The Ethnic Patterning of Health: New Directions for Theory and Research

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Abstract This paper argues that analysis of the ethnic patterning of health has failed adequately to examine the social meaning of ethnicity, while too often becoming enmeshed in unhelpful dualities which counterpose material to cultural explanations, multiculturalism to anti-racism, and sociology to epidemiology. Against the background of anthropological, objectivist and postmodern theories in the broader sociology of 'race' and ethnicity, the paper develops a concept of ethnicity for the purposes of health research. This is used to evaluate biological, migration-based, material, cultural and racism-based explanations for the ethnic patterning of health. It is argued that these types of explanation are best understood within an interactive framework. The methodological implications of this for future research are discussed.

Keywords: ethnicity, culture, health inequalities, sociological theory

Introduction

The study of health and illness and the study of 'race' and ethnicity have constituted two key areas of substantive enquiry in sociology over recent years. It is curious, then, that sociological study of the health dimensions in ethnic experience - or, for that matter, the ethnic dimensions in health experience - has been relatively neglected. Most of what we know about the ethnic patterning of health derives from the work of epidemiologists and clinicians who, although providing an impressive evidential base, have been less concerned with interrogating the social significance of their findings, and have tended to focus on patterns of specific clinical disease at the expense of a broader picture of ethnic health experiences. While sociological insights have been invoked to criticise some of this research, the result has too often been a crudely drawn contrast between the essentialism of explanations which invoke a concept of ethnic 'culture', and...
material explanations which emphasise the role of socio-economic status and, sometimes, racism.

This paper attempts to circumvent such unproductive exchanges by developing a particular concept of ethnicity which, it is argued, can resolve some of the apparent contradictions in existing approaches to health and ethnicity while providing the basis for a more coherent analytical framework for future research. The paper begins by discussing some of the main ways in which sociologists have sought to understand ethnicity. This takes the reader a considerable distance from the familiar territory of studies in 'ethnic health', but it is a major purpose of the paper to suggest that these studies have suffered from a failure to engage adequately with the implications of a broader understanding of ethnicity. Thus, a concept of ethnicity – based principally on the work of Pierre Bourdieu – is developed which, in the third and fourth sections of the paper, is used to criticise the entrenched oppositions of epidemiology:sociology, multiculturalism:anti-racism, material:cultural etc. which currently bedevil the ethnic health literature. The third section examines critically some of the prevalent theoretical approaches to the concept of ethnicity in health research, while the fourth section describes an analytical framework which gives methodological substance to the preceding argument and which, I suggest, might underpin a theoretically informed sociology of ethnicity and health. The implications of this for future research are briefly laid out in the concluding section.

The sociology of ethnicity

The ways in which ethnicity manifests itself in everyday contexts seem straightforward enough to most people. Yet, as with many principles of social life, attempts by sociologists to define and explain the concept have proved curiously difficult. In keeping with the everyday sense of ethnicity, a pragmatic test for a useful theory would be its ability to explain the concept both as a mode of identity (an affective claim by which we identify a human collectivity to which we feel a belonging, thus distinguishing an 'us' from a 'them'), and as a principle of social structuring (by which ethnic collectivities enjoy differential access to a variety of social resources). Analysts specifically interested in health must pose additional questions about the possible relationship between the concept of ethnicity emergent from this identity-structure duality and a systematic patterning of health. In contrast to a common contemporary approach which asks if there is 'too much ethnicity' (Fenton et al. 1995; see also Rogers 1992, Sheldon and Parker 1992) – that is, whether apparently 'ethnic' differences in health can be explained by reference to other, usually material, factors – this paper suggests that the first requirement is an adequate concept of ethnicity whose implications for the systematic patterning of

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health can then be interrogated. It is to this requirement that the remain-
der of the section is devoted.

Comaroff (1987) notes that there is an ontological duality in the way ethnicity has been characterised in sociological thought. On the one hand, it has been regarded as an explanatory principle *sui generis*, which can itself explain various dimensions of human action. On the other, it can be constituted as an object of analysis, something to be explained with reference to other modes of human action. This opposition between objective and objectified recalls the venerable argument in social science between idealists who claim that we live in a neo-Kantian world of the mind's invention, and materialists who insist that social structures are nothing more than the outcome of human agency in the service of practical ends, an argument that students of ethnicity have recast in the competing claims of 'primordialists' and 'instrumentalists'. The former hold that ethnicity is a potent encapsulation of people's fundamental orientation to the world, and thus a stable if not objectively fixed marker of identity, while 'instrumentalists' argue that ethnic symbols are simply part of a repertoire which serves the mobilisation of collective political and economic interests. If such oppositions are frequently overdrawn (Sahlins 1976; Bentley 1987), most interventions have nevertheless invested the bulk of their theoretical energies on one side or the other of the divide, and, as we shall see, their legacy continues to animate a good part of the controversy in the ethnic health literature.

Some commentators have detected an implicit racism in the primordial argument (Mason 1986). However, in contrast to the meta-historical claims of 'natural' differences between peoples which underlie most forms of racism, both positions acknowledge the ultimate arbitrariness of ethnic symbols. Ethnic identities, even for primordialists, invoke myths of origin, and ethnicity is therefore always in some sense a social construct. Nevertheless, there are sharp – if not always explicit – differences in the analytic status accorded the concept by different approaches. As a basis for developing the subsequent argument, I draw out here some of these differences in characterising what I have termed anthropological, Marxist and postmodern approaches.

**Anthropological Approaches**

Despite a longer pedigree in sociological thought associated particularly with the work of Max Weber (Gabriel and Ben-Tovim 1979), the basis for much contemporary thinking about ethnicity was laid when, in the 1950s and 1960s, anthropologists realised that the 'tribes' they had been working amongst might better be conceptualised as interacting ethnic groups (Cohen 1978). While broader debates about the nature of ethnicity now inflect anthropological enquiry, the original response within the discipline – captured most notably in Barth's (1969) seminal collection –
has been enormously influential. In essence, the approach puts flesh on the bones of the 'ethnicity as social construct' argument by suggesting that ethnic distinctions are a classificatory device by which the social world is divided up and made intelligible. Ethnicity thus inheres in artifices of difference selected from the panoply of human attributes: physical, religious, territorial, historical, linguistic, economic, customary and so forth. Special emphasis is placed upon some characteristic or group of characteristics in which it is held that difference inheres, at the expense of other possible dimensions of difference which may well cut across the putative ethnic distinction. Ethnic ascription is therefore a profoundly social process, in which the obvious facts of human variation act as raw material for the construction of ethnic categories. The particular choice of the 'material' by which ethnic boundaries are created – whether biological or cultural – therefore has little significance in itself. The important questions concern how these boundaries came to be constructed in particular historical, social and political circumstances and the consequences of ethnic boundary construction for social life.

The anthropological approach therefore takes the existence of ethnic categories as an analytical point of departure, and trains its attention upon the formation and permeability of the ethnic boundaries themselves (Wallman 1986). An appropriate theoretical rationale for this is provided by Cohen (1985), who discusses with considerable sophistication the use of symbolic representations by which particular 'communities' are able to invest themselves (and by implication others) with social identity. Cohen argues that the essence of symbolic identity is in providing a simplifying metric around which the diversity of attitudes, behaviours and orientations among those actually composing the community are reconciled into a self-conscious identification of common interests. Thus, an internally differentiated 'community' represents itself externally as a homogeneous entity, and constructs other putative 'communities' in similar light. This explains why external descriptions of the nature of community values rarely seem to ring true for members of the community described; community symbols become stereotypes in others' hands.

