

ETHNIC INEQUALITIES IN HEALTH: ADDRESSING A SIGNIFICANT GAP IN CURRENT EVIDENCE AND POLICY

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SUMMARY

Ethnic inequalities in health have been substantially neglected in policy discussions, most notably in the recent Marmot Review.¹ The reasons for this are likely to be complex, but this does leave a substantial gap in terms of a critical, policy relevant, analysis of the growing body of empirical material in this field. Through this contribution I will:

- Summarise key elements of the evidence on ethnic inequalities in health, identifying health differences across and within ethnic groups.
- Show that evidence on ethnic inequalities in health is of variable quality and often very disease-specific, making it difficult to draw broad conclusions on the underlying reasons for such inequalities.
- Discuss and evaluate possible explanations for observed ethnic inequalities in health, contrasting approaches that see causes as internal to ethnic categories – *for example, genetic differences and culture* – and those that focus on external context and inequalities.
- Introduce the argument and evidence that health inequality is driven by social and economic inequalities, rather than by inherent cultural or genetic factors. Such social and economic inequalities include those related to socio-economic position, area deprivation, and experiences of racism and discrimination. They differ across generations and across places, so are not inevitable.
- Conclude that social and economic inequalities are the driving force for ethnic inequalities in health and that there remains a need for substantial policy development in this field.
- Recommend that local policies to reduce health inequalities should be built around improving the employment conditions of public sector workers. My recommendation draws on the public sector as a substantial employer of staff, particularly of ethnic minority groups, and a major procurer of goods and services. It exploits huge scope for the sector to raise employment standards and reduce inequalities, for example by:
 - a. setting standards regarding good equitable employment practices, including through its supply chain, for example, on holidays, sick pay, parental leave, and limits to unpaid overtime;
 - b. ensuring more equitable distribution of salaries across employment grades; and
 - c. developing and protecting pension rights to minimise inequalities in income, post-retirement.

In specific reference to health and wellbeing boards, I recommend that they **make the labour market conditions of those delivering the services they commission a key dimension of their ambition to reduce inequalities in health and wellbeing.**

Introduction

Health inequalities have been a recurrent theme in public health policy since the New Labour government took office in 1997. Soon after its electoral success, New Labour established the Independent Inquiry into Inequalities in Health (chaired by Sir Donald Acheson),

following which there have been numerous policy initiatives around inequalities in health. More recently (since 2007), three significant events have occurred. The Secretary of State for Health established a Health Inequalities Expert Panel (chaired by Professor Chris Ham) to review the Department of Health's strategy for tackling health inequalities; the House of Commons Health Select Committee conducted its Inquiry on Reducing Health Inequalities; and the Department of Health established a Strategic Review of Health Inequalities in England Post-2010 (chaired by Sir Michael Marmot). Given the range of these activities, it is disappointing, though not surprising, to see that the issue of ethnic inequalities has taken a marginal and somewhat contested position. Most shocking, though, has been the complete neglect of ethnic inequality in The Marmot Review.¹ This marginalisation and neglect reflects two contrasting viewpoints. Firstly, that ethnicity somehow reflects exceptional, perhaps exotic, factors that drive differences in health experience; and secondly, that ethnic differences are simple reflections of class inequalities that are adequately captured by general discussions of socio-economic inequalities in health.

Here I will summarise key elements of the evidence on ethnic differences in health, examine potential explanations for these differences, draw out the implications of existing evidence for policy, and, finally, address the question: 'what one policy could make a difference if implemented at a local level?' Addressing this question is difficult for three reasons. First, we need to consider the complex inter-dependencies of policy development in social, economic and health arenas when attempting to identify just one policy. Second, the development and application of local policy clearly depends on the context set by national policy, where budgets and practice frameworks are determined, and where questions around inequality are, rightly, framed. Third, within the field of ethnic inequalities in health, there is little evidence on what works – interventions have largely focussed on service provision.

Consequently, my hopefully cogently argued, but poorly evidenced, proposed intervention concerns improving the employment conditions of public sector workers. This:

- a. is within the grasp of local agents;
- b. will impact positively on local labour markets; and
- c. will improve the circumstances of public sector employees. Particularly those in lower employment grades and more uncertain employment conditions, among whom there appears to be a disproportionate number of ethnic minority people.

