

Evidence to the Birmingham Policy Commission: Healthy Ageing in the 21st Century

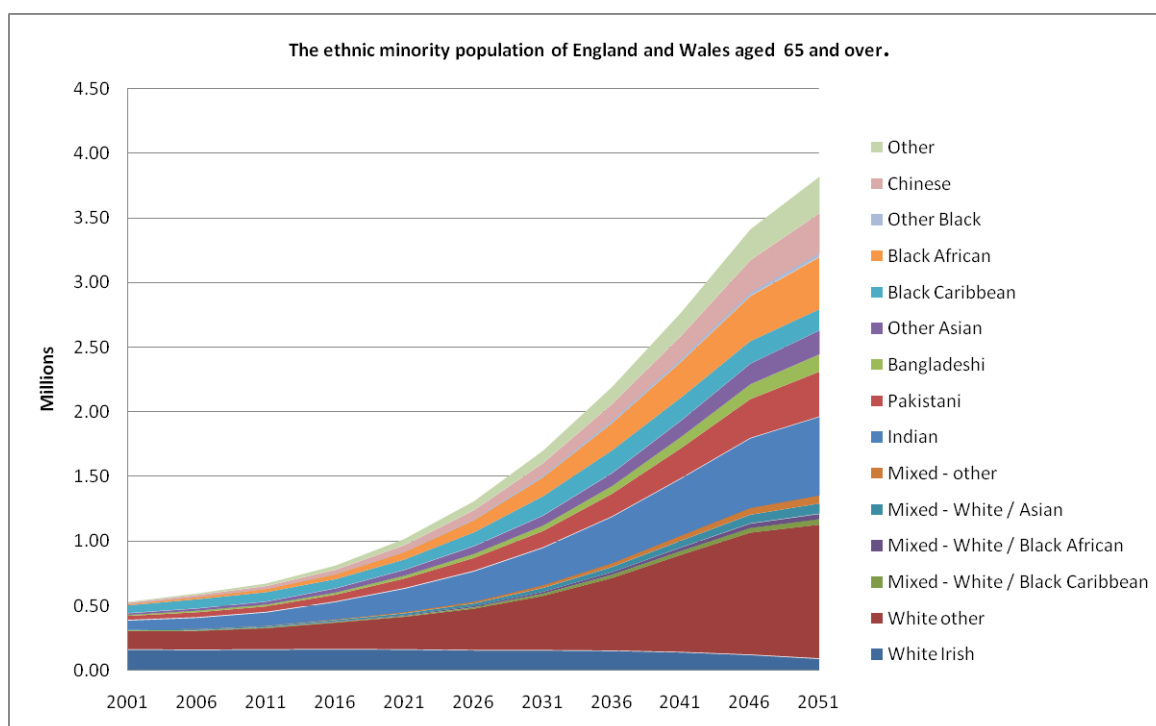
Nat Lievesley, Centre for Policy on Ageing, February 2013

Cultural, ethnic or social-economic factors that help to promote or prevent healthy ageing

Projections carried out at the Centre for Policy on Ageing in 2010¹, based on the 2001 census, estimate that Black and minority ethnic groups will make up 21.4% of the population of England and Wales in 2016, 26% in 2026, and 36% by 2051. The latest census results are in line with these estimates with BME groups making up 19.5% of the population of England and Wales in 2011 compared with 12.7% in 2001.

Black and minority ethnic groups are, on average, much younger than the majority 'White British' population with the notable exceptions of the White Irish, Indian, 'Other White' and Black Caribbean groups but, despite this, in England and Wales,

- there will be 2.4 million BMEs aged 50 and over by 2016 with 3.8 million by 2026 and 7.4 million by 2051
- there will be over 800 thousand BMEs aged 65 and over by 2016 with 1.3 million by 2026 and 3.8 million by 2051
- there will be over 500 thousand BMEs aged 70 and over by 2016 with over 800 thousand by 2026 and 2.8 million by 2051



¹ Lievesley, *The future ageing of the ethnic minority population of England and Wales*, Runnymede Trust and Centre for Policy on Ageing, 2010

Cultural differences that may affect healthy ageing

a) Physical activity

There is widespread evidence that physical activity both throughout life and in older age improves the health, quality and length of life for older people. Older people who carry out more intense physical activity for longer periods live longest on average.²

