

Inequalities and ethnicity: evidence and intervention

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Introduction

The Acheson Report (Acheson, 1998) included a chapter on 'Ethnicity', an important dimension of inequalities in health in the UK. The chapter acknowledged the difficulties in defining ethnicity and considered evidence on health inequalities from different definitions of ethnicity. Apart from documenting the patterns of morbidity and mortality among the major ethnic groups living in Britain, the report noted differences in socioeconomic status between ethnic groups. Unemployment, poverty and poor housing conditions among Pakistani and Bangladeshi households were highlighted as potentially contributing to their poorer health in general. However, there remains considerable debate about specific factors that underlie both ethnic differences in health and differences in health within ethnic groups.

The inquiry made recommendations in two general areas: first, general policies targeted at disadvantaged socioeconomic groups in which minority ethnic groups are disproportionately represented; and second, policies specifically targeted at ameliorating health service access for minority ethnic groups. As minority ethnic communities typically contain a higher proportion of households with children, living in disadvantaged socioeconomic conditions, these communities should benefit from general policies targeted at mothers, children and families and those related to education, employment, poverty and housing. The inquiry argued that separate policies for minority ethnic groups risked marginalising minority ethnic issues, with the implication that the health problems in minority ethnic groups are different from those in the ethnic majority, with different causes and different solutions. Any such implication would run counter to the evidence that suggests that the similarities between ethnic groups in the causes of health inequalities are greater than the differences (Bhopal, 1997).

On the other hand, the inquiry also acknowledged that failure to

consider minority ethnic issues risked increasing ethnic inequalities by unintentionally favouring policies that benefited the ethnic majority. So the inquiry also made recommendations specific to ethnic minorities. These were:

- the further development of services that are sensitive to the needs of minority ethnic people and that promote greater awareness of their health risks; and
- the specific consideration of minority ethnic groups in needs assessment, resource allocation, healthcare planning and provision.

In addition, as data on the health of minority ethnic groups are particularly hard to collect and are based on inappropriate definitions of ethnicity, the inquiry's general recommendation to improve the capacity to monitor inequalities in health and their determinants is especially valid for ethnic minorities.

This chapter will update the evidence available on health patterns among ethnic groups by considering significant findings from data sets that have become available since the report of the Acheson Inquiry was published. The Acheson Report examined evidence on the major ethnic groups and so 'excluded' other minority groups such as religious and cultural groups and the Traveller/Roma communities. In addition to new findings from new data sets, this chapter considers some evidence on access to and use of health services by ethnic groups and how the responsibilities of public services have changed with the 1999 publication of Sir William Macpherson's report on the Stephen Lawrence inquiry and the Race Relations (Amendment) Act in 2000. Finally, we return to the dilemma of general and specific policies and their likely effects on health inequalities. In conclusion, recommendations for tackling inequalities are made.

Post-Acheson Report evidence on health patterns

New data

Since the Acheson Report's publication, four significant population representative sources of data have become available that add to the overall picture. The first of these is the 2001 census variables on ethnicity. In the England and Wales 2001 census, Pakistani and Bangladeshi men and women in England and Wales reported the highest rates of 'not good' health in 2001 (ONS, 2005). Pakistanis had age-standardised rates of 'not good' health of 13% (men) and 17% (women). The age-standardised rates for Bangladeshis were 14% (men) and 15% (women).

These rates, which take account of the difference in age structures between the ethnic groups, were around twice those of their White British counterparts. Chinese men and women were the least likely to report their health as 'not good'.

Second, the ethnicity data in the ONS Longitudinal Study have been used to describe patterns of morbidity and mortality (Harding and Rosato, 1999; Harding and Balarajan, 2000; Harding and Balarajan, 2001) as well as test complex hypotheses about intergenerational changes in the associations about ethnicity and health. For example, for South Asians and Black Caribbeans poor health has persisted across generations, and for Black Africans health has worsened (Harding and Balarajan, 2000). Among mothers of Black Caribbean, Black African, Indian, Pakistani and Bangladeshi ethnicity, mean birth-weights of infants of migrant mothers were similar to those of infants whose mothers were born in the UK, contrary to the expectation that UK-born minority ethnic mothers would have higher birth-weight babies than migrant mothers (Harding et al, 2004). In terms of social mobility, between 1971 and 1981 there was some upward social mobility among South Asian and West Indian migrants, but most minority ethnic groups remained socially stable, and relatively disadvantaged compared with the majority population (Harding and Balarajan, 2001). Social disadvantage persists across generations of ethnic minorities. Evidence from the life-course literature shows that the accumulation of disadvantage across the life course results in poorer health trajectories. This suggests that an increase in health inequalities among ethnic minorities and migrants can be expected (Harding and Balarajan, 2001).