The pattern of ethnic differences in health in the UK

Differences in health across ethnic groups have been repeatedly documented in the UK.^{2,3,4,5} Health is, of course, a multi-dimensional and complex concept, yet in statistics it is often reduced to death and/or specific disease categories such as coronary heart disease, hypertension, or diabetes. And the quality of research is often poor, with poor measurement of ethnicity, inadequate sampling of populations, and a crude characterisation of 'risk' factors. Nevertheless, some conclusions can be drawn. Here I will discuss both sources of data and the pattern of difference these reveal.

In the UK, mortality data are not available by ethnic group, but country of birth is recorded on death certificates and mortality rates have been published by country of birth using data

around the 1971, 1981, 1991 censuses and, to a more limited extent, the 2001 census. Given the relatively recent migration of most groups to the UK, analyses of mortality by country of birth are typically taken to indicate *ethnic inequalities* in health. Despite being statistically robust, these findings cannot be extrapolated easily to ethnic categories. The most obvious problem is that they do not cover the experience of UK-born ethnic minority people, which may well differ from migrants.⁶ Also important is that such statistics rely on the quality of the death certification process, which, in terms of both cause of death and characteristics such as occupation, is uncertain.⁷

In addition to these mortality data, over the last two decades there has been a growth in data on ethnic differences in morbidity in the UK.^{3,4,5} Although these contradict the immigrant mortality data in some respects (most notably in relation to conclusions drawn on the health of 'Irish' people), they are basically similar. In broad terms, data on ethnic differences in self-reported general health showed considerable difference in experience across minority groups, with the non-White groups having a variably increased risk of poor health compared with the White groups. Most notable, perhaps, is the wide variation in health experience for the three main South Asian groups, with Indian people having better health than Pakistani people, who have better health than Bangladeshi people.

In more detail, morbidity and mortality data have identified the following kinds of differences in health across ethnic groups:

- generally poorer health among non-White minorities, with Bangladeshi people having the poorest health, followed by Pakistani, Black Caribbean, Indian and Chinese people;
- high, but variable, rates of diabetes across all non-White groups;
- high rates of heart disease among 'South Asian' people, but particularly among Bangladeshi and Pakistani people;
- high rates of hypertension and stroke among Caribbean and African people, but low rates of overall mortality, and mortality from coronary heart disease, for men born in the Caribbean;
- low rates of respiratory illnesses across all non-White groups;
- high rates of admission to psychiatric hospitals with a diagnosis of psychotic illness for young Black Caribbean men;
- high rates of suicide among young women born in South Asia, or, more particularly, born in India;
- high rates of sexually transmitted illnesses among Black Caribbean people; and
- high rates of congenital abnormality and childhood disability among Muslim children.

Unfortunately, such findings and the analyses that underlie them do no more than provide a description of differences in health. The detail of the aetiological pathways – the sequence of interdependent events culminating in disease – underlying these specific differences in health is likely to vary considerably.

This complexity makes it tempting to generate explanations as to why ill health occurs based on the ethnic categories used to characterise populations. For example, it is easy to speculate on what it is to be South Asian that might lead to a greater risk of heart disease (genetics, diet, or other health behaviours?). Or what it might be about Caribbean families and cultures that lead to the high risk among young people of psychotic or sexually

transmitted illness. Or how marriage patterns might lead to high rates of congenital disease in Muslim children. Given the ease with which we can draw on explanations based on such stereotypes of racial difference/boundaries and cultural practices, it is important that such 'hypotheses' are robustly tested. But they are not. Explanations based on racialised identities typically go unchallenged. And it is also important that the social character of ethnicity is carefully considered in relation to the generation of these health inequalities.

So, it is worth a quick diversion to consider what we mean by ethnicity, or race, in this context. Here I draw heavily on the work of Solomos,⁸ who argues (I paraphrase here) that ethnic or race categories are 'discursive formations', calling into being a language through which apparent biological and cultural differences are identified and accorded social significance, and by which ethnic minority categories are shaped, named and also explained. Within such a framework, the relative social and health position of ethnic minority people is most easily understood to be a consequence of supposed biological and cultural differences, which are reified, generalised, and personalised across all of those who are seen to be members of the group. If this is the case, we need to understand why ethnic categories take the form and the meanings they do. How do the categories that we use in research and policy come to be? And how are the meanings attached to these categories lived and resisted?

