Ethnicity, health and health behaviour: a study of older groups

Summary report of main findings
Ethnicity, health and health behaviour: a study of older age groups

Summary report of main findings

Helen Cooper, Sara Arber, Tom Daly, Chris Smaje and Jay Ginn
Department of Sociology, University of Surrey
The research described in this document was originally commissioned by the Health Education Authority (HEA) as part of its Forward Research programme which began in 1996. Other projects from the programme included studies examining health inequalities, social capital, community participation and the evaluation of social action programmes. There was also a focus on particular population groups such as black and minority ethnic communities and older people. By 31 March 2000, the findings from much of this work had already been published. However, a number of important studies were still outstanding.

On 1 April 2000 the Health Development Agency (HDA) was established, in accordance with the government white paper Saving Lives: Our Healthier Nation, following the demise of the Health Education Authority (HEA).

The Health Development Agency (HDA) is a special health authority with a remit to improve the health of people in England – in particular, to reduce inequalities in health between those who are well off and those on low incomes or reliant on state benefits. It achieves this by:

- working with key statutory and non-statutory organisations at national, regional and local level
- finding out what works and maintaining this evidence base
- turning the evidence into action by building up the skills and capacity of those working to improve the public's health
- advising on the setting of standards for public health planning and practice.

In keeping with its remit, the HDA aims to publish the outstanding reports from the Forward Programme and to continue to disseminate the findings from these and other studies as widely as possible.

This report summarises the main findings from a study of health inequalities among white, African Caribbean, Indian, Pakistani and Bangladeshi adults aged 50 and above. Three large-scale British datasets are used to explore the relationship between age, ethnicity and health. Ethnic differences in alcohol consumption, cigarette smoking and tobacco chewing among older men and women are analysed and the likely contribution of these health-related behaviours to the health of these groups is discussed.

The results from this study of ethnic differences in health and health-related behaviours of older age groups described in this report clearly have value in the public health field and will help inform the work of all those working in this priority area.

Dominic McVey
Head of Research
Health Development Agency
Introduction

Ethnicity and age are rarely integrated in health research. Many existing studies analysing ethnic variation in health are based on the general adult population aged 16 and above (Nazroo, 1997; Modood et al. 1997), whilst those focusing on the older population rarely distinguish ethnic groups (e.g. Department of Health, 1992). Contributing to this lack of research are assumptions that the number of older people from minority ethnic groups is presently too small for concern, that migrants will 'return to their homeland' in old age, or that the health needs of these older people will be catered for within supportive family networks (Blakemore and Boneham, 1994; Ahmad and Walker, 1997).

Our previous analysis of large-scale British survey data showed that the health and health-related behaviour of older men and women is structured by socioeconomic circumstances, including occupational social class, income and access to material resources (Cooper, Arber and Ginn, 1999). The current research report extends these earlier analyses by firstly examining ethnic variation in social position and material resources among older age groups and then showing how ethnicity and social position relate to the reported health, smoking and alcohol consumption of men and women aged 50 and above.

This summary report presents the main findings and conclusions from a secondary analysis of three British datasets: the General Household Survey (1992–96), the HEA surveys of Black and Minority Ethnic Groups (1992 and 1994) and the 1992 HEA Health and Lifestyles Survey (HALS). A copy of the full report is available from the Health Education Authority.

Ethnicity and old age

Exactly what constitutes 'ethnicity' is difficult to define and could incorporate religion, language and cultural norms, as well as country of birth and skin colour – all of which may contribute to an individual's affiliation with a particular ethnic group. Among the current cohort of older adults, the vast majority of those from minority ethnic groups were born outside of the UK and migrated to this country during the 1950s and 1960s. Migration itself is associated with changes in material and social environments which may have an impact on health in later years. Working patterns in this country following migration – in terms of type of occupation, levels and length of employment and unemployment – have increasing relevance as individuals grow older, for example, determining pension and benefit entitlement.