Societies cannot, however, be divided up neatly into a number of mutually exclusive communities. Communities overlap, and individuals are often able to position themselves strategically in relation to one or more of them. This notion underlies the idea of 'situational ethnicity' whereby, far from representing an ineluctable component of personal identity, ethnic labels can be navigated by individuals to their own ends. Comaroff (1987) provides eloquent testimony to the salience of these processes, even in the context of aggressively maintained social hierarchies such as those of colonial Africa. Although ethnic ascription was an important component of these hierarchies, Comaroff shows that systems of social relations based upon ethnicity nevertheless allowed a considerable degree of purposeful individual manipulation. By extension, it could be argued that a simi-
lar flexibility may obtain in contemporary Britain. For example, one can imagine not only how the same individual may identify themselves with the categories of ‘Black’, ‘Asian’, ‘Hindu’, ‘Gujarati’, ‘Brahmin’ and, indeed, possibly ‘White’, in varying circumstances, but also how these categories may be transformed by appeal to other components of personal identity such as gender, class, education and lifestyle. This is not to argue that the social significance of ethnicity can be, as it were, banished by individual action. No amount of strategic manipulation alters the direction of the racist’s fist. In varying social circumstances ethnic boundaries can be more or less permeable, and the consequences of inhabiting a particular ethnic ‘space’ more or less determinant of social experience. Nevertheless, the concept of situational ethnicity emphasises the complex, processual nature of ethnic categories. Here, the answer to what constitutes an ethnic group or to what ethnic group an individual belongs can rarely be definitive. This insight, though limited, is important. Its implications are further discussed in a later section.

While the anthropological approach as stated emphasises the arbitrary, constructed nature of ethnic categories, it does not provide any account as to why and how ethnic boundaries are constructed. One attempt to do so within a broadly anthropological framework is offered by Comaroff, who argues,

The emergence of ethnic groups and the awakening of ethnic consciousness are . . . the product of historical processes which structure relations of inequality between discrete social entities. They are . . . the social and cultural correlates of a specific mode of articulation between groupings, in which one extends its dominance over another . . . situates the latter as a bounded unit in a dependent and unique position within an inclusive division of labor; and . . . regulates the terms upon which value may be extracted from it. By virtue of so doing, the dominant grouping constitutes both itself and the subordinate populations as classes. (1987: 308)

A similar position is developed by Rex in his work on colonial migrants in British cities (see, for example, Rex and Moore 1967). Rex argues that the systematic exclusion of colonial migrant labour from state welfare redistribution in postwar Britain constituted it as a racialised ‘underclass’. Although Rex rejects primordialism in favour of class analysis, he maintains an explicitly Weberian position in his insistence on a theoretical distinction between ethnicity and class,

when it comes to organisation, consciousness and social bonding, new bonds formed on the basis of sheer class interest are not necessary, because they already exist in the ethnic organisation of those concerned. (1986: 75)
In these approaches, then, while ethnicity is almost of necessity immured in class conflict, it nevertheless remains ontologically distinct from class. Yet, despite the possible ambivalence this lends the anthropological concept of ethnicity towards the identity-structure duality introduced earlier, the approach still leans towards an emphasis on structure since, to borrow a phrase from Sahlins, a focus on ethnic boundaries typically 'is inclined to trade off the semantic value of the categories for their social effects' (1976: 117). As I will argue later, this is also a feature of the rather different Marxist position outlined below.

Marxist Approaches

The title of this section is somewhat misleading, for while many varieties of Marxist analysis have been applied to ethnicity (see, for example, Solomos 1986, Gilroy 1987), only one is discussed here. This is the so-called 'migrant labour model' associated with the work of Robert Miles and Annie Phizacklea (Miles 1982, 1984, Phizacklea 1984) which, curiously perhaps, has exerted considerable influence on the more critical strands of the ethnic health literature (Sheldon and Parker 1992, Ahmad 1993, Fenton et al. 1995).

In contrast to the ontological autonomy accorded the concept of ethnicity in the anthropological approach, the migrant labour model – under the influence of a strong Marxist materialism – regards ethnicity as a reification, a fetish of capitalist relations of production. Thus, any theory which accords analytic status to a concept of ethnicity confuses the ideological character of everyday ethnic categories with the means of their analysis. As Miles puts it,

I recognise that people do conceive of themselves and others as belonging to 'races' . . . but I am also arguing that these categories of everyday life cannot automatically be taken up and employed analytically by an inquiry which aspires to objective or scientific status (1982: 42).

For Miles and Phizacklea, distinctions between 'race' and class are false constructions, obscuring the extent to which 'race' itself is merely an ideological product of 'racialised' social relations. For example,

In the historical instance of labour migration from the New Commonwealth to Britain since 1945, the political and the ideological have had determinate effects, simultaneously with the economic, in creating and reproducing a racialised fraction of the working class (and other classes). Thus, this group of migrants . . . have been allocated to and are being reproduced within a range of positions within and outside production relations (Miles 1984: 229).
If this formulation seems bafflingly vague, it is perhaps because Miles is attempting to square a circle. On the one hand, to avoid the charge of a crude reductionism of race to class, he seems to argue that the specific form of the ‘racialised class fraction’ is an irreducible consequence of the totality of social relations in a given society. On the other, to preserve the encompassing rationality of a ‘scientific’ Marxism, this form is subordinated to the material logic of the production process (see also Miles 1984: 233). Despite the sophistication and empirical depth of Miles’s more recent work (1989, 1994) this remains a persistent tension in the migrant labour approach. Thus, its anti-essentialism only goes so far, for behind the concept of racialisation – elusive, perhaps, but never far away – is the notion that ‘race’ and racism serve the interests of a social order necessarily linked to the functional demands of capitalism.

In terms of the identity-structure duality orienting my own approach to ethnicity, the migrant labour model provides a well-rehearsed argument on the question of structure, but can only treat identity as a consequential (and, indeed, regrettable) epiphenomenon of the latter. However, Miles’s attempt to dissolve the race-class duality (and, implicitly, the corresponding opposition between identity and structure) in the interests of ‘objective’ analysis has important implications which are developed further in a later section.

Postmodern Approaches

While writers like Miles reduce ethnic categories to another level of putatively ‘objective’ explanation, analysts influenced by postmodern and post-structuralist thought eschew any appeal to notions of a rational, exterior objectivity. Instead, they affect a more radical deconstruction of everyday ethnic concepts and their analysis in academic debates, treating all such narratives of human experience as nothing more than partial and partisan constructions of the social world (Rattansi 1994). Opposing any claim that rational standpoints from which to evaluate the social world can be uncovered, postmodernists view the classical theories of Marx, Weber and Durkheim which underlie in one form or another most of the analytical approaches to ethnicity described in this paper as ‘grand narratives’ of modernity which, in attempting to explain, resolve or transcend the social products of modernity by procedures constituted within modernity itself, merely entrenched the contradictions of their putative ‘rationality’ (Foucault 1970, Baudrillard 1988). This amounts to a kind of super-idealism: not only do people think up their world, they also inevitably think up the way they think this thought-up world works. In this sense, there is no single ‘postmodern approach’. Postmodernism can only destabilise other analytical orientations from within, by claiming to reveal how these orientations are themselves constitutive of the objects of their enquiry.

Despite this nihilistic epistemology, those influenced by postmodernism
frequently ground their arguments by drawing attention to the increasing uncertainties of social life in a 'postmodern' world. Here, the old productivist determinisms linking class position and ideology are replaced by a more ambiguous politics of consumption which focuses upon use values, cultural spaces and the body. Appadurai (1990) argues that the globalisation of political relations and mass communication creates heterogeneous local communities of migrants and an increasingly homogeneous 'world culture' at one and the same time. This, and an accompanying sense of alienation may break open categories of hitherto ascribed social status such as ethnicity. According to bell hooks,

The overall impact of postmodernism is that many other groups now share with black folks a sense of deep alienation, despair, uncertainty, loss of a sense of grounding even if it is not informed by share circumstances. (1991: 27)

Here, ethnicity shades almost into a rootless local pluralism, and it has even been said that contemporary welfare policy breaks the links between production, consumption, culture and ethnicity (van Amersfoort 1992).

