

As part of a series exploring the socioeconomic influences on health and wellbeing, this article focuses on ethnicity and its contribution to health inequalities in society

PART 4 OF 5: SOCIOLOGY IN NURSING

The impact of ethnicity on health inequalities

In this article...

- Health challenges facing minority ethnic groups
- Issues concerning racism
- How to define ethnicity

Author David Matthews is lecturer, health and social care, Coleg Llandrillo, Rhos on Sea.

Abstract Matthews D (2015) Sociology in nursing 4: the impact of ethnicity on health inequalities. *Nursing Times*; 111: 44, 18-20. Ethnicity is a complex, sensitive subject that deserves greater attention if we are to achieve health equality for the population. Minority ethnic groups generally have poorer health than the general population, but the reasons are many and much debated. This article explores the impact of ethnicity on health and wellbeing.

The impact of ethnicity on the social distribution of health has been recognised as a serious issue since the 1970s (Karlsen and Nazroo, 2000). Evidence from research shows that, on average, individuals from black and minority ethnic backgrounds display greater levels of poor health than the general population (Barry and Yuill, 2011). While the reasons for this are contested, sociology rejects biological and genetic interpretations due to the lack of evidence and the limitations of such assumptions (Nazroo and Williams, 2006) and, instead, social and economic inequalities are said to be the main causes of this disparity (Karlsen and Nazroo, 2011).

Ethnicity and race

Before investigating the causes of health inequalities between different ethnic groups, it is necessary to separate the concept of ethnicity from race. The terms are often used interchangeably but race is different – and of little analytical use. Race

was often used in the past to argue the existence of biological differences between global populations (Box 1), but this position is discredited – there is no evidence to justify dividing populations along biological grounds (Bartley, 2004).

Global population groups may be characterised as possessing certain genes, but these predominantly influence hair, eye and skin colour, and are of little importance in predicting susceptibility to disease (Bartley, 2004). Different population groups have more biological and genetic commonalities than differences; variations that do exist are no greater than those in a single population group (White, 2013).

Race reduces health disparities to biological factors, thereby marginalising the social forces that are overwhelmingly the main causes for health inequalities among different groups. Focusing on race directs attention at individuals rather than unequal social relationships that cause ill health.

Defining ethnicity

More recent research into the distribution of health has centred on ethnicity rather than race, but defining ethnicity is complex (Mason, 2000). Broadly, it refers to the identification of population groups based on social, cultural and historical variations. Ethnic groups are characterised by organised cultural boundaries such as language, religion and country of origin (Platt, 2006).

Ethnicity is a subjective concept, comprising both self-identification and categorisation (Mason, 2000). Individuals can recognise themselves as belonging to a particular group, with their perception of their own ethnicity influenced by the way

5 key points

1 People from minority ethnic groups generally have poorer health than the rest of the population

2 Ethnicity should not be confused with race, which is a different concept and of little analytical use

3 Ethnicity is based on social, cultural and historical variations

4 There are geographical health inequalities among minority ethnic groups, with London displaying the greatest disparities

5 Research suggests that socioeconomic inequality is the key factor in the health disparities experienced by minority ethnic groups



Minority ethnic groups may experience poorer health than the majority population

they act and think, so ethnicity can be considered as an active construction of its members. At the same time, however, individuals can be categorised by others as belonging to a particular ethnic group.

The arbitrary nature of how an ethnic group is defined is challenging for health researchers, as understanding varies culturally and historically (Annandale, 2014). In Britain, statistics are largely drawn from government data, but this is based on varying interpretations of what constitutes an ethnic group. Examples from the most recent census include white British, white and black Caribbean, black British (of African or Caribbean origin), gypsy and Irish traveller, Indian and Pakistani classifications (Office for National Statistics, 2012). These show that ethnicity is defined by racial understandings as well as cultural and national variations, resulting in a complex picture of Britain's ethnic construction. However, researchers have no choice but to use these classifications (Annandale, 2014); Box 2 shows the ethnicity question recommended for use in England.