Third, the EMPIRIC (Ethnic Minority Psychiatric Illness Rates in the Community) study (Sproston and Nazroo, 2002), a quantitative and qualitative survey of rates of mental illness among different ethnic groups in England, published its findings. This study showed that Black Caribbean people do not have significantly higher prevalence of psychotic illnesses compared to the White majority group, whereas they do show much higher rates of first contact with treatment services for such illnesses. In contrast to studies on rates of contact with services, the EMPIRIC study indicated a twofold higher rate for Black Caribbean people compared with the White group. This difference was not significant for men or the total Black Caribbean population and was not significant at the level of estimated rates of psychosis. Even if Black Caribbean people are more vulnerable to psychotic illnesses, the discrepancy between the data from psychiatric services and the general population suggests that they are also treated differently in the UK. Possible explanations suggested by the EMPIRIC study are

racism by psychiatrists and in the community, misunderstanding of cultural expressions of distress, differential responses by police and social and treatment services and social inequality. However, why such factors should operate for Black Caribbean people and not for other ethnic minorities is not clear. The EMPIRIC results are important in illustrating how ethnic group influences a person's pathway through the health services.

Fourth, there have been two large-scale population surveys of adults and children, representative of minority ethnic groups across England – the Health Survey for England in 1999 (Erens et al, 2001) and in 2004 (Sproston and Mindell, 2006). Both surveys reveal a complex distribution of health among the major ethnic groups. While some minority ethnic groups have significantly higher rates of disease (for example, cardiovascular disease among Pakistani and Bangladeshi groups, tuberculosis and sexually transmitted infections among Black African groups), other minority ethnic groups like the Chinese have better health than the majority White population. The two surveys are especially useful for looking at trends in patterns of health by ethnic group since the Acheson Report. Although a gap of five years is a relatively short time for analysing changes in population health, the rare availability of such population-representative data on ethnic minorities in 1999 and in 2004 makes it useful to see if there has been any narrowing of the health gap between ethnic groups living in England.

As may be expected, the trends by ethnicity are complex. For some health conditions, there is little change. Among the general population and all minority ethnic groups, there was no change in the prevalence of bad or very bad self-reported general health between 1999 and 2004. The pattern for age-standardised prevalence of doctor-diagnosed diabetes among minority ethnic groups relative to the general population was the same in 2004 as in 1999, among both men and women. Overall, the patterns for obesity by ethnic group in 2004 were similar to those in 1999, although for most groups the absolute levels of overweight and obesity have increased.

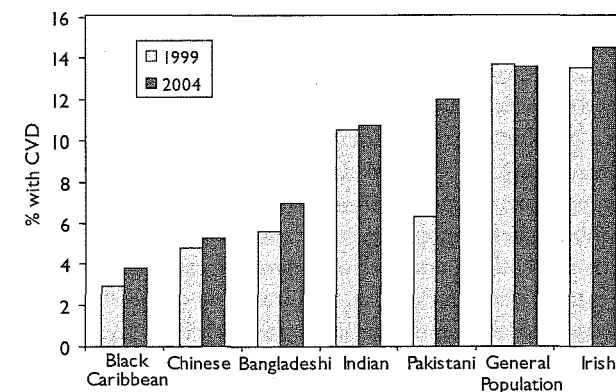
For other health indicators, there is some narrowing of the health gap (for example, smoking among Irish and Black Caribbean men, and physical activity among Bangladeshi and Chinese men). However, there is also a worrying increase in poor health for some minority ethnic groups. The levels of long-standing illness and limiting long-standing illness were significantly higher for Pakistani women in 2004 than they were in 1999. There was a general increase in the prevalence of cardiovascular disease (CVD) in all minority ethnic groups between

1999 and 2004. This increase was non-significant except for Pakistani men where the prevalence of CVD doubled significantly between the two surveys (see Figure 6.1). The prevalence of hypertension was higher in 2004 than in 1999 in most minority ethnic groups, although many of the increases were not statistically significant. There was a notable reduction in regular physical activity participation among Pakistani men between 1999 and 2004. Mean C-reactive protein generally did not change for different minority ethnic groups between 1999 and 2004 except for Pakistani men, in whom a significant increase was found in the proportion of informants with high levels. Between 1999 and 2004, mean ferritin increased significantly in Pakistani and Irish men, and in Black Caribbean and Bangladeshi women. Black Caribbean women showed significant increases in both mean LDL cholesterol, and in the prevalence of raised LDL cholesterol, which is an important risk factor for cardiovascular disease.