Of course, we can only understand this in relation to broad historically embedded social processes, some of which are reflected in actions of the state. It is, however, worth asking why the contemporary consequences of these processes are not addressed more forcefully – who benefits from the failure to adequately consider ethnic inequalities?

What do we know about explanations for ethnic differences in health?

Not surprisingly, the pattern of explanations proposed for ethnic differences in health tend to follow the model developed in the Black Report, with some additional explanations included to cover issues considered particularly relevant to ethnicity. The list of explanations typically includes:

- genetic differences;
- migration effects (selection of healthy, or unhealthy, people into the migrant population, and the impact of migration and new context on people);
- culturally based differences in lifestyle;
- poorer access to good quality healthcare; and
- socio-economic inequalities, including experiences of racism and discrimination.

Although each of these has some relevance, below I focus on the contrast between explanations based on some internal, or essentialised, characteristics of ethnicity (genetics/biology and culture) and those based on the social circumstances of ethnic minority people.

Much medical research has concentrated on biological differences between ethnic groups, on the assumption that biological differences simply reflect genetic difference, and that genetics provide the explanation for ethnic differences in health. Although such work

has uncovered biological difference (for example in levels of blood glucose and blood pressure), it has failed to identify (or even test for) genetic underpinnings. Such research has also failed to adequately characterise ethnicity, instead using crude groups that reflect 'race' thinking, such as South Asian, Black and White. This fails to observe important diversity in clinical and biological outcomes within such racially defined groups. Most important is that such work has generally ignored the possibility that biological differences could result from exposure to socially determined factors, as well as genetic differences.

Another dominant theme in medical research has been an exploration of supposedly unhealthy lifestyles associated with ethnic minority cultures, for example a high fat 'South Asian' diet. And some have connected genetic risk with poor health behaviours, most notably in relation to vitamin D, where low levels among 'South Asian' people are argued to be a consequence of skin colour and clothing choices. Here people in ethnic minority groups are, conveniently, seen as the cause of their own problems. In fact, research examining health behaviours and lifestyles has led to mixed conclusions. For some behaviours, ethnic minority people generally fare well (namely diet, alcohol and smoking); and for others they fare less well (namely exercise). But there is also great variation in behaviours across groups, generations and genders. For example, the pattern of smoking among South Asian people varies dramatically across the three main groups, across men and women, across religions and across generations.⁴ Importantly, where we see shifts in health behaviours across generations, towards a more 'white' lifestyle, the impact on health is, if anything, adverse.⁶ And, as for biological differences, such behaviours relate very strongly to social class.

In contrast to research focussing on possible genetic or cultural underpinnings of ethnic differences in health, there is now considerable evidence that the social and economic inequalities faced by ethnic minority groups make a substantial contribution to ethnic inequalities in health. Inequalities in economic position across ethnic groups are marked and complex. The full nature of economic inequalities cannot be captured using single, or crude, measures of socio-economic position, such as occupational class, housing tenure, or area deprivation – although this is commonly attempted in health research. For example, within particular class groups, ethnic minority people earn less than White people, and Pakistani and Bangladeshi people in professional/managerial groups earn an average income that is equivalent to White people in semi- and un-skilled manual classes.⁹ This reflects the multi-dimensional nature of the economic and social inequalities that ethnic minority groups face, including: economic activity; employment levels; educational outcomes; housing; geographical location; area deprivation; racism and discrimination; citizenship, and claims to citizenship.

Nevertheless, those few empirical studies that attempt to address the complexity of the economic inequalities faced by ethnic minority people (rather than using single crude indicators) demonstrate that much, if not all, of ethnic inequalities in health are the product of economic inequalities.^{4,9} And there is now clear evidence that morbidity and mortality within all ethnic groups – regardless of the condition focussed on – is strongly patterned by socio-economic position. For example, richer South Asian people have low rates of cardiovascular disease.¹⁰ This variation within groups indicates the lack of an inherent link between ethnic (minority) category and disease outcome. In short, explanations that are based on an essential set of attributes for each ethnic category are not sufficient to explain why one individual is more prone than another to contracting a particular disease or illness.

