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Race and ethnicity in UK public policy: education and health

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> No sooner do we mention 'race' than we are caught in a treacherous bind. To say 'race' seems to imply that 'race' is real; but it also means that differentiation by race is racist and unjustifiable on scientific, theoretical, moral, and political grounds. We find ourselves in a classic Nietzschean double bind: 'race' has been the history of an untruth, of an untruth that unfortunately is our history ... The challenge here is to generate, from such a past and a present, a future where race will have been put to rest forever. (Radhakrishnan, 1996 cited in Gunaratnam, 2003)

The idea that there are groups of people so distinct that they form separate races has long been discredited by biologists (Bodmer & Cavalli-Sforza, 1976; Gribbin, 1985 and others). Genetic variation within a supposed racial group will be greater than that commonly found between groups (Hirst and Woolley, 1982; Washburn, 1980). Mindful of this, sociologists have turned to concepts of ethnicity which refer to socially constructed differences grounded in cultural processes, ancestry and language (Fenton, 1999)[1]. However, this manoeuvre does not obviate all the difficulties associated with biological race; over 40 years ago Franz Fanon (1962) saw ethnicity as the 'new racism' (see Gillborn, 1999 for a more recent account). Indeed, an *essentialist* concept of ethnicity, which constructs ethnic groups as fixed, homogenous, cultural groups characterised by sets of immutable characteristics has often been employed to 'rationalise difference, enact stereotyping and justify discrimination' (Ellison, 2005 p.68). Nevertheless, such a notion of ethnicity, derived from classical anthropology, underpins much of the discussion of cultural diversity and ethnic difference within the discourses of both education and healthcare (May, 1999; Culley, 2001a). Although subjected to extensive theoretical challenge from new approaches that stress the dynamic, fluid and contextual nature of ethnic identifications, and the importance of understanding the intersectionality of ethnicity with other dimensions of difference (gender, class, sexuality), cultural essentialist concepts of ethnicity still dominate much 'professional discourse' (Gustafson 2005) and are to be found in official policy documentation. However, most policy documents fail to discuss the conceptual basis of the terminology they deploy. In education and health policy documents, and debate, the terms race and ethnic group

are frequently used interchangeably (Bradby, 1995; Fenton, 1999). The terms race, ethnicity, culture, multicultural, multiethnic, multiracial and, as we shall see, several others are used to denote alleged group difference and/or coherence. These terms coexist in legal, academic and public policy documents; often on the same page and even in the same paragraph. Sometimes terms are placed in inverted commas as a way of acknowledging their problematical character. More often, conceptual problems as such are simply ignored.

Some of the terminology deployed in policy debate and documentation is the legacy of a process of legislative development in the UK dating back to the 1960s. A largely untheorised discourse of 'race relations' (rather than ethnic relations) was enshrined in the 1965 Race Relations Act and maintained in subsequent updating of legislation. This has been further reinforced by recent legal changes following the 'watershed' publication of the report of the inquiry into the death of black teenager Stephen Lawrence (Macpherson, 1999). The Race Relations (Amendment) Act (2000) puts public authorities under a statutory duty 'actively to promote race equality' through *all* policies, practices and procedures; commonly referred to as 'the race equality duty'. This duty entails three distinct parts: to work to eliminate unlawful racial discrimination; to promote equality of opportunity; and to promote good race relations. The promotion of 'race equality' has become an important political objective in new Labour's modernising agenda and the public sector is required to 'set the pace in the drive for equality' and to 'lead by example'. All government departments including the Department for Education and Skills and the Department of Health, as well as individual healthcare Trusts and specific education institutions, have a mandatory requirement to publish a 'race equality scheme' (referred to as a race equality *policy* in schools, colleges and universities) summarising each public authority's overall approach to racial equality and saying how this links to its corporate aims and objectives. If a public authority does not meet the general duty to promote race equality, its actions, or failure to act, can be challenged in a High Court (or Court of Session in Scotland) for judicial review. The Commission for Racial Equality has powers under the The Race Relations (Amendment) Act (2000) to issue a compliance notice to a public body which it believes is not fulfilling its duties to promote race relations.

