Centre for Ageing Better

Ethnic health inequalities in later life

The persistence of disadvantage from 1993-2017

November 2021

in partnership with:

University of Sussex

The University of Manchester

Key findings

There are stark inequalities between the health status of different ethnic groups in the UK, with people from some ethnic minority backgrounds experiencing worse health than their White peers.

1 The health status of different ethnic groups begin to diverge at around 30 years of age. From that age on, the gap in health between ethnic minority and White majority groups gets gradually larger and so is particularly pronounced in later life.

2 At any given age after 30, Pakistani and Bangladeshi people experience the highest rates of poor self-rated health; their rates of poor health are equivalent to those of White people who are at least 20 years older.

3 These ethnic health inequalities have persisted, unchanged, for almost 25 years.

4 Ethnic health inequalities result from experiences of racism and racial discrimination which have a direct impact on health by causing physical and mental stress, and an indirect impact through their effect on socioeconomic status.

Introduction

Throughout their lives, people from ethnic minority backgrounds experience worse health than their White peers. Racism and racial discrimination are important causes of health inequalities because they produce both mental and physical stress that adversely impacts on health.[1]

Racism also impacts health indirectly, via its effect on socioeconomic status which is itself related to health. By and large, health status mirrors socioeconomic status – groups with the poorest health are also the most disadvantaged in terms of education, work, housing, income and wealth. Consequently, there are also parallels between the health inequality and the socioeconomic inequality that exists between ethnic groups.

To date there has been a lack of data on the lives and circumstances of ethnic minority people in later life. Those studies which do exist show clear differences in the physical health of older people from different ethnic groups, but there is still a great deal that we don't know concerning the extent of, and reasons for, these health inequalities in later life.

This briefing presents the findings of recent research from Dr Sarah Stopforth and Dr Laia Becares at the University of Sussex and Dr Dharmi Kapadia and Professor James Nazroo at the University of Manchester looking at ethnic inequalities in health in later life in the UK[2] – specifically, how they vary with age; whether levels of inequality have changed over time; and to what extent they can be explained by socioeconomic inequality and self-reported experiences of racism and racial discrimination.

[1] Wallace, S., Nazroo, J., & Bécares, L. Cumulative exposure to racial discrimination across time and domains: exploring racism's long term impact on the mental health of ethnic minority people in the UK. American Journal of Public Health 2016;106(7):1294-1300.

[2] Stopforth, S., Kapadia, D., Nazroo, J., & Bécares, L. (2021). Ethnic inequalities in health in later life, 1993–2017: The persistence of health disadvantage over more than two decades. Ageing and Society, 1-29.

Ethnic inequalities in health accumulate over the life course

This analysis shows that rates of poor self-rated health increase rapidly with age in every ethnic group in the UK, but the rate of the increase is particularly pronounced among Pakistani, Bangladeshi, and Indian men and women and Black Caribbean men from the age of 40 onwards (Figure 1).

What is also very noticeable about the health trajectories of different ethnic minority groups is how they diverge from that of White/White British people from about the age of 30. Up to this age, the proportion of people who report that they have poor health is about the same for each of the ethnic groups shown in Figure 1.

But after the age of 30, the proportion of people who report that they have poor health rises much faster for ethnic minority groups than for the White/White British group. The resulting health inequality between ethnic minority groups and White/White British gets larger with age so that it is especially pronounced in later life.

For example, **22% of White British women in their 80s report poor health**, the same proportion as for **Pakistani women in their 50s (23%)**. And the proportion of **Bangladeshi women in their 50s who report poor health (31%) is even higher than that of White British women in their 80s**. Similarly, the rate of **poor health of Bangladeshi women in their 40s (14%) is equivalent to that of White British women in their 70s (14%)**. Similar trends are found for Pakistani and Bangladeshi men when compared to White British men.

