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Examining ethnic inequalities in health and tenure in England: A repeated cross-sectional analysis

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ABSTRACT

Ethnic minorities experience multiple inequalities across different domains including health and tenure. Notwithstanding extensive research demonstrating a clear connection between tenure and health, the relationship between health, tenure and ethnicity is under-explored. In this paper, we examine ethnic inequalities in health and tenure in England using cross-sectional census microdata for 1991, 2001 and 2011. We find that ethnic inequalities in health persist over time while the relationship between health and tenure varies between ethnic groups. These results suggest that traditional explanations linking health and tenure are not sufficient to adequately capture the myriad experiences of different ethnic groups.

1. Introduction

Housing and housing quality are of fundamental importance to our health: place of residence determines access to a wide range of facilities and exposure to hazards, both in the home and local environment. Differential access to the housing market and tenures may therefore contribute to the creation and maintenance of health inequalities in the population. This is pertinent to ethnic inequalities in health given that experiences of and access to the housing market varies between ethnic groups. The housing careers of ethnic minorities have historically been shaped by the settlement patterns of first generation migrants, varying to that of the native majority. Arriving in inner city areas near transport hubs, first generation migrants sought affordable, readily available homes: typically, private rentals. For some, longevity gradually heralded eligibility for social housing while others, after accumulating capital, sought affordable, appropriate home-ownership. Despite movements away from traditional settlement areas and entry into different tenures, ethnic minority groups continue to be disadvantaged in the housing market: living in overcrowded accommodation, disproportionately burdened by insecure tenures and seeing some of the greatest growth in privately rented accommodation (Finney and Harries, 2013).

Persisting inequalities in the housing sector for ethnic minority groups are of critical importance if such disparity translates into multiple inequalities across different social, economic and crucially, health domains. Health inequalities within and between ethnic minority groups are widely documented (Nazroo, 1997; Cooper, 2002; Sproston and Mindell, 2006; Salway et al., 2007a; Bécares, 2015; Darlington et al., 2015) with evidence suggesting these inequalities are transmitted across generations (Harding and Balarajan, 2000; Smith et al., 2009). Explanations for these inequalities are increasingly sought in discussions of the interaction between ethnicity and broader socio-economic and spatial inequalities between ethnic groups (Nazroo, 2003; Nazroo and Williams, 2006; Mindell et al., 2014), rather than discussions of genetic difference (see Kaufman et al., 2015). However, the inter-relationships between health, tenure and ethnicity are under-explored in the context of ethnic inequalities in health.

This paper addresses this research gap, contributing to current debates on the nature of ethnic inequalities in health and the extent to which ethnically differentiated experiences of the housing market shape these differences. Health and housing are inextricably and historically linked (Avecedo-Garcia et al., 2004), entwined through the complex inter-relationships between area characteristics, housing quality, housing tenure and health. However, the dynamics of the relationship between health, tenure and ethnicity will vary over time and across space according to changing migration histories, changes in the housing market, changing patterns of internal migration; and across the life-course. The extent to which responses to these changes are ethnically differentiated may depend on length of residency in England, attachment to traditional values and cultural norms, and broader contextual factors.

To proceed, we review key debates on the relationships between tenure and health, ethnicity and health, and ethnicity and tenure. In particular, this section draws on literatures assessing the causal pathways between tenure and health; exploring segregation, residential

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mobility and the extent to which ethnic minorities have become concentrated in different housing tenures; and the social determination of ethnic inequalities in health. We then address the following research questions:

1) Are the relationships between tenure and health ethnically differentiated?
2) Is this consistent over time?

2. Context

2.1. Ethnicity and health

Ethnic minorities tend to have poorer health than majority ethnic groups. Nazroo (2003) found a higher risk of cardiovascular disease (CVD) amongst Indians, higher risk of diabetes amongst Pakistanis and Bangladeshis, and higher rates of stroke and hypertension amongst Caribbeans in the UK. More generally, Pakistanis, Bangladeshis and Caribbeans have relatively higher rates of poor health when measured by general mortality and morbidity (Nazroo, 1998; Harding, 2003; Bécares et al., 2012; Darlington et al., 2015). Whilst Indians tend to experience relatively good health overall, Babb et al. (2004) found gendered differences noting the poorer health of Indian women. Supposed biological differences or inherent features of distinct ethnic groups are no longer thought to explain these disparities in health. Instead, we must consider both the socioeconomic composition of different ethnic groups in relation to social determinants of health, and the possible additional impact of an 'ethnic penalty'. Contemporary research increasingly finds that ethnic inequalities in health are maintained within unfair societies, divided along social and economic lines (Smaje, 1995; Nazroo, 2001; Stronks and Kunst, 2009). A breadth of research reveals sustained ethnic disadvantage in the labour market (Nazroo, 1997; DWP, 2014; Kapadia et al., 2015; Catney and Sabater, 2015); lower incomes (Hills et al., 2010; Nandi and Platt, 2010); increased risk of living in deprived neighbourhoods (Jivraj and Khan, 2015); and, despite a narrowing gap in educational attainment (Lymperopoulou and Parameshwaran, 2015) ethnic minorities reap less return on their educational investment (Lynch and Kaplan, 2000). Where ethnic minorities are disproportionately concentrated in more disadvantaged circumstances (Modood et al., 1997; Barnard and Turner, 2011), it follows that the uneven exposure to different social determinants of health results in uneven health outcomes (Marmot, 2005; Bambra and Eikemo, 2008).