Complexity of ethnicity and health

Attempts to understand the impact of ethnicity as a social factor are hampered by the fact that there are few large-scale survey data sets reflecting the social distribution of health among ethnic groups (Annandale, 2014). However, data from a variety of independent and academic sources allows us to establish a broad picture. Using the same classifications as the census, Bécaries (2013) argued that, overall, minority ethnic groups in Britain have poorer health than the rest of the population:

- » Between 1991 and 2011, Pakistani and Bangladeshi women had mortality rates 10% higher than white women;
- » In 2011, men from white gypsy or Irish traveller minority groups, along with mixed white-black Caribbean men, white Irish men and black Caribbean men, all had higher rates of long-term illness than white men;
- » Long-term illness in men aged >65 years was reported by 69% of white gypsy or Irish traveller men, 69% of Pakistani men and 64% of Bangladeshi men, compared with 50% of white men. Women of the same minority ethnic groups reported even higher rates of long-term illness compared with white women.

There are also geographical health inequalities among minority ethnic groups; London has the greatest disparities. Bécaries (2013) states inequalities in London are more severe than the rest of Britain; for example, Bangladeshi women in London

BOX 1. RACE, SUPERIORITY AND INFERIORITY

Imperial expansion between the 17th and 19th centuries led to the classification of different global populations based on the idea of inherent biological variations, drawing on physical characteristics such as skin colour, head shape, body size and hair texture. These variations were used to support the argument that some indigenous populations were naturally inferior to others (Bhopal, 1998). This resulted in the subjugation and exploitation of a large proportion of the global population (Nazroo, 2004). In many cases medical knowledge was used to justify the exploitation and subordination of individuals considered racially different (Annandale, 2014). These ideas have long been discredited.

are 30% more likely than white women to report a long-term illness versus 15% for Britain as a whole.

Mental health studies show that Afro-Caribbeans display higher levels of depression and rates of schizophrenia than the majority of the population (Rogers and Pilgrim, 2014). In general, BME groups are over-represented in mental health inpatient settings (Rogers and Pilgrim, 2014).

Conventional wisdom is that minority ethnic groups display higher levels of poor health, but the health of some is better than in the majority population. Between 1991 and 2011, those of Chinese origin displayed better rates of health than white British people, while white and black African women had lower levels of long-term illness than white British women (Bécaries, 2013).

Although Arab men and women have poorer health than the majority population in London, across the rest of Britain their health is better (Bécaries, 2013). Evidence suggests people of Asian origin are less prone to depression and anxiety compared with the white British population, while Afro-Caribbean individuals are less prone to anxiety (Rogers and Pilgrim, 2014).

Social and economic inequality

Many efforts to explain health disparities have reduced them to cultural factors, suggesting the origins of ill health are found in the cultural norms and values of the minority group, with any disadvantage resulting from their own practices or attitudes. However, this can be seen as a "blaming" approach, as it considers the culture to be at fault (Nazroo, 2004), ignoring contributing social and economic factors.

The second article in this series (Matthews, 2015) argued that socioeconomic status affects health. With the number of people from minority ethnic groups experiencing social deprivation, poverty and unemployment on a scale greater than the majority population (Barry and Yuill, 2011), research has begun to show socioeconomic inequality as a principal cause of the health disparities experienced by these groups (Nazroo, 2010). From research conducted in

the 1990s, Nazroo (2004) concluded there was a strong relationship between socioeconomic status and the health of all ethnic minorities as, once the impact of socioeconomic status was removed, the risk of poor health fell. Evidence from the US supports this, with high-income white and black groups displaying better health than lower-income counterparts (Williams, 2012).

While socioeconomic status has a significant impact, when factors accounting for this are adjusted, there remain health disparities between minority ethnic groups and the ethnic majority. When the health status of individuals in both groups in the same socioeconomic position are compared, individuals from minority ethnic groups still display poorer health. As Nazroo (2004) argued, there is another component of ethnicity that increases the susceptibility of ethnic minorities to poor health: accounting for this "other" factor is not simple and various causes have been identified – one of which is racial prejudice and racism (Annandale, 2014).

