Health of Ethnic Minority Elders in London

Respecting diversity

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PREFACE

This report is one of a series of major publications produced by The Health of Londoners Project, a public health research and intelligence initiative that was established in 1995 and is funded by London's 16 Health Authorities and the London Regional Office of the NHS Executive. It sets out for the first time the implications of an ageing minority ethnic population for the capital's health and related services.

As the point of arrival for a high proportion of migrants, London has for many years been characterised by a changing and increasingly ethnically diverse population. Population projections show that while London's total older population will reduce in size over the next ten years, the numbers of elders from black and minority ethnic groups will increase significantly. A diverse population, both ethnically and in terms of other socio-economic factors, means a greater risk of social and health inequalities between groups. Older people from black and minority ethnic communities are a vital group for services in London to consider in the minimisation of health inequalities, since they experience disproportionate levels of poverty and social exclusion.

Our report makes it clear that policy makers and practitioners from national through to London government and local services must act now if we are to prevent inequalities in health from growing in the future. Our recommendations offer a policy framework for action at multiple levels. As a minimum, we would like to see evidence of commitment to this framework translated into local Joint Investment Plans, the National Service Framework for Older People, the government's National Plans for health and social care and last but not least, the work of the Mayor's new Health in London Commission. The additional costs of ensuring equal access to culturally appropriate care must be recognised and explicitly addressed in health improvement planning. Effective scrutiny of health and social care for minority ethnic elders will be needed on both a pan-London and a local basis.

We hope our work will be widely used as a resource and tool for advocacy for black and minority ethnic elders and agencies working on their behalf across London. Above all, we would like the needs of this growing sector of London's population to be clearly recognised and action to be taken.

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FOREWORD

The changing age profile of populations in developed countries, which have a rapidly growing proportion of older people, has been a focus of both research and policy development for a number of years. However, in Britain the health and social care needs of older ethnic minority people have not figured much in these activities, perhaps because they have been considered to be a small population whose needs will be met by their families. Now, those who migrated to Britain as young adults in the 1950s and 1960s are moving into retirement. They are a unique generation who, since migrating to Britain, have made a major contribution to the country's economy. Addressing the needs of this generation in ways that recognise cultural diversity is an important and current task facing health and social care service providers.

This important public health report is a timely contribution to our understanding of the situation of older ethnic minority people. It will go a long way towards providing the information and strategies needed to plan effective and acceptable services for older ethnic minority people in London, and will also be of great value for other ethnically diverse areas of the UK. It is the outcome of a large collaborative effort, centred around the activities of a core task group of researchers, academics and policy leads, but which has also involved careful consultation with a range of constituencies, including community groups, voluntary organisations, public sector staff, and other academics and researchers working on these issues.

The report provides a review of the policy context and the sources of data that are currently available, describes ethnic differences in health, health behaviours and service use, and, most importantly, provides projections of the changes in population structures and service use that will occur over the next decade. It contains extremely useful discussions of the wider policy context and outlines a series of recommendations. As such, the report provides an indispensable and detailed resource for those involved in the planning and delivery of health and social services for older people. It contains the most recent data covering a wide range of issues, but also provides data at borough level to facilitate the planning of local services that reflect local needs.

It is clear that the delivery of services to an ethnically diverse population presents great challenges, challenges which require imaginative, but not necessarily costly or complex responses to ensure that services are acceptable and sensitive to cultural context. Reports such as this provide an important resource that greatly help us to meet such challenges. The conclusion contains recommendations for both central and local service planning and a careful reading of this chapter will provide a useful starting point for the planning for services and a focus for action.

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EXECUTIVE SUMMARY

Introduction

This report is aimed at every person and organisation with an interest in, or an effect on, health in London. For many years now, specialists have drawn attention to the ageing of ethnic minority groups: this report, prepared on behalf of the Directors of Public Health in London, sets out for the first time the overall health implications of this change for the most ethnically diverse city in the country. It seeks to identify the impact of the shift in the ethnic balance of London's older population on its health, and on health and related services in the capital. It brings together and analyses the available information about older people from ethnic minority groups, their health and the services which they need and use in London; draws conclusions and makes recommendations to improve health and services for this growing sector of the capital's population.

Ethnicity has a number of dimensions, which vary in importance to different people, their health and their use of health services. Culturally-driven health behaviours and genetics have an obvious impact on health. People's nationality, country of birth, skin colour, religion and language also affect health and access to services through their life course and socio-economic circumstances. Some analyses in this report relate to the ten "ethnic group" categories used in the 1991 Census, which combine nationality and skin colour, and so have their limitations. The next census in 2001 will bring some improvements, identifying Irish and mixed groups separately. Other analyses relate to country of birth: although this bears a closer relationship to ethnicity for current elders than for younger age groups, there are important anomalies, and it will become increasingly irrelevant as a proxy for ethnicity in the future. Equally, while some arbitrary age groups are used for analysis, we recognise that "old" and "elders" are only relative terms.

Policy background

In a complex and crowded policy agenda (see Chapter 2), there are many competing priorities, and in most local agencies there is no one individual or department to take the lead for this particular group of people. However, older people from black and minority ethnic groups are an important group for all sectors in London to consider if health is to be improved, and inequalities in health reduced, to meet current health priorities and targets. Key issues are:

- The current direction of welfare reform, and the future pattern and funding of hospital, intermediate and long term care, have big implications for older people and carers – especially those with relatively few resources to finance their health and social care needs. These will include, alongside the most disadvantaged people in the white majority, a disproportionate number of black and minority ethnic elders.
- Following the MacPherson Inquiry's findings on institutional racism, race relations and European human rights legislation will increase the formal requirement on health and local

authorities to provide effectively for minority groups; but these issues still need product champions to take them into the mainstream.

- For all older people, the new NHS Plan and the coming National Service Framework should define the way towards better services for the future. A test of their success will be their outcomes for black and minority ethnic elders.
- Minority communities and older people want to engage in policy making and to make services better. Such involvement needs to be incorporated in mainstream decision making, and properly resourced, in order to be effective.
- London's administrative complexity has brought fragmentation of services, and also stark inequalities in access to Local Authority and health services. 'Postcode rationing' in the NHS, and differential charging for care services between local authorities, make for inequity across the capital. Different eligibility criteria for continuing care are a particular example of geographic difference, which we recommend should be addressed collectively across London.

The establishment of the Greater London Authority (GLA), a London Regional Office for the NHS, and the Mayor's London Health Commission offer opportunities to address some of these issues across local boundaries. Joint Investment Programmes and flexible partnerships are the potential vehicles for change at a local level, which is where services for older people need to be.

Population characteristics and projected change

London is the point of arrival for a high proportion of migrants. As set out in Chapter 3, this means that:

- ethnic diversity is a continuing feature of London's population;
- services need to respond to changing populations;
- there is a high risk of social inequalities between groups.

Projections from the London Research Centre (LRC) – now the GLA's Information and Research Directorate – suggest that, unlike most of the UK, London's population of older people will decline over the next ten years. However, the population of elders from black and minority ethnic groups will increase – in fact numbers will approximately triple by 2011 when compared to the 1991 Census, reaching almost 140,000. These changes result from the arrival in the UK, largely at different periods of the twentieth century, of various groups of migrants. These are now at different stages of growth and ageing, and some, such as Black Caribbeans, already include substantial proportions of elders. London also has several "hidden" ethnic minorities within the white population, such as the Irish, Cypriots, and East Europeans – again, some of these include large numbers of older people. While some groups are relatively concentrated, others are more widely scattered, forming very small minorities in a number of boroughs. These differential distributions of minority groups give differing needs profiles to health and local authority areas.

Socio-economic characteristics, ethnicity and health

The level and type of disadvantage from language, life experience, socio-economic characteristics and racism differs between and within ethnic minority groups. These factors will all impact on health and service use, while ageism and the relative deprivations of old age are shared with many in the majority white population. Elders from most minority ethnic groups tend to be disadvantaged in both employment histories and income. These have consequences for immediate health status, and also compound longer term effects, which are important given current debates about pensions and about the state's role in funding long-term care. Religion, gender profiles and household characteristics of different groups may have implications for health status and health care needs, although stereotypical assumptions about individuals should always be avoided (Box S1).

Box S1: Socio-economic characteristics of London's ethnic minority elders

- Most older people from minority ethnic groups were born outside the UK; however over 90% have lived in the UK for over ten years.
- Elders from South Asian ethnic groups tend to live in larger households, and more multi-generational households, than White or Black Caribbean elders.
- South Asian and black older age groups include higher proportions of men than white and other groups.
- More Black Caribbean and African older men live alone than do men from other minority ethnic groups.
- Minority ethnic groups have lower incomes. For example:

  - elders from Black Caribbean and Pakistani/Bangladeshi ethnic groups are significantly more likely to have semi-skilled and unskilled manual occupational backgrounds;

  - at ages 40-60, men from minority ethnic groups are more likely to be unemployed;

  - minority ethnic groups are proportionately over-represented in the lowest fifth of the income distribution – although Indian elders also include over-representation in the top quintile.
- Bangladeshi and Black Caribbean elders are less likely to be owner-occupiers, and more likely to be living in social housing than white or Indian groups. Levels of overcrowding are especially high for older people from South Asian ethnic groups.
- Elders from minority ethnic groups in London report higher levels of limiting long-term illness. Such differences appear to exist even within income groups.

There may be changes over time: for example, within South Asian groups, a convergence towards local, less extended family structures. Housing pressures are a particularly big driver: historically the better off, and the second generation of migrant communities, have been more likely to move from inner to outer London and from London to elsewhere, leaving poorer and older people in the inner city. LRC projections assume that minority groups will converge towards London's overall pattern of mobility. If they do not do so, then more elders from minority groups will stay in London, particularly in their current, largely but not exclusively, inner London Boroughs.

Health behaviours and health status

There are some important differences between ethnic groups in terms of health-related behaviours and health status (see Chapter 4). Black and minority ethnic groups show some positive health behaviours: for example, less use of alcohol and tobacco than whites. However, Bangladeshi men follow the pattern of the poorest white groups with a high rate of smoking, while exercise levels in South Asians, especially amongst women, are low and obesity has been identified especially in black and Pakistani women and Irish men. In addition, health behaviours do not always follow traditional cultural expectations: alcoholism and elder abuse, for example, are not unknown in groups where alcohol is traditionally proscribed, and where older people are traditionally well respected.

There is some evidence that presenting ill health, including self-reported limiting long-term illness and general health, is more frequent in elders from certain minority groups (Box S1). So are some particular conditions, such as heart disease, diabetes, hypertension, kidney disease (a consequence of both of these), eye problems, risk of hip fracture, and mental illness.

More specific information about health of older people across London is drawn from mortality data by country of birth. In general, relative overall mortality rates for elders in London are lower than national averages, however cause-specific mortality rates reflect some of the important ethnic differences seen in national studies (Box S2).

Box S2: Mortality rates for over 65's in London by country of birth 1996-98

- Mortality rates (all causes) for London are lower that those for England & Wales (Standardised Mortality Ratio = 96.9).
- Rates for most recent migrant groups are significantly lower than the London average. Rates for older people born in the Caribbean & West Indies and Bangladesh are close to those for people born in England & Wales
- The highest all cause mortality rates amongst elders in London are for those born in Ireland and Scotland.
- Mortality rates for particular causes:
  - Coronary heart disease: high in South Asians, low in people born in the Caribbean
  - Stroke: high in elders from some South Asian countries and the Caribbean
  - Diabetes: high in elders from the Caribbean, Africa, Asia and the Middle East
  - Most cancers: highest in Irish, lowest in people from Africa, Asia and the Middle East
  - Prostate cancer: high in Caribbean-born men
  - Infectious diseases: highest in people born in the Caribbean, Africa and Asia.
  - Accidents and injury: highest in older people born in Eastern Europe

There is little evidence of ethnic differences in some of the other disabling conditions of old age, such as falls, arthritis, incontinence and dementia. Some minority groups have sensitivities and taboos about certain conditions – cancers, mental illness, incontinence, for example, which offer challenges to effective treatment. Some of the rarer genetic conditions found in particular minority groups, especially sickle cell anaemia, are increasingly manageable with improving medical treatment, so that more people with these conditions will be living into old age in the future. It will therefore become increasingly important for services which promote health, and those which care for older people with poor health, to address the diversity and specific needs of ethnic minorities.

Quantifying hospital use

Hospital admissions are an unusual instance of a service where ethnicity of users is routinely recorded. Although ethnic coding of Hospital Episode Statistics has been a formal requirement for several years, these data are rarely used – which discourages better data collection. The analysis in this report (see Chapter 5) aims to break this cycle. In showing the service planning implications of the available data for London (Box S3), it emphasises the need to improving coding quality. There are still major problems with, for example, incomplete codes covering 31% of all admissions of Londoners over the age of 65.

Box S3: Hospital admissions of Londoners aged 65 and over, 1997/98

- Relative overall admission rates for over 65's are significantly higher than average for the Pakistani and Indian ethnic groups, but lower than average for Black Caribbean, Black African and White ethnic groups.

- For particular conditions there are:
  - higher admissions for diabetes amongst all minority ethnic groups;
  - high admission rates for coronary heart disease in South Asian groups
  - low admissions for coronary heart disease in Black Caribbean and Black African groups;
  - higher rates of stroke admissions in Black Caribbeans, Indians and Bangladeshis;
  - higher admission rates for cancer in the white group;
  - high admission rates for infectious disease in South Asian and Black African groups;
  - higher admission rates for mental illness in Black Caribbeans and Bangladeshis.

- Admissions for selected treatments
  - lower rates of hip and knee replacement in several black and Asian groups;
  - high rates of cataract replacement in all black and minority ethnic groups;
  - high rates of coronary revascularisation among Indians and Pakistanis (not Bangladeshis).

Modelling the effect of ethnic balance on specific conditions

Differences in the ethnic mix of the older population may affect the underlying local incidence of certain specific key conditions where we know ethnic differences exist. Projected changes in the population can then be applied to the same ethnic differences to model possible future scenarios.

Results (see Chapter 5) from different models for selected conditions show how ethnicity might affect the current underlying incidence or prevalence of some common conditions (Box S4).

Box S4: Modelling the effect of difference and change in proportions of minority ethnic elders in respect of selected conditions

- Differences in the ethnic mix of London Boroughs are likely to produce significant differences in the underlying prevalence of common conditions. Diabetes showed the most variability, with expected rates in some areas 20-30% higher than the London average – solely as the result of ethnic differences in prevalence.

- The most important population change in terms of the potential burden of ill health is the overall reduction in the number of over 65's in London, especially for the white ethnic group. This means that even for conditions such as coronary heart disease or stroke, which are more common in some minority ethnic groups, the net effect is towards a reduction in annual cases seen – other things being equal. Models for diabetes and renal (kidney) failure suggest some increase in total caseload in London over the next 10 years, which at their highest are a 10% increase in diabetes and 17% in demand for renal replacement therapy.

- When population changes are combined with mortality differentials by ethnic group (mapped from country of birth data), the results suggest a decline in the numbers of cases for almost all causes, although Standardised Mortality Ratios would increase for some conditions such as tuberculosis and diabetes.

Population change will have a differential effect at borough level, with increases in certain conditions far more likely in some areas than others. Areas such as Kensington & Chelsea, Bexley and Croydon where little or no reduction is expected in the older population, are likely to see more significant increases as a result of population change.

In summary, these models suggest that the changing ethnic mix of London's elders will not, for the next few years, bring with it massive increases in certain conditions, but rather changes in the overall pattern of ill health. However, with likely further growth in the older populations beyond that timescale, the overall pattern of health may depend on targetted action taken to improve the health of particular groups in respect of conditions like diabetes, cardiovascular and renal disease, where the disadvantage of older people from black and minority ethnic groups is clear.

Quality and access in the wider range of services

A wide range of services that reduce disease, disability and dependence are provided by the NHS, local authorities, the voluntary sector and community groups, and by informal carers who include many older people (see Chapter 6). Quantitative information on the amount and quality of service received, and on its costs, is very limited: the lack of ethnic monitoring is a feature even of most statutory sector services. Nevertheless, there is some evidence of differential access or late referral to primary, hospital and community care services, including mental health services and palliative care. These may be related to low awareness, or to perceived or actual poor quality of services available. There is also evidence that communication problems, and a lack of cultural awareness and sensitivity on the part of service providers, make for a worse experience for many older people from minority ethnic groups.

Health and welfare services have to adapt to ensure that they are appropriate for individual people from a culturally diverse population. The spectrum of services, including the essential mainstream services, should cater appropriately for the whole community. In some cases, there may be options for separate or integrated multicultural services. Preferences differ between and within different ethnic groups, and as for any user, a choice would be the ideal. Nursing and residential home care is a particular concern for some minority groups. At present, a high proportion of community-based support for black and minority ethnic elders comes from voluntary agencies, often with modest and insecure funding. Staffing in health and care services needs to better reflect at every level, and to be well informed about the community that is served. Racism among staff and, sometimes, users has to be addressed. Communication and language are major issues in access to and provision of services, particularly for older people. Provision across London of interpreting, translation and advocacy services is patchy and not always related to need, and the funding for such additional requirements of minority ethnic groups is not readily identifiable.

A checklist of standards, outlining the key components of good provision, is proposed. Prime issues are equity and standards for all. Clinical governance frameworks, the National Service Framework for older people and the new National Care Standards will be important here, though the latter may increase costs for both statutory and non-statutory sectors.

Conclusions

Older people from minority ethnic groups are a growing proportion of London's population. They include a wide social and cultural range, with disproportionate levels of poverty and deprivation. While overall mortality levels are mixed, some important ethnic differentials in diabetes, heart disease, stroke, eye disorders, infectious and genetic diseases and mental illness continue into the older age groups. Prevention, treatment and rehabilitation for these conditions needs to be geared more specifically to minority ethnic groups. However, the broader range of services which promote good health, including informal, private and voluntary sector support for

older people and carers as well as social and health care, has also to address minority groups' needs. Equality of access requires effective communication, based on cultural sensitivity and good information.

Recommendations

Policy and resources

1. Effective diversity strategies should be in place, which include prevention of discrimination on grounds of age or ethnic origin. These should be integral to both **national and local service policies and strategies**, for example National Service Frameworks for particular health conditions and care groups, Health Improvement Programmes, Joint Investment Programmes; and also to **staffing, recruitment, training and education programmes for London**.

