

Better
Health
Briefing

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**Tackling health
inequalities for
minority ethnic
groups:
challenges and
opportunities**

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A Race Equality Foundation
Briefing Paper

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Key messages

- 1 Health inequalities exist in the UK: both between and within minority ethnic groups
- 2 Health inequalities vary by social class *between* ethnic groups and *within* ethnic groups
- 3 Health inequalities reflect inequalities in the distribution of health determinants, such as access to good housing, transport, education and employment opportunities
- 4 Reducing health inequalities is possible utilising the ‘ingredients’ of National Health Service system reform.

Introduction

The Government’s *Cross Cutting Review* of health inequalities, published earlier this decade, reminded us that not only do health gaps still exist in the UK but, in some cases, they are growing ever wider:

There are wide geographical variations in health status, reflecting the multiple problems of material disadvantage facing some communities. These differences begin at conception and continue throughout life. Babies born to poorer families are more likely to be born prematurely, are at greater risk of infant mortality and have a greater likelihood of poverty, impaired development and chronic disease in later life. This sets up an inter-generational cycle of health inequalities.
([DH, 2002b, p. 1](#))

This statement reflects the shift in focus of policy during the last twenty years in which there has been a growing interest in the health of different communities in the UK.

Throughout this period, the provision of health care for minority ethnic groups has become a particularly important area of debate. It has also led to the introduction of a series of high-profile government initiatives which have sought to achieve a better understanding of health inequalities and to reduce health inequalities among minority ethnic groups. These initiatives include (see Box 1):

- Tackling Inequalities in Health — A Programme for Action ([DH, 2002b](#));
- Health Survey for England — Minority Ethnic Groups ([Sproston and Mindell, 2006](#));
- Race for Health ([Race for Health, 2007](#));
- Spearhead Primary Care Trusts ([DH, 2004c](#));
- Health Challenge England ([DH, 2006a](#)).

Box 1 Recent government initiatives to tackle health inequalities*Tackling Inequalities in Health – A Programme for Action*

This initiative, launched in 2003, set out plans to tackle health inequalities over the next few years. It established the foundations required to achieve the challenging national target for 2010 to reduce the gap in infant mortality across social groups, and to raise life expectancy in the most disadvantaged areas faster than elsewhere (DH, 2002b).

Health Survey for England

The Health Survey for England is an annual survey of the health of the population. It has an annually repeating core which is accompanied by different topic modules each year. The focus of the 2004 report was on the health of minority ethnic groups, which provided a rich source of evidence of the health inequalities experienced between and within ethnic groups (Sproston and Mindell, 2006).

Race for Health

The Race for Health programme enables Primary Care Trusts (PCTs) in England to make the health service in their areas significantly fairer for black and minority ethnic communities. The programme supports a network of fifteen PCTs around the country, working in partnership with local black and minority ethnic communities to improve health, modernise services, increase choice and create greater diversity within the National Health Service (NHS) workforce (Race for Health, 2007).

Spearhead Primary Care Trusts

This initiative covers the sixty-two PCTs and seventy local authorities with the worst health experience in the country, and has been established to fast-track the implementation of the *Choosing Health* White Paper (Public Health) (DH, 2004c).

Health Challenge England

In 2004, the Public Health White Paper *Choosing Health: Making healthy choices easier* (DH, 2004a) set out an ambitious agenda of new thinking and practical action to tackle inequalities in health and engage people in looking after their own health. *Health Challenge England – Next steps for choosing health* sets out how the Department of Health has been developing this new approach to public health, which aims to ensure that all sectors of society can contribute to the nation's health. It provides data on progress and makes recommendations for action at local level (DH, 2006a).

The following section establishes the evidence for inequalities in health in the UK.

1 Evidence of inequalities in health

There is a plethora of evidence highlighting that people from minority ethnic groups experience poorer health than the overall UK population. Some examples include the observation of higher rates of diabetes, cardiovascular disease and mental illness among certain minority ethnic groups. Furthermore, the data suggests that patterns of poor health vary *within* ethnic groups. Large-scale surveys, such as the Fourth National Survey of Minority Ethnic Groups (Nazroo, 1997) and the Health Survey for England (Sproston and Mindell, 2006), show that minority ethnic groups as a whole are more likely to report ill health, and that ill health among minority ethnic groups starts at a younger age than among the white British (see Box 2).