From this heterogeneous pattern of changes in ethnic minority health from 1999 to 2004, perhaps the most consistent pattern is the widening gap between the health of the majority population and that of Pakistani men and women. This widening gap is compounded by the fact that they experience some of the poorest health in the population, and suggests that efforts to reduce the health gap between ethnic groups are not being successful, at least at the population health level.

In addition to these population representative surveys, there has been a large-scale epidemiological study of Gypsies and Travellers

Figure 6.1: Prevalence of any cardiovascular disease by ethnic group in 1999 and 2004 among men aged 16 and over



Source: Health Survey for England 2004 (Sproston and Mindell, 2006)

(Parry et al, 2004). Results of this quantitative survey show that Gypsy Travellers have significantly poorer health status and significantly more self-reported symptoms of ill health than other UK-resident, English-speaking ethnic minorities. Furthermore, their social circumstances are more disadvantaged compared with other ethnic groups: Gypsy and Traveller children are among the ethnic groups most eligible to receive free school meals.

The patterns of poverty, employment status and geographical location and the specifics of age structure and gender are significant in understanding the differential effects of socioeconomic position on measurable health outcomes (Cooper, 2002). Part of this differential is that some minority ethnic groups are doing better in terms of wealth and health than the ethnic majority, while others are doing considerably worse and within ethnic groups such as 'South Asian' or 'Black African' there can be considerable divergence between sub-groups. Therefore, health inequalities within ethnic groups as well as between the ethnic majority and minority groups need to be considered.

Evidence on health service use and access

The routine recording of ethnic group was first introduced into the NHS in 1995/96. On admission to hospital, patients were asked to assign themselves to one of a list of ethnic groups matching those used in the 1991 census. The percentage of hospital inpatients with missing ethnicity was 52% in 1996/97 and 40% in 2000/01 (LHO, 2003). In 2001, the new census coding for ethnic groups was adopted and NHS hospitals were required to collect information on ethnicity in the revised format. By 2002, the proportion of hospital records with missing ethnicity coding dropped to 32%. In other NHS services, including Primary Care, Community and Mental Health Trusts, the range of ethnicity data varies hugely from 100% to just 17% (LHO, 2003). This provides a graphic illustration that some trusts can achieve high levels of valid recording, while others do not routinely collect ethnic origin data. For example, ethnic origin is not included in cancer registration data, despite higher than average incidence rates of specific cancers for men born in Scotland and Ireland (Harding and Rosato, 1999). The variable quality of these data makes monitoring of the effects of health services on mortality and morbidity inequalities very difficult. The complexity of what is meant by 'access to' and 'use of' health services has been illustrated by a case study of diabetes services in which minority ethnic patients who had access to the service could not necessarily

make full use of it, nor could they assume that their healthcare needs were being met appropriately (Rhodes et al, 2003). In a prospective study of coronary disease, among patients who were suitable, South Asian patients were less likely than White patients to receive coronary artery bypass grafting (Feder et al, 2002). The differences could not be attributed to physician bias and, in the absence of any comparison of clinical outcomes, could not straightforwardly be interpreted as the result of discrimination.

Ethnicity is not at present recorded on either birth or death certificates in the United Kingdom. A proposal has been made to include ethnicity at birth and death registration in England and Wales (Aspinall et al, 2003).

Explanations for inequalities

As well as documenting patterns of difference, there has been significant progress in establishing explanations of the patterns of health inequalities by ethnic group (see also Chapters Four and Five of this volume for a discussion of explanations of health inequality). A life-course approach has shown how the accumulation of socioeconomic disadvantage over time is related to higher risks of mortality among South Asian groups (Harding and Balarajan, 2001). The independence of the relationship between health and the experience of racism has been convincingly demonstrated (Karlsen and Nazroo, 2002). This is conceptually significant, since racism has often been assumed to be an aspect of deprivation, without a separate ill effect on health. Serious attempts to reduce behavioural risk factors for heart attack and stroke have shown the need to adopt differential strategies that emphasise different risk factors among different ethnic groups, especially in relation to alcohol use in the White population and weight in the Black Caribbean population (Dundas et al, 2001).

