, and, as was done by arguing the case for class as explaining 'ethnic' differences rather more convincingly than ethnicity per se, to be open to different ways of looking at relationships and to challenge

the idea that a statistically significant association necessarily corresponds to a causal effect.

But even if (as I am suggesting) the ethnicity can be taken back out (or partially taken back out), then there may well still be very good reasons for group / community (including groups defined in other ways than through their ethnicity) sensitive health care, which can take account of people's lived experience and their ways of receiving and dealing with information, and which can demonstrate their success and effectiveness – as Julia Davis' diabetes example illustrated.

Moreover, the absolute facts of higher morbidity don't disappear even if we can explain how they appear, and we cannot afford to ignore ethnic group differences until there are not these gross differences in health outcomes – for even though we might spend some time looking in the wrong directions – there is more chance than if we don't look at all the we will note inequalities and that they will, through their visibility demand attention.