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South Asian Muslim Health Outcomes in Great Britain: The National Health Service and the British National Imaginary

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Abstract

Britain's National Health Service (NHS) ensures equal access care to all British residents. Health outcomes, nonetheless, vary across socioeconomic class, education level, and geographic location, a phenomenon particularly affecting Britain's South Asian Muslim communities. This paper will contextualize the NHS within the British national imaginary and analyze discursive, social, and economic variables influencing Pakistani and Bangladeshi poor health. I will integrate religious-based analysis into healthcare studies and question if health outcomes act as a marker of distinction between minority and majority populations. Though Muslim organizations, the NHS, the Department of Health, and government multicultural policies hope to reverse health disparities, I argue that the NHS, as a collective institution, reproduces societal hierarchy and enhances a discourse separating the British national Self from the Muslim Other.

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Introduction

The National Health Service, the United Kingdom's largest healthcare provider, ensures equal access care to all British residents. Though care is universal, health outcomes vary between social and economic class. Currently, Pakistani and Bangladeshi communities suffer from significantly higher risks of long-standing illness, diagnosed diabetes, poor self- health assessments, and raised waist-hip ratio (Karlsen and Nazroo 2009, 111). Likewise, Pakistani and Bangladeshi residents have higher rates of heart disease, stroke, and Type 2 Diabetes (Hippisley-Cox et al. 2008) (Mindell and Zaninotto 2006) (Atkinson et al. 2001). These statistics beg the question: why does equal access care not result in equitable health outcome? Why is the South Asian community disproportionately affected?

This paper will contextualize the National Health Service (NHS) within the British national imaginary, and analyze discursive, social, and economic variables influencing and co-producing health outcome. Though British healthcare provides publicly funded care, health disparities exist and reproduce across generations. Does the British health structure reproduce societal stratification? How can we analyze inequalities through health? How does health become a marker of distinction within British society?

I argue that the NHS, as integrated into the British national imaginary, may unintentionally Otherize Pakistani and Bangladeshi Muslim communities. Pakistanis and Bangladeshis suffer economic, social, and educational marginalization (Modood

Multicultural) (Khattab 2009) (Gilliat-Ray 2010), and these socio-economic conditions

directly influence the life course and healthcare interactions. Poor health outcomes are

then additional markers of distinction between the majority and minority populations, and

similarly reinforce and reproduce socio-economic stratification. Religious-based

identities likewise proliferate within this setting, and a "Muslim Other" narrative

integrates into the British national imaginary. Though the National Health Service

actively promotes and strives towards equitable and egalitarian health coverage, South

Asian Muslim health outcomes and interactions with the NHS further distinguish them

from the British ideal.

A Short History of the National Health Service

In 1948, the British government established the National Health Service, a publicly

funded and nationally run healthcare system. Upon creation, the NHS provided residents

free delivery at the point of entrance, and made services available "on the basis of need

and not on the ability to pay" (Pollock 2004, 25). At this time, government officials hired

and appointed leaders to dictate NHS funding and determine hospital management

(Locock 2000, 93). In other words, the initial NHS structure relied on a centralized and

government-sponsored system and offered equal-access care for all British residents.

Starting in the 1980s, the British government began altering the National Health

Service's structure and initiated a de-centralization plan. Margaret Thatcher's

conservative government established these initiatives to privatize certain aspects of the National Health Service (Pollock 2004, 25). Likewise, in 1990, the government created a quasi-market in the health system, granted health authorities purchasing power over care providers, and created Trusts with contractual funding (Locock 2000, 93). General practitioners (GPs) could similarly establish financial plans for their patients and maintain budgetary power over doctors. These changes aimed to "introduce market incentives towards greater efficiency" (Locock 2000, 93).

Though the British government outlaws "blanket exclusions" of potentially beneficial services and treatments, health authorities have significant control over care options. Some believe this new NHS policy imposed medical decision-making "expressed through guidelines and protocols, rather than purely individual clinical judgments" (Locock 2000, 104). Others believe this process gives significant authority to large private managers lacking medical knowledge, and has lead to under-funding for specialized services, thus placing more responsibility on the individual recipients (Pollock 2004, 25). These privatizing schemes cut certain services, such as dentistry and long-term care initiatives.

Risk pooling often plays an influential role within healthcare systems. Under universal healthcare, risk pooling assumes no provider or service should independently proceed with "risky" high-priced treatments. The market, however, likes to segment and divide services into "winners" and "losers" to make profits from low-cost treatments (Pollock 2004, 26). This process moves the locus of control away from planning

authorities and places preference and funds into major large-scale hospitals. These

hospitals are often grouped into Trusts, each with a specific service or surgical focus

(Dowding and John 2011, 1406). The GPs aim to maximize their funds, and budgetary

savings typically go to doctors. The NHS's reliance on GPs has increased significantly;

between 1997 and 2007 the number of GPs grew by over 19 per cent (28,046 to 33,364)

(Department of Health 2009, 113).

  The British Department of Health plays an influential role in establishing clinical

priorities. According to the Department of Health, a major objective for sustainability and

equity advancement involves "improving health as well as treating sickness" ("High"

2008, 10). Because the NHS only spends about 4 per cent of funding on prevention

("Fair" 2010, 26), hospitals and clinics employ community and local organizations to

improve health outcomes in economically deprived areas ("High" 2008, 36) (Department

of Health 2009, 17). This process implies a proactive rather than reactive approach to

health. These outreach programs connect local NHS branches to education authorities,

public and private businesses, and volunteer sectors to "improve outcomes for local

people" (Department of Health 2009, 17).

  In the past two decades, these GPs and local NHS hospitals and Trusts began

ethnic demographic data collection. The Department of Health and the National Health

Service believe this data collection is a foundation to analyze and assess health disparities

and inequalities (DH 2005, 5). Until the 1980s, the government made little effort to

advance ethnic monitoring for national organizations, and the National Health Service

first obtained ethnic information in 1995 (Psoinos et al. 2011, 4). The NHS initially

utilized the 1991 British Census categories when collecting patient ethnicity (White,

Black-Caribbean, Black-African, Black-Other, Indian, Pakistani, Bangladeshi, Chinese,

Other groups- Asian, Other) ("Office of Population" 2012), but later included 16

categories and codes (DH 2005, 19). More recently, the Department of Health suggested

the NHS begin documenting and assembling additional information on religion,

language, and diet (DH 2005, 19-20).

Though the NHS embraced this monitoring scheme, levels of completion for

healthcare ethnic data collection remain low (Szczepura 2005, 141). While a recent study

shows gradual improvement in data usage (Mathur 2013), healthcare professionals and

government bodies may not properly utilize or study collected data (Aspinall and

Anionwu 2002) (Curcin et al. 2012) (Iqbal et al. 2012). Even with this slow progression

towards ethnic demographic collection for health analysis, employing such terms adds an

important and influential dimension to healthcare studies. Within a multi-ethnic and

religiously diverse region, these terms hold particular weight in understanding health

inequities.

