



Psychosocial Intervention

ISSN: 1132-0559

pi@cop.es

Colegio Oficial de Psicólogos de Madrid
España

Ingleby, David

Ethnicity, Migration and the 'Social Determinants of Health' Agenda

Psychosocial Intervention, vol. 21, núm. 3, 2012, pp. 331-341

Colegio Oficial de Psicólogos de Madrid

Madrid, España

Available in: <http://www.redalyc.org/articulo.oa?id=179824562009>

- How to cite
- Complete issue
- More information about this article
- Journal's homepage in redalyc.org

redalyc.org

Scientific Information System

Network of Scientific Journals from Latin America, the Caribbean, Spain and Portugal

Non-profit academic project, developed under the open access initiative

Ethnicity, Migration and the ‘Social Determinants of Health’ Agenda*

Etnicidad, Migración y la Agenda de los ‘Determinantes Sociales de la Salud’

David Ingleby

University of Amsterdam, The Netherlands

Abstract. One of the most promising recent developments in health policy has been the emergence of a global ‘health equity’ movement concerned with the social determinants of health. In European research and policy-making, however, there is a strong tendency to reduce ‘social determinants’ to ‘socioeconomic determinants’ and to ignore the role of ethnicity, migration and other factors in the creation of inequities. This threatens to hold up the development of work on ethnicity and migration and thus to perpetuate inequities linked to these factors. The present article sets out to illustrate this tendency and to investigate the reasons which may underlie it. The justifications often put forward for neglecting ethnicity and migration are shown to be erroneous. An integrated approach, simultaneously taking account of socioeconomic status, migration and ethnicity as well as other determinants of inequity, is essential if work on the social determinants of health is to make progress. Equity is indivisible; researchers investigating different aspects of social stratification should not treat each other as rivals, but as indispensable allies. An integrated, intersectional, multivariate and multilevel approach will improve our understanding of health inequities and make available more resources for tackling them.

Keywords: ethnicity, health equity, migration, social determinants of health, socioeconomic status.

Resumen. Uno de los avances recientes más prometedores en política sanitaria ha sido la aparición de un movimiento global por la “igualdad sanitaria” que aborda los determinantes sociales de la salud. Sin embargo, en la investigación y legislación europeas hay una fuerte tendencia a reducir los “determinantes sociales” a “determinantes socioeconómicos” pasando por alto de esta forma el papel que juegan la etnicidad, la migración y otros factores que contribuyen a la aparición de desigualdades. Este hecho supone una amenaza para el desarrollo de estudios sobre etnicidad y migración, perpetuándose de esta manera las desigualdades asociadas a estos factores. El presente artículo tiene como objetivo describir esta tendencia y analizar las razones subyacentes. Las justificaciones que con frecuencia se aducen por este descuido de la etnicidad y la inmigración han demostrado ser erróneas. Un enfoque integrado que tenga en cuenta simultáneamente el nivel socioeconómico, la migración y la etnicidad, así como otros factores determinantes de desigualdad, es esencial si se pretende avanzar en la investigación sobre los factores determinantes de salud. La igualdad es indivisible; los investigadores que estudian distintos aspectos de la estratificación social no deberían considerarse mutuamente como rivales, sino como aliados indispensables. Un enfoque integrado, intersectorial, multivariado y multinivel ampliará nuestros conocimientos sobre las desigualdades sanitarias y posibilitará que se empleen más recursos para abordarlas.

Palabras clave: determinantes sociales de la salud, equidad sanitaria, estatus socioeconómico, etnicidad.

The last ten years have seen a remarkable increase in the attention paid by researchers and policy-makers all over the world to the social determinants of health (SDH). A key role has been played by the WHO’s

Commission on the Social Determinants of Health under its chair Sir Michael Marmot, in particular through the ground-breaking report *Closing the gap in a generation* (CSDH, 2008).

The idea that health has social determinants is of course a very old one. It is the axiom on which the disciplines of social medicine and public health were founded in the 19th century, when medical pioneers campaigned for action to tackle the appalling living

Correspondence: David Ingleby, Centre for Social Science and Global Health, University of Amsterdam, OZ Achterburgwal 185, 1012 DK Amsterdam, The Netherlands. E-mail: J.D.Ingleby@uva.nl

*Versión en castellano disponible en [spanish version available at]: www.psyshosocial-intervention.org

conditions and health problems of the new industrial working class. Rudolf Virchow is famous for his remark (Virchow, 1848) "Medicine is a social science and politics is nothing else but medicine on a large scale". During the 20th century, however, the link between health problems and social inequalities remained a neglected topic in research and policy-making. This was especially true in the USA (Guralnik & Leveille, 1997). Nevertheless, the American Civil Rights Movement focused the spotlight on racial and ethnic health disparities (Dittmer, 2009), while in Europe the health of migrants and ethnic minorities has increasingly become the topic of research and policy initiatives during the last 3-4 decades. The relation between health and class, usually referred to today as 'socioeconomic status' (SES) or 'socioeconomic position' (SEP), was highlighted in reports by Black (DHSS, 1980), Marmot et al. (1991) and Acheson (DHSS, 1998). In the 21st century, however, this topic has attained world-wide prominence.

A 'health equity movement' among researchers began to gather momentum in the 1990's, but it was chiefly the WHO which was responsible for translating this theoretical interest into a global policy drive by setting up the Commission on the Social Determinants of Health in 2005. In doing so, the WHO seemed to have regained its political voice. Ever since its foundation in 1947, it has had to balance the commercial interests of wealthy countries (which continually strive to expand the global market for their drugs, technology and professional expertise) with its normative role of promoting health, especially in the poorest countries (Chorev, 2012). In the years following the strikingly radical *Declaration of Alma-Ata* (WHO, 1978), the organization's focus on prevention and primary care became blurred and it was often accused of losing sight of its core global functions (Ruger & Yach, 2008). The new commitment to SDH and health equity signalled a return to the WHO's normative mission, which has been further emphasised by the adoption of the principle of 'health in all policies' (WHO, Government of South Australia, 2010).