There is also a growing body of evidence that additional dimensions of social inequality faced by ethnic minority groups – such as racism, discrimination and area deprivation – also impact on the health of members of minority groups. So, where research has been conducted, the clear indication is that both physical and mental health are adversely affected by: experiences of racial harassment; fear of experiencing racial harassment; experiences of discrimination; and the belief that people generally discriminate against ethnic minority people.^{11,12,13} These 'indicators' of racism and discrimination reflect general perceptions of society as racist (belief that minority groups are discriminated against, fear of racism), personal threat (fear of racism and experiences of harassment), and experiences of events that undermine status and identity (experiences of harassment and experiences of discrimination).

Similarly, there is strong evidence that the economically poorer areas in which ethnic minority people on average live, negatively impact on health over and above individual socio-economic markers.^{14,15} But, in contrast to this, there is also evidence that the aggregation of ethnic minority people in areas with those of similar ethnicity is beneficial, particularly for mental health.¹⁶ This is likely to arise through a combination of increased security (lower exposure to racial harassment and discrimination) and increased social support. Indeed, there is some evidence demonstrating that ethnic minority people rate the areas where they live much more highly than would be implied by official indices of deprivation. This is precisely because these are locations where a sense of inclusive community for people like them has developed.¹⁷

It is also possible that, as a consequence of institutional racism, ethnic minority people receive poorer quality healthcare and that this contributes to ethnic inequalities in health. In the UK, there remains (almost) free universal access to healthcare. This is reflected in an equal or greater use of primary care health services (except possibly in the case of Chinese people) by ethnic minority people compared with White English people.¹⁸ Similarly, for conditions managed in primary care, it seems that the outcomes of care (levels of undiagnosed or poorly managed illness) are as good for ethnic minority people as they are for White English people.¹⁸ This all indicates that quality of healthcare does not contribute to ethnic inequalities in health.

Nevertheless, the experience of care seems poorer for ethnic minority people. In primary care, ethnic minority people are more likely to be dissatisfied with various aspects of the care received,^{3,19} to wait longer for an appointment,¹⁹ and to face language barriers during the consultation.³ And, there is a convincing body of evidence suggesting that the higher admission rates of young Black men for severe mental illness reflects the ways in which they are racialised (for a full discussion of this, see (20)).

So, although a concern with the causes of specific conditions in particular groups might lead to a focus on the genetic and behavioural differences, work on social and economic causes shows clearly that the social and economic inequalities associated with ethnicity are the main drivers of ethnic differences in health.

But this is not just a simple reflection of class disadvantage. The complex and multi-dimensional nature of the economic and social inequalities faced by ethnic minority people makes their situation both complex to research and in need of specific policy responses. In fact, interventions aimed at countering socio-economic disadvantage in general – such as the

early years investments advocated by The Marmot Review¹ (and covered by Edward Melhuish in this publication) – may have little effect on the circumstances of ethnic minority people. This is particularly true if they are more likely to be excluded from such interventions,²¹ and if structures of racist discrimination persist into later life, for example, within the education system and labour market. Of course, such social and economic inequalities are resistant to serious policy analysis, making it extremely difficult to develop recommendations for policy intervention that are both effective and acceptable to the powers that be.

Ways forward: the need for policy development

As indicated earlier, it is clear that there has been little policy development to specifically address ethnic inequalities in health at a national level. This has been compounded by only occasional and fragmented implementation of policy at a local level; and no real evaluation of the impact on ethnic inequalities in health of targeted, or general, policies. Where policy has been developed and implemented, it has largely been concerned with addressing questions of accessibility to, and delivery of, services. There has typically been a focus on language and communication in health service provision through the provision of interpreters and translated material, rather than addressing the social and economic inequalities highlighted above. As a result, there is a shortage of useful evidence arising from the development and evaluation of policy.

In relation to ethnic inequalities more broadly, however, there is not a policy 'vacuum'. Rather there are a series of policies around culture, community and segregation that are populist and that disregard the evidence base. Examples are the neglect of the importance of deprivation in the Cattle inquiry into inner city disturbances in the North West of England;²² and more recent unfounded pronouncements on 'sleep-walking' to segregation.²³ Both of these continue to strongly influence government discussion and policymaking.

