Survey of Ethnic Minorities (FNS), a representative survey of ethnic minority and White people living in England and Wales in 1993–4. Because none of the White sample were asked the set of questions on ethnic identity, the chapter is restricted to minority ethnic groups for which there were sufficient numbers for reliable statistical analyses (Caribbean, Pakistani and Bangladeshi, Indian and African Asian groups).

The final chapter in Part 1 examines and applies a range of measures of socio-economic status to illuminate the multiple pathways along which it affects health. The authors note how socio-economic position is associated with differences in power, prestige and forms of consumption (like exercise routines and tastes in food). It is associated, too, with differences in employment conditions and how much control an individual exercises over the pace and content of their work. Socio-economic status also captures differences in people's material living standards: in what people can afford by way of housing, diet, etc. The chapter uses existing measures of socio-economic status which tap these different dimensions to map the pathways linking socio-economic inequality to health inequalities among women. The analysis includes both measures of health and risk factors like cigarette smoking linked to heart disease. It draws on two surveys for its analysis: the Health and Lifestyle Survey (HALS) and the Health Survey for England (HSFE).

2 Ethnicity, health and the meaning of socio-economic position

George Davey Smith, Katherine Charsley, Helen Lambert, Sheila Paul, Steve Fenton and Waqar Ahmad

Introduction

Observed differences in both health status and health service use across ethnic groups have been variously attributed to cultural, socio-economic and genetic differences, as well as to the impact of individual and institutional racism. The roles of health-related selection at the point of migration and of possible artefacts in the process of data collection have also been examined (Smaje 1995). The contribution of differences in socio-economic circumstances to health differentials between ethnic groups has been an area of particular – and often polemical – concern. Research into ethnicity and health often utilizes inappropriately crude and simplistic cultural variables, sometimes neglecting issues of social deprivation entirely (Sheldon and Parker 1992; Ahmad 1996). Alternatively, some authors who are concerned with socio-economic differences have interpreted their data as showing that differentials in mortality between ethnic groups are essentially due to income or class inequalities (Navarro 1990), while other studies suggest that this explanation is at best partial (Cooper 1993).

Health research in this area has also tended to treat the construct of 'ethnicity' itself as unproblematic, taking certain ethnic categories (for example 'Indian' or 'Asian' in Britain) for granted, and presuming that the 'ethnic groups' so termed are essentially and unproblematically different from the majority ethnic population in a concrete and unchanging manner (see Chapter 3; Senior and Bhopal 1994; Ahmad 1999; Fenton and Charsley 2000). In fact, many of the factors which, taken together, compose and constitute

ethnicity – language, religion, experience of racism, migration, family life, ancestry, culture and forms of identity – are constantly changing (or their definitions are changing) and cannot be used to draw an immutable 'line' around a given population. Where the possible causal pathways for ill-health are not made explicit, 'untheorized ethnicity' (Nazroo 1998) can lead to the pathologizing of minority ethnic status in itself.

Although it is, nonetheless, possible to take some operational definition of ethnically-bounded populations as reasonable working categories, analysing ethnic differentials in terms of cultural or social class differences remains subject to several difficulties (Navarro 1990; Ahmad 1996; Lambert and Sevak 1996). Studies which emphasize cultural difference as the primary explanatory factor suffer from two main problems: they may overemphasize cultural differences between groups and neglect socio-material conditions (Lambert and Sevak 1996), while the existence of socio-economic differences within minority ethnic populations may be ignored (Ahmad 1996; Bhopal *et al.* 1999). Apparent socio-economic differentials in health status within minority ethnic communities may not be of equal magnitude or even in the same direction as those among the majority ethnic population, although this could reflect artefacts within particular studies (Smaje 1995). Whatever the reasons, simple adjustment for socio-economic position within multi-ethnic samples is clearly problematic (Davey Smith in press).