After taking into account differences in the age structure of the populations, participation in physical activity of at least moderate intensity is less for most ethnic minority groups than for the white British majority. Taking the general population as a standard (100%), comparative levels of participation range from 58% for Bangladeshi men to 95% for Black Caribbean men and from 43% in Bangladeshi women to 93% in Black African women.³ The ethnic minority groups with the lowest levels of participation in physical activity, after standardising for age, are Bangladeshi women, Bangladeshi men, Pakistani men, Pakistani women, Chinese women, Indian men, and Indian women.

b) Smoking

Smoking is generally recognised as one of the most important preventable causes of ill health in older age. Smoking patterns vary considerably between ethnic groups^{4,5} with older men and women tending to smoke less than their younger counterparts. Older women (aged 55+) from most ethnic minority groups are less likely to be smokers than older women from the general population (15%). The notable exception is older Irish women who are more likely to be smokers (21%). Older men from the Bangladeshi (29%), Black African (25%) and Irish (25%) communities as well as the Indian (19%) and Pakistani (18%) communities are more likely to be smokers than older men overall (14%).⁶ This implies the need for a targeted intervention to reduce smoking aimed at these particular high smoking groups.

Health differences

The health experiences of ethnic minority groups are not the same as each other or that of the majority white population, even after differing age structures and socio-economic factors have been taken into account.

The 2004 Health Survey for England, with a boosted BME sample revealed, for example, that older Bangladeshi men are more than three times as likely to have diabetes than older men in the general population, that Pakistani older men have unusually high rates of Cardiovascular Disease overall while Black Caribbean older men and Bangladeshi older women have the highest prevalence rates for Stroke.

The 2002 EMPIRIC⁷ study examined variations in the prevalence rates for mental illness among ethnic minority groups.

² Hrobonova et al., *Higher levels and intensity of physical activity are associated with reduced mortality among community dwelling older people*, Journal of Aging Research ID 651931, 2011

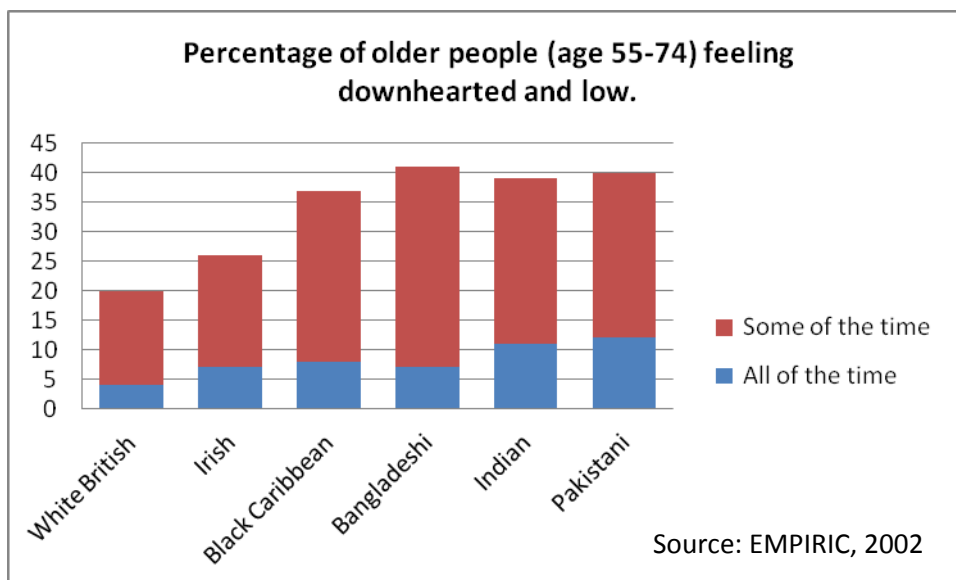
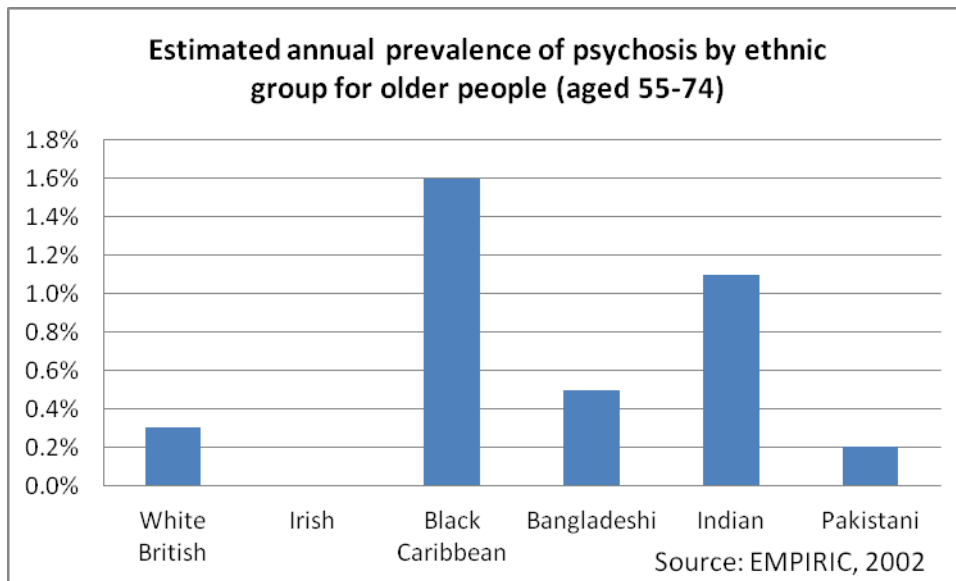
³ Stamatakis, *Health Survey for England 2004: Physical activity*, The Information Centre, 2006