Brief Theoretical Background

Close to 8% of the British population identifies as an ethnic minority (Hansen 2007, 4)

(Karlsen and Nazroo 2009, 107). Individuals and communities form such discursive

identities within an imagined national context. The nation-state, though diverse, is a

discursively constructed region "imagined as a community, because, regardless of the

actual inequality and exploitation that may prevail in each, the nation is always conceived

as a deep, horizontal comradeship" (Anderson 1991, 7). The nation is an imagined *space*

encompassing a regionally and geographically specific *place*. At the same time, this

construction excludes certain populations and communities from entering the State. The

mass media, political movements, and civil society's "reifying, figurative discourses"

combine with the education system, military, and other societal institutions to normalize

national ideals and propagate national identities (de Cillia 1999, 153). In this sense, the

intersection and co-production of knowledge, power, and spatial constructions, create and

reproduce the nation.

Majority and minority populations occupy and internalize space differently and

often oppositionally, and national spaces often reinforce societal and economic

stratification (Lefebvre 1991, 282). Identities and identity performances are enacted

within these hierarchical spaces, and groups form reactionary identities within region-

specific environments. These identities of difference distinguish the Self from the deviant

Other (Foucault 1970, 326) (Foucault 1978, 60). This process, though individualized, can

likewise apply to national and community contexts. The nation's social, political, and

economic elite exert power to create normative ideals, and national narratives perpetuate

this oppositional relationship. In other words, normative ideals dominate and re-

appropriate constructed national spaces (Lefebvre 1991, 345).

Majority powers predominantly create non-national and exotic Others when minority populations threaten socially produced norms. These positional identities continuously reproduce because narratives, constructed histories, mass media, and textual evidence "create not only knowledge but also the very reality they appear to describe" (Said 1979, 94). This minority Other, is often internalized and reproduces both itself and its majority counterpart. Identities become performative (Butler 1990, 23-4) within society and both individuals and the public sphere naturalize the socially constructed narratives governing life realities. When marginalization and stratification increases, minorities often reassert politicized identities to combat their subjugated social position. In other words, essentialized minority populations are often "incited to discourse" (Foucault 1978, 18). Individuals and communities express their identities as a discourse, and thus reinforce the bounds dictating identity formations.

South Asian Communication and Migration to Britain

Britain interacted, communicated, and worked with Muslim travellers and traders from early exchanges with the Ottoman Empire in the 16th Century. These preliminary connections established discursive narratives; Muslims were either exalted and/or perceived as exotic Others distinct from the Western norm. Such initial migrations produced travel diaries and documents from Christian Britons and created an academic and philosophical field surrounding political rights and unity. Starting in the 17th Century,

the public generally desired to "understand" Islam and Muslim travelers (Gilliat-Ray 2010, 19).

Some early translators of the Qur'an, such as John Gregory, praised the Holy Book as a less problematic and more religiously sound Bible (Matar 1998, 82). Likewise, from the late 17th Century to the mid 18th Century, British scholars studied Muslim and Islamic histories and social structures (Matar 2008, 284). Within this tradition, John Locke expanded philosophy on religious integration. While he did not question or threaten Christian authority in Britain, Locke claimed the British Kingdom must accept and protect Muslims as individuals living with "Moral Ideas" (Matar 2008, 286-7). Locke distinguishes between Muslims and Islam, thus separating the individual from the collective or political. Similarly during this time, prominent writer Joseph Morgan began translating Muslim oral traditions into English and focused his work on "cross cultural" understanding (Matar 2008, 295).

Some of these goals, however, produced rather distorted interpretations of Islam. One pertinent example includes the factually incorrect and defamatory *The True Nature of Imposture fully displayed in the life of Mahomet* (published in 1697). Many considered this novel an authoritative and reliable account of Islamic practice (Gilliat-Ray 2010, 21), and the novel influenced perceptions of both Islam as a religion and Muslims as individuals. These perceptions and interpretations grew as trade increased in the 17th and 18th Centuries.

The East India Trading Company established new migration and emigration patterns to Britain. While asserting its economic and political force in the 18th Century, the British economy welcomed and necessitated more migrant workers (Gilliat-Ray 2010, 26). The East India Company also helped establish major shipping cities across Britain. Cities such as Cardiff, South Shields, and Liverpool particularly attracted migrant workers from India, Yemen, and Somalia (Gilliat-Ray 2010, 29-30). Bangladeshi workers concentrated in London and Birmingham, while Pakistani communities formed in Manchester, Lancashire, West Yorkshire, Birmingham, and the Midlands (Lupton and Power 2004, 4).

The shift from sail to coal power likewise influenced migration patterns. As Britain expanded and revolutionized its shipping industry, it required more manpower and labor. Before and during World War I, these cities were centers for maritime labor and material productions (Gilliat-Ray 2010, 37). Similarly these maritime cities created major cultural hubs for South Asian immigrants in the decades following World War I; such preexisting communities were bases for the major migrant and immigrant influxes into the country after World War II.

After World War II, immigration quickly expanded across Europe. Because many Western European countries lacked both national narratives and structural policies surrounding immigration integration, the large influx of workers in the mid-20th Century forced economic, social, and political institutions to re-evaluate and quickly encompass a growing foreign populace. The United Kingdom initially received immigrants from past

colonial regions, and the citizenship policy after the War converted former colonial subjects into British citizens (Hansen 2003, 26). Following the War, South Asian workers particularly congregated in the port cities of Birmingham, Cardiff, and Manchester; this congregation led to both ethnically and religiously-based business and social networks (Geaves 1996, 52) (Gilliat-Ray 2010, 48-9).

South Asian immigration peaked in the early 1960s with the Commonwealth Immigration Act of 1962 (Abbas 2005, 9). This Act promoted extended family migration into the UK (before 1962 male migrant workers typically entered alone). This trend ended in 1968, however, when the government greatly restricted all South Asian immigration, particularly those emigrating from Pakistan and Bangladesh (Abbas 2005, 9-10). By the 1970s, public hostility rose and questions surrounding immigration policy amplified; the public began claiming foreign workers increased competition for scarce jobs and utilized excess social security benefits (Hansen 2007, 1).

Initial post-War immigration composed mostly of unskilled and semi-skilled workers. Great Britain, like many Western European countries, brought laborers for specific job markets and with particular qualifications; this early foreign workforce was consequently less adaptable to changing economies and markets (Hansen 2003, 33). As immigration continued, however, the British government initiated recruitment policies to attract skilled and professional workers. The government aimed to "manage" migration by recruiting highly skilled economic migrants with the Nationality, Immigration and Asylum Act and the Highly Skilled Migrant Program (Hansen 2007, 2). These new

policies, attracting a number of Indian, Chinese, and Afro-Asian migrants, created and

enhanced divisions between highly skilled, educated workers and the unskilled mid-20th

Century immigrants and immigrant families.

Policies surrounding Muslim immigration intensified after September 11th. Since

2001, the "international agenda" has dominated British domestic politics, swaying the

government to tighten homeland security/anti-terrorist measures and introduce a new

citizenship test for incoming immigrants (Abbas 2005, 16). Even with these heightened

controls, currently, 1.8% of the population identifies as Indian (22.7% of the minority

ethnic population), 1.3% identifies as Pakistani (16.1% of the minority ethnic

population), and 0.5% identifies as Bangladeshi (6.1% of the minority ethnic population)

(Hansen 2007, 4-5) (Karlsen and Nazroo 2009, 107). Within both the Pakistani and

Bangladeshi communities, over 92% of individuals identify as Muslim (Peach 2005, 23).