Mortality data

Table 1 highlights mortality in the first year of life in relation to ethnic group. It is evident that perinatal mortality (deaths between twenty-eight weeks gestation and the end of the seventh day after delivery) rates are higher among infants of mothers born outside the UK. Rates for neonatal mortality (deaths in the first twenty-seven days of life), postneonatal mortality (deaths after twenty-eight days of life but before one year) and infant mortality (deaths in the first year of life) are higher in particular among the Bangladeshi, Pakistani and Caribbean ethnic groups, whereas they are lower among the Indian group.

Table 1 *Mortality in the first year of life per 1000 births by mother's country of birth, England and Wales, 1996*

	UK	East Africa	Bangladesh	India	Caribbean	Pakistan
Perinatal mortality	8.2	12.4	9.5	11.3	11.5	15.8
Neonatal mortality	3.9	4.1	4.2	3.9	4.7	6.5
Postneonatal mortality	1.9	2.0	2.2	1.5	3.6	3.6
Infant mortality	5.8	6.1	6.3	5.4	8.4	10.1

(Source: Harding and Maxwell, 1997)

Tables 2 and 3 present standardised mortality ratios (SMRs) for deaths among men and women of working age, from all causes and from various specific causes, according to country of birth. All-cause mortality is markedly higher for men and women born in West/South Africa, East Africa, Scotland and Ireland. Ischaemic heart disease (characterised by reduced blood supply to the heart) and lung cancer are the major causes of death, regardless of ethnic group. Ischaemic heart disease is particularly high for men and women born in the Indian subcontinent, and for men born in East Africa, but lower in people born in the Caribbean and West/South Africa. Stroke mortality is elevated for all the ethnic groups.

Table 2 SMRs for men aged 20–64 years, by country of birth, England and Wales, 1991–93

	All causes	Ischaemic heart disease	Stroke	Lung cancer	Other cancer	Accidents and injuries	Suicide
Total	100	100	100	100	100	100	100
Caribbean	89*	60*	169*	59*	89	121	59*
West/South Africa	126*	83	315*	71	133*	75	59*
East Africa	123*	160*	113	37*	77	86	75*
Indian subcontinent	107*	150*	163*	48*	65*	80*	73*
India	106*	140*	140*	43*	64*	97	109
Pakistan	102	163*	148*	45*	62*	68*	34*
Bangladesh	133*	184*	324*	92	74*	40*	27*
Scotland	129*	117*	111	146*	114*	177*	149*
Ireland	135*	121*	130*	157*	120*	189*	135*

*p<0.05, compared to overall rate.
(Source: [Harding and Maxwell, 1997](#))

Table 3 SMRs for women aged 20–64 years, by country of birth, England and Wales, 1991–93

	All causes	Ischaemic heart disease	Stroke	Lung cancer	Other cancer	Accidents and injuries	Suicide
Total	100	100	100	100	100	100	100
Caribbean	104	100	178*	32*	87	103	49*
West/South Africa	142*	69	215*	69	120	a	102
East Africa	127*	130	110	29*	98	a	129
Indian subcontinent	99	175*	132*	34*	68	93	115
Scotland	127*	127*	131*	164*	106	201*	153*
Ireland	115*	129*	118*	143*	98	160*	144*

a: too few deaths to undertake analyses.

*p<0.05, compared to overall rate.
(Source: [Harding and Maxwell, 1997](#))

Morbidity data

As mentioned in Box 1, the Health Survey for England in 2004 had a particular focus on minority ethnic groups ([Sproston and Mindell, 2006](#)).

The key points reported in the Survey were as follows ([Sproston and Mindell, 2006](#)):

- Bangladeshi and Pakistani men and women and Black Caribbean women were more likely than the general population to report bad or very bad health.
- Pakistani women and Bangladeshi men were more likely than those in the general population to report a limiting long-standing illness. Pakistani men and women were more likely than the general population to report acute sickness.
- Doctor-diagnosed diabetes was almost four times as prevalent in Bangladeshi men and almost three times as prevalent in Pakistani and Indian men than in men in the general population.