2. There is a need to earmark resources, and access funding available through **partnership across all sectors**, for example through London-wide regeneration and local authority budgets as well as the NHS, to improve health for older people from black and minority ethnic groups. Resources for **modernising the NHS in London** should include a ring-fenced element to address minority ethnic health issues.

3. There should be explicit recognition – by the **Department of Health and NHS at national and local level** – of the additional costs to health and other service providers of ensuring equal access to appropriate services. This should be reflected in national funding formulae, or in specific allocations.

4. London-wide continuing care eligibility criteria, based on a standardised assessment and minimum dataset, should be considered as part of the **local** implementation of the NHS Plan, and in the development, led by **London's NHS RO and Social Services Inspectorate**, of a London Strategy for Older People.

5. **Pan-London, multi-district and London NHS sector-level** initiatives should be promoted where necessary to meet the particular needs of the relatively small and dispersed minority ethnic groups, which may be too small locally for any Primary Care Group, borough or Health Authority to prioritise.

6. An audit of Joint Investment Programmes for Older People should be undertaken, in preparation for the National Service Framework for Older People, to establish the planned provision of accessible, appropriate and acceptable services for minority ethnic groups. This should be led by **London's NHS Regional Office and Social Services Inspectorate**.

Better Health

7. All the **agencies which affect health**, such as those responsible for housing development and regeneration initiatives at **local and London** (for example **GLA**) level, should take account of the best possible information on our diverse and changing population of black and minority ethnic elders and their health needs.

8. Promoting health and independence for older people and their communities must include:
   - involving users and carers in improved individual assessment and care planning **(care of the elderly teams, both health and social care)**;
   - targetting local populations appropriately for relevant health improvement measures, taking account of the best available local data (**local partnerships**);
   - engaging older people themselves in collective planning, as an integral part of developing **local and London-wide** strategies for health improvement;
   - development and capacity building in the black and minority ethnic communities and the voluntary sector – again scope for **local, supra-district and London-wide** action.

Better services

9. **Health Authorities, Primary Care Groups and Trusts, Local Authorities and others responsible for the commissioning and quality assurance of services**, need to ensure:

9.1 Better recognition of, and support to, community-based service providers:
   - through longer term contracts;
   - promoting organisational development;
   - allowing time and resource for participation in the wider management and planning of services;
   - especially through organisational change in the NHS and related services;
   - to maximise social capital while meeting Best Value and efficiency criteria for service provision.

9.2 Provision of more acceptable and appropriate services for different cultural groups, especially in residential/nursing care settings, whether short-term (acute, intermediate and respite care) or longer term.

9.3 That **all health and care services** respond in respect of quality and quantity to their older populations. To do this they need to know and meet the needs of a relevant range of ethnic groups, with regard to:
   - strategies for information dissemination which meet the specific needs of older people, including availability in local facilities used by diverse communities;
   - written and spoken communication, in formats and languages which can be understood by older people;

- same-gender carers, professional staff and facilities where these are preferred;
- food and food preparation to meet cultural and religious requirements;
- specific personal care and personal hygiene needs;
- respect and accommodation for culturally specific customs and special days;
- space and time for religious observance;
- advocacy services for those who need help articulating their needs.

10. **All health and care services** should have in place effective multi-agency arrangements and written strategies for minimising and responding to abuse of any kind, including physical, emotional, financial or racial abuse of ethnic minority elders and of staff.

11. Access to interpreting, translation and advocacy services across London should be improved and made more equitable. The **NHSE London RO**, with its partners in the **Health in London Commission**, should develop standards for interpreting and translation, including estimates of quantities, and as a first step all **health and local authority** budgets for these services should be identified and published.

12 **NHS commissioners** need to plan for the changing clinical needs of the older age groups. For example, haemoglobinopathies and other rare genetic conditions will be seen in more older people; while more diabetes, mental health, cardiovascular and renal services will be used by minority groups.

13. It is important for the **NHS and other service providers** to value diversity in their staff as well as their clients. Positive action is needed to support the employment of black and minority ethnic people in services. This does not mean positive discrimination. Front-line staff through management and professions to board level are all important, and targets should be established, particularly for senior levels.

14. Training in ethnic minority issues and in cultural diversity should be integral to **all staff education and training programmes**.

15. The quality of service provision for minority ethnic elders should be ensured through the framework of **clinical governance**.

Better Information and better use of information

16. Better information and research is needed about different ethnic groups, including:
- cultural differences;
- attitudes and beliefs about health and disease;
- expressions of need;
- levels of carer support,
- the physical and mental health, and activities of daily living, of older people;

to inform health and related services in providing and planning for older people. This should form part of London's **Research & Development** activity. **Community groups** should be involved in providing this information.

17. More widespread ethnic monitoring, of both service use and staffing, should be implemented across **all services for older people**.

18. Within London's NHS, ethnic coding should be pursued by **NHSE London RO** as well as more locally by **service commissioners**, with regard to:
- performance management;
- initiation in primary care;
- edit-checking of Hospital Episode data;
- use of the data.

19. There is a need for better ethnic coding frames for use across sectors (primary care, disease registers etc), and better systems to assure overall data quality and comparability. Accreditation may be insufficient. These frameworks must be linked to census categories, including the 2001 Census categories for ethnic groups and religion. Language needs should also be included. The **Department of Health** and **NHSE London RO** should collaborate to promote this.

20. Death and birth certification should be changed to include recording of ethnicity. The **NHSE London RO** should promote this, and support implementation on a pilot basis.

CHAPTER 1

INTRODUCTION

Aim of this report

This report has been produced for the public health community in London, in response to the ageing of some of the capital's ethnic minority populations. Recent population projections suggest a threefold increase between 1991 and 2011 of people aged over 65 in non-white ethnic groups, while the size of London's white older population is in decline. The health of older people is of major concern, first to the people themselves, their families and their communities, but also to the health service, local authority and voluntary and private sector services which are established to meet their needs. This report seeks to identify the impact of a shift in the ethnic balance of London's older population on its health, and on health and related services in London.

Methods

The report has been prepared by a multi-agency Task Group supported by The Health of Londoners Project core team. We have brought together information and research evidence relevant to London's population of ethnic minority elders, to health and its determinants in these groups, to service provision and service use. From this some conclusions are drawn about the style and content of services for the future. In doing this we have differentiated where possible between identifiable ethnic minority groups, between geographic areas to a Health Authority and a Local Authority level and between the late middle-aged and much older people. We have drawn on published research, and on the experience and perceptions of a range of service providers and user groups; and have undertaken the first London-wide analyses of some routinely available data to establish the current and future health profile of this section of the population. We have tried to focus our conclusions and recommendations on issues which are common and specific to London, and to draw out particularly those which could best be addressed by pan-London action. We have also sought to reflect the views of older people and carers about their health and what affects it. The Task Group is listed at Appendix A.

Some definitions: Ethnicity and elders

The concept of ethnicity operates within a complex and sometimes emotive area. Its definition has varied over time and place, and some of the report which follows demonstrates this complexity. Dimensions, which have real meaning to people in differing circumstances, include:

- Nationality
- Birthplace
- Skin colour
- 'Race'
- Language
- Religion
- Culture.

As much of this report is about quantitative data, we have been obliged to use those categorisations of ethnic group which are available and attached to these data. One important example is the nine or ten main "Ethnic Groups", a mixture of nationality, country or area of origin and colour, used to summarise the 1991 census respondents' self-definition, and since then increasingly applied to a range of public sector information, including some in the National Health Service. (Box 1.1)

Box 1.1: Ethnic groups from the 1991 Census

White	Indian	Chinese
Black Caribbean	Pakistani	Other Asian
Black African	Bangladeshi	Other
Black Other		

An alternative is the older census categorisation by country of birth, of either the individual, or of the head of their household. This provided only a partial proxy for ethnic group even when most minority groups were relatively new migrants, and has become increasingly invalid as they move into second, third and later generations, as mixed marriages increase, and as national boundaries and groupings change. Despite these drawbacks, this classification is inevitably used in much published research, and is still the only relevant variable included in the recording of births (which include parents' birthplaces) and deaths.

The limitations of both of these groupings are fully recognised: an examination of both categories, and especially of the relationship between the two, gives a broad picture of London's very diverse population yet still fails to identify some significant ethnic groups. It is also clear that for some aspects of health and of service access, genetics, culture, religion, and language are more significant.

It is worth noting that for the 2001 Census, ethnic group categories will include Irish and several "mixed" ethnic groups, and more scope for self-defined answers; there may be a separate question on religion; country of birth will remain a separate question.

Elders, or older people, as a relative term, can also be defined in various ways. Health service approaches often focus on those aged over 65, differentiating where possible and relevant between those aged 65+, 75+ and 85+ to reflect their differing levels of health need. However the perception and experience of ageing itself varies between ethnic groups, and the proportions of very old minority ethnic elders have hitherto been small: for both these reasons, some studies and analyses include younger age groups in their definition of "elders", or are based mainly on younger age groups. Pensionable age (currently 60 for women, 65 for men) is also significant as a criterion for accessing many non-NHS services, and the report takes account of evidence about

the numbers of people in different ethnic groups who are approaching old age and will be the elders of the future.

Contents

Separate chapters in this report set out:

- The policy background, identifying key initiatives and developments which link health, ethnic minorities, older people, health and related service provision, and change in Greater London.
- Population estimates and projections, and the social and economic characteristics of ethnic minority elders in London – using census data; population projections for ethnic groups by London borough produced by the London Research Centre; special analyses from the Ethnicity Multi-Year Data from the General Household Survey (EMYD).
- Health: relating what is known about health behaviours, about general health and ill-health, and about specific conditions which are important for older people and, in some cases, differentially so for some ethnic minorities. Special analyses of mortality by country of birth contribute to this chapter, as well as the EMYD.
- Some detailed analyses of hospital admissions data by ethnic group; and models of the potential impact of the ethnic balance of London's older population, and projected change in that balance, on particular conditions.
- The wider range of services: linking the available evidence and information about health and related service provision and utilisation.
- Conclusions: drawing together the implications of the evidence already presented, in the light of the current and future environment in London; identifying key issues for older people from the main minority groups; offering recommendations to improve health and health care for this growing part of our population.

CHAPTER 2

POLICY BACKGROUND

Summary

- Current emphases on reducing inequalities in health, and improving health to meet *Our Healthier Nation* targets, have important implications for older people, and for people from ethnic minority groups.
- A broad based approach to improving health by addressing its determinants, will have differential impacts on minority ethnic elders.
- Proposals for older people include changes to pensions, which will leave some minority ethnic elders among the most disadvantaged. Fuel poverty measures, recognition of carers and the involvement of older people in government are positive developments.
- Amendments to the Race Relations Act, following the MacPherson Inquiry, mean ethnic minority issues are a priority for all public services: all minority groups including asylum seekers, refugees and their older relatives are entitled to health and health care, and this should mean access on an equitable basis.
- The modernisation processes, developments in care standards and longer term planning underway by partnerships across London in health and related services must take account of the specific needs of older people from black and minority ethnic groups.
- Ethnic minority groups' evidence to the Royal Commission on long-term care stressed the inequitability of continued dependence on minority community groups for service provision.
- Changes now proposed to the funding of long term care will still leave geographic variations across London in criteria and charges for this and other elements of care.
- Creation of a Greater London Authority, with requirements on equality and on health in its constitution, and the shift of health, social care and other agencies to a matching London boundary, give the opportunity to progress health of ethnic minority elders as a London issue.

Introduction

This chapter outlines current policy developments affecting older people and black and minority ethnic groups, and draws out the implications for the health and health care of older people from minority ethnic groups in London. In doing so, it highlights issues which either raise particular concerns for these communities, or alternatively offer opportunities for action to improve their health. It is important to note that the developments described here are those which seem important at the time of writing: and are not a comprehensive or an unchanging list. In particular, the NHS Plan (Dept of Health 2000a) is newly issued, and only its immediately relevant implications are identified at this stage.

Recently there has been a wide range of policy initiatives, affecting both local and central government activity and structures as well as the NHS, which impact upon different aspects of the lives of black and minority ethnic older people. The first part of this chapter examines initiatives aimed at directly or indirectly improving the health of the population, and of particular groups within the population. The second section reviews reforms in the area of pensions, and other initiatives aimed specifically at older people and their carers. The third discusses developments on racism and the institutional responses to minority ethnic groups, whilst the fourth outlines structural changes to health and social services, the relationship between them, and the organisation of care for older people. The final section discusses the implications of the devolution of some central government responsibilities to regional government, and specifically the Greater London Assembly and Mayor for London.

1. Improving health – reducing inequalities in health

Current health policy is characterised by recognition of inequalities in health, of the multiple causes of those inequalities, and the need for multi-sectoral action to improve health.

The Acheson Inquiry into Inequalities in Health

The Independent Inquiry into Inequalities in Health, chaired by the former Chief Medical Officer Sir Donald Acheson, was commissioned by government to review the information, identify evidence-based priorities for action, and report for publication as a contribution to the development of a new strategy for health (Acheson, 1998). Its recommendations have relevance for a wide range of agencies. Three recommendations were identified as being of highest priority:

1. As part of health impact assessment, **all policies** likely to have an impact on health should be evaluated in terms of their impact on health inequalities, and formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities.
2. Policies aimed at improving health and reducing health inequalities in women of childbearing age, expectant mothers and young children should be given a high priority.
3. Policies which will further reduce income inequalities, and improve the living standards of households in receipt of social security benefits, should be given a high priority.

The second of these priorities can improve the health of ethnic minority elders only in future generations. However, the first and third would impact upon the health of today's elders by establishing better monitoring and evaluation, and improving the levels of benefits and pensions, as well as their take-up.

Some of the more specific recommendations related to older people: improving their housing; maintaining mobility, independence and social contacts; developing their health and social services in order to be more accessible and distributed according to need. Regarding ethnicity, the Inquiry recommended its specific consideration in policy development and implementation; development of services which are sensitive to needs, and which promote greater awareness of health risks; and specific consideration in needs assessment, resource allocation, health care planning and provision.

Acheson's remit excluded costing, which kept it a step away from implementation and his recommendations may be seen as a backdrop, rather than integral to government policy. The government's initial response, published alongside *Our Healthier Nation* (see next para), was to point to initiatives planned and underway which would address many of Acheson's detailed

recommendations and some of these are included in the following paragraphs. Importantly, they include some potentially positive elements for ethnic minority elders. The NHS Plan in addition proposes the first national targets for reducing health inequalities; national monitoring through the Performance Assessment Framework; and to bring primary healthcare provision into the NHS' needs-based resource allocation system.

Saving Lives - Our Healthier Nation

The White Paper Our Healthier Nation (Department of Health, 1999a) set out national targets for improvements in health to be achieved by the year 2010, and also introduces some mechanisms to improve people's health and their access to health services.

The targets are directed mainly at major killer conditions, and comprise: reductions in deaths of under 75's from cancer and cardiovascular disease, reductions in both incidence and deaths from accidents, and reductions in suicide. While higher than the age-band originally proposed, the "under 75" criterion for the first two of these is disappointing from the perspective of older people and could be regarded as ageist. The focus on the most easily measured outcome, i.e. death rates rather than disability, is also unhelpful for the many older people living with the latter. The White Paper referred to improving the health of black and minority ethnic groups, without identifying any specific actions.

The White Paper also reiterated the roles of contributors to health - the individual, the health services, and wider partnerships with other agencies and the community; establishes the Health Development Agency; and made some changes in practice and funding for the Public Health function, including establishment of a Public Health Observatory in every NHS Region.

Chapter 4 of this report examines some of the health targets in relation to London's ethnic minority elders. Going back to Acheson's recommendations discussed above, a London Health Observatory would need to consider these groups very specifically as part of its health monitoring function.

Health Action Zones

Health Action Zones (HAZs) have been established in 4 areas in London:

- Lambeth, Southwark and Lewisham
- Brent
- Camden & Islington
- East London (Hackney, Newham and Tower Hamlets) & The City.

Zones are multi-agency partnerships intended to improve health in areas of particular need. Of London's HAZs, Camden and Islington's includes a focus on older people, while all include

specific work relating to ethnic minorities. For the future, the NHS Plan suggests integration with other 'action zones' into Local Strategic Partnerships to tackle inequalities.

National policies aimed at improving public health

A number of national policies and programmes may impact on the health of the general population and, in some cases, differentially on ethnic minority elders. These include:

- the new Food Standards Agency
- moves towards a ban on tobacco advertising and sponsorship
- the review of Air Quality Strategy
- the requirement for all Local Authorities to produce a Community Safety Plan, involving police, probation and health services
- moves towards an integrated transport policy, which aims to create a healthier environment while promoting greater use of public transport, cycling and walking.

Some regeneration initiatives are also likely to target communities which include ethnic minority elders, and to directly or indirectly improve health. They include:

- Single Regeneration Budget, which in most recent years includes health-led projects
- Neighbourhood Renewal programmes - the issues for minority ethnic groups in these areas, including health and primary healthcare funding, have been specifically recognised (Cabinet Office, 2000).

2. Older people and carers

Current policies for older people and carers include promotion of independence and self-reliance – both physical and financial; more involvement in policy-making; moves towards more uniform standards in care settings; more recognition and support for informal carers.

Pensions and welfare reform

In 1998, the government outlined proposals for reform of the British pension system in the Green Paper *A New Contract for Welfare: Partnership in Pensions* (Department of Social Security, 1998a). A central plank of these reforms was the introduction of new 'stakeholder pensions' for all those who earn above £9,000 a year. For those earning less than £9,000 the government proposed to introduce a 'second state pension' to provide a top-up to the current basic state pension, whose value is projected to fall from 14% of average male earnings in 1997 to just 9% in 2020 (Falkingham, 1998). In reality, even those who receive a second state pension plus basic pension will be just £1 above the income support level when the new proposals reach maturity (Rake *et al*, 1999). Thus, in effect all of those who do not contribute to a new stakeholder pension will be living on a low income in later life.

Looking at the relative income position of 40-59 year olds it is clear that members of some minority ethnic communities are disproportionately disadvantaged in income terms. The average (median) usual gross weekly income of Pakistani/Bangladeshis aged 40-59 was just £116 a week in 1994/95 (Chapter 3, Table 3.12c). Even after allowing for inflation to current prices, this falls well below £9,000 per annum. Thus it is likely that, even after the current reforms, a significant proportion of individuals from minority ethnic groups will not be able to accumulate sufficient pension entitlement to ensure an adequate income in old age.