British Multiculturalism and Political Participation

This influx of foreign workers forced Britain to adopt a new multicultural narrative.

During the Labour Party's rule in the 1990s, multicultural policies were fashionable in

British politics, and the public celebrated a multicultural populace. By 2010, however,

multiculturalism held negative connotations in government and the media. Currently,

politics and the mass media focus on "common Britishness" opposed to a "multicultural

landscape" (Hansen 2007, 4). The majority elite construct this discourse, like other social

narratives, to endorse and perpetuate specific social hierarchies. In common British discourse, ethnicity and religion, particularly for South Asian Muslims, tend to merge and encompass one identity.

In Great Britain, state and public run policies and decrees often enact multiculturalism, and New Labor supports a State-multiculturalism that directs change at the policy level. For example, including halal foods at school and allowing the veil in the workforce are nation-wide initiates. Legal policy changes surrounding minority rights fall under this governing scheme. The Employment Regulations in 2003, the Religious and Racial Hatred Act in 2006, and the Equality Acts of 2006 and 2010 all ensure certain protections in the workplace and school setting. At the same time, much of this legislature only utilizes racial and ethnic terminology, leaving space open for religious discrimination and/or bias. For example, Muslims report and experience discrimination at higher rates than other religious groups (Weller 2011, viii)**.**

Muslims are becoming increasingly active within government. Muslim representatives influence policy makers and have gained significant ground surrounding common interests (such as inclusion of religious data collection on the Census) (O'Toole et. al. 2013, 6). Likewise, activism has increased significantly since the mid 1980s during the Salman Rushdie Affair. Following Salman Rushdie's *The Satanic Verses* in 1988, many South Asian Muslims protested the author and the novel for its controversial references to the Prophet Mohammad (Modood *Multicultural*, 106). Due to the considerable South Asian Muslim population, Britain experienced backlash and

mobilization against both Rushdie and the British government. In response to the novel, then Iranian Supreme Leader Ayotollah Ruholla Khomeini issued an official fatwa against Rushdie. For British Pakistanis and Bangladeshis, Khomeini's fatwa "spoke to the hearts of many Muslims who felt despised, powerless, and without recourse in law" (Modood *Multicultural*, 107). Similarly, following 9/11 and the London Bombings in 2005, British Muslims quickly organized and furthered participation with government; in 2005, for example, a record number of Muslim voters participated in local and national elections (Klausen 2009, 97).

This political action often takes place at the local level (O'Toole et. al. 2013, 22) and focuses on community-based initiatives. Local-level politics, however, do not necessarily correlate with House of Lords or House of Commons representation. Only five members of the House of Lords and only two members of the House of Commons identify as Muslim (Anwar 2005, 38). As Islamic scholars Abdulkader H. Sinno and Eren Tatari explain, many Muslim representatives in Parliament either only work in districts with high Muslim representation, or are pawns in a greater political game; to enter the political spectrum, Muslims representatives must benefit the preexisting political parties (Sinno and Tatari 2009, 120-1). In other words, Muslim politicians in Parliament may act as tokens. This tokenism plays a role in potential political representation and policy outcome. At the same time, local-level activism has become a rallying source for many South Asian Muslim communities and induced a stronger sense of community for Pakistanis and Bangladeshis.

The British National Imaginary and Religious Identities

Narratives continuously move towards an "authentic British" rhetoric. A current movement is taking place "from a perceived *neglect* to *affirmation* of 'Britishness' presented as a meta-membership with which all, including Muslim minorities and non-Muslim majorities, should engage" (Modood and Meer 2012, 93). This Britishness and its relevance to multicultural policies, political involvement, and social and economic integration, rely on the constructed majority and minority binary distinguishing the British from the non-British.

To be "British," one could argue, is "to participate in a conversation, an imaginative rather than a mythical engagement, about the country's history, culture, and society. The conversation changes, of course, but there is recognizable discursive continuity as well" (Aughey 2010, 484). Britishness involves more than citizenship or legal rights, but a perceived acceptance and integration into history. The national elite often construct this belonging through markers of distinction. This history creates an "established" British populace that, even for progressive Britons and proponents of multicultural policy, essentializes a secular/Anglican, and ethnographically white history, imagination, and narrative; an incompatibility between multicultural policies and "radical secularism" heightens this process (Modood *Multicultural*, 20).

Pakistani and Bangladeshi communities face racialized, culturalized, and religious discrimination within this framework. A visibly non-normative skin color, when attached to other religious and cultural differences, act as markers of distinction within British society. According to British academic Tariq Modood, "racialized groups that have distinctive cultural identities or a community life defined as 'alien,' will suffer an additional dimension of discrimination and prejudice" (Modood *Multicultural*, 38). 305).

This Otherization ignites an incitement to discourse. As stereotypes proliferate though the media and political bases, "Muslims react to the perceived bias and appropriate the label as a source of countermobilization" (Klausen 2009, 101). South Asian communities in Britain assert ethnic (Pakistani and Bangladeshi) and religious identities publicly and politically. The Rushdie Affair, while heightening political participation, likewise strengthened religious identity assertions. Muslim and Islamic identities became key protest forms against Rushdie, and many South Asian youth first articulated Muslim identities during and following the affair (Jacobson 1998, 39). Part of this identity assertion came from the British government's lacked reaction to the fatwa, and the government's response to Muslim accommodation and integration into political, social, and economic bodies, which intensified feelings of isolation and marginalization amongst British Muslims (Jacobson 1998, 39). Changing multicultural narratives, the mass media, and the political right similarly enforced and perpetuated these religious identities. For many Muslims in Great Britain, the Rushdie Affair had long-term significance beyond Salman Rushdie himself; these groups questioned cultural and

religious minority rights in a Christian and "secular" majority European country

(Modood *Multicultural*, 112). Increasingly, many Muslim youth actively engage with

local mosques, work with religious community centers, and organize around religious

political movements.

The mass media plays a large and foundational role in perpetuating British

hegemonic elite normative ideals. The mass media and right-wing political circles

conceptualize and build distinct boundaries between the British, the Pakistani, and the

Bangladeshi that leaves little space or representation for minority populations (Jacobson

1998, 71). The media helps solidify the constructed narrative dominating the British

spatial reality by converging ethno-religious identities and placing the Muslim as

spatially and temporally distinct. When a group utilizes an oppositional identity and

opposes or highlights dissatisfaction with a popular societal institution, the elite further

place them outside the national Self.

Satisfaction with the National Health Service and Placement within the British National

Imaginary

All British residents can access a GP to obtain hospital and specialized service references

(Dowding and John 2011, 1406). This process, however, may lead to long waiting lines

for certain hospital procedures. While overall, time frames shortened significantly in

recent years (Jarmon 2005), dissatisfaction rates remain high for those experiencing long

waiting times (Dowding and John 2011, 1408) (Richmond 1996). Because ethnic

minorities experience, on average, longer waiting periods (Department of Health 2004),

respondents from ethnic minority groups rate all aspects of care substantially lower than

the white majority (Mead and Roland 2009).