- Doctor-diagnosed diabetes was more than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and Black Caribbean women, and two-and-a-half times as likely in Indian women compared to women in the general population. This was also the case in 1999, when diabetes was more than five times as prevalent in Pakistani and Bangladeshi men and women, and more than four times as likely in Black Caribbean women (compared to men and women in the general population).
- Self-reported prevalence of cigarette smoking was greater among Bangladeshi and Irish men than in the general population. Use of chewing tobacco was most prevalent among the Bangladeshi group, with 9 per cent of men and 16 per cent of women reporting using chewing tobacco. Among Bangladeshi women, use of chewing tobacco was greatest among those aged thirty-five and over (26 per cent).
- Black Caribbean and Irish men had the highest prevalence of obesity; Pakistani and Bangladeshi men and women, and Black Caribbean and Black African women, were more likely than the general population to have raised waist to hip ratio and raised waist circumference.
- Indian, Pakistani and Bangladeshi men and women were less likely than the general population to meet the physical activity recommendations (of at least thirty minutes of moderate or vigorous exercise on at least five days a week).
- Black African boys were more likely to be obese than boys in the general population (31 per cent and 16 per cent respectively). Otherwise, the prevalence of obesity was similar among all groups. The prevalence of obesity among Black Caribbean and Bangladeshi boys increased between 1999 and 2004 from 16 per cent to 28 per cent, and 12 per cent to 22 per cent respectively.
- Irish and Black Caribbean women are much more likely to have high blood pressure than women in the general population.

It is important to recognise that health inequalities are the result of a complex and wide-ranging network of factors — known as wider determinants. People who experience material disadvantage, poor housing, lower educational attainment, insecure employment or homelessness are among those more likely to suffer poorer health outcomes and an earlier death compared to the rest of the population. A number of these underlying health determinants appear to be more prevalent among certain minority ethnic populations.

2 Ethnicity and social class

The relationship between social class and ethnicity and its impact on health outcomes is a complex one. The aforementioned Fourth National Survey of Minority Ethnic Groups provides illuminating data concerning this issue ([Nazroo, 1997](#)). Table 4 highlights data relating to morbidity outcomes, ethnicity and social class. It is evident from this data that not only are social class differences prevalent *between* ethnic groups, but they are also present *within* ethnic groups. Consequently, it is essential that any solutions to rectifying inequalities in health recognise the impact of an individual's social class as well as their ethnic group.

Table 4 Age- and gender-standardised prevalences per 100: Fourth National Survey of Ethnic Minorities – morbidity outcomes, ethnicity and social class

	White	All minority ethnic groups	Caribbean	Indian or African Asian	Pakistani or Bangladeshi
Reported fair or poor health					
Non-manual	21	24	25	20	30
Manual	23	30	29	27	35
No full-time worker in household	37	38	38	34	44
Respiratory symptoms					
Non-manual	23	14	16	13	13
Manual	23	17	28	13	12
No full-time worker in household	35	21	26	17	20
Diabetes					
Non-manual	1.1	4.1	4.1	2.8	6.4
Manual	1.1	4.5	3.2	3.5	8.3
No full-time worker in household	2.1	6.3	4.5	7.1	7.6
Hypertension					
Non-manual	8	8	15	5	6
Manual	12	11	15	9	10
No full-time worker in household	11	12	18	8	11
Angina or heart attack – by tenure					
Owner-occupier	3.0	3.2	2.7	2.5	5.2
Tenant	4.1	4.0	3.8	3.5	5.2
No full-time worker in household	3.9	4.5	4.0	4.3	5.4
Regular current smoking					
Non-manual	21	16	24	9	16
Manual	33	18	30	8	18
No full-time worker in household	46	25	39	19	18
Ever drinks alcohol					
Non-manual	95	49	81	45	7
Manual	91	46	83	39	5
No full-time worker in household	84	46	84	41	2

(Source: Nazroo, 1997)

Box 2 Availability of ethnicity data contributes to the launch of the ‘Can we count on you?’ South Asian and African-Caribbean organ donor campaign

The following example, of how the availability of clear data highlighting health inequalities has led to positive action to rectify the situation, is cited as an exemplar of good practice by the Race for Health programme (Race for Health, 2007).

South Asians (those originating from the Indian subcontinent) and African-Caribbean communities have a high prevalence of Type 2 diabetes: recent studies indicate a prevalence rate four times greater than for white people. It has been reported that 20 per cent of South Asians aged forty to forty-nine have Type 2 diabetes, and by the age of sixty-five the proportion rises to a third (DH, 2002a).

A further complication is that diabetic nephropathy (a kidney disease) is the major cause of end-stage renal failure (ESRF) in South Asian and African-Caribbean patients receiving renal replacement therapy (RRT), either by dialysis or by transplantation. Nationally, this higher relative risk, when corrected for age and sex, has been calculated in England as 4.2 for the South Asian community and 3.7 for those with an African-Caribbean background (DH, 2004b). Furthermore, UK data shows that South Asian people with diabetes are up to ten times more at risk of developing ESRF compared to white people (Lightstone, 2001). Thus, not only are South Asian people and African-Caribbean people more prone to diabetes than white people, they are more likely to develop ESRF as a consequence.