Fuel poverty

Fuel poverty, that is households' inability to heat their home adequately, is widespread. The government's own figures estimate that 77% of single pensioners and 43% of older couples in winter 1998 were fuel poor (Hansard, 1999a). In response to this, the government has established an annual £150 winter payment to pensioner households in respect of fuel costs, and extended the Home Energy Efficiency Scheme (HEES) which provides grants to improve the energy efficiency of homes, including the installation of central heating and insulation. These improvements can have a direct effect upon the health and well being of older people.

Better Government for Older People

The aim of this initiative is to improve public services for older people by better meeting their needs, listening to their views, encouraging and recognising their contribution, through partnerships led by local authorities, but involving central government, voluntary, private and community sectors and older people themselves. National pilots include five in London boroughs: Hackney, Hammersmith & Fulham, Harrow, Kensington & Chelsea, and Lambeth, while Camden and Haringey are running related initiatives. Hackney and Kensington & Chelsea both report specific reference to black and minority ethnic groups or services. There are some uncertainties about the way these will relate to other decision-making processes, especially while local government itself is undergoing organisational change.

National Carers' Strategy

Caring about Carers: A National Strategy for Carers (Department of Health, 1999) proposed three strategic elements to improve carers' lot:

- **Information**: including a new charter (see above); improved consistency of charging; health information; a carers' help-line within NHS Direct; internet provision of government information.

- **Support**: involvement in service planning and provision; consultation of carers' organisations; various ways of involving carers.
- **Care**: carers' rights to have their own needs met; new powers for local authorities to provide services for carers; first focus of these on helping carers take a break; a new special grant, with funding for three years, to enable this; continuing review of financial support for carers.

The 2000 Carers and Disabled Children Bill covers these rights and powers, including options of direct payments to carers, and charges for services which they receive.

Other specific measures include: entitlement of carers to a second pension; council tax reductions for more people being cared for; carers centres; a new census question to address the information deficit; particular support for young carers.

Both cared for and carers include a high proportion of older people, and the vast majority of care for older people is provided by informal carers rather than by formal services. While carers' interests are separate and at times divergent from those for whom they care, the gradual move towards recognition of their work can only benefit the overall support network for older people.

3. Black and minority ethnic groups and human rights

UK legislation on ethnic minorities in the last century was characterised by a tension between changes, broadly restrictive, on immigration (which have partly shaped the demography of minority populations) and the introduction of race relations and other provision to limit the expression of racism and promote equal opportunities for people within the country. Some of the most recent strands, including the NHS reponse, are described below.

The MacPherson Inquiry and institutional racism

The Inquiry which followed the murder in South London of Stephen Lawrence found evidence of institutional racism, defined as "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin". It made recommendations about the provision of training in racism awareness and valuing cultural diversity (MacPherson, 1999). These findings have been acknowledged as relevant to all sectors of public service. It is particularly important that services for vulnerable older people, which include an increasing proportion of minority ethnic groups, should take this to account. The Department of Health's Race Equality agenda (see below) can be seen as an initial response from the NHS to the MacPherson report.

Race Relations (Amendment) Bill 2000

Following the MacPherson Inquiry, the Race Relations Act is being extended to the police and other public bodies in respect of both direct *and* indirect discrimination, and will introduce a positive duty to all public bodies to promote race equality. This has very substantial implications for these bodies, including Local and Health Authorities, and NHS Trusts, both as employers and as service providers.

Race equality agenda of the Department of Health

In response to the MacPherson Inquiry, an independent study of Black, Asian and ethnic minority issues was commissioned by the Department of Health (Alexander, 2000). Its conclusions focus on five major areas:

- Service Delivery – in research and development, needs assessment, appropriate targetting, improving standards and outcomes.
- Workforce - in professional and other staff in health and social services.
- Policy development – recognising diversity, involving ethnic minorities and information about them, and recognising race equality issues in the policies of all departments and agencies which impact on health.
- Research and development – calling for a more equitable balance.
- Information – reflecting on current problems in health data, looking to Electronic Patient Records as a future solution; noting coming developments in social services data collection; proposing locally adjusted targets for provision and employment.
- Boards and Committees – proposing extension, within the Department of Health's sphere of influence, of the improvements over recent years in the numbers of ethnic minority appointees.

In response to the report, the Department of Health stated "we will not achieve substantial change if we simply tackle 'race' issues as a separate theme or initiative. Instead, we are working to mainstream these issues in everything we do as part of our programme of modernisation and specific priorities for action" (Department of Health, 2000b).

Initiatives since then include the *Vital Connection* equalities framework document (NHSE, 2000a). This sets out three strategic aims for the NHS which link employment, service delivery and the community:

- To recruit, develop and retain a workforce that is able to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of different groups and individuals;
- To ensure that the NHS is a fair employer, achieving equality of opportunity and outcomes in the workplace;

- To ensure the NHS uses its influence and resources as an employer to make a difference to the life opportunities and the health of its local community, especially those who are shut out or disadvantaged.

Inequalities in access to services for black and minority ethnic communities are explicitly recognised in the NHS Plan as an issue for national performance assessment.

Immigration & Asylum Act 1999

The recent Immigration and Asylum Act aims to minimise invalid asylum claims, and to disperse asylum seekers on first arrival to "cluster" areas largely outside London and the South East. The health characteristics of London's asylum seekers and refugees, and health service issues arising from their experience and status here, have been separately explored (Aldous *et al*, 1999) and there are clear overlaps with those of black and minority ethnic elders. A proportion of those who have grown old in London, or their families, came initially as refugees, and their particular experience has affected their lives and thus their health in old age. Few current asylum seekers on arrival are over 60 (2% in 1997), although some dependent over 60's are allowed, on varying terms, to join their children who have been granted either full refugee status or Exceptional Leave to Remain in the UK. It remains to be seen whether the Act's initial dispersal arrangements, which will only be enforced while applicants' claims are processed, will result in any significant shift of minority communities in the longer term (Audit Commission, 2000a). All asylum seekers and refugees, and older relatives brought to live with them on family reunion terms, are entitled to the full range of NHS services. In addition, asylum seekers can only be excluded from discretionary social services provided under the Health Services and Public Health Act 1968 and the National Health Service Act 1977 if their need arose solely from destitution. Older asylum seekers with needs arising from ill health or disabilities would thus still be eligible to access such services.

Human rights legislation

The integration into UK law of European human rights legislation takes effect from October 2000. Its application is potentially very wide; it means that the rights incorporated in that legislation can be pursued directly through the British courts.

4. Health and Local Authority services

Health, social and housing services are all changing as part of the government's modernisation agenda. This includes elements of centralisation in terms of standards and monitoring, but also increased integration and partnership working at a local level - especially relating to care services for older people, which are also included in this section.

The New NHS and The NHS Plan

The White Paper *The New NHS – Modern, dependable* (Department of Health, 1997) introduced a number of significant developments on quality issues within the NHS, including the Commission for Health Improvement, National Institute for Clinical Excellence, clinical governance. It also introduced the concept of the Health Improvement Programme (HImP) as the key planning vehicle for Health Authorities and their partners in the NHS, local government and other sectors, and outlined a series of structural changes which are now in the process of implementation.

The NHS Plan includes proposals to accelerate modernisation of the NHS, using additional funding allocated for a four year period and addressing five key areas:

- **Prevention** – tackling health inequalities and causes of avoidable ill health;
- **Partnership** – making the health and social care system work better together, and ensuring the right emphasis at each level of care;
- **Patient care** – including both access (to be fast and convenient) and empowerment and information for patients (so they can be more involved in their own care);
- **Performance** – improving clinical performance and health service productivity;
- **Professions and the wider NHS workforce** – increasing flexibility in training and working practices and removing demarcations, in the context of major expansion of the healthcare workforce.

The agenda is very broad, and full implications of its implementation will emerge over time.

One of the most significant issues for older people is the shift towards more integration between health and social services, especially through the introduction of Primary Care Groups (PCGs). This offers opportunities for greater sensitivities to local needs, which may help elderly people whose needs are best met by integrated local services, but also some challenges in the maintenance of support to minority communities, some of which are scattered or otherwise too small to be a local priority for smaller geographic areas. London's initial 66 PCGs inevitably reflected GP alliances rather than other administrative boundaries, with some relating to more than one local authority.

The transition to Primary Care Trusts (PCTs), incorporating community health service provision, started in April 2000 with, in London, Hillingdon (a merger of three PCGs) and Nelson (from a single PCG covering parts of Sutton and Merton). The NHS Plan proposes the further development of Care Trusts, able to commission all health and social care for older people and other client groups; and also combined mental health and social care Trusts.

Direct access to the NHS

Alternatives to conventional immediate access routes (via GPs or Accident & Emergency) are being promoted within NHS modernisation. One specific service development is the NHS Direct telephone access service to health advice. Engagement with local black and minority ethnic communities, interpreter availability and ethnic/language monitoring are being built in. The service could have significant benefits to older, less mobile people: however, telephone access is not yet universal or effective for this age group. Walk-in primary care services are also being promoted, particularly for hard to reach groups.

The key to success of these approaches may lie in their integration with other parts of the health and social care system. The NHS Plan proposes taking them further, in particular:

- NHS Direct nurses will make routine checks on frail that older people.
- NHS Direct will be used to access a free and nationally available interpreting and translating service
- Care Direct will be set up – a new service, particularly for older people, comprising telephone, drop-in, on-line and outreach access to social, benefits and other services as well as NHS.

National Service Frameworks

National Service Frameworks (NSFs) are another aspect of quality improvement in the Health Service. There is a rolling programme of publication:

a. Older people

The NSF for older people will refer to issues regarding accessibility for all over 65's who can benefit. The NHS Plan indicates that the NSF will cover:

- physical health, including strokes and falls, and the major mental health issues
- ageism in the NHS, with special action on resuscitation policies
- all agencies recognising needs with regard to respect; holistic treatment; palliative care; good clinical practice.

b. Mental health services

This relates explicitly to people "of working age". Dementia and depression in the over 65's are to be addressed in the NSF for older people. The mental health NSF does refer to the specific health promotion needs of refugees, and the need to take into account the experience and views of users and carers "including those from black and minority ethnic communities".

c. Coronary heart disease

Published early 2000, this addresses in very general terms the issue of ensuring accessibility to all who can benefit.

d. Diabetes
This is due 2001 and is expected to refer to specific ethnic minority needs.

Royal Commission on Long-Term Care

The purchasing and provision of long-term care has for many years been a setting for inequity, inefficiency and cost-shifting between health, social care, social security, private and voluntary providers, informal carers and the users themselves. The Royal Commission, reporting in March 1999, made a recommendations on long-term care and its funding. The Commission considered care for younger people with disabilities as well as older people, but the latter were its primary focus. The main recommendations were that:

- The costs of long-term care should be split between living costs, housing costs and personal care. Personal care should be available after assessment, according to need and paid for from personal taxation. The rest should be subject to a system of co-payments between the State and users, according to the users' means.
- The Government should establish a National Care Commission to monitor trends, including demography and spending, ensure transparency and accountability in the system, represent the interests of consumers, and set national benchmarks, now and in the future. Some elements of this have been taken forward in the Care Standards Bill – see below.

More specific recommendations included that:

- It should be a priority for government to improve cultural awareness in services offered to black and minority ethnic elders.

Evidence presented to the Royal Commission (Patel, 1999) on black and minority ethnic elderly perspectives was based partly on seminars held in Edinburgh, Leeds and London. It stressed a number of key issues:

- Concerns about the continuing and inequitable dependence on inadequately supported minority community groups, rather than mainstream services, as primary providers.
- Heterogeneity of needs within minorities, as within majority groups.
- The principle that "those who have means must pay; those who have no means must be provided for without hesitation or humiliation".

The 'Coughlan' Appeal Court judgement in July 1999 confirmed some Health Authority and some Local Authority funding responsibilities, and all authorities were required as a result to review the criteria they use to decide on eligibility for such funding. However, differences between Authorities' criteria remain.

Following an initial response in December 1999 (Hansard, 1999 b), the government has confirmed with the NHS Plan that, while nursing care costs will be met for *all* older people in both nursing and residential care settings and in their own homes, their personal care costs will be subject to means-tested charges (Department of Health, 2000 c).

Care Standards Bill

Proposals to establish an independent National Care Standards Commission are included in the 1999 Care Standards Bill. It is proposed that the Commission will regulate and inspect a range of care providers including both nursing and residential care homes provided by voluntary, private and statutory sectors, as well as independent sector hospitals and clinics, and domiciliary care agencies. There will be required national standards, rather than a local system as currently exists. The Bill also establishes a General Social Care Council for England to regulate social care workers, and sets up a Protection of Vulnerable Adults list to ensure unsuitable people are prevented from working with vulnerable adults. Following the report *Charging with Care*, which demonstrated wide variations in charges for non-residential care (Audit Commission, 2000 b), an amendment was announced which would allow central government to issue statutory guidance to local authorities on these charges. The Bill should result in improvements in the quality of community services for all older people.

Protecting Vulnerable Adults

Local Authority social services departments are required to lead the development by 2001 of local multi-agency codes of practice for the protection of vulnerable adults, including frail older people, from abuse. Abuse in this context includes discriminatory abuse, as well as physical, sexual, financial or material abuse, or abuse from neglect and acts of omission. (Department of Health/Home Office 2000).

Better care, higher standards: A charter for long-term care

The Charter for England, published 1999, sets out a framework of expectations for local standards from housing, health *and* social services for adults needing care because of old age, long-term illness or disability, and their carers. It also includes information on social security benefits. The national charter refers to availability of key information, and more specifically care plans, in appropriate languages and is itself available in eight minority languages, as well as tape and braille. Local authorities were expected to produce their own Charters by June 2000 (Department of Health/Department for the Environment, Transport and the Regions 1999).

National Beds Inquiry and Intermediate Care

This inquiry looked at the long-term future of acute hospital beds and related services (Department of Health, 2000b). Unsurprisingly it found that two-thirds of beds are occupied by people aged 65 and over. Whilst the Inquiry also considered services for children and for people

with mental health problems, the main focus was on provision for older people. This was in the context of an expected national increase in the number of persons aged 85 and over of between 22% and 50%. Taking account of historic trends and expected future demographic change, the report set out three possible future scenarios for the period to 2020. These options were:

a) Maintain current direction of change;
b) Acute bed focussed scenario;
c) Care closer to home scenario. This assumed,in comparison with a)

- Slower rise in emergency admission rate
- Decline of 20% in acute hospital length of stay
- Expansion of community and social care, often **intermediate** care to reduce emergency admissions and facilitate earlier discharge - intermediate care places rise more than acute beds loss, to reflect emphasis on promoting independence
- Further increases in primary care.

The NHS Plan supports the last and more radical of these scenarios. Intermediate care is already being promoted in the context of immediate 'winter pressures' as well as for the longer term. Suggested service components are: rapid response teams; intensive rehabilitation (normally in hospital), short term care in nursing home or similar accommodation; one-stop primary care/social care services and integrated home care teams, together with more community equipment and technical support, and more respite for carers.

As Chapter 6 demonstrates, the current balance of services in London is atypical, and there may well be questions for London about the ability to locate and staff in this more dispersed pattern of care within the capital. Any further shift from health to social care provision is likely to raise some of the funding and charging anomalies already experienced in the context of long-term care. The NHS Plan also confirms the intention to use private and voluntary sector nursing home places, funded by the NHS, for short-stay rehabilitation. Appropriateness and acceptability of provision for minority ethnic elders, wherever based, must be ensured.

Older People in The NHS Plan – other issues

As well as issues mentioned elsewhere, the NHS Plan includes

- Explicit recognition of the difficulties of older people from black and minority ethnic communities in accessing appropriate services
- An NHS retirement health check
- Raising from 65 to 70 the top age limit for breast cancer screening
- Single assessment processes for health and social care, initially for vulnerable older people
- Personal care plans for these older people and, if appropriate, their carers
- Clinical leadership, with potential for nurse consultants and specialist nurses for older people
- A National Director for Services for Older people.

Patient and public involvement in the NHS

In supporting the continued development of partnership between service and users at both the individual and the organisational level, government guidance (Department of Health, 1999c) identifies both the risks of poorly considered ways of involving black and minority ethnic groups, and the opportunity afforded by some of these communities' long tradition of voluntary and self-help work.

The NHS Plan proposes new Patient Advocacy and Liaison Services in health and the new joint care trusts; local residents' advisory fora for each HA area; patient and citizenship representation on a range of other bodies; older people to be represented on all visiting teams of the Commission for Heath Improvement; and roles for local authorities in public scrutiny of the NHS and consultation on service change. These will replace the current roles of Community Health Councils.

Modernising social services: Promoting independence, improving protection and raising standards

This White Paper (Department of Health, 1998) set out government proposals to modernise social services in line with their proposals for the NHS and for improving public health and reducing health inequalities. It focussed on 6 key areas of change: improving standards; ensuring fair access; improving consistency; promoting independence; reforming regulation; providing better training.

Key innovations included:

- Setting new national standards of performance and publishing annual reports on all local authorities' performance.
- Strengthening of the role of the Social Services Inspectorate and their joint Reviews with the Audit Commission, with tough new powers for the Secretary of State to step in when standards are not met.
- Raising professional standards through the establishment of the General Social Care Council (GSCC), to set conduct and practice standards and register workers 'in the most sensitive areas'. It will regulate training and develop a national training strategy for all social care staff.
- The Fair Access to Care Initiative laying down consistent rules on who is eligible for care services. This was to overcome inconsistencies across the country.
- To ensure a greater level of consistency and fairness, and to promote greater independence, the National Service Framework for older people to be developed in partnership with the NHS (see above).
- In addition, the White Paper extended the system of direct payments, already an option to allow disabled people greater control over their lives by giving them the money and letting them make their own decisions about how their care is delivered, to people over 65. This was implemented in early 2000.

Modernising Local Government: Best Value

Significant changes for all local government departments include the options, now being pursued by a number of London Boroughs, for different structures, including cabinet-style government by selected councillors to replace traditional committees. "Best Value" approaches are replacing Compulsory Competitive Tendering for council services - these require a rolling programme of service reviews, incorporating local consultation, from 2000.

