

## **The future funding of care for the UK's black and minority ethnic (BME) groups**



**A research summary**

**Linstock Communications and Stimulating World**

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## Longer lives – major challenges

In July 2010, the Dilnot Commission on Funding of Care and Support began its review into the long-term funding of social care. Its eagerly awaited white paper, due some time in 2011, will make recommendations as to how we fund the care of older people as we continue to live longer.

Figures from the Office for National Statistics (ONS) lay bare the scale of the challenge. The number of people in the UK aged 65 and over increased by 1.7 million between 1984 and 2009, a growth from 15% to 16% of the population. By 2034, this proportion is projected to rise to 23 per cent<sup>1</sup> and life expectancy will be around 83 years for men and 86 for women. While increasing longevity is something to be celebrated, the impact of these demographic changes on the long term care sector will be profound. 16.5 million people will require some form of long term care and support by 2034. The think tank Policy Exchange has calculated that total public spending on long term care for the elderly had already reached £16.17 billion in 2008-09<sup>2</sup>.

In facing up to this challenge, and the opportunity it presents, the long term care sector requires a detailed understanding not only of the demographic statistics, but of the changing aspirations, needs and cultural nuances of older people in the future. Most importantly, the people who will require long term care in the future need to have their voices heard today. The danger is that one significant demographic issue – ethnicity – could get lost in the desire to address the needs of all.

To ensure social care for all and fairness for the entire population, as described in the Commission's call for evidence, the specific needs and views of the UK's black and minority ethnic (BME) groups must be taken into account. Ethnic communications specialist Linstock Communications and research agency Stimulating World have come together to research<sup>3</sup> the views of BME communities to determine how their attitudes might affect the Dilnot review and the future of the long term care sector as a whole.

### Why is ethnicity important?

The population of the UK is growing, but the UK's BME population is growing faster still. BME groups totalled 8.7% of the UK's population in 2001. That figure is projected to rise to 16.3% in 2016, 20.1% by 2026 and 27% in 2051.<sup>4</sup> As a consequence of both this increase and improved longevity, the elderly BME population in the UK is also projected to grow. In 2007 there were 675,000 over-65s from BME groups. This figure is projected to rise to 810,000 in 2016, 1.3m in 2026 and 3.8m in 2051 – a more than five fold

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<sup>1</sup> ONS, <http://www.statistics.gov.uk/cci/nugget.asp?id=949>

<sup>2</sup> Careless: Funding long-term care for the elderly, Henry Featherstone and Lilly Whitham

<sup>3</sup> Stimulating World, 'Social care for the elderly and BME communities'

<sup>4</sup> Research commissioned by Runnymede, a leading independent thinktank on race equality and race relations, written by the Centre for Policy on Ageing.

increase in around forty years. By this time, it's reasonable to expect that one in five<sup>5</sup> people requiring long term care of some sort will be from BME communities.

People from different cultural backgrounds have opinions, views and perspectives that often differ from the perceived mainstream. The issues of care for the elderly and infirm, and the use of social care, can be particularly polarising.

Unless the Dilnot Commission on Funding of Care and Support considers issues specific to the BME population as part of its review, the very real danger is that the UK's rapidly growing minority ethnic groups will be left facing a social care system that does not understand them and is ill-prepared to provide for them. If the long term care sector is not prepared to address the needs of BME communities, commercial opportunities will be lost and social justice will suffer.

### **What are the culture-specific attitudes to care amongst the BME population?**

In association with Linstock Communications, Stimulating World undertook focus groups with people of Bangladeshi, Pakistani, Indian (Hindu) and Black Caribbean ethnicity, as well as a group with white mainstream participants.

All of the participants were aged over 45, with ageing relatives, and were considering the long term care options for those relatives.

Our research reveals that BME groups' attitudes to caring for family, and perceptions of social care, differ considerably from the mainstream views held by the white British population.

In these minority ethnic groups, there is a strong emphasis on caring for elderly relatives as a duty. Elderly relatives are thought to deserve the reciprocity of their children's care and attention, and participants in the research revealed that first generation arrivals within their communities frown on the idea of sending elderly relatives to a care home. In their own words, family is everything:

"They brought us up...it is our duty to look after them."