Education, Race and Ethnicity

Education practice and policy-debate has developed over many years (there is insufficient space to report a full history here but see May, 1999 *inter alios*) during which time the terms ethnicity, ethnic background, multiethnic and multicultural have gained strong currency in reference to supposed differences thought to be associated with distinct 'culture, learning and socialisation'. In addressing the exigencies of a 'multicultural society', teachers are required to have 'better awareness' of their pupils' interests and needs; although precisely how the latter are calculated is rarely, if ever, clearly delineated. Nevertheless, official and unofficial discourse in education usually constructs teachers as caring professionals who are 'aware of difference' but nevertheless even-handed, fair or even 'colour-blind'. This latter term is frowned upon since its criticism over twenty years ago by the Swann Report (1985). However, it probably represents the outlook of the majority of teachers in England; although there is no *reliable* evidence on the matter [2].

Recently, in compliance with the requirements of the Race Relations (Amendment) Act (2000), the Department for Education and Skills published its *Race Equality Scheme* (2005b). The document makes use of a plethora of terms. Within the space of a few pages the reader can find: ethnic groups; Asian backgrounds; Chinese and Indian (in the UK); White British; ethnic minority groups; Black Caribbean pupils; Black and Asian students; Black British; Asian British (all on the same page); minority ethnic groups; pupils from Pakistani and Bangladeshi backgrounds; BME which is explained in a Glossary at the end of the document as meaning Black and Minority Ethnic; BEMG which is said to refer to Black Ethnic Minority Group; Traveller; Irish heritage; Gypsy/Roma; individual minority ethnic groups; Black young people; White British young people; Black young males; and Ethnic Minority and ethnic diversity; Black, Asian and people of mixed ethnic origin (Department for Education and Skills, 2005b). The Department for Education and Skills encourages its partners (schools, colleges and universities) 'to meet the needs of all minority ethnic groups and uses both formal and informal contact to pursue this' (ibid.).

The 'needs of all minority ethnic groups' is a very broad remit but it does not fall into an ideological vacuum. The dominant theme in education policy debate in the UK continues to be the concern over differences in the achievement rates of identified 'ethnic' groups. This theme was given public voice a quarter of a century ago by the Rampton Report (1981) and was firmly established by the subsequent Swann Report (1985). Today the theme of 'ethnic differences in achievement' is well established as an important aspect of public policy debate (Department for Education and Skills, 2005a). It is a focus of investigation by the Office for Standards in Education (Ofsted) which records and publishes data on the achievement of pupils aged 16 and 18 in public examinations. This shows that whilst there is variation within and between individual schools, and also between local education authorities, significant overall differences are reported between children from different ethnic backgrounds; with Chinese and Indian girls performing best and African-Caribbean boys least well. Moreover, although recorded achievement rates have varied over time, Gillborn and Mirza (2000) reported that 'available evidence suggests that the inequalities of attainment for African-Caribbean pupils become progressively greater as they move through the school system; such differences become more pronounced between the end of primary school and the end of secondary education'. Similar conclusions were reached five years later in a report by the Department for Education and Skills (2005a). There is also longitudinal evidence of difference in rates of school exclusions with those whom the Department for Education and Skills (2005c) refers to as Black boys topping the charts (also see Gillborn, 2004; Crozier, 2005).

It is in this context that teachers in England are, at least formally, required to 'take account of the varying interests, experiences and achievements of boys and girls, and pupils from different cultural and ethnic groups, to help pupils make good progress' (Teacher Training Agency, 2003: S3.3.6). Teachers are sometimes urged to 'address racism' or to promote 'anti-racism' in academic texts which form part of their 'required reading' during their training and by some of their tutors. Following the publication of the Macpherson Report in 1999, the Teacher Training Agency has supported an online initiative called 'Multiverse' (www.multiverse.ac.uk) which addresses racism. The Agency has funded a 'school-based research agenda' on a range of issues including racism in schools. Nevertheless, in official pronouncements, in the collection of data, and the presentation of official statistics it is the notion of

'minority ethnic groups' that prevails. However, the notion of ethnicity is seldom theorised; rather, notions of 'ethnic groups' and people from 'minority ethnic backgrounds' have become proxies for race. Such notions sometimes bring with them stereotypes that teachers are not always required to challenge in their training or in their day-to-day work in schools (see Gillborn, 2004; Crozier, 2004). Whilst there *are* those who are willing to challenge racism and racialised categories, others insist on their culture and/or 'colour blindness' and are content with uncontested and unchallenged notions of ethnicity.