Partnership in Action

This document (Department of Health, 1999d) incorporated several ways to improve joint working between health, social services and other parts of local government, in the context of The New NHS and local HImPs:

- Removing legislative barriers, to enable: Pooled budgets; lead commissioners; integrated provision.
- Incentives: Extending powers of Health Authorities to transfer money to Local Authorities under section 28a of the 1977 NHS Act; enabling delegation of these powers to Primary Care Trusts; power for Local Authorities to transfer funds to NHS bodies; joint finance monies to be incorporated in budgets, with indicative targets for transfer.
- Monitoring and review through: Joint national priorities guidance; new performance frameworks; exploring joint health/social services review of services at the interface; considering joint inspection also by central bodies.

The 1999 Health Act effected many of these provisions, and the funding flexibilities outlined became available for use from April 2000. Once Health Improvement Programmes (HImPs) became operational, Joint Consultative Committees (JCCs) could cease to exist. This last provision stresses the importance to voluntary organisations – recognised hitherto with statutory representation on JCCs – of HImP development as the key opportunity for their involvement in local health strategies and plans. Joint Investment Programmes (JIPs) are the vehicle for future joint planning for particular care groups. JIPs for older people were required for 1999-00, and updated for 2000-01.

The NHS Plan takes partnership arrangements further , with the establishment of joint social and health care trusts. In addition, partnership will be developed through a 'concordat' with private and voluntary sector providers for intermediate and acute care. This will include involvement in planning; admission and discharge protocols; workforce and activity information exchange.

Supporting People

At present, people in supported housing may have their support costs funded by either part of their housing benefit, by a management grant paid through the Housing Corporation to individual Registered Social Landlords, or by the probation service. Supporting People (Department of

Social Security, 1999b) will bring together these different funding streams from April 2003, to be managed by social services in local authorities on the basis of local and individual needs. The intention is to improve the range and quality of support services including: 'floating support', where appropriate; integration of housing support with wider local strategies; integration of monitoring and inspection; introduction of effective decision making and administration. Older people in sheltered housing are major users of these support services, and specialist support for refugees and asylum seekers will also be affected. Joint commissioning arrangements may be the way to ensure that the particular support needs of ethnic minority elders are taken into account.

5. London and the Greater London Authority (GLA)

The establishment of a directly elected mayor and assembly for Greater London has the potential to impact upon health and on minority group issues. The new Authority will have direct responsibility for a range of functions and strategies, all of which impact upon people's health:

- Transport
- economic development and regeneration
- environment – biodiversity, air quality, waste management, ambient noise
- planning
- police, fire and emergency planning
- culture, media and sport.

The GLA is expected also to have indirect political influence on other areas which are not its direct responsibility, for example education, housing, and health services. The Assembly's scrutiny powers will enable it to call all of these services to account.

The GLA is required to exercise its powers "in a way which it considers best calculated…. to promote the health of persons in London", and is also required, in exercising its own functions, to "promote equality of opportunity for all persons irrespective of their race, sex, disability, age, sexual orientation or religion".

The shift to a Greater London boundary for a new tier of government has been accompanied by similar shifts in some other statutory organisations, not least the NHS. The NHS Executive's London Regional Office is developing its strategy for care of older people during 2000-01, and has already supported a multi-sectoral health strategy, which includes a reduction in health inequalities and improvements in black and minority ethnic health as main priorities, together with transport and regeneration (NHSE, 2000b). The coalition of agencies engaged in this strategy has been adopted by the Mayor as a starting point for his own London Health Commission. The NHS Plan similarly proposes joint public health directorates, accountable to the NHS and regional government, to support regeneration and tackle inequalities

London-wide structures can also be seen as an opportunity to recognise and support the needs of minority groups which are characteristic of London, but which sometimes are too small in any one individual borough, health authority or Primary Care Group area to establish a presence.

In the wider context of devolution, the GLA could be the first step towards regional government in England. It follows the establishment of Assemblies for Scotland and Wales, which some black and minority ethnic commentators have seen as undermining the "British" identity of which many 20th century immigrants and their families expected to be a part. The challenge for London is to ensure that its black and minority ethnic elders can fully identify with their home city.

CHAPTER 3

POPULATION CHARACTERISTICS AND PROJECTED CHANGE

Summary

- London has proportionately fewer older people than the UK average. There are around 882,000 people aged over 65 in London - 11% of the total population. Population projections for the next ten years suggest this number will decline by over 40,000. The reduction is least for the older age groups (age 85+).
- At the 1991 Census minority ethnic groups made up less than 5% of the population of London aged 65+. Projections for the future suggest that by 2011 this will have increased to over 16% of the total.
- The absolute numbers of people aged 65+ in minority ethnic groups are projected to reach almost 140,000 by 2011, triple those at the time of the 1991 census; the oldest age groups are expected to increase most.
- Largest changes are 29,000 more over-65's in the Black Caribbean group, and 25,000 in the Indian group.
- The 'white' majority ethnic group includes some large and distinct minority communities.
- Country of Birth also helps to indicate some important minorities in London, but others remain hidden within the broad categories of census and related data.
- Ethnic minority groups are differentially distributed across London, as are the effects of population change.
- The majority of older people from minority ethnic groups were born outside the UK; however over 90% have lived in the UK for over ten years.
- Historical data suggest that elders from South Asian ethnic groups tend to live in larger households and more multi-generational households than White or Black Caribbean elders.
- South Asian and black older age groups include higher proportions of men than the white and other groups.
- More Black Caribbean and African older men live alone than is the case in men from other minority ethnic groups.
- A number of indicators point to the tendency to lower incomes amongst minority ethnic groups. For example:
  - elders from Black Caribbean and Pakistani/Bangladeshi ethnic groups are significantly more likely to be from semi-skilled and unskilled manual occupational backgrounds;
  - at ages 40-60, men from minority ethnic groups are more likely to be unemployed;
  - minority ethnic groups are proportionately over-represented in the lowest fifth of the income distribution – although Indian elders are also over-represented in the top quintile.
- Older people from Bangladeshi and Black Caribbean groups are less likely to be owner occupiers and more likely to be living in social housing than white or Indian groups. Levels of overcrowding are especially high for older people from South Asian ethnic groups.
- Older people from minority ethnic groups have a wide experience of xenophobia and racism.
- A vast number of different languages and dialects are spoken in London households.
- The proportion of the older population without formal educational qualifications is higher in some minority ethnic groups; and people from minority ethnic groups tend to have worse employment experience than others with similar qualifications.

Introduction

This chapter aims to quantify and describe the older minority ethnic population living in London;

and to summarise what is happening, and expected to happen, to the numbers of that population. While there is a very general awareness that many ethnic minority communities are ageing, and that they are likely to form an increasing proportion of the older age groups, the key questions to be explored are:

- Who are London's ethnic minority elders?
- When, where and in what groups is the increase in older people becoming apparent?
- How big will it be?
- What are the specific characteristics of the minority populations, and particularly older people in those groups that are significant for health?

The focus is on the most recent available information relating to the period 2000 – 2011: but reference is made where appropriate to earlier and later time periods. Some of the key sources of information are listed in Box 3.1.

Box 3.1: Sources of information on ethnic minority populations in London

- 1991 Census – Local Base Statistics – and analyses based on it. The 1991 Census was the first to include a question on ethnic group, as well as that on country of birth which was previously used as a proxy for ethnicity of individuals and households.
- London Research Centre Ethnic Group Projections to 2011: 1998 Round Projections have been produced by the London Research Centre (LRC, now the GLA's Research and Information Directorate) for populations by age and gender for each London Local Authority area; and in a linked series since 1995, by ethnic group. Many of the analyses in this and subsequent chapters are based on these projections (see Appendix B for methodological assumptions).
- Office for National Statistics population projections to 2021: The Office for National Statistics (ONS) has also produced population projections by Health and Local Authority to 2021. Unlike the LRC projections, these do not take into account constraints of local circumstances, in particular the housing supply; and there are no projections by ethnic group. They are however significant to Health and Local Authorities because of their application in resource allocation.
- General Household Survey: Pooled data over several years (between 1984-94) allows for sufficient sample size for analysis by ethnic group categories similar to those used in the 1991 Census (see Appendix C).

THE OLDER POPULATION OF LONDON

LRC projections suggest that by 2001 there will be around 882,000 residents of London aged 65 or over. These will make up around 12% of the total population. The proportion of people aged 65 and over is less in London than in England & Wales overall. This reflects historic patterns of migration of young people into London, while older people tend to move out of the capital on retirement.

Table 3.1 shows the overall results for two different population projections, one by the LRC, the other by ONS. Both sets of population projections suggest there will be a reduction in the

numbers of over 65's in London between 1991 and 2011 - but the decrease predicted by ONS is smaller than that projected by LRC. The ONS model also suggests that the decline in numbers aged 65+ will not continue through the second decade in Outer London, or in the 65-74 age group. Although projections to 2021 are inevitably less reliable, it is also important to note that ONS projects an increase by then of over 65's, particularly in the 65-74 age group and particularly in Outer London, to a level 5 % above that of 1991.

Table 3.1: Population projections (thousands) for older age groups: ONS* compared with LRC**

			2001		2011		2021
		1991***	ONS	LRC	ONS	LRC	ONS
Greater London							
	65-74	518.7	462.6	456.4	487.3	451.3	592.9
	75-84	349.7	423.7	304.6	394.4	271.4	430.4
	85+	101.3		121.0		115.8	
Greater London	**65+**	**969.7**	**886.3**	**882.1**	**881.7**	**838.6**	**1023.3**
Inner London	**65+**	336.3	291.5	298.8	275.3	278.7	314.6
Outer London	**65+**	633.4	594.6	583.3	606.5	559.8	708.7

*Sources: * Office for National Statistics - Subnational population percentage 1996 - based Series PP3 No. 10*
*** London Research Centre 1998 Round Ethnic Group Projections P1/M96*
**** 1991 Census (OPCS 1993)*

Table 3.2 summarises the position at three points in time 1991, 2001 and 2011 based on the LRC population projections at borough level. Looking initially at all people aged 65+, the key points are:

- This age group in 1991 comprised almost a million people in Greater London, but is projected to decline in absolute and relative terms by 2011.
- From 14.1% of the total population in 1991, a 14% decline in this age group is expected to bring it to 11.6% by 2011.
- The expected rate of decline overall is faster in the first of these decades than in the second, though boroughs differ.
- Older age groups form a slightly lower proportion of the total population in Inner London boroughs. Inner London's older population is also set to decline more sharply than that in Outer London. The biggest reductions (around 30% between 1991 and 2011) are expected in Wandsworth and in Hammersmith & Fulham; whilst modest increases (less than 5% between 1991 and 2011) are projected for Bexley and Croydon.

Looking at the different age bands within the older population of London it is clear they show different patterns. The numbers of people aged 65-74 are expected (LRC projections) to reduce by 13%, mainly in the first decade, and the numbers aged 65-74 to reduce by a total of 22% over two decades. In contrast the numbers of people aged over 85 are expected to increase by 20% between 1991 and 2001 before a reduction in levels in 2011 – though the overall effect is of a net increase in the very oldest age group.

Table 3.2: Borough level populations age 65+: estimates and projected changes 1991-2011

	Population aged 65+ ('000s)			% of total pop aged 65+			Projected % change	
	1991	2001	2011	1991	2001	2011	1991-2001	1991-2011
City of London	0.6	1.0	1.0	14.3%	12.0%	10.1%	76%	74%
Barking & Dagenham	25.4	24.3	21.0	17.4%	15.0%	12.2%	-5%	-17%
Barnet	47.9	41.1	37.9	16.0%	12.6%	11.5%	-14%	-21%
Bexley	32.3	32.3	32.7	14.7%	14.8%	14.7%	0%	1%
Brent	29.6	29.1	29.4	11.9%	11.6%	11.4%	-2%	-1%
Bromley	49.2	46.5	44.2	16.7%	15.5%	14.5%	-6%	-10%
Camden	25.9	23.7	22.5	14.3%	12.5%	11.8%	-8%	-13%
Croydon	43.3	43.4	44.4	13.6%	12.9%	12.9%	0%	3%
Ealing	36.5	34.0	32.8	12.9%	11.4%	11.1%	-7%	-10%
Enfield	39.4	35.7	34.1	15.0%	13.4%	12.8%	-9%	-13%
Greenwich	31.7	27.8	26.3	14.9%	12.8%	12.0%	-12%	-17%
Hackney	21.8	21.2	20.2	11.6%	11.0%	10.5%	-3%	-7%
Hammersmith & Fulham	19.8	15.4	14.0	12.7%	9.7%	8.7%	-22%	-29%
Haringey	24.0	22.1	21.6	11.4%	10.2%	9.9%	-8%	-10%
Harrow	30.4	27.3	26.3	14.9%	13.3%	13.1%	-10%	-13%
Havering	36.3	36.6	35.2	15.6%	16.0%	15.3%	1%	-3%
Hillingdon	34.1	32.9	30.7	14.4%	13.2%	12.2%	-4%	-10%
Hounslow	27.1	24.3	23.6	13.0%	11.5%	10.7%	-10%	-13%
Islington	22.0	19.8	18.6	12.7%	11.0%	10.2%	-10%	-15%
Kensington & Chelsea	18.4	16.9	17.8	12.6%	10.4%	10.7%	-8%	-3%
Kingston upon Thames	21.8	18.2	16.7	15.8%	12.2%	11.2%	-17%	-23%
Lambeth	30.5	28.3	26.2	11.9%	10.7%	10.2%	-7%	-14%
Lewisham	33.5	28.5	24.8	13.9%	11.7%	10.5%	-15%	-26%
Merton	26.4	23.8	22.3	15.4%	12.8%	11.9%	-10%	-16%
Newham	25.8	23.9	22.7	11.7%	10.1%	9.6%	-8%	-12%
Redbridge	36.1	31.8	30.7	15.6%	13.8%	13.0%	-12%	-15%
Richmond upon Thames	27.3	23.5	22.2	16.6%	12.6%	11.7%	-14%	-19%
Southwark	30.8	28.4	25.5	13.5%	12.0%	10.6%	-8%	-17%
Sutton	27.2	23.9	22.5	15.9%	13.6%	12.8%	-12%	-17%
Tower Hamlets	20.8	19.7	17.1	12.4%	11.1%	9.5%	-5%	-18%
Waltham Forest	31.3	27.5	26.7	14.4%	12.4%	12.1%	-12%	-15%
Wandsworth	35.4	27.8	24.8	13.3%	10.2%	8.9%	-21%	-30%
Westminster, City of	27.2	23.8	22.9	14.5%	11.2%	10.4%	-12%	-16%
Inner London	336.3	298.8	278.7	12.8%	10.8%	10.0%	-11%	-17%
Outer London	633.4	583.3	559.8	14.9%	13.2%	12.5%	-8%	-12%
Greater London	969.7	882.1	838.5	14.1%	12.3%	11.6%	-9%	-14%

Source: London Research Centre 1998 Round Ethnic Group Projections P1/M96

Ethnic diversity in London

London has the largest and most diverse range of ethnic minorities in the UK. The 1991 Census introduced a question on ethnic group, which categorised people into one of ten groups (see Box 1.1, Chapter 1) according to their own self-perception. These groups, although far from ideal, have become widely adopted by other agencies in the years since 1991. (The NHS, for example, has used the same groupings, except that the self-declaration approach is a little less

comprehensive, and there is no separation between the "Other Asian" and "Other" groups.) One feature of the census classification is that the "Black Other" group includes people who identified themselves as "Black British". Another is that several minority communities – for example Cypriot, Turkish and Irish people – are included in the majority "White" group; all the other groups are essentially non-white. Some Census analyses are available for those born in Ireland, alongside the ten 'ethnic' groupings, however this is an exception.

The 1991 Census recorded that 20.1% of Greater London residents were from non-white ethnic minority groups. The biggest single minority groups were Indian and Black Caribbean. The three black groups totalled 535,200 (8.0%) and the three South Asian groups (Indian, Pakistani, Bangladeshi) comprised 520,600 (7.8%) of the total population.

Within the majority "White" group, census information about country of birth shows that 210,200 (3.1%) were born in Ireland and 112,000 in Scotland. A further 48,900 were born in Cyprus and 18,300 in Turkey; together these two groups make up 1.0% of the total London population. Many European countries have also contributed to the population: for example there were 21,800 born in Poland. Maps at Figure 3.1(a-e) show the distributions of people aged over 55 from these countries in 1991. Some of these groups are distinctly localised: the Scottish-born are the most widely dispersed of those shown here. All but those born in Turkey include higher proportions of older people than do the minority "ethnic" groups.

What cannot be shown by these data are the communities, known to be significant in London, from some individual countries - such as Somalia and Ethiopia - which not separately identified in the Census. Nor can we identify those from the more or less distinct communities, who are likely to have been born in several different countries as well as the UK, such as Jewish, Kurdish, Armenian and Roma people, or travellers. Neither the very broad "ethnic" groupings of the Census, nor its "country of birth" category, can distinguish these populations.

Community-focussed studies are a potential source of information about particular groups, though they vary in terms of methods and reliability. Some examples – not intended to be representative or comprehensive – are summarised below.

Some estimates and projections of the Jewish population (Jewish Care, 1999), based on data from the Board of Deputies and drawn initially from synagogue registration, suggest:

- A national population of around 283,000 in 1999, with about 72% in London and the Home Counties, and at least half in boroughs north of the Thames – especially Barnet with 50,000.
- Around 63,000 (23%) aged over 65, including 37,000 (13%) aged over 75 – an untypically high elderly population, linked to high birthrates until the late 1920's.
- A trend over recent years of reducing numbers in Inner and East London (Hackney, Redbridge, Brent) with increases in some Outer London boroughs (Enfield, Barnet, Harrow, Hillingdon) and adjacent counties. Migration outwards is initially led by younger families.

A small survey of the Iraqi community in London found:

- Most respondents lived in West, North West and Central London: 60 per cent in Ealing, Westminster, Hammersmith & Fulham, Brent, Camden or Harrow. However there were responses from every borough.
- A relatively young population – only 3% aged over 60 (Jafar, 2000).

Armenians have come to Britain, sometimes as second generation migrants, via India, Cyprus, the Middle East and more recently direct from the former Soviet Union:

- The estimated population of Armenians in London is 15,000, including around 25% aged over 55.
- Most live in Ealing, Hounslow and Brent (Inquilab, 1996).

