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Two decades on: the continuing health disadvantage of South Asian elders

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In a landmark study, Evandrou (2000) highlighted the existence of significant differences in health status between ethnic elders in the UK, with the greatest health disadvantage being experienced by older people of South Asian heritage (Indian, Pakistani and Bangladeshi). In the wake of the McPherson Report and the Acheson Inquiry (Acheson, 1998), in the closing moments of the twentieth century, the Government reaffirmed the priority of tackling ethnic inequalities in health, putting a renewed focus on the social determinants of health (DH, 1999). This report draws upon recently available survey data in order to update Evandrou's earlier analysis to investigate the progress that has been made since then.

Key Points

- Even after controlling for social and economic disadvantage, Black and Minority Ethnic (BME) elders are more likely than White British elders to report limiting and poor self-rated health.
- The 'health disadvantage' in later life appears to be most marked amongst BME elders of South Asian origin:
  - Indian, Pakistani and Bangladeshi older men are all more likely than White British older men to report limiting health
  - Older women from Indian, Pakistani and Bangladeshi groups are more likely to report poor self-rated health than White British older women
- The scale of the health divide remains remarkably similar, if not wider, to that found in data from the mid-1990s, indicating the need for a renewed policy focus on improving the health and socio-economic position of South Asian and BME elders in the UK.

Introduction

In the late 1990s a number of key policy documents highlighted both an ethnic disadvantage in health and the pressing need to tackle these inequalities (Acheson, 1998; McPherson, 1999; DH, 1999). Much of the evidence, and thus policy attention, focused on people of working age. This was in part due to the absence of nationally representative data containing information on health and ethnicity and with sufficient sample sizes to identify ethnic elders. In a landmark study, Evandrou (2000)

used pooled data from six years of the General Household Survey (1991-96) to explore ethnic inequalities in health in later life, demonstrating that health inequalities were actually wider in older age than earlier in the life course, with BME elders from South Asia consistently reporting the worst health outcomes in terms of long-standing illness and ill-health.

In the 15 years since that study, the number of South Asian elders has increased significantly, both as a result of the ageing of the population in situ and the in-migration of accompanying family members. As of the 2011 census, there were 2,984,670 individuals of Indian, Pakistani and Bangladeshi heritage living in England and Wales, of whom 261,225 (or 9%) were aged 60 and over.

Addressing the health divide

To shed light on progress in addressing this health divide, this paper uses data collected between 2009-2011 from Understanding Society; a nationally representative survey of the UK. The survey includes an Ethnic Minority boost sample designed to include at least 1,000 individuals from five key ethnic groups: Indian, Pakistani, Bangladeshi, Caribbean and African - making it an ideal dataset for this study. In total there are 47,678 respondents with complete information; 10,815 are aged 60 and over, 631 of whom came from the five ethnic groups above.

The ethnic health divide

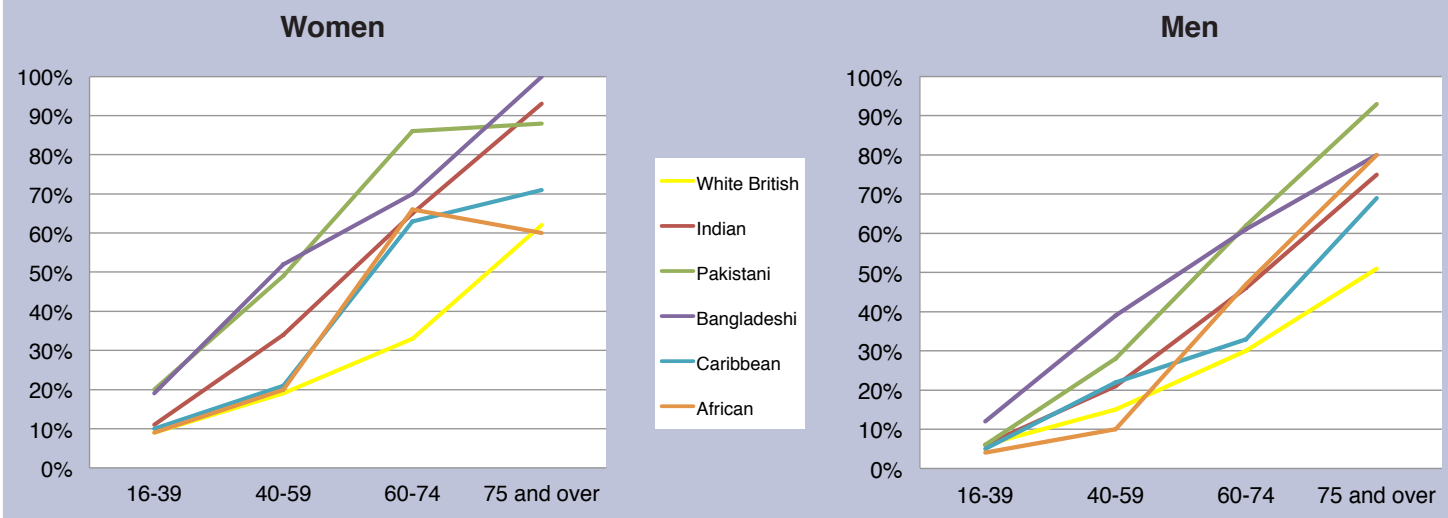
Figure 1 shows that a higher proportion of people of BME heritage, particularly those from South Asia, report that their health limits their typical activities. Furthermore the ethnic differential in health widens with increasing age, underlining the importance of focusing on later life.