Postmodern thought has, on the whole, been cautiously received by those concerned with the sociology of ethnicity. It has been noted that while notions of 'difference' and 'otherness' are central to the postmodern critique of rationality, the voices of the ethnic 'other' have seldom been heard in postmodern debates on the limitations of European thought (hooks 1991, Slater 1994). Indeed, more broadly, the extent to which the crisis of representation which typifies postmodern thought is a general property of contemporary life or an anxiety confined mainly to certain academic elites is rarely addressed in postmodernist writings (Miller 1994). Keith and Cross have argued that while postmodernism celebrates ethnicity 'in the collage of the exotic ethnic pick-and-mix' (1993: 8), it consistently elides the role of migrant labour and its legacy in the urban political economies which have enabled a postmodern cultural politics to be articulated. On the other hand some writers have endorsed postmodernism's anti-essentialism, its refusal to accept the groundedness (and therefore the oppressive potential) of any category, including 'black' or 'female', as well as its shift from the structures of production towards an emphasis on consumption, identity and the body (hooks 1991, Rattansi 1994).

What, then, are the implications of the postmodern approach in terms of the identity-structure duality set out earlier? Postmodernism dissolves it absolutely. In keeping with its radical anti-essentialism, there is no such thing as ethnic identity, only identities, and social structure is likewise a reified conceit of the sociologist's gaze. Yet despite its current vogue in sociology, there are some obvious problems with this position as a disciplinary foundation. Not the least of them is the complete relativism of a complete anti-essentialism, a problem which Rattansi (1994) acknowl-
edges but does not address. Taking gender as an example, he argues that since “all subjects are produced by relations of power and knowledge’ the category ‘women’ loses its analytical stability because ‘gender is not constructed in a consistent form in varying historical contexts’ (1994: 34). Thus, unable to make general claims about any category for fear of the crime of essentialism, every category must be accorded its own specificity, and sociology becomes nothing more than a gigantic mirror to the social world. This in fact seems to typify postmodern writing on ‘race’, with its constant allusions to ‘discourses’, ‘diversities’, ‘racisms’ and ‘racialised identities’. It is as if the use of the plural and the passive voice can itself effect a theoretical transcendence of now unfashionable questions like agency and determination. But it is impossible to talk sensibly about society in this way. And, indeed, Rattansi makes constant reference to highly essentialist notions such as ‘the minority communities’, ‘the West’ and even ‘the Western project’. I shall argue in the following section that such essentialism is not always inappropriate, but it can hardly be justified in the name of postmodernism. The contradictions in Rattansi’s argument reflect the insuperable difficulties of coupling a ‘postmodern frame’ to a sociological enterprise which attempts to do more than simply deconstruct other accounts of social life (see also Bourdieu, 1984).

On matters of identity, some writers have detected an element of sophistry in the postmodern onslaught against essentialist categories (hooks 1991, Keith and Cross 1993). As hooks has put it,

It never surprises me when black folks respond to the critique of essentialism, especially when it denies the validity of identity politics by saying ‘Yeah, it’s easy to give up identity, when you got one.’ Should we not be suspicious of postmodern critiques of the ‘subject’ when they surface at a historical moment when many subjugated people feel themselves coming to voice for the first time. (1991: 28)

Thus, while postmodernism might criticise the very basis of an identity-structure duality, its arguments run into several difficulties of their own.

An Alternative Approach: Bourdieu’s Theory of Practice

Of the three approaches examined above, the anthropological and Marxist perspectives place their emphasis upon the second aspect of the identity-structure duality. While both acknowledge a role for identity, it is secondary to and contingent upon structure. Postmodernism rejects the duality, but is forced surreptitiously to re-invent its basic form. None of the approaches addresses both identity and structure adequately, or offers a convincing transcendence of the duality. However, it is suggested in this section that the theory of practice developed by Pierre Bourdieu (1977) can offer a more fruitful approach to the problem.

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Bourdieu begins his argument by suggesting that while modes of analysis he terms 'objectivist' (such as the anthropological and Marxist approaches described above) break usefully with the idea that primary knowledge of the social world (i.e. our self-conscious explanations for our actions) is sufficient to explain it, they grasp social practices from the outside, artificially constructing them as the mechanical consequence of determining 'objective' structures. In some respects, this resembles Sahlins's 'law of diminishing returns to functionalist explanation' (1976: 77), whereby the more distant the level of explanation from the level of practice to which it refers, the less complete can be the explanation of the practice itself. The solution, however, is not a relativist return to the simple truths of primary knowledge. Rather, for Bourdieu, it is necessary to effect a second break in which practices are grasped from the inside 'in the very movement of their accomplishment' (1977: 3) by a theoretical construction of the dispositions which generate them.

Crucial to this theory of practice is Bourdieu's notion of the 'habitus'. The habitus, the 'durably installed generative principle of regulated improvisations' (1977: 78) is the set of dispositions which structure people's social, spatial and temporal orientations to the world. These orientations are not conceived as determining practice in the manner postulated by objectivism, but rather as structuring, enabling and delimiting the set of improvisations which constitute what Postone et al. call the 'game of social interaction' (1993: 4). However, although the habitus is the source of meanings which people consciously manipulate, the habitus itself – the generative scheme which is inculcated at an early age – acts unconsciously. Thus, while actions and identities may be purposive and strategic, their orienting logic is simply habitual, mediated by symbolic representations which implicate,

a whole body of wisdom, sayings, commonplaces, ethical precepts ("that's not for the likes of us") and, at a deeper level, the unconscious principles of the ethos which . . . determines 'reasonable' and 'unreasonable' conduct for every agent. (Bourdieu, 1977: 77)

Thus, the logic of practice resists the demands of purely instrumental reason, and the generative schemes of the habitus help naturalise the arbitrariness of the established order (1977: 164). Moreover, this 'order' – social structure itself – intersects with the genesis of individual human agency via the schemes of the habitus. Identity and structure are here related in a 'dialectic of objectification and embodiment', which, Bourdieu suggests, dissolves theoretical oppositions between constructions privileging one term or the other. In his rather arcane terms,

the mental structures which construct the world of objects are constructed in the practice of a world of objects constructed according to
the same structures. The mind born of a world of objects does not arise as a subjectivity confronting an objectivity: the objective universe is made up of objects which are the product of objectifying operations structured according to the very structures which the mind applies to it. (1977: 91)

These are complicated and somewhat abstract arguments. However, they can, I believe, assist in specifying the nature of ethnicity. At the same time, they may be clarified by more concrete illustration. It is to these tasks that the remainder of the section is dedicated.

Figure 1 represents alternative formulations of the identity-structure duality implicit in some of the approaches described above. Part (a) illustrates objectivist approaches in which identity – affective affinities within ethnic categories – arises as a consequence of structural differentiation. This ordering is reversed in the idealist and primordial models illustrated in part (b), where structure is in some measure the outcome of pre-existing identities. In part (c), however, the theory of practice posits the ‘objective’ conditions of structure and the subjective affinities of identity as mutually constituted by and constitutive of the habitus.

(a) Objectivism

(b) Idealism

(C) Theory of Practice

Fig. 1. Identity and structure in theories of ethnicity

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The anthropological and Marxist objectivisms represented in part (a) contain a model of ethnicity in which, to quote Bentley, ‘ethnic identities appear as empty vessels whose content is anchored externally in conventional but arbitrary oppositions between categories’ (1987: 36). By contrast, the theory of practice holds that while in some ultimate, meta-historical sense the signifiers of ethnicity are indeed arbitrary, their emergence and perpetuation in given social contexts entail particular and concrete outcomes from those contexts which are deeply ingrained in the schemes of practice. In this sense, ‘race’ and ‘ethnicity’ – as represented, for example, by the physical markers of ‘blackness’ and the religious-cultural markers of ‘Jewishness’ – can have particular meanings and historical trajectories which do not ‘feel’ arbitrary, and which may directly and independently affect the societies in which they are articulated.  