Controlling for socio-economic differences when comparing ethnically defined populations is essential if we are to avoid misleading conclusions regarding the causes of apparent health variations between and within ethnic groups; but we must also be sure that the measures of socio-economic position are not themselves misleading. In the UK, conventional measures which have long been used in studying health variations among the White majority ethnic population are generally employed in studies that include ethnicity as a characteristic of the populations being investigated, or that attempt to investigate ethnic variations in health directly. For example, a recent study concluded that tuberculosis is not associated with socio-economic disadvantage among South Asians, because area-based deprivation measures which predicted tuberculosis rates among the White majority population did not do so among South Asians (Hawker *et al.* 1999). However, if conventional indices of socio-economic position are not associated in the same way with the actual material conditions of life in minority ethnic groups as they are in the majority ethnic population, then such conclusions could be misleading. Thus it is known that income levels within social classes are lower and employment patterns more unfavourable (e.g. levels of shift work) for some minority ethnic groups than the majority ethnic population (Pirani *et al.* 1992). Occupational social class categorizations, too, will have different connotations according to labour market position. This is particularly pertinent for women in some minority ethnic communities. For example, compared to the overall population, African Caribbean

women have greater involvement in the labour market, while Pakistani and Bangladeshi women remain largely outside the formal labour market, although are often engaged in piecework or homeworking (Ballard 1994).

Given these important differences, the standard practice of adjusting for occupational social class provides an inadequate way of attempting to deal with material inequalities when examining the links between ethnicity, social position and health. Moreover, other measures may also vary in relation to ethnicity and hence fail to provide reliable comparative indicators when used to adjust for socio-economic position in multi-ethnic samples. For example, current income is related to wealth, or to real purchasing power, in a different manner in different ethnic groups (Pirani *et al.* 1992; Cooper 1993).

The study on which this chapter is based confronts the limitations of conventional measures of socio-economic position directly by investigating the meanings of socio-economic position within and between different ethnic groups, including the White majority population. The chapter focuses mainly on qualitative work with members of minority ethnic populations.

Studying ethnicity and socio-economic position

The findings presented here form part of a larger study. Involving comparative work in two cities, Bristol and Leeds, the study combines qualitative and quantitative techniques in an attempt to contribute to the improvement of the use of socio-economic indicators in multi-ethnic population health studies.

The qualitative phase, from which these findings come, employed ethnographic research and in-depth interviewing. Initial consultations with 'community leaders', health professionals and other 'gatekeepers' aimed both to introduce the two full-time researchers to potential contacts in the field as well as to capture their knowledge of each city and its ethnic communities – an exercise we termed 'city mapping'. This enabled the identification of potential field sites, which were then visited to assess their suitability for participant observation. A number of community group settings were chosen and the researchers made frequent visits to these sites throughout this phase of the fieldwork.

This initial fieldwork facilitated the development of a 'topic guide' comprising issues to be explored in semi-structured interviews with adults from White, African Caribbean and South Asian communities, with a target of 90 such interviews in each city. All individuals were interviewed in the language of their choice. Initially, interviewees were recruited at field sites, and by snowballing from these contacts. As the research progressed, sections of the population which proved difficult to access through these routes were identified and new strategies, such as approaching workplaces, were employed to contact potential interviewees. Part-time research assistants/interviewers

recruited from the minority ethnic communities helped to broaden the scope of potential contacts, and provided invaluable assistance to the study as key informants.

In the following sections, we draw on the qualitative material to give some indications of the complexity of the links between ethnicity and socio-economic position. Membership of a minority ethnic community does not necessarily imply that individuals and their networks possess particular characteristics; it does not predict behaviour, or even guarantee the experience of discrimination. However, the influence of different dimensions of ethnicity – including migration, language, religion, experience of racism and family formation – can create circumstances in which conventional indicators of socio-economic position, such as housing tenure, occupational class and education, have different meanings, and so may not function as expected in health research. We also show how the interlinking of different elements of ethnicity produce contingent meanings, depending on complex interactions with other aspects of life. In consequence, their meaning cannot simply be 'read off' from an initial identification of the ethnic affiliation of an individual, household or community.

Migration, racism, education and employment

The number of years of education and/or educational qualifications are commonly used in health research as a marker of socio-economic position. One problem faced by some adult migrants is the loss of recognition of their qualifications and experience in the new country. As a result, educational qualifications do not provide an equivalent degree of access to employment within all ethnic groups. This means that some migrants are being classed with those who have similar educational qualifications but greater employment opportunities and thus potentially higher standards of living. A 67-year-old Kenyan Asian man related his experience on arriving in Britain in the 1970s:

> I trained to be a teacher . . . which was again in Kenya . . . our tutors were all English, and at that time the understanding was that the training they were giving us was the same equivalent to the one which was given to the teachers there. And if we ever came over to this country our education would be . . . accepted, which well [laughs] never happened . . . Well, when I came to this country I was 41 years old. I tried to get into teaching but as I said before because they did not accept my qualifications . . . In Kenya? Oh yes, oh yes. I mean, I was a deputy head of a big junior school where we had 1100 pupils.