Socio-economic factors influence satisfaction and interactions with healthcare.

The well educated and economically stable (the "alert" population according to Dowding

and John) are more likely to voice dissatisfaction with the NHS. This "alert" population

may not impact overall satisfaction rates, however, because "the better educated and

better-off, are also more likely to be able to exit from NHS care" (Dowding and John

2011, 1409). The upper classes can obtain outside health services; income, social

standing, and educational background impact perceptions and access to outside

healthcare services. In other words, there are distinct socio-economic conditions

influencing care; those affording private healthcare coverage utilize the NHS as a "last

resort" because of private healthcare coverage restrictions (Pollock 2004, 27).

Overall, however, politicians and the general public rarely criticize the health

system or structure itself. Statistics show 81% of British citizens are satisfied with their

personal health care services, while 43% believe certain aspects of care should be altered

(Dowding and John 2011, 1405). In this sense, the universal healthcare structure is

socially and politically exalted while the NHS's practical aspects receive complaint.

Because the NHS provides equal-access care, and has made substantial efforts in past

years to improve overall health outcome ("Fair" 2010) ("High" 2008) (DH 2005)

(Department of Health 2004) (Department of Health 2009), satisfaction remains relatively high.

A representative recently claimed; "The NHS is more than a system; it is an expression of British values of fairness, solidarity and compassion" ("The NHS" 2013, 6). Many citizens and politicians are "very loyal" to the NHS (Pollock 2004, 28), and the system itself asserts an egalitarian presence representative of "British" values. The NHS thus obtains an identity and is subsequently placed within the British national imaginary. The NHS becomes a British ideal and exalted as an inherently "British" organization. Mass media campaigns and large-scale celebrations (as seen in the 2012 London Olympic opening ceremony, for example) proliferate and normalize this ideal. As a nationalized system, the NHS operates as a function of the State, and, therefore, recreates existing hierarchy and mechanisms of power through the production and distribution of dominant ideology. As inherently "British," the healthcare system acts as a device separating communities who do not properly utilize or benefit from the system. Health then becomes a term within the discursive process separating the normative ideal from minority Other.

To understand health disparities, however, it is necessary to contextualize health within the greater socio-economic landscape in Britain. Education, economics, and socio-political positions are key markers of status and acceptance in the UK, and have direct impacts on individual and familial life courses. Economic mobility, education level, geographic location, social acceptance, political integration, and perceptions and

utilization of healthcare facilities all directly impact health outcome and lead to disparities between class, ethnicity, and religion.

Socio-Economic Influences on Health

According to Hilary Graham, health inequalities are "systematic differences in the health of people occupying unequal positions in society" (Graham 2009, 3). Graham's definition encompasses the structural, institutional, and social factors within society influencing health outcome and stratification. The educational, economic, and political structures in the UK, combined with geographic and social segregation, reproduce health inequalities and hierarchy in Britain. According to Graham, health inequalities are differences between the privileged and the disadvantaged populations in a given society (Graham 2009, 4-5). Health is therefore comparative, relational, and representative of societal preconditions and discriminations.

Current research highlights the correlation between socio-economic positions and overall health outcome. Economic stability, employment, and class directly influence health and the life course. Life expectancy, for example, varies between class; those in social Class V (semi-routine and routine occupations) have significantly shorter life expectancies compared to those in Social Classes I and II (managerial and professional occupations (about 72 years vs. 80 years) (Graham 2009, 12) (Department of Health 2009, 118). The economically disenfranchised not only live, on average, seven years less,

but also more likely live with preexisting disabilities ("Fair" 2010, 10). Following this trend, if all British residents had equitable death rates comparable to the most advantaged class in England, the population would experience between 1.3 and 2.5 million additional years of life ("Fair" 2010, 12). In this sense, extending life expectancy "also means helping people stay in employment" ("High" 2008, 37).

Though life expectancy has risen for all classes in the past thirty years, socio-economic factors and inequities in mortality rates of women rose between 2001 and 2007 ("Health Statistics" 2007). Babies born in Classes I and II, compared to those in Class V, experience fewer mortalities (Health Statistics Quarterly- No. 24 2004) (Dorling and Thomas 2009, 67). More specifically, for every 10 infant mortalities affecting Classes I and II, between 11-12 infant mortalities occur in Class V (Dorling and Thomas 2009, 68). Economic and social class thus impact personal and familial life courses, disproportionately and negatively affecting lower class health outcomes and life expectancies.

Once established, health is then an influential variable in stratification reproduction across generations; those in good health are likely to advance economically and educationally (Graham 2009, 13). Behavioral risks likewise bolster within poor socio-economic settings. Households with greater socio-economic positions more commonly receive healthy diets (based on the government recommended five portions of fruit and vegetables per day) and the recommended 30 minutes or more of exercise per day (Graham 2009, 14-5). Healthy diet, physical activity, smoking, and alcohol

consumption all directly impact an individual's life course. The school setting often reinforces these habits. Education is a particularly influential factor in health outcome, and the longer children remain in school, the greater their overall wellbeing (Law 2009, 30). Similarly, people with university degrees experience better health and longer life expectancies than those without ("Fair" 2010, 3).

Other studies posit neighborhood and geographic location as key factors in health outcome. Current statistics show that 10% of variation in health comes directly from physical and geographical neighborhood of residence (Macintyre and Ellaway 2009, 86). For example, those living in "deprived" neighborhoods have higher rates of obesity, even when taking socio-economic status into account (Macintyre and Ellaway 2009, 87). In these neighborhoods, health-promoting resources, facilities, infrastructures, and education programs are less accessible to the public. Similarly, environmental injustices disproportionately affect certain areas. Industrial towns, for example, experience environmental threats such as waste-disposals, air pollution, and toxic industrial fumes (Macintyre and Ellaway 2009, 89).

Education Attainments for Pakistani and Bangladeshi Youth

While Great Britain's state multicultural policies influence the school setting, many South Asian Muslims do not fully integrate and advance within the education system. Great Britain's multiculturalism focuses on school accommodations for minority

students; many schools offer adopted uniforms for Muslim girls, prayer facilities, and halal food options. Unfortunately, these policies do not address pedagogical practices influencing educational outcomes and perceptions (Gilliat-Ray 2010, 150), and some argue there is a general lack of "culturally sensitive" curriculum in the British education system (Jacobson 1998, 40). Such multicultural initiatives, therefore, do not fully promote integration or accommodation into the school structure itself and create feelings of isolation for Muslim youth. This pedagogy combines with structural factors to perpetuate education stratification on religious, ethnic, and economic lines.

Educationally, students with Pakistani and Bangladeshi backgrounds have made the least progress in academic assessments (Modood *Multicultural*, 83), which greatly influences future employment prospects. While second and third generations progress at higher rates, they still lag behind the "British white." In terms of GCSE qualifications (education certificates), Bangladeshis and Pakistanis have the highest percentage without qualifications (50.97% and 45.03%) followed by white Britons (36.64%) and Black Caribbeans (34.26%). On the other hand, Afro-Asians and Chinese are almost twice as qualified as their white peers beyond A-level education (Modood "Educational Attainments," 290). Though white students have lower qualifications, social, cultural, and economic capital provide job opportunities beyond the primary education level.