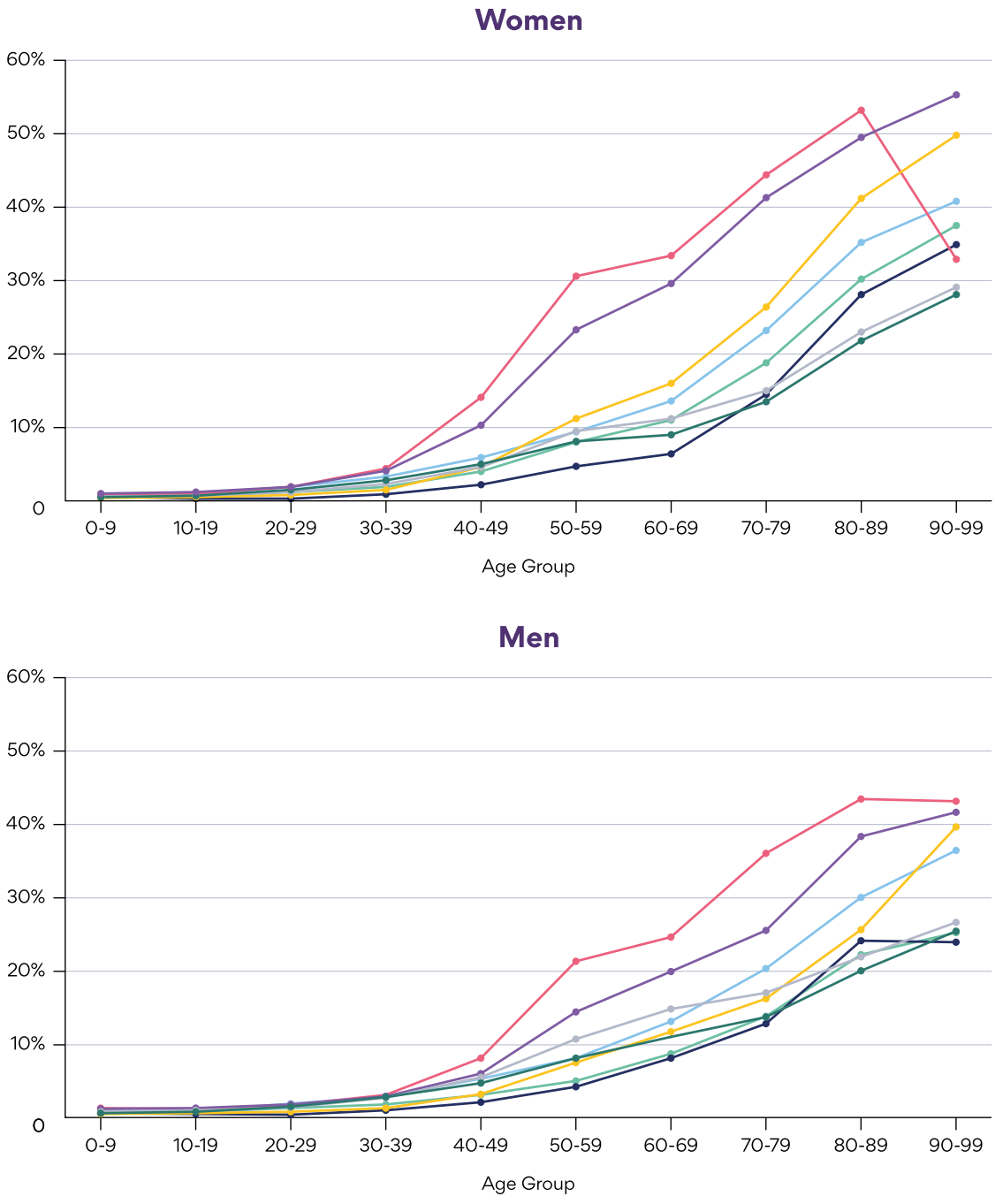
As a result, the rates of poor self-rated health among Pakistani and Bangladeshi people are equivalent to, or worse than, the rates for White British people who are at least twenty years older.

Similar trends are seen for other ethnic groups: rates of poor health among Black Caribbean men and women are equivalent to those of White British men and women who are ten years older.

The analysis shows that these ethnic inequalities have persisted over time. In fact, after controlling for gender and age (shown by the blue dots in Figure 2), **the odds of reporting poor self-rated health have been at least double for the Pakistani group; 1.64 times higher for the Bangladeshi group and 1.5 times higher for the Black Caribbean group than for the White/White British group** in all the years for which we have data since 1993/1994.

Figure 1:

Percentage of men and women with poor self-rated health by age and ethnicity.



Source: 2011 Census, own calculations. Poor self-rated health aggregates 'bad' and 'very bad' health.

Explaining ethnic health inequalities

To try to explain the pronounced ethnic health inequalities observed in the UK, the researchers first accounted for the differences in socioeconomic status that exist between ethnic groups. Using income, level of education and occupation as measures of socioeconomic position shows that White, Irish, and Chinese people occupy the highest socioeconomic positions in the UK, and Pakistani and Bangladeshi people occupy the lowest. Black Caribbean people also tend to be in more disadvantaged socioeconomic positions.