The WHO-led SDH agenda is thus long overdue and greatly to be welcomed – all the more so after three decades in which the dogmatic implementation of neo-liberal economic policies has increased inequalities between and within countries. These policies now appear to have plunged the world into a lengthy period of economic slow-down, in which the most vulnerable social groups face high unemployment as well as drastically impaired social protection.

Nevertheless, when one examines the small print of the SDH programme, some doubts arise. Certainly, socioeconomic differences are a major factor underlying health inequities – but many other factors need to be considered as well. The CSDH report itself (op. cit., p. 18) mentions for example 'gender, age, ethnicity, disability and geography'. In the report and much of

the work that it has stimulated, however, these other factors are relegated to the background: a coherent view on the complex genesis of social inequalities is sacrificed to the goal of highlighting the correlation between health and a single variable, SES.

For example, we know that migrants and ethnic minorities are often among the most marginalised groups in any country (WHO, 2010) – but in the 200-page CSDH report the words 'migrant' or 'migration' occur only 40 times. Half of these references are to rural-urban migration, 7 are to migration of health workers and only 14 are concerned with international migration. Ethnicity is mentioned 16 times. More importantly, there is no serious discussion of the effects on health of either migrant status or ethnicity. These topics are only mentioned in passing, as if the authors of the report felt obliged to include them but had no real interest in pursuing them in depth.

Perhaps not entirely by coincidence, this one-dimensional approach also characterises much European research on health inequalities. In this literature, the term 'social determinants' almost always turns out to mean 'socioeconomic determinants': for many researchers the two terms appear to be synonymous. The clearest demonstration of this is the EUROTHINE report (Erasmus Medical Centre, 2007), entitled *Tackling Health Inequalities in Europe: An Integrated Approach*. In 646 pages, the words 'migrant', 'migration', 'ethnic' or 'ethnicity' do not occur once. This project was the outcome of extensive collaboration between European epidemiologists, so we may assume that this one-sided interpretation of the term 'health inequalities' is widely shared.

A slightly more balanced approach is visible in the EC Communication *Solidarity in Health: Reducing health inequalities in the EU* (EC, 2009). This brief (11-page) declaration refers three times to 'migrants and ethnic minorities' and once to 'migrants' by themselves: special attention is recommended for these 'vulnerable groups'. However, no connection is suggested between migrant status, ethnicity and the report's central topic – social stratification. Migration and ethnicity are not excluded from the report's field of vision, but as in the CSDH report, they are only mentioned in passing. Here too, one receives the impression that they were only included because it would have been politically unacceptable to leave them out. As well as social marginalisation, these groups are thus subjected to *scientific* marginalisation, in a new, streamlined research agenda that is already undermining work on migration and ethnicity in the EU.

The use of the term 'health gradient', incidentally, subtly reinforces this fixation on SES. One cannot speak of a *gradient* between two categories such as 'native-born and migrant', 'Black and White' or 'male and female': between categories, only *gaps* can exist. Of course, the SDH programme has a legitimate reason for stressing the 'gradient' in relation to SES: it wishes

to emphasize the importance of examining the full range of health differences at every level of society, rather than just comparing 'rich' and 'poor'. This in itself is a worthwhile and original aim. However, if 'health gradients' are defined as the only focus of attention – ignoring 'health gaps' – differences between categorical variables such as ethnic group, migrant status and gender will inevitably be overlooked.

Migration and ethnicity were also conspicuously neglected in the *Strategic Review of Health Inequalities in England Post 2010*, otherwise known as the 'Marmot Review' (Marmot et al., 2010). There is a particularly strong tradition of work on ethnic differences in the UK, which is backed up by government policies and legislation: the criticism of the report by prominent researchers on ethnicity (Salway et al., 2010) was therefore to be expected. Describing its neglect of ethnicity as 'shocking', the researchers commented: "While the report includes passing reference to the social and health disadvantage experienced by particular ethnic groups in a number of places, it fails to give any meaningful attention to this key dimension of identity and division of modern British society". Other outputs of the SDH programme show the same blind spot: for example, browsing the website of the UCL Institute of Health Equity (<http://www.instituteofhealthequity.org/>) reveals a striking dearth of material on migration and ethnicity.

The same is true of the website launched by the WHO at the World Conference on Social Determinants of Health in October 2011. ACTION:SDH is a new tool intended to provide the public health community with a 'one-stop portal' on SDH (<http://www.actionsdh.org/>). However, at the time of writing 'ethnicity' is only mentioned on the site in passing, and 'migration' almost never. (The one exception, significantly, is a report from the South Australian government).

Hopefully, enough examples have by now been given to make the point that the SDH programme has a strong tendency to prioritise socioeconomic determinants of health at the expense of other factors, and that this tendency is shared by many European epidemiologists. Interestingly, we do not see it in North American and Australian work. In the USA (where the term 'disparities' is traditionally used rather than 'inequities'), most research on SDH considers SES and ethnicity or race side by side (Exworthy, Bindman, Davies & Washington, 2006): the same is true in Canada and Australia. In these countries, researchers seem to recognise that social stratification is intimately linked to the ethnic diversity resulting from large-scale immigration, as well as the oppression of indigenous groups by settlers. In the USA, slavery is another historical determinant of stratification that is impossible to ignore. Researchers in these countries acknowledge that social inequalities are linked to the legacy of colonialism and racism, and few are so naïve as to

imagine that these historical influences have been eliminated.

Many Europeans, by contrast, regard the legacy of colonialism and slavery as an issue for the rest of the world – but not for them. There is a readiness to admit that 'the white man' inflicted many injustices on the rest of the world, but modern democratic European societies themselves seem to be regarded as meritocracies or 'level playing fields'. In Europe, so the story runs, we do not need to look at people's ethnic origin if we want to understand their socioeconomic and health status. Under the Nazi's, of course, things were different – but this period tends to be regarded as simply an isolated incident, a deplorable lapse from 'European' values.

