

Health inequalities persist in old age, as individuals' health status is an accumulation of lifelong socioeconomic, ethnic and gender-based influences

**PART 5 OF 5: SOCIOLOGY IN NURSING**

# The effect of ageing on health inequalities

## In this article...

- › A discussion of the health inequalities associated with ageing
- › The socioeconomic influences on ageing
- › A discussion of age discrimination

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**Abstract** Matthews D (2105) Sociology in nursing 5: The effect of ageing on health inequalities. *Nursing Times*; 111: 45, 18-21. The final article in this five-part series on the relationship between sociology and nursing practice discusses age-related health inequalities. Age has a direct influence on individuals' health and wellbeing. From a sociological viewpoint, individuals' health status in old age is a reflection of experiences throughout their lifetime, which means that health inequalities accumulate.

Ageing is increasingly viewed in social sciences from the perspective of the life course, which can be described in stages based on biological and cognitive development, such as childhood, adulthood and old age (Larkin, 2013). However, in sociological terms, the life course considers ageing to be a social construction that varies both culturally and historically (Larkin, 2013). Although lifelong biological and cognitive development cannot be denied, ageing is equally a social phenomenon, the experience of which is affected by social, political and economic factors.

An advantage of the life course approach is that it recognises that the social, political and economic forces affecting individuals at a particular stage in life have cumulative effects: the significance of old age as a social determinant of health is a result of the cumulative effects

to which an individual has been exposed before they reach old age.

### Ageing as a health inequality

Life expectancy has increased globally over the past century, with the number of people aged 65 years or over increasing at a faster rate than total population growth (Kaneda et al, 2011). This presents societies with new challenges in terms of health and wellbeing, such as caring for increasing numbers of people with long-term conditions (Kinsella and Phillips, 2005).

Research from Canada illustrates that the main long-term health problems for those over 65 include:

- » Mobility;
- » Arthritis
- » Cognitive impairment;
- » Declining vision;
- » Heart problems (Griffith et al, 2010).

Health professionals can therefore expect to deal with increasing numbers of patients with particular health and wellbeing needs, and health systems must adapt to these needs.

Changing demographics mean that, in many countries, most deaths now occur in people over the age of 65 years (McCracken and Phillips, 2012). In Britain, for example, 91% of all deaths in 2012 were among the older population (Age UK, 2015).

With increasing life expectancy, a greater proportion of the overall burden of ill health is being carried by this older population (Grundy and Holt, 2001), constituting a notable health inequality. However, while a disproportionate burden of health on the older population can be considered to be a health inequality, older

## 5 key points

**1** The life course approach asserts that ageing is more than just a biological process; it is a social phenomenon affected by social, political and economic factors

**2** The social, political and economic forces that people experience before old age have cumulative effects

**3** The number of people aged 65 years or over is increasing at a faster rate globally than the total population growth

**4** Evidence suggests that the quality of NHS care that older patients receive is worse than that of younger patients

**5** Age discrimination can be felt directly from an individual or indirectly via discriminatory systems set up in an institution



Many women's caring responsibilities peak just before they reach old age

people do not experience the effects of old age on health equally: socioeconomic status, gender and ethnicity have as much influence on health status in old age as they do in other life stages.

### Ageing and socioeconomic status

Recent estimates suggest that a total of 1.6 million pensioners live on or below the poverty line in the UK. Of these, 900,000 are classed as living in severe poverty, with those aged over 85 years being at significant risk (Age UK, 2015).

The risks of living in poverty as an older person are not equally distributed, as those who have been socioeconomically disadvantaged throughout their life course are likely to remain so in their old age (Draper and Fenton, 2014). Between 1982-86 and 2002-06, there was a consistent picture of socioeconomic inequalities concerning mortality in Britain in 60-84-year-olds. People from the lower socioeconomic groups had the highest death rate, while those from managerial and professional classes had the lowest (Office for National Statistics, 2013a).

Huisman et al (2004) illustrated the impact of material disadvantage in a study of 11 European countries, including England and Wales. Using education levels and housing tenure as indicators of socioeconomic status, they argued that material disadvantage had a notable impact on mortality in older populations. They found that educational inequalities that existed in people who were aged under 65 years persisted, and the mortality gap between those who had high and low levels of education continued into late old age.

Huisman et al (2004) found a similar

pattern in relation to housing, with higher rates of mortality for individuals who were renting their accommodation compared with those who were homeowners; only in late old age did the rates converge. One possible reason for this convergence is that, by this stage, people who are still living independently are healthier and those who are unable to do so have moved more easily into caring institutions (Huisman et al, 2004). It should also be noted that people who remain in their homes in late old age do not necessarily do so because they are healthy enough to live independently, but because they are too ill to move (Huisman et al, 2004).

