

Better  
Health  
Briefing

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**The health and  
social care  
experiences  
of black and  
minority ethnic  
older people**

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A Race Equality Foundation  
Briefing Paper

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## Key messages

- 1 Older people from black and minority ethnic groups continue to receive poorer treatment from health and social care services; they are also often under-represented among those using services
- 2 Barriers to accessing services include lack of information, language difficulties, and differing expectations about how services can help
- 3 Stereotyped assumptions on the part of professionals may also act as a barrier to service use
- 4 There is a growing body of evidence about what older people from black and minority ethnic groups want from services
- 5 Good services exist, but it has been difficult to bring them into the mainstream.

## Introduction

Reducing health inequalities is an important government target (see Randhawa, 2007). The National Service Framework for Older People made specific references to improving the levels of service received by older people from minority ethnic groups, and the Race Relations (Amendment) Act 2000 places a duty on public bodies to outlaw racial discrimination and promote equal opportunities. Despite this, there is still evidence that ethnicity continues to play a part in influencing the quality of services that older people from black and minority ethnic groups receive (Healthcare Commission, 2006a, 2006b).

Reasons for this include:

- ¥ barriers to accessing services;
- ¥ stereotyped ideas about the needs and preferences of older people from minority ethnic groups on the part of some professionals;
- ¥ a lack of suitable good quality services.

As well as being inequitable, this may contribute to poorer outcomes. For example, older people with dementia from minority ethnic groups may access services only when the dementia has become severe (Bowes and Wilkinson, 2003) and they and their carers are less able to benefit from supportive interventions. However, there is a growing body of research on successful engagement with older people from minority ethnic groups, and this could be used to help develop better partnerships between those planning services and

those for whom they are intended. This is especially important in the context of government plans (HM Government, 2007) aimed at transforming the way in which services are provided in order to raise standards and increase choice. Organisations responsible for planning local health and social care services will not be able to achieve this without a clear understanding of the needs and preferences of the communities they serve.

## The health of older people from minority ethnic groups

1

Many research studies do not distinguish between older and younger people from minority ethnic groups, making it difficult to establish the effects of other influences on health, such as income and age. Those that do have found that older people from black and minority ethnic groups tend to report poorer health than their white counterparts (Bajekal *et al.*, 2004). Some also report that they experience age-related changes at an earlier age (Ebrahim *et al.*, 1991). Indeed, it has been suggested that health differences by ethnicity are actually greatest among older people (POST, 2007). However, despite evidence of greater need, for many years there has been a pattern whereby people from black and minority ethnic groups are over-represented among those consulting their GP, but under-represented among those using secondary health care (Acheson, 1997) or social care (Butt and Mirza, 1996; Bowes, 2006).

## Barriers to using services

2

Research presents a consistent picture with regard to why older people from minority ethnic groups are under-represented among those using services (Butt and O Neil, 2004; Bowes, 2006).

### *Lack of information*

Older people from minority ethnic groups tend to be less aware of what services are available and how to access them (Butt and O Neil, 2004). However, it is important to recognise that this varies across different communities. For example, many older Black Caribbean women have been employed in health and social care settings and may actually have better knowledge of what help is available (Moriarty and Butt, 2004), although other barriers may prevent them from accessing services. By contrast, groups that have arrived in the UK more recently, such as some Somali and Yemeni people, may find it particularly difficult to find out about services (Manthorpe *et al.*, in press). More attention needs to be paid to ensuring that information is available in different languages and formats. This highlights the need for an integrated approach that includes written information, telephone helplines, outreach services and media campaigns (see Mir, 2007).

## Resources 1

### *Research and policy*

#### **The Social Care Institute for Excellence**

[www.scie.org.uk/publications/signpostinginfo.asp](http://www.scie.org.uk/publications/signpostinginfo.asp)

The Social Care Institute for Excellence has introduced a system of signposting by preparing a brief summary of its publications, including material on ethnicity.

#### **Age Concern Black and Minority Ethnic Elders Forum**

[www.ageconcern.org.uk/AgeConcern/bme\\_forum.asp](http://www.ageconcern.org.uk/AgeConcern/bme_forum.asp)

Age Concern Black and Minority Ethnic Elders Forum is open to organisations and professionals with an interest in influencing policies and services for older people from minority ethnic groups.

#### **The King's Fund**

[www.kingsfund.org.uk/health\\_topics/black\\_and.html](http://www.kingsfund.org.uk/health_topics/black_and.html)

The King's Fund has an area on its website summarising its current work looking at ethnicity and health. This includes reading lists summarising recent publications and resources.

### *Not speaking the dominant language*

Written and spoken levels of fluency in English vary across different groups of older people, with lower levels tending to be found among Chinese, Vietnamese, Somali, Pakistani and Bangladeshi older people.

A systematic review based largely on North American research showed that the use of good quality professional interpreting services could raise the quality of care for people with limited proficiency in English to levels comparable with those who are fluent (Karliner *et al.*, 2007). Unfortunately, attention is not always given to the quality of interpreting and translation services (e.g. in ensuring that there is a shared understanding of what words mean). UK research has shown that the quality of interpreting services may be variable (Gerrish *et al.*, 2004), particularly if there is a reliance on family members.

