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Health status and health care utilisation amongst elderly persons in Britain

Background Briefing Paper
London Commission

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DRAFT VERSION

Abstract

The aim of this background paper is to report on the patterns of morbidity, degrees of dependency, use of both primary care and acute care, and also provision of community health and social services among the elderly population in Britain. This is based upon both existing evidence and the findings of empirical research using the latest evidence, most notably the General Household Survey data. Particular emphasis will be placed upon the regional differences within these patterns, distinguishing Greater London from other Metropolitan areas, and Non-Metropolitan areas. Sub-groups among the elderly population are differentiated. Part II of the report focuses specifically on the patterns of health status and health care use amongst black and minority ethnic elders in London and Britain, using hitherto unpublished data from a unique dataset developed at the Kings Fund Institute - the GHS Ethnicity Multiyear dataset.

Contents

Executive Summary

- All elderly persons

- Ethnic Elders

The findings from the empirical analysis of the Ethnicity Multiyear GHS database emphasise the heterogeneity of social and economic positions of ethnic elders in Britain and also in London.

The predominance of many different ethnic elders groups located in the bottom quintile of the income distribution has implications for their health and well-being. Many are from manual backgrounds and will not be in a position to contribute financially to health and social care support - although some may well have the means to do so.

The proportion of black and minority ethnic elders is currently small, however policy planners and purchasers, in particular care managers, will face even more challenging times in service development and delivery, as the numbers will be increasing in the next two to three decades. Most ethnic elders are younger, with the exception of Chinese elders, they reside in different household structures reflecting diverse kinship patterns, with Pakistani, Bangladeshi and Indian elders being most likely to live in three generational households with dependent children. Elderly people from minority ethnic communities report higher levels of ill health compared to white elders.

Ethnic elders report higher levels of GP consultations, particularly Indians, Pakistani and Bangladeshi elders (standardising on age, sex and morbidity patterns). However, this higher use cannot be accounted for by higher levels of acute or chronic indicators of morbidity. They also report higher outpatient attendance among, especially amongst Black Caribbean elders. Existing studies have found consistently low take of preventative and screening services among ethnic elders. With respect to inpatient use, this analysis found ethnic differences to be less marked amongst the ethnic elders.

Part I: Health status and health care utilisation amongst elderly Londoners

1. The health of elderly Londoners today

Life expectancy has been increasing. More people can expect to survive into old age than ever before. A key question, however, is whether elderly people are living longer and healthier lives or whether the quality of these extra years of life will be limited by disability or illness (Bone, 1995). In the following section we examine the health of London's elderly today. We then go on to examine the use of health and personal social services and see the extent to which use of these services is related to need as measured by self-reported morbidity or dependency.

There are a variety of measures of health. The General Household Survey (GHS) contains information on self-reported long standing illness (limiting and non-limiting), acute illness in the last two week and general health status over the past 12 months. In 1994, the General Household Survey contained a special section of questions addressed specifically to those aged 65 and over. These questions included information about the elderly person's ability to perform various activities of daily living.

Link health, impairment and disability (Challis, 1996).

1.1 Self reported morbidity

In 1994, 58 percent of all persons aged 60 and over reported a long-standing illness, yet 78 percent reported their general health as good or fairly good. This suggests that either many chronic conditions do not affect health, or that perceptions of general health may change with increasing age so that long-standing illnesses, such as arthritis, are more likely to be accepted by the respondent as part of every day living (DoH, 1992).

- **Are London's elderly healthier?**

Amongst the population aged 60 and over in Great Britain, 40 percent of men reported a limiting long-standing illness in 1994. However amongst those aged 60 and over in London, this proportion fell to 35 percent. This was not the same for women.

Other measures of health status also point to London's elderly being healthier than the national picture with 18.6 percent of London's elderly women reporting an acute illness in the last two weeks compared to 21.3 percent for Britain as a whole. Similarly only 20.8 % of London's men and 18.7% of London's women reported 'not good' health status over the last year, compared to a national average of 22.3% for men and 22.0% for women.

The elderly population of London tends, on average, to be slightly younger than those living outside of London. Since the likelihood of reporting ill health is positively associated with age, we might expect the elderly living in London to be healthier. Tables A.1.1a to A.1.1c and A.1.2 in Appendix 1 shows the proportion of the elderly population who reported ill health, within age groups for men and women in 1994 from the General Household Survey. These rates are

summarised in the age-sex standardised ratios presented in Figures 1 to 3.

Even *after* controlling for differences in age and sex composition between regions, Figures 1 to 3 show that elderly Londoners report *better* health on a range of indicators than elderly persons living elsewhere in Britain.

Age-sex standardised ratios compare the observed prevalence of, for example limiting long standing illness in each region (London, Other Metropolitan area, Non-metropolitan area), with the rate that would be expected if the rates for each age group in the total sample were applied to the age distribution for those sub-groups.
These ratios allow comparisons of sub-populations with different age-sex structures. Values over 100 indicate a higher than expected prevalence, whilst values below 100 indicate a lower rate than would be expected on average.

Figure 1 indicates that