⁴ Millward and Karlsen, *Tobacco use among ethnic minority populations and cessation interventions*, Race Equality Foundation, 2011

⁵ *Tobacco and ethnic minorities*, Ash, 2011

⁶ Wardle, *Health Survey for England 2004: Use of tobacco products*, The Information Centre, 2006

⁷ Sproston, Nazroo et al, *Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC)*, TSO, 2002



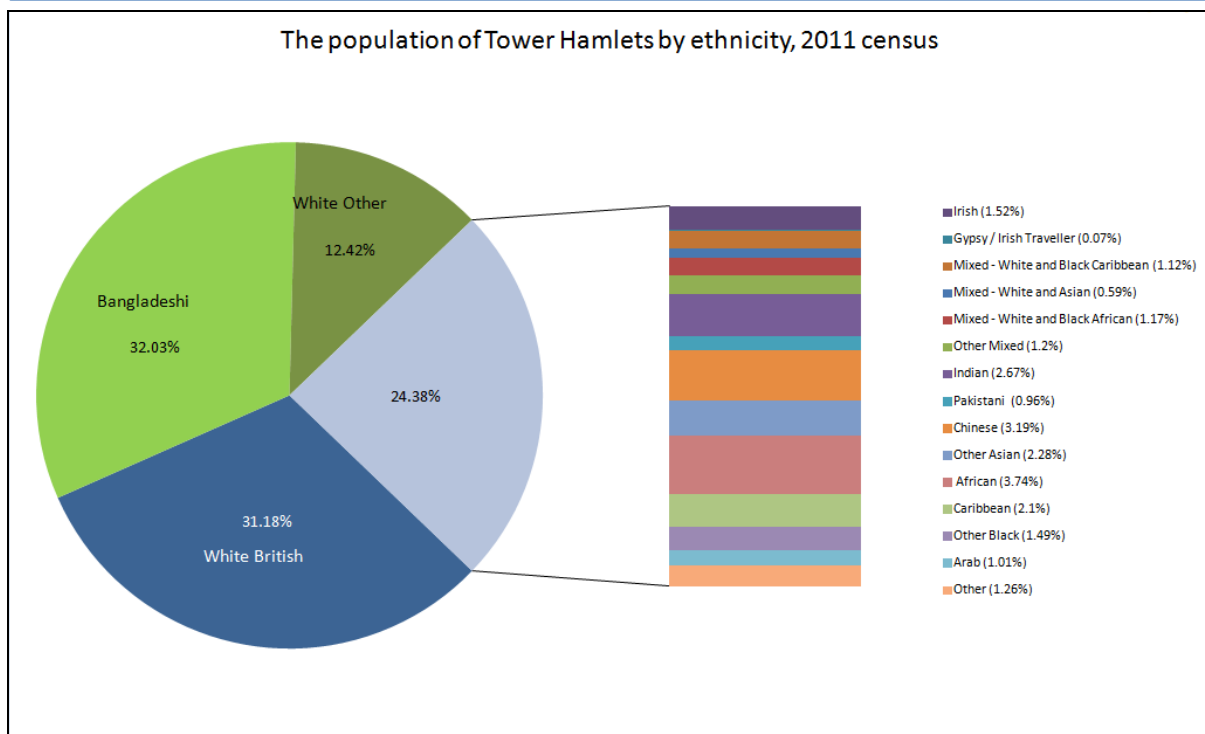
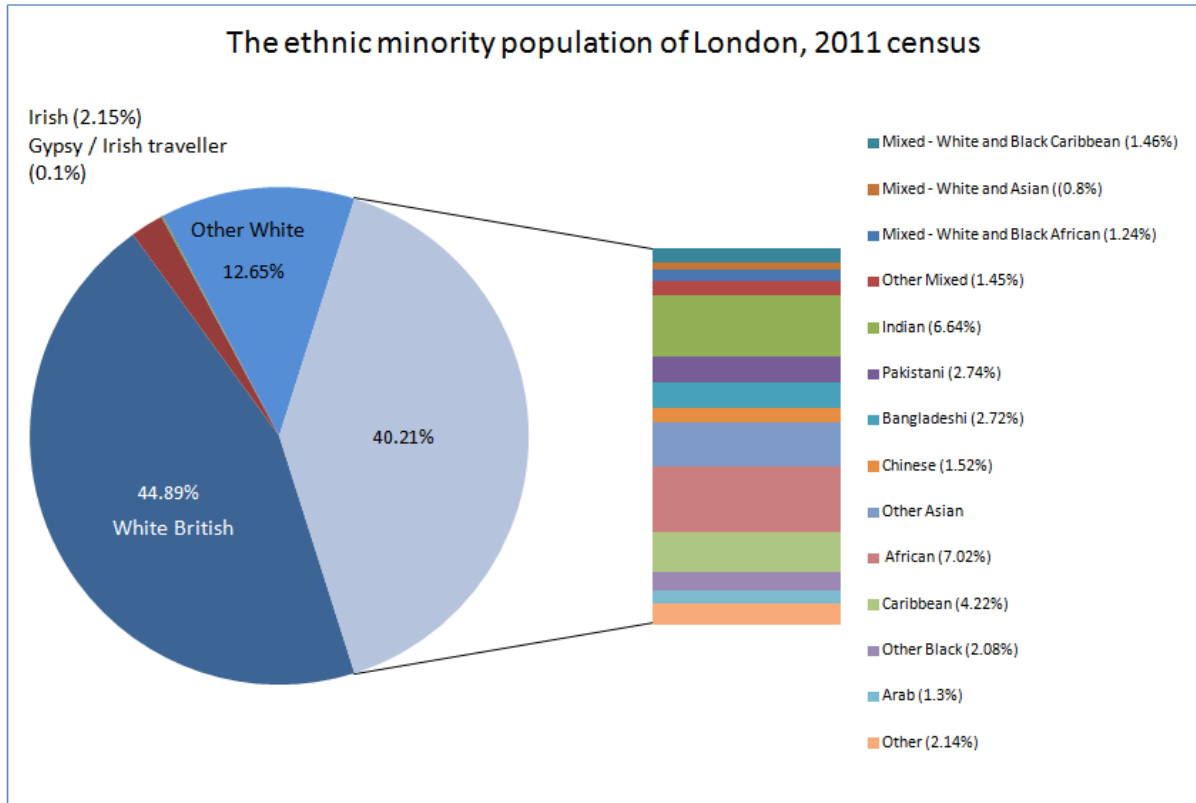
There is a need to update these key information sources and variations in the incidence and prevalence of disease in ethnic minority communities need to be taken into account when assessing the future health and care needs of the BME community.

Regional differences

The ethnic minority population of England and Wales is not evenly spread but is concentrated in the four major conurbations of London, the West Midlands, Greater Manchester and West Yorkshire. Some argue that this concentration will even out over time⁸ but while, in the 2001 census, over 50% of black ethnic groups in England and Wales lived in London (Black Caribbean 53%, Black African 57%, Black Other 53%), by 2011 this had risen to around 60% (Black Caribbean 58%, Black African

⁸ Wohland et al, *Ethnic population projections for the UK and local areas*, University of Leeds School of Geography, 2010

58%, Black Other 61%). This compares with 8% of the 'White British' population and 15% of the population of England and Wales overall that live in London. The ethnic 'minority' population now makes up more than 50% of the population of London as a whole and in some areas, such as Tower Hamlets there are much greater concentrations of individual ethnic groups.