Racism

The publication in 1999 of Macpherson's report on the Stephen Lawrence Inquiry brought the term 'institutional racism' to public attention, defining it as follows:

... the collective failure of an organisation to provide appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviours which

amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority people. (Macpherson, 1999, para 6.34)

By highlighting institutional racism as a problem in the police force, the report also made it a matter of concern for public services in general. Despite its widespread use in terms of tackling health inequalities caused or exacerbated by institutionalised racism, Macpherson's definition is problematic because of its imprecision. This imprecision has its strategic uses, for instance in arguing that service provision failures such as inadequate translation and interpretation in the NHS can be seen as institutional racism and should be addressed and rectified (Green et al, 2002). The problem is that the documentation of how institutionalised racism operates organisationally, necessary in order to unravel its effects, is largely missing from the research literature. Instead, what can be found is the assertion of its presence due to the documentation of inequity, as in the following excerpt from a report on mental health services for minority ethnic groups that defines institutional racism as:

... a feature of institutions where there are pervasive racist attitudes and practices, assumptions based on racial differences, practices and procedures which are discriminatory in outcome, if not intent, and a tolerance or acceptance of such differences. (DH, 2003, p 37)

2000 Race Relations (Amendment) Act

To promote race equality in a modern, diverse Britain, the 2000 Race Relations (Amendment) Act places a general duty on public sector services, including the English, Welsh and Scottish NHS, to eliminate unlawful racial discrimination and to promote equality of opportunity and good relations between persons of different racial groups. This duty covers all aspects of an organisation's activities, policy, planning and service delivery, as well as employment practice (LHO, 2003). Furthermore, public sector organisations are required to monitor their activities for any adverse impact on race equality and demonstrate that they are making progress in race equality over a three-year period.

Requirements for ethnicity monitoring are set out in a range of NHS strategies, and yet there is little evidence of a consistent approach (LHO, 2003). A report into the implementation of the Race Relations (Amendment) Act among English strategic health authorities found

wide variation in the approach taken towards race equality performance management (Bhatt, 2003). It pointed in particular to a lack of knowledge and understanding of the Act and its implications, lack of clarity about the relationship between the implementation of the Act and delivering on the modernisation agenda and *The NHS Plan* (DH, 2000), and differences in understanding of the role of health authorities in performance management of this area. Strategic health authorities tend to focus on targets related to waiting lists and times, financial balance and hospital ratings, with less priority being assigned to race equality. It cannot be assumed that NHS organisations will independently pick up on race equality areas in the future without centrally driven and sustained agenda and priority setting.

General and specific policies

The two types of recommendations considered by the Acheson Inquiry to reduce ethnic inequalities in health – general initiatives to tackle poverty and those specifically targeted at minority ethnic people – have their own strengths and weaknesses. The task of assessing whether such policies are contributing towards the narrowing of inequalities between ethnic groups is hampered by the relative lack of robust, nationally representative data sets with appropriate measurement of ethnicity and authoritative analysis. It is only in the past few years that it has become possible to investigate ethnic inequalities in health and their structuring through social and economic disadvantage (Nazroo, 2003). Our assessment of the pattern of inequalities by ethnicity makes reference to population-representative data that have been published since the Acheson Inquiry. The inquiry confined itself to its tightly defined brief in terms of evidence surveyed and scope of recommendations. This left a number of features of ethnic minorities in Britain that were not addressed, such as religion and language, yet they may be relevant to health inequalities.

Anti-poverty and regeneration policies of the past decade have often been locality-based (for example, Sure Start, New Deal and Health Action Zones). While community ownership of state-funded policies has merit as a means of promoting engagement, the extent to which the population of impoverished people can be reached with locality-based initiatives is a problem in terms of promoting equity (see Chapter Eleven for further discussion of community-based initiatives). The difficulties of reaching people of minority ethnicity in poverty differ from those of reaching the general population because of geographic and demographic factors. The overwhelming concentration of minority