Although, pace Miles’s Marxist objectivism, such ethnic categories may very well be manipulated instrumentally for or against the interests of the contemporary (capitalist) order, it does not necessarily follow that they are a creation of that order.

A major advantage of Bourdieu’s theory of practice is that it can provide a non-essentialist but not, as it were, an anti-essentialist account of social categorisation. Using examples and metaphors drawn from analysis of kinship and language, Bourdieu shows how people strategically manipulate social categories, but always within the orienting logic of the habitus. This establishes a firmer theoretical basis for concepts such as situational ethnicity. Like kinship, ethnicity provides models through which power is both disguised and contested ‘under the veil of enchanted relationships’ (Bourdieu 1977: 191), and in which an objectified self-identity is constantly engaged in dispute with the objective identity imputed by others. These models are worked upon by people with a diversity of motives. Thus, a binary ethnic category such as black:white may inform, inter alia, racists seeking to subjugate, states and bureaucracies seeking to control, co-opt or placate, researchers seeking to analyse and activists seeking to organise. Just as we need to be cautious of essentialising such a category (normally achieved painlessly enough by converting black to ‘black’), so we need to be cautious of abolishing it completely, not only because we then encounter the difficulties either of a postmodern relativism or of objectivist claims to a higher truth, but because analytically we then abolish our object: constitutive practices at work, or, in Bourdieu’s words, ‘the double reality of intrinsically equivocal, ambiguous conduct’ (1977: 179). Debates in academic, political and everyday contexts about the location and rigidity of ethnic boundaries are at the very heart of this constitutive process, but, from an analytical perspective, lose their force when they abandon a dynamic and relational understanding for prescriptive, formal models of what ethnicity ‘is’. For similar reasons, Rattansi (1994) rightly criticises the ‘strong classificatory’ approach to ethnicity which some sociologists adopt. However, the failure of such an approach to provide a

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convincing general account does not imply that the empirical complexity manifested by constructions of ethnicity resists any analytical generalisation. Beneath the shifting terrain of ethnic boundaries lies a symbolic logic which denies the legitimacy of many potential ethnic allegiances even as it enables others. In so far as the categories which emerge have distinct histories and social implications, putting them in the service of analytical objectives need not therefore always be the essentialist outrage which some commentators have identified. For example, as it was suggested above, in Britain the referent of skin colour constitutes an intractable ethnic boundary which informs the constructions of racists and anti-racists alike. In Haiti, on the other hand, perceptions of colour are transformed by those of status such that it never makes sense to call someone ‘black’ simply by virtue of their appearance (Trouillot 1990). These differences may reflect nothing more than historical circumstances. The analytical task, however, lies in revealing how these circumstances are related to the logic of ethnic categories in everyday life.

It is in providing a general account of this logic that Bourdieu’s approach is apposite. There are, to be sure, some problems and evasions in his work (for a critical account, see Calhoun et al. 1993). In particular, the extent to which he provides an account of the relationship between ethnicity, power and social structure which genuinely transcends the antinomies of other approaches could be questioned. While his ‘dialectic of objectification and embodiment’ deals in general terms with the limits of habitus and its relation to ‘objective’ structure, the solution may seem unsatisfactorily vague.³

At the same time, one could look to other analysts to provide a foundation for the symbolic logic of ethnicity. For example, Comaroff (1987), quoted above, develops a more traditional anthropological argument for the transformation of separate groups into economic classes which concretise their ‘ethnic’ differences. Domínguez (1977) shows how ethnic labels can act as a repository of historical meanings which are deployed in relation to the contingencies of contemporary politics, and Miller (1994) argues that prior ethnic distinctions objectify a society’s image of itself even in situations where the cultural practices associated with these distinctions merge.⁴ The detail of these authors’ arguments is developed through particular ethnographic examples, as indeed is much of Bourdieu’s work, and one should perhaps resist the temptation of forced and context-free comparison. Nevertheless, my aim for present purposes is merely to suggest that the emphasis common to these approaches, whereby – crudely – ethnicity emerges from the political manipulation of historical distinctions by diverse groups, assists in transcending some of the more unhelpful consequences of other theoretical orientations.
Health and Ethnicity: Theoretical Perspectives

Now armed with a theoretical approach to ethnicity, the paper turns to an examination of research on the relationship between ethnicity and health in Britain. This research has developed mainly in the last twenty years or so in the context of the postwar migrations from the Caribbean, East and West Africa and the Indian subcontinent ('South Asia') which have mainly, though not exclusively, defined common contemporary ethnic distinctions. It constitutes a complex and sometimes apparently contradictory body of evidence, while its over-reliance upon specific disease and migrant studies further inhibits casual generalisation (see Smaje 1995a, for a critical overview). Nevertheless, the existence of distinctive health patterns in the ethnic groups defined above is broadly accepted. Finding appropriate theoretical positions within which to interpret it has proved much more controversial. Some analysts have made reference to the sociology of ethnicity in order to debate appropriate explanatory frameworks, while others have looked for parallels in the literature on class inequalities in health. However, arguably predominant has been what might be termed the 'epidemiological approach' which is typically devoid of any specified concept of ethnicity at all. Marmot has provided the most explicit defence of this position,

The vagueness of the term 'ethnic'... does not invalidate this area of study. If two groups, however defined, have different rates of disease, productive aetiological explanations may follow. (1989: 13)

The first sentence condenses an epidemiological objectivism. From the privileged position of observer, the epidemiologist constructs meta-theoretical ethnic categories prior to empirical and analytical engagement (meta-theoretical, but not a-theoretical: why, for example, is the aggregation 'Asian' so commonly employed?). This is not an inappropriate procedure. Against the wilder claims of social constructionism, I would defend the utility of an epidemiological approach which shows, for example, that the perinatal mortality rate among babies of Pakistani-born women in Britain is nearly double that of the general population. Yet while, for Bourdieu, objectivism is a 'necessary moment in all research', it also 'demands its own supersession', and it becomes 'necessary to pass ... from statistical regularity ... to the principle of the production of this observed order' (1977: 72). Here, Marmot's position begs the question of whether objectivist ethnic categories 'however defined' can ever be usefully preserved in the subsequent phase of aetiological explanation. In practice, as a number of commentators have argued, epidemiological explanations often entrench crudely essentialist notions such as unitary ethnic 'cultures' (Ahmad 1994).
A justifiable but ingrained suspicion of clinically-oriented, objectivist models among the more sociological writers on health and ethnicity may explain why a paper by Sheldon and Parker (1992), which drew together many of the arguments against this approach, has escaped criticism for its own brand of objectivism. Paraphrasing from Phizacklea's (1984) migrant labour model, Sheldon and Parker argued,

if public health workers continue to use the term 'race' because people act as though race exists, they are guilty of conferring analytical status on what is nothing more than an ideological construct. (1992: 105)

In effect if not intent, ethnicity for Sheldon and Parker is merely a proxy for various kinds of social disadvantage, and the appropriate research strategy must be to focus upon the latter. Clearly, there is considerable merit in emphasising the material and social marginalisation of minority ethnic groups and its relevance for understanding patterns of health (a position informing overviews by Baxter and Baxter 1988, Kushnick 1988, Ahmad 1992). However, as with the 'too much ethnicity' aphorism of Fenton et al. (1995), very often the argument is put much more strongly: if the ethnic patterning of health can be explained purely on the grounds of socio-economic disadvantage then the status of ethnicity as a relevant analytical variable is undermined. There is no theoretical basis for this position. If it were possible to demonstrate such a result (and this is doubtful) the key empirical question would simply shift to the nature of the relationship between ethnicity and socio-economic status. Here, of course, the migrant labour model has ready-made answers which, depending upon the subtlety with which it is deployed, skirt close to a reductionism of ethnicity to class. However, as I will argue in the following section, many insights are lost if the concept of ethnicity is simply emptied into class disadvantage in this way.