Not all population subgroups experience equivalent levels of poor health in equivalent disadvantage, suggestive of an ethnic penalty: are ethnic minorities penalised in some way over and above what would be expected given their socioeconomic status? The additional health disadvantage experienced by ethnic minorities after adjusting for socioeconomic status or defined features of disadvantage (e.g. deprivation) can be explained by experiences of discrimination, marginalisation and racial harassment (Nazroo, 1998; Karlsen and Nazroo, 2002; Williams and Mohammed, 2009; Harris et al., 2012).

2.2. Tenure and health

Research consistently finds housing tenure to be associated with mortality and morbidity. Those in owner-occupied accommodation tend to be in better health than those in rented accommodation, with further differences found between private and social rentals (Macintyre et al., 1998; Macintyre, 2001; Macintyre et al., 2003; Cairney and Boyle, 2004; Shaw, 2004). In older ages, risk of entry into long-stay care facilities varies by tenure, with lower risks for those in owner-occupied accommodation contrasting with higher risks for renters (Connolly, 2012). However, it is unclear why this association arises: does tenure act as a marker of socioeconomic status or income and therefore indicate material well-being? Or, do variations in health arise through exposure to different hazards in the home environmental or local area?

A study of elderly adults across Europe found lower levels of educational attainment amongst renters compared to owners (Dalstra et al., 2006) suggesting that the composition of tenures may be an important determinant of health differences. Similarly, an Australian study found no independent effect of tenure on mental health outcomes explaining health differences by tenure compositions (Baker et al., 2013). Nevertheless, tenure has an independent significant relationship with health after adjusting for socioeconomic attributes such as educational attainment or social class (Macintyre et al., 2001). However, the strength of the association varies between countries (Dalstra et al., 2006). In countries where the association is stronger, this may arise from the differential exposure to different levels of health hazards, with housing quality and type varying dramatically between tenures, and differences in the characteristics of the local area also often varying by tenure (Windle et al., 2006; Habib et al., 2009). For example, inner city *more deprived* areas may feature more socially provided housing or private rentals than *less deprived*, more suburban or rural areas characterised by owner-occupied accommodation. Uneven health outcomes by tenure may therefore relate to wider contextual features.

The quality of housing, often tied up in the nature of the tenure, and the security of the tenure are also related to mental health (Evans et al., 2000). Wider aspects of the domestic environment, linked to housing, are also associated with mental and general health (Dunn, 2002). Where housing is viewed as a reflection of self-identity (analogous to views that tenure acts as a socioeconomic marker), a retreat, 'place of refuge' or place to exercise control (Dunn, 2002: 672), the association with mental and general health status may vary.

2.3. Ethnicity and tenure

The changing housing market positions of ethnic minorities are influenced by historic migration trajectories and settlement patterns governing the types of housing to which they are exposed. Traditionally, first generation migrants settled within the least desirable urban areas, typically within poorer quality, cheaper housing (Murie and Musterd, 1996; Musterd and Duerloo, 1997; Özüekren and van Kempen, 2003; Musterd, 2005). Settlement areas are characterised by specific employment and housing structures amenable to new arrivals (Catney and Simpson, 2010). Affordable, readily available housing is key because of the relatively disadvantaged labour market position of first generation migrants (Hamnett and Butler, 2008). Over time, theories of assimilation hold that ethnic minorities integrate into the social and economic structures of society while moving away from traditional settlement areas (Alba and Nee, 1997). Ethnic minority spatial mobility is therefore an important marker of immigrant integration (Bolt and van Kempen, 2010). We might therefore assume that, over time, ethnic minority distribution across tenures would converge to that of the majority population.

However, the socioeconomic and spatial trajectories of ethnic minorities in Britain who arrived during the post-World War II period are diverse in terms of occupational profile, geography and tenure (Peach, 1998). Further, there is growing differentiation within and between ethnic groups in their tenure profiles (Hamnett and Butler, 2008). Differentiation between ethnic groups (something that is not specific to the UK context) can be explained in a number of ways which are pertinent to the purpose of this paper. Mulder (1993) defines constraints as those which prevent groups from viewing certain parts of the housing market as opportunities: for ethnic minorities, this might mean the availability or accessibility of appropriate housing which meets their familial and financial needs. As housing stocks vary geographically, ethnic minorities may concentrate in those areas where availability meets demand. Relatedly, resources may constrain or enable housing choices for different ethnic minorities: as ethnic