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Ethnic density effects on health and experienced racism among Caribbean people in the US and England: A cross-national comparison

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ABSTRACT

Studies indicate an ethnic density effect, whereby an increase in the proportion of racial/ethnic minority people in an area is associated with reduced morbidity among its residents, though evidence is varied. Discrepancies may arise due to differences in the reasons for and periods of migration, and socioeconomic profiles of the racial/ethnic groups and the places where they live. It is important to increase our understanding of how these factors might promote or mitigate ethnic density effects. Cross-national comparative analyses might help in this respect, as they provide greater heterogeneity in historical and contemporary characteristics in the populations of interest, and it is when we consider this heterogeneity in the contexts of peoples' lives that we can more fully understand how social conditions and neighbourhood environments influence the health of migrant and racial/ethnic minority populations.

This study analysed two cross-sectional nationally representative surveys, in the US and in England, to explore and contrast the association between two ethnic density measures (black and Caribbean ethnic density) and health and experienced racism among Caribbean people. Results of multilevel logistic regressions show that nominally similar measures of ethnic density perform differently across health outcomes and measures of experienced racism in the two countries. In the US, increased Caribbean ethnic density was associated with improved health and decreased experienced racism, but the opposite was observed in England. On the other hand, increased black ethnic density was associated with improved health and decreased experienced racism of Caribbean English (results not statistically significant), but not of Caribbean Americans. By comparing mutually adjusted Caribbean and black ethnic density effects in the US and England, this study examined the social construction of race and ethnicity as it depends on the racialised and stigmatised meaning attributed to it, and the association that these different racialised identities have on health.

Introduction

There have been significant levels of migration from the Caribbean to Europe and North America since the 1880s (Goulbourne & Solomos, 2004). Comparative studies of Caribbean migrants who have settled in different countries show that the contemporary situation of Caribbean ethnic communities in their host countries depend as strongly on the social context that received them as on the skills and motivations that the migrants arrived with (Portes & Grosfoguel, 1994). Understanding the context of specific migrant populations is important (Williams, Mohammed, Leavell, & Collins, 2010), but unfortunately most research on migrant and second generation integration has been conducted within a single nation state (with the vast majority done in the United States), with little comparative analysis (Waters, 2010). The only study that to our knowledge has compared health inequalities and socioeconomic circumstances of US and English black Caribbeans showed marked differences in health and socioeconomic markers between black Caribbean people in the US and in England, whereby the former group had better health than their English counterparts (Nazroo, Jackson, Karlsen, & Torres, 2007). Framing these findings in the context of migration differences between the two Caribbean populations suggested that results were driven by differences in available opportunities in the destination countries (Nazroo et al., 2007), since Caribbean migration to the US happened at a time when migrants were able to take advantage of the civil rights movement in a way that the pre-existing African American

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population and the black Caribbean population in the UK were not. In fact, Caribbean migrants to the UK migrated to England as labour migrants after World War II in the face of considerable hostility from some of the English population (Nazroo et al., 2007). Although the study by Nazroo and colleagues is the first cross-national study to examine how the context of migration and post-migration circumstances influence the health of black Caribbean groups in the US and England (Nazroo et al., 2007), its results were limited by a lack of consideration given to the role of neighbourhood in patterning health profiles across populations. Living in deprived neighbourhoods has been associated with increased mortality and morbidity, independent of individual-level attributes (Pickett & Pearl, 2001; Riva, Gauvin, & Barnett, 2007), and it is now well established that racial/ethnic minorities in both the US and England are more likely than their white counterparts to be residentially concentrated in the most deprived neighbourhoods (Karlsen, Nazroo, & Stephenson, 2002; Massey & Denton, 1993). However, when the detrimental association between concentrated neighbourhood deprivation and health is accounted for, and focus is placed on the association between living among other ethnic minority people and health, neighbourhoods with high levels of racial/ethnic minority concentration have been found to provide its residents with protective effects on health through the ethnic density effect, which posits that as the proportion of an ethnic minority group in a neighbourhood increases, their health complications will decrease (Halpern & Nazroo, 2000). Theoretical discourses of the ethnic density effect propose that positive health outcomes are attributed to the protective and buffering effects that enhanced social cohesion, mutual social support and a stronger sense of community and belongingness provide from the direct or indirect consequences discrimination and racial harassment (Bécares, Nazroo, & Stafford, 2009; Halpern & Nazroo, 2000; Smaje, 1995). Several studies have examined the effects of ethnic density on health, with some studies finding a protective ethnic density effect, and others reporting a detrimental or null association. The evidence for or against ethnic density effects varies depending on the ethnic minority group analysed, and on the measure of health examined. For example, studies that have explored the association between ethnic density and self-rated health among US and English black populations have all reported null associations (Bécares et al., 2009; Karlsen et al., 2002; Mellor & Milyo, 2004; Pickett, Shaw, Atkin, Kiernan, & Wilkinson, 2009; Robert & Ruel, 2006; Usher, 2007; White & Borrell, 2006), and although English studies have differentiated between black African and black Caribbean groups (Bécares et al., 2009; Karlsen et al., 2002; Pickett et al., 2009), none of the studies conducted in the US have considered ethnic group differences among black populations. Other markers of physical morbidity, such as hypertension, have received less attention, with no English studies focussing on this outcome, and only one study in the US examining black ethnic density effects on hypertension, which reported a null association (Cozier et al., 2007). More consistent ethnic density effects have been found for mental health outcomes, including suicide. Two studies have explored ethnic density effects on suicide-related outcomes among black people in the UK; one found a trend for a protective effect of black ethnic density on suicide as most probable cause of unnatural death (Neeleman & Wessely, 1999), and the other reported protective ethnic density effects on deliberate self-harm (Neeleman, Wilson-Jones, & Wessely, 2001). To date, no studies have examined the association between suicide and ethnic density in the US.