To address this gap in policy development and evidence, the following steps should be considered:

- A review should be conducted to develop evidence-based policy options in the specific field of ethnic inequalities in health – something that was within the remit of, and should have been covered by, The Marmot Review.¹
 - This should lead to trials of policy options and the rolling out of successful policy, paying careful consideration to the specificities of ethnic groups, places, and context.
 - The evidence base of existing policy around ethnicity, segregation, culture and citizenship should be carefully examined. In particular, there should be careful scrutiny of policies that undermine the citizenship claims and the social status of ethnic minority people. This scrutiny should focus on the evidence base for such policies and their likely negative impact on the health and wellbeing of such individuals and the communities within which they live.
 - These processes should be linked to an 'ethnic proofing' of policies focussed on social and health inequality more generally, with particular attention paid to possible implications for a widening, or narrowing, of ethnic inequalities.
 - Evaluation of policies focussed on social and health inequality should be designed and implemented in a way that allows for an explicit consideration of issues relating to ethnicity.
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Which policy for health inequalities at a local level?

The implications of the evidence base for policy development are that ethnic inequalities in health require, in the short-term, welfare, tax and benefit changes targeted at reducing economic inequalities. There should be a particular focus on the adverse economic position of ethnic minority people. Long-term policies must promote equitable life chances and address racism and the marginalisation of people with different ethnic backgrounds.

As for other inequalities in health, the development and implementation of such policies are in the hands of central, not local, government. The devolution of public health to local authorities should not be a means for central government to avoid responsibility for health inequalities. We could, and should, ask why such an important and difficult to address issue appears to have been devolved to local responsibility, particularly when central government still frames and sets local budgets and local policies.

So, in this context, which concrete policy at a local level could achieve aspirations around the reduction of ethnic inequalities in health? I have argued above that the key determinants are social and economic inequalities. As such, I would like to identify a policy that addresses these at a fundamental level, rather than be distracted into a discussion of promoting healthy behaviours, social participation and empowerment, or the provision of equitable services. Indeed, rather than consider the public sector in terms of the provision of services, we could consider it in terms of its role as an employer.

As an employer and trainer of staff, the public sector has the opportunity to provide a significant leadership role at a local (as well as national) level. For example, in 2005 the NHS directly employed 1.3 million people. Of these, 1.1 million were non-medical staff, of which 12.8% were from ethnic minority groups (ranging from 19% of nursing/midwifery/health visiting staff to 7.2% of managers). Of the medical staff employed, 43% had ethnic minority backgrounds. Indirectly, the NHS also employs a large number of people through sub-contracts (such as for cleaning services) and through associated industries.

The possibility of using the public sector as an employer to influence local labour market conditions has been recognised by the current coalition government. The Chancellor, in his March 2012 budget statement, raised the possibility of establishing regional variation in the salaries of public sector workers to reflect regional variations in labour markets. But, rather than using public sector employment to further lower the employment conditions of those working in other sectors, we could instead use the power of public sector employers to raise employment standards and reduce inequalities.

The public sector, as an employer, is able to set standards regarding good, equitable, employment practices. Furthermore, the sector is able to ensure that sub-contractors and independent contractors providing public services also meet these standards. Such practices could cover employment rights, holidays, sick leave, study leave, maternity leave, job security, job flexibility, limits to unpaid overtime, and management practices that promote autonomy and control at work. Such changes are likely to mostly benefit those in lower employment grades and more uncertain employment conditions.

In addition, improvements in employment conditions could also include financial benefits targeted at ensuring a more equitable distribution of salaries across employment grades.

And, this includes developing and protecting pension rights with the explicit intention of minimising inequalities in income, post-retirement. The immediate and longer-term impact of this on the broader social determinants of health inequalities is likely to be significant, particularly so for ethnic minority groups, who are over-represented in public sector workforces. Importantly, this would impact on local job markets, meaning other employers would need to follow suit if they were to compete.

Conclusion

In conclusion, **the policy I would recommend is for local government to place public health and the need to address inequalities in health at the centre of their employment practices.** This is something that could be a focus of the health and wellbeing boards that commenced operation in April 2013. These boards will continue the production of 'Joint Strategic Needs Assessments' (JSNAs) for their local area. They will use these to inform a local, Joint Health and Wellbeing Strategy (JHWS) that involves a wide range of sectors, including housing, education, transport, police, and the voluntary sector. Crucially, the boards will include representatives of clinical commissioning groups (CCGs) and will influence commissioning plans. The boards could make the labour market conditions of those delivering the services they commission a key dimension of their ambition to reduce inequalities in health and wellbeing.