groups in London and other big cities is such that rural poverty is not currently a significant issue for this group. Despite the concentration of minority ethnic groups in cities, there is little evidence of the development of neighbourhood ghettos (Dorling and Thomas, 2004). Data from the 2001 census show that even in localities with the highest concentration they are nonetheless a minority: in Tower Hamlets 33% of the population is of Bangladeshi origin; in Leicester 26% is of Indian origin. The highest proportion of all minorities in England and Wales can be found in London, with the exception of those of Pakistani origin, who are concentrated in greatest numbers in the West Midlands and Yorkshire and Humber. So the issue of the reach of locality-based policies is problematic for minority ethnic groups, as for the ethnic majority. Anti-poverty policies are greatly needed among those minorities who suffer disproportionate levels of unemployment and material deprivation compared with others: within socioeconomic class grouping there is a minority ethnic disadvantage, particularly for people of Bangladeshi and Pakistani origin (Nazroo, 1998). The youthful age structure of minorities, especially those who migrated more recently, can exacerbate poverty because of the greater number of dependants per household.

A study by the Centre for Analysis of Social Exclusion at the London School of Economics (Hills and Stewart, 2005) has surveyed the evidence on the impact of government policies aimed at alleviating poverty, inequality and social exclusion since the Labour government was elected in 1997. The study suggests that policy responses have been variable, with certain areas such as employment, education, child poverty and neighbourhood regeneration being equipped with substantial new resources, and other areas, including the tackling of inequalities between ethnic groups, having received considerably less attention and resources. The study concluded that ethnicity was generally a sub-focus within social disadvantage, rather than the focus of specific policies. While there was a narrowing of the gap between ethnic groups in GCSE attainment (General Certificate of Secondary Education taken during the fifth year in secondary school), other dimensions of socioeconomic disadvantage such as lack of labour market participation continued to show a strong association with ethnic minority groups.

Policies specifically targeted at minority groups might offer some hope of addressing carefully defined and specific local problems with greater success than general policies; the devolution of commissioning to Primary Care Trust level makes this a current possibility. However, targeted policies are by no means a panacea and can reinforce ill-founded assumptions of homogeneity and immutability about the

targeted group, which may in turn further disadvantage people who have atypical health needs. The definition of a health priority for a particular ethnic group may be used, albeit inadvertently, as a summary of that group's needs, which may subsequently feed into a stereotyped way of treating that group. An example is the Asian Mother and Baby Campaign funded by the Department of Health, which sought to address some of the adverse outcomes observed in mothers of South Asian origin and their babies by employing interpreters and link workers to undertake health advocacy roles (Parsons and Day, 1992). However, difficulties in accessing care have also been attributed to poverty and a lack of transportation (Hayes, 1995), issues that cannot be easily addressed by good interpretation services or health advocacy.

An unavoidable (and recognised) problem with the Acheson Inquiry's recommendations on ethnicity and health inequalities was the incomplete evidence base on which they drew. What is meant by ethnicity and the proxies used for its measurement has varied greatly over the past 30 years as ethnicity and health has grown as a field of research. While a question on ethnic group was asked in the 1991 census, it was amended in the 2001 census (Aspinall, 2000), when a question on religion was asked for the first time in England and Wales. The recent arrival of these questions means that statutory data offer snapshots whose validity and reliability is hard to interpret. Categories for ethnic monitoring in the NHS were modified in 2001 and the ongoing poor quality of the data does not provide a good basis for understanding inequalities in employment, service use or outcome by ethnic group. If the value of the Acheson Report is to be judged by the quality of its evidence base, the work on minority ethnic health inequalities was, inevitably, limited.

Conclusion

The inequity of material deprivation, with well-documented ill effects on morbidity and mortality rates, can be compounded by forms of exclusion that are peculiar to minority ethnic groups. Discrimination based on religion, skin colour or an aspect of appearance such as dress that is perceived as racism may be further compounded by the deleterious effects of institutional organisations that create barriers for those who, for instance, do not speak English or who follow a special diet. Poverty, racism and various forms of discrimination operate so as to compound one another's effects and therefore it would seem that policies need to tackle the particularities of minority ethnic inequalities. However, the danger of having interventions targeted at

specific minorities is that the policy is proscriptive about the culture in question and this reinforces the idea that minority cultures are bounded and static (Bradby, 2003). There is also a danger that new minorities, arriving as illegal immigrants, refugees and asylum seekers, whose culture has not yet been recognised by public services, may be excluded. Health policy should seek to embed the protection of minority ethnic health into mainstream healthcare delivery, but how this can be done with the current patchy research database and the absence of good monitoring data remains unclear. The widening health gap for some minority ethnic groups, most notably for Pakistani men, suggests that the recommendations from the Acheson Report on reducing inequalities in health between ethnic groups are not currently effective at the population health level.