Another important analytical orientation in attempts to explain the ethnic patterning of health has been informed by the debate on class inequalities in health. Attention to this question first rose to prominence with the publication of the Black Report in 1980 (Townsend and Davidson 1992). To account for the inverse association found between social class and premature mortality the Black Report proposed four categories of explanation: artefact, selection, cultural and material, arguing in favour of material explanations (i.e. the direct or indirect effects of environmental and economic deprivation) as the principal factor. Andrews and Jewson (1993) sketch a similar but expanded framework for examining the ethnic patterning of health, which incorporates the additional categories of biological/genetic factors, selective impact of health care, migration factors and racism (see also Smaje 1995a).

The Black Report's categories have provided a useful schema within which subsequent attempts to account for health inequalities have been
framed. In addition, they have the merit of emphasising the multifactorial basis of health inequalities. However, the choice of these particular categories has also had some unfortunate consequences. Debate has become ensnared in a largely political opposition between, on the one hand, a (radical) emphasis on the material or structural determinants of health, and, on the other, a (conservative) privileging of cultural explanations embedded in the notion of unhealthy individual lifestyles. This opposition is replicated in the literature on ethnic patterns in health, with 'cultural' explanations which appear to 'blame the victim' counterposed to material ones which 'blame society'. A similar opposition appears in the anti-racist critique of multiculturalism, in which it is suggested that the well-meaning efforts of the latter to celebrate cultural variety reifies cultural difference and deflects attention from persistent social inequalities. A key aim of this paper is to attempt to resolve some of the divergent implications of these approaches and categories of explanation into a more consistent approach to ethnicity and health.

Explaining the ethnic patterning of health

This section evaluates the contribution of various kinds of explanation for the ethnic patterning of health. The aim is not to summarise the weight of the empirical evidence - for which reason, no discussion is offered of artefact explanations - still less to apportion degrees of importance to different approaches. Rather, my purpose is to preserve where appropriate the insights of existing research while attempting to place them within a broader critical context. To orient the discussion, an explanatory framework based on Andrews and Jewson's (1993) expansion of the Black Report's categories is employed. It is not suggested that these categories are analytic isolates. Indeed, the main argument of this part of the paper is that treating each factor separately is to miss a crucial dimension. In particular, it is suggested that the well-worn debate about the competing claims of 'material' versus 'cultural' accounts of ethnic patterns in health has outlived its usefulness.

A biological legacy? The role of genetic factors

Accounting for the ethnic patterning of health on the basis of genetic factors constitutes an explanation of the longest possible historical range. Here, contemporary experience of the material and social environment is mediated by the biological legacy of earlier environmental adaptations. To account in these terms for ethnic patterns in health, however, it needs to be established that,

1. Systematic genetic differences exist between populations which can be aetiologically linked to disease processes.
It has been shown that 75 per cent of genes (i.e., functional segments of the DNA molecules which mediate the composition of body cells) are identical in each human being. The remaining 25 per cent — so called ‘polymorphic’ genes — can occur in two or more forms (‘alleles’). It is an oft-repeated finding that there is no allele which uniquely identifies any defined population which is constituted as a ‘race’. Regardless of how such populations are defined, genetic variation cuts across them. In fact, it would seem that about 85 per cent of human genetic variation occurs at the between-individual level within given local populations, and only about 7 per cent between ‘races’, as they are typically defined (Jones 1981, Rose et al. 1984).

This finding is commonly — and correctly — used to demonstrate the fallacy of imputing an underlying biological consistency to human ‘races’. However, it does not mean that there can be no role for genetic explanations in the ethnic patterning of health. Polymorphisms are not necessarily distributed at random throughout human populations. For example, there are some average physiognomic differences between particular geographically defined populations which reflect between-population genetic differences, and around which people have constructed notions of ‘racial’ difference. Similarly, there is a non-random distribution of the polymorphic genes which underlie the occurrence of certain hereditary diseases such as phenylketonuria and haemoglobinopathies like sickle cell disease. Phenylketonuria is little known in African populations but occurs with greater frequency in North European ones. The reverse holds true for sickle cell disease.

If there can be a genetic element to the ethnic patterning of health, how can this be reconciled with the sociological emphasis on ethnicity as a social construction? The answer lies in the correlation between the social categories defining ethnicity and the biological legacy of differentiated geographic populations. Commonly identified ethnic categories in Britain are the ideological reflection of a colonial historical process which traversed the globe bringing hitherto distant populations into relationships with one another according to the vicissitudes of its own material dynamic. The notion of ‘Asians’, ‘Africans’ or ‘African-Caribbeans’ as ethnic groups — indeed the entire post-Columbian history of the Caribbean — is predicated upon this logic. The ‘ethnic groups’ gathered in the postcolonial metropolis therefore reflect a recent history of highly varied geographical-environmental origins, and it should therefore come as little surprise that genetic differences exist between them.

At the same time, attention to genetic explanations should not mislead. For example, while ‘African’ or ‘African-Caribbean’ ethnicity may usefully be regarded by health professionals as a risk factor for sickle cell
disease, the true indicator for the condition is the presence of the relevant gene forms, which has nothing to do with ethnicity *per se*. Moreover, the contribution of wholly genetic disorders to the overall burden of disease is in fact rather small. Most diseases, albeit that they involve a genetic component which may vary between ethnic groups, are enormously influenced by environmental factors. Indeed, it is a biological truism that the effects of genotype are always mediated by environmental factors (Cooper and David 1986). Thus, it is in the consequences of ethnic categorisation for environmental experience that the bulk of explanatory potential lies. These consequences are, of course, *social* consequences. Despite a residual role for genetic explanations, the key processes affecting the ethnic patterning of health are therefore sociological rather than biological.

*Migration processes*

Although many writers are suspicious of accounts which, in emphasising migration, turn attention away from the socio-political forces which continue to impinge upon established minority ethnic populations, nevertheless, slightly more than half the people who classified themselves in the 1991 Census into ethnic groups other than ’White’ were born abroad (Smaje 1995a). If health determinants exist which are associated with migration, it is important that they are not neglected.

Four kinds of migration-based hypotheses for the ethnic patterning of health can be advanced. First, it may be that exposure to particular health determinants in the country of origin continues to exert an influence upon health experience in Britain, either directly in migrants themselves or in the children of migrant women exposed to these influences. It has been suggested that both the low incidence of respiratory disease and the high incidence of coronary heart disease among South Asian populations may be partially explicable in these terms (Marmot *et al.* 1984, Williams 1993).

Second, there may be selection or cohort effects acting upon health in migrant populations. The concept of health selection refers to the possibility that the social patterning of health results from the effect of health itself in allocating social position, rather than *vice versa*. Clearly, one’s ethnicity is entirely independent of health, but this may not be true of migrant status. Migrants may be positively selected for health – as with ambitious people looking to improve their prospects by travelling to work abroad – or negatively selected, as with socially marginal, and perhaps mentally ill, people moving on from communities which cannot support them.