### The influence of capitalism

Analyses by Walker (1981) and Estes et al (1982) frame the sociological impacts of old age within the economic inequalities produced by capitalism. Estes et al (1982) argued that ageing, as well as the status of older individuals and their resources, must be understood as being determined by position within society's socioeconomic structure. Pre-empting Draper and Fenton (2014), Walker (1981) argued that living standards and employment conditions before retirement significantly influence the status of older individuals. Inequalities persist after working age; the experience of old age is affected by the impact of:

- » Unequal incomes;
- » Rates of savings;
- » Pension rights;
- » Access to property (Walker, 1981).

Walker (1981) and Estes et al (1982) both argued that the impact of old age is

## BOX 1. WOMEN WHO CARE

Most carers are aged 50-64 years, with women having a 50% chance of being a carer by the age of 59 (Carers UK, 2014). With many women's caring responsibilities peaking just before old age, both the physical and mental strain of this role inevitably have negative consequences on the health of women in old age. As a result of this, it can be argued that the health risks of caring accumulate during a woman's lifetime.

significantly mediated by its relationship with the economy; both analyses firmly located their understanding of old age inequality within the unequal distribution of material rewards generated by the economy. This process is one of the key determinants affecting health in old age. As with its impact on health before retirement, socioeconomic status is the single most important social determinant of health affecting individuals aged over 65.

### Ageing and gender

Women make up most of the older global population. In Britain, life expectancy in 2011-13 was 83 years for women and 79.3 years for men, while in 2011, women outnumbered men by 2:1 in those aged 85 years and over (Office for National Statistics, 2013b).

When asked how they perceived their own health, men and women aged 65-74 years reported similar rates of health levels; however, gender differences emerged in those aged over 85 years, with 31% of men and only 25% of women rating their health as "very good/good" (Office for National Statistics, 2013b).

In terms of marital status, while both single men and women aged over 85 years reported the highest rates of "very good/good" health, and had similar self-reported health rates, the largest difference between the genders was for married people, with significantly more married men than married women considering their health to be "very good/good" (Office for National Statistics, 2013b).

Self-reported poorer health among older women can be considered to be significantly related to women's roles within society before they reach old age. Society expects women to take on the role of carer – looking after children and older relatives – and this role pervades their experiences, and acts as a significant structural

TABLE 1. LONG-TERM CONDITIONS IN OVER-65S

Ethnic group	Percentage	
	Men	Women
White British	50	56
White Gypsy/Irish Traveller	69	73
Pakistani	69	77
Bangladeshi	64	76

Source: Becares (2013)

constraint (Matthews, 2015b). The health consequences that women experience due to being carers in their early years undoubtedly contributes to poorer health in later years. In addition, the effects are undoubtedly exacerbated by the period within the life course during which the caring responsibilities of women often peak (Box 1).

Socio-economic status continues to have an influence, interacting with gender. Largely as a result of caring responsibilities, many women have had fewer years of employment and so generally have less total income. Their intermittent employment history means the link between lifetime earnings and pension levels is subsequently less than if they had an unbroken employment history (Larkin, 2013). As a result, older women are more likely to live in poverty and have lower average incomes (Gunnarsson, 2002).

**Ageing and ethnicity**

Ethnic minorities constitute only 8% of those over 60 years of age in Britain (Age UK, 2015) as, overall, this group is younger than the majority population. However, any attempt to analyse the pattern of health among older ethnic minority groups meet an immediate barrier. As with the analysis of ethnicity in general, there is limited evidence on the impact of ethnicity on the health of older populations. Mainstream studies of ethnicity have largely ignored ageing (Phillipson, 2015).

The available evidence demonstrates a mixed picture. Figures from 2011 show that in over-65s there is a higher percentage of long-term illness reported in some ethnic minority groups in both men and women (Table 1). However, not all ethnic minorities were worse off than the majority population – Black African and Chinese older individuals reported lower rates (Becares, 2013).

Since more research is needed into the impact of ethnicity on health needs, especially in relation to the older population, only broad assertions can be made as to

some of the reasons for health inequalities. It is worth noting that, as with older women in general, there are higher rates of self-reported illness among some older ethnic minority women than men. This may show that the female role throughout the life course of ethnic minority women has a similar impact as it does on women from the majority population; there is no reason to assume otherwise, as women's dominant role in caring is a feature of many cultural backgrounds in Britain.

Since ethnic minorities over 65 are more likely to live in poverty than the majority population (Age UK, 2015) it is reasonable to assume that the socio-economic status of the older members will have a detrimental affect on their health, as it does for the majority population. It has been previously argued that a higher proportion of ethnic minorities are located in lower socio-economic groups (Matthews, 2015a), and the cumulative effects of this throughout the life course of many ethnic minority individuals will undoubtedly have a negative effect on their health.

**Ageism and discrimination**

While the impact of ageing as a social determinant of health is largely the result of its interaction with other social influences, another important factor is independent of these other social determinants: age-related discrimination. No discussion of the impact of ageing on health and wellbeing can afford to ignore the phenomenon of ageism and the issue of age discrimination.