Pakistani and Bangladeshi youth are significantly and proportionally less qualified than their majority peers in obtaining steady employment after graduation (Khattab 2009, 305). And, in terms of continuing post-compulsory education, there is a

substantial difference between the Christian white and the "ethno-religious" minorities

(Khattab 2009, 309). While universities represent Pakistani and Bangladeshi students,

they are particularly enrolled in "less prestigious, less resourced post-1992 universities

(which till 1992 were called 'Polytechnics')" (Modood "Educational Attainments," 298).

Pakistani and Bangladeshi men are disproportionately placed in less funded universities,

and 70% (as opposed to 35% of white students) still enter technical schools (Hansen

2007, 9).

Social class plays a large role in university qualification attainment and future

employment prospects. Because Pakistanis and Bangladeshis experience economic

disadvantages, household overcrowding, geographic segregation, and high rates of

disease (Gilliat-Ray 2010, 123-4), second and third-generation Pakistani and Bangladeshi

Muslim immigrants are less likely than other Asian and non-Asian minorities to *complete*

a higher degree. In this sense, the social and educational capital from families and

neighborhoods influences education completion and perceptions, particularly for

prestigious university degrees. Because qualifications are often synonymous with social

and economic integration and upward mobility, these degrees directly influence and help

reproduce the socioeconomic hierarchies in the UK.

The hegemonic and normative elite dominate and construct the school system

within the State. In this sense, schools "are a part of the wider community and the world

at large, and the impact of the political on the educational cannot be underplayed" (Sha

2006, 229). For Muslim youth, there is a growing need to reassert a religious identity

within this stagnating institution. Muslim school children and young adults are

recognizing and voicing their religious identity to a larger and more profound extent than

their ancestors (Kashyap and Lewis 2012, 18). As these Muslim youth reassert a religious

identity, the British majority perceives them as a greater threat, and a discursive binary

grows.

Pakistanis and Bangladeshis in the Economic Sphere

Ethnic and religious minority discrepancies likewise exist and reproduce in the economic

sector. Pakistani and Bangladeshi Muslims have significantly lower employment rates

and pay compared to other Britons. Bangladeshi Muslim men, for example, have a four

times higher unemployment rate compared to a white, British man (20% vs. about 5%)

(Gilliat-Ray 2010, 125). Other statistics posit Bangladeshi unemployment at closer to

38%, significantly higher than any other group (Hansen 2007, 9). In other words, the

employment rates for Bangladeshi Britons is between 35-41% (as opposed to 75% for

working age white men) (Hansen 2003, 33). And, in terms of weekly wage earnings for

full-time male employees, white Britons, Afro-Asians, and Chinese workers earned more

than Caribbean and Indian workers, and significantly more than Pakistani and

Bangladeshi full-time employees (Modood *Multicultural*, 67).

Men and women from "ethno-religious" groups are significantly less likely to

obtain managerial and professional jobs (Sha 2006, 316), and about 33.7% of Muslim

men still work in semi-skilled and unskilled fields (Gilliat-Ray 2010, 125). These semi

and unskilled positions likely reflect Pakistani and Bangladeshi educational attainments.

Similarly, a changing economy is disproportionately affecting South Asian Muslims.

Currently, Indian and Chinese workers transition to self-employment at higher rates than

Pakistanis and Bangladeshis (Modood *Multicultural*, 62). Skilled recruitment programs,

higher education qualification rates, and less racialized and religious bias in the

workplace may influence British Chinese and Indian advancements.

From the start, these immigrants partook in low-paid, manual work, suffered high

levels of unemployment, and experienced poor living conditions (Modood *Multicultural*,

60). Even within the British class system, Pakistani and Bangladeshi workers have lower

incomes (Karlsen and Nazroo 2009, 116) (Nazroo 2001). Like the education system,

economic opportunities and pay reproduce stratification and hierarchy within the nation.

The economic structures and labor market aid the majority white while repressing the

Other. Likewise, both education and economic advancements are key markers of socio-

economic integration into the national narrative. These two bodies co-produce and

reproduce across generations; education is a key indicator of economic position and

economic class influences childhood education perceptions and performances.

While some ethnic minority groups advance economically, Chinese and Afro-

Asians for example, Muslim groups, confronting racial and cultural discrimination,

perpetually face economic, political, and social marginalization (Modood *Multicultural*,

80). Often Islam itself is blamed for this economic stagnation, and the term "Muslim"

becomes an enhanced and politicized religious identity in the market (Modood

Multicultural, 167). This identity is posited as intrinsically different from the national

Self and outside both the British economy and the national imaginary. Within this

position, Islamic identities proliferate and South Asian Muslim communities are often

essentialized,

Pakistani and Bangladeshi Health Outcomes and Interactions with the National Health Service

Pakistani and Bangladeshi economic conditions, education levels, and socio-political

positions within society directly impact overall health within the region. In 2005, babies

from Pakistani families had infant mortality rates of 9.6 deaths per 1,000 live births (more

than double the rate of white Britons at 4.5 deaths per 1,000 live births) (Department of

Health 2009, 120). More recent statistics show an increase in infant mortality since 2005;

from 2007, infant mortality rose to about 10.5 deaths per 1,000 births (DH 2005, 48),

while overall infant mortality has dropped to 4.2 per 1,000 in 20011 ("Infant" 2013).

Pakistani and Bangladeshi British residents have higher rates of heart disease,

stroke, and Type II Diabetes (Hippisley-Cox et al. 2008) (Mindell and Zaninotto 2006)

(Atkinson et al. 2001). These communities likewise suffer from significantly higher risks

of long-standing illness, diagnosed diabetes, poor self- health assessments, and raised

waist-hip ratio (Karlsen and Nazroo 2009, 111). South Asian women over 65 had the

highest rate of limiting and long-term illness in 2001 (64.5% compared to 53.1% for other women over 65) (DH 2005: 48). This trend continues today, with Pakistani women experiencing higher rates of both longstanding and limited-longstanding illness at a growing rate (Sproston and Mindell 2006, 5).

In 1999, both Pakistani and Bangladeshi men and women were 6 times more likely than the general population to have diabetes (DH 2005, 49), and this trend continued in the past two decades (Mindell and Zaninotto 2006). South Asian Muslims are more likely to die prematurely from coronary heart disease than the general population (DH 2005, 9). Likewise, South Asian children have higher incidence of Hodgkin's disease (Stiller 1991).

Bangladeshi and Pakistani men and women are the most likely to self-report bad or very bad health (Karlsen and Nazroo 2009, 111). This self-reported health analysis is likely connected to lifestyle-based diseases. Pakistani and Bangladeshi communities have lower rates of physical activity compared to the majority public, and are less likely to meet the physical activity recommendations of at least 30 minutes of moderate or vigorous exercise at least five days a week (Fischbacher et al. 2004), This activity level couples with diet and smoking intake to produce severe health outcomes. About 40% of Bangladeshi men and 29% of Pakistani men smoke, compared to 24% in the general male population (White 2006). Similarly, Pakistani and Bangladeshi male youth are less likely to meet recommended exercise and fruit and vegetable intake (McAloney et al. 2013),

and Pakistani and Bangladeshi children overall are less likely to reach the 5-A-Day fruit and vegetable recommendation compared to other British children (Donin et al. 2010).