In view of the emphasis on labour in postwar migrations, it would be surprising if some kind of healthy worker effect – the notion that a population comprised of those seeking work are likely to be more healthy than a general population including those not in the labour market – did not
manifest itself among migrants to Britain. Indeed, superior health outcomes – as measured by indicators such as all cause mortality or psychological symptom levels – among otherwise disadvantaged migrant populations have often been attributed to positive selection (Cochrane and Stopes-Roe 1981, Marmot et al. 1984). There is also some evidence of negative selection among distinct sub-populations of Irish migrants (Williams 1992). In other cases, such as among refugees, selection effects are likely to be weaker. However, few studies have directly examined the existence of health selection, doubtless due to the extremely detailed data required for such an undertaking. Plausible selection hypotheses can be constructed to account for more or less any observed patterning of health, but they are difficult to test empirically. It is therefore important that selection explanations are not invoked indiscriminately where other kinds of argument appear to fail. Moreover, selection is likely to be of diminishing importance as the period of primary migration recedes. Nevertheless, its potential to explain part of the ethnic patterning of health should not be discounted.

The selection approach can also be broadened to encompass the role of cohort effects in migrant health. While conventional ethnic labels such as ‘Asian’ conjure images of an undifferentiated migrant population, there is a need to go beyond this, not merely in distinguishing between South Asians of different nationality or religion, but also in considering the finely-grained process by which particular sorts of people migrated to Britain from particular local areas and at particular times. It may well be that the specificity of these migrations was associated with distinctive health experiences or orientations which continue to exert an influence in Britain.

Third, it is appropriate to examine the broader complex of experiences and expectations attending the migration process. This may encompass disparate factors including: psychosocial effects of migration itself (Hull 1979); the effect of pre-existing expectations and beliefs in transforming the experience of conditions in Britain (Andrews and Jewson 1993); and long-term intentions to remain in Britain and their impact in financial and psychosocial terms (Anwar 1979). Detailed migrant history approaches have been little employed in examining the health of migrants to Britain, yet they may be useful in providing a subtler account of particular experiences and their legacy than is possible from the data available from routine sources, upon which most existing knowledge of migrant health rests.

Finally, the social and economic context of primary migration continues to exert an influence beyond the migrant generation. As the work of Rex and Moore (1967), Smith (1989) and others has shown, Britain’s postwar demand for colonial migrant labour and the attendant ‘racialised’ patterning of welfare state provision has concentrated minority ethnic populations spatially and socially, and affected access to

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resources such as housing, employment and education. This has had long-term socio-economic effects which undoubtedly contribute to patterns of health experience. It is clearly inappropriate to isolate migration alone as the variable of interest in examining these effects; they must be considered within the broader historical context of British racism and the demand for colonial labour, perhaps along the lines of the migrant labour model examined above (Miles 1982, 1989). Nevertheless, it is impossible to make much sense of the cluster of issues – inner city residence, economic marginality, housing disadvantage – which affect the health of minority ethnic groups in contemporary Britain without making reference to the recent process of colonial labour migration.

Material factors

There can be little doubt that material factors such as employment and housing disadvantage have a major impact upon the health of people from minority ethnic populations. Having said this, such statements are more often asserted than empirically demonstrated. Remarkably few analyses have attempted to examine exactly how material factors may influence health within particular ethnic groups. Most commonly, research findings simply report values for some dimension of health between ethnic groups, thus failing to indicate the extent to which these may reflect differences in socio-economic status between ethnic groups (see Smaje 1995a). Sometimes researchers control statistically for such differences, particularly on the basis of readily available data like social class (a measure based upon occupation) or, less commonly, housing characteristics or employment status (Ahmad et al. 1989, Fenton et al. 1995). The latter are among the most important and sophisticated analyses of the ethnic patterning of health in Britain. However, there is a more general danger that the use of techniques which adjust for socio-economic status, treating it as a confounding variable in the relationship between ethnicity and health, can have the unfortunate effect of directing attention away from a key analytical question, namely the nature of the relationship between ethnicity, socio-economic status and health.

Three problems may result from this statistical sleight of hand. First, there are serious doubts about the validity of variables like social class as useful general measures of socio-economic status (Benzeval et al. 1995). Moreover, there is some evidence to suggest that such variables exhibit differential validity between ethnic groups, thus introducing the possibility of residual confounding in statistical results where these variables are controlled across ethnic groups. For example, it has been argued that patterns of occupation and gender relations differ between ethnic groups such that people from different groups ranked in the same social class do not enjoy equivalent social standing, as the use of the social class measure assumes (Coronary Prevention Group 1986; Ahmad 1994). The assumption that
socio-economic status is controlled when considering health across ethnic groups among people in the same category is therefore undermined.

Second, attempting to control for socio-economic status on the basis of commonly available variables does not help to advance understanding of how socio-economic circumstances affect health. Indeed, without carefully developing and examining explicit models of the social processes by which material factors impact upon health some rather misleading results may be produced. For example, national comparisons of health status between ethnic groups which control for social class may conceal the extent to which the constrained residential options of many people from minority ethnic populations are linked both to their health and their occupational status. Moreover, if area of residence exerts an independent effect upon health, as a good deal of recent research appears to indicate (see, for example, Humphreys and Carr-Hill 1991), closer attention needs to be paid to the highly dissimilar geographic distributions of different ethnic groups, and to the range of possible factors explaining the independent effect (this issue is discussed more fully in Smaje 1995b). There may also be much more finely grained processes at work such as ethnic differentials in the impact of social roles and social support on health, which are missed in simply controlling for material factors on the basis of a small number of proxy variables (Williams et al. 1992, Benzeval et al. 1995). More generally, controlling for such factors across ethnic groups assumes that they operate in the same fashion, with ethnicity itself acting merely as an additive effect. This ignores the extent to which the socio-economic processes affecting health may vary between ethnic groups.

Finally, controlling for socio-economic factors in the manner described above tends to desocialise and de-historicise the processes by which material factors affect the health of ethnic groups. This leads straight back into the debate about the ontological status of ethnicity outlined in the previous section, a debate which the 'too much ethnicity' argument mentioned above short circuits. If it is held that ethnicity is in any sense conceptually distinguishable from class, then studies which describe how much the ethnic patterning of health is 'explained' by socio-economic status, though formally accurate, elide important questions about the disparate ways in which socio-economic status may be produced and reproduced in different ethnic groups. Here, an appropriate account of the relationship between socio-economic status and racism is required, a point which will be examined further below. In summary, while socio-economic factors are of crucial importance in understanding the ethnic patterning of health, more work of both an empirical and theoretical nature is needed in examining the processes by which such factors operate.

Cultural Factors

Another possibility is that cultural factors underlie the ethnic patterning of
health. Unfortunately, researchers have often invoked 'culture' somewhat lazily as a convenient explanatory category in the absence of other convincing candidates. The concept of culture deployed is thus residual, undifferentiated and essentialist, with little analysis of which particular cultural elements may protect or damage health, and the context in which they occur. Moreover, such explanations are often ethnocentric, suggesting implicitly that the wilful pursuit of 'unusual' cultural practices is inevitably accompanied by departure from the health 'norms' of the ethnic majority (Donovan 1984, examines several examples). It is hardly surprising, then, that cultural explanations have been 'bitterly attacked by many social scientists for ethnocentrism, covert racism, diverting attention from racism, "blaming the victim", reification and gross oversimplification (Andrews and Jewson, 1993: 148).

It is nevertheless a central contention of this paper that research needs to re-engage with the possibility of cultural explanations for the ethnic patterning of health. There are a number of dimensions to a revised cultural framework. First, as Sweeting and West (1995) have pointed out in addressing the more general issue of class inequalities in health, discussion of the role of culture has been restricted to an extremely narrow emphasis on putatively 'voluntary' lifestyle factors such as smoking, exercise and diet. While this might be in keeping with the ideological dimensions of the inequalities debate, it constitutes a very restricted view of the role of culture in producing health experience. Sweeting and West argue that a broader view of culture as a 'complex of attitudes, values, orientations and behaviours' (1995: 163) not only provides a more complete basis upon which to understand the potential impact of cultural patterns upon health, but also suggests the possibility of various different mechanisms of 'cultural' influence, including both material and psychosocial factors.