Teacher Recruitment

In common with other professions and quasi-professions, recruitment is regarded as an important issue to be addressed. The recruitment of more teachers from 'minority ethnic backgrounds' is promoted by the UK government via its Teacher Training Agency; renamed the Teaching and Development Agency for Schools (TDA) in September 2005. The Agency has responsibility for the oversight of teacher recruitment although most of the actual recruitment is carried out by university education departments and a handful of other specialist organisations. One of the Agency's stated policies is to increase the recruitment of trainees from minority ethnic backgrounds to 9% (Teacher Training Agency, 2003) so as to create a more 'representative workforce' in schools.

Leaving aside more general issues associated with reported difficulties of teacher recruitment, and the fact that the Agency as such is not directly involved, there are several matters that require scrutiny; not least the question of 'representation'. According to the Department for Education and Skills (2005a), the UK school population includes 17% of pupils categorised as from minority ethnic backgrounds. The 2001 census had found 7.9% of the UK population as a whole willing to categorise themselves as from minority ethnic backgrounds. There are, of course, significant differences between school populations in different geographical locations both within specific towns and cities and across the different regions of the UK. It is not clear what percentage of teachers from specific minority ethnic backgrounds is imagined to be appropriate in any specific school, college or university. There is no suggestion of policy-makers imagining that there should or could be any attempt at

'matching' the ethnic background of school teachers to pupils. Given that no agency is responsible for the direction of labour, it is not clear how teachers from specific backgrounds would come to find themselves working in particular schools. During the course of a recent research project on minority ethnic teacher recruitment (Carrington et al., 2001) it was found that teachers-in-training did not necessarily see themselves taking-up posts in schools where the pupil population somehow 'matched' their own particular ethnic background. Neither was there strong evidence that new teachers from minority ethnic backgrounds saw their future careers in terms of work in 'multicultural' schools. Furthermore, even if it were thought desirable or possible to achieve, there is no evidence that a policy of attempting to match teachers and pupils, in terms of their ethnicity, would be welcomed by many schools or by the teachers currently working in them. There is anecdotal evidence to the contrary. For example, Abbas (2004) reports a 'senior Indian teacher' contemplating new appointments referring to 'having an Asian teacher' but going on to say that 'maybe we should have a teacher from the West Indian community as well'. However, he concludes that 'You shouldn't just appoint someone because of their colour' (op cit., p.125).

Apart from its 9% of workforce policy, the recording of rates of pupil achievement on the one hand and rate of exclusions from schools on the other, and calls for 'better awareness' of the needs of pupils from 'different ethnic backgrounds' there is little else that the UK government and its education-related agencies has to offer that is specific to minority ethnic education. Of course, the UK government has plenty of other policies that affect the educational opportunities of its citizens. We will return to the question of how these might affect pupils from different ethnic backgrounds towards the end of this chapter.

Health, Race and Ethnicity

As with education, health policy manifests an 'uncomfortable mix' of ethnic and racial terms (Aspinall, 2002). The terms ethnic minority; minority ethnic; black and minority ethnic; black and ethnic minority (BME); Asian; Black and other minority ethnic; 'non-white' are all deployed. As Apsinall argues, this largely reflects the

changing political ideology of the State. The racialised categories that were enshrined in the Race Relations legislation of the 1960s and 1970s were defined in the context of race and colour rather than multiculturalism. More recently, government health reports have used the language of diversity and refer to 'multicultural' and 'multi-ethnic' Britain. Nevertheless, the term race is to be found in the titles of most of the major strategy and policy documents, and their texts interchange the language of race and ethnic diversity in a similar way to the education documents discussed earlier.