Importantly, the South Asian and African-Caribbean populations in the UK are relatively young compared to the white population. Since the prevalence of ESRF increases with age, this has major implications for the future need for RRT and highlights the urgent need for preventive measures (Randhawa, 2003). The incidence of ESRF has significant consequences for both local and national NHS resources. The National Renal Review estimated an increase over the next decade of 80 per cent in the 20 000 or so patients receiving RRT and a doubling of the current cost, about £600 million a year, of providing renal services (Raleigh, 1997).

Kidney transplantation is the preferred mode of RRT for patients with end-stage renal failure. There are currently over 5500 people on the transplant waiting list in the UK. The majority are waiting for kidney transplants, but substantial numbers are also waiting for heart, lung and liver transplants. However, a closer examination of the national waiting list reveals that some minority ethnic groups are disproportionately more greatly represented than others. Fourteen per cent of people waiting for a kidney transplant are South Asian and over 7 per cent are African-Caribbean, even though they comprise only 4 per cent and 2 per cent respectively of the UK general population (Randhawa, 2004). South Asians are also disproportionately more greatly represented on the liver transplant and heart transplant waiting lists. South Asians and African-Caribbeans have to wait, on average, twice as long as a white person for a kidney transplant. White patients wait on average 722 days, South Asian patients wait 1496 days, and African-Caribbean people wait 1389 days.

The situation is clear. There is an urgent need to address the number of African-Caribbean and South Asian patients requiring a kidney transplant, otherwise the human and economic costs will be very severe. In the short term, a greater number of donors need to come forward from these communities to increase the pool of suitable organs (Randhawa, 2003). In the long term, greater attention needs to be paid to developing preventive strategies to reduce the number of African-Caribbeans and South Asians requiring RRT. The latter can be achieved only if we begin to address the problem of poor access to services for minority ethnic groups (Randhawa, 2003).

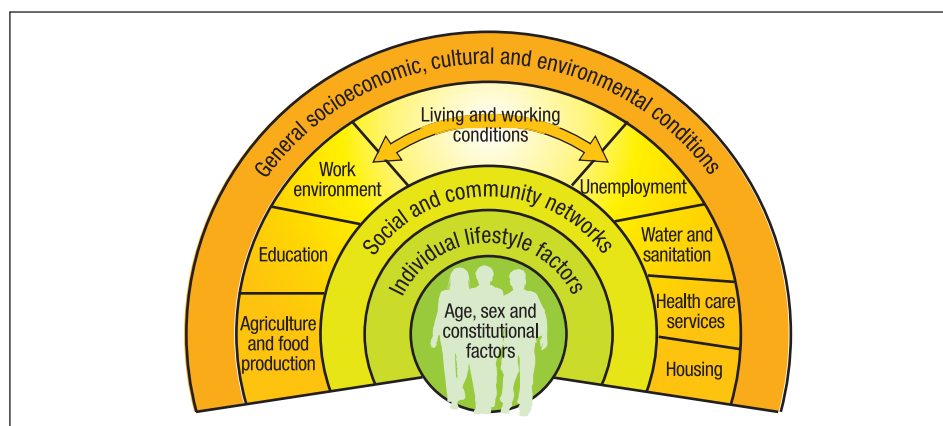
The availability of clear evidence of these inequalities has led to affirmative action by the Department of Health and UK Transplant via the establishment of specific organ donor awareness campaigns targeting South Asian and African-Caribbean communities. The early part of 2007 saw the launch of the 'Can we count on you?' organ donor campaign targeting South Asian and African-Caribbean communities at grass-roots level (UK Transplant, 2007).

Tackling health inequalities

3

Inequalities in health are multifactorial. They are influenced by issues such as environment, housing, educational achievement, material wealth, discrimination and lifestyle. As mentioned earlier, these are commonly referred to as the wider determinants of health (see Figure 1). As such, reducing health inequalities cannot take a ‘one size fits all’ approach and requires a multitude of efforts at different layers of society, engaging a wide variety of stakeholders. These stakeholders range from government level through local statutory level and local voluntary sector level, to grass-roots community level. All can contribute to an individual’s good health.