Although many South Asian and African Caribbean migrants arrived in Britain several decades ago, similar difficulties may face more recent arrivals. A Jamaican accountant who came to Britain four years ago complained that he was unable to gain positions which reflected his skills and qualifications:

> The thing is in Jamaica the positions were higher . . . the technical knowledge was much more demanding, here I just move through . . . The thing what I found was that the conversion wasn't accurate – although they say it's English exams, and you passed those exams, you are not classified in the same category as a man who passed it in England, . . . Anyway I scored the same marks as the [other] person and they called us back for a second interview, but then you're in that interview room and I told them my [recent accountancy exam] results and said this push me a bit further if we were on equal footing before, but yet still they didn't give me the job. That scoring thing, there's something wrong there. I mean the job was a joke really in terms of my abilities. So say if they found someone better than me, that means that people in England are very qualified or somebody is telling a lie.

A South Asian man who had brought his wife to Britain from Pakistan complained that, although she was a qualified doctor and an 'AA student', she had had to complete a conversion course before applying for jobs in this country. Having completed the course, he felt that her continuing difficulties in gaining employment were attributable to racist attitudes. For these last two people, difficulties in gaining recognition for qualifications seem to have been compounded by discrimination in the job market. These experiences show how migration and racism can combine to alter the meaning of education as an indicator of socio-economic position for sections of the minority ethnic communities.

Racism may continue to prevent the conversion of educational qualifications into employment opportunities for subsequent generations who have not themselves experienced migration. A South Asian man who had studied law had been unable to gain employment in the field: 'There's so much indirect racism in the law field, and there is about seven Asians in the whole of Bristol that studied law and can't get a job'. His younger brother had also been unable to find a job and had won a case for discrimination against one of the companies who rejected his application: 'When I wrote my CV I wrote my name, and I wrote "Singh". And probably they know he's Asian'.

Again, the influence of aspects of ethnicity is multiple and complex. Both these young men perceive that their background has hindered their prospects in other ways: as the first graduates from their household, they felt they had no familiarity with the culture of professional workplaces and no access to the 'old school tie' networks which the elder brother feels exist in law practices.

Migration, paid work and standard of living

As well as influencing the level of paid work which educational credentials can obtain for people, migration has several other influences on working lives. For example, a Pakistani woman reported how she negotiated with her husband about the propriety of women working:

> I never work before. I get two kid when I come from Pakistan, and when I had four kid, and he can't go to work properly because he was ill. And I said to him, why don't you allow me to go to work, and he was so angry with me! He said no – it's a shame for me. I said no, it's not shame for you. Because in Pakistan, it is shame, but not in here. Now, in these days, now everyone is working in Pakistan too, mind . . . and I go to work myself with my friend part-time. And he shout on me, and we fight. I said, I'm not going to stop my work because it's not wrong. Is everybody going to work. Plus you can't go to work properly and it does help when you get extra money. And after little while, he was angry but he just keep quiet because he know I won't stop. I was doing a part-time job in laundry . . .

There are other aspects of employment and standard of living that mean migrants and their families may differ from the majority ethnic population. In the years following migration to the UK, not only did many members of minority ethnic groups suffer a loss of socio-economic position exacerbated by racism, but in the struggle to establish themselves and their families in Britain, many made conscious sacrifices in terms of their standard of living. In our interviews, second generation African Caribbeans talked of the long hours their parents had worked in order to be able to afford to bring their children to Britain, and to support them once they were here. A Pakistani woman in her sixties who had been a factory worker spoke of how she had invested everything in giving her children a private education, despite the fact that they were living in poor-quality housing. While these sacrifices may themselves have had impacts on health, they could also disturb the assumed association between socio-economic position and health. However, the process of settlement has to be seen within the historical trajectory of migration: in the early phase, migrants may experience a large financial burden through remittances, while also saving for housing and children's education. Expenditures as well as income may therefore differ greatly from the majority ethnic group.