This failure to consistently and adequately theorise ethnicity is reflected in health research. Here too, confusion between race and ethnicity is not uncommon. Racialised notions have been deployed in the past to explain health differences (in terms of inherent genetic traits) and while now eschewed, similar ideas exist in a revised form. Unlike the situation in education, there is still an unresolved debate about the relative significance of genetic and social factors as contributors to ill health. 'While few would publicly argue [against the evidence], for instance, that, as a people, the Chinese are genetically predisposed to poor academic performance, they may be prepared to argue that there is some connection between the genetic inheritance of an ethnic minority and their patterns of ill health' (Bradby, 1995: 408). Bradby argues that the latter is considered a more acceptable assertion because it is evidently true, to some degree, in some circumstances. Karslen & Nazroo (2002a) demonstrate that in current epidemiological research, in particular, there remains an assumption that ethnic differentials in health are at least in part a consequence of innate characteristics; whether these are explicitly described as 'ethnic' or 'racial' differences.

However, relationships between the social, genetic and environmental patterning of health and ethnicity are complex and still somewhat obscure (Sudanoa & Baker 2006). Whilst there is abundant 'evidence' of ethnic differences in morbidity and mortality, the precise effectivity of ethnicity remains unclear. However, the work of James Nazroo and others has demonstrated that, in order to understand ethnic inequalities in health, researchers must take account of the relationship between ethnic minority status and structural disadvantage (Nazroo 1998; Karlsen & Nazroo, 2002a; Cooper, 2002; Nazroo, 2003). The ethnic groups with the worst health status are those who suffer the greatest socio-economic disadvantage (Pakistani and Bangladeshi

communities in the UK context), while the health status of some other minority ethnic groups is on a par with that of the white population (Nazroo, 1997). There is a clear socio-economic effect in the relationship between ethnicity and health which suggests that to understand ethnic inequalities in health researchers need to explore the *mechanisms* by which ethnic minority status leads to socio-economic disadvantage (Smith, 2000). Recently, researchers have begun to explore the impact of experienced and perceived racism on health and it has been suggested that racism (rather than culture or biology) may well be a key route through which social structure influences inequalities in health (Karlsen & Nazroo, 2002b; Krieger, 2003, Sudanoa & Baker 2006).

Race and health policy

While such debates continue in the sociological and epidemiological literature, they do not commonly surface in the policy arena. The Department of Health's *Race Equality Strategy* (Department of Health, 2005a) is predicated on the assumption that 'minority ethnic groups' experience 'disadvantage' which is expressed in terms of key health outcomes such as general levels of ill health, cardiovascular disease and diabetes. There is seldom any discussion of the potential impact of socio-economic status on the relationship between ethnicity and ill-health. Indeed, perhaps surprisingly, questions of causality rarely feature in policy documents; despite the obvious importance of the need to understand mechanisms of inequality before devising policies. Given the prevalence of essentialist discussions in the epidemiological literature, it is not unreasonable to suggest that underlying the failure of government policy documents to discuss explanations of ethnic inequalities in health is an assumption that these arise as a result of genetic or cultural characteristics of minority ethnic groups, rather than their socio-economic location. As several authors have pointed out, this arises from the use of ethnic classifications that 'allow ethnicity to be treated as a natural and fixed division between social groups, and the description of ethnic variations in health to become their explanation' (Nazroo, 1998: 717). There remains a heavy concentration on studies which *describe* differences in measured health status or service use. Moreover, many studies refer to high-level group categories such as 'Asian', combining sub-groups with distinctive socio-

cultural features and thereby losing explanatory power. There are very few studies that describe and evaluate effectively the effects of risk factors on health. At the level of service planning and delivery health policy for 'black and ethnic minorities' thus becomes directed towards assessing the needs of (racialised) fixed and homogenous ethnic groups, which might variously have their origin in genetic, cultural, religious or lifestyle 'differences' from an allegedly homogenous 'white' population. Once 'needs' are uncovered, health agencies are expected to respond in a way which 'meets these needs'.