Although minority ethnic adults form a small proportion of the older adult population – our analysis of the General Household Survey (GHS) (1992–96) showed only approximately 3 per cent of men and 2 per cent of women aged 50 or above were from minority ethnic groups – the health needs of older minority ethnic adults will become increasingly important for health service providers as the number of older minority ethnic adults dramatically increases over the next two decades.
Researchers in America have claimed that minority ethnic adults experience 'double jeopardy' in old age, faced with the combined disadvantages of age and racial discrimination. This has been linked to greater health inequality between older Black Americans and whites than for younger age groups of white and minority ethnic adults (Dowd and Bengston, 1978). The economic, social and psychological barriers of old age and a minority ethnic status are viewed as doubly detrimental to older people's health and an explanation for the high levels of morbidity among older Black Americans. Other authors have argued that gender inequality or inequitable health service provision (Norman, 1985) further contribute to the health disadvantage of older minority ethnic adults, using the term 'triple jeopardy' to describe ethnic inequality in older people's health.

Theories of 'jeopardy' are however contested. Whilst socioeconomic disadvantage and discrimination are considered to have undoubted negative consequences for health, others have argued that ethnic differences are not exacerbated in later life. Rather, ethnic differences in health may be a persistent feature of the life-course, or else old age may transcend ethnic boundaries, reducing socioeconomic or health inequality across ethnic groups (Kent, 1971). This argument implies that old age 'levels out' ethnic inequalities in health, and greater social support or the revered status of older people from minority ethnic groups is often cited as an advantage.

There has been less systematic investigation of the disadvantages which may be experienced by older minority groups living in the UK. Current knowledge about ethnicity and health in old age is largely based on small-scale surveys or qualitative work in one locality, or focus in detail on the reported health of one ethnic group, such as 'Asian'. However, large-scale surveys based on minority ethnic populations have drawn attention to ethnic inequalities in health and socioeconomic status among the adult population aged 16 and above (Nazroo, 1997; Modood et al., 1997).

One commonly cited explanation for ethnic differences in health refers to 'cultural differences' in health-related behaviour between ethnic groups, and this has made a large contribution to health promotion policies targeted at minority populations (see Ahmad, 1996). The argument that ethnic differences in health are mediated by lifestyle choices is controversial, not least because it neglects material explanations for ethnic differences in health and risks 'blaming the victim' for poor health.

In our analysis of health inequalities, the relationships between ethnicity and age are examined in detail to see whether arguments of jeopardy may be relevant in a British context. We investigate how older white and minority ethnic adults may differ in their socioeconomic resources, tobacco and alcohol consumption and then assess the likely contribution of these factors to ethnic inequalities in older people's health. Before presenting the main findings, the following section discusses the data used in this analysis.
Data used in the analysis

(i) The General Household Survey, 1992-96
The GHS is a large and nationally representative annual survey which interviews all adults aged 16 and over in about 10,000 private households in Britain each year, achieving a response rate of approximately 80 per cent (Bennett et al., 1996). In our analysis, five years of the GHS data are combined (1992 to 1996) in order to increase the number of older men and women from minority ethnic groups.

The GHS provides detailed information on health status, smoking and drinking behaviour which can be analysed according to the living circumstances, occupational social class and material resources of older people. We examined ethnic differences in reported general health and limiting longstanding illness and used information on current cigarette smoking and alcohol consumption available in alternate years of the survey (1992, 1994 and 1996).

(ii) HEA surveys of Black and Minority Ethnic Groups (1992 and 1994) and the 1992 HEA Health and Lifestyles Survey
The HEA commissioned two large-scale surveys of Black and Minority Ethnic Groups (BMEGs) focusing on the health needs of Black and Asian groups in Britain, carried out in 1992 and 1994. The 1992 BMEG survey interviewed 3550 and the 1994 BMEG survey interviewed 4452 minority ethnic adults aged between 16 and 74 years. For both years, sample selection was based on Census enumeration districts (EDs) where 10 per cent or more of the population lived in households where the head of household was born outside of the UK, according to the 1981 Census. From these EDs, addresses were randomly selected from the Small Users' Postcode Address File (PAF).

As the BMEG surveys focus exclusively on minority ethnic groups, comparable information from the 1992 Health and Lifestyles Survey was included for 1394 white older people aged between 50 and 74. The sampling procedure for this survey was based on EDs which were stratified by regional health authorities in England and by country in Great Britain. Within each enumeration district, a random sample of addresses was taken from the PAF. In the HALS and BMEG surveys, one adult aged between 16 and 74 years was randomly selected for interview at each address.