Figure 3.1a

Figure 3.1b

Figure 3.1c

Figure 3.1d

Figure 3.1e

Londoners aged over 65 by Ethnic Group and Country of Birth

The White ethnic group formed the overwhelming majority of older people in London, accounting for over 95 per cent of over 65's in 1991. This applied in both Inner and Outer London. The range between boroughs in 1991 was from Havering, where the White groups accounted for 99.4% of older people, to less than 90 per cent in only three boroughs: Brent (84.9%), Hackney and Lambeth (see Table 3.3: similar tables for all ethnic groups are in Appendix B).

Table 3.3: Estimates and projections of persons in the White ethnic group aged 65+ by London borough

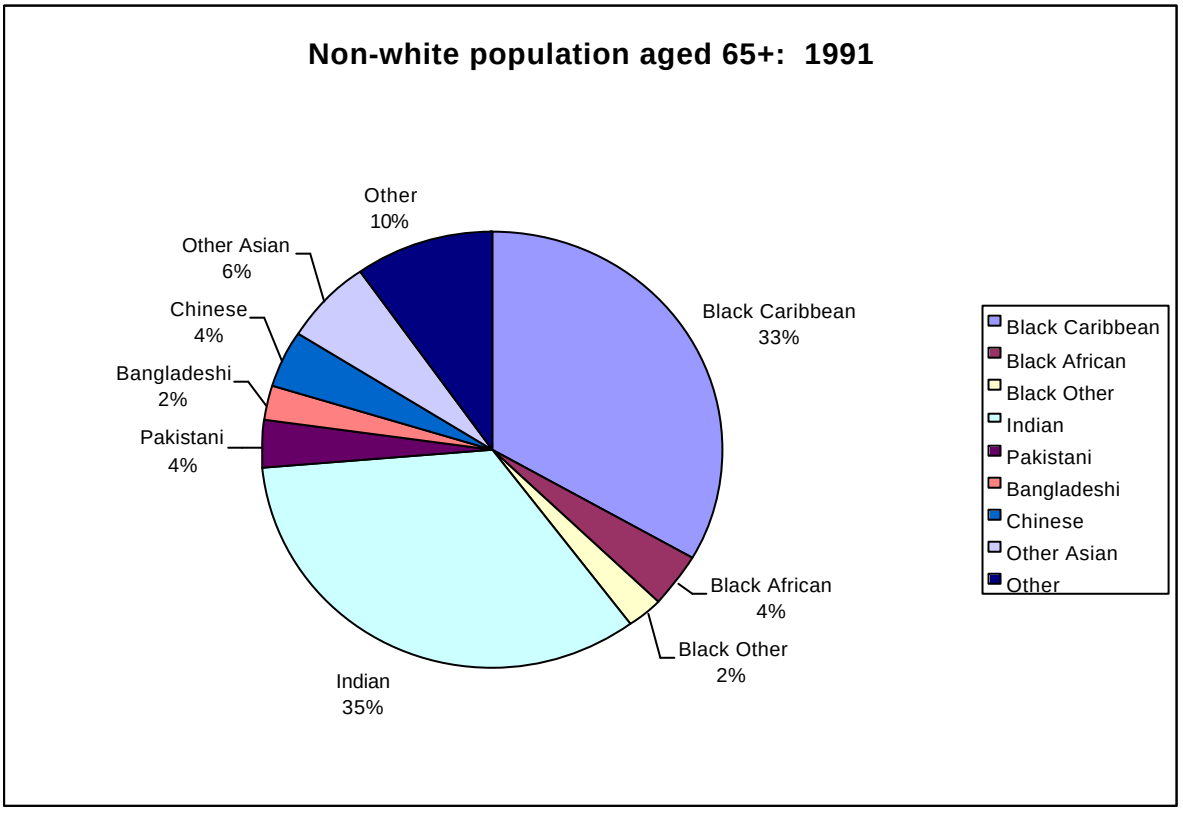
	Population ('000s)			% of all 65+ in borough			Projected % change	
	1991	2001	2011	1991	2001	2011	1991-2001	2001-2011
City of London	0.6	1.0	0.9	98.9%	94.4%	92.0%	68%	-4%
Barking & Dagenham	25.2	23.6	19.9	99.2%	97.3%	94.5%	-6%	-16%
Barnet	46.0	37.2	32.1	96.1%	90.5%	84.7%	-19%	-14%
Bexley	31.9	31.4	31.2	98.7%	97.1%	95.5%	-2%	0%
Brent	25.1	19.9	17.3	84.9%	68.5%	58.7%	-21%	-13%
Bromley	48.8	45.5	42.7	99.0%	97.9%	96.6%	-7%	-6%
Camden	24.8	22.1	20.6	95.6%	93.1%	91.4%	-11%	-7%
Croydon	41.2	38.7	37.5	95.2%	89.3%	84.4%	-6%	-3%
Ealing	33.1	27.0	23.4	90.7%	79.4%	71.2%	-18%	-13%
Enfield	38.3	33.2	30.0	97.4%	93.0%	87.9%	-13%	-10%
Greenwich	31.0	26.3	23.9	97.5%	94.6%	90.9%	-15%	-9%
Hackney	19.5	16.4	13.8	89.5%	77.3%	68.5%	-16%	-15%
Hammersmith & Fulham	18.8	13.4	11.4	94.8%	86.6%	81.5%	-29%	-15%
Haringey	21.9	17.6	15.8	91.0%	79.5%	72.8%	-19%	-10%
Harrow	28.4	22.9	19.8	93.6%	83.9%	75.0%	-20%	-14%
Havering	36.0	36.0	34.4	99.4%	98.6%	97.6%	0%	-5%
Hillingdon	33.4	31.4	28.0	97.9%	95.4%	91.2%	-6%	-11%
Hounslow	25.3	20.4	17.9	93.3%	83.8%	75.7%	-20%	-12%
Islington	20.8	17.4	15.5	94.4%	87.8%	83.2%	-16%	-11%
Kensington & Chelsea	17.6	15.6	15.9	95.6%	91.9%	89.6%	-11%	2%
Kingston upon Thames	21.4	17.4	15.4	98.4%	95.9%	92.2%	-19%	-12%
Lambeth	27.3	22.2	18.9	89.6%	78.4%	72.3%	-19%	-15%
Lewisham	31.8	24.7	19.9	95.0%	86.6%	80.2%	-22%	-19%
Merton	25.3	21.6	19.0	96.1%	90.9%	85.2%	-15%	-12%
Newham	23.5	18.4	14.8	91.1%	77.1%	65.3%	-22%	-20%
Redbridge	34.8	28.5	25.4	96.2%	89.6%	82.6%	-18%	-11%
Richmond upon Thames	26.9	22.9	21.3	98.7%	97.4%	95.9%	-15%	-7%
Southwark	29.3	24.9	20.7	95.2%	87.7%	81.4%	-15%	-17%
Sutton	26.9	23.2	21.4	98.8%	97.3%	95.3%	-14%	-8%
Tower Hamlets	19.4	16.3	12.9	93.4%	82.8%	75.4%	-16%	-21%
Waltham Forest	30.1	24.3	21.5	96.2%	88.3%	80.6%	-20%	-11%
Wandsworth	33.2	23.7	19.8	93.8%	85.1%	79.6%	-29%	-16%
Westminster, City of	25.8	21.0	19.2	94.9%	88.3%	84.2%	-19%	-8%
Inner London	314.1	252.2	218.1	93.4%	84.4%	78.2%	-20%	-14%
Outer London	609.3	530.7	482.0	96.2%	91.0%	86.1%	-13%	-9%
Greater London	923.4	782.9	700.0	95.2%	88.8%	83.5%	-15%	-11%

Source: London Research Centre 1998 Round Ethnic Group Projections P1/M96

- Within the 9 non-white groups, totalling 46,300 in 1991, the largest were Indian and Black Caribbean, each accounting for approximately a third of London's non-white elders.
- The miscellaneous "Other" group, including a variety of non-black and mixed race groups, was the next biggest non-white group in 1991.
- All the other more specific groups at that time comprised less than 10% of the non-white over 65's, and less than half a percent of all over 65's, with Bangladeshi elders the smallest group of all (Figure 3.2).

In every non-white ethnic group, people aged over 65 comprised in 1991 a far smaller minority than their white contemporaries: Black Caribbean and Indian elders, the biggest, were each around 5% of their ethnic group, whereas white elders comprised over 17% of theirs.

Figure 3.2: Proportions of minority ethnic groups amongst people aged 65+ in London



Source: 1991 Census (OPCS, 1993)

Looking at the country of birth as well as ethnic group of older London residents (over 65) in 1991 shows:

- A majority of all the non-white groups were born outside the UK. This is not true for younger age groups (see Table 3.4).

- The white over 65's (and under 45's) also included 11% born outside the UK.
- In certain of the white minority groups, proportions of elders were far higher: people over 65 comprised 18% of residents born in Ireland; and 13% of those born in Cyprus (Table 3.5).
- Around a quarter of the older people born in India, and a significant proportion of those born in the rest of the New Commonwealth, were white – reflecting perhaps the colonial past.
- Most of the elders born in East Africa were of Indian ethnic group, and these comprised 8.1% of London's Indian elders.

Table 3.4: Proportion of population born in UK or abroad by ethnic group and age group at 1991 Census

	White	Black Caribbean	Black African	Black Other	Indian	Pakistani	Bangladeshi	Chinese	Other Asian	Other
Ages <45										
Born in UK*	89%	74%	39%	89%	46%	54%	41%	30%	25%	61%
Born abroad	11%	26%	61%	11%	54%	46%	59%	70%	75%	39%
Ages 65+										
Born in UK*	89%	7%	15%	24%	4%	8%	9%	4%	5%	17%
Born abroad	11%	93%	85%	76%	96%	92%	91%	96%	95%	83%

** 'Born in UK' includes persons born in England, Scotland, Wales, Northern Ireland, Channel Islands, Isle of Man and UK (otherwise not stated)*

Source: 1991 Census County Reports (OPCS, 1993)

Table 3.5: Numbers of London residents aged 65+ by ethnic group and country of birth, 1991

Country of birth	Total persons	White	Black Caribbean	Black African	Black Other	Indian	Pakistani	Bangladeshi	Chinese	Other Asian	Other
Total persons	963,903	917,506	15,458	1,853	1,129	15,792	1,659	1,081	2,015	2,904	4,506
United Kingdom*	816,539	812,932	1,159	283	271	677	140	94	83	146	754
England	771,253	767,906	1,087	263	243	625	134	90	77	129	699
Scotland	18,783	18,705	21	9	5	12	0	2	2	2	25
Wales	19,633	19,516	36	10	12	18	5	1	2	7	26
Northern Ireland	6,297	6,260	11	0	8	9	1	0	0	5	3
Irish Republic**	38,875	38,494	119	27	49	77	13	24	5	19	48
Old Commonwealth	3,580	3,549	4	5	2	5	0	1	3	0	11
New Commonwealth	52,090	14,245	14,027	1,125	612	14,696	1,489	958	784	1,890	2,264
Eastern Africa	1,960	272	9	81	10	1,285	58	0	4	183	58
Other Africa	1,011	58	16	883	19	10	0	1	4	5	15
Caribbean	15,809	741	13,918	106	310	216	8	4	116	48	342
Bangladesh	1,025	40	5	4	3	13	8	927	0	8	17
India	19,426	4,485	17	11	63	12,624	396	11	17	347	1,455
Pakistan	1,876	403	0	2	5	333	1,012	7	3	42	69
South East Asia	1,255	460	6	0	6	58	3	3	602	62	55
Cyprus	6,069	5,869	20	4	110	3	1	3	5	17	37
Other New Commonwealth	3,580	3,549	4	5	2	5	0	1	3	0	11
Other European Community	17,840	17,654	20	8	41	21	6	0	4	12	74
Other Europe	21,902	21,658	21	8	28	27	4	3	1	4	148
United States of America	1,593	1,557	6	7	7	2	0	0	4	2	8
China	1,063	331	0	0	1	4	0	0	712	8	7
Vietnam	706	26	0	0	4	0	0	1	366	306	3
Rest of World	9,715	7,060	102	390	114	283	7	0	53	517	1,189

Source: 1991 Census (OPCS, 1993)
** United Kingdom includes Channel Islands, Isle of Man and UK (not stated)*
***Irish Republic includes Ireland (part not stated)*

Older age groups in black and minority ethnic groups

In terms of use of health and welfare services, patterns amongst the oldest age groups are particularly important.

- Within the over 65's, the non-white ethnic groups included in 1991 very few people aged 75-84 (10,100, or 2.9% of that age group), and over 85 (2,100, only 2.0% of the age group, see Table 3.6).
- In the two older age groups, Indians were the largest minority ethnic group; whereas in the 65-74 group, they were outnumbered by Black Caribbeans.
- Of the 442,100 over 75's, 13,500 (3%) were Irish-born; 1,850 (0.4%) were born in Cyprus; 16,600 (3.8%) were born in continental Europe.
- Of the 95,800 over 85's, 1812 or 1.9 % were Irish-born, 246 or 0.3% originated from Cyprus and 3913 or 4.1% from continental Europe – reflecting pre- and post-war migration. 86,800, or 90.6% were UK-born – 383 of these from black and minority ethnic groups.

Gender

In 1991, the smaller minority groups followed to some extent the same pattern as whites in having more women than men aged over 65 (Table 3.7). However, differential migration patterns and marriage/family practice resulted in a different balance in some groups: there were more Black Caribbean, Black African, Indian, Pakistani and Bangladeshi men than women among the over 65's of the same ethnic groups. This showed in the 65-74 age group: only in the small Bangladeshi group was it evident among the over 75's.

Table 3.6: Population projections by age band and ethnic group

	Persons ('000's)				*Percentage of age group*			
1991	**65-74**	**75-84**	**85+**	**65+**	**65-74**	**75-84**	**85+**	**65+**
White	484.6	339.6	99.2	923.4	93.4%	97.1%	98.0%	95.2%
Black Caribbean	12.1	2.8	0.5	15.4	2.3%	0.8%	0.5%	1.6%
Black African	1.4	0.3	0.1	1.8	0.3%	0.1%	0.1%	0.2%
Black Other	0.8	0.3	0.1	1.1	0.2%	0.1%	0.1%	0.1%
Indian	11.3	3.7	0.8	15.8	2.2%	1.1%	0.7%	1.6%
Pakistani	1.3	0.3	0.1	1.7	0.2%	0.1%	0.1%	0.2%
Bangladeshi	0.9	0.2	0.0	1.1	0.2%	0.0%	0.0%	0.1%
Chinese	1.4	0.5	0.1	2.0	0.3%	0.1%	0.1%	0.2%
Other Asian	2.1	0.7	0.1	2.9	0.4%	0.2%	0.1%	0.3%
Other	2.9	1.3	0.3	4.5	0.6%	0.4%	0.3%	0.5%
Total	**518.7**	**349.7**	**101.3**	**969.7**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
% per age band	*53.5%*	*36.1%*	*10.4%*	*100.0%*				

	Persons ('000's)				*Percentage of age group*			
2001	**65-74**	**75-84**	**85+**	**65+**	**65-74**	**75-84**	**85+**	**65+**
White	384.8	281.4	116.7	782.9	84.3%	92.4%	96.4%	88.8%
Black Caribbean	26.8	7.9	1.2	35.8	5.9%	2.6%	1.0%	4.1%
Black African	3.8	1.1	0.2	5.1	0.8%	0.4%	0.2%	0.6%
Black Other	1.4	0.5	0.1	2.0	0.3%	0.2%	0.1%	0.2%
Indian	20.9	7.8	1.6	30.2	4.6%	2.6%	1.3%	3.4%
Pakistani	3.9	0.9	0.1	5.0	0.9%	0.3%	0.1%	0.6%
Bangladeshi	3.7	0.7	0.1	4.5	0.8%	0.2%	0.1%	0.5%
Chinese	2.3	0.9	0.2	3.4	0.5%	0.3%	0.2%	0.4%
Other Asian	4.4	1.5	0.3	6.2	1.0%	0.5%	0.3%	0.7%
Other	4.5	1.9	0.5	6.9	1.0%	0.6%	0.4%	0.8%
Total	**456.4**	**304.6**	**121.0**	**882.1**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
% per age band	*51.7%*	*34.5%*	*13.7%*	*100.0%*				

	Persons ('000's)				*Percentage of age group*			
2011	**65-74**	**75-84**	**85+**	**65+**	**65-74**	**75-84**	**85+**	**65+**
White	363.9	229.2	107.0	700.0	80.6%	84.4%	92.4%	83.5%
Black Caribbean	25.7	16.0	3.0	44.6	5.7%	5.9%	2.6%	5.3%
Black African	7.3	2.3	0.5	10.0	1.6%	0.8%	0.4%	1.2%
Black Other	1.8	0.8	0.2	2.8	0.4%	0.3%	0.2%	0.3%
Indian	25.3	12.2	2.9	40.4	5.6%	4.5%	2.5%	4.8%
Pakistani	6.0	2.3	0.3	8.6	1.3%	0.8%	0.3%	1.0%
Bangladeshi	4.7	1.9	0.2	6.8	1.0%	0.7%	0.2%	0.8%
Chinese	3.2	1.4	0.4	5.0	0.7%	0.5%	0.3%	0.6%
Other Asian	7.6	2.7	0.6	10.8	1.7%	1.0%	0.5%	1.3%
Other	5.9	2.7	0.8	9.5	1.3%	1.0%	0.7%	1.1%
Total	**451.3**	**271.4**	**115.8**	**838.5**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
% per age band	*53.8%*	*32.4%*	*13.8%*	*100.0%*				

Source: London Research Centre 1998 Round Ethnic Group Projections P1/M96

Table 3.7: Population projections by age band, ethnic group and gender

	Males (000's)				Females (000's)			
1991	**65-74**	**75-84**	**85+**	**65+**	**65-74**	**75-84**	**85+**	**65+**
White	213.5	122.1	22.8	358.5	271.1	217.5	76.4	565.0
Black Caribbean	6.5	1.3	0.1	8.0	5.5	1.6	0.3	7.4
Black African	0.8	0.2	0.0	1.1	0.5	0.2	0.1	0.8
Black Other	0.4	0.1	0.0	0.5	0.4	0.2	0.0	0.6
Indian	5.9	1.8	0.3	8.0	5.4	2.0	0.4	7.8
Pakistani	0.8	0.2	0.0	1.0	0.5	0.1	0.0	0.7
Bangladeshi	0.6	0.1	0.0	0.8	0.2	0.1	0.0	0.3
Chinese	0.7	0.2	0.0	0.9	0.7	0.3	0.1	1.1
Other Asian	0.9	0.3	0.0	1.2	1.2	0.4	0.1	1.7
Other	1.4	0.5	0.1	1.9	1.6	0.8	0.2	2.6
Total	**231.6**	**126.6**	**23.5**	**381.8**	**287.1**	**223.1**	**77.7**	**587.9**