Discrepancies in ethnic density effects may arise due to differences in the countries of origin of the predominant minority groups, reasons for migration, and differences in the cultural, economic and demographic profiles of both the ethnic groups and the places where they live. It is important to increase our understanding of how these factors might promote or mitigate ethnic density effects, and one useful way of achieving greater insight into the mechanisms behind ethnic density is through cross-national comparisons of ethnic density effects. Cross-national comparative analyses provide greater heterogeneity in historical and contemporary characteristics in the populations of interest, and it is when we consider this heterogeneity in the contexts of peoples' lives that we can more fully understand how social conditions and processes such as neighbourhood environments, including ethnic density, influence the health of migrant and ethnic minority populations.

The US and England differ in key processes that shape the "context of reception" in which migrants arrive (Nazroo et al., 2007), including motivations for and patterns of migration, both historical and contemporary ethnic relations, and the extent and nature of racial/ethnic residential segregation. This latter process is particularly relevant to cross-national comparisons of ethnic density effects given the importance that analytical power obtained from the range of ethnic density has been found to have in detecting ethnic density effects (Shaw et al., in press). Levels of residential concentration vary greatly in the US and England (Peach, 1999), and particularly for British black Caribbean people who are one of the least concentrated racial/ethnic groups. One might thus expect ethnic density effects to differ across these two national contexts given methodological and contextual differences. Health researchers have been encouraged to pay attention to the ways in which segregation may affect the health of black migrants (Williams et al., 2010), and so cross-national comparisons of Caribbean migrants to the US and England should incorporate existent evidence on neighbourhood effects on health, and examine how ethnic density theories relate to the health patterning of Caribbean groups in both contexts.

Experiences of racial harassment and discrimination are also encompassed within this concept of "context of reception," as they result from the socialisation of migrant populations into racialised ethnic identities that reflect historical and current racial/ethnic relations. Black Caribbean migrants, given that they are both black and migrant, have been suggested to face more pressures and inequalities compared with native blacks or white migrants (Williams et al., 2007). Studies in the UK show an association between increased ethnic density and decreased experiences of racism (Bécares et al., 2009; Stafford, Bécares, & Nazroo, 2010), and an indication of a reduction in the detrimental association between racism and health as ethnic density increases, but to the best of our knowledge no study to date has examined whether this applies in the US.

Entry into a hostile national climate can adversely affect the well being of migrant groups (Williams et al., 2010), and cross-national studies seeking to understand the patterning of health across racial/ethnic groups in different countries should pay attention to factors that might be included under the concept of "context of reception" as explanatory variables in health outcomes (Nazroo et al., 2007), including ethnic density and experienced racism. The present study aims to examine and compare ethnic density effects among US black Caribbean (hereon: Caribbean American) and British black Caribbean (hereon: Caribbean English) in order to: 1) examine whether experiences of Caribbean American and Caribbean English differ in terms of ethnic density effects on health; 2) examine whether increased ethnic density is associated with decreased experiences of racism among Caribbean people in the US, and whether it differs from that of their English counterparts; and 3) explore whether a buffering effect of ethnic density exists in the association between racism and health, in other words, whether the detrimental association between experienced racism and poor health is reduced in neighbourhoods of high ethnic density.