The HEA survey data have the advantage of larger numbers of minority ethnic adults and information on the use of chewing tobacco that is not available in the GHS. Differences in the sampling and question design of the GHS and HEA surveys are discussed in our full report.
Main findings: ethnic inequalities in health

(i) Double or triple jeopardy?
Using the GHS data, we examined levels of reported ill health at different ages for each ethnic group, showing how age and ethnic group may interact to influence health – for example, whether ethnicity is associated with health in a similar way for all age groups, or whether increasing age contributes to greater ethnic inequality in health (‘double jeopardy’) or ‘levels out’ any such inequality. Table 1 shows the percentage of adults in each age and ethnic group who replied ‘not good’ to the question ‘Over the last 12 months would you say your health has on the whole been good, fairly good or not good?’

Table 1: Percentage reporting ‘not good’ health by ethnic group and age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>White</th>
<th>Black Caribbean</th>
<th>Indian</th>
<th>Pakistani</th>
<th>Bangladeshi</th>
<th>All minority ethnic groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-19</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>N</td>
<td>3,971</td>
<td>50</td>
<td>98</td>
<td>76</td>
<td>30</td>
<td>399</td>
</tr>
<tr>
<td>20-29</td>
<td>5</td>
<td>8</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>N</td>
<td>12,960</td>
<td>166</td>
<td>224</td>
<td>147</td>
<td>57</td>
<td>1,011</td>
</tr>
<tr>
<td>30-39</td>
<td>7</td>
<td>13</td>
<td>8</td>
<td>11</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>N</td>
<td>15,023</td>
<td>207</td>
<td>348</td>
<td>134</td>
<td>39</td>
<td>1,135</td>
</tr>
<tr>
<td>40-49</td>
<td>10</td>
<td>17</td>
<td>16</td>
<td>22</td>
<td>48</td>
<td>16</td>
</tr>
<tr>
<td>N</td>
<td>14,294</td>
<td>107</td>
<td>247</td>
<td>72</td>
<td>23</td>
<td>715</td>
</tr>
<tr>
<td>50-59</td>
<td>16</td>
<td>23</td>
<td>30</td>
<td>36</td>
<td>39</td>
<td>28</td>
</tr>
<tr>
<td>N</td>
<td>11,602</td>
<td>120</td>
<td>161</td>
<td>59</td>
<td>23</td>
<td>468</td>
</tr>
<tr>
<td>60+</td>
<td>21</td>
<td>36</td>
<td>34</td>
<td>49</td>
<td>41</td>
<td>34</td>
</tr>
<tr>
<td>N</td>
<td>22,850</td>
<td>131</td>
<td>139</td>
<td>45</td>
<td>17</td>
<td>429</td>
</tr>
<tr>
<td>All 16+</td>
<td>12</td>
<td>17</td>
<td>14</td>
<td>16</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>N</td>
<td>80,700</td>
<td>783</td>
<td>1,217</td>
<td>533</td>
<td>189</td>
<td>4,157</td>
</tr>
</tbody>
</table>

Differences are statistically significant for all age groups, except 16- to 19- and 20- to 29-year-olds

Source: General Household Survey, 1992–96

For all ethnic groups, reported ill health increased with older age. There was no significant variation in health across ethnic groups at age 16–19 or 20–29, but from age 30 and above morbidity was higher among minority ethnic groups than for white adults. However, the patterning of health differed between ethnic groups: morbidity was highest for Black Caribbean and Pakistani adults aged between 30 and 39 years and lowest for the Bangladeshi group. In contrast, Bangladeshis in their 40s and 50s were more likely to report poor health than any other ethnic group; 48 per cent had ‘not good’ general health compared with 16 per cent of Indians and only 10 per cent of white adults. The difference in reported health status between white and minority ethnic groups was greatest for older age groups: overall 34 per cent of minority ethnic adults aged 60 or above reported poor health, compared with 21 per cent for whites of the same age.

The marked ‘health disadvantage’ of minority ethnic elders appears
to refute the argument that old age ‘levels out’ ethnic differences in health but strongly suggests that increasing age amplifies ethnic inequalities in health.

The relationship between age and ethnic group was analysed separately for men and women in the HEA surveys, focusing particularly on gender inequality in health among older ethnic groups. These results were based on the BMEG and HALS question ‘Would you say that for your age your health is very good, fairly good, fairly poor or very poor?’ Responses of ‘fairly poor’ and ‘very poor’ were combined to indicate all those assessing their health as poor. Reported morbidity was generally higher for minority ethnic groups in the BMEG compared with the GHS and ethnic inequalities in health occurred in all age groups. However, the magnitude of ethnic differences in health increased with advancing age for men and women.