In recent surveys, Bangladeshis reported "major difficulties in accessing and understanding available health information" (Alam et al. 2012, 164). Both GP practice and language barriers between patients and healthcare workers likely cause this lack of understanding. About 54% of patients feel their GP did not provide sufficient information or advice on diet and exercise, while over 70% feel their GP did not ask adequate questions relating to emotional and mental health ("High" 2008, 28).

While some studies claim religious differences alone cause health inequities in the hospital setting (Chowdhury et al. 2003) (Grace et al. 2008) (Griffiths et al. 2005), language is often a causal factor in healthcare service and spiritual care use. Poor communication skills and modest English fluency reduce GP-patient interactions, and likewise influence service utilization (Alam et al.2012, 165). Statistics show that only one third of older Bangladeshi and Pakistani women (50–75 years) can read English, and less than two thirds of 50-75 year old men (Szczepura 2005, 144). Such communication styles influence possible medical options and perceivable services. Bangladeshi men and women are the least likely group to use complementary or alternative medicines (14% of men and 15% of women) (Sproston 2006, 16), and Pakistanis and Bangladeshis utilize less specialized secondary care (Nazroo et al. 2009).

Responses and Recommendations

Following the Race Relations Act in 2000, the NHS, local councils, and public bodies

demonstrated "compliance with the statutory duty to promote race equality" (DH 2005,

12). This "compliance" involved greater employment of ethnic data monitoring,

community outreach, and comprehensive studies on ethnic inequalities in health.

According to the Department of Health, the NHS has "made good progress over the past

decade in improving the overall quality of care for patients" ("High" 2008, 11).

The National Health Service has both economic and moral incentives to address

and remove ethnic, religious, and class-based disparities in health. Productivity losses

from health inequities range from £31-33 billion per year, with lost taxes and higher

welfare payments reaching £20-32 billion per year; for the NHS specifically, health costs

from inequities exceed £5.5 billion per year ("Fair" 2010, 12). Decreasing health

inequalities thus decreases government and NHS Trust debt.

The Department of Health and the NHS established goals to decrease inequalities

between classes and ethnicities. The NHS recently created a subsection on its website

specifically targeting South Asian communities, particularly focusing on lifestyle choices

and health options. One initiative, developed by both the NHS and the Department of

Health, involves greater expenditure on infant and childhood health, including education

programs, stemming across and catered towards different social gradients ("Fair" 2010,

16). Because, in some cases, certain services for minority-dominated illnesses (such as

cystic fibrosis and Type II Diabetes) receive less provision (Szcepura 2005, 144), the

NHS must likewise increase expenditure for specialized care services and procedures.

Underlying expenditure policies, the NHS is taking steps to ensure linguistic and

culturally specific care (Szcepura 2005, 144). Providing resources and culturally

competent service can, to an extent, help alleviate and/or prevent barriers facing Pakistani

and Bangladeshi patients and families within hospitals and clinics. Such steps will

likewise provide more information on disease prevention (a major priority in the NHS)

("Fair" 2010, 26). These in-hospital recommendations work alongside NHS collaboration

with local education boards and community centers.

Because most care initiatives currently focus on ethnicity rather than religion

(most likely because ethnic-based data is readily available while religious information is

a new, but growing, phenomenon in Britain), the NHS must further introduce religious-

based and spiritual care programs to reduce Muslim, rather than purely Pakistani or

Bangladeshi, health inequalities. The Muslim community helped spur this movement by

pushing policy for government-wide religious data collection (as seen on the 2001

Census) (O'Toole et. al 2013, 6). Organizations such as the Muslim's Women's Network

and the Muslim Council of Britain similarly introduce and combat health-based

discrepancies across the UK. Currently, the spread of Muslim chaplaincy in hospitals

adds additional spiritual care services and options for Muslim patients, families, and staff

(Gilliat-Ray et al. 2013). These measures are steps towards enhanced care, but,

unfortunately, do not necessarily influence social, economic, and discursive variables influencing health and hierarchy.

Conclusions: Understanding Inequality Reproduction

Economic class, education level, social status, and health outcomes work congruently and co-produce ethnic and religious stratification in the United Kingdom. From initial interactions with the "Islamic East" in the 16th Century, Muslims faced exoticization and Otherization. This process then combined with British immigration and worker policy following World War II. Geographic segregation, economic and educational stagnation, and social stigmatization prevent South Asian Muslim entrance into the British national imaginary. The national imaginary is a discursive acceptance into the British narrative and encompasses British ideals, such as egalitarianism, an Anglo-secularism, and a shared historical past. This imaginary distinguishes the "British" from the "non-British" through discursive ideologies and mass media.

This national imaginary co-produces and reifies both identities and structures within society. Societal institutions reinforce class-based, ethnic, and religious hierarchies and stratifications. Socio-economic/political factors and structures combine with discursive Otherization to deter upward mobility for the politicized British Muslim minority. Underprivileged socio-economic conditions directly influence health outcomes for Pakistani and Bangladeshi communities, and poor health is then a factor re-producing

socio-economic status. Though the National Health Service takes strides to ensure

equitable care across socio-economic and ethnic boundaries, and Muslim political

activism and community organizations highlight religious and health based concerns,

health disparities exist and proliferate in Britain.

Pakistani and Bangladeshi interaction with the NHS and overall health positions

within society further distinguish them from the constructed British ideal. Health

becomes another marker of distinction working alongside and co-producing economic,

social, and political terms differentiating South Asian Muslim communities. The National

Health Service, as a structural encompassment of British idealism and discursive

egalitarianism, likewise plays a role in reproducing a binary between the white Briton and

the South Asian Muslim. Because Pakistani and Bangladeshi communities have lower

satisfaction rates, are the least likely to utilize specialized services, and experience overall

worse health outcomes, the NHS is an avenue to introduce health terms and institutions

into this constructed binary. Likewise, analyzing the National Health Service within the

discursive British national imaginary provides a nuanced understanding of healthcare

structures and societal interactions with minority populations.

Questions, therefore, remain. Is it possible for the British national narrative and

imaginary to incorporate an increasingly diverse demographic without Otherizing

specific and politicized minority populations? Because socio-economics and health exist

in a cyclical co-production, and the NHS is a function of British civil society, can equal-

access care ever translate into equitable care? If healthcare cannot equalize society, do

healthcare systems (even when their organizations and discourses aim to end inequitable health outcomes) simply reproduce inequalities? Likewise, how will religious data collection influence future healthcare studies? As religion and religious identities proliferate, will ethnicity and religion become distinct categories? Will institutions utilize religious rather than ethnic terminology when discussing and analyzing societal stratification? How can healthcare studies further integrate religious-based analysis?

Bibliography

Abbas, Tahir. 2005. "British South Asian Muslims: State and Multicultural Society." In
    Muslim Britain: Communities Under Pressure, ed. Tahir Abbas, 3-17. New York:
    St. Martin's Press.