When socioeconomic position (shown by the red dots in Figure 2) is accounted for, it can be seen that the probability of having poor health for the most disadvantaged ethnic groups is now closer to that of the White British group. Some (though not all) of the inequality in health status between ethnic groups has been accounted for by adjusting for socioeconomic status; this reflects the socioeconomic disadvantage that most ethnic minority groups experience, and the strong association that poverty has with health. However, even accounting for differences in socioeconomic position, poor health is still more common among Pakistani, Bangladeshi, Black Caribbean, and Indian people when compared to White/White British people.

The researchers then included self-reported experience of racial discrimination in the model (green dots in Figure 2) and found that this makes a small additional contribution to reducing the gap in health status between groups. This means that the experience of racism is also partially responsible for driving health inequalities in our models.

Although the analysis shows most ethnic minority groups still have a greater probability of reporting poor health than White/White British people even after taking socioeconomic status and self-reported experience of racism into account, it is unlikely that there are additional, meaningful factors that contribute to ethnic health inequalities that haven't been captured in the model. Rather, it is likely that the measures of socioeconomic status and racism used in the model do not fully capture these multi-dimensional and nuanced experiences. Moreover, they are only measured at a single point in peoples' lives and there is currently no way of capturing exposure to disadvantage over a lifetime. In addition, the model inevitably uses self-reports of racism and racial discrimination and so does not capture the impact of experiences which may be racist and discriminatory but are not reported, or which are not explicitly asked in the questionnaire.

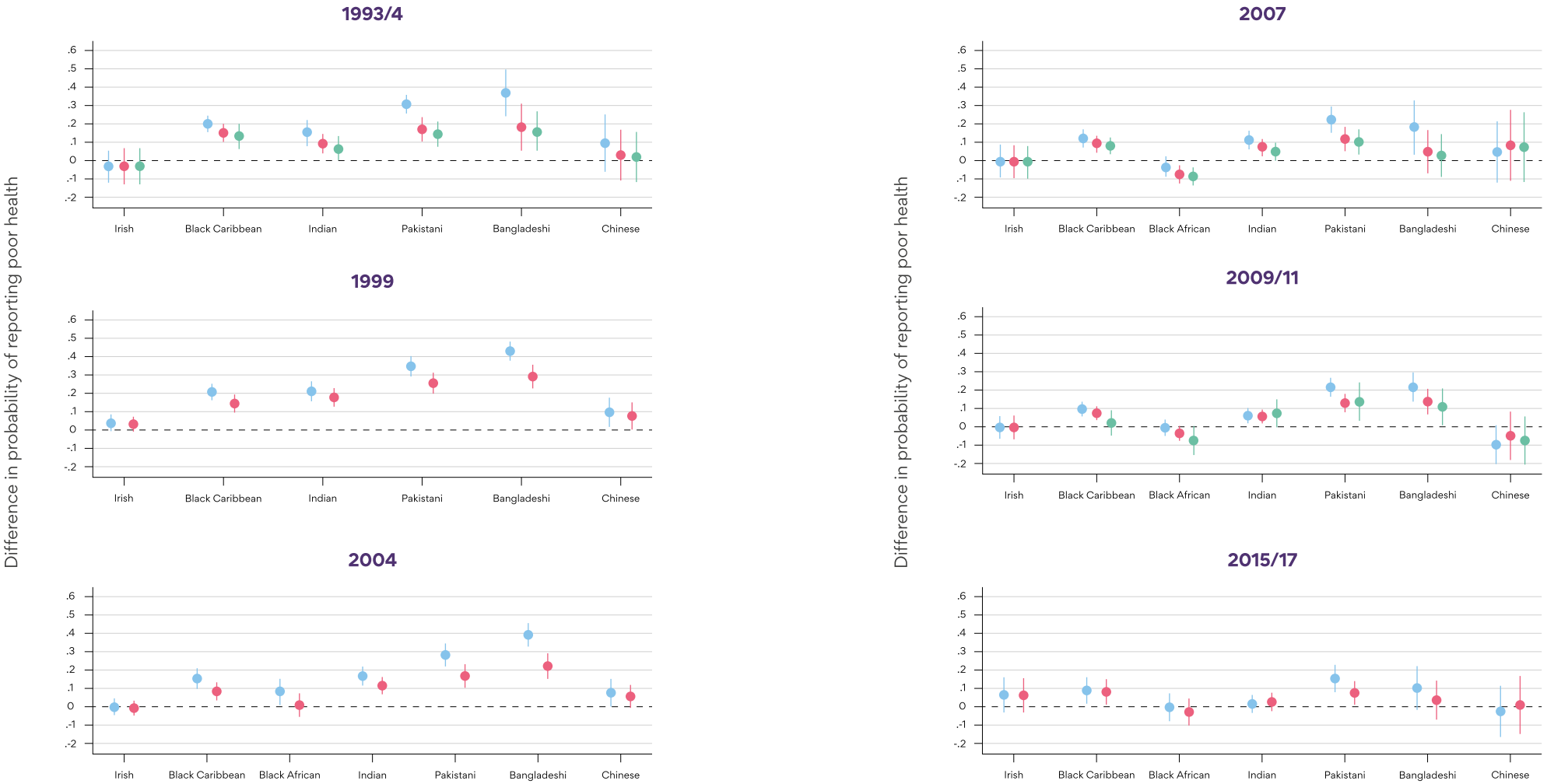
Nevertheless, even with these imperfect measures there is clear evidence of ethnic health inequalities that are largely explained by **socioeconomic inequality** and by experiences of **racism and racial discrimination and that have persisted, undiminished for the last 24 years**. It is known that living in a society structured by systems of oppression – including racism – that disadvantage ethnic minority people is both directly linked to health outcomes (through the physical and mental stress produced) and indirectly linked to health outcomes (through impact on socioeconomic status).