Notwithstanding the theoretical limitations underlying such an approach, it is clear that despite over twenty years of such 'policy', the most basic and obvious 'needs' of some members of some minority groups are a long way from being met by the UK National Health Service (NHS). The clearest example of this is in the area of communication support. 'Language barriers' have long been identified as a major obstacle to some members of minority ethnic communities receiving appropriate healthcare in the UK. While the ability to understand English varies widely across and within ethnic groups, there are substantial numbers of people who are not fluent in English (Attwood et al., 2003). This has repeatedly been shown to create difficulties in accessing care and to affect the quality of healthcare received (Rhodes & Nocon., 2003; Gerrish, Chau, Sobowale & Birks, 2004; Szczsepura, Johnson, Gumber, Jones, Clay & Shaw 2005). Nevertheless, it is widely accepted that the standard of provision of NHS interpretation and translation services in many parts of country remains poor (Alexander et al., 2004; Gerrish et al., 2004). Despite the range of language groups in the UK (evident since 1948) it was only in 2004 that a policy for comprehensive communication support was proposed (Department of Health, 2004) and this has yet to be implemented.

Several studies have demonstrated marked variation in health care utilisation across ethnic groups in the UK, with minority groups having lower use of secondary services, despite a higher use of primary care, although interpretation of such data is difficult because of a number of confounding variables (Smaje & Le Grand, 1997). A recent methodologically sophisticated analysis which takes account of both need and local supply variables does suggest inequity of utilisation (i.e. people with the same needs consume different amounts of care). However, the complex pattern of variation,

both by ethnic group and by stage in the health care process, makes devising policies to correct such inequity very difficult (Morris, Sutton & Gravelle, 2005).

Over the last ten years there has been a growth of projects and interventions, many at a local level, in relation to coronary heart disease, cancer care, diabetes, mental health and screening in particular, directed to improving access to care and reducing ethnic health inequalities. Much of the most innovative work has taken place in the voluntary sector rather than through the NHS. Very few interventions have been subjected to effective evaluation of outcome or impact. Many initiatives in both sectors suffer from the lack of on-going funding and commitment of staff and projects often close without significant impact on mainstream service provision (Johnson 2004). It remains to be seen whether the provisions of the Race Relations (Amendment) Act (2000) results in an improvement in the sustainability of what are currently pockets of 'good practice'.

Under the provisions of the Race Relations (Amendment) Act (2000) every NHS Health Trust (hospitals and primary care organisations) must have in place a Race Equality Scheme which 'promotes race equality'. Trusts are obliged to monitor all policies for their impact on promoting race equality through a 'Race Equality Impact Assessment'. No definition of race equality is provided. Despite a plethora of exhortations about the significance of 'valuing diversity', guides to the implementation of race equality schemes and codes of practice, it remains to be seen whether the latest policies on race and health will have any noticeable impact on ethnic health inequalities. A pessimistic, though possibly realistic, assessment would suggest a minimal impact is likely. The attribution of *all* ethnic difference in health to socio-economic factors *per se* is untenable not least because of the intertwining of racism and socio-economic status (Karslen & Nazroo 2002b). However, if, as we have argued, ethnic inequalities are related in complex but fundamental ways to wider social and economic inequalities, the prospects are not promising. Current public health policies (Department of Health, 2004) which attempt to address adverse health behaviours may be laudable, and *may* improve health for all groups, but they are likely to result in only modest decreases in ethnic health disparities.

The evidence on general health inequalities suggests that despite a government with an unprecedented explicit commitment to reducing health inequalities, the gap between the health of the rich and poor is growing. A Department of Health-commissioned report found the gap in life expectancy between the bottom fifth and the population as a whole had widened by 2% for males and 5% for females between 1997-99 and 2001-03. This shift means the life expectancy in the wealthiest areas is seven to eight years longer than the poorest areas. The gap in the infant mortality rate between the poorest ('routine and manual groups') and the total population, was 19% higher in 2001-3 compared to 13% higher in 1997-99 (Department of Health, 2005b).