The impact of racism

The extent of racial prejudice in Britain is difficult to quantify, primarily because people may be unwilling to admit to it. However, the British social attitudes survey in 2013 showed that 30% of the British population described themselves as racially prejudiced (National Centre for Social Research, 2014). Direct experience of racial prejudice, or awareness that such attitudes exist, can have significant negative consequences for individuals' health, particularly their mental health (Annandale, 2014; Barry and Yuill, 2011). Karlsen et al (2005) argued that experiencing racial prejudice increases the risk of anxiety disorders and depression, as it has among Caribbean, Indian, Pakistani and Irish minorities.

Similarly, racially prejudiced attitudes can be embedded in how society operates, causing social structures and institutions to function in a racist manner. Rather than just focusing on the actions of individuals, we need to look at social structures and institutions that may operate in a

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discriminatory manner and influence the actions and attitudes of those within them. Institutional and structural discrimination can be found in health and other government services in the health sector; for example, it has been argued that the institutional attitudes and practices of mental health services and the criminal justice system have contributed to some of the ethnic disparities identified.

The reasons for the over-representation of black individuals, especially young men, in mental health settings are hotly contested (Annandale, 2014) but one underlying reason is how mental health services and associated institutions respond to them (Rogers and Pilgrim, 2014). The likelihood of individuals being labelled as mentally ill increases in proportion to the cultural gap between those who are labelled and those who are labelling (Horwitz, 1983).

Young Afro-Caribbean men are far more likely to come into contact with mental health services than other groups, especially via the criminal justice system; it is claimed this is because society – the wider public and criminal justice institutions – perceives them as a social threat (Barry and Yuill, 2011). As a result, the criminal justice system is more likely to interpret their behaviour negatively and, as that behaviour is more likely to be “visible” to criminal institutions working in collaboration with the health system, the individuals are more likely to be labelled as having a mental illness.

In this respect mental health services can be viewed as institutions of social control (Rogers and Pilgrim, 2014), based on dominant perceptions of young Afro-Caribbean men exhibiting behaviour seen as a social threat. This is supported by research from the last three decades, which shows this group is more likely than its ethnic majority counterpart to be compulsorily admitted to mental health institutions and placed in locked wards (Rogers and Pilgrim, 2014).

Suggestions of discrimination in the institutional practices of health services are contentious (Bradby, 2012). The purpose here is not to claim that those working in these services are racially prejudiced, but to suggest that the manner in which these services and institutions operate may discriminate against minority ethnic groups due to embedded norms, values and practices that impact on how their health status is understood.

Conclusion

Of all the social determinants of health, the analysis of ethnicity is possibly the most complex. Although important and insightful research has been conducted by

BOX 2. RECOMMENDED QUESTION ON ETHNICITY

What is your ethnic group? Choose one option that best describes your ethnic group or background.

White

- English/Welsh/Scottish/Northern Irish/British
- Irish
- Gypsy or Irish traveller
- Any other white background, please describe

Mixed/multiple ethnic groups

- White and black Caribbean
- White and black African
- White and Asian
- Any other mixed/multiple ethnic background, please describe

Asian/Asian British

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background, please describe

Black/African/Caribbean/black British

- African
- Caribbean
- Any other black/African/Caribbean background, please describe

Other ethnic group

- Arab
- Any other ethnic group, please describe

Source: Office for National Statistics (2015)

academics, the lack of large-scale official datasets is a significant obstacle to developing an understanding of the inequalities experienced by minority ethnic groups. While there is a broad consensual perspective arguing that, on average, these groups experience poorer health, the recognition that some have better health than the majority population, along with numerous competing arguments attempting to explain ethnic disparities, only adds to the uncertainty.

While competing explanations may exist, however, we must not allow recourse to biological explanations using the concept of race. These avoid analysing the social and economic causes of inequality and, consequently, fail to challenge the social and economic structures that create an inequitable society. **NT**

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