It is this essentially 'colour-blind' view of their own society which seems to underlie the approach of many European epidemiologists to SDH. As we will argue below, however, this view flies in the face of historical, political and economic realities, ignoring in particular the way in which colonial relations have been revived and reconstructed in modern Europe through social stratification according to ethnicity and migrant status.

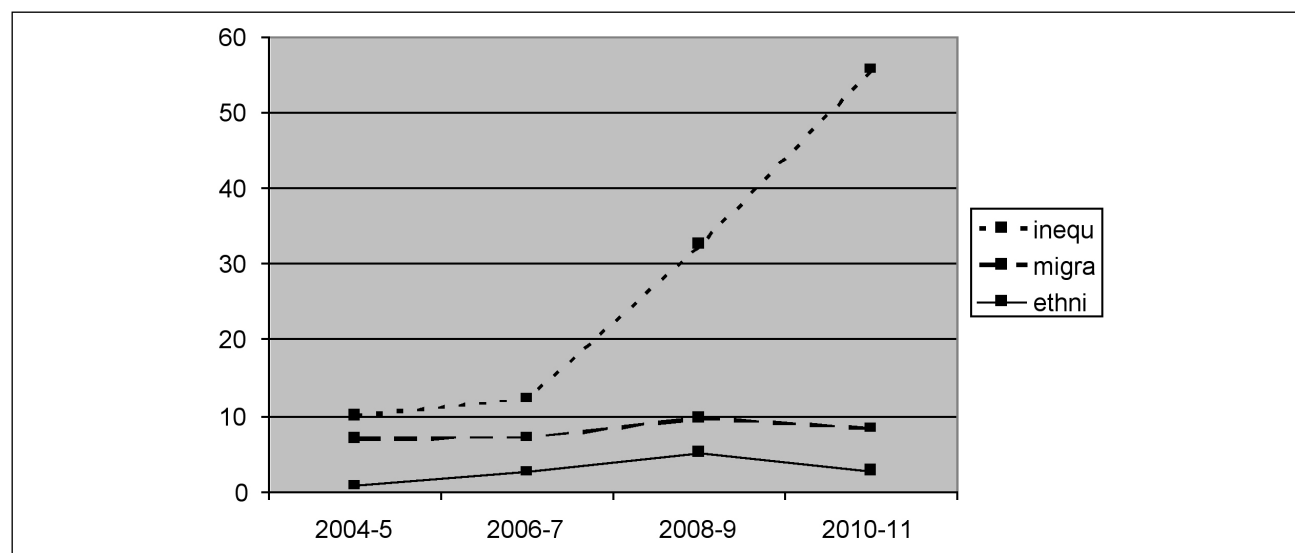
The negative effect of the SDH programme on studies of migration and ethnicity

Given that both economic hardship and the vulnerability of migrants and ethnic minorities are likely to increase during the current economic crisis, it is a matter of grave concern that the SDH programme is ignoring the contribution of migration and ethnicity to health inequities. Worse still, there is evidence that this one-sidedness is actually undermining work on migration and ethnicity, particularly in EU-supported research programmes.

To support this contention we report here an analysis of the relative numbers of subsidies for projects, conferences, and operating grants awarded by the European Commission's Executive Agency for Health & Consumers (EAHC) during the period 2004-2011. We distinguish three categories: projects which included the letter groups 'migra', 'ethni' and 'inequ' in their title, acronym, abstract or keywords. This categorisation identifies projects which mentioned terms such as migrants or migration, ethnicity or ethnic groups, and inequities or inequalities. The information was extracted from the DG SANCO database at <http://ec.europa.eu/eahc/projects/database.html> on 30th July 2012. In the graph shown in Figure 1, pairs of years have been summed in order to reveal the trends more clearly.

Common sense suggests that the percentage of projects subsidised in each category will reflect (a) the content of the published Calls for Proposals, (b) the number and quality of the proposals submitted, and (c) the preferences of the Agency and its assessors. The graph shown in Figure 1 shows that the percentage of subsi-

Figure 1. Percentage of subsidies awarded by EAHC for different topics (2004-2001)



dies for work on 'inequalities', 'inequities' and related terms increased sharply after 2007. This increase was probably driven by the Calls for Proposals, which incorporated the increasing emphasis in EC policy during this period on tackling health inequalities.

Considering the individual years 2006 to 2011, the correlation between the percentage of subsidies in the category 'inequ' and the year in which the subsidy was awarded is $r = .93$ ($p < .005$ one-tailed). The corresponding correlations for the categories 'migra' and 'ethni' are $r = .30$ and $.29$ (n.s.). Using Fisher's r -to- z transformation, the correlation for the 'inequ' category is found to be significantly higher than that for either of the other two categories ($z = 1.67$ and 1.65 , $p < .05$ one-tailed). That is to say, the percentage of subsidies for projects containing keywords related to 'inequities' or 'inequalities' has increased significantly faster than the percentage for either of the other two types of project. (In all the years studied, the percentage of successful projects mentioning migration was higher than the corresponding figure for ethnicity.)

Of course, it is possible that some of the projects related to migration and/or ethnicity also mentioned terms such as 'inequality'. But looking at the graph we can see that there has been a dramatic increase in the percentage of projects which mention inequality, but do *not* mention migration or ethnicity.

The increased attention for work on health inequalities has thus created a large new body of research that ignores migration and ethnicity. Since research funding is limited, it seems inevitable that this trend will lead to a reduction of work on these topics. Some researchers are already drawing the conclusion that they have a better chance of getting funding if they do *not* mention migration or ethnicity.

