

## **Caring for Older People**

### ***Ethnic elders***

#### **Shah Ebrahim**

The numbers of elderly people from ethnic groups within Britain is rising rapidly as postwar immigrants age. Ethnic elders face problems owing to age-associated increased risks of common chronic diseases, racial discrimination, and poor access to many health services and social services. This disadvantage will be alleviated through increased understanding of health beliefs held by ethnic elders and ensuring better access to services through mechanisms such as employment of more staff from ethnic minority groups in senior positions, better training of staff, and more appropriate and sensitive environments. The myths that family care is sufficient, that no use of services implies no need, and that assimilation into the majority population will occur must be discounted. Since the 1870s Britain has received large numbers of immigrants from different countries and cultures (fig 1). Migration is due to “push” and “pull” factors. After the second world war, Britain actively recruited labour from Commonwealth countries to aid the reconstruction effort—a major “pull”; many came thinking they would earn enough money to return home and retire in comfort. “Push” factors are poverty, political instability, and oppression. Immigration policy became much less flexible during the 1980s and led to reductions in the numbers of new arrivals. New migrants arrive daily from some countries (such as Somalia) where political oppression endangers life but not from others (former Yugoslavia). British immigration policies are not consistent. The distribution of ethnic minorities in Britain is strongly biased towards inner city areas of major industrial towns. Bradford, Leeds, Manchester, Nottingham, Wolverhampton, Leicester, Birmingham, Coventry, and London have high numbers of elderly people of different ethnic origins.

#### ***OPCS classification of ethnicity for 1991 census***

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

#### **Ethnicity**

Ethnicity is a complex idea. It includes skin colour, culture, language, religion, birthplace, food, beliefs, and behaviour. Ethnicity is impossible to define clearly and in most contexts refers to the “otherness” of people who do not belong to the predominant population. The classification used by the Office of Population Censuses

and Surveys' emphasises the "visible" criterion of skin colour, reflecting British views of ethnicity. Not surprisingly, people who share a skin colour do not necessarily have much else in common. It is wrong to assume that

### **Jeopardy**

Ethnic elders are at risk by virtue of old age because of associated ill health and loss of role. They are further jeopardised by the multiple disadvantages due to racism, resulting in poor living conditions, overcrowding, low incomes, and a sense of alienation. They do not make use of many statutory and voluntary services because they perceive these services as being for the majority white population and being insensitive to their needs.<sup>2</sup> Disease patterns are broadly a reflection of those experienced by most older people. Rare or "exotic" tropical diseases are seldom encountered, but the diagnosis of heart failure, asthma, or tuberculosis may present a major challenge because of communication problems. With the exception of Chinese people, older people from all ethnic groups seem to have more chronic disease than white British people until very old age (fig 3).<sup>3</sup> Explanations for the excess morbidity are poverty, poor housing, and lifestyle (smoking, lack of exercise, diet), all of which contribute to higher risks of cardiovascular disease, diabetes, and other chronic problems. Morbidity may be due to factors operating in the "home" country, selection of who migrates, or the process of adaptation and adjustment.<sup>3</sup>

### **Health beliefs**

A variety of beliefs can determine our views about causation and treatment of disease. Many older people from ethnic minorities (in common with many white British people) hold contradictory beliefs, ranging from a modern understanding of infectious and chronic degenerative disease, a religious view that it is God's will that disease occurs and that prayer will help, and traditional beliefs in spirits or the "evil eye" that must be dealt with by rituals. It is not possible to generalise about the specific beliefs held by an individual. Sensitive inquiry about beliefs should be an essential part of taking a history, whatever the patient's ethnicity.

### **Consultations in primary care**

The number of consultations in general practice by older people from ethnic minorities is high (fig 4),<sup>4</sup> and this may cause consternation for the general practitioner or nurse. Having excluded anaemia, osteomalacia, tuberculosis, diabetes, asthma, and ischaemic heart disease, what next? Most older people from ethnic minorities consider themselves to be sicker than white British people. This suggests that excess consultation may simply reflect excess ill health.