Migration, culture and social support

Strong support networks have frequently been seen as typical of certain minority ethnic families and communities, in particular of South Asian communities. It has been suggested that this 'cultural' feature has a 'buffering' effect between life stresses and health (Cochrane and Stopes-Roe 1981), although the stereotype of a 'protective Asian culture' has in turn been criticized (Sashidharan and Francis 1993; Nazroo 1998). Recent work on caring in minority ethnic communities shows that carers do not receive greater family support than White carers, and that many may be receiving considerably lower levels of support (Katbamna *et al.* 1998). In our fieldwork, several people of South Asian heritage pointed to the importance of close family ties in their communities and many testified to the vital support (from helping with housework and child care to providing employment or access to interest-free loans) that these ties provided. However, we also found close kinship networks to be an invaluable source of social and financial support among many of the White working-class families in our study. Conversely, some interviews with South Asians revealed a number of counter-examples where the 'cost' of strong social networks in terms of restrictions and obligations may be very high. In some cases, respondents reported that they had moved house, area, or even city to escape the negative influence of 'the community'. Some of those interviewed attributed a decision to move into an area with few or no other South Asians to a desire to escape constant scrutiny and pressure to conform. In a few cases, individuals had been forced to move away after transgressing the boundaries of, as they saw it, approved behaviour; or had chosen to live separately from other members of their extended families as a result of experiencing physical or mental abuse within the joint household.

As well as providing a more nuanced picture of the negative as well as positive dimensions of 'social support', our material also demonstrates that the preference of many South Asian families for living in joint households results, at least partially, from socio-economic considerations rather than from some abstract cultural imperative. Several young married couples of South Asian origin were able to save towards buying their own homes while living with their parents, thus having greatly reduced living costs. Conversely, the benefits to a South Asian woman, who had been abused, of moving into a separate household were partially offset by the increased financial burden that this entailed for her and her husband.

This latter example is not intended to suggest that extended families are necessarily a source of stress. The reduction in social support which can result from the severing of ties with family and friends as a result of migration is often felt hardest by those without the financial means to make return visits, or even keep in frequent telephone contact. One Pakistani woman who had come to Britain for marriage reported spending most of her time sleeping or crying from loneliness. She considered that language problems and pressure against women working outside the home, combined with migration and a radical shift in living circumstances from extended family to nuclear household, contributed to her depression.

Housing and ethnicity

Housing tenure is a commonly used socio-economic indicator (see Chapters 8 and 12), however, it has limitations as a marker of housing quality in multi-ethnic studies. For example, South Asian owner-occupiers are more likely to live in accommodation which is older, unmodernized and overcrowded (Jones 1993) or lacking in basic amenities (Nazroo 1997). Thus, they may not have the usual socio-economic advantages of owner-occupiers. Indeed, it has been argued that high levels of owner occupation among South Asians should be understood, at least partly, as a reaction to racism in council home allocation (Smith 1989) and as a result of the mismatch between housing availability and need in housing allocation (Bowes *et al.* 1997).

In contemporary residential distribution, the influence of differing aspects of ethnicity can act as both carrot and stick, incentive and constraint. The support gained from proximity to family, community and specialized services may combine with limited financial resources and discrimination to perpetuate areas of high minority ethnic concentration in relatively deprived inner-city locations. As the African Caribbean man quoted below shows, while social support and access to such culturally important services as specialist food shops might be seen to increase well-being, such areas often present other problems which could damage health. For example, it is widely considered that inner-city areas suffer from poor quality health service and educational provision as well as more environmental hazards, like traffic danger and lack of play space:

> This area, it's got a lot of advantages, the only thing about the areas where Black people live in Bristol is that it's all dead close to the motorway and it's all dead polluted . . . It's a great place to live in terms of people. As far as the housing is concerned, it's difficult to have a private garden, a lot of people are living in places that are too small for themselves, there's too much traffic around here, it's not a good place to bring kids up in terms of health. So there's all those disadvantages and if you want to change all that you need to move to an area where there's no Black people. It's a catch-22 in Bristol.