Figure 1 Wider determinants of health model
(adapted from *Dahlgren and Whitehead, 1991*)



Consequently, Local Strategic Partnerships (LSPs) have an important role to play in bringing together the various agencies — both statutory and voluntary — that are able to influence and direct resources to ensure that ill health is prevented. The contribution that LSPs can make to impacting positively on the wider determinants of health should not be underestimated. Tackling health inequalities has recently been introduced as a mandatory target within Local Area Agreements (LAAs), which LSPs need to achieve.

Definitions

Local Strategic Partnerships are non-statutory, multi-agency partnerships which match local authority boundaries. LSPs bring together, at a local level, the different parts of the public, private, community and voluntary sectors, allowing different initiatives and services to support one another so that they can work together more effectively.

A Local Area Agreement is a three-year agreement made between central government and a local area. The local area is represented by the local authority and other key partners, through the Local Strategic Partnership.

Resources 1

Race for Health

www.raceforhealth.org

Race for Health is a programme which supports a network of Primary Care Trusts around the country, working in partnership with local black and minority ethnic communities to improve health, modernise services, increase choice and create greater diversity in the workforce.

NHS Specialist Library for Ethnicity and Health

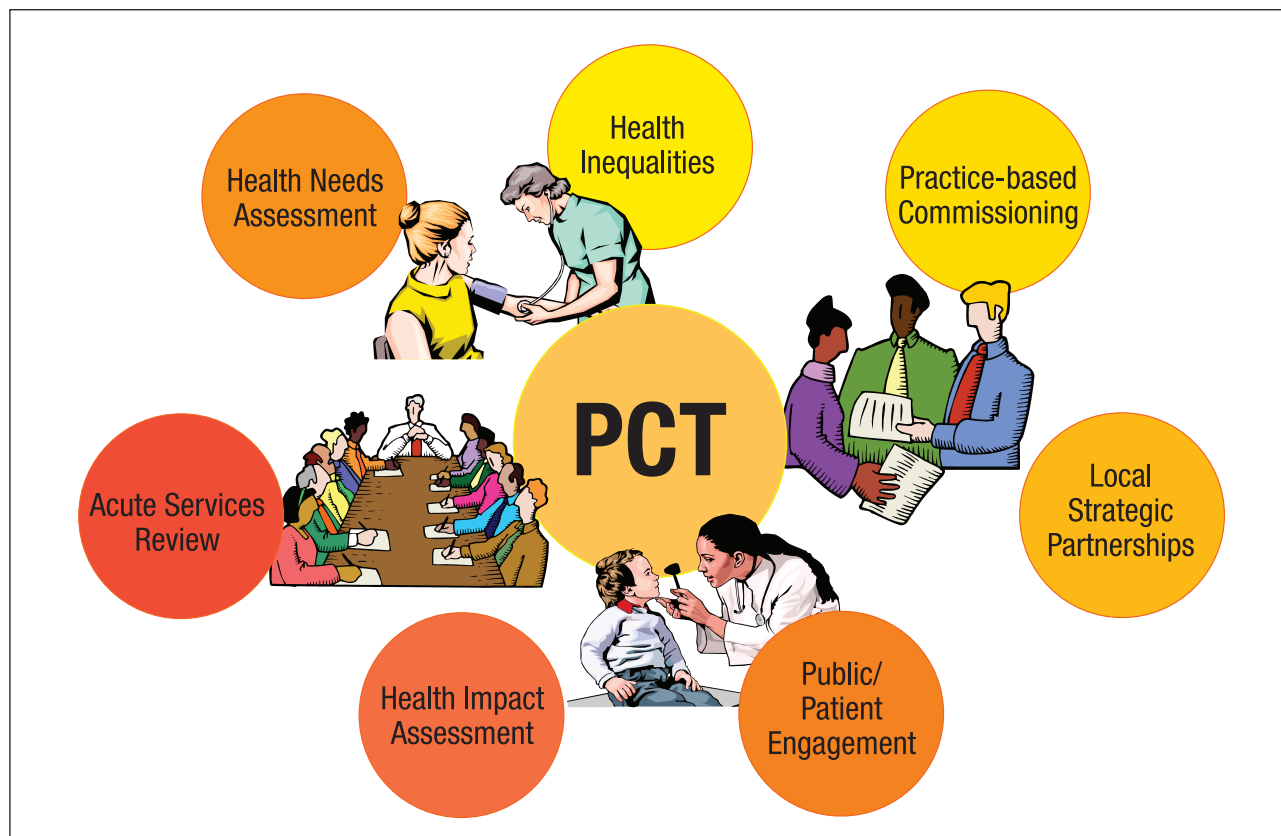
www.library.nhs.uk/ethnicity

This specialist library provides evidence about specific needs in health care for minority ethnic groups and about the management of a health care service in a multicultural, diverse society. The library attempts to select the *best available* evidence relevant to ‘culturally competent health care’ for minority ethnic groups and cultures present in Britain in significant numbers. Please note that this specialist library provides guidance only on *electronically available* resources.