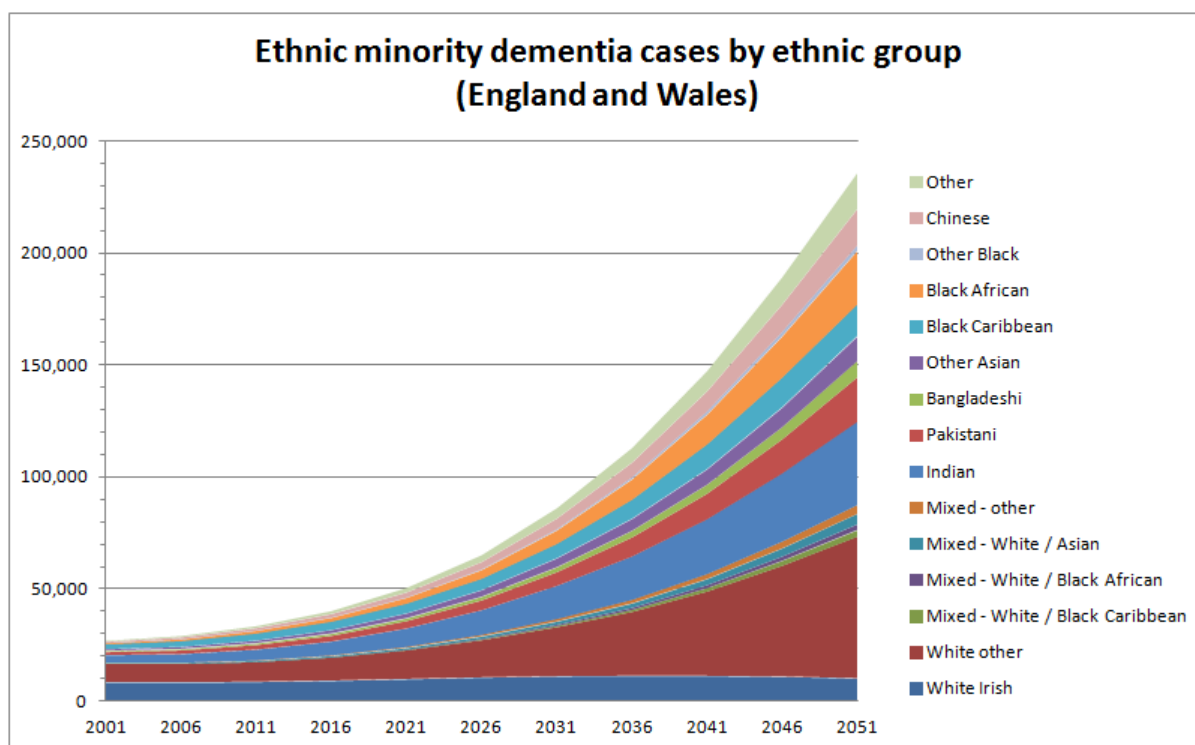
This means that national projections are of limited value in projecting the future BME demand for health and social care in the local community and local projections are required.

The future health and care needs of the BME community

It is commonly assumed that prevalence rates for Dementia, while very much age dependent, are the same across communities. Also, there is no evidence as yet to support the view that black and minority ethnic groups are any more or less likely than the general population to require care home care in older age. On the assumption that these rates are the same as for the general population we can estimate future dementia rates and the future demand for care home care in the BME community.