Discrimination by lenders has probably contributed to the low levels of owner occupation among Black Caribbeans (Phillips and Karn 1992), while the process of housing allocation as well as the cultural value placed on home-owning may help to explain high levels of home ownership among some South Asian groups. A national survey found much Pakistani and Bangladeshi owner-occupied property to be of poor quality and lacking basic amenities (Lakey 1997), a fact supported both by local housing surveys in Bristol (Lambert and Razzaque 1997) and Leeds (Law *et al.* 1996), and our own research. In our study, several members of owner-occupied

Pakistani households on low incomes in the Harehills area of Leeds reported great difficulty in meeting mortgage payments and affording household repairs, and could not envisage being able to move to more appropriate properties.

Occupational class and ethnicity

Occupational class is perhaps the most commonly used marker of socio-economic position in British health research. However, minority ethnic groups are often concentrated in less favourable locations within a given occupational grade, suffering from job insecurity, stress and unsociable hours (Nazroo 1997). Even when in the same occupation as her White colleagues, this African Caribbean former midwife felt that her working conditions in one particular hospital were much worse:

> I felt very much that I was put in situations that were very dangerous and, if I complained, it was very much that I was stirring it and making trouble. So far as me writing letters to the managers to say how unsafe I felt professionally. And I felt very unsupported yet the blond-haired, blue-eyed people had as much support as they wanted. They would be promoted far quicker than the Black or ethnic minority midwives that were there. And I had never come against that kind of racism on such a huge scale because it was very subtle, they didn't come out with it, you know what I mean.

There are also some distinct patterns of minority ethnic employment. In Bristol at the time of the 1991 census, for example, while Indians and East Africans were over-represented in occupational class 1 (professional), Pakistani men were over-represented in the category of the self-employed. High levels of self-employment among South Asians present a particular challenge to occupational classifications, as the category is very broad. Several of those interviewed had been self-employed at one time, but their businesses had failed. Others, however, are evidently doing well from self-employment, as this Pakistani man running a general store with his brother makes clear when talking about his financial situation:

> If I need something, I'll go and buy it, and that's it . . . For example, if I need a car, I'll go and buy a car. If I need a sofa, go and buy a sofa. If I want something I can go and buy it. I can't say I can go and buy a plane, but not everybody wants a plane, well I don't want a plane, but I'm saying to my own requirements, whatever I need, I can go and buy.

A recent study carried out in Glasgow confirms the difficulties in measuring occupational class which are presented by the scale of the South Asian small business economy. Williams *et al.* (1998) credit business ownership

with having disrupted the relationship between class and standard of living, and therefore between class and health. Not only are the self-employed difficult to categorize, but domestic use of business goods (and vice versa), combined with sharing of goods through social networks, may raise the standard of living afforded at particular levels of income.

Even if present occupational social class can be readily assigned, current measures of socio-economic position do not necessarily provide an accurate picture of lifetime social circumstances. One African Caribbean man who had spent the bulk of his working life in the building trade until the most recent UK recession, and who described himself as poor, had grown up in a wealthy family in Jamaica until his father answered the call for labour from the 'mother country' and became a bus driver in Britain. But others who participated in the research had experienced childhood deprivation and their current classification into a particular social class would mask this past experience of poverty. With reference to some of the cases described above, the South Asian woman who had worked in a factory to send the children to private school reported that her children were currently at university or in employment. She also revealed that at one stage in their childhood, the family was living in such poor conditions, their poverty compounded by a lack of information on the benefits system, that a neighbour reported their situation to the social services. For her children, their educational attainment and occupational position reported in adulthood would mask this experience of early life deprivation.

Implications

The ways in which the measurement of socio-economic position can influence understanding and assessment of its contribution to ethnic group differentials in health status has been discussed by several authors (e.g. Kaufman *et al.* 1997; Davey Smith *et al.* 1998, Davey Smith in press). The sections above have illustrated how socio-economic categories – whether based on education, employment, occupational social class or housing tenure – may have neither the same nor consistent meanings in different ethnic groups. Aggregated socio-economic indicators (for example the area-based deprivation indices commonly utilized in British studies) and individual-level indicators may capture different aspects of socio-economic position. Areas with a high level of individual socio-economic disadvantage may also be disadvantaged with respect to transport, retail outlets, leisure facilities, environmental pollution and social disorganization, in ways that influence health independently of the individual socio-economic characteristics of the people living in these areas (see Chapters 8, 9, 10 and 12). These disadvantages may be greater in areas where a high proportion of people with minority ethnic heritage live.