Note on the author

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References

- 1 Marmot, M. (2010), *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010*, London: The Marmot Review. www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
 - 2 Marmot, M., Adelstein, A. M., Bulusu, L. and OPCS (1984), *Immigrant mortality in England and Wales 1970–78: Causes of Death by Country of Birth*, London: HMSO.
 - 3 Rudat, K. (1994), *Black and Minority Ethnic Groups in England: Health and Lifestyles*, London: Health Education Authority.
 - 4 Nazroo, J. Y. (2001), *Ethnicity, class and health*, London: Policy Studies Institute.
 - 5 Erens, B., Primatesta, P. and Prior, G. (2001), *Health Survey for England 1999: The Health of Minority Ethnic Groups*, London: The Stationery Office.
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- 6 Smith, N. R., Kelly, Y. J. and Nazroo, J. Y. (2009), 'Intergenerational continuities of ethnic inequalities in general health in England', *Journal of Epidemiology and Community Health*, 63, 253–258, doi:10.1136/jech.2008.077495.
 - 7 Swift, B. and West, K. (2002), 'Death certification: an audit of practice entering the 21st century', *Journal of Clinical Pathology*, 55, 4, 275–279.
 - 8 Solomos, J. (1998), Beyond Racism and Multiculturalism, *Patterns of Prejudice*, 32(4), 45–62.
 - 9 Nazroo, J. Y. (1998), 'Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health', *Sociology of Health and Illness*, 20, 5, 710–730.
 - 10 Nazroo, J. Y. (2001), 'South Asians and Heart Disease: An assessment of the importance of socioeconomic position', *Ethnicity and Disease*, 11, 3, 401–411.
 - 11 Krieger, N. and Sidney, S. (1996), 'Racial Discrimination and Blood Pressure: The CARDIA Study of Young Black and White Adults', *American Journal of Public Health*, vol. 86, no. 10, pp. 1370–1378.
 - 12 Karlsen, S. and Nazroo, J. Y. (2002), 'The relationship between racial discrimination, social class and health among ethnic minority groups', *American Journal of Public Health*, vol 92, pp. 624–63.
 - 13 Williams, D. R., Neighbors, H. W. and Jackson, J. S. (2003), 'Racial/Ethnic Discrimination and Health: Findings From Community Studies', *American Journal of Public Health*, 93, 200–208.
 - 14 Karlsen, S., Nazroo, J. Y. and Stephenson, R. (2002), 'Ethnicity, environment and health: putting ethnic inequalities in health in their place', *Social Science and Medicine*, 55, 9, 1647–1661.
 - 15 Bécares, L., Nazroo, J., Albor, C., Chandola, T. and Stafford, M. (2012), 'Examining the differential association between self-rated health and area deprivation among white British and ethnic minority people in England', *Social Science and Medicine*, 74, 616–624 doi: 10.1016/j.socscimed.2011.11.007.
 - 16 Bécares, L., Nazroo, J. and Stafford, M. (2009), 'The buffering effect of ethnic density on experienced racism and health', *Health and Place*, 15, 670–678, doi: 10.1016/j.healthplace.2008.10.008.
 - 17 Bajekal, M., Blane, D., Grewal, I., Karlsen, S. and Nazroo, J. (2004), 'Ethnic differences in influences on quality of life at older ages: a quantitative analysis', *Ageing and Society*, 24, 5, 709–728.
 - 18 Nazroo, J., Falaschetti, E., Pierce, M. and Primatesta, P. (2009), 'Ethnic inequalities in access to and outcomes of healthcare: Analysis of the Health Survey for England', *Journal of Epidemiology and Community Health*, 63, 12, 1022–1027, doi:10.1136/jech.2009.089409.
 - 19 Airey, C., Bruster, S., Erens, B., Lilley, S., Pickering, K. and Pitson, L. (1999), *National Surveys of NHS Patients: General Practice, 1998*, London: NHS Executive.
 - 20 Nazroo, J. and Iley, K. (2011), 'Ethnicity, race and mental health'. In: Pilgrim, D., Rogers, A. & Pescosolido, B. (Eds.), *Handbook on Mental Health*, London: Sage, 80–102.
 - 21 Craig, G. (2007), *Sure Start and Black and Minority Ethnic Populations*, London: DfES.
 - 22 Cattle, T. (2001), *Community Cohesion: A Report of the Independent Review Team*, London: Home Office.
 - 23 Finney, N. and Simpson, L. (2009), *'Sleepwalking to segregation'? Challenging myths about race and migration*, Bristol: The Policy Press.
-