Future cases of dementia among ethnic minority groups

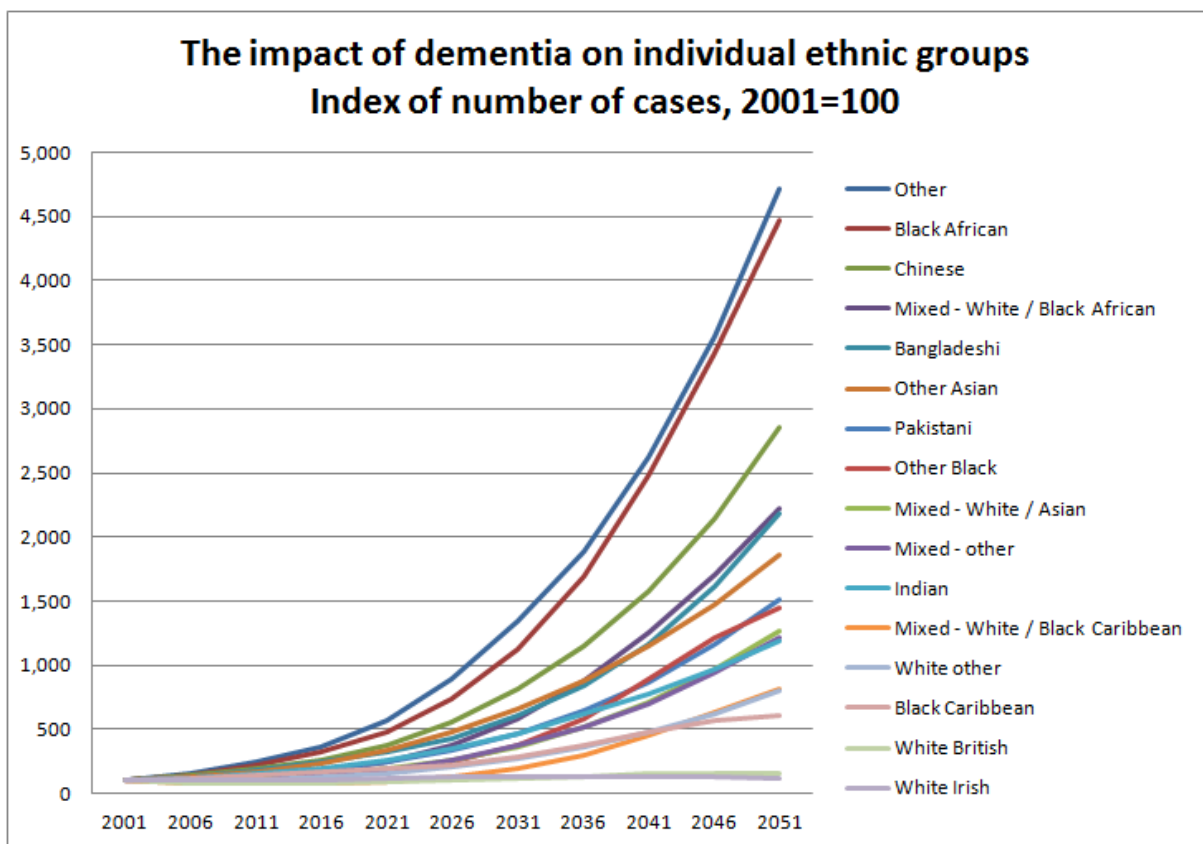
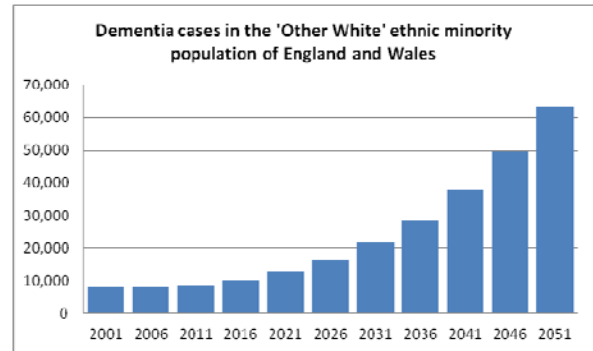
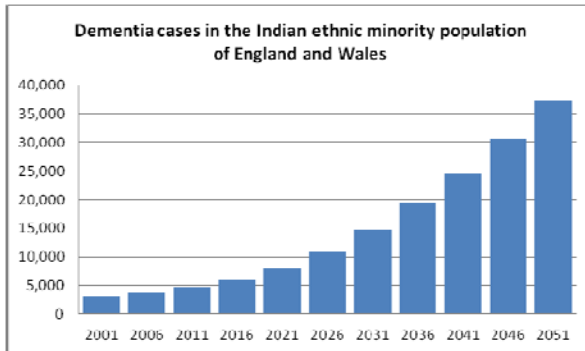
As the ethnic minority population ages, the number of ethnic minority dementia cases is expected to rise from fewer than 27,000 cases in 2001 to over 235,000 by 2051.



The ethnic groups with the largest impact on dementia numbers overall will be the larger ethnic groups and those with ageing populations. The 'White other' and Indian ethnic groups will experience the largest increase in the number of dementia cases rising from fewer than 8,000 cases in 2001 to nearly 64,000 cases in 2051 for the 'White other' and from 3,000 to over 37,000 cases for the Indian ethnic group.