4 Utilising the 'ingredients' of NHS system reform

The current system reforms in the NHS (see Figure 2) should offer the opportunity to develop services specific to local communities' needs (DH, 2006b). The impact of system reform should not be underestimated as it offers a genuine chance to mainstream some of the patchy and opportunistic special projects and programmes that have been taking place across the UK in an effort to reduce health inequalities among minority ethnic groups. Alongside the system reform agenda is the introduction of the Department of Health's Race Equality Scheme which clearly places an obligation on NHS organisations to 'do more to deliver services which meet the particular needs of black and minority ethnic groups' (DH, 2005, p. 4). A first step in achieving this is to ensure robust data collection of ethnic monitoring statistics. Unfortunately, ethnic monitoring is mandatory only in the secondary care sector of the NHS. Within primary care, there is no mandate to collect ethnic data, which represents a serious flaw in developing local services. The Department of Health's Quality and Outcomes Framework (QOF) (the contract for general practitioners) has recently introduced a small incentive scheme to encourage GP practices to collect data on the ethnicity of their patients. It remains to be seen, however, whether such a scheme will prove successful.

Figure 2 'Ingredients' of NHS system reform: mainstreaming health and inequalities



Box 3 'Ingredients' of NHS system reform

PCTs The key functions of Primary Care Trusts are:

- to secure, both in the role of commissioner and provider, high-quality health services for the local population;
- to improve public health and reduce health inequalities;

- to be the lead NHS organisation in local partnership with NHS Trusts, the local authority, other PCTs and the voluntary and private sectors, in order to secure seamless provision of care.

Primary Care Trusts are the 'drivers' for system reform.

Health inequalities are one of the top six priorities for the PCTs, thereby providing increased impetus and opportunity to ensure that the needs of minority ethnic groups are met. Concomitant with this, as mentioned above, is the introduction of a health inequalities target in LAAs, which LSPs will be required to meet.

Health Needs Assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities. PCTs and LSPs are utilising HNAs to determine commissioning opportunities.

Health Impact Assessment (HIA) is an approach that ensures decision making at all levels and considers the potential impacts of decisions on health and health inequalities. It identifies actions that can enhance positive effects and reduce or eliminate negative effects on populations. PCTs and LSPs will be utilising HIAs to inform future service developments, ensuring a focus on improving health and reducing inequalities.

Practice-based Commissioning is a recently introduced commissioning process that enables a consortium of local general practices (with support from their PCT) to identify the health needs of their local population and, in conjunction with local stakeholders, identify the appropriate services to be provided. This is a vitally important system reform that could yield major benefits for minority ethnic groups where general practices clearly understand the needs of their local patient population.

Acute Services Review is a current initiative that is taking place in many parts of the country, examining the appropriate configuration of hospital-based services.

Public/Patient Engagement is the process by which PCTs will ensure that users' views are taken into consideration when developing future services and seeking views on current service provision.

Conclusion

Health inequalities do exist for minority ethnic groups, and the underlying reasons are complex. It is possible, via Local Strategic Partnerships and utilising current NHS system reform, to improve the health of minority ethnic groups. However, there remains an urgent need to improve data collection relating to ethnic monitoring so that the reality and the scale of the challenge in reducing health inequalities are clearly understood.

Resources 2

Health Challenge England

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139514

Health Challenge England – Next steps for choosing health sets out how the Department of Health has been developing this new approach to public health, which aims to ensure that all sectors of society can contribute to the nation's health. It is aimed at policy makers across the public, business, voluntary and community sectors.

Race Equality in the NHS

www.dh.gov.uk/en/Policyandguidance/Equalityandhumanrights/Raceequality/DH_4135739

Information and guidance for NHS organisations on their statutory duty to promote race equality: in particular, organisations must review and consult on their race equality schemes.

King's Fund

www.kingsfund.org.uk/current_projects/bme_access_to_care/index.html

In February 2006, the King's Fund launched a programme of work that aims to pull together the evidence base about inequities in access to care experienced by black and minority ethnic groups and, longer term, to analyse the practical efforts by the NHS to improve access to health care for black and minority ethnic groups.

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