Practical steps to tackle inequalities

Since poverty and racism compound one another's effect so as to disadvantage people experiencing exclusion for reasons of material deprivation and for reasons of discrimination on grounds of poverty and racialised assumptions about difference, both have to be tackled. Ethnicity, like class and gender, is a complex, dynamic and contingent characteristic whose properties can pertain to individuals, families and larger groups. The context-dependent, labile nature of ethnicity means that a single policy to ameliorate all deficits associated with ethnicity is unlikely. However, there are two problems that affect minority ethnic groups disproportionately and never trouble the British ethnic majority in the British welfare state: first, the lack of a common language for communication with professionals; second, discrimination based on racialised ideas of difference. The lack of shared language disadvantages individuals seeking services and the availability and quality of interpretation services in the NHS is patchy, at best (Bradby, 2001). A widespread assumption that minorities should assimilate to a British norm may explain why the expense of interpretation services is often a low priority for trusts. A commitment to removing language as a barrier to accessing health services would have a significant impact on the quality of care, advice and information for people without fluent English. A translation service that was able to ensure the uptake of services and benefits by marginalised groups could have a long-term effect on the well-being of minority groups. It might also have a symbolic effect in signalling a willingness to cater for minorities on their own terms.

Racism is a separate issue, but tackling it at an institutional level would

be likely to have a beneficial effect on health at the individual level. The 2000 Race Relations (Amendment) Act could aid in reducing institutional racism and its effects on the health of minority ethnic groups, but the issues are likely to vary across the UK. Nine per cent of England's population was of minority ethnicity according to the 2001 Census (including so-called mixed categories) and these people are concentrated in London. The experience of racism in London may differ considerably from Wales (where 96% of those responding to the 2001 census gave their ethnic origin as White British), Scotland (88% White Scottish) or Northern Ireland (99% gave their ethnic group as White). Whether a single piece of legislation will be effective in these different settings remains to be seen. Interpersonal racism is much harder to tackle and to legislate against. Perhaps the most practical step in tackling ethnic inequalities arising from both poverty and racism is to make sure that data on ethnicity are reliably collected and coded in all surveys.

References

- Acheson, D. (1998) *Independent inquiry into inequalities in health*, London: The Stationery Office.
- Aspinall, P. (2000) 'The new 2001 census question set on cultural characteristics: is it useful for the monitoring of the health status of people from ethnic groups in Britain?', *Ethnicity and Health*, vol 5, no 1, pp 33-40.
- Aspinall P.J., Jacobson, B. and Polato, G.M. (2003) *Missing record: The case for recording ethnicity at birth and death registration*, London: London Health Observatory.
- Bhatt, C. (2003) 'Promoting race equality in the English NHS: a progress review', Report to the Commission for Racial Equality (http://193.113.211.175/downloads/docs/sha_report.doc).
- Bhopal R. (1997) 'Is research into ethnicity and health racist, unsound, or important science?', *BMJ*, vol 314, pp 1751-6.
- Bradby, H. (2001) 'Communication, interpretation and translation', in S. Dyson and L. Culley (eds) *Sociology, ethnicity and nursing*, Basingstoke: Macmillan, pp 129-48.
- Bradby, H. (2003) 'Describing ethnicity in health research', *Ethnicity and Health*, vol 8, no 1, pp 5-13.
- Cooper, H. (2002) 'Investigating socio-economic explanations for gender and ethnic inequalities in health', *Social Science and Medicine*, vol 54, no 4, pp 693-706.
- DH (Department of Health) (2000) *The NHS Plan: A plan for investment, a plan for reform*, Cm 4818, London: The Stationery Office.

