Discrimination and public health

See Articles page e200

The public health community has been slow to acknowledge the central role of discrimination in health inequality.[1] Discrimination has been defined as a set of "policies, practices, and behaviours that perpetuate inequities between socially-defined groups".[1,2] This definition identifies discrimination as a mechanism through which social stratification and its consequences are established and maintained. Discrimination is most apparent at the level of individual social interactions, but also operates at the institutional level (eg, by affecting access to employment and health care) and at the structural level, whereby societal norms can systemically disadvantage certain groups.[3] For example, substantial empirical evidence shows that health inequalities affecting African Americans are to a large extent accounted for by systematic societal disadvantage among this group.[4,5]

In this issue of *The Lancet Public Health*, Sarah Jackson and colleagues[6] report analyses of age-related discrimination among adults participating in the English Longitudinal Study of Ageing (ELSA). The population comprised 7731 participants with a mean age of 67 years in 2010–11. Respondents were asked a series of structured questions about their experiences of discrimination. Overall, 1943 (25·1%) participants reported experiences of discrimination. Perceived discrimination was more frequent in the lowest wealth quintile than in the highest (28% *vs* 20%). Even after adjustment for differences in age, sex, and wealth, experiences of discrimination were more frequent in people with limiting long-standing mental or physical illness than in those without these conditions, and in people who self-rated their health as fair or poor than in those with better self-rated health. During 6 years of follow-up, people who reported experiences of discrimination had increased odds of reporting new onset coronary heart disease, stroke, chronic lung disease, depressive symptoms, and limiting long-term illness, and of reporting fair or poor self-rated health. The number of discriminatory experiences showed a graded association with health status in both cross-sectional and longitudinal analyses. These results are important because they draw attention to the high frequency of perceived discrimination that older adults experience. Although the inter-relationships between age, socioeconomic status, health status, and experienced discrimination are complex, these results support the findings of other studies suggesting that discrimination not only causes short-term psychological distress, but also could have an important effect on long-term mental and physical health outcomes.[7]

In high-income countries, older adults represent the most rapidly expanding sector of the population.[8] The mean age of 67 years for respondents in the ELSA study does not now represent an advanced age. Jackson and colleagues' results raise concerns about whether experiences of discrimination could be even more frequent in patients in their seventies, eighties, or nineties. Their results are also important in showing how discrimination can be directed at several aspects of an individual's identity. Discrimination on the grounds of age could be reinforced by discrimination based on female gender, lower socioeconomic status, lack of participation in employment, declining physical function, disability, and cognitive impairment. Bauer and Scheim[9] advocate the concept of intersectionality in health, which encourages researchers to avoid focusing on a single aspect of discrimination but rather to assess the experiences of groups facing multiple intersecting forms of discrimination. The extent and multifaceted nature of age-related discrimination should be investigated further. In view of demographic changes and the growing size of the elderly population, there is also a need to change public perceptions so that older people are not characterised by vulnerability but by the important contributions that they can make as citizens.

Jackson and colleagues' results also challenge assumptions about how health systems should respond to older adults. Are existing arrangements institutionally ageist? One item in Jackson and colleagues' survey concerned people's experiences of receiving "poorer service or treatment than other people from doctors or hospitals".[6] This item raises questions about how health care should be adapted for older people. The evidence base for intervention is generally weaker for older people than for younger people, because they are infrequently included in clinical trials. Hazra and colleagues[10] expressed concern that the so-called fair-innings argument raised the possibility of reduced entitlement to health care once a "normal" lifespan was

achieved. But how should the equity–efficiency trade-off be adjusted to accommodate the care of people at advanced ages? Should the founding principles of the UK's National Health Service extend to addressing the social care needs of people with dementia?

The structural context for discrimination could be changing over time. Globalisation and secularisation might have made traditional forms of discrimination less salient. But the emergence of the information economy and the development of digital channels of communication could have introduced new potential for discrimination against groups who are not digitally native.[11] The observations reported by Jackson and colleagues[6] raise a rich set of questions that merit investigation by social and behavioural scientists. Future research should aim to identify actions that can reduce problems from age-related discrimination at all levels.

Martin Gulliford
School of Population Health and Environmental Sciences, King's College London, London SE1 1UL, UK
martin.gulliford@kcl.ac.uk

I declare no competing interests.

1 Krieger N. Discrimination and health inequities. *Int J Health Services* 2014; **44:** 643–710.
2 Scheim AI, Bauer GR. The Intersectional Discrimination Index: development and validation of measures of self-reported enacted and anticipated discrimination for intercategorical analysis. *Soc Sci Med* 2019; published online Jan 21. DOI:10.1016/j.socscimed.2018.12.016.
3 Krieger N. Embodying inequality: a review of concepts, measures, and methods for studying health consequences of discrimination. *Int J Health Services* 1999; **29:** 295–352.
4 Bailey ZD, Krieger N, Agénor M, et al. Structural racism and health inequities in the USA: evidence and interventions. *Lancet* 2017; **389:** 1453–63.
5 Smith GD. Learning to live with complexity: ethnicity, socioeconomic position, and health in Britain and the United States. *Am J Public Health* 2000; **90:** 1694–98.
6 Jackson SE, Hackett RA, Steptoe A. Associations between age discrimination and impaired health and wellbeing: cross-sectional and prospective analysis of the English Longitudinal Study of Ageing. *Lancet Public Health* 2019; **4:** e200–08.
7 Williams DR, Mohammed SA. Racism and health I: pathways and scientific evidence. *Am Behav Sci* 2013; **57:** 1152–73.
8 Hazra NC, Gulliford M. Evolution of the "fourth stage" of epidemiologic transition in people aged 80 years and over: population-based cohort study using electronic health records. *Population Health Metrics* 2017; **15:** 10.
9 Bauer GR, Scheim AI. Methods for analytic intercategorical intersectionality in quantitative research: discrimination as a mediator of health inequalities. *Soc Sci Med* 2019: published online Jan 21. DOI:10.1016/j.socscimed.2018.12.015.
10 Hazra NC, Gulliford MC, Rudisill C. "Fair innings" in the face of ageing and demographic change. *Health Econ Policy Law* 2018; **13:** 209–17.
11 Chartered Institute of Taxation. Digital exclusion. London: Chartered Institute of Taxation, 2012.