Employment initiatives in the NHS

The NHS is the biggest UK employer of individuals from minority ethnic groups. The Department of Health race equality strategy is also concerned with the status and advancement of minority ethnic workers. In the UK there is a long history of largely ineffective public sector equal opportunities employment policies (Johns, 2005). Since the election of a Labour government in 1997 with a more determined approach to tackling disadvantage and discrimination in employment, the Department of Health has announced a disparate collection of policy documents and initiatives. A general strategy document on diversity issues was published in 2000 which included a consideration both of employment issues and service delivery issues (Department of Health, 2000). Since 2000, there has been a series of initiatives and national development programmes with the objective of recruiting and promoting people from minority ethnic communities within the NHS, with the aim of 'ensuring that the NHS workforce at all levels, represents Britain's multiethnic society'. Indeed, several government documents make an explicit connection between the recruitment of a diverse workforce and the provision of services to minority ethnic communities, arguing that the improvement of the latter will occur as an inevitable consequence of the achievement of the former; a position which has been challenged both on theoretical and empirical grounds (Gerrish et al., 1996; Culley, 2000; Iganski & Mason, 2002). The race and employment agenda includes initiatives such as setting targets to increase the minority ethnic representation on Trust Boards; leadership

development programmes for minority ethnic employees; policies on racial harassment and the implementation of ethnic monitoring both for staff and patients.

The impact of these new employment policies is yet to be evaluated. However, the under-representation of ethnic minorities at the higher levels of employment in the NHS and in the more prestigious specialities has been acknowledged for many years. There have been many previous policy pronouncements designed to address these issues with relatively little success to date (Iganski & Mason, 2002). The NHS has, by its own admission, failed to implement the minimum employment standards required for compliance with the 1976 Race Relations Act and the Race Relations (Amendment) Act (2000). In the twenty years since the Commission for Racial Equality first issued guidelines on good practice for employees NHS organisations have consistently failed to comply with them (Esmail, 2005; Wrench, 2005). Research has continually demonstrated the unwillingness of many NHS employers to engage fully with equal opportunities policies; particularly those that require any form of positive action (Carter, 2000; Culley, 2001b; Johns, 2005). There is little evidence that such resistance has diminished. However, as with the case of education, while there are strong social justice arguments for ensuring 'fair treatment' of minority ethnic employees, it is not clear how this would *necessarily* translate into better health outcomes for minority ethnic patients.

Marketisation in health and education

The policy implications of the Race Relations (Amendment) Act (2000) and associated initiatives in education and health are best seen in the context of broader UK government policy on the growing marketisation of the public sector and the 'commodification' of public services. To some extent covertly in education, but much more explicitly in health policy, the current policy direction is towards stronger market incentives and decentralisation of budgetary power. In the case of health policy, for example, despite initially rejecting the notion of an internal market in the NHS (a central plank of Conservative Party policy), the Labour government has re-introduced competition into health services since the start of its second term of office in 2001. The health market now emerging is the product of a series of separate policy

developments, including expanding the role of the private sector; increasing the autonomy of local healthcare providers from central control, introducing payment by results and extending choice of provider (Lewis & Dixon, 2005).

This restructuring of healthcare under the rubric of promoting 'patient choice' may further entrench social inequalities in a number of ways. Effective patient choice requires empowering and involving patients through improved access to health information. Patients' understanding of health information varies considerably and is hard to predict. However, there is evidence that lower health literacy is more common in some minority ethnic groups and this has been identified as a major problem in accessing services at the present time. It is possible then that 'patient choice' initiatives, could have the effect of exacerbating existing health inequalities, including those related to ethnicity (Ellins, 2005). Furthermore, the possible introduction of private commissioning of NHS Services provokes some important legal questions for the implementation of race equality policies and may present the prospect of two tier rights in the NHS. Patients who are subject to private commissioners may not enjoy identical rights to those within statutory primary care trusts since private sector companies are not subject to judicial review and there are important differences in the implementation of the Freedom of Information Act and the Human Rights Act in the public and private sector (Newdick & Danbury 2006).