This stark conclusion is supported by the results

reported by Karl-Trummer (2010) of an analysis carried out for DG RESEARCH on projects funded up to 2009 within the Framework Programmes FP5, FP6 and FP7. Twenty-six projects identified as highly relevant to the theme of social inequalities in health were subjected to detailed analyses of their methodology, partnership, target groups, variables studied etc. The only 'vulnerable groups' identified in these projects were children, elderly people and people suffering from obesity and physical or mental disabilities. *None of the projects studied migrants or ethnic minorities.* In other words, all of them exemplified the 'colour-blind' view of European society that we have identified as a feature of much work in this area.

Reasons for the neglect of migration and ethnicity

The next question we shall examine is: what arguments are used to justify the current one-sided emphasis on SES? Of course, some researchers may be responding to increasing hostility to migrants and ethnic minorities in their own country by choosing politically 'safer' topics; however, they are unlikely to state this openly as a reason for their choice. In this section we will consider only the scientific arguments which have been put forward.

Arguments in terms of numbers

Some argue that there are so few migrants and ethnic minority members in Europe that their contribution to health inequalities is very small. Attention for these groups is therefore a distraction from the main task of reducing socioeconomic differences. This has been

argued, for example, by the epidemiologist Mackenbach in an interview (Dahhan, 2007, p. 73). But although numbers vary considerably between countries, there are not many places in Europe where this viewpoint is still tenable. During the last 60 years migrant stock has increased to the point where in many countries, migrants and their descendents form more than 20% of the population – often the most disadvantaged part. In the Netherlands, ‘non-Western’ migrants and their offspring form 16.5% of the population under 25 (CBS Statline, 2012), while unemployment among this sub-group is three times as high as among native Dutch youths (FORUM, 2012). In countries with a large Roma population, this group may well be the major source of health inequalities, because their health disadvantages are often extreme.

Arguments in terms of need

A second argument is that many migrants or members of ethnic minorities are not, in fact, disadvantaged, at least in terms of their health: indeed, they may actually be healthier than the majority population. This advantage (the ‘healthy migrant effect’) may be due to the fact that those who migrate tend to be young and healthy and have a relatively short exposure to the health-threatening aspects of life in the West. It may also be due to culture-bound traditions (e.g. stricter sexual morality and not drinking alcohol) that actually promote health.

The analysis of health differences in terms of migrant status or ethnic group membership is therefore often criticized on the grounds that it may yield few significant results and have a needlessly stigmatising effect. The danger of lumping together members of ethnic or migrant groups is that it encourages stereotyping: often the differences within such groups are much larger than the mean difference between them and the majority population.

This argument needs to be taken very seriously if researchers want to be part of the solution to inequity, rather than part of the problem. On this issue one can identify two extreme standpoints: one which prioritises the importance of not stereotyping and would prefer to ban all research in terms of such categories (a common view in France), and another which argues that disadvantaged groups cannot be helped without targeted data collection and interventions (‘no data – no progress’, e.g. OSF, 2010). Clearly, it is necessary to find the optimal compromise between these two extremes. In doing so, we should be guided by the strength of the evidence that a group suffers serious disadvantages. Where this is so, the group in question is much more likely to welcome having attention drawn to its problems than when these are mild or disputable.

Objections to explanations in terms of ethnicity and migrant status

Another reason why many people prefer to explain health inequalities in terms of SES rather than ethnicity or migrant status is the assumption that the latter explanations locate the cause of problems in minorities themselves, and are therefore a form of ‘blaming the victim’. This assumption supposes that the only way in which ethnicity or migrant status could affect health is through cultural differences, or – potentially even more stigmatising – genetic ones. Kaufman, Cooper, & McGee (1997) analyse in detail the pitfalls of ‘controlling for SES’, in order to demonstrate that many studies which claim to have done this are probably flawed by ‘residual confounding’ and thus purport to show ethnic differences that may not really exist. From the text it is clear that this critique is aimed at researchers who think that the effects of ethnicity are purely due to genetic or cultural differences. The tendency of some epidemiologists to explain away ethnic differences in terms of SES may thus be motivated by a wish to avoid ‘blaming the victim’.

However, the effects of belonging to a group may have nothing to do with the characteristics of its members: they may primarily reflect the *societal reaction* to the group. Asylum seekers, for example, may have nothing in common with each other apart from the fact that they have sought asylum, yet the legal system and public opinion treat them very differently from other groups. Thus, explaining problems by reference to migrant status or ethnicity does not necessarily locate the cause of problems in the groups themselves.

This issue is reminiscent of the controversies that have raged over the past half century about the factors responsible for the educational disadvantage of children from ethnic minority groups. Already in the 1970’s, a strong polarisation developed between two schools of thought on this issue. One attributed educational disadvantage to ‘cognitive deficit’, ‘cultural deprivation’ or ‘inferior genes’, while the other adopted a ‘structural’ or ‘sociological’ view which sought to explain differences entirely in terms of the social position of the child’s family. This opposition proved to be scientifically and practically unproductive. Because it failed to consider *interactions* between individual, social and cultural factors, it failed to produce a coherent and useful vision on educational disadvantage (Pels & Veenman, 1996).

Incidentally, a concern to avoid ‘blaming the victim’ should not deflect us from the conclusion that some factors affecting health may be linked to cultural differences or genes. We have already mentioned the health advantages of certain religious practices – and there are also, of course, disadvantages. Population genetics may prove to be a factor that has been taken into account when investigating vulnerability to illness or response to treatments, although traditional racial cat-

egories have little relevance to modern genetics.

If those investigating SES have paid too little attention to ethnicity, the converse is probably also true: those working on migration and ethnicity have sometimes overlooked material living conditions and placed too much emphasis on 'culture'. The history of research on educational disadvantage shows that only a multidisciplinary, multivariate and multilevel approach, considering the interplay of *all* factors, is likely to be fruitful.

Statistical arguments

Perhaps the most common argument used for prioritising SES is a statistical one: the claim that many effects of migrant status or ethnicity disappear or are reduced to insignificance when SES is controlled for. There are two issues here: firstly, how often is this true? Secondly, what are the implications if it is true? We will discuss these questions in relation to ethnicity, though the implications for migrant status are the same.