Figure 1(a) and Figure 1(b) show the percentage of men and women aged 50–59 and 60–74 who reported poor health by ethnic group.

Fig. 1. Percentage of men and women reporting ‘fairly or very poor’ health by ethnic group and age

(a) 50-59 years

Source: HEA BMEG and HALS surveys, 1992

The results suggest that minority ethnic women may have a greater health disadvantage than men in some ethnic groups. In the 50–59 age group, African Caribbean, Indian and Pakistani women were more likely than men to assess their health as ‘fairly poor’ or ‘very poor’ but there was no gender difference in reported health for white adults in this
age group, and a greater proportion of Bangladeshi men than Bangladeshi women reported poor general health. However, among adults aged between 60 and 74, the results were more inconsistent. Only Indian women in the oldest age group reported greater morbidity than men; fewer African Caribbean and Bangladeshi women reported poor health than men and there was no gender difference in health for older Pakistanis. From this finding we conclude that old age and minority ethnic status are associated with a two-fold health disadvantage consistent with 'double jeopardy', but there is no evidence to suggest that older minority ethnic women are in a position of 'triple jeopardy' for health.

The assessment of 'double' or 'triple' jeopardy is, however, limited by the cross-sectional survey data used in this analysis. Differences in health between age groups could be partially because of age-related factors such as cohort effects, historical period and migration (Blakemore and Boneham, 1994). A more adequate assessment of theories of jeopardy would therefore require longitudinal data to examine ethnic differences in health for the same individuals as they age.

(ii) Socioeconomic inequality and health
Racism may be a key factor underlying double jeopardy, and some authors have suggested that one consequence of racial discrimination is greater socioeconomic inequality between older whites and minority ethnic groups than at any other age (Dowd and Bengston, 1978). Using the GHS and HEA survey data we can assess both the extent of socioeconomic inequality among older men and women and how socioeconomic position contributes to ethnic differences in older people's health.

(a) Socioeconomic inequality among older ethnic groups
Our analysis of the GHS and HEA surveys showed that across a number of dimensions – including social class, educational qualifications and material resources – older minority ethnic groups experienced greater socioeconomic disadvantage than their white counterparts.

However, the level of deprivation was not uniform across minority ethnic groups: those from the Caribbean were worse off than the white population, but even they were comparatively advantaged compared with older Pakistani and Bangladeshi groups. Within the Asian ethnic groups, there was a hierarchy of deprivation for people aged over 50: Indians were least likely to be materially disadvantaged and in some cases were equivalent to or more advantaged than the white population. These findings are consistent with results reported for all white and minority ethnic adults aged 16 and above (Modood et al., 1997).

A high proportion of older Asian women had never been in paid employment. Our results suggested that Asian women were more economically disadvantaged than Asian men, but older Black Caribbean women were more advantaged, in terms of occupational class and education than Black Caribbean men.
(b) Socioeconomic position and ethnic differences in health

Our analysis examined whether ethnic differences in reported health were mediated by the poorer socioeconomic position of some older minority ethnic men and women reported above. Figure 2 shows how reported 'fairly poor' or 'very poor' general health was associated with social class for each ethnic group. In the 1992 HEA surveys, social class information was not obtained from the long-term unemployed, chronically sick/disabled and those looking after the home, whilst the never worked were excluded from the occupation-based measure of social class. Therefore a separate category representing this 'excluded' group is shown in Figure 2, and the limitations of this class measure to represent older minority ethnic women in particular should be acknowledged.

Despite the problems associated with this class measure, Figure 2 shows significant class gradients in reported 'fairly poor' or 'very poor' general health for African Caribbean and Indian groups which were very similar for men and women. Approximately one-third of African Caribbean and Indian adults aged 50-74 in the manual social class reported poor health compared to less than 20 percent in a non-manual class. Class gradients in reported health were evident for older Pakistani and Bangladeshi men. However, the class analysis for Pakistani and

Fig. 2. Percentage reporting 'fairly poor' or 'very poor' general health by ethnic group and Registrar General's social class

Source: HEA BMEG and HALS surveys, 1992 and 1994
Bangladeshi women was limited by the small sample size and the sizeable proportion who were excluded from the class measure. For older white adults, poorer health was found in the manual class for women, but there was no class difference in health for men. For all ethnic groups, reported morbidity was substantially higher in the excluded group which included the sick and disabled and never worked.

