UNIVERSITY OF BIRMINGHAM

BIRMINGHAM POLICY COMMISSIONS

Planning and superdiversity.

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The initial literature review conducted by the Birmingham Policy Commission identified that there was a paucity of research in relation to diversity and ageing and that whilst initial work had been done in relation to planning and management of health services in relation to Black and Minority Ethnic (hereafter BME) communities in some areas, this was on the whole a neglected field that did not recognise the superdiverse context for which services were being designed and delivered. Further, there was no explicit focus on healthy ageing and cultural variation within the identified literature for the UK, although examples of literature on this subject could be extrapolated from international settings with salient findings for the UK.

The Birmingham Policy Commission through its evidence gathering process addressed this idea and sought evidence from a range of professionals in practice; academics; lay members of the community, and has through this investigation set out this recommendation about planning for an ageing in a superdiverse multi-cultural UK context.

Why do we need better planning to accommodate an ageing population?

The fact that we are unaware of the impact of the cultural nuances on experiences of positive ageing means that by definition this has not to date been overtly considered in relation to planning. This is of concern. Further, superdiversity of the kind experienced in the UK now, is little understood. What we do know about planning for an ageing population is that we are not at present proactively planning for healthy ageing; we are still planning for disease burden and risk mitigation. This needs to shift.

Whilst we have models and practice based on functional understandings of ageing, work such as that of McCann et. al (2008), shows that broader understandings of ageing need to be understood in relation to sub-populations (in this instance women) but also more widely. Their research challenges the focus on purely functional ageing finding that "participants' views on successful ageing are far more diverse and complex than Rowe and Kahn's paradigm of successful ageing might allow. This suggests a need to expand our understanding of the way late mid-life and older people view successful ageing" (McCann Mortimer *et al.*, 2008: 203). Their study also identified that "any meaningful definition of successful ageing must take cognisance of the opinion of the ageing person to whom it is applied. Spiritual and religious affiliations are a source of support and well-being to the older women in this study and they may continue to be so until their life is over. This area is deserving of further research involving a wider population" (McCann Mortimer *et al.*, 2008: 203). This research supported findings of Sharon Wray, who looked at gender and perceptions of successful ageing, finding that there had been a "neglect of the diverse individual and collective strategies women use to maintain agency and control in later life" and that "empirical evidence presented in the article suggests there are significant cultural differences in the meanings older women attach to self-fulfilment and 'successful ageing'" (Wray, 2003: 511).

We also know that whilst we need to plan better for different groups in order to better facilitate successful ageing across the population, demographically by 2025 it is predicted that within Europe, 20% of Europeans will be aged over sixty five, with a particularly rapid increase in the number of persons aged over eighty (European Commission Ageing Policy website, 2013). Whilst services preoccupy with planning for bed shortages and disease burden in the short term, it is also necessary to plan for the future in a way that optimises opportunity for successful ageing. Health promotion in only one aspect of what generates successful ageing, therefore forward thinking planning across services and at all levels of governance needs to take place.

Why do we need to focus on superdiversity and cultural sensitivity?

The Policy Commission has seen that there are cultural nuances in relation to understandings of ageing and what healthy ageing means (Clarke and Warren, 2007; Sin, 2007; Chong *et al.*, 2006; Hung *et al.*, 2010; Lau and Morse, 2008; Sandra Torres, 1999; Torres, 2013; Thiamwong *et al.*, 2013). In a presentation from the Centre for Policy on Ageing on their work on the future of ageing of the ethnic minority population of England and Wales, Nat Lievesley reported that the report found that in line with an ONS report from 2003 "ethnicity is a 'multi-faceted and changing phenomenon' that may reflect a combination of a number of features including country of birth, nationality, language spoken at home, ancestral country of birth, skin colour, national or geographical origin, racial group and religion" and that "an individual's ethnicity is a self-assessed concept that may change over time and is not the same as country of birth or nationality". This understanding of ethnicity is important to consider in a superdiverse UK context and especially important to individuals lived experience of ageing and in consideration of the findings from the literature review conducted for the Commission that found based on the work of (Clarke and Warren, 2007), that early experiences of migration and in particular racism, had a profound effect on older people and their expectations in relation to ageing.

Dr Warren in her submission to the Birmingham Policy Commission identified that there were issues of gender and representation of ageing and gender that needed to be considered in planning and proactively in relation to supporting a healthy ageing population. She also noted an absence of positive imagery particularly around gay or ethnic minority women, highlighting that when women are featured in the media it is often in images of passive dependency. Dr Warren was looking at the broader issue in relation to the need of support of the Cross Parliamentary Group on Body image to start a campaign about ageing and images of women.

The commission also heard evidence from Professor Naina Patel (Director of the Policy Research Institute on Ageing and Ethnicity). In Professor Patel's work on healthy and positive ageing in particular relation to the BME population in the UK, she showed that there had been slow progress into research in this area and that this was not felt to be on the policy agenda. Further, she found that BME elders were treated as a homogenous group without cultural or socio-economic distinctions being made. These distinctions are important as we have seen in the evidence submitted by Professor Goldblatt and the work the Policy Commission has undertaken in relation to ageing and health inequalities, that socio-economic disadvantage is an important feature of healthy inequality and is an inequality that persists into old age with real consequences. Professor Patel referred also to the importance of social clubs and initiatives run in communities by the third sector, and how due to changes in commissioning structures and funding cuts, these smaller organisations risked being lost, potentially damaging the bridges between policy, BME communities and BME community organisations.

Professor Patel focussed on healthy and positive ageing and the past and future for research and through this work identified five factors that were specifically described as important in relation to

health for BME groups, including: effective information with care systems; good communication; full access to services; identity appropriate care (in terms of culture and faith); hygiene and cleanliness of health services and staff to be professional and behave with integrity. Whilst these things might be felt to be important to all older people, the specific emphasis and importance placed on each factor is important in enhancing our understandings of how to care better for older persons from an array of cultural and diverse backgrounds. Some of these themes were presented within the policy commissions' focus group and the findings from these conversations overlapped crucially with the ideas identified in Professor Patel's research.

One feature highlighted in Professor Patel's research was the need to provide further education and better access to resources and services that may support healthy ageing as a process. She mentioned the idea of community champions as one potential solution, however better access to information about healthy ageing and support about lifestyle choices and activities would be of benefit across communities, whilst targeting specific issues identified in relation to BME communities.

What does planning this look like in practice?

How do we accommodate planning for older people into general planning as something that is automatically thought about and part of standard practice? There needs to be recognition in any potential changes to planning for healthy ageing in the 21st century that successful and healthy ageing will only work when it is a shared endeavour of an individual living within a community that facilitates healthy ageing and is adequately supported by the state. The tripartite relationship is important (Hockey and James, 2004). Central to the work of the Commission and the way in which evidence was gathered, was the understanding that **healthy ageing has to take into account the views of those to whom the understanding is applied.**

Professor Philip Tew and Dr Nick Hubble presented their work on Fiction and the Cultural Mediation of Ageing Project (FCMAP) that took place at Brunel University and found that older people's capacity to control their own personal narratives was 'central to good ageing' and 'generally essential for effective social agency', that 'is precisely at the point when older people lose control variously of their personal narrative that good ageing is diminished or ceases'. This links to this idea of the importance of the tripartite relationship. Further, they called for an intergenerational approach to local service delivery, arguing that segregation according to age groups could further exclude those whom were already socially isolated. They felt that there were a plethora of benefits to be gleaned from the informal support, skill sharing and opportunities presented through having different generations access local service providers and they called for challenge to the notion that activities and services should be age specific, rather they should be flexible and inclusive.

Age UK had been developing examples of projects working with BME communities in the UK, and the Policy Commission heard from Claire Ball, a Policy Advisor at Age UK, on the health promotion programme that they had developed. Within this programme, the questions of 'whose responsibility' is it to promote healthy ageing was seen to be central, and they concluded that from their practical project based experience it was the responsibility of several actors. The recent Fit as a Fiddle initiative targeting these groups focused on the functional aspects of healthy ageing and disease prevention (Age UK, 2012). The findings in relation to the BME community and their use of services showed that BME elders will have experienced more indirect or other discrimination and consequently due to their migrant experiences of ageing they do not use services or 'go elsewhere' which was seen as a factor in declining demand and an obstacle to inclusion and opportunities for healthy ageing being missed within these communities. Their work and the work of Fit as a Fiddle (Age UK, 2012) further found that social class and the concentration of poverty across all

communities had healthy implications, supporting the work of the Commission on health inequalities.

In relation to health policy and the importance of planning, the Commission heard evidence from Public Health in Birmingham, who identified what they described as four 'poverties in relation to older people. These poverties were identified as:

- Information poverty: older people need to be able to access online and other information in relation to healthy ageing and services.
- Fuel poverty: poor insulation and the rising cost of fuel prices was cited as an issue for older people in Birmingham.
- Food poverty: There was explicit concern about local corner shops closing or being very expensive and the difficulty if you have poor mobility of eating healthily if you are not asset rich.
- Health poverty: There were specific issues addressed in relation to the changing nature of primary care and the difficulty older people have in relation to the way GP's are being encouraged to practice in a more technical, less interpersonal way.

They further identified the importance of safety as a feature of healthy ageing and of specific importance to older people, arguing that towns and cities are not designed for older people and that there should be consideration when planning in organising these around safety and exercise. They further identified that buses could be improved in how they supported older people and the introduction of 20mph zones with less congested public transport being a good idea.

Specific issues in relation to transport and planning are addressed both in the findings of this commission and also in one of the other recommendations so will not be dwelt upon here, however it is useful to point out that these recommendations and findings are interwoven to create as holistic a picture of healthy ageing in the 21st century as possible.

In relation to the early literature review undertaken for the Policy Commission, and in line with the evidence submitted from a wide ranging professional and lay audience and community on the importance of healthy ageing and what form this should take, the Commission has developed a recommendation around the importance of planning.

The Birmingham Policy Commission recommends that when planning services for an ageing population in the UK there is a need to recognise and accommodate superdiversity; cultural sensitivity should be a vital component in all future services for older people.

The Birmingham Policy Commission further feels that this goal needs to be approached in a variety of ways and could be achieved by:

- **The Birmingham Policy Commission recommends that support is given at a local level to 'championing' healthy ageing and providing advice on how this can be achieved in a culturally sensitive way.**

- **The Birmingham Policy Commission recognises that healthy ageing is a shared responsibility, held by individuals in relationship to the state and to the community in which they live. This relationship needs work and support from all sides and policy developments and planning services for the future must take this into account.**

- **The Birmingham Policy Commission recommends that ageing policy takes into account the need for intergenerational interaction and that segregating people into the 'elderly' and**

the 'oldest old' in relation to services delivered may not be the best approach in relation to findings on healthy and successful ageing; that older people must not be viewed as a homogenous group either by gender, age, or culture. Effective planning needs to recognise the reality, challenges and opportunities of superdiversity, and the particular rights and interests of members of a superdiverse population.

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