It is certainly the case that many ethnic differences disappear or become smaller when SES is held constant. To achieve this, one can either use multivariate methods (partialling out the effects of SES statistically), or compare groups at different levels of SES. However, there are many differences that do not disappear when this is done (see e.g. Bhopal, 2007; Karl-Trummer & Sardadvar, 2012; Nazroo, 1998).

There are also serious methodological problems involved in 'controlling for SES', whichever of the above two methods is used. To name a few of these:

- SES differences may be so extreme that there is little or no overlap between groups: particular ethnic minority or migrant groups may be so acutely disadvantaged that there is hardly any overlap between them and the majority population.
- There may also be problems of validity: the same indicators of SES cannot necessarily be used in different social groups. An Iranian refugee in the UK may be a qualified neurosurgeon or physicist, but unable to find an employer who will recognise this qualification. Ways of measuring income or wealth may also need to be adapted for groups which tend to manage their finances in different ways. It is true that in most cases, increasing the validity of measures of SES would increase the amount of variance that can potentially be accounted for by partialling this variable out; nevertheless, the opposite effect is also possible.
- Kaufmann et al. (1997) discuss in detail how difficult it is to avoid 'residual confounding' due to measurement problems and other factors. The relationship between SES and ethnicity as determinants of health can be complex and seemingly

paradoxical. The influence of SES may differ between ethnic groups (see, e.g. Agyemang et al., 2010); or putting it the other way around, the influence of ethnicity may be different at different levels of SES. Finally, 'controlling for SES' may actually increase differences rather than decreasing them.

All this shows the dangers of taking for granted that ethnic differences will generally disappear when SES is controlled for. To illustrate the next stage of the argument, however, let us confine ourselves to cases in which it *does* disappear. Does this mean that ethnicity is not the 'real' cause of the difference and only SES needs to be considered? This is the conclusion that researchers often appear to draw – yet it is based on an elementary statistical fallacy.

To appreciate this, let us suppose that a correlation is found between ethnicity and some form of ill-health. We can be reasonably sure of the direction of causality, because there are few ways in which ill-health could alter one's ethnicity. (Nevertheless, if ethnicity is *self-ascribed*, such an effect is not impossible.)

Ethnicity → ill-health

Further research then demonstrates that SES is also correlated with ill-health:

Ethnicity → ill-health

SES ↗

It then emerges that when SES is controlled for, the correlation between ill-health and ethnicity disappears. What conclusion should we draw?

The usual conclusion is that SES has created a spurious association between ethnicity and ill-health, i.e. that it is a *confounder* in the relation between them, and that this has happened because SES and ethnicity are (for some extraneous reason) correlated with each other. The influence of ethnicity can then be regarded as an artefact and ignored.

The association between ethnicity and illness is then treated like that between carrying a cigarette lighter and developing lung cancer. People who carry a lighter are often smokers, but controlling for smoking will quickly show that lighters themselves do not cause cancer. In this example, smoking is the confounder which produces the misleading correlation between carrying a lighter and developing lung cancer.

However, a basic rule in statistics is that a confounder may not lie on the causal path between an independent and dependent variable. This is not the case with cigarette lighters, but it may well be with ethnicity or migrant status. The correct analogy is with a different kind of example: consider a disease which kills people by causing very high fever. A strong association will be found between having the disease and

dying. However, if one controls for body temperature (either by matching cases or partialling out this variable statistically), the association between having the disease and dying will be reduced and may even disappear. This potentially misleading result has been reached because body temperature is erroneously being treated as a confounder, when in fact it lies on the causal path between having the disease and dying.

Returning to our topic, we need to consider the possibility that the causal path looks like this:

Ethnicity → SES → ill-health

– in other words, that being a migrant or a member of an ethnic minority leads to ill-health by lowering one's socioeconomic status. There are many ways in which this could happen: discrimination may lower one's chances of getting a good job, education or housing; legislation may deny one's group many rights and privileges (for example, if one is an undocumented migrant); one may experience linguistic and cultural barriers; and one's social capital may be reduced if one moves to a new country in which one's own social 'currency' is worthless. The work of Nancy Krieger (e.g. Krieger, 1999) has explored the manifold pathways (both direct and indirect) through which discrimination can influence health.

If SES is an intervening variable in the causal pathway between discrimination and ill-health, statistically removing its influence will render the effect of migration or ethnicity invisible, just as partialling out body temperature will make the disease in our hypothetical example seem harmless. But anyone who thinks that SES (or, in the example, fever) has thus been shown to be the 'root cause' of ill-health will be deceiving themselves. We could give members of minority groups an artificial boost by compensating them for the social barriers they experience, and this might improve their health – just as it might help our hypothetical patients to apply treatments which reduce their fever. However, doing this would be 'treating the symptoms' rather than removing the causes of the problem. In the case of the disease this might be a rational policy, because lowering the fever might enable them to stay alive while their body fought the disease. Similarly, short-term help for marginalised groups may also be a life-saver. However, neither approach is satisfactory in the long run. As the SDH programme itself often states, we need to tackle 'the causes of the causes'. This means combating the processes of social exclusion that keep migrants and ethnic minorities in their supposed 'place'.

Illusions about (European) society

Let us examine more closely the notion which was briefly mentioned above – that ethnic stratification is

something which might play a role in former colonies and caste-based societies like India, but which is not really relevant to Europe. Many epidemiologists seem implicitly to subscribe to this view. They may acknowledge and deplore the existence of discrimination and xenophobia, but they regard these as incidental problems and do not see ethnicity as a *structural* determinant of inequalities – at least, not in Europe.

In his 'theory of durable inequality' the American sociologist Charles Tilly (1998) presents an entirely different view of the role of ethnicity, the implications of which for public health have been analysed by Lorant and Bhopal (2011). Tilly's theory is complex, but one of its basic notions is that the connection between social stratification and ethnicity is a structural one. His explanation for this can be understood by analogy with the social-psychological approach to stereotyping developed by Tajfel (1981). According to Tajfel, stereotypes about groups – however deplorable they may be – are not a sign of warped personalities, but the result of a basic human mechanism which enables us to steer a course through a world full of confusion and uncertainty. In human cognition, oversimplification and overgeneralization are the rule rather than the exception.