	Males (000's)				Females (000's)			
2001	**65-74**	**75-84**	**85+**	**65+**	**65-74**	**75-84**	**85+**	**65+**
White	175.1	107.0	30.6	312.7	209.7	174.4	86.1	470
Black Caribbean	13.4	3.8	0.4	17.6	13.5	4.1	0.7	18
Black African	2.2	0.6	0.1	2.9	1.5	0.6	0.1	2
Black Other	0.6	0.2	0.0	0.9	0.7	0.3	0.1	1
Indian	10.6	3.5	0.6	14.7	10.3	4.2	1.0	15
Pakistani	2.5	0.5	0.1	3.0	1.4	0.4	0.1	2
Bangladeshi	2.7	0.4	0.0	3.1	1.1	0.2	0.0	1
Chinese	1.2	0.4	0.1	1.6	1.1	0.6	0.2	2
Other Asian	2.2	0.6	0.1	2.9	2.2	0.9	0.2	3
Other	2.3	0.8	0.2	3.3	2.2	1.1	0.4	4
Total	**212.7**	**117.8**	**32.1**	**362.7**	**243.7**	**186.8**	**88.9**	**519**

	Males (000's)				Females (000's)			
2011	**65-74**	**75-84**	**85+**	**65+**	**65-74**	**75-84**	**85+**	**65+**
White	166.6	91.0	30.0	287.6	197.3	138.2	77.0	412.4
Black Caribbean	10.8	7.2	1.2	19.2	14.9	8.8	1.7	25.4
Black African	3.8	1.2	0.2	5.2	3.5	1.1	0.3	4.8
Black Other	0.8	0.4	0.1	1.2	1.0	0.5	0.1	1.6
Indian	11.9	5.5	1.1	18.4	13.4	6.8	1.8	21.9
Pakistani	3.3	1.3	0.1	4.7	2.8	1.0	0.2	3.9
Bangladeshi	2.6	1.2	0.1	4.0	2.1	0.7	0.1	2.8
Chinese	1.5	0.6	0.1	2.2	1.7	0.8	0.3	2.7
Other Asian	3.5	1.2	0.2	4.9	4.1	1.5	0.4	5.9
Other	3.0	1.2	0.2	4.5	2.9	1.5	0.5	5.0
Total	**207.7**	**110.7**	**33.5**	**351.9**	**243.6**	**160.7**	**82.3**	**486.6**

Source: London Research Centre 1998 Round Ethnic Group Projections P1/M96

Projected changes in the population of black and minority ethnic elders

The main points in respect of over 65's (Tables 3.3, 3.6, 3.7, 3.8 and Appendix B) from the LRC projections by ethnic group are:

- By 2011 the White over 65's, while expected to decline overall from 1991 by 24%, will still comprise the vast majority (83.4%) of the older population.
- The decline in the White group is expected to be bigger in Inner London, with the biggest reductions expected in Wandsworth and in Hammersmith & Fulham, and the smallest reductions in Bexley and Havering.
- By 2011 there will be a bigger difference between boroughs: while Brent will have less than 60% of its over 65's in the white group, Barking & Dagenham, Havering, Richmond upon Thames and Sutton will still have over 95%.
- All non-white ethnic groups are projected to show an increase in over 65's between 1991 and 2011, though at differing rates, and by a total of 92,000 or 200%.
- The smallest projected proportionate increase is of 110% in the "Other" group: the biggest is in the Bangladeshi group, at 530%. However these both start from a relatively small baseline.
- The biggest absolute increases over the 20 year period are those of 29,200 in older Black Caribbeans, and of 24,600 in older Indians.
- For both of these larger groups, most of this increase is expected in the first decade; for some of the smaller groups, however, the increase from 2001–2011 is bigger.

For the age and gender groups within the over-65's (Tables 3.6, 3.7) the results show:

- Numbers of people aged 65–74 are expected to increase through the 20 year period in almost all the non-white groups: Black Caribbeans will however show a decrease between 2001 and 2011 in the number of men, which more than offsets the increased number of women.
- In 75–84 year-olds, all non-white ethnic groups show increases through two decades, growing fourfold in total. The biggest proportionate increases are in Bangladeshi, Pakistani and Black African groups; then Black Caribbeans, especially in the second decade.
- The very elderly (85+) age group is projected to increase in all ethnic groups in the first decade, and in all non-white groups in the second, giving a five-fold increase in these groups over twenty years.
- The excess of men in the over 65's is projected to persist until 2001 in Black African, Indian, Pakistani and Bangladeshi groups, and continues until 2011 only in Pakistanis and Bangladeshis.

On a geographic basis:

- For every non-white group, a bigger proportionate increase is projected for Outer London than for Inner London. As Outer London is starting from a lower baseline, this means that for most non-white ethnic groups, Outer London overall will have by 2011 a similar *proportion* within its over 65 population to that seen in 1991 in Inner London.

- Largest absolute increases in ethnic minority elders are projected for boroughs which already have a substantial number in their population (Brent, Ealing, Newham).

The projected distribution for 2011 across London boroughs of over 65's in each of the black and minority ethnic groups is shown in maps at Figures 3.3(a–j). The small Chinese group is the most widely scattered and the Bangladeshi group the most concentrated in borough terms.

Table 3.8: Population projections for non-white ethnic groups

	Persons aged 65+ (000's)			% of all 65+ in borough			Projected % change	
	1991	2001	2011	1991	2001	2011	1991-2001	2001-2011
City of London	0.0	0.1	0.1	1.1%	5.6%	8.0%	772.7%	42.0%
Barking & Dagenham	0.2	0.7	1.1	0.8%	2.7%	5.5%	224.4%	73.0%
Barnet	1.9	3.9	5.8	3.9%	9.5%	15.3%	107.8%	47.8%
Bexley	0.4	0.9	1.5	1.3%	2.9%	4.5%	121.1%	57.6%
Brent	4.5	9.2	12.1	15.1%	31.5%	41.3%	104.5%	32.3%
Bromley	0.5	1.0	1.5	1.0%	2.1%	3.4%	108.6%	52.0%
Camden	1.1	1.6	1.9	4.4%	6.9%	8.6%	45.6%	18.5%
Croydon	2.1	4.7	6.9	4.8%	10.7%	15.6%	123.0%	48.9%
Ealing	3.4	7.0	9.5	9.3%	20.6%	28.8%	106.8%	34.6%
Enfield	1.0	2.5	4.1	2.6%	7.0%	12.1%	144.0%	65.4%
Greenwich	0.8	1.5	2.4	2.5%	5.4%	9.1%	92.3%	58.9%
Hackney	2.3	4.8	6.3	10.5%	22.7%	31.5%	110.7%	32.0%
Hammersmith & Fulham	1.0	2.1	2.6	5.2%	13.4%	18.5%	100.4%	25.3%
Haringey	2.2	4.5	5.9	9.0%	20.5%	27.2%	108.8%	29.9%
Harrow	1.9	4.4	6.6	6.4%	16.1%	25.0%	124.7%	50.1%
Havering	0.2	0.5	0.9	0.6%	1.4%	2.4%	137.4%	62.6%
Hillingdon	0.7	1.5	2.7	2.1%	4.6%	8.8%	113.2%	78.3%
Hounslow	1.8	3.9	5.7	6.7%	16.2%	24.3%	117.9%	45.3%
Islington	1.2	2.4	3.1	5.6%	12.2%	16.8%	96.3%	29.4%
Kensington & Chelsea	0.8	1.4	1.9	4.4%	8.1%	10.4%	71.9%	34.5%
Kingston upon Thames	0.4	0.7	1.3	1.6%	4.1%	7.8%	113.4%	74.7%
Lambeth	3.2	6.1	7.2	10.4%	21.6%	27.7%	93.7%	18.6%
Lewisham	1.7	3.8	4.9	5.0%	13.4%	19.8%	127.9%	28.8%
Merton	1.0	2.2	3.3	3.9%	9.1%	14.8%	111.4%	52.0%
Newham	2.3	5.5	7.9	8.9%	22.9%	34.7%	138.5%	43.4%
Redbridge	1.4	3.3	5.3	3.8%	10.4%	17.4%	140.2%	61.1%
Richmond upon Thames	0.4	0.6	0.9	1.3%	2.6%	4.1%	75.1%	49.1%
Southwark	1.5	3.5	4.7	4.8%	12.3%	18.6%	137.7%	36.0%
Sutton	0.3	0.6	1.1	1.2%	2.7%	4.7%	99.2%	64.3%
Tower Hamlets	1.4	3.4	4.2	6.6%	17.2%	24.6%	146.7%	23.9%
Waltham Forest	1.2	3.2	5.2	3.8%	11.7%	19.4%	170.1%	61.5%
Wandsworth	2.2	4.1	5.1	6.2%	14.9%	20.4%	88.3%	22.8%
Westminster, City of	1.4	2.8	3.6	5.1%	11.7%	15.8%	99.7%	30.0%
Inner London	22.2	46.6	60.6	6.6%	15.6%	21.8%	109.9%	30.2%
Outer London	24.1	52.6	77.9	3.8%	9.0%	13.9%	118.5%	48.1%
Greater London	46.3	99.2	138.5	4.8%	11.2%	16.5%	114.4%	39.7%

Source: London Research Centre 1998 Round Ethnic Group Projections P1/M96

Figure 3.3a

Figure 3.3b

Figure 3.3c

Figure 3.3d

Figure 3.3e

Figure 3.3f

Figure 3.3g

Figure 3.3h

Figure 3.3j

Figure 3.3j

SOCIO-ECONOMIC CHARACTERISTICS AND LINKS TO HEALTH AND ETHNICITY

This section describes the social and economic characteristics of London's ethnic minority elders, focussing particularly on those with significance for health and for health care.

The Census and other sources give information about the socio-economic circumstances of older people and of ethnic groups within them. The following are drawn mainly from:

- 1991 Census data for London , including:
  - specialist tables commissioned by LRC;
  - analyses published by LRC on people of pensionable age – women aged 60+, men aged 65+ (Leeser, 1996), and ethnic minority and Irish-born groups (Storkey, 1994; Storkey et al, 1997).
- Recent analyses of the Ethnicity Multi-Year Data (EMYD: Evandrou, 2000), focussing on people in different ethnic groups aged 40-59, and 60+; in London and Great Britain. The data are drawn from the national General Household Survey for 1984-94, and are described in Appendix C.

Family and household structures

Differences in household structure by ethnic group have been observed before. For example, Leeser (1996) showed how the proportion of Londoners of pensionable age living alone was higher in 1991 among white than non-white groups. This was partly because white pensioners included more of the oldest age groups. More of the black elders, especially Black Caribbean and Black African men, and also more of the Irish-born male elders, were living alone than other minority groups; much smaller proportions of all the Asian elders, especially South Asians, were living alone.

Information from EMYD (Evandrou, 2000) confirms this picture for South Asian compared with White and Black Caribbean elders with regard to average household size. The results for London are largely the same as for Britain as a whole. The following section shows just London data from the EMYD sample. Comparing household size, Table 3.9a shows several features including:

- Elders from all the minority groups live, on average, in larger households than white elders.
- South Asian elders live in the largest households, with Pakistani/Bangladeshi elders living in households comprising of 5 persons on average.
- The average number of children under 18 in the household is very low in both Whites and Black Caribbeans, but Pakistani/Bangladeshi elders live, on average, with 1.5 children (compared to just 0.02 for white elders).
- Average household size amongst minority ethnic elders in London is larger than for Britain as a whole.

Table 3.9a: Average household size amongst persons aged 40-59 and 60 and over by ethnicity, Greater London

	Age 40-59			Age 60 and over		
	Adults	Children	Total	Adults	Children	Total
White	2.49	0.49	2.98	1.81	0.02	1.83
Indian	3.25	0.94	4.19	3.28	0.79	4.17
Pakistani/Bangladeshi	3.13	1.83	4.97	3.21	2.17	5.38
Chinese	2.76	1.10	3.86	3.40	0.50	3.90
Black Caribbean	2.59	0.61	3.20	2.19	0.11	2.30
African	2.33	1.08	3.42	2.29	0.14	2.43
Mixed	2.35	0.71	3.06	3.35	-	3.35
Other	2.47	1.00	3.47	2.34	0.34	2.68
Total pop.	2.55	0.57	3.12	1.86	0.05	1.92

Note: ANOVA F-statistic for both 40-59 and 60 and over significant at p<0.001.
Source: Evandrou (2000)

Table 3.9b shows the household composition amongst persons aged 40-59 and 60 and over for people living in London. The majority of elderly South Asians live in *multi-generational* households (i.e. 3 or more adults with or without children), whilst the majority of Caribbean elders live in households of one or two adults. Within the South Asian communities there are marked differences between Indian and Pakistani/Bangladeshi elders, with elders from the latter being more likely to co-reside with children under 18.

Table 3.9b: Household composition amongst persons aged 40-59 and 60 and over by ethnicity, Greater London (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Age 40-59				
Live alone	10	4	3	15
Couple only	31	13	6	20
1-2 adults, plus children	19	22	34	18
3+ adults	29	29	21	28
3+ adults, plus children	12	31	36	19
Total	100%	100%	100%	100%
(N)	(5580)	(407)	(89)	(324)
Age 60 and over				
Live alone	36	7	8	21
Couple only	50	27	13	43
1-2 adults, plus children	0	1	83	6
3+ adults	12	27	13	27
3+ adults, plus children	1	38	58	3
Total	100%	100%	100%	100%
(N)	(5730)	(112)	(24)	(114)

Note: Chi-squared for both 40-59 and 60 and over significant at p<0.001.
Source: Evandrou (2000)

The Policy Study Institute's 4th National Survey found a similar pattern (Modood & Berthoud, 1997). Whether a person lives in a multi-generational household is dependent on many factors, including whether they have any adult children residing in Britain with whom they can live. The 4th National Survey found that amongst South Asians, nearly 80% of those aged 60 plus live with their adult children, compared with 25% of Caribbean elders and 15% of white elders. These figures reflect the diverse kinship patterns within different communities.

Table 3.9c: Relationship to household head amongst persons aged 40-59 and 60 and over by ethnicity, Greater London (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Age 40-59				
Head/spouse of head	96	93	92	98
Parent/parent in law	-	3.	2	-
Child/child in law	3	-	-	1
Other relative	1	4	3	1
Non relative	1	-	2	1
Total	100%	100%	100%	100%
(N)	(5580)	(407)	(89)	(324)
Age 60 and over				
Head/spouse of head	95	57	63	92
Parent/parent in law	2	42	29	4
Child/child in law	0	-	-	-
Other relative	2	1	8	2
Non relative	1	-	-	1
Total	100%	100%	100%	100%
(N)	(5730)	(112)	(24)	(114)

Note: Chi-squared for both 40-59 and 60 and over significant at p<0.001.
Source: Evandrou (2000)

Table 3.9c shows the relationship to the head of household amongst Londoners aged 40-59 and 60 and over amongst different ethnic groups in the EMYD sample. A much greater proportion of South Asian elders live with their adult children than do White or Black Caribbean elders.

Carers and families

The fact that a higher proportion of South Asian elders live with adult children indicates that there is a *potential* availability of family care. This contrasts with the position of Black Caribbean elders, where 75% of them do not live with adult children and 21% live alone (closer to the pattern in white elders). The fact that these elders do not co-reside with their adult children does not preclude them receiving family support; nor can it be assumed that South Asian elders living with adult children, and who need support, are receiving it from their families. However, the importance of informal, mostly family carers to frail older people means that these differentiated family patterns may have implications for the pattern of service needs in different communities. The higher proportion of South Asian, and particularly Pakistani/Bangladeshi, over 60's living in multi-generational households with dependent children suggests that more of these may be taking everyday childcare responsibilities than other groups.

Some estimates of the numbers of informal carers of people who need help because they are elderly, or sick, or have a disability by ethnic group across London are given in Chapter 6. Because of generally younger age structures, these suggest that most ethnic minority populations, apart from Indians, include a lower proportion of such carers than the white group. Nevertheless there are estimated to be 121,700 adults from black and minority ethnic groups who are providing this kind of care, with 9,200 of these carers themselves aged over 65.

Socio-economic group

The EMYD information suggests that the majority of minority ethnic elders are from manual occupational backgrounds, although there is diversity between ethnic groups (Tables 3.10a and 3.10b). A higher proportion of Indian elders (24%) are classified in professional and managerial groups (i.e. groups 1 and 2) than either white or Pakistani/Bangladeshi elders (16%); and in London this differential widens to 36% compared to 12-15%. Only 3% of Black Caribbean elders fall into this category.

Table 3.10a: Socio-economic group amongst persons aged 40-59 and 60 and over by ethnicity, Great Britain (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Age 40-59				
1 & 2	22	21	18	7
3 Non-manual skilled	32	20	14.	25
4 Manual skilled	22	28	28	27
5&6	24	31	40	40
Total	100%	100%	100%	100%
(N)	(59530)	(773)	(269)	(564)
Age 60 and over				
1 & 2	16	24	16	3
3 Non-manual skilled	28	14	2	13
4 Manual skilled	23	27	22	24
5&6	33	35	60	60
Total	100%	100%	100%	100%
(N)	(53330)	(170)	(63)	(211)

Note: Chi-squared for both 40-59 and 60 and over significant at p<0.001.
Source: Evandrou (2000)

Table 3.10b: Social class amongst persons aged 40-59 and 60 and over by ethnicity, Greater London (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Age 40-59				
1 & 2	25	24	18	7
3 Non-manual skilled	37	27	23	27
4 Manual skilled	18	25	24	24
5&6	20	24	35	42
Total (N)	100%	100%	100%	100%
	(5410)	(362)	(66)	(302)
Age 60 and over				
1 & 2	15	36	12	4
3 Non-manual skilled	36	16	6	14
4 Manual skilled	22	25	29	22
5&6	28	23	53	60
Total	100%	100%	100%	100%
(N)	(5510)	(73)	(17)	(106)

Note: Chi-squared for both 40-59 and 60 and over significant at p<0.001.
Source: Evandrou (2000)

Black Caribbean and Pakistani/Bangladeshi elders in London are significantly more likely to be in the semi-skilled and unskilled manual occupational groups (53-60%) compared with

Indian elders (23%) and white elders (28%). These patterns are similar to the national picture, though the differential in London is somewhat more marked.