Fig 1 -Trends in world migration to Britain

### ***Triple jeopardy for ethnic elders***

- Age
- Cultural and racial discrimination
- Lack of access to health, housing, and social services

## **Common diseases among ethnic elders**

- Ischaemic heart disease
- Stroke
- Diabetes
- Asthma
- Tuberculosis
- Osteomalacia
- Cataract
- “Exotica”-tropical diseases

The general practitioner must be aware that these patients are likely to have multiple consultations with alternative practitioners and to take drugs obtained overseas, and should ask about these practices. Employing practice staff from a predominant local ethnic minority group is an excellent way of gaining insight into these expectations and practices.

## **The hospital experience**

Hospital admission is a frightening, demeaning, and difficult experience for anyone and is even harder for ethnic elders. Familiarity with hospital routines (which white people gain from watching TV hospital soaps) is non-existent, and language may present insuperable barriers. Staff from ethnic minorities can help make hospitals more sensitive to people’s needs. However, it is vital that equal employment opportunities are not limited to menial roles if improvements in equity and accessibility of services are to be achieved.

## **Rehabilitation**

The process of rehabilitation is not widely understood by many ethnic elders. If you are ill, you should lie in bed until you get better or die. Active rehabilitation may be thought unhelpful and is counterintuitive. Careful explanation and negotiation is required with the patient and family and with community services to establish aims and methods of rehabilitation and to ensure a reasonable outcome.’ Activities of daily living are widely used to assess progress and determine discharge from hospital and the need for follow up rehabilitation. Aims are culturally specific and differences in customs of dressing, bathing, and eating must be taken into account. These factors may explain some, but not all, of the relative dependency of Asians aged over 75 in Leicester (fig 5).<sup>4</sup> Language, religion, and food are the most obvious differences between ethnic groups, but the health service and social services are not responding to these needs in ways that reflect our multicultural society. Provision of trained interpreters, places for prayer, and culturally acceptable food are all needed in hospitals but are seldom found.

Religious beliefs and social customs must be observed to ensure that the processes of dying and bereavement are not made unnecessarily painful. Knowledge of practices of the major religions (box 5) is not widespread. It is always sensible to ask relatives about specific requirements and not to make assumptions.

## ***Creating a better hospital environment***

- Interpreters-available for inpatient and outpatient work
- Meals culturally appropriate and likely to be enjoyed by all
- Visiting-acceptance of large family groups, particularly after death
- Signs-use of direction markings comprehensible to those not literate in any language
- Patient information-booklets, cassette tapes, hospital radio in several languages
- Discharge and follow up-equity with white population in provision
- Equal opportunities employment at all levels-ethnic monitoring, particularly of medical short listing and appointments committees

### **Myths about ethnic elders**

- Numbers are very small
- The family supports old people
- No use of services equals no need for services
- People from ethnic minorities will return home in old age
- It would be better if they spoke English

### **Family and social factors**

The return home in old age was the expectation of many migrants, particularly from the West Indies. For many this hope will never be realised, but some may have the resources and desire to bury their bones on home soil. Arranging for overseas travel for a frail or very dependent person is quite possible and can often result in much happiness. It is vital that the family have clear information to give the airline on the person's disabilities and likely needs during travel. A comprehensive medical, nursing, and treatment summary is also essential for continuity of care once the person gets back home. The social services have made little progress in adapting to our multicultural society.<sup>7</sup> This is a reflection of political pressure to sustain services for the white (voting) majority, assumptions that no use equals no need, and a widely held belief that assimilation into the wider population will occur. Thus the need for specific ethnic services is avoided. In general, social services should now be making contracts for service provision of meals on wheels, home care, day centres, and lunch clubs with local voluntary groups run by ethnic minorities themselves. The extended family is popularly believed to exist among ethnic minorities and to be capable of coping with almost any chronic disease. Extended family groups work by mutual support through well defined roles. A dementing older person is not able to fulfill a useful role, and supervision and care become major problems when everyone else is out at school and work. To cope successfully, families require advice, support, respite, and practical help with disability and financial benefits.