Tilly constructs a similar explanation, but at the social rather than the individual level. Inequalities in power or wealth are easier to maintain if they can be matched with 'external' characteristics of individuals. Thus, the distinction between 'manager' and 'worker' will be easier to organise and sustain if it corresponds to an ethnic difference: in that case, the power differential will not have to be repeatedly justified, but will instead become accepted as 'the way things are'. Ethnic stratification is a matter of *organisational* convenience, just as individual prejudice, according to Tajfel, is a matter of *cognitive* convenience (Desrosiers, 2007). Of course, other models will be needed to explain which groups get allocated to which roles or stereotypes.

The path of least resistance, at both social and individual levels, is thus for ethnic stratification and stereotyping to become stronger rather than weaker – unless they are opposed by effective resistance, public campaigns and legislation. Individuals belonging to a given ethnic group can rise 'above their station' or fall below it, but only in exceptional circumstances. The opinion sometimes voiced that Western societies have entered a 'post-racial' era, in which anybody can become anything, is simply a revamped version of the American Dream of infinite social mobility (Kaplan, 2011).

Such theories offer possibilities for explaining how ethnicity and other group characteristics become structurally linked to socioeconomic inequalities. The SES gradient is not the root cause of differences in health, but needs itself to be explained in terms of deeper factors and processes ('the causes of the causes'). All the

more extraordinary, therefore, that so little attention is paid in the SDH programme to factors such as ethnicity and migrant status (and, for that matter, sex, age, disability, religion and sexual orientation). The idea of tackling the SES 'gradient' first and then dealing with other factors is self-defeating and self-contradictory – for as long as these other forms of discrimination are in operation, equity in SES can never be achieved.

The 'colour-blind' view of European societies as democratic meritocracies marred only by occasional racist lapses is in urgent need of revision. The following – highly oversimplified – historical sketch may help in this. At the end of the Second World War, the 'external distinction' (Tilly) which maintained and justified SES differences in Europe was primarily class: which side of the tracks you were born on. However, thanks to the spectacular economic expansion in the 1950's and 1960's, led by the German *Wirtschaftswunder*, a large part of the European working class improved their educational qualifications and broke through the stereotypes that had kept them 'in their place': they moved upwards and joined the middle class. In order to carry out the work which they now considered to be beneath their station, and thus keep up the momentum of economic expansion, it was necessary to import large numbers of unskilled, uneducated 'guest workers'. These migrants (many of whom did not return home later to their families, but instead brought their family members to join them) filled the vacuum that upward social mobility had created. They became, to a large extent, the new European proletariat, inheriting also the social opprobrium that the middle class had always directed at the 'dangerous' working class. Some migrants, of course, avoided this fate – but in most cases, these were not numerous enough to enable their group as a whole to escape from its disadvantaged position. Migration and ethnicity have therefore become a powerful source of stratification in Europe.

The most recent development in this process is that EU member states have increased restrictions on immigration from non-European countries to the maximum level possible without violating human rights legislation and incurring crippling expenses for border control and surveillance. As a result, irregular migrants (who, incidentally, are usually not illegal entrants but 'overstayers' or rejected asylum seekers) have increased to the point where they probably number around 3 million in the EU27 (Kovacheva & Vogel, 2009).

Irregular migrants occupy a position on the social ladder which is even lower than that of regular migrants from non-Western countries. For employers, particularly in countries with a large informal economy, they form an ideal source of cheap labour: they have hardly any rights, and because of their need to remain invisible are unlikely to claim the few rights which they have. They are available at short notice,

need be paid little or nothing, and can be laid off without any consequences for the employer. Alongside the Roma population, they are probably the most disadvantaged group which Europe currently harbours. It is encouraging to see that the *Interim second report on social determinants of health and the health divide in the WHO European Region* (WHO EURO, 2011) focuses special attention on both Roma and irregular migrants (See Also Marmot et al., 2012).

The need for a combined approach

Arguments for joining forces

The data analysed above show that researchers on SDH on the one hand, and migration and ethnicity on the other, are currently competing for funds with each other rather than looking for ways to collaborate. EU research financing policy appears to be encouraging this split. Such a competitive approach is pointless, because as has been argued above, understanding the role of migration and ethnicity in generating and maintaining social stratification is essential to tackling socioeconomic inequalities in health. Different approaches need to work hand in hand, rather than seeing each other as rivals. They are essential for each others' success, as the following arguments show.

In the first place, there is a long tradition of work on ethnicity and migration (as well as on sex, disability, age etc.) which forms an invaluable resource for combating health inequalities. Research traditions and methods of intervention have been developed over a period of decades, although nobody would claim that they have reached anything like maturity. Thanks to this work, we now know better how to investigate the problems of so-called 'hard-to-reach' groups and to tailor interventions and services to their needs (Rechel et al., 2011; Ingleby et al., 2012a, 2012b). Service provision for marginalised social groups requires special approaches, such as targeted methods of health promotion (Netto, Bhopal, Lederle, Khatoon & Jackson, 2010). Ways of involving migrant communities in projects to improve health have been pioneered in the discipline of Community Psychology (García-Ramírez, Hernández-Plaza, Albar, Luque-Ribelles & Suárez-Balcazar, 2012). Progress in tackling social inequalities in health will only be delayed if SDH researchers insist on reinventing the wheel and ignoring these resources.