"If I put my mum in a home the whole street would want to know why!"

Amongst second generation BME groups, there is still a very strong family bond – but the influence and adoption of a western lifestyle places extra pressures and strains on the traditional care models previously in existence within these communities.

The second generation BME population is often more mobile, with full time careers and a lifestyle that sees them away from home regularly. Consequently, the sheer mechanics of caring for elderly family members become much harder. One simple example is the changing role of women, who in many BME groups have traditionally 'stayed-at-home' and taken time to care for housebound elderly relatives. Today, of course, that traditional female stereotype is changing:

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<sup>5</sup> Comparing number of over 65 BMEs against all over 65s in 2051, based on ONS figures for the projected population of 78 million in 2051: <http://www.oheschools.org/ohesch6pg3.html>

“It is difficult to live at home and look after parents in the West. People have to look after kids, house, parents and work.”

“Girls can do less now because they are involved in more activities outside the home.”

At the same time, elderly members of the BME population in need of care are increasingly insisting that their children don't look after them. They realise that their children want and need more independence and freedom:

“I don't want to be a burden...I don't want them to have the strain.”

“I told my son to go, I don't want him here...he wants his freedom and I want mine.”

Mobile western societies have been grappling with these stresses and strains for some time now, so their emergence amongst upwardly mobile BME groups in the UK should not come as too much of a surprise.

The research reveals the problem posed by this change, and one the Dilnot review and long term care sector needs to recognise; the stigma attached to placing relatives in social care amongst these BME communities is unlikely to erode at the same rate as the traditional family model. This will create a gap in the ability of BME communities across Britain to provide or access appropriate care.

### **What is the current provision for BME social care?**

At present, the general consensus amongst BME groups is that care homes in the UK are not suitable for them. Some mirror views held in certain parts of the mainstream population. They consider social care to be sterile and uncaring, unable to replicate the level of personal care and attention that can be provided by a family member in a one-on-one situation.

The second and more ethnically specific view of care homes amongst BME groups is that they do not provide care specific to their cultural, religious and dietary needs. This applies to both care homes, and culture-specific day care.

Language is also considered a big problem, as many elderly BME citizens may have only a small grasp of English, or, quite simply, may just prefer to communicate in their mother tongue. This feeds into another common concern; that the carers themselves are often of a different ethnic background. Among some BME groups, this gives the impression that these carers are not in tune with their personal needs.

### **The difficulties of personalisation**

In its call for evidence document, the Dilnot Commission states clearly its belief in personalisation as an important part of any funding model. However, across different groups that make up the BME population there are varying levels of understanding around personalisation.

Some first generation communities are unfamiliar with the concept whereas groups with a higher number of second and third generation families, such as the Black Caribbean

community have a better understanding of how it works, and how it can give them greater control over the specific care they need.

### **What does this mean for BME groups in need of care?**

Quite clearly, the different groups that make up Britain's BME population will have specific requirements for social care. In addition, the views and opinions of social care are likely to change amongst future BME generations, which will in turn affect their demand. When the projected growth of the BME population in the UK over the next ten to forty years is taken into account, it is abundantly clear that the Government Commission cannot afford to neglect these issues when debating recommendations and proposals ahead of future legislation on funding social care.

The very real danger if these issues do not form part of the review's decision-making process is that the UK finds itself funding a care system which is narrow, inflexible and ultimately unfair.

### **What needs to happen?**

The scale of the challenge in reforming social care is massive. At the same time, the challenge presents an equally massive opportunity to care home providers across the UK.

Three things need to happen:

1. The review needs to seek advice from BME groups and those who work with them in order to understand the particular needs and views of this growing population.
2. Care homes need to understand the way in which they are perceived by ethnic minority groups in order that they can improve the sensitivity of their services.
3. The care home sector needs to consider how it can better communicate with BME communities in order to break down the stigma that exists about the services that it provides.

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