Ethnicity & Health
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/ceth20

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Published online: 12 Mar 2014.

To cite this article: Ursula M. Read (2014) Health inequalities: from ethnicity to diversity, Ethnicity & Health, 19:2, 119-121, DOI: 10.1080/20445911.2014.887044

To link to this article: http://dx.doi.org/10.1080/20445911.2014.887044

Ethnicity & Health, 2014
Vol. 19, No. 2, 119–121, http://dx.doi.org/10.1080/20445911.2014.887044

Routledge
Taylor & Francis Group

EDITORIAL

Health inequalities: from ethnicity to diversity

Researchers have long questioned the theoretical integrity of ethnic categories in health research (Bradby 2003), yet evidence of enduring inequalities in contexts of growing diversity means that enquiry into the causes remains of primary importance. Though research on ethnicity and health now generally includes measures of socio-economic circumstances (SEC), individual, group and contextual variables moderate this relationship, disavowing views of ethnicity as simply a proxy for disadvantage. The papers in this issue grapple with this complex intersection of ethnicity with other vectors of differentiation including migration history, age and gender, revealing differences in the ways in which these operate across diverse contexts. De Grande et al. in Belgium and Sevillano et al. in Spain, for example, explore variations in self-reported health within and between ethnic groups based on gender or migration history which was not consistently attenuated by SEC. These findings suggest limitations in overarching theories such as the 'healthy migrant effect' or 'acculturation'. As in these studies, migration history is increasingly recognised as vital for a more nuanced understanding of the relationship between ethnicity and health. However, limiting this to distinguishing between 'first' and 'second generation' obscures how histories of empire and religion, as well as global and local economic and political changes, play out in dynamic patterns of migration with far-reaching consequences for those who migrate and their descendants. As evidenced in Meschke et al.'s study with Hmong in the USA, the disadvantages and trauma faced by refugees and other forced migrants represent very different categories of experience from those who migrate in search of opportunities for employment or education.

Focusing on young adults from ethnic minorities throws these issues into relief. At a period of significant transition, young adults engage with diverse influences from parents, peers and the wider community. Theories of convergence and acculturation suggest that the second generation will move closer to the health, lifestyle and values of the dominant culture. However, it is increasingly clear that this is not the trajectory for many. Rather identities and practices are marked by fluidity and improvisation within and between cultures (Weller 2009). Significantly, de Grande et al. and Flink et al. assign ethnicity as other than 'Belgian' or 'Dutch' where one or more parent was born abroad, highlighting the ways in which ethnic categories risk eliding such hybridity. Yet both studies reveal the challenges of negotiating this complexity and the potential impact on family relationships. Meschke et al. suggest that conflicts between parents and children arise from 'acculturation disparity'. However, recent studies have suggested beneficial effects from access to a diverse repertoire of cultural resources in child and adolescent development (Gregory et al. 2013) which may enhance rather than erode social capital (Holland, Reynolds, and Weller 2007). Acknowledging the potential benefits of diversity should not suggest the dawn of a cosmopolitan utopia. The societies represented in these studies

remain marked by inequality and inequity, heightened by global economic recession. In the UK, for example, unemployment among young adults from ethnic minorities is significantly higher than White British (Department for Work and Pensions 2014). This suggests the need to consider the role of discrimination, which may be reinforced in contexts of scarcity and account for greater differences in self-reported health than SEC (Hudson et al. 2013). Of the papers in this issue, only Sevillano et al. include a measure of perceived discrimination. Yet responses to discrimination are also marked by diversity, with some studies suggesting that coping skills, social capital and family support can enhance resilience (Hughes et al. 2006). On this theme, Gayman et al. report on differences in coping between African-Americans and Latinos, arguing for recognition of historical influences and 'cultural transmission' on the development of coping styles.

In the first study of ethnic differences in psychiatric hospital admission and diagnosis in Scotland, Bansal et al. illustrate the potential added value of data linkage to explore the interaction of ethnicity with contextual variables. Wide variations between ethnic groups were not consistently correlated with SEC and, as in the wider UK, an overuse of compulsory treatment among ethnic groups suggests inequities in access to treatment. A systematic review of ethnic variation in the use of UK mental health services (Bhui et al. 2003) cautions against relying solely on ethnicity to explain such variation, highlighting the need to account for discrimination and disparities in service delivery and practice.

These papers underscore the pertinence of Vertovec's (2007) call for researchers to develop theory and methods which engage with 'superdiversity', the dynamic interaction of variables beyond ethnicity and other common markers of differentiation. Browne et al. convincingly argue against introducing ethnic categories into health records in Canada unless they are linked to robust measures of other determinants of inequity. As they conclude, social exclusion and discrimination, rather than self-identified ethnicities, perpetuate inequalities. Though it may not be time to abandon ethnic categories altogether, they are only of value so long as they are considered in conjunction with contextual variables in ways which enable a deeper understanding of the causes of inequality and the factors which sustain it.

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