

# Ethnic health disparities among older adults in England equivalent to 20-year age difference, even before COVID-19

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Experts call for policy reform to improve ethnic equity of socioeconomic opportunity, service provision, and health outcomes.

They also call for long-term studies to investigate how structural and institutional racism generate these ethnic inequalities in health.

In 15 out of 17 minority ethnic groups, [health](#)-related quality of life in [older age](#) (over 55 year-olds) was worse on average for either men, women, or both, than for White British people according to an observational study published in *The Lancet Public Health* journal.

In five of those groups—Bangladeshi, Pakistani, Arab, and Gypsy or Irish Traveller—the difference compared with the White British group is equivalent to, or greater than, the [health impacts](#) of being 20 years older.

The older population of England is becoming increasingly ethnically diverse. Although previous evidence suggests there are substantial health inequalities between ethnic groups, there is currently little detailed research available on this. Using a large nationally [representative survey](#) asking participants how their daily life is impacted by their health, the new study provides the first detailed analysis of health inequalities among older adults in England from a broad range of ethnic groups.

Lead author on the study, Dr. Ruth Watkinson, University of Manchester, UK, says "The disproportionate number of deaths due to COVID-19 in minority ethnic groups has highlighted ethnic inequalities in health among older adults in England. Our study adds detail to evidence of these inequities and their drivers before the pandemic. Now, we need decisive policy action to improve equity of socioeconomic opportunity and transformation of health and local services to ensure they meet the needs of all people in the multi-ethnic English population."

The study used surveys taken by patients over 55-years-old registered at GP practices across England from July 2014 to April 2017. The authors analysed how ethnicity was associated with five self-reported aspects of daily life impacted by the health of participants: mobility (i.e. walking),

[self-care](#) (i.e. washing and dressing), ability to engage in daily activities (i.e. working, studying, housework, spending time with family), pain or discomfort, and anxiety or depression. These five areas were combined to give an overall 'health-related quality of life' score for each ethnic group, which ranged from 1 (perfect health) to -5.94 (poorest health). Health-related quality of life was then compared across ethnic groups.

They did a further analysis to understand what the underlying causes of the ethnic disparities might be, estimating the association between ethnicity and five factors known to impact health. The survey asked if participants had one or more of 14 long-term health conditions, received high quality health care, received enough support from local services (such as [social care](#) and support groups) and were confident in managing their own health. The authors also considered level of deprivation in participants' residential area.

Out of the 1,394,361 survey respondents included in the analysis, 11% (152,710) self-identified as belonging to a minority ethnic group. The patterning of disadvantage observed between groups varied by sex.

Across most of the 15 ethnic groups that showed relative disadvantage compared with White British, the size of disadvantage was greater for women than men. Both men and women in Gypsy or Irish Traveller, Bangladeshi, Pakistani, and Arab ethnic groups showed substantial health disadvantage compared with the White British participants.

A 20-year increase in age was associated with an average change in health-related quality of life score of -0.065 for men and -0.094 in women. The average difference among people from each stated group compared to the White British group were: Gypsy or Irish Traveller (-0.192 in men; -0.264 in women), Bangladeshi (-0.111 in men; -0.209 in women), Pakistani (-0.084 in men; -0.206 in women), and Arab (-0.061 in men; -0.145 in women).

The two ethnic groups who were healthier than White British people were Chinese (men and women), and Black African (men only). However, this only applied across all age groups for Chinese men, whereas for Chinese women and Black African men further analyses suggested they were only healthier in the younger age groups (55-64 years for Black African men, and 55-74 years for Chinese women).

When looking at the association between ethnicity and factors that could cause poor health outcomes, the study suggested inequalities in health were accompanied by increased long-term health conditions (particularly diabetes), poor experiences of primary care, insufficient support from local services, low confidence in managing their own health, and high local social deprivation.

The authors emphasise that social deprivation, although more common in ethnic minority groups, could not fully explain the health disparities they observed, and suggest that other factors are also at play, such as structural and institutional racism in health care and local service provision.

Dr. Watkinson continues, "We must consider how social deprivation intersects with gender, ethnicity, and other personal characteristics, such as immigration status or religion, to affect poor [health outcomes](#). Looking forward, we need much more long-term research to understand how structural and institutional racism creates health inequalities."

The large sample size of the study allowed them to look at 17 ethnicities that are often grouped under just four categories (White, Asian, Black, and other). However, the authors found that health-related quality of life varied widely between ethnicities placed within these ethnic "meta-groups", raising questions about the usefulness of such categorizations.

Commenting on the importance of gathering more detailed data, co-

author Dr. Alex Turner, University of Manchester, UK, says, "Our study found large differences between ethnicities often grouped together in broad categories. For example, Bangladeshi, Pakistani and Chinese ethnicities are often all categorised as 'Asian'. In our study, people of Bangladeshi and Pakistani ethnicity had among the worst disadvantage in health, compared with White British, whereas people of Chinese ethnicity had a relative advantage. This emphasises the need for more nuanced research to understand the specific difficulties that older adults from particular minority ethnic groups experience."

The authors note some limitations of their study. Although the large sample size and relatively high survey response rate among older adults allowed the authors to analyse outcomes for smaller ethnic groups, estimates for some ethnic groups were still imprecise owing to small numbers. They also note that some bias may have been introduced by those who chose not to respond to the survey and by the survey being taken from patients registered at a GP surgery (potentially excluding vulnerable adults or those without a fixed residence). In addition, the dataset used was recorded in 10-year age groups, so the authors were unable to ensure exact like-for-like age comparisons. This may have made some ethnic groups appear healthier, which the authors say are more likely to be minority [ethnic groups](#) than the White British group, due to younger overall age structures in the population.

Writing in a linked Comment, lead author Professor Seeromanie Harding (who was not involved in the study), from King's College London, UK, says, "Despite biases, such as the absence of data on ethnicity specific survey non-response rates and the social determinants of health, Watkinson and colleagues present strong evidence of ethnic inequalities in HRQoL [health-related quality of life], the presence of long-term conditions, and poor experiences of primary care. There seems to be inadequate support from local services to manage long-term conditions in ethnic minority groups. Although constrained by the



availability of granular data, the report reinforces the need to consider the intersectional influences of sex and ethnicity on inequalities in healthy ageing."

**More information:** Ruth Elizabeth Watkinson et al, Ethnic inequalities in health-related quality of life among older adults in England: secondary analysis of a national cross-sectional survey, *The Lancet Public Health* (2021). [DOI: 10.1016/S2468-2667\(20\)30287-5](https://doi.org/10.1016/S2468-2667(20)30287-5)

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