The ethnic health divide in later life

Tables 1 and 2 show the proportion of people aged 60 and over reporting limiting health and 'poor' self-rated health, by ethnicity. Both older men and women of Indian, Pakistani and Bangladeshi heritage have a clear disadvantage compared to the White majority group and Black Caribbean elders. It has been argued that ethnic inequalities in health in part reflect other inequalities between ethnic groups, i.e. in terms of socioeconomic position and social class, health service access and use, as well as racial discrimination (Nazroo, 2003). We have found that more than 35% of Indian, Pakistani and Bangladeshi elders are in the poorest fifth of the income distribution compared to 19% of White British elders (Evandrou et al., under review). BME individuals are also less likely to receive the state pension or an occupational/ private pension above the state pension age (60 for women, 65 for men) (Vlachantoni et al., under review), and their income from a state pension is lower, on average, than among their White British counterparts (DWP, 2014).

Given the strong relationship between one's socio-economic status and health, it is important to explore whether the report of poorer health outcomes among South Asian elders remains even after controlling for socio-economic status.

Figure 1: Percentage of women and men reporting that health limits typical activities, by age and ethnicity, Great Britain



Source: Authors' own analysis of Understanding Society (2009-11)

Note: Chi-square significant at p<0.001

We find that Indian men over 60 are twice as likely as White British older men to report limiting health, while Bangladeshi older men are 2.7 times more likely and Pakistani men are almost 4 times more likely (Odds ratios 2.16, 2.77 and 3.74 respectively, see Table 3). For older women, those of Bangladeshi origin are 3 times more likely to report health that limits their activities than their White British counterparts, Indian women are 4 times more likely and Pakistani women are 13 times more likely (See Table 3 for associated confidence intervals).

In terms of poor health, older women from Indian, Bangladeshi and Pakistani groups are more likely to report poor self-rated health than White British older women (Odds ratios 2.61, 3.12 and 6.66 respectively).

Our results indicate that once differences in age, gender, income and deprivation are controlled for, there remain significant ethnic differences in health amongst people aged 60 and over. This suggests that although ethnic inequalities in socio-economic status make a significant contribution to ethnic inequalities in health, other factors are also important.

Table 1: Percentage of persons aged 60 years and over reporting that health limits typical activities by age, sex and ethnicity

	White British	Indian	Pakistani	Bangladeshi	Black Caribbean
Men					
60-74	30%	45%	62%	61%	34%
75 and over	51%	78%	93%	80%	69%
Women					
60-74	33%	65%	86%	70%	63%
75 and over	62%	93%	88%	100%	71%

Source: Authors' own analysis of Understanding Society (2009-11)

Table 2: Percentage of persons aged 60 years and over reporting 'poor health' by age, sex and ethnicity

	White British	Indian	Pakistani	Bangladeshi	Black Caribbean
Men					
60-74	12%	8%	40%	22%	4%
75 and over	15%	30%	50%	40%	33%
Women					
60-74	10%	18%	37%	25%	17%
75 and over	16%	33%	63%	100%	32%

Source: Authors' own analysis of Understanding Society (2009-11)

Table 3: Odds ratios of reporting that health limits typical activities amongst persons aged 60 years and over