Economic activity

The 1991 Census shows the different economic positions of main ethnic groups of pensionable age in London at that time (Leeser, 1996). All of the minority groups apart from Indian and Pakistani elders were more likely than white older people to describe themselves as economically active – that is, working or seeking work. Within the economically active, the Chinese were most likely, and the Irish least likely, to be self-employed, and all minority groups more likely than Whites to be unemployed – especially Bangladeshis and Black Africans. Among the economically inactive, the White group included the lowest proportion of permanently sick, and the South Asian groups the highest. The highest proportion of retired people was found in the Whites, Irish-born and Black Caribbean groups.

The EMYD shows significant differences in employment patterns by ethnicity, and age and gender (Table 3.11a). Looking first at those in the pre-retirement years (aged 40-59), ethnic minority men fare less well than white men, with higher proportions unemployed and out of the labour force (this includes 'looking after the home or family', student, permanently sick, or something else). In particular, a much lower proportion of Pakistani/Bangladeshi men report being employed in the last week (53%). The pattern is replicated for London (Table 3.11b).

The picture for women is somewhat different. Black Caribbean women aged 40-59 report higher employment rates compared to white women of the same age (76% vs 68%). Just over half of Indian women of this age group are in employment, but only 14% of Pakistani/Bangladeshi women are economically active. As many as 85% of Pakistani/Bangladeshi women aged 40-59 report being out of the labour force, the majority of whom are 'looking after the home or family'.

Table 3. 11a Employment status amongst persons aged 40-59 by ethnicity by sex, Great Britain (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Men				
Employed	85	79	53	73
Unemployed	7	9	24	15
Retired	2	0	-	2
Out of labour force	7	12	23	10
Total	100%	100%	100%	100%
(N)	(29290)	(468)	(233)	(267)
Women				
Employed	68	51	14	76
Unemployed	3	4	2	7
Retired	3	0	-	-
Out of labour force	27	45	85	17
Total	100%	100%	100%	100%
(N)	(31070)	(413)	(171)	(306)

Note: Chi-squared for both Men and Women significant at p<0.001. *Source: Evandrou (2000)*

Table 3.11b: Employment status amongst persons aged 40-59 by ethnicity by sex, Greater London (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Men				
Employed	86	83	58	71
Unemployed	7	8	23	17
Retired	1	1	-	2
Out of labour force	6	9	19	10
Total (N)	100% (2630)	100% (220)	100% (52)	100% (135)
Women				
Employed	70	57	22	78
Unemployed	5	3	3	7
Retired	4	-	-	-
Out of labour force	21	40	76	53
Total (N)	100% (2870)	100% (182)	100% (37)	100% (171)

Note: Chi-squared for both Men and Women significant at p<0.001.
Source: Evandrou (2000)

Amongst those aged 60 and over, 14% of Black Caribbean women continue to work compared with 7% of white women and 3-4% of South Asian women (Table 3.11c). In London this proportion rises to 20% (Table 3.11d). One in ten men aged 65 and over amongst the South Asian communities remain in employment compared to 7% of white men and 5% of Black Caribbean men (Table 3.11c). This may reflect a number of factors, including the need to remain in paid employment for financial reasons, as well as the nature of employment. A high proportion of South Asian men who continue to work beyond retirement age are self-employed.

Table 3.11c: Employment status amongst persons aged 60 and over by ethnicity by sex, Great Britain (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Men aged 60 and over				
Employed	19	27	12	27
Unemployed	2	2	5	4
Retired	74	54	59	53
Out of labour force	6	17	24	16
Total	100%	100%	100%	100%
(N)	(23750)	(139)	(59)	(118)
Men aged 65 and over				
Employed	7	10	11	5
Unemployed	0	1	-	-
Retired	92	82	89	95
Out of labour force	1	6	-	-
Total	100%	100%	100%	100%
(N)	(17020)	(78)	(33)	(56)
Women aged 60 and over				
Employed	7	4	3	14
Unemployed	-	1	-	2
Retired	58	19	6	68
Out of labour force	35	76	91	15
Total	100%	100%	100%	100%
(N)	(31660)	(121)	(33)	(98)

Note: Chi-squared for both Men and Women significant at p<0.001. Source: Evandrou (2000)

Table 3.11d: Employment status amongst persons aged 60 and over by ethnicity by sex, Greater London (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Men aged 60 and over				
Employed	21	35	29	29
Unemployed	1	2	-	4
Retired	73	55	43	55
Out of labour force	5	9	29	13
Total	100%	100%	100%	100%
(N)	(2320)	(58)	(14)	(55)
Men aged 65 and over				
Employed	9	16	(3)	7
Unemployed	1	-		-
Retired	90	78	(6)	93
Out of labour force	-	6		-
Total	100%	100%	100%	100%
(N)	(1670)	(32)	(9)	(30)
Women aged 60 and over				
Employed	7	6	(1)	20
Unemployed	-	2	-	2
Retired	65	27	(2)	66
Out of labour force	28	65	(7)	13
Total (N)	100%	100%	100%	100%
	(3390)	(49)	(10)	(56)

Note: Chi-squared for both Men and Women significant at p<0.001.

Note: numbers in brackets indicate cell count, where count less than 10.

Source: Evandrou (2000)

A similar pattern with regard to employment by ethnicity was found in the 4th National Survey (Modood & Berthoud, 1997). The survey found that the position of Caribbean women relative to white and other women is much better than that of Caribbean men, as compared to other men; Caribbean women averaged the highest female earnings from full-time employment. Pakistanis and Bangladeshis are consistently at a disadvantage, both compared to the white population and to other ethnic groups. This is associated with high male unemployment rates and low female economic activity rates, and when in employment, these groups face disproportionately low wages, which has to be stretched further to support a larger than average household. These disadvantages may feed through into later life.

Income levels and sources

The Census does not ask directly about income, and there are no comprehensive data for this key component of inequality. The Retirement Income Inquiry reported that elderly people in general are disproportionately represented in the bottom of the income distribution (RII, 1997). The 4th National Survey found that minority ethnic households in general are disadvantaged with regard to income: for example, four out of five ethnic households have an income below half the national average, compared to one quarter of white households. However, very little is known about the relative income position of minority ethnic elders. The EMYD is therefore a particularly valuable source of information on this topic.

Table 3.12a shows the proportion of older people within each ethnic group, in relation to the quintile group of the income distribution of the total population. Total gross family income was calculated by adding the gross income of all family members together. Differences in family size and composition were then taken into account using the McClements equivalence scale. Income data for each year was deflated to 1994/5 prices using the Blue Book GDP deflator. If there were no relationship between age and income or ethnicity and income, one would expect to find 20% of each ethnic group in each quintile. In fact, there is both an age effect and a relationship with ethnicity.

Twenty-seven percent of white over 60's are in the bottom fifth of the income distribution compared to 65% of Pakistani/Bangladeshi elders, 55% of Indian elders, 43% of Black Caribbean and 46% of Chinese elders (Table 3.12 a). A similar picture is found for London, although small cell counts only allow one to focus on Indian and Black Caribbean elders (Table 3.12b). Elderly people in London tend to be slightly better off than in Britain as a whole, with a higher proportion located in the top quintile group for both white and minority ethnic elders than in the general population.

Table 3.12a: Income - quintile of equivalised usual gross income of the family amongst persons aged 40-59 and 60 and over by ethnicity, Great Britain (%)

	Bottom	**2**	**3**	**4**	Top	**Total (N)**
Age 40-59						
White	12	14	19	24	30	100% (44717)
Indian	23	19	21	19	19	100% (635)
Pakistani/Bangladeshi	52	30	9	5	5	100% (329)
Chinese	34	17	15	8	27	100% (79)
Black Caribbean	21	20	24	23	13	100% (384)
African	29	8	16	27	20	100% (84)
Mixed	24	12	20	18	25	100% (103)
Other	20	11	16	21	33	100% (231)
All aged 40-59	13	16	19	24	30	100% (46831)
Age 60 and over						
White	27	37	17	10	9	100% (39141)
Indian	55	19	9	8	9	100% (187)
Pakistani/Bangladeshi	65	24	(5)	(1)	(2)	100% (72)
Chinese	46	(6)	(5)	(1)	(1)	100% (24)
Black Caribbean	43	29	14	12	(5)	100% (148)
African	(7)	(1)			(1)	100% (9)
Mixed	38	31	(3)	(2)	(4)	100% (29)
Other	39	29	(5)	13	(9)	100% (75)
All aged 60 and over	27	37	17	10	9	100% (39841)

Note: Chi-squared for both 40-59 and 60 and over significant at p<0.001.
Note: numbers in brackets indicate cell count, where count less than 10.
Source: Evandrou (2000)

Table 3.12b: Income - quintile of equivalised usual gross income of the family amongst persons aged 40-59 and 60 and over by ethnicity, Greater London (%)

	Bottom	2	3	4	Top	Total (N)
Age 40-59						
White	9	8	14	25	45	100% (4033)
Indian	18	14	22	21	26	100% (280)
Pakistani/Bangladeshi	34	31	16	(6)	(6)	100% (64)
Chinese	38	(4)	(3)	(1)	35	100% (29)
Black Caribbean	22	14	23	25	16	100% (205)
African	30	(4)	16	27	21	100% (63)
Mixed	32	(3)	(4)	(7)	36	100% (44)
Other	16	13	11	25	36	100% (135)
All aged 40-59	12	9	15	24	41	100% (4885)
Age 60 and over						
White	22	37	17	10	14	100% (3770)
Indian	51	19	(6)	(6)	16	100% (81)
Pakistani/Bangladeshi	70	(3)	(1)		(2)	100% (20)
Black Caribbean	39	24	17	17	(3)	100% (72)
All aged 60 and over	24	36	17	10	14	100% (4048)

Note: Chi-squared for both 40-59 and 60 and over significant at p<0.001.
Note: numbers in brackets indicate cell count, where count less than 10.
Source: Evandrou 2000.

The predominance of ethnic minority elders in the bottom fifth of the income distribution has implications for their health and well-being. The majority are from occupational manual backgrounds and many will not be in a position to contribute financially to the costs of health and social care - although some will have the means to do so. A small proportion of elders are in the top fifth of the overall income distribution. 9% of both White and Indian elders are in the richest quintile of the population (Table 3.12a). There is a clear bi-modal distribution of income within the Indian elder population; with over half experiencing very low income while a tenth are well off (16% in London). This is not, however, the case amongst the other minority groups.

A similar pattern is found using an alternative measure of material well-being. Employing an amended version of Townsend's index of deprivation (Townsend *et al,* 1988), Indian elders are least likely to experience multiple deprivation, displaying similar levels to White elders, whilst over half of Pakistani and Bangladeshi elders and two-fifths of Black Caribbean elders experience high or medium levels of deprivation (Evandrou, 2000a).

The average levels of current net income and usual gross income of the individual (in 1994/5 prices) are shown in Tables 3.12c and d, along with the mean and median value of adult equivalent gross family income. Not surprisingly, the average income of people aged 60 and over is much lower than that for people aged 40-59. Amongst those aged 60 and over, the median value of usual gross weekly income for most ethnic groups is under £81. The average NI pension payment in 1994/5 was £61.63 (Evans, 1997). Mean income is higher than median income, reflecting the skewed distribution of income.

Average income in London is higher than for Britain as a whole (Table 3.12d). Family income, after adjusting for family composition and size, is generally higher than individual

income, reflecting the pooling of resources and economies of scale. However, amongst Pakistanti/Bangladeshi elders, equivalent gross family income is actually lower than individual gross income, reflecting the fact that family income is shared between more members, including children. Thus, although average individual income may not be that different between the different ethnic minority groups, there are marked differences in the financial well-being of the family unit.

Table 3.12c: Average income (£) - a) usual gross weekly income of the individual; b) current net weekly income of the individual; c) equivalised usual gross income of the family amongst persons aged 40-59 and 60 and over by ethnicity, Great Britain

	Usual gross weekly income		Current net weekly income		Equiv. Gross family income	
	Mean	Median	Mean	• Median	Mean	Median
Age 40-59						
White	246	186	182	147	249	215
Indian	227	158	167	132	204	162
Pakistani/Bangladeshi	146	116	122	109	101	76
Chinese	216	132	167	110	219	124
Black Caribbean	197	186	151	141	176	166
African	258	232	192	188	209	194
Mixed	238	184	175	139	216	185
Other	264	211	200	164	239	211
All aged 40-59	244	185	181	146	246	213
Age 60 and over						
White	125	81	108	79	146	102
Indian	122	79	103	70	125	72
Pakistani/Bangladeshi	94	82	91	76	86	67
Chinese	140	74	96	68	130	89
Black Caribbean	106	75	95	74	119	86
African	87	71	87	68	92	61
Mixed	106	77	96	75	152	91
Other	120	69	106	68	137	103
All aged 60 and over	125	81	108	78	145	102

Note: ANOVA F-statistic significant at p<0.001, for 40-59 for all sources of income and for equivalent gross family income for 60 and over.
Source: Evandrou (2000)

Table 3.12d: Average income (£) - a) usual gross weekly income of the individual b) current net weekly income of the individual; c) equivalised usual gross income of the family amongst persons aged 40-59 and 60 and over by ethnicity, Greater London

	Usual gross weekly income		Current net weekly income		Equiv. Gross family income	
	Mean	Median	Mean	• Median	Mean	Median
Age 40-59						
White	325	261	235	186	317	271
Indian	257	194	182	150	232	185
Pakistani/Bangladeshi	183	139	144	119	137	97
Chinese	259	143	194	118	247	147
Black Caribbean	209	193	161	148	184	176
African	260	239	198	197	214	203
Mixed	276	241	204	160	260	239
Other	275	223	209	171	247	228
All aged 40-59	312	248	226	181	300	251
Age 60 and over						
White	145	89	121	85	169	109
Indian	143	75	118	70	142	79
Pakistani/Bangladeshi	110	76	107	76	102	67
Chinese	93	68	72	68	117	105
Black Caribbean	111	77	98	75	126	93
African	88	71	87	68	100	62
Mixed	101	84	96	84	145	105
Other	105	69	93	68	120	103
All aged 60 and over	144	88	120	85	167	105

Note: ANOVA F-statistic significant at p<0.001, for 40-59 for all sources of income.
Source: Evandrou 2000

Table 3.13 compares sources of income. Income Support is a means-tested benefit which is payable to people on low incomes. The percentage of a community who are in receipt of Income Support is therefore a good indicator of the financial disadvantage within that community. The proportion of elders who report being in receipt of income from selected welfare benefits is shown in Table 3.13. A significantly higher proportion of people aged 40-59 from minority ethnic communities are in receipt of Income Support than white people of the same age. A third of all Pakistani/Bangladeshis and a quarter of Black Caribbeans receive Income Support compared with just 8% of whites.

The proportion in receipt of Income Support rises with age. Amongst those aged 60 and over, nearly two-third of Pakistani/Bangladeshi elders (64%), over half of Chinese elders (57%) and two-fifths of Indian elders (41%) report receiving Income Support, compared with 16% of White elders. This confirms the fact that a significant proportion of ethnic minority elders are financially disadvantaged and are dependent upon income from the State. In addition, there may be many older people in need of income support but who do not apply for it. Presently about 18% to 24% of all people entitled to social assistance do not take it up (DSS 1998a, Table H4.01). The figures may in fact be higher for older people, who are particularly reluctant to claim despite large-scale DSS efforts, and this may be particularly true amongst ethnic minority elders who may be less aware of their entitlements.

Table 3.13: Percentage in receipt of income from selected benefits amongst persons aged 40-59 and 60 and over by ethnicity, Greater London & Great Britain

	Greater London		Great Britain	
	NI pension	Income Support	NI pension	Income Support
Age 40-59				
White		9%		8%
Indian		12%		14%
Pakistani/Bangladeshi		28%		33%
Chinese		20% (2)		15%
Black Caribbean		27%		24%
African		24% (8)		23%
Mixed		5 %(1)		13%
Other		18%		17%
All aged 40-59		10%		8%
Age 60 and over				
White	86%	14%	85%	16%
Indian	49%	35%	55%	42%
Pakistani/Bangladeshi	68%	56%	67%	64%
Chinese	43% (3)	60% (3)	61%	57%
Black Caribbean	65%	33%	65%	35%
African	83% (5)	-	73%(8)	11% (1)
Mixed	95%	80% (4)	78%	33% (4)
Other	59%	50%	72%	58%
All aged 60 and over	84%	16%	85%	17%

Note: numbers in brackets indicate cell count, where count less than 10.
ANOVA F-statistic significant at p<0.001, for both 40-59 and 60 and over, and for all sources of income.
Source: Evandrou (2000)

The ethnic pattern is similar within London, although the absolute proportions are somewhat lower, reflecting the fact that Londoners are slightly better off than the national average. As with the measures of overall income, the Pakistani/Bangladeshi groups, who include more recent arrivals, appear worse off than the Black Caribbean and Indian groups whose settlement in this country is of longer standing. This has direct implications for their ability to financially contribute to the costs of health and social care.

Housing tenure and housing quality

Access to good quality housing is an important factor in health, and housing-related health problems are a particular feature of London (Bardsley *et al*, 1998). Sample data on housing tenure from the 1991 Census (Leeser, 1996*)* suggested that London's Black Caribbean and Indian pensioners were less likely than Whites to live in households which owned their houses outright. Black Caribbeans were more likely to be renting from Local Authorities, Indians most likely to be buying their homes.

Analysis of London all-age data within national surveys (from 1993-7) indicates that people from the Indian ethnic group are more likely to be owner-occupiers (LRC, 1999). Pakistanis have a tenure pattern similar to White groups, although with more private renting and less owner-occupiers. Bangladeshis are much more likely to be living in Local Authority housing and the Black groups more likely to be in Housing Association or local authority properties.

The EMYD data similarly suggests that nationally over half (60%) of white elders are owner-occupiers, most without mortgage commitments (Table 3.14a). Indian and Pakistani/Bangladeshi elders have higher rates of owner-occupation (78% & 66% respectively), although a significant proportion live in owner-occupied housing with a mortgage. This reflects the housing tenure of the younger household members they reside with. Black Caribbean elders are more likely to reside in local authority/housing association accommodation. Owning outright is of course a function of the number of years a person has been resident in Britain.