Further analyses of socioeconomic differences in health for older white and minority ethnic adults using alternate measures based on material resources and housing tenure confirmed that poor general health and limiting long-standing illness were concentrated among lower social groups.

Multivariate analysis was used to assess the relative contribution of socioeconomic disadvantage to ethnic inequalities in older people’s health. The odds ratios from a logistic regression analysis are presented in Figure 3 for men and women aged 50-74 in the BMEG and HALS surveys. Figure 3(a) shows the magnitude of ethnic inequality in general health for older men and women after adjusting for age differences and Figure 3(b) illustrates how this ethnic variation was modified by controlling for the socioeconomic characteristics of educational level, social class, housing tenure and car availability. White adults are the reference category in each figure (value = 1.00).

Fig. 3. Odds ratios of 'fairly poor' or 'very poor' general health: men and women aged 50–74
Reference category of 'whites' = 1.00
(a) Odds ratios adjusted for age

(b) Odds ratios adjusted for age, and socioeconomic status*

*Includes measures of social class, educational level and material deprivation

Source: HEA BMEG (1992 and 1994) and HALS (1992)
The results for men and women clearly show higher odds of reporting poor general health for all minority ethnic groups compared to whites. Bangladeshi men and women had the highest odds ratios of poor health; more than 10 times higher for men and over seven times higher for women.

When the analysis controlled for socioeconomic characteristics, the health disadvantage of older minority ethnic adults was greatly reduced relative to whites. For example, the odds ratio of poor health for Bangladeshi men was reduced by approximately half in Figure 3(b) compared to Figure 3(a). Comparable results were found using a measure of limiting long-standing illness which strongly suggests that socioeconomic disadvantage makes a large contribution to ethnic inequalities in older people’s health.

Poor socioeconomic circumstances cannot, however, fully account for the high morbidity reported by minority ethnic groups, as significant ethnic variation in health is still evident for minority ethnic men and women in Figure 3(b). It is argued that existing socioeconomic measures have only a limited ability to capture the social position of minority groups and the insensitivity of these measures is likely to contribute to the continuing ethnic variation in health.

**Main findings: ethnic inequalities in tobacco and alcohol consumption**

Our analysis considers whether ethnic inequalities in health may be mediated by ethnic differences in health-related behaviour. This section presents the main findings from our study of alcohol consumption and tobacco use among white and minority ethnic groups.

Studies based on the general adult population have reported ethnic differences in smoking and drinking behaviours (Nazroo, 1997), but little is known about ethnic variation in health-related behaviour among older age groups.

(i) **Alcohol consumption**

Analysis of alcohol consumption for white and minority ethnic adults aged 50 and above in the GHS showed very low levels of drinking for all minority ethnic groups, particularly women. No Bangladeshi men or women said they drank over the recommended weekly limit (over 14 units/week for women and over 21 units/week for men) and ‘high drinking’ was non-existent for older Indian and Pakistani women. This contrasted with the much higher levels of alcohol consumption found among white men and women.

(ii) **Tobacco consumption**

Our analysis of smoking focused on current cigarette smoking and information about the use of chewing tobacco among older Asians in the BMEG surveys.

There was no gender difference in current cigarette smoking for white adults aged 50 and above in the GHS (22 per cent were smokers)
which contrasted with marked differences in cigarettes smoking between minority ethnic men and women. Only 4 per cent of Black Caribbean women and 3 per cent of Indian women reported smoking, compared with 21 per cent and 11 per cent of men in these respective ethnic groups. The gender differences in cigarette smoking were most evident for older Pakistanis and Bangladeshis: no women in these ethnic groups were current smokers. Smoking was higher among Bangladeshis than for any other ethnic group at 77 per cent, but average daily cigarette consumption was lower for Bangladeshis than for white men.

The general finding of lower cigarette smoking among older minority ethnic adults than for whites was also found in the HEA data, except for the large proportion of Bangladeshi men aged 50–74 who were current cigarette smokers.