Secondly, there is probably more social support available for tackling other forms of inequity than there is for reducing the SES gradient as such. To start with, EU legislation defines nine 'protected characteristics', making it illegal to discriminate (whether directly or indirectly, individually or institutionally) on grounds of race, disability, gender, age, gender reassignment, sexual orientation, pregnancy and maternity,

religion or belief, and marriage and civil partnerships. A legal apparatus exists to combat discrimination on the basis of these characteristics, which can lend powerful legitimation to efforts to reduce related health inequalities. However, 'class' or SES is *not* a protected characteristic (although the last Labour government in the UK made a short-lived attempt to insert a 'socio-economic duty' into equality legislation). It is therefore somewhat paradoxical that the only form of inequality which the SDH programme has chosen to prioritise is the one which is not covered by legislation. There are also traditions of activism and social engagement built up around the struggle against diverse sorts of discrimination and inequity. The SDH programme could tap into these movements as sources of energy and support, if only it would broaden its scope to embrace a wider view of 'health inequalities'.

Thirdly, much more attention needs to be paid to the ways in which different forms of inequality interact with each other. Complex dynamics link (for example) ethnicity, SES and gender, so that only limited results can be expected from approaches which attempt to tackle these issues separately. To argue that we should first tackle the most general form of inequity, that related to SES, and deal with the other issues later, is to ignore the fact that different forms of inequity are interconnected and mutually reinforcing. In this connection we need to think not only of ethnicity and migration, but also of sex, age, disability and other differences.

There is increasing interest among social scientists in the phenomena of 'intersectionality' or 'multiple discrimination', which the health equity movement would do well to emulate. Östlin et al. (2011, p. 3) argue that "coordinated and urgent efforts are needed to shift research from single risk factor analysis to more comprehensive perspectives". They ask: "What are the interactions between the axes of social differentiation and how do these contribute to the patterning of inequity at population level? ...More specifically, how do economic status, ethnicity, and gender intersect to shape health risks and outcomes?"

This, indeed, seems the only way forward for the health equity movement. What is needed is a truly integrated approach to inequities in health, in which attention is paid to all relevant factors at the same time – however challenging this may be methodologically. Health equity is indivisible, and there is little sense in prioritising one type of inequity at the expense of another. If the SDH programme is seriously interested in tackling 'the causes of causes', it cannot avoid the need to make an explicit analysis of social stratification, utilising insights from sociology and other social sciences. Moreover, the type of analysis which is appropriate is likely to vary between times and places; it seems unlikely that the dynamics of stratification in Bogota will be identical to those in Barnsley.

Acknowledgements

I would like to thank Raj Bhopal, Mark Johnson, Ursula Karl-Trummer, Vincent Lorant, Sarah Salway and Karien Stronks for their valuable comments on an earlier draft of this article. They are not responsible for the errors and omissions that remain.

References

- Agyemang, C., van Valkengoed, I., Hosper, K., Nicolaou, M., van den Born, B. J., & Stronks K. (2010). Educational inequalities in metabolic syndrome vary by ethnic group: evidence from the SUNSET study. *International Journal of Cardiology*, 141, 266-74.
- Bhopal, R. S. (2007). *Ethnicity, race, and health in multicultural societies; foundations for better epidemiology, public health, and health care*. Oxford: Oxford University Press.
- CBS Statline (2012) Online database. Heerlen: Centraal Bureau voor de Statistiek. Retrieved from <http://statline.cbs.nl/StatWeb/?LA=nl>
- Chorev, N. (2012). *The World Health Organization between North and South*. Ithaca, NY: Cornell University Press. Retrieved from <http://books.google.nl/books?id=OvdUFPp1oW4C&dq>
- CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on the Social Determinants of Health*. Geneva: World Health Organization. Retrieved from <http://bit.ly/xqmJdD>
- Dahhan, N. (2007). *Gezondheidszorg & etnische diversiteit in Nederland: Naar een betere zorg voor iedereen*. Amsterdam: PaceMaker in Global Health.
- Desrosiers, M. (2007). *Framing strategies to play the communal card: Illustrations from the Sri Lankan and Bosnian cases*. Paper presented at the annual meeting of the International Studies Association 48th Annual Convention, Hilton Chicago, Chicago, IL, USA. Retrieved from <http://bit.ly/OySk0J>
- DHSS (1980). *Inequalities in health: report of a research working group (The Black report)*. London: Department of Health and Social Security.
- DHSS (1998). *Independent inquiry into inequalities in health (The Acheson Report)*. London: Department of Health and Social Security.
- Dittmer, J. (2009). *The good doctors: The medical committee for Human Rights and the struggle for social justice in health care*. New York: Bloomsbury Press.
- EC (2009). *Solidarity in health: reducing health inequalities in the EU*. Brussels: European Commission. Retrieved from <http://bit.ly/yFK9Bw>
- Erasmus Medical Centre (2007). *Tackling health inequalities in Europe: An integrated approach EUROTHINE*. Rotterdam: University Medical Centre. Retrieved from <http://bit.ly/RiegWP>
- Exworthy, M., Bindman, A., Davies, H. T. O., & Washing-