Second, again developing a point made by Sweeting and West, the focus on between-group differences in both the ethnic and class inequalities literatures has tied cultural difference analytically to class or ethnic difference. This reified and deterministic view of culture empties it of its ability to complement material approaches and, unwittingly no doubt, resurrects the old-fashioned brand of Marxist objectivism which holds that the material (class) base determines the 'cultural' superstructure. In contrast to much-criticised approaches which posit unitary cultural practices as singularly related to objectively definable ethnic groups, the first requirement of a new approach to cultural explanation is in showing how the activities of people both inside and outside an ethnic group objectify particular 'cultural' orientations which are seldom coincident with the putative boundaries of the group in question. Thus, for example, a Caribbean identity emergent in contemporary Britain makes sense only in the context of the practices and orientations both of the people so designated and of wider society (a wider society which, as Gilroy (1993) has forcefully argued, extends far beyond the boundaries of Britain itself).
Moreover, this identity provides cultural practices and meanings which other people may incorporate or reject as part of the definition of their own identity (witness, for example, the complex syncretisms involved in Caribbean music and festivals in contemporary Britain). This opens up the possibility that, far from the view of 'white' and 'British' (or, more problematically, English, Welsh, Scottish, Irish and other white ethnicities) as simply the cultural identity of the ethnic majority, this identity is forged explicitly in the context of an engagement with other ethnic identities. In this sense, one of the biggest omissions in research on ethnicity is its silence on the construction of contemporary 'white culture'.

It is with this rather complex and dynamic concept of culture that health researchers must now grapple. Sweeting and West's work on the role of family structure and family culture in determining subsequent health and social experience provides one starting point. They found that differences in family structure (intact, reconstituted or single parent) bore little relation to teenagers' current and subsequent health. However, family culture (measured in terms of collective activities and relationships) had significant effects independently of material circumstances, with children of less conflictual families faring better on a range of health measures. The emphasis here is on psychosocial processes acting at the level of the individual and their relationships with their families and communities (albeit with possible long-term material consequences). Clearly, this kind of approach could usefully be applied to ethnicity although, as Miller (1993) cautions, it is important not to over-essentialise family forms. A developing North American literature has begun to open up enquiry precisely of this sort, examining ethnic patterns in concepts of illness (Anderson et al. 1989), the effects of kinship and social networks upon health (Dressler 1988; Brown et al. 1992; Williams et al. 1992), the importance of religion (Levin 1994), and the impact of cultural context upon particular types of health-related behaviour (Dressler 1993). There is much of benefit in this work which could be applied to Britain. Certainly, the enormous variety in background, customs, migration patterns, personal histories, social networks and contemporary living arrangements among people in Britain should sensitise analysts both to the richness of the resources available for the construction of cultural identities and the complexity of any link with health experience. While in some cases simple behavioural traits may exist which can be readily linked to health patterns in particular ethnic groups, the broader task is to examine — as in Sweeting and West's work — the effects of cultural variables which cross-cut social or ethnic status. To the extent that such variables do not cross-cut ethnicity at random, there is scope for cultural explanations of the ethnic patterning of health. Clearly, however, simple accounts of 'cultural difference' will not do. Moreover, in contrast to the 'culture as deviance' assumption criticised by Donovan (1984) and others, it is already clear from empirical research that cultural factors operating
in minority ethnic groups can often have a beneficial rather than a detrimental effect on health (Smaje 1995a, 1995b).

This ground is not new. The relationship between structure, culture and social outcomes was a founding concern of sociology as a discipline in both Europe and the USA. But we need to tread carefully nonetheless. Conservative thinkers used the ‘culture of poverty’ models prevalent in the USA during the 1960s to explain racial inequalities in terms of culture, while scholars of the Caribbean and black America inverted the causal argument to posit culture as the outcome of social process (see, for example, Rainwater and Yancey 1967, Stack 1974). With sociological theories of culture foundering in these opposed determinisms, and the subsequent rise of the poststructuralist onslaught against rationalism of any kind, the debate has largely been laid to rest in mainstream sociology. Yet, as Wilson (1987) has argued, the empirical questions posed by the persistence and in some cases growth of traditional class and ethnic inequalities are as pressing as ever. At the same time, a new generation of black American scholars has resurrected the question of ‘race’ and culture with less of the political baggage of the old debate (Henry 1992, Miller 1993). These developments demand a return to a theoretical and empirical engagement with questions of culture. An approach that posits the partial autonomy of culture, such as the one charted above, may invite the suspicion of some radicals. However, alternatives which subsume culture into class structure are questionable not only for their functionalism, but, as a number of black writers have suggested, also for their ethnocentrism (Gilroy 1987, hooks 1991, Miller 1993).

Racism

It is clearly impossible to understand the ethnic patterning of health in contemporary Britain without making reference to racism. However, the appropriate way in which to address the question is harder to determine. This reflects broader divisions in the sociology of ‘race’ about how to theorise racism, divisions which substantially conform to the variety of approaches to ‘race’ described above. Many writers now talk of racisms to emphasise the diverse manifestations of discrimination in action, but as Miles (1989) points out in his critique of the ‘conceptual inflation’ of the term, this often leads to an inability to define the specificity of racism vis-à-vis other forms of discrimination. Thus, while for some analysts racism refers to any position or practice which succours social organisation based on ‘racial’ disadvantage (see, for example, Wellman 1977), Miles reserves it for the more specific meaning of a false but essentially coherent, ‘representational form which, by designating discrete human collectivities, necessarily functions as an ideology of inclusion and exclusion’ (1989: 79). The position one adopts within these debates determines to an important extent the analytic role accorded racism in the ethnic patterning of health. Here, I argue that racism can affect health in two ways, one straightforward, the other less so.

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First, it has been shown that the experience of discriminatory treatment occasioned by racism can have a direct and negative impact upon health. This has been shown both correlational in epidemiological studies, and in the context of psychological experimentation (see Smaje 1995a). While the literature is far from conclusive, there is some clear evidence for a direct effect.

Second, there are questions about the more general process by which racism inflects the socio-economic position of minority ethnic groups, and thus the health of individuals in these groups. It could be argued that the whole process of postwar labour migration to Britain was shaped, through the prior ‘racialisation’ of society, by exclusionary racist sentiments which had major consequences for the subsequent socio-economic experience of minority ethnic groups in terms of economic and educational opportunities, housing, area of residence and so on. Of course, these opportunities have not been structured solely by racism; the socio-economic status of the original migrants and contingent economic factors in areas of high minority ethnic residence are also significant. Thus, depending upon one’s definition of racism, it may or may not be invoked as a partial explanation of socio-economic position among different ethnic groups. Here, it might be useful to invoke Wilson’s (1987) distinction between past and present racism, whereby past racism continues to influence the reproduction of spatial and socio-economic patterns regardless of the way in which contemporary social experience is structured by racial meanings. At the same time, there is some evidence to suggest that people from minority ethnic groups often face more adverse circumstances across the full range of socio-economic status (Smaje, 1995a), a finding that may involve both past and present racism. Thus, as well as the direct influence of racism, in some cases an indirect influence can also be distinguished which, in structuring socio-economic opportunity in a variety of complex ways, also contributes to the ethnic patterning of health.

Conclusion: towards a new research agenda

This paper has argued that to comprehend the social consequences of ethnicity, a satisfactory account of the concept as both identity and structure is required. This is as true for analysts concerned primarily with health as it is in the broader sociology of ethnicity. A number of positions in this latter, broader literature were examined, and it was argued that a fruitful approach – derived from Pierre Bourdieu’s theory of practice – treated identity and structure as dynamic and mutually constitutive, thus avoiding both the reification of structure (objectivism) and its complete abolition (postmodernism). Drawing this line between identity and structure is one of the central issues in contemporary theoretical, cultural
and policy debates around the issue of ethnicity. The older anti-racist insistence on a universal political 'blackness' united against the equally universalising structures of discrimination is both contested by and defended against a new politics of culture and diasporic identity which points to the limitations and failures of anti-racism (see, for example, Gilroy 1987, 1990; Hall 1988; Modood 1988; Mason 1990).