We extended our analysis of smoking to consider the use of chewing tobacco or ‘smokeless tobacco’ by Indian, Pakistani and Bangladesh older people. Existing research suggests that the practice of adding tobacco to an oral chewing mixture that may include betel nut and/or areca nut is not uncommon among some Asian groups (Bedi, 1996). Chewing tobacco is addictive and has been linked to the development of oral cancers, but within some Asian groups chewing may be valued for its perceived medicinal properties and as a symbol of prosperity and longevity.

Our indicator of tobacco chewing is based on questions in the BMEG surveys which asked Indian, Pakistani and Bangladeshi respondents whether or not they chewed betel and tobacco and/or used paan. However, there is no distinction between paan users who did or did not add tobacco, and it is important to note that individuals may not always be aware if tobacco is added to their chewing mixture.

Table 2. Cigarette smoking and tobacco chewing* among older Asian men and women

<table>
<thead>
<tr>
<th></th>
<th>Indian</th>
<th>Pakistani</th>
<th>Bangladeshi</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men aged 50–74</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No cigarettes or tobacco</td>
<td>63</td>
<td>65</td>
<td>12</td>
</tr>
<tr>
<td>Chew tobacco only</td>
<td>15</td>
<td>7</td>
<td>26</td>
</tr>
<tr>
<td>Smoke cigarettes only</td>
<td>17</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>Smoke cigarettes and chew tobacco</td>
<td>5</td>
<td>3</td>
<td>43</td>
</tr>
<tr>
<td>%</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>N</td>
<td>230</td>
<td>214</td>
<td>263</td>
</tr>
<tr>
<td><strong>Women aged 50–74</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No cigarettes or tobacco</td>
<td>85</td>
<td>92</td>
<td>7</td>
</tr>
<tr>
<td>Chew tobacco only</td>
<td>14</td>
<td>5</td>
<td>78</td>
</tr>
<tr>
<td>Smoke cigarettes only</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Smoke cigarettes and chew tobacco</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>%</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>N</td>
<td>221</td>
<td>102</td>
<td>116</td>
</tr>
</tbody>
</table>

* Defined as use of betel + tobacco and/or the use of paan

Source: HEA BMEG survey, 1992 and 1994
Table 2 shows overall tobacco use among older Asian groups, based on their reported use of chewing tobacco and cigarettes. The results show marked differences across ethnic groups and between men and women.

A large proportion of Bangladeshi men who smoked also chewed tobacco: 43 per cent compared to 20 per cent who smoked cigarettes only and one-quarter who chewed tobacco but did not smoke. In contrast, high tobacco use among older Bangladeshi women was restricted to tobacco chewing alone: this accounted for 78 per cent of women in this ethnic group. Unlike men, tobacco chewing was not strongly associated with cigarette smoking, but a higher percentage of Bangladeshi women smoked and chewed tobacco (12 per cent) than smoked cigarettes only (2 per cent).

The pattern of tobacco use for older Indian and Pakistani men and women was very different from the older Bangladeshi group. Only a small proportion of older men in these ethnic groups smoked cigarettes and chewed tobacco, and no Indian or Pakistani women reported both behaviours. One-quarter of Pakistani men smoked cigarettes only and tobacco chewing among this group was much less common (7 per cent). There was less difference between cigarette smoking and tobacco chewing for Pakistani women, but more than 90 per cent of this group did not consume any tobacco. Roughly equivalent proportions of older Indian men were smokers or chewed tobacco, whereas Indian women were much more likely to chew tobacco (14 per cent) than smoke cigarettes (1 per cent).

The propensity to chew tobacco and/or smoke cigarettes was related to religious group. The Sikh religion is most prohibitive about tobacco use and over 90 per cent of Sikh men and nearly all Sikh women reported that they did not use any tobacco. Tobacco chewing was more common among Pakistani and Bangladeshi Muslims and other research suggests that the use of betel and/or paan may have an important social and medical significance (Bedi, 1996).

A more detailed analysis of cigarette smoking for white and minority ethnic older men showed greater cigarette smoking among the lower socioeconomic groups than for more advantaged social groups. This confirms previous findings of socioeconomic gradients in cigarette smoking for all older adults (Cooper, Arber and Ginn, 1999) and strongly suggests cigarette smoking is structured by socioeconomic circumstances such as low social class and poor material circumstances.