As people from ethnic minority groups approach later life, the social and economic disadvantage and the impact of the racism and racial discrimination that they have experienced across the life course accumulates[3]. Therefore, ethnic health inequalities get larger with age. As our population ages, older generations are becoming increasingly ethnically diverse and population health inequalities could grow without urgent action to narrow health inequality throughout the life course.

[3] Geronimus AT. The weathering hypothesis and the health of African-American women and infants: evidence and speculations. Ethn Dis, 1992;2(3):207-21.

Figure 2:

Difference between minority ethnic group and White/White British group in probability of reporting poor health, by year, people aged 40 and older.



Sources: Fourth National Survey 1993/94; Health Survey for England 1999; Health Survey for England 2004; Citizenship Survey 2007; Understanding Society wave 1 2009/11; Understanding Society wave 7 2015/17. White/White British rate is represented by the dotted line at 0.

Recommendations

1 **Close the ethnicity data gap**

- **Ethnicity data reporting must be mandatory** in all official and statutory statistics and data monitoring.
- In order to be accurate and more precisely **reflect the experiences of ethnic minority groups, specific categories** (e.g. Pakistani, Bangladeshi, Indian people) should be used instead of broad categories (e.g. South Asian). The use of broader categories like BAME, BME should be discontinued when more accurate categories are possible.
- To effectively document and understand ethnic health inequalities in later life and **identify drivers of healthy ageing for ethnic minority people**, studies must include suitable sampling designs with representative and sufficiently large samples of ethnic minority groups. Surveys must include questions on ethnicity, identity and key determinants, such as experiences of racism and racial discrimination.

2 **Produce and implement a national race equality strategy – which specifically takes into account healthy ageing. This should:**

- Include a clear plan for **how ethnic minority older people will be supported** to recover from the effects of the pandemic.
- Set out how ethnic health inequalities will be tackled across the life course in order to **prevent these inequalities worsening in later life.**

3 **Consider – and work to address – inequalities, in all policy activity relating to people in and approaching later life.**

- This includes analysing the **potential impact on different ethnic groups of the upcoming review of the State Pension Age.**

Methods

To describe ethnic inequalities in later life we analysed data from the 2011 Census and provided age and sex-specific rates of poor health (as reported by individuals themselves) over 10-year age bands. We harmonised six nationally representative health and social datasets (Fourth National Survey of Ethnic Minorities 1993/94, the Health Survey for England 1999, the Health Survey for England 2004, the Citizenship Survey 2007, Understanding Society Wave 1 (2009/11) or Understanding Society Wave 7 (2015/17)) that span more than two decades (1993-2017)†. We focus on people aged 40 and over to reflect the earlier onset of disease and ill health for many people from ethnic minority groups.
To ensure that these surveys and their measures are as comparable as possible over time, we harmonised health and socioeconomic measures. We used regression models to examine ethnic inequalities in health, while taking into account gender, age, socioeconomic characteristics, and experiences of racism and racial discrimination as reported by individuals themselves.

†In each survey, respondents were asked to assess their general health on a five-point Likert scale. The exact wording of the questions and response options differ slightly between surveys, but we dichotomise into good health (combining responses of excellent, very good, or good health) and poor health (combining the responses of fair, poor/bad, or very poor/very bad health).

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Centre for Ageing Better

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Let's make ageing better.

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