The lack of availability of good quality interpreting and translating services can make some older people from minority ethnic groups especially reliant on link workers, in the form of local volunteers and bilingual workers in voluntary organisations, in order to access services. While they appreciate this help (Chau, 2007; Kwan Chan *et al.*, 2007), it can lead to feelings of dependency, and attitudes towards these workers may be ambivalent (Chau, 2007). For this reason, bilingual workers are an especially important resource (see Mir, 2007) and may be one explanation why, exceptionally, some local services have been able to achieve similar levels of access across different ethnic groups (Odutoye and Shah, 1999).

### *Differing expectations about the help that is available*

Expectations about health may be held by an individual both about themselves and their own health status or quality of life, and about health care services and systems. These expectations have a major influence on satisfaction with those services. Ethnicity plays an important role in our expectations because these are influenced by our understanding of the world and the social and political contexts in which we are located.

Research is beginning to suggest that expectations may have some influence on the way in which older people from different ethnic groups will identify and select differing sources of help (Chahal and Temple, 2005). For example, while older people from different ethnic groups have a shared understanding of the causes of depression, they have differing ideas about strategies for dealing with it and their preferences for medication or counselling (Lawrence *et al.*, 2006). Similarly, Asian and Black Caribbean families may have differing ideas about changes that can be attributed to so-called normal ageing and changes that may be a result of dementia, which mean that they are less likely to consider asking for help at an earlier stage (Bowes and Wilkinson, 2003). The existence of stigma, particularly about mental health problems in old age, may also be higher in some communities than others (Marwaha and Livingston, 2002).

## Attitudes of professionals

3

Professionals can also create barriers to service use, particularly if they have stereotyped assumptions about the preferences of older people from minority ethnic groups and the availability of other sources of support from within the family (Katbamna *et al.*, 2004).

There is a risk of making assumptions about people on the basis of their ethnicity, and of defining culturally competent care on the basis of the concerns of the dominant majority. For example, one study examining primary care professionals' perceptions of depression in older people found that participants were reluctant to talk about depression to older Asian and Caribbean people because they thought that these patients would not want to consider the possibility they might be depressed (Murray *et al.*, 2006). This was despite interviews with older people from minority ethnic groups as part of a linked study (Lawrence *et al.*, 2006), which showed that they valued the opportunity to talk about depression when it was described as isolation, loss or bereavement.

Stereotyped assumptions may also lead to a tendency to underestimate differences between and within different ethnic groups. On the one hand, some professionals argue that they treat all people using their services in the same way. On the other hand, at the same time they treat other people from minority ethnic groups in ways that may marginalise or exclude those defined as 'others'. Thus, older people from minority ethnic groups have reported feeling that professionals do not always take their concerns seriously (Gunaratnam, 2006), and that they have been subjected to instances of racism from health and social care professionals (Butt and O Neil, 2004). All these experiences can lead to a lack of trust (Brown *et al.*, 2007) and concerns about being able to freely express ideas about ways of self-managing illness (Higginbottom, 2006).

## What people want

4

Professionals and older people using services may have differing ideas about what constitutes need and which needs should be prioritised. Older people from minority ethnic groups share views similar to their white counterparts in terms of their ideas about what constitutes a good quality service (e.g. reliability and treating people as individuals), but they may have additional concerns, such as being able to share the same language. They also place particular importance on linking the quality of health and social care services with other factors impacting on health, such as poverty, housing, crime and racism (Butt and O Neil, 2004; Chahal and Temple, 2005; Manthorpe *et al.*, in press).

In their research with different groups of people using health and social care services, Innes and colleagues (2006) found that people from black and minority ethnic groups reported better experiences from services that specialised in

## Resources 2

### *Resources for practice*

Some organisations provide translated leaflets that can be downloaded free of charge from their websites.

Leaflets on dementia in sixteen different languages can be downloaded from **Alzheimer Scotland Action on Dementia**:  
[www.alzscot.org/pages/info/otherlanguages.htm](http://www.alzscot.org/pages/info/otherlanguages.htm)


**The Alzheimer's Society** has translated the booklet *Worried About Your Memory?* into eight languages:  
[www.alzheimers.org.uk/site/scripts/documents\\_info.php?categoryID=200308&documentID=536](http://www.alzheimers.org.uk/site/scripts/documents_info.php?categoryID=200308&documentID=536)

Translated leaflets on other topics, such as depression, are available from **Multikulti**:  
[www.multikulti.org.uk/about/](http://www.multikulti.org.uk/about/)

**Alzheimer Concern Ealing** has produced a video, *Dementia Does Not Discriminate*, which can be used by family members and community groups and for cultural awareness training with staff. Contact:  
[alzconcern@btconnect.com](mailto:alzconcern@btconnect.com)

**The Race Equality Foundation** has produced a video and resource guide, entitled *Respect*, aimed at social care staff working with black and minority ethnic older people:  
[www.raceequalityfoundation.org.uk/publications/index.asp](http://www.raceequalityfoundation.org.uk/publications/index.asp)





supporting people from minority ethnic groups. However, they also cited other research warning that if commissioners relied only upon specialist services, this could discourage them from making improvements to mainstream services (Butt and O Neil, 2004).