	Men		Women	
	ORs	95% CI	ORs	95% CI
Age	1.05***	(1.04-1.06)	1.06***	(1.06-1.07)
Ethnicity (ref White British)				
Indian	2.16***	(1.44-3.22)	3.99***	(2.50-6.39)
Pakistani	3.74***	(2.03-6.89)	13.1***	(4.54-37.68)
Bangladeshi	2.77*	(1.27-6.03)	3.00*	(1.08-8.33)
Caribbean	0.86	(0.56-1.32)	2.44***	(1.58-3.79)
African	1.01	(0.47-2.15)	2.11*	(1.00-4.43)
Income quintile (ref top)				
4th Quintile	1.52***	(1.27-1.81)	1.27*	(1.02-1.60)
3rd Quintile	1.34**	(1.11-1.62)	1.21	(0.97-1.51)
2nd Quintile	1.60***	(1.30-1.97)	1.18	(0.96-1.46)
Bottom	1.49***	(1.19-1.87)	1.12	(0.91-1.37)
Deprivation (ref 1st quartile, least deprived)				
2nd Quartile	1.28**	(1.08-1.52)	1.29**	(1.09-1.52)
3rd Quartile	1.77***	(1.48-2.12)	1.63***	(1.39-1.92)
4th Quartile	2.90***	(2.42-3.48)	2.39***	(2.04-2.81)

****p<0.001; **p<0.01; *p<0.05 (models also include all other ethnic groups; not shown)*

Source: Authors' own analysis of Understanding Society (2009-11)

Table 4: Odds ratios of reporting 'poor health' over the last year amongst persons aged 60 years and over

	Men		Women	
	ORs	95% CI	ORs	95% CI
Age	1.00	(0.99-1.02)	1.02**	(1.01-1.03)
Ethnicity (ref White British)				
Indian	0.98	(0.55-1.76)	2.61***	(1.53-4.46)
Pakistani	4.44***	(2.52-7.80)	6.66***	(3.39-13.11)
Bangladeshi	1.96	(0.85-4.54)	3.12*	(1.06-9.18)
Caribbean	0.72	(0.40-1.29)	1.29	(0.76-2.19)
African	1.67	(0.73-3.86)	1.37	(0.55-3.40)
Income quintile (ref top)				
4th Quintile	1.63***	(1.25-2.14)	1.31	(0.95-1.82)
3rd Quintile	1.62***	(1.23-2.14)	0.98	(0.70-1.35)
2nd Quintile	1.51**	(1.11-2.05)	0.80	(0.58-1.11)
Bottom	1.54**	(1.11-2.14)	0.72*	(0.52-0.99)
Deprivation (ref 1st quartile, least deprived)				
2nd Quartile	1.40*	(1.06-1.85)	1.78***	(1.32-2.40)
3rd Quartile	2.57***	(1.97-3.35)	2.52***	(1.90-3.35)
4th Quartile	3.59***	(2.77-4.66)	4.27***	(3.27-5.58)

****p<0.001; **p<0.01; *p<0.05 (models also include all other ethnic groups; not shown)*

Source: Authors' own analysis of Understanding Society (2009-11)

It is interesting to compare the size of the odds ratios with those found in Evandrou (2000), even though the outcome variables are not identical so direct comparisons are not possible. In the mid 1990s, the odds of reporting 'not good' health were 2-3 times higher amongst South Asian men and women compared to their White British counterparts; by 2009-2011 the odds of reporting 'poor health' were 2-6 times higher. In the mid 1990s, there were no statistically significant differences in the odds of reporting a limiting long standing illness amongst older men, however by 2009, older South Asian men had at least double the likelihood of reporting health that limits typical activity than White British men. Amongst older women in the 1990s, the odds were 2-6 times higher and by 2009 this had increased to 3-13 times higher.

Summary

South Asian elders face a clear health disadvantage in later life. Moreover the results are indicative of a widening of the health divide between White British and South Asian elders (especially those of Pakistani and Bangladeshi origin), despite the policy focus on addressing the social determinants of health during the past two decades. At the end of the millennium, the report *Saving Lives: Our Healthier Nation* highlighted that "in addressing the health of people from black and minority ethnic groups we need a new approach" (DH, 1999 para 9.29). Nearly twenty years on, it remains clear that a renewed effort is required.

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