- DH (2003) *Inside outside: Improving mental health services for black and minority ethnic communities in England*, London: The Stationery Office.
- Dorling, D. and Thomas, B. (2004) *People and places: A 2001 Census atlas of the UK*, Bristol: The Policy Press.
- Dundas, R., Morgan, M., Redfern, J., Lemic-Stojcevic, N. and Wolfe, C. (2001) 'Ethnic differences in behavioural risk factors for stroke: implications for health promotion', *Ethnicity and Health*, vol 6, no 2, pp 95-104.
- Erens, B., Primatesta, P. and Prior, G. (eds) (2001) *Health Survey for England 1999: The health of minority ethnic groups. Vol 1: Findings. Vol 2: Methodology and documentation*, London: The Stationery Office.
- Feder, G., Crook, A.M., Magee, P., Banerjee, S., Timmis, A.D. and Hemingway, H. (2002) 'Ethnic differences in invasive management of coronary disease: prospective cohort study of patients undergoing angiography', *BMJ*, vol 324, pp 511-16.
- Green, G., Bradby, H., Chan, A., Lee, M. and Eldridge, K. (2002) 'Equity and culture: is the NHS failing to meet the needs of mentally distressed Chinese origin women in England?', *Journal of Health Services Research and Policy*, vol 7, no 4, pp 216-21.
- Harding, S. and Balarajan, R. (2000) 'Limiting long-term illness among Black Caribbeans, Black Africans, Indians, Pakistanis, Bangladeshis and Chinese born in the UK', *Ethnicity and Health*, vol 5, no 1, pp 41-6.
- Harding, S. and Balarajan, R. (2001) 'Longitudinal study of socio-economic differences in mortality among South Asian and West Indian migrants', *Ethnicity and Health*, vol 6, no 2, pp 121-8.
- Harding, S. and Rosato, M. (1999) 'Cancer incidence among first generation Scottish, Irish, West Indian and South Asian migrants living in England and Wales', *Ethnicity and Health*, vol 4, no 1/2, pp 83-92.
- Harding, S., Rosato, M.J. and Cruikshank, J.K. (2004) 'Lack of change in birthweights of infants by generational status among Indian, Pakistani, Bangladeshi, Black Caribbean, and Black African mothers in a British cohort study', *International Journal of Epidemiology*, vol 33, no 6, pp 1279-85.
- Hayes, L. (1995) 'Unequal access to midwifery care: a continuing problem', *Journal of Advanced Nursing*, vol 21, no 4, pp 702-7.
- Hills, J. and Stewart, K. (eds) (2005) *A more equal society? New Labour, poverty, inequality and exclusion*, Bristol: The Policy Press.
- Karlsen, S. and Nazroo, J. (2002) 'Relation between racial discrimination, social class, and health among ethnic minority groups', *American Journal of Public Health*, vol 92, no 4, pp 624-31.

- LHO (London Health Observatory) (2003) *Ethnic health intelligence in London: The story so far*, London: LHO (www.lho.org.uk/HEALTH_INEQUALITIES/EHIP/EthnicHealthIntelligence.aspx).
- Macpherson, W. (1999) *The Stephen Lawrence Inquiry: Report of an inquiry by Sir William Macpherson of Cluny*, Cm 4262-I, London: The Stationery Office (www.archive.official-documents.co.uk/document/cm42/4262/sli-06.htm).
- Nazroo, J.Y. (1998) 'Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health', *Sociology of Health and Illness*, vol 20, no 5, pp 710-30.
- Nazroo, J.Y. (2003) 'The structuring of ethnic inequalities in health: economic position, racial discrimination and racism', *American Journal of Public Health*, vol 93, no 2, pp 277-85.
- ONS (Office for National Statistics) (2005) *Focus on ethnicity*, London: ONS (www.statistics.gov.uk/downloads/theme_compendia/foe2004/Ethnicity.pdf).
- Parry, G., Van Cleemput, P., Peters, J., Moore, J., Walters, S., Thomas, K. and Cooper, C. (2004) *Health status of Gypsies and Travellers in England*, Report of Department of Health Inequalities in Health Research initiative, Sheffield: School of Health and Related Research, University of Sheffield.
- Parsons, L. and Day, S. (1992) 'Improving obstetric outcomes in ethnic minorities: an evaluation of health advocacy in Hackney', *Journal of Public Health Medicine*, vol 14, no 2, pp 183-91.
- Rhodes, P., Nocon, A., and Wright, J. (2003) 'Access to diabetes services: the experiences of Bangladeshi people in Bradford, UK', *Ethnicity and Health*, vol 8, no 3, pp 171-88.
- Sproston, K. and Nazroo, J. (2002) *Ethnic minority psychiatric illness rates in the community (EMPIRIC): Quantitative report*, London: The Stationery Office (www.doh.gov.uk/public/empiric.htm).
- Sproston, K. and Mindell, J. (2006) *Health Survey for England 2004. Vol 1: The health of minority ethnic groups*, London: National Centre for Social Research.

CHALLENGING HEALTH INEQUALITIES

From Acheson to 'Choosing health'

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