With a few notable exceptions (see, for example, Stubbs 1993) the full implications of this quarrel over identity and structure have not translated into the health literature. Here, against the prevailing orthodoxy of an epidemiological objectivism, critical perspectives typically enjoin researchers against both the reification of 'blackness' implicit in the crude white:non-white contrast employed in much -- particularly US -- research (LaVeist 1994), and the reification of difference in more complex taxonomies, such as the one employed in the British 1991 Census (Ahmad and Sheldon 1991). These criticisms are well taken, but can easily lead to fruitless debates about ideal ethnic taxonomies, or an equally fruitless retreat from generalisation into the postmodern language of 'discourses', 'racisms' and 'difference'.

By contrast, an identity-structure dynamic conceived in terms of Bourdieu's theory of practice provides another way of engaging critically with the inevitably imperfect results of empirical research. The impact of structures (employment patterns, housing, varieties of racist exclusion) can be readily investigated along lines well charted in the health inequalities literature, provided the social processes linking ethnic categorisation and objective position are not neglected. Here, as Bourdieu usefully points out,

individuals grouped in a class that is constructed in a particular respect . . . always bring with them, in addition to the pertinent properties by which they are classified, secondary properties which are thus smuggled into the explanatory model. This means that a class or class fraction is defined not only by its position in the relations of production, as identified through indices such as occupation, income or even educational level, but also by a certain sex-ratio, a certain distribution in geographical space (which is never socially neutral) and by a whole set of subsidiary characteristics which may function, in the form of tacit requirements, as real principles of selection or exclusion without ever being formally stated (1984: 102).

Here, singular objective categories always contain an abundance of additional characteristics which are analytically important. This is the context in which I suggested the need for greater refinement in the way material factors are hypothesised to act upon health, and the need for a new focus on identities and culture in ethnic health research.

What, then, are the methodological implications of this revised research

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agenda? First, there remains considerable scope for the use of routine data such as censuses and population surveys in tracing the social and socio-economic patterning of health among ethnic groups. This is particularly the case as new data sets become available, such as the Health Education Authority’s health and lifestyles survey (HEA 1994) and the Policy Studies Institute’s Fourth National Survey of Ethnic Minorities, which present more sophisticated analytical opportunities than were hitherto available. Nevertheless, there can be little substitute for more specifically tailored epidemiological studies, such as the West of Scotland Twenty-07 Study, which as well as providing the data for Sweeting and West’s (1995) analysis described above, has informed some important work on the Punjabi population of Glasgow (Williams 1993, Williams et al. 1994).

Research of this sort has already begun to help unravel some of the complex causalities involved in the impact of migration, material and cultural factors upon health. However, bearing in mind Bourdieu’s argument on the conceptual abundance of ‘objective’ categories, it is vital to recognise that the neat ethnic categories demanded by research (and typically assumed in everyday life) are partly fictional. Thus, insights derived from this research are best used to help formulate further questions about the social contexts within which both ethnicity and health experience are framed. Instead of closing down enquiry by erecting simplistic antinomies such as material: cultural or ethnicity: socio-economic status (antinomies which presuppose much of what they ought to explain), analysis must reveal how various dimensions of social and economic experience correlate with health in different populations to provide a more nuanced picture from which our constructions of ethnicity and socio-economic status can proceed. Such a picture would certainly need to include information on area of residence and social mobility, as well as gender, family, household and community dynamics.

At the same time, many issues can best be approached through qualitative research. Most qualitative work to date has either addressed the interactions of minority ethnic users with service providers or provided quite generalised accounts of the relation between health and other aspects of life among minority ethnic groups. This needs to be supplemented by research which focuses upon some of the outstanding questions in the framework developed above. Ethnographic techniques have been relatively little employed in the field but can illuminate important questions such as the social meanings imputed to health in different populations and the nature of participation in family and community networks which help promote health and welfare. Most crucially in the light of the identity-structure duality discussed above, such work can also prepare the way for examining how ethnic identities are constructed and maintained, and in beginning to analyse the variety of possible ways this might affect health. I do not seek to suggest that this focus on culture
and identity is of greater importance than the daily realities of poverty and racism faced by many people from minority ethnic populations. I do, however, wish to argue that the relationships between socio-economic status, ethnicity and health need to be theoretically constructed and empirically examined. They should not be either assumed or dissolved in objectivist or postmodern approaches which obliterate the complexity of social life.

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Acknowledgement

I would like to thank Sara Arber, Martin O'Brien and two anonymous referees for their helpful comments on earlier versions of this paper.

Notes

1 It may be objected that this typification could equally apply to class or gender. Indeed, it is harder than it might at first appear to define the specificity of race or ethnicity in contradistinction to other concepts of human difference. Later in the paper, I shall argue that this specificity inheres in the content of the material by which identity is articulated, and the political strategies which attend it. For a variety of attempts to address the question at hand, see Barth (1969), Comaroff (1987), Miles (1989), Miller (1994).

2 This may form part of an answer to the perennial but rather fruitless debate about the relationship between race and ethnicity, but will not be pursued here.

3 The issue of agency (particularly in relation to the state) confronted here is, I would suggest, a critical one for an understanding of ethnicity, and one which few analysts have tackled convincingly. Theoretical abstraction is unlikely to progress the issue far, which perhaps explains why Gilroy rejects the question in favour of a more limited empirical project (1987: 27). This might be the pragmatic option, but hardly constitutes a resolution of the issue.

4 Miller develops his argument by applying a concept of objectification akin to that of Bourdieu in the ethnographic context of material culture in Trinidad. He goes on to suggest,

if we start from gender we can reduce many other areas of West Indian social practices to gender by demonstrating at least partial homologies or oppositions. But the same is true of class, of ethnicity, of age and other social dimensions. In general, social groups are better understood as objects in this process rather than subjects. That is to say gender, class and ethnic groups are constantly used as a means of objectifying a sense of order and are inscribed with particular characteristics thereby. (1994: 259)

This radical reversal of subject-object relations is, indeed, one implication of Bourdieu's dialectic. Its potential for re-casting much of the debate about the
social construction of ethnicity is intriguing, but its full implications are not
developed in this paper.
5 Bhopal (1988) has argued that the importance of differences in these patterns
has been over-emphasised relative to the commonality of health experience
between ethnic groups. The point is well taken, and indeed many of the more
important determinants of health I discuss below are not most usefully viewed
as specific to any particular ethnic group. Nevertheless, to the extent that ethnic
categories are imbued with social meaning, it is appropriate to interrogate the
variability as well as the commonalities in health associated with them.
6 Though see Little and Nicoll (1988) for some important caveats.
7 Though see, for example, Strathern (1992).

References

Research Unit.
University Press.
Ahmad, W. (1994) Reflections on consanguinity and the birth outcome debate,
Newsletter, 48, 27–33.
ployment on the perceived health of a sample of general practice attenders,
Community Medicine, 11, 2, 148–56.
chronic illness, ethnicity and the discourse on normalisation, Sociology of
Health and Illness, 11, 3, 253–78.
of recent statistical evidence for materialist explanations, Sociology of Health
and Illness, 15, 2, 137–56.
Appadurai, A. (1990) Disjuncture and difference in the global cultural economy,
Theory, Culture and Society, 7, 295–310.
British National Health Service, International Journal of Health Services, 18, 4,
563–71.
Benzeval, M. Judge, K. and Smaje, C. (1995) Beyond race, class and ethnicity:
deprivation and health in Britain, Health Services Research, 30, 1 (II), 163–77.
Bentley, G. (1987) Ethnicity and practice, Comparative Studies in Society and

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