As with racism, sexism, homophobia and other forms of discrimination, the prevalence of ageism in society is unclear, but its existence is generally acknowledged, with Minichiello et al (2003) arguing that it is widespread. Ageism is a form of oppression (Clarke and Korotchenko, 2015), reflected by, and embedded within, social relations. There is an unequal distribution of power among those who are categorised as “old” and those who are not, resulting in a tendency for many older people to be denied access

to resources and opportunities, and subsequently being victim to social exclusion. Ageism exists as a shared subjective phenomenon – what could be called society's collective consciousness – in terms of stereotypes and prejudices. It also exists materially in terms of how society's social institutions operate and the way in which social and economic resources are distributed.

Whether through the actions of individuals based on negative attitudes or as a result of the way in which social institutions operate, ageism results in the emergence of age-related discrimination. Age discrimination can be felt directly – when an individual is deliberately treated unfairly and suffers a disadvantage as a result of age – and indirectly whereby, although unintentional, the behaviour of individuals and the actions of social institutions disadvantage older individuals (Roberts, 2000).

**Age discrimination in healthcare settings**

Evidence suggests that older people have been, and continue to be, victims of discrimination as a result of the attitudes of health professionals and the operation of healthcare services in Britain and globally. Recent data argues that 60% of older people in Britain agree that discrimination is a part of everyday life, with 51% claiming that older people receive poor standards of healthcare and 66% arguing that they receive poor care in general, in care homes and in their own homes (Age UK, 2015). Lievesly (2009) found evidence of prejudicial and ageist attitudes among some healthcare professionals. Observations of clinical staff behaviour by other team members showed health professionals being patronising, speaking over an individual, speaking about them while in their presence and not keeping them informed of their condition (Lievesly, 2009).

Lievesly (2009) also found evidence that age is a factor controlling access to treatment. In a response to a hypothetical question about patients exhibiting heart-related symptoms, for some GPs and cardiologists, age dictated the treatment and access given. Comments included:

- “Age does come into it so only the oldest are excluded”;
- “If they are in their 90s with chest pain and angina I might be less likely to refer”;
- “I would be less likely to prescribe for an older person”;
- “...once you start hitting the 75, 80, 85 mark you then start getting put off

because you worry about complications” (Lievesly, 2009).

This is not to suggest that doctors deliberately discriminate based on age, rather that many are taking into consideration issues such as the impact on quality of life should surgery occur. This is clear in one respondent’s comments:

“I like to think I would treat the individual. I think generally you have to try and identify from an individual what is in their best interest. I don’t think bypass surgery in an 87-year-old is in their interests” (Lievesly, 2009).

These statements do illustrate that age is used as a factor to determine access to resources, with older people less likely to receive treatment (Lievesly, 2009).

Potentially discriminatory behaviour can also be illustrated in the way health services operate. It could be argued that the most explicit forms of age discrimina-

tion here is not to argue that the NHS is a discriminatory institution, but that ageism – at times direct, but more often indirect – can be a feature of health professionals’ attitudes and behaviour, and the operation of healthcare services.

The NHS is a universal service, one principle of which being that all members of society, regardless of who they are, are entitled to equal treatment. However, evidence suggests that older patients can experience a different service than those who are younger. Despite the values underpinning the universal nature of the British healthcare system, with the health service being embedded within society, it inevitably reflects prevailing cultural norms and values, both positive and negative.

### Conclusion

Ageing must not be considered as solely a biological process, but also a significantly social phenomenon influenced by wider social, political and economic factors.

## ***As with its impact on health before retirement, socioeconomic status is the single most important social determinant of health affecting individuals aged over 65 years***

tion within the NHS (Lievesly, 2009) are the age limits given to screening programmes. Although for some there are genuinely purposeful upper age limits, others have no evidence-based justification and can only be considered as overtly institutional discrimination (Lievesly, 2009). Other forms of potential discrimination towards older people of a more indirect kind have been identified and include the lack of:

- » Privacy;
- » Single-sex wards;
- » Foods of a nutritious standard, with evidence suggesting that older people do not have a satisfactory experience of meal times;
- » Palliative care (Lievesly, 2009).

There is also evidence to show that various illnesses are handled differently in older people. For example, there is a notable decline in the investigation and treatment of cancer, with higher mortality rates among older patients in recent years in Britain than other Western European nations and the US (Lievesly, 2009).

These are just some examples of possible forms of age-related discrimination that have been identified within the health service. The purpose

Although none of the determinants analysed in this series operate completely independently, the impact and experience of old age as a social determinant is heavily mediated through other determinants. It is not uncommon for older people to be portrayed as a homogeneous group with the same interests and needs. However, while it might be a period of biological and physical decline for all, the rate at which this occurs and how it does so is significantly influenced by social conditions.

As with the population in general, significant social inequalities exist among older people that affect their health status. These inequalities are largely the cumulative effects of the advantages and disadvantages experienced in the early years of life, with the impact of social inequality on individuals’ health being something that is ever present, from birth to death. **NT**

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