There are increasing numbers of examples of successful engagement with older people from minority ethnic groups in order to identify problems and discuss solutions (Butt and O Neil, 2004; Begum, 2006). In addition, some organisations have developed specialist advocacy services in order to address some of the limitations in the way that many mainstream advocacy services have provided support to older people from minority ethnic groups (Rai-Atkins *et al.*, 2002).

However, it is important to ensure that participation results in clear improvements (Butt and O Neil, 2004) and that it is extended to include those who are seldom heard (Begum, 2006). Otherwise, there is a danger of focusing on established groups, at the expense of smaller invisible ethnic communities. This risks ignoring the latter and alienating the former where consultation is not followed through with visible change (Chahal and Temple, 2005).

Equally, although this briefing has described some of the difficulties experienced by older people from minority ethnic groups, services need to take account of their strengths (Butt and O Neil, 2004). This is particularly important in areas such as quality of life and social support (Bajekal *et al.*, 2004; Moriarty and Butt, 2004) where older people from minority ethnic groups may experience advantages as well as disadvantages. For example, it has been suggested that the shared experiences associated with migration, such as establishing oneself in a new country or dealing with racism, may create a stronger sense of solidarity and social capital (Janjuha-Jivraj, 2003). The tendency for older people to be clustered in certain localities may bring some disadvantages in, for example, housing quality, levels of crime, and transport. However, it may also confer advantages in terms of people's satisfaction with their local amenities, such as places of worship and local shops (Bajekal *et al.*, 2004). This is an area where UK research has tended to lag behind that in North America, where the literature on the strengths and resourcefulness of older people from minority ethnic groups is better developed.

## 5 Bringing services into the mainstream

Mainstreaming equalities — for example, through the Race Relations (Amendment) Act 2000 and the establishment of the Equality and Human Rights Commission — has been identified as an important way in which governments have aimed to achieve national and local improvements (Bowes, 2006). However, progress in implementing schemes in local government (Manthorpe, 2004) and the National Health Service (Thorlby and Curry, 2007) has proved to be mixed.

Engaging with local community and voluntary groups has been shown to be an important way of achieving improvements, but small voluntary organisations, which have a good record of supporting local communities, often lack the resources to expand (Butt and Mirza, 1996; Kwan Chan *et al.*, 2007). In addition, strategies for engagement may focus on those groups that are proportionally larger or longer established. Some groups forming a smaller proportion of the overall local minority ethnic population have identified improvements in services overall, but feel that the needs of their own communities have yet to be fully recognised (Manthorpe *et al.*, in press). These factors may mean that developments occur in a piecemeal way, with groups often competing with each other for funding (Bowes, 2006).

However, many improvements could be achieved without substantial increases in funding. For example, there needs to be better use of mental health services for older people with depression from minority ethnic groups. This might happen if referring agencies, such as primary care or Adults Services, gave greater emphasis to the role of specialist mental health services in treating depression and the likelihood of successful outcomes (Marwaha and Livingston, 2002). Similarly, a study of Black Caribbean people with Type 2 diabetes found that dietary advice did not take account of the ingredients and ways of cooking that they preferred. Participants suggested that services should work more closely with local community groups and ensure that information resources and leaflets included advice especially geared towards people with a Caribbean background (Brown *et al.*, 2007).

## Conclusion

Much of the research reporting the experiences of older people from minority ethnic groups contains methodological limitations: most notably the failure to differentiate between older and younger participants within the same study, and the predominance of smaller-scale pieces of work. Despite this, there is an increasing body of research outlining some of the barriers to accessing good quality services as experienced by many older people from minority ethnic groups (Chahal and Temple, 2005). The Race Relations (Amendment) Act 2000 has highlighted the need for services to identify which communities are under-represented among their users and how they can find ways of making improvements. This includes providing appropriate training for staff. The quality of services for people with limited proficiency in English may be raised by investing in good interpreting services and recruiting bilingual workers. Older people themselves have ideas about how to achieve improvements and there is scope for better systems of engagement that will allow health and social care services to benefit from their expertise.

## Resources 3

**MECOPP** (Minority Ethnic Carers of Older People Project) provides advocacy, training and respite services to carers based in Scotland. The website contains links to other projects as well as material that can be downloaded:

[www.mecopp.org.uk/contact\\_us\\_home.php](http://www.mecopp.org.uk/contact_us_home.php)

**The Department of Health** has developed an audit tool that can be used to audit local services for minority ethnic older people:

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4002762](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002762)

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We welcome feedback on this paper and on all aspects of our work. Please email [briefings@racefound.org.uk](mailto:briefings@racefound.org.uk)

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