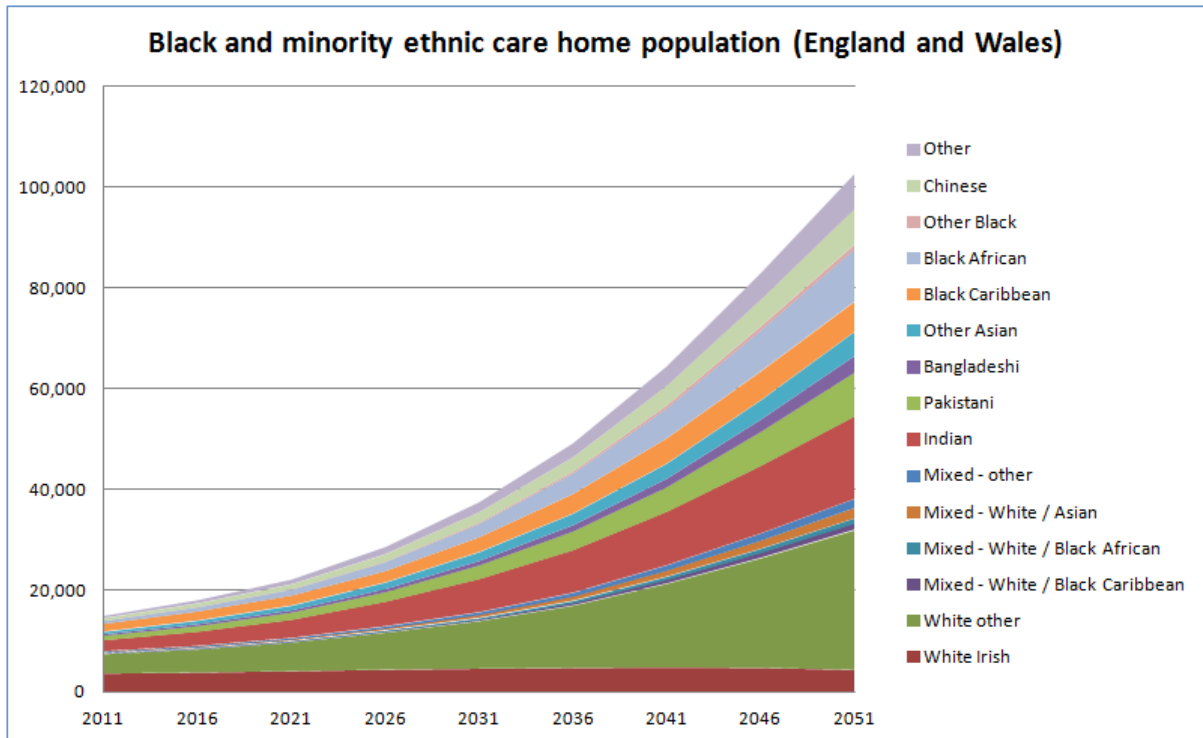
Although these groups will see the greatest increase in numbers, the group who will feel the greatest impact may be those experiencing the greatest proportionate changes. Using 2001 as a base year, the 'other' and Black African ethnic groups will experience a 47 and 45-fold increase

respectively in the number of dementia cases to 2051 and the Chinese ethnic group will experience a 28-fold increase.

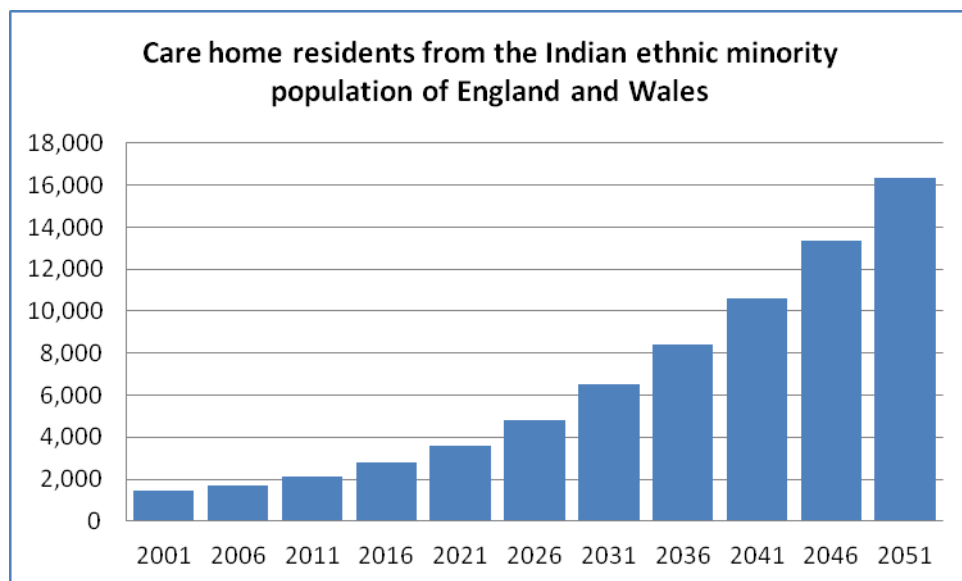


The future demand for care home care

The demand for care home places by the black and minority ethnic communities of England and Wales will increase five-fold in the next 40 years from fewer than 20,000 places in 2011 to over 100,000 by 2051. This demand will not be evenly spread but will be concentrated in the conurbations of London, the West Midlands, Greater Manchester and West Yorkshire.



The greatest demand will be from those ethnic groups with the oldest population structure, for example the Indian population which will experience an eight-fold increase in demand from 2011 to 2051.



Culturally competent care

Research commissioned by the Panicoa programme (Prevention of Abuse and Neglect in the Institutional Care of Older Adults), reviewed and summarised by CPA, included a study of the care home care of older people from black and minority ethnic groups.⁹

Many of the aspects of good care for older people in care homes from black and minority ethnic communities, are the same as for all other residents including treating residents as individuals, providing a homely atmosphere, human relationships, safety and security and providing the basics of care, food drink and toileting, in an appropriate manner. For BME residents, communication is important and it is advantageous to be able to talk with residents in their own first language, whenever possible. A person's language is part of their personal identity but good communication is more than just the use of a particular language. Good communication is essential and has to be achieved, without good language skills, where the use of language is limited either by linguistic differences or by dementia.

Attitudes and relationships are very important. Not only relationships between staff and residents but between individual residents, particularly in a multi-cultural environment.

Relationships need to be carefully managed to allow residents to spend time with those whose company they prefer while avoiding isolating individuals, cultural stereotyping or racism. The layout and facilities of the home are instrumental in managing relationships, for example the use of more than one lounge. Staff may also be drawn from black and minority ethnic groups and there is a risk of cultural stereotyping and racism not only from staff but also towards staff as well as between residents. Some staff feel that some residents from some cultures may have a tendency to see them as servants.

Culturally competent care involves a knowledge and awareness of cultural diversity and the views and practices of the individual religions and cultures of residents so that care may be offered in an appropriate way. Training in cultural competence should be part of staff training.

Handling cultural diversity is complex and may give rise to difficult dilemmas. Older people in care homes will reflect the attitudes and experiences of the wider society from which they are drawn. This may range from the ties, parochialism and tensions of a close-knit ethnic community causing issues with gossip to an acute sensitivity to perceived racism based on actual experiences as a migrant within the broader community.

⁹ Bowes, Avan and Macintosh, *Dignity and respect in residential care: issues for black and minority ethnic groups*, Panicoa, 2012

About CPA

The Centre for Policy on Ageing was set up by the Nuffield Foundation in 1947 and, in 2012, celebrated 65 years of policy analysis and information provision on older age issues during which it has produced over 150 reports and reviews.

CPA is an independent charity promoting the interests of older people through research, policy analysis and the dissemination of information. The Centre aims to raise awareness of issues around ageing, influence the development of policies to enable older people to live their lives as they choose, and to support good practice. CPA's overarching focus since its inception has been on empowering older people to shape their own lives and the services they receive. The fundamental touchstone of its approach is to discover and advocate what older people themselves want and need.

We are currently working in partnership with the Joseph Rowntree Foundation to support their Ageing Society programme.

The Centre for Policy on Ageing is an information service provider and hosts the Ageinfo database and the National Database of Ageing Research (NDAR). We publish regularly updated readings on key topics and publish the bulletin *New Literature on Old Age*.

CPA has recently carried out a number of secondary analyses and reviews including a series of four reviews¹⁰ on Age Discrimination in Health and Social Care, commissioned by the Department of Health in England, in the lead up to the Equality Act 2010 and work on Dance in Older Age and Prevention and the Sustainability of Health and Wellbeing in Older Age, commissioned by Bupa.

Recent work on Care Homes includes the *Changing Role of Care Homes* report which incorporated an analysis of Bupa census data, an updated census analysis following the 2012 Bupa census and a report on the administration of medication in care homes as part of a DH funded programme.

In 2010 CPA developed a demographic model, commissioned by the Runnymede Trust, to examine the future ageing of the ethnic minority population of England and Wales.

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¹⁰ <http://www.cpa.org.uk/reviews>