A growing body of research has demonstrated that lifetime social

circumstances contribute to health (see Chapter 5) and that using only data regarding social circumstances in adulthood fails to take into account the full effect of such lifetime circumstances (Davey Smith *et al.* 1997). Studies utilizing only one measure of socio-economic position will leave considerable potential for residual confounding by other health-influencing aspects of social experience. As the evidence presented in this chapter suggests, the degree to which this occurs will differ between ethnic groups. At the same apparent level of, say, current occupational class, the lifetime social circumstances or area-level social characteristics will differ across and within different ethnic groups. Similarly, at the same level of education, incomes differ between ethnic groups; or at the same level of income, there may be wealth disparities.

The qualitative research excerpted above demonstrates the different ways in which socio-economic indicators have diverging connotations in different ethnic groups or in different contexts of ethnicity. A failure to appreciate these problems when studying the contribution of socio-economic position to health differences between ethnic groups produces a form of reasoning by elimination, which leads to explanations concentrating on assumed genetic or cultural differences. For example, in a recent study of ethnic group differences in stroke in London, Stewart *et al.* (1999) compared stroke rates among two groups which they defined as Black (African Caribbean, 'Black African' and 'Black other' according to the 1991 British census categories) and White (a group they don't define). The stroke rates among Blacks were around twice as high as among Whites, and statistical adjustment for occupational social class only partly accounted for this elevated stroke rate. On the basis of this, the authors suggest that ethnic differences in genetic, physiological and behavioural risk factors for stroke require further elucidation. As demonstrated above, adjustment for occupational social class will only capture some aspects of the socio-economic environment that influence stroke risk and may not provide an index of social circumstances in the same way among the groups which Stewart *et al.* refer to as Blacks and Whites. This then produces data which apparently – but spuriously – demonstrate that health differences are due to genetic or cultural/behavioural factors.

As some minority ethnic groups are among the most disadvantaged sections of British society, measures which misrepresent the standard of living of minority ethnic groups risk not only perpetrating but exacerbating disadvantage through inadequate investment of public resources. Equally, an improved understanding of the processes which underlie ethnic differences in socio-economic position and health has the potential to lead to more appropriately targeted interventions. There is therefore a pressing need to develop more sensitive indicators of socio-economic position, particularly for use in research into the causes of ethnic inequalities in health. As a result of the qualitative fieldwork from which these findings are drawn, a survey

tool has been developed and is being piloted in Leeds at the time of writing. While the qualitative findings described above have allowed for the close observation of the variety of ways in which ethnicity may change the meaning of indicators of socio-economic position, the numbers of people involved are necessarily much smaller than can be accessed by quantitative survey techniques. The two methods, qualitative fieldwork and quantitative surveys, must therefore be used in combination to produce new indicators for use in the study of health and illness across ethnic groups.

Acknowledgements

This chapter draws on research funded by the ESRC (L128251007) under the Health Variations Programme. Our thanks to Kathy Powell for fieldwork direction in Leeds and Ghazala Mir, Shakeel Razak, Marcia Hylton and Faye Scott for fieldwork assistance, and our advisory committees for guidance.

References

Ahmad, W.I.U. (1996) The trouble with culture, in D. Kelleher and S. Hillier (eds) *Researching Cultural Differences in Health*. London: Routledge.

Ahmad, W.I.U. (1999) Ethic statistics: better than nothing or worse than nothing? in D. Dorling and S. Simpson (eds) *Statistics in Society: The Arithmetic of Politics*. London: Arnold.

Ballard, R. (ed.) (1994) *Desh Pardesh: The South Asian Presence in Britain*. London: Hurst & Co.

Bhopal, J., Unwin, N., White, M. *et al.* (1999) Heterogeneity of coronary heart disease risk factors in Indian, Pakistani, Bangladeshi and European origin populations: cross-sectional study. *British Medical Journal*, 319: 215–20.

Bowes, A., Dar, N. and Sim, D. (1997) Pakistanis and social rented housing: a study in Glasgow, in A. Bowes and D. Sim (eds) *Perspectives on Welfare: The Experience of Minority Ethnic Groups in Scotland*. Aldershot: Ashgate.