- ton, A. E. (2006). Evidence into policy and practice? Measuring the progress of U.S. and U.K. policies to tackle disparities and inequalities in U.S. and U.K. health and health care. *Milbank Quarterly*, 84, 75-109.
- FORUM (2012) *Alloctonen op de arbeidsmarkt 1e kwartaal 2012*. Utrecht: FORUM.
- García-Ramírez, M., Hernández-Plaza, S., Albar, M-J., Luque-Ribelles, V., & Suárez-Balcázar, Y. (2012). Building healthcare stakeholder coalitions: a community psychology approach to user involvement for migrant populations. In Ingleby, D., Chiarenza, A., Devillé, W., & Kotsioni, I. (Eds.) *Inequalities in health care for migrants and ethnic minorities. COST Series on Health and Diversity* (Volume II, pp. 188-204). Antwerp/Apeldoorn: Garant.
- Guralnik, J. M., & Leveille, S. G. (1997). Race, ethnicity, and health outcomes – unraveling the mediating role of socioeconomic status. *American Journal of Public Health*, 87, 728-730.
- Ingleby, D., Chiarenza, A., Devillé, W., & Kotsioni, I. (Eds.) (2012b). *Inequalities in health care for migrants and ethnic minorities. COST Series on Health and Diversity* (Volume II). Antwerp/Apeldoorn: Garant.
- Ingleby, D., Krasnik, A., Lorant, V., & Razum, O. (Eds.) (2012a). *Health inequalities and risk factors among migrants and ethnic minorities. COST Series on Health and Diversity* (Volume I). Antwerp/Apeldoorn: Garant.
- Kaplan, H. R. (2011). *The myth of post-racial America: Searching for equality in the age of materialism*. New York: Rowman & Littlefield.
- Karl-Trummer, U., & Sardadvar, S. (2012). The interplay of health, migrant status and socioeconomic status in eight EU countries. In D. Ingleby, A. Krasnik, V. Lorant & O. Razum (Eds.), *Health inequalities and risk factors among migrants and ethnic minorities. COST Series on Health and Diversity* (Volume I, pp. 79-92). Antwerp/Apeldoorn: Garant.
- Karl-Trummer, U. (2010). *EC funded research projects tackling health inequalities in Europe in the 5th/6th/7th framework programs – Where are the migrants?* Presentation at meeting of COST Action IS0603, 'Health and social care for migrants and ethnic minorities in Europe', Brussels. Retrieved from [http:// bit.ly/MmqNDc](http://bit.ly/MmqNDc)
- Kaufman, J. S., Cooper, R. S., & McGee, D. L. (1997). Socioeconomic status and health in Blacks and Whites: The problem of residual confounding and the resiliency of race. *Epidemiology*, 8, 621-628.
- Kovacheva, V., & Vogel, D. (2009). *The size of the irregular foreign resident population in the European Union in 2002, 2005 and 2008: Aggregated estimates*. Hamburg Institute of International Economics. Database on Irregular Migration. Working Paper No.4/2009. Retrieved from <http://bit.ly/zYtDge>
- Krieger, N. (1999). Embodying inequality: A review of concepts, measures, and methods for studying health consequences of discrimination. *International Journal of Health Services*, 29, 295-352.
- Lorant, V., & Bhopal, R.S. (2011). Ethnicity, socioeconomic status and health research: insights from and implications of Charles Tilly's theory of Durable Inequality. *Journal of Epidemiology and Community Health*, 65, 671-675.
- Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). *Fair Society, healthy lives: strategic review of health inequalities in England post 2010*. London: UCL. Retrieved from <http://bit.ly/PpHFDk>
- Marmot, M. G., Stansfeld, S., Partel, C. North, F., Head, J., White, I., ... Smith, G. D. (1991). Health inequalities among British civil servants: the Whitehall II study. *The Lancet*, 337, 1387-1393.
- Nazroo, J. Y. (1998). Genetic, cultural or socioeconomic vulnerability? Explaining ethnic inequalities in health. *Sociology of Health and Illness*, 20, 710-730. Retrieved from <http://bit.ly/MfJ3rO>
- Netto, G., Bhopal, R., Lederle, N., Khatoon, J., & Jackson, A. (2010). How can health promotion interventions be adapted for minority ethnic communities? Five principles for guiding the development of behavioural interventions. *Health Promotion International*, 25, 248-57.
- OSF (2010). *No Data—No Progress. Country Findings. Data Collection in Countries Participating in the Decade of Roma Inclusion, 2005–2015*. New York: Open Society Foundations. Retrieved from <http://bit.ly/Ouiofy>
- Östlin, P., Schrecker, T., Sadana, R., Bonnefoy, J., Gilson, L., Hertzman, C., ... Vaghri, Z. (2011). Priorities for research on equity and health: Towards an equity-focused health research agenda. *PLoS Medicine*, 8, e1001115. doi: 10.1371/journal.pmed.1001115
- Pels, T.V.M., & Veenman, J. (1996). Onderwijsachterstanden bij allochtone kinderen: het ontbrekende onderzoek. *Sociologische Gids*, 63, 131-146.
- Rechel, B., Mladovsky, P., Devillé, W., Rijks, B., Petrova-Benedict, R., & McKee, M. (Eds.) (2011). *Migration and health in the European Union*. Maidenhead: McGraw Hill / Open University Press. Retrieved from <http://bit.ly/JzLkmd>
- Ruger, J.P., & Yach, D. (2009). The global role of the World Health Organization. *Global Health Governance* 2. Retrieved from <http://bit.ly/Qkbha4>
- Salway, S., Nazroo, J., Mir, G., Craig, G., Johnson, M., & Gerrish, K. (2010). Fair society, healthy lives: a missed opportunity to address ethnic inequalities in health: rapid response, 12 April 2010. *British Medical Journal*. Retrieved from <http://bit.ly/ReymMN>
- Tajfel, H. (1981). *Human Groups and Social Categories*. Cambridge: Cambridge University Press.
- Tilly, C. (1998). *Durable Inequality*. Berkeley, CA: University of California Press.
- Virchow, R. (1848). *Die medizinische Reform*, 2. In H.E. Sigerist (1941), *Medicine and Human Welfare* (p. 93). New Haven: Yale University Press.
- WHO (1978). *Declaration of Alma-Ata*. Geneva, World Health Organization. Retrieved from <http://bit.ly/OLsdGY>
- WHO (2010). *How health systems can address health*

- inequities linked to migration and ethnicity*. Copenhagen: WHO Regional Office for Europe. Retrieved from <http://bit.ly/hKAe3T>
- WHO EURO (2011). *Interim second report on social determinants of health and the health divide in the WHO European Region*. Copenhagen: World Health Organization Regional Office for Europe. Retrieved from <http://bit.ly/P6o52r>
- WHO, Government of South Australia (2010). *Adelaide Statement on Health in All Policies*. Geneva: World Health Organization. Retrieved from <http://bit.ly/PEHu7K>

Manuscript received: 17/09/2012

Review received: 08/11/2012

Accepted: 09/11/2012