In education, aspects of the quasi-market left by the outgoing Conservative administration have been retained by new Labour and other, non-market initiatives, have been introduced (Demaine, 2005). However, during late 2005 and early 2006 'parent choice' was once again at the forefront of Labour's agenda with critics from within the party arguing that Labour's policy could well have the effect of exacerbating existing educational inequalities (see Demaine, 2006). Critics argued that proposals set out for the reform of secondary education in the 2005 White Paper *Higher Standards, Better Schools For All: More choice for parents and pupils* and subsequently presented to parliament in the *Education and Inspections Bill* (2006) will have the capacity, despite government assertions to the contrary, to increase inequality of educational opportunity, inequality of educational attainment, pupil disaffection, pupil absenteeism and school exclusion. If this turns out to be so, it is hard to see how the interests of pupils from most minority ethnic communities would

be advanced. Labour 'backbench' members of parliament had published a document titled *Shaping the Education Bill: Reaching for Consensus*, setting out objections and making alternative proposals (Abbot, et al., 2006). Labour Party members, including former Secretaries of State for Education and a former Leader of the Labour Party Neil (now Lord) Kinnock expressed their surprise and criticised Blair's policy. Critics argued that the central ideas delineated in the *Education and Inspections Bill* (2006) could lead to better schools for *some* (not all) and more choice for *schools* rather than for parents and pupils. To many observers on the political right, as well as those on the left, Blair's education policy looked remarkable similar to right wing policy proposed in the 1980s with all the questions as to whom it would benefit (see Demaine, 1990, 1999). It is significant that no Conservative member of parliament voted against the second reading of the Bill whilst 52 Labour members voted against. Critics inside and outside parliament argued that those who usually benefit from markets will be the ones who will have most to gain from an enhanced market in education.

Conclusion

In this chapter we have shown how 'race' and 'ethnicity' are invoked in policy discourse. We have criticised essentialist concepts of ethnicity which construct 'ethnic groups' as fixed homogenous cultural groups characterised by sets of immutable characteristics. Such notions have been the subject of extensive theoretical challenge from newer approaches that stress the dynamic, fluid and contextual character of ethnic identifications. We have shown how essentialist concepts of ethnicity still dominate UK legislation, social policy documentation and professional discourse on cultural diversity and ethnic difference in education and healthcare. Nevertheless, we recognise that the British Labour's policy in implementing the Race Relations (Amendment) Act (2000), which puts public authorities under a statutory duty to promote race equality, is well-intentioned. The positive effects include several prosecutions for 'racially motivated' crimes often involving attacks on citizens for no other reason than the colour of their skin. These prosecutions have been given a high profile in the media which in itself is a positive thing. However, the policy implications of the Race Relations (Amendment) Act (2000) and associated initiatives

in education and health are best seen in the context of other government policy. Despite initially rejecting the notion of an internal NHS market, when it came to power in 1997, the British Labour government re-introduced competition into health services at the start of its second term of office from 2001. The health market now emerging is the product of a series of separate policy developments; including extending choice of provider, expanding the role of the private sector and introducing 'payment by results'. In education, the quasi-market introduced initially by the Conservatives has been retained alongside other non-market initiatives. Legislation making its way through parliament during 2006 will further enhance the education market and has the capacity to increase inequality of educational opportunity. Whilst there have been some successes in reducing child poverty and improvements in housing for the worst off, there is little evidence of *effective* interventions to address social inequalities in Britain and, indeed, many wider economic policies have had the effect of increasing the income and wealth gap. The marketisation of education and healthcare, and the promotion of the idea of parent and patient 'choice' may further entrench social inequalities. Effective parent and patient choice presupposes the 'empowerment' of parents and patients through improved access to health and education information. Parents' and patients' understanding of education and health information varies considerably and it is possible that choice initiatives could have the effect of exacerbating existing inequalities. The rhetoric of race equality is unlikely to provide an effective mask for the racialised effects of public policy.

FOOTNOTES

1. Although there are no races, the *idea* of race is still socially and politically significance. Race is not real but *racism* is. Evidence abounds of the persistence of ideas about racial categories in everyday discourse and their very real effects in many forms of racist exclusion (Goldberg 1993).

2. The evidence on teacher ideology is not reliable (see Foster, Gomm and Hammersley, 1996). Citing the latter does not imply taking sides with those authors in the debate over alleged racism in English schools. The lack of reliable evidence does not imply one thing or the other. For other arguments see the work of Gillborn, *passim* and Crozier, 2005, for example.

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