However, there was much less class variation in cigarette smoking among older Asian men than for men in other ethnic groups: only a slightly higher percentage of Pakistani and Bangladeshi men in the manual class reported smoked cigarettes only compared with the non-manual class. There was no consistent relationship between tobacco chewing and social class across Indian, Pakistani and Bangladeshi groups; chewing tobacco only was most likely in the non-manual class for Indian and Bangladeshi men, but slightly greater for Pakistani men in the manual class. There was some evidence that a higher proportion of Indian and Bangladeshi men in the manual class combined cigarette
smoking with chewing tobacco relative to non-manual men in these ethnic groups, but this was not found for Pakistani men.

Conclusions and recommendations

There were marked differences in reported health and health behaviour according to the ethnic group of men and women aged 50 and above. Reported ill health was substantially higher among older minority ethnic adults than older whites, particularly for Bangladeshis.

Ethnic inequalities in health were more marked among older age groups than for adults under 50 years of age, providing some support for 'double jeopardy' theories of health inequalities: namely that old age and minority ethnic status are associated with a two-fold health disadvantage.

The availability of longitudinal data would permit a more thorough investigation of jeopardy theories than is possible with cross-sectional data. These issues are likely to become more central to thinking about health promotion in the UK as the number of older adults from minority ethnic groups increases.

Socioeconomic characteristics including social class, material resources and housing accounted for a sizeable proportion of the health disadvantage experienced by older minority ethnic groups. This was particularly evident for older Pakistanis and Bangladeshis, who were more likely to experience poor living and working conditions than older people from other ethnic groups.

Attention needs to be given to structural inequality, especially to the poor labour market position and material circumstances of some older minority ethnic groups. Most relevant to older age groups is how racial discrimination and migration may confound employment opportunities in the UK. The implications of unemployment and non-employment in reducing pension entitlement after retirement and increasing the need to rely on state benefits also need to be addressed.

An important finding is that cigarette smoking and drinking behaviour is much lower among older minority ethnic adults than for older whites, particularly for Asian women. The only exception was the high level of cigarette smoking found among Bangladeshi men, but cigarette consumption was notably lower for Bangladeshi men than for white men.

The paradoxical nature of these findings – that ill health is much greater among older minority ethnic adults than for whites, despite lower levels of smoking and drinking – strongly suggests that potential explanations for ethnic inequalities in older people's health must lie outside differential alcohol and cigarette consumption.

However, the prevalence of chewing tobacco among older South Asian groups does provide cause for concern. A sizeable proportion of Bangladeshi women reported chewing tobacco and it was not uncommon for older Bangladeshi men to report both chewing tobacco and smoking cigarettes.

More information is needed about the meaning and context of
tobacco chewing to inform intervention strategies for these ethnic groups. Research on the Bangladeshi population in Tower Hamlets has drawn attention to the social pressures on young Bangladeshi women to begin chewing tobacco and also the very low level of awareness about the health risks of using chewing tobacco (Bedi, 1996).

The relationships between ethnic group and health behaviour need to be further explored for older age groups. Our study did not examine ethnic differences in other health-related behaviours, such as physical activity and diet, and further investigation is needed to show how these behaviours may be associated with ethnic inequalities in older people's health.

A final important point relates to the use of self-reported measures of health and health behaviour in the GHS and HEA surveys. More qualitative research is needed which examines lay perceptions of 'good health' among older adults from white and minority ethnic groups, particularly how individuals assess risks to health.

References


For a copy of our full report *Ethnicity, health and health behaviour: a study of older age groups* please contact:

Dr Seta Waller
Health Development Agency
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Ethnicity, health and health behaviour: a study of older age groups

Cooper, Arber, Daly, Smaje and Ginn

This report presents the key findings from a study of health inequality among white and minority ethnic adults aged 50 and above. It extends the authors’ previous analysis of large-scale British survey data and discusses how socio-economic inequality, gender and minority ethnic status contribute to the marked health disadvantage of many older minority ethnic groups. Ethnic differences in alcohol consumption, cigarette smoking and tobacco chewing among older men and women are analysed and the report discusses the likely contribution of these health-related behaviours to the health of these groups. On the basis of these findings, the report makes a number of recommendations for future research which are relevant to the health promotion of older people from white and minority ethnic groups.

This report provides valuable insights into the health and health-related behaviour of an increasingly important population group and will be of interest to policy makers, social researchers, health promotion workers and all those concerned with the health and well-being of older people.

ISBN 1 84279 006 4