Cochrane, R. and Stopes-Roe, M. (1981) Social class and psychological disorder in natives and immigrants to Britain, *International Journal of Social Psychiatry*, 27: 173–82.

Cooper, R.S. (1993) Health and social status of Blacks in the US, *Annual Epidemiology*, 3: 137–44.

Davey Smith, G. (in press) Ethnicity, health and socio-economic position in Britain and the USA: learning to live with complexity, *American Journal of Public Health*.

Davey Smith, G., Hart, C., Blane, D., Gillis, C. and Hawthorne, V. (1997) Lifetime socio-economic position and mortality: prospective observational study, *British Medical Journal*, 314: 547–52.

Davey Smith, G., Neaton, J.D., Wentworth, D., Stamler, R. and Stamler, J. (1998) Mortality differences between black and white men in the USA: contribution of income and other risk factors among men screened for the MRFIT, *Lancet*, 351: 934–9.

Fenton, S. and Charsley, K. (2000) Epidemiology and sociology as incommensurate games: accounts from the study of health and ethnicity, *Health*, 4(4): 403–25.

Hawker, J.I., Bakhshi, S.S., Ali, S. and Farrington, C.P. (1999) Ecological analysis of ethnic differences in relation between tuberculosis and poverty, *British Medical Journal*, 319: 1031–4.

Jones, T. (1993) *Britain's Ethnic Minorities*. London: PSI.

Katbamna, S., Bhakta, P., Parker, G., Ahmad, W.I.U. and Baker, R. (1998) *Experiences and Needs of Carers from South Asian Communities*. Leicester: Leicester University Nuffield Community Care Studies Unit.

Kaufman, J.S., Cooper, R.S. and McGee, D.L. (1997) Socio-economic status and health in blacks and whites: the problem of residual confounding and the resiliency of race, *Epidemiology*, 8: 621–8.

Lakey, J. (1997) Neighbourhoods and housing, in T. Modood, R. Berthoud and J. Nazroo *et al.* (eds) *Ethnic Minorities in Britain: Diversity and Disadvantage*. London: PSI.

Lambert, C. and Razzaque, K. (1997) *Asian Housing Needs in Bristol*. Bristol: UWE.

Lambert, H. and Sevak, L. (1996) Perceptions of health and the sources of ill-health among Londoners of South Asian origin: is 'cultural difference' a useful concept? in D. Kelleher and S. Hillier (eds) *Researching Cultural Differences in Health*. London: Routledge.

Law, I., Davies, J., Philips, D. and Harrison, M. (1996) *Equity and Difference: racial and ethnic inequalities in housing needs and housing investment in Leeds*. Leeds: University of Leeds 'Race' and Public Policy Research Unit, School of Sociology and Social Policy.

Navarro, V. (1990). Race or class versus race and class? *Lancet*, 336: 1238–40.

Nazroo, J. (1997) *The Health of Britain's Ethnic Minorities*. London: PSI.

Nazroo, J. (1998) Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health, *Sociology of Health and Illness*, 20: 710–30.

Phillips, D. and Karn, V. (1992) Race and housing and a property owning democracy, *New Community*, 18: 355–69.

Pirani, M., Yolles, M. and Bassa, E. (1992) Ethnic pay differentials, *New Community*, 19: 31–42.

Sashidharan, S. and Francis, E. (1993) Epidemiology, ethnicity and schizophrenia, in W.I.U. Ahmad (ed.) *'Race' and Health in Contemporary Britain*. Buckingham: Open University Press.

Senior, M. and Bhopal, R. (1994) Ethnicity as a variable in epidemiological research, *British Medical Journal*, 309: 327–30.

Sheldon, T. and Parker, H. (1992) Race and ethnicity in health research, *Journal of Public Health Medicine*, 14: 104–10.

Smaje, C. (1995) *Health, Race and Ethnicity*. London: King's Fund Institute.

Smith, S.J. (1989) *The Politics of Race and Residence*. Cambridge: Polity.

Stewart, J.A., Dundas, R., Howard, R.A., Rudd, A.G. and Woolfe C.D.A. (1999) Ethnic differences in incidence of stroke: prospective study with stroke register. *British Medical Journal*, 318: 967–71.

Williams, R., Wright, W. and Hunt, K. (1998) Social class and health: the puzzling counter-example of British South Asians, *Social Science and Medicine*, 47: 1277–88.