Alam, Rahul, Shaun Speed, and Kinta Beaver. 2012. "A scoping review on the
    experiences and preferences in accessing diabetes-related healthcare information
    and services by British Bangladeshis". *Health & Social Care in the
    Community.* 20 (2): 155-171.

Anderson, Benedict R. O'G. 1991. *Imagined communities: reflections on the origin and
    spread of nationalism*. London: Verso.

Anwar, Muhammad. 2005. "Muslims in Britain: Issues, Policy and Practice." In *Muslim
    Britain: Communities Under Pressure*, ed. Tahir Abbas, 31- 46. New York: St.
    Martin's Press.

Aspinall, P.J. and E. Anionwu. 2002. "The role of ethnic monitoring in mainstreaming
    race equality and the modernization of the NHS: a neglected agenda?" *Critical
    Public Health* 12(1): 1-15.

Atkinson M., Clark M., Clay D., Johnson M. & Szczepura A. 2001. "Systematic review
    of ethnicity and health service access for London." Centre for Health Services
    Studies, University of Warwick, Coventry, UK. Accessed 12 March, 2014.
    Available at: www.mighealth.net/uk/images/5/56/System.doc

Aughey, Arthur. 2010. "Questioning British Identity." *Journal of Contemporary History* 45 (2): 478-486.

Butler, Judith. 1990. *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.

Curcin, V, M Soliak, and A Majeed. 2012. "Managing and exploiting routinely collected NHS data for research." *Inform Prim Care* 20(4): 225-31.

de Cillia, Rudolf, Martin Reisigl, and Ruth Wodak. 1999. "The discursive construction of national identities." *Discourse & Society* 10 (2): 149-173.

Department of Health. 2004. "Race equality in the department of health". Produced by the Department of Health. Accessed 12 March, 2014.

Available at: www.doh.gov.uk/race equality

Department of Health. 2009. "Tackling Health Inequalities: 10 Years On A review of developments in tackling health inequalities in England over the last 10 years". Published by the Department of Health. Accessed 20 March, 2014.

Available at: http://www.dh.gov.uk/publications

DH/Health and Social Care Information Centre/NHS Employers. 2005. "A Practical Guide to Ethnic Monitoring in the NHS and Social Care". Published by the Equality and Human Rights Group. Accessed 10 March, 2014. Available at:

http://www.dh.gov.uk/PolicyandGuidance/EqualityAndHumanRights

Donin AS, Nightingale CM, Owen CG et al. 2010. "Ethnic differences in blood lipids and

dietary intake between UK children of black African, black Caribbean, South

Asian, and white European origin: the Child Heart and Health Study in England

(CHASE)." *American Journal of Clinical   Nutrition* 92: 776–83.

Dorling, Danny and Bethan Thomas. 2009. "Geographical inequalities in health over the

last century." In *Understanding Health Inequalities*, ed. Hilary Graham, 66-83.

Berkshire, England: Open University Press.

Dowding K, and P John. 2011. "Voice and choice in health care in England:

understanding citizen responses to dissatisfaction." *Public Administration* 89 (4):

1403-418.

Ewing, Katherine Pratt. 2008. *Stolen honor: stigmatizing Muslim men in Berlin*. Stanford:

Stanford University Press.

"Fair Society, Healthy Lives: The Marmot Review Executive Summary". 2010. The

Marmot Review. Strategic Review of Health Inequalities in England Post-2010.

Accessed 20 March, 2014. Available at:

http://www.ucl.ac.uk/whitehallII/pdf/FairSocietyHealthyLives.pdf

Fischbacher C.M., Hunt S. & Alexander L. 2004. "How physically active are South

Asians in the United Kingdom? A literature review." *Journal of Public Health* 26:

250-258.

Foucault, Michel. 1970. *The Order of Things: An Archaeology of the Human Sciences*.

New York: Vintage Books.

Foucault, Michel. 1978. The History of Sexuality. New York: Pantheon Books.

Foucault, Michel. 1984. "Space, Knowledge, and Power". In *The Foucault Reader*,

    ed. Paul Rabinow. New York: Pantheon.

Geaves, R. 1996. *Sectarian Influences Within Islam in Britain: with Reference to the*

    Concepts of 'Ummah' and 'Community.' Leeds: Leeds Department of Theology

    and Religious Studies, University of Leeds.

Grace, C., R. Begum, S. Subhani, P. Kopelman, and T. Greenhalgh. 2008. "Prevention of

    type 2 diabetes in British Bangladeshis: qualitative study of community,

    religious, and professional perspectives." *British Medical Journal* 337 (a): 1931.

Graham, Hilary. 2009. "Introduction: the challenge of health inequalities." In

    Understanding Health Inequalities, ed. Hilary Graham, 1-21. Berkshire, England:

    Open University Press.

Griffiths C., Motlib J., Azad A. et al. 2005. "Randomised controlled trial of a lay- led

    self-management programme or Bangladeshi patients with chronic disease."

    British Journal of General Practice 55: 831-837.

Gilliat-Ray, Sophie. 2010. *Muslims in Britain: an introduction*. Cambridge:

    Cambridge University Press.

Gilliat-Ray, Sophie, Stephen Pattison, and Muhammad Mansur Ali. 2013. *Understanding*

    Muslim Chaplaincy. Burlington, VT: Ashgate Pub. Company.

Hansen, Randall. 2003. "Migration to Europe since 1945: Its History and its Lessons."

    The Political Quarterly 74: 25-38.

Hansen, Randall. 2007. "Country Profile: United Kingdom." *Focus Migration* 12: 1-11.

"High Quality Care For All NHS Next Stage Review Final Report". 2008.

> Department of Health. TSO (The Stationery Office): London. Accessed 15 March,

> 2014. Available at:

> https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/22

> 8836/7432.pdf.

"Health Statistics Quarterly- No. 24, Winter 2004". 2004. Published by the Office For

> National Statistics. Accessed 5 March 2014. Available at: http://www.ons.gov.uk/

"Health Statistics Quarterly- No. 36, Winter 2007". 2007. Published by the Office

> For National Statistics. Accessed 5 March, 2014. Available at:

> http://www.ons.gov.uk/

Hippisley-Cox J., Coupland C., Vinogradova Y., Robson J., et al. 2008. "Predicting

> cardiovascular risk in England and Wales: Prospective derivation and validation

> of QRISK2." *BMJ* 336 (7659): 1475-1482.

"Infant mortality rate in England and Wales hits record low". 2013. Published by the

> Office For National Statistics. Accessed 20 March, 2014. Available at:

> http://www.ons.gov.uk/

Iqbal, Gulzan, Mark RD Johnson, et. al. 2012. "UK ethnicity data collection for

> healthcare statistics: the South Asian perspective." *BMC Public Health* 12(243):

> 1-8).

Jacobson, Jessica. 1998. *Islam in transition: religion and identity among British*

> *Pakistani youth*. London: Routledge.

Karlsen, Saffron and James Nazroo. 2009. "Religion, ethnicity and health inequalities."
In *Understanding Health Inequalities*, ed. Hilary Graham, 103-124. Berkshire,
England: Open University Press.

Kashyap, Ridhi, and Valerie A. Lewis. 2012. "British Muslim youth and religious
fundamentalism: a quantitative investigation." *Ethnic and Racial Studies*
36(12): 1-24.

Khattab, Nabil. 2009. "Ethno-religious Background as a Determinant of Educational and
Occupational Attainment in Britain." *Sociology* 43 (2): 304-322.

Kibria, Nazli. 2008. "The 'new Islam' and Bangladeshi youth in Britain and the
US." *Ethnic and Racial Studies* 31 (2): 243-266.

Klausen, Jytte. 2009. "Muslims Representing Muslims in Europe: Parties and
Associations after 9/11." In *Muslims in Western Politics*, ed. Abdulkader H.
Sinno, 96-112. Bloomington: Indiana University Press.

Law, Catherine. 2009. "Life-course influences on children's futures." In *Understanding*
Health Inequalities, ed. Hilary Graham, 25-47. Berkshire, England: Open
University Press.

Lefebvre, Henri. 1991. *The production of space*. Oxford, OX, UK: Blackwell.

Locock, Louise. 2000. "The Changing Nature of Rationing in the UK National Health
Service." *Public Administration* 78 (1): 91-109.

Lupton, Ruth and Anne Power. 2004. "Minority Ethnic Groups in Britain". Case-
Brookings Census Briefs. The London School of Economics and Political

Science. Accessed 22 March, 2014. Available at: http://sticerd.lse.ac.uk/

Macintyre, Sally and Anne Ellaway. 2009. "Neighborhood influences on health."

In *Understanding Health Inequalities*, ed. Hilary Graham, 84-100. Berkshire,

England: Open University Press.

Matar, N. 1998. "Alexander Ross and the First English Translation of the Qur'an."

MUSLIM WORLD 88 (1): 81-92.

Matar, Nabil. 2008. "Islam in Britain, 1689-1750." *Journal of British Studies* 47 (2).

McAloney, K, Graham, H, Law, C, Platt, L, Wardle, H & Hall. 2013. "Fruit and

vegetable consumption and sports participation among UK Youth." *International*

Journal of Public Health: 1-5.

Mead, Nicola and Martin Roland. 2009. "Understanding why some ethnic minority

patients evaluate medical care more negatively than white patients: a cross

sectional analysis of a routine patient survey in English general practices." *BMJ*

339(b3450): 1-10.

Mindell J & Zaninotto P. 2006. "Cardiovascular disease and diabetes". In *Health Survey*

for England 2004: The Health of Minority Ethnic Groups, eds. K Sproston and J

Mindell, 63–94. Leeds: The NHS Information Centre.

Modood, T. 1997. "'Difference,' Cultural Racism and Anti-Racism." In *Debating*

Cultural Hybridity: Identities and the Politics of Anti-Racism, eds. P. Werbner

and T. Modood, 154-172. London: Zed Books.

Modood, Tariq. 2005. *Multicultural politics: racism, ethnicity, and Muslims in Britain*.

Minneapolis: University of Minnesota Press.

Modood, T. 2005. 'The Educational Attainments of Ethnic Minorities in Britain." In
Ethnicity, Social Mobility and Public Policy in the US and UK, eds. G. Loury, T.
Modood & S. Teles, 288-308. Cambridge: Cambridge University Press,

Modood, Tariq and Nasar Meer. 2012. "Britain: Contemporary developments in cases of
Muslim-state engagement." In *Muslims in 21st Century Europe: Structural and
Cultural Perspectives*, ed. Anna Triandafyllidou, 78- 102. New York: Routledge.

Nazroo, J.Y. 2001. *Ethnicity, Class and Health*. London: Policy Studies Institute.

Nazroo, J.Y., Falaschetti E., Pierce M. & 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: 1022 -1027.

"Office of Population Censuses and Surveys, 1991 Census: Aggregate data (England and
Wales)." 2012. UK Data Service Census Support. Accessed 22 March, 2014.
Available at: http://casweb.mimas.ac.uk.

O'Toole, Therese, Daniel Nilsson DeHanas, Tariq Modood, Nasar Meer, and Stephen
Jones. 2013. "Taking Part: Muslim Participation in Contemporary Governance."
Centre for the Study of Ethnicity and Citizenship. University of Bristol. Accessed
28 March, 2014. Available at:
http://www.bristol.ac.uk/ethnicity/projects/muslimparticipation/documents/mpcgr
eport.pdf

Peach, Ceri. 2005. "Muslims in the UK." In *Muslim Britain: Communities Under*

Pressure, ed. Tahir Abbas, 18-30. New York: St. Martin's Press.

Pollock, A. 2004. "NHS, Inc.: The Accelerating Marketization of the UK's National

 Health Service." *Multinational Monitor* 25 (10): 25-28.

Psoinos, M., Hatzidimitriadou, E., Butler, C. and Barn, R. 2011. "Ethnic Monitoring in

 Healthcare Services in the UK as a mechanism to address Health Disparities: A

 Narrative Review". Kingston University. Accessed 18 March, 2014. Available at:

 http://eprints.kingston.ac.uk/18866/

Said, Edward W. 1979. *Orientalism*. New York: Vintage Books.

Richmond, C. 1996. "NHS Waiting Lists Have Been A Boon For Private Medicine

 In The UK." *CMAJ* 154(3): 378-381.

Shah, Saeeda. 2006. "Leading Multiethnic Schools: A New Understanding of Muslim

 Youth Identity." *Educational Management Administration & Leadership* 34 (2):

 215-237.

Sinno, Abdulkader H and Eren Tatari. 2009. "Muslims in UK Institutions: Effective

 Representation or Tokenism?" In *Muslims in Western Politics*, ed. Abdulkader H.

 Sinno, 113-134. Bloomington: Indiana University Press.

Sproston K and Mindell J, eds. 2006. "Health Survey for England 2004. Volume

 1: The Health of Minority Ethnic Groups." The Information Centre. Accessed 20

 March, 2014. Available at:

 www.ic.nhs.uk/webfiles/publications/healthsurvey2004ethnicfull/Health

SurveyforEnglandVol1_210406_PDF.pdf

Stiller, CA, PA McKinney, KJ Bunch, CC Bailey, and IJ Lewis. 1991. "Childhood

cancer and ethnic group in Britain: a United Kingdom children's Cancer Study

Group (UKCCSG) study." *British Journal of Cancer* 64 (3): 543- 548.

Szczepura, A. 2005. "Access to health care for ethnic minority populations." *Postgrad*

Med J 81: 141-147.

The National Health Service England. 2013. "The NHS Belongs to the People."

Accessed 12 March, 2014. Available at: http://www.england.nhs.uk/

Weller, Paul. 2011. "Religious discrimination in Britain: A review of research evidence,

2000-10." Equality and Human Rights Commission Research Report 73.

University of Durban. Accessed 28 March, 2014. Available at:

http://www.equalityhumanrights.com/uploaded_files/research/research_report_73

_religious_discrimination.pdf

White M, J Bush, J Kai, R Bhopal, and J Rankin. 2006. "Quitting smoking and

experience of smoking cessation interventions among UK Bangladeshi and

Pakistani adults: the views of community members and health professionals."

Journal of Epidemiology and Community Health 60 (5): 405-11.