Table 3.14a: Housing tenure amongst persons aged 40-59 and 60 and over by ethnicity, Great Britain (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Age 40-59				
Owns outright	22	22	23	11
Owns with mortgage	53	66	51	53
Local Authority/Housing Assoc.	19	8	15	33
Other renter	6	4	11	3
Total	100%	100%	100%	100%
(N)	(60990)	(890)	(409)	(596)
Age 60 and over				
Owns outright	51	33	38	26
Owns with mortgage	9	44	28	29
Local Authority/Housing Assoc.	32	16	31	42
Other renter	8	7	3	2
Total	100%	100%	100%	100%
(N)	(55560)	(266)	(93)	(222)

Note: Chi-squared for both 40-59 and 60 and over significant at p<0.001.
Source: Evandrou (2000)

Table 3.14b: Housing tenure amongst persons aged 40-59 and 60 and over by ethnicity, Greater London (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Age 40-59				
Owns outright	17	17	14	7
Owns with mortgage	55	71	48	52
Local auth/housing assoc.	23	8	24	39
Other renter	4	5	15	3
Total	100%	100%	100%	100%
(N)	(5580)	(406)	(89)	(324)
Age 60 and over				
Owns outright	49	25	21	20
Owns with mortgage	11	56	17	33
Local auth/housing assoc.	30	17	54	43
Other renter	11	7	8	4
Total	100%	100%	100%	100%
(N)	(5730)	(112)	(24)	(114)

Note: Chi-squared for both 40-59 and 60 and over significant at p<0.001.
Source: Evandrou (2000)

The picture in London (Table 3.14b) is similar to the national picture, although a higher proportion of White and Indian owner-occupiers have outstanding mortgage commitments. Amongst Pakistani/Bangladeshi elders living in London, the majority reside in local authority

accommodation. This pattern is in contrast to Britain as a whole: the sub-sample size is small, but may reflect the housing pattern in the areas where these groups live, particularly Bangladeshis in Tower Hamlets where this is a common form of tenure (Storkey, 1994).

One measure of the quality of people's housing is whether they have access to certain amenities such as central heating or double-glazing. Data from the English House Condition Survey (DoE, 1991) indicated that Pakistani/Bangladeshi households (all ages) were less likely to have central heating than other communities, with only 59% compared to 81% of White households.

Another indicator of housing standard is overcrowding. One measure of overcrowding is the 'bedroom standard', which sets the number of bedrooms a household 'needs' depending upon its composition and the relationship of its members to each other (e.g. couples have 1 bedroom, children of same sex can share a bedroom, different sex children have own bedroom). Where the number of rooms is one or more below the bedroom standard, the household is classified as overcrowded. The Survey of English Housing 1994/5 found that nearly half of all households of Bangladeshi origin live in overcrowded accommodation, compared with only 2% of white households.

A simpler measure is the number of persons per room (not including kitchens or bathrooms). Tables 3.15a and 3.15b from the EMYD show the proportion living in overcrowded conditions amongst persons aged 40-59 and 60 and over. Only 1% of white elders reside in accommodation with 1 person or more per room. The likelihood of living in overcrowded conditions is much greater among black and minority ethnic elders. Pakistani and Bangladeshi elders are particularly prone to living in more crowded conditions, with 37% living in households with more than one person per room. Within London this percentage rises to 43%. A lower proportion of Chinese elders experience overcrowding (14% in Britain as a whole), but again this rises in London, with 30% living in households with 1 person or more per room.

Table 3.15a: Overcrowding (number of persons per room) amongst persons aged 40-59 and 60 and over by ethnicity, Great Britain (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Age 40-59				
1 person or more	6	23	52 [a]	12
Under 1 person per room	94	77	48	88
Total	100%	100%	100%	100%
(N)	(55400)	(805)	(373)	(528)
Age 60 and over				
1 person or more	1	21	37 [b]	3
Under 1 person per room	99	79	63	97
Total	100%	100%	100%	100%
(N)	(49870)	(240)	(87)	(209)

[a] *includes 9% living in households with more than 1.5 persons per room, i.e. 'severe overcrowding'.*
[b] *includes 12% living in households with more than 1.5 persons per room.*
Note: Chi-squared for both 40-59 and 60 and over significant at p<0.001.
Source: Evandrou (2000)

Table 3.15b: Overcrowding (number of persons per room) amongst persons aged 40-59 and 60 and over by ethnicity, Greater London (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Age 40-59				
1 person or more	6	21	53 [a]	10
Under 1 person per room	94	79	47	90
Total	100%	100%	100%	100%
(N)	(5080)	(378)	(74)	(287)
Age 60 and over				
1 person or more	1	24	43 [b]	3
Under 1 person per room	99	76	57	97
Total	100%	100%	100%	100%
(N)	(5130)	(101)	(21)	(108)

[a] *includes 8% living in households with more than 1.5 persons per room.*
[b] *includes 24% living in households with more than 1.5 persons per room.*
Note: Chi-squared for both 40-59 and 60 and over significant at p<0.001.
Source: Evandrou (2000)

Communal establishments

Of London pensioners resident in communal establishments in 1991, the vast majority were white, and this is not totally accounted for by the differing age structure of the ethnic groups. South Asian pensioners in particular were less likely to live in such establishments than other main groups (Leeser, 1996). These include both care establishments, such as hospitals, residential and nursing homes, and non-care establishments – educational establishments, hotels and clubs.

A more recent survey by the London Care Homes Information Network (Brooker & Davies, 1998) showed that across the residential, dual registered and the Elderly Mentally Infirm (EMI) establishments which they surveyed, the ethnic mix was broadly in proportion to that of the population aged over 75. There was however some clustering of non-white groups in a small number of homes; and local authorities were accommodating a higher proportion of non-whites than were the voluntary and private sector homes.

Mobility and migration

Aspects of the migration experience of people from ethnic minority groups include their country of birth; the length of time they have lived in the UK; and mobility within the UK. Census data give us some information about country of birth for the 1991 London population (see Table 3.5).

The EMYD suggests that while the proportion of minority ethnic elders who have been resident in Britain all their lives is very small, the majority have lived in Britain for more than ten years (Table 3.16a and b). The Bangladeshi/Pakistani group includes more recent arrivals, and these more recently established communities are the ones with the worst employment, income and housing experience.

Table 3.16a: Length of residence in Britain amongst persons aged 40-59 and 60 and over by ethnicity, Great Britain (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Age 40-59				
Lifetime	96	2	1	4
Over ten years	4	95	93	95
Five to ten years	0	2	5	0
Less than five years	-	1	1	-
Total	100%	100%	100%	100%
(N)	(60620)	(816)	(385)	(524)
Age 60 and over				
Lifetime	96	2	-	5
Over ten years	4	94	91	96
Five to ten years	-	3	7	-
Less than five years	-	2	2	-
Total	100%	100%	100%	100%
(N)	(55260)	(254)	(88)	(202)

Note: Chi-squared for both 40-59 and 60 and over significant at p<0.001.
Source: Evandrou (2000)

Table 3.16b: Length of residence in Britain amongst persons aged 40-59 and 60 and over by ethnicity, Greater London (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Age 40-59				
Lifetime	88	2	-	1
Over ten years	12	96	93	99
Five to ten years	0	2	6	-
Less than five years	-	1	1	-
Total	100%	100%	100%	100%
(N)	(5470)	(369)	(86)	(283)
Age 60 and over				
Lifetime	90	4	-	-
Over ten years	10	91	79	100
Five to ten years	-	4	17	-
Less than five years	-	2	4	-
Total	100%	100%	100%	100%
(N)	(5640)	(108)	(24)	(108)

Note: Chi-squared for both 40-59 and 60 and over significant at p<0.001.
Source: Evandrou (2000)

The reasons for migration of individuals or of groups can range from study or work for a short term period, through much longer term economic migration with a view to settlement, to the particularly stressful circumstances of arrival as a refugee seeking asylum. London's black and minority ethnic elders include people from all of these groups, and their descendants. The particular health needs of refugees and asylum seekers include some physical, but more mental health problems, and these latter can be long-lasting (Aldous *et al*, 1999).

Some older people from minority groups have come to join their children settled in the UK permanently, under "family reunion" provisions for over 60's particularly for relatives of refugees. While they are fully entitled to health care and educational services, some of these elders have limited rights to welfare and other benefits such as housing benefit. This means that they are more likely to be financially and socially dependent on their children.

For some other older people, who have not come as refugees, the possibility of returning to an original 'home' may be possible but not always desirable or easily achieved (Byron, 1999). There is anecdotal evidence that, while many older Irish or Caribbean people would like to return to their country of birth, they may be inhibited from doing so by factors such as:

- social change since they left
- establishment of family and social links in the UK
- practical obstacles such as limited transferability of pension rights
- differential costs of living, and also property costs, in their country of origin.

Racism and discrimination

The experience of many minority ethnic elders includes encounters with direct and indirect racism and xenophobia. Examples reported to the task group include experiences from arrival in the UK at a time when "No blacks – no dogs – no Irish" was frequently attached to accommodation, to racist graffiti on foreign language signs in sheltered housing, anti-Irish feelings through periods of terrorist activity in London, anti-Semitism, discrimination in employment including medicine (see also Anon, 2000) and poor attitudes by health and other service staff. There is also some experience of racism on the part of elders themselves – both to their contemporaries as fellow users of services, and to staff.

There is evidence of an independent relationship between health and the experience of racism. Data from the 4th National Survey suggest significant independent relationships between the reporting of fair or poor health, and perceived racial discrimination in employment – 60% greater odds; and experience of increasing degrees of racial harassment – 50 to 100% greater odds (Karlsen & Nazroo, 2000). In addition, there is the indirect impact of discriminatory attitudes on relative physical and mental health through their effect on employment, pay, housing, education and access to services.

Language

A key defining feature of some ethnic groups, and one which is most significant for access to health information and health care, is language. There are little routine data available about this, and although it was considered for the 2001 Census, there will again be no question about language.

The HEA Survey of Black and Ethnic Minority Health & Lifestyles (HEA, 1992) found that, nationally, older people from the South Asian communities are less likely to speak English than their younger counterparts. Two key findings stand out:

- Bangladeshi men aged 50-74 are less likely to speak English (51%) than Pakistani men (55%) and Indian men (86%) of the same age.
- Women are significantly less likely to speak English than men, with only 10-15% of 50-74 year old Bangladeshi and Pakistani women, and 47% of Indian women, being able to speak English. The same survey found similar patterns with respect to the ability to read English.

In London, a recent study of the home languages of schoolchildren illustrates a huge diversity, with around 350 languages (some overlapping) named. This includes derived estimates, using LRC's ethnic population projections of the total number of all-age speakers of the top 40 languages in London (Storkey in Baker & Eversley, 2000). Those linked to the Indian sub-continent predominate. Apart from the acknowledged unreliability of data for the French and the English Creoles, and accepting, among other assumptions, a constant language structure across age groups, these are probably the best estimates of overseas language distribution in households across the capital. It would, however, seem likely that elders, particularly those born overseas and migrating after initial education, would retain their first language even if it is not used in households with children, and that the proportions of overseas languages (and also dialects) may differ for older people from those shown here (Table 3.17).

First languages can become particularly important to older people who become mentally frail, as even people fluent in more than one language can lose these skills in those circumstances and need to communicate in their mother tongue (See Chapter 4). Dialects and accents are also important not only in basic communication, but in shaping attitudes and relationships.

Education

Educational background has been linked to lifetime income, health and well-being. From the EMYD, among elderly people nationally aged 60-69, 64% of white elders have no qualification compared with 59% of Indian elders, 71% Pakistani/Bangladeshi and 89% Black Caribbean (Table 3.18). There is clear evidence of a cohort effect, with a lower proportion of those in middle age (40-59) leaving school with no qualifications for all communities. The 'education gap' appears to be narrowing for the Black Caribbeans, with 50% having no qualifications and 15% with degrees. However 63% of Pakistani/Bangladeshis aged 40-59 still have no qualifications (possibly reflecting the fact that the main wave of migration amongst this group was later). Migrants, and especially older people, from some countries have experienced minimal primary education, so that literacy even in people's first language cannot be assumed, while others are very highly qualified.

Table 3.17: Estimated total numbers of speakers (to the nearest hundred) of the top 40 languages in London

Rank	Language	Scenario A*	Scenario B**
1	English	5,737,400	5,636,500
2	Panjabi	143,600	155,700
3	Gujarati	138,000	149,600
4	Hindi/Urdu	125,900	136,500
5	Bengali + Sylheti	119,900	136,300
6	Turkish	67,600	73,900
7	Arabic	49,500	53,900
8	English Creoles	46,300	50,700
9	Cantonese	45,100	47,900
10	Yoruba	43,300	47,600
11	Greek	28,600	31,100
12	Portuguese	26,900	29,400
13	French	25,300	27,600
14	Akan (Twi + Fante)	25,000	27,500
15	Spanish	24,500	26,700
16	Somali	19,037	22,343
17	Tamil	17,700	19,200
18	Vietnamese	15,800	16,800
19	Farsi	14,900	16,200
20	Italian	11,300	12,300
21	Tagalog	8,600	9,300
22	Igbo	8,200	9,000
23	French Creoles	7,700	8,400
24	Polish	6,600	7,200
25	Kurdish	6,200	6,800
26	Swahili	4,500	4,500
27	Lingala	4,100	4,500
28	Japanese	4,000	4,300
29	Albania	3,900	4,200
30	German	3,600	3,900
31	Luganda	3,400	3,700
32	Ga	3,400	3,700
33	Russian	3,200	3,500
34	Serbian/Croatian	3,100	3,400
35	Korean	3,000	3,200
36	Hebrew	2,800	3,100
37	Sinhala	2,200	2,300
38	Tigrinya	1,900	2,300
39	Pashto	1,600	1,700
40	Amharic	1,000	1,200

Note: these figures should be treated with caution. They are estimates, which have been calculated by making a large number of assumptions.

**** Scenario A** assumes all those outstanding unknowns after calculations have English as their first language.*
***** Scenario B** assumes that 91% of all those outstanding unknowns after calculations have English as their first language and that the others have first languages in proportion to the schools study percentages.*

Source: Storkey in Baker & Eversley (2000)

Data for London (small numbers) suggest that the educational differentials within London amongst 60-69 year olds are similar to the national picture, but are less marked amongst those aged 40-59. The proportion of people 40-59 amongst the Pakistani/Bangladeshi communities with no qualifications is much lower (48%), and a higher proportion have a degree (13%).

It must also be noted that while educational qualifications are increasingly essential for employment, they are not always sufficient. Census data for London (all working age adults

in 10% sample) show higher unemployment rates among people from minority groups with a postgraduate qualification, especially the Black African, Pakistani and Bangladeshi groups, and generally higher rates in Inner London than in Outer London boroughs. The Irish-born in this case fare a little better than average (Table 3.19).

Table 3.18: Highest educational qualification amongst persons aged 40-59 and 60 and over by ethnicity, Great Britain (%)

	White	Indian	Pakistani/ Bangladeshi	Black Caribbean
Age 40-59				
No qualification	46	44	63	50
O level/GCSE	30	36	28	19
A Level	6	6	2	2
Degree	17	13	8	15
Total	100%	100%	100%	100%
(N)	(57700)	(732)	(264)	(522)
Age 60-69				
No qualification	64	59	71	85
O level/GCSE	23	32	20	10
A Level	2	-	-	2
Degree	11	9	9	3
Total	100%	100%	100%	100%
(N)	(26340)	(107)	(35)	(151)

Note: Chi-squared for both 40-59 and 60 and over significant at p<0.001.
Source: Evandrou (2000)

Table 3.19: Percentage unemployed among persons qualified at levels a, b or c (beyond first degree level)

	Inner London	Outer London	Greater London
Black African	16.1%	10.8%	14.1%
Pakistani	12.2%	12.5%	12.4%
Bangladeshi	15.0%	7.1%	10.8%
Other	11.5%	8.6%	10.0%
Black Other	11.9%	7.4%	9.9%
Other Asian	8.7%	5.2%	6.3%
Black Caribbean	7.9%	3.6%	5.7%
Indian	6.1%	5.6%	5.7%
Chinese	5.1%	4.6%	4.8%
White	5.7%	3.3%	4.4%
All	6.5%	3.9%	5.0%
Born in Ireland	6.1%	3.1%	4.3%

Source: 1991 Census (OPCS, 1993)

Religion

There are no comprehensive data on the religious affiliations of London residents. The 2001 Census is expected to include a question that would allow a baseline to be established, and give a clearer picture of this aspect of ethnic identity. Religious affiliation and practice are important as determinants of health behaviours and health. For example, some religious groups abstain from specific foods, alcohol or tobacco. Religion also has implications for health and social care services, where the need for same-sex practitioners and space and time

for religious observance, as well as respect for personal hygiene and dietary customs, must be taken into account if services are to be acceptable. Spiritual support and religious-based organisations can be particularly important for older people and for their family and social networks, while many churches, synagogues, temples and mosques in London are a focus for ethnic minority and migrant communities.

However, not all older people are participants or adherents, and those who are not may feel more excluded and isolated. Examples include older Irish and Caribbean people who are not members of the churches which involve many in their communities, or people who are unable to abstain from, say, alcohol when their religion demands it. Nor is it clear that succeeding generations in all ethnic groups will maintain the same religious observance and links in an increasingly multicultural and secular society.

Elders from minority ethnic groups in London report higher levels of limiting long-term illness. Such differences appear to exist even within income groups. There may be changes over time: for example, within South Asian groups, a convergence towards local, less extended family structures. Housing pressures are a particularly big driver: historically the better off, and the second generation of migrant communities, have been more likely to move from inner to outer London and from London to elsewhere, leaving poorer and older people in the inner city.Â If they do not do so, then more elders from minority groups will stay in London, particularly in their current, largely but not exclusively, inner London Boroughs. 7. Health behaviours and health status. New NHS data has revealed ethnic breakdowns among the patients in London hospitals who have died with coronavirus. Black people account for 13% of the city's population but 16% of deaths. Epidemiologist Dr Shikta Das said there was a high rate of ethnic minority people among front line workers, who were exposed to greater risk. But Dr Das said it was difficult to draw conclusions as data needed to be more specific to areas of London. London has seen nearly 5,000 deaths linked to the virus. Coronavirus in London: Who is being most affected? NHS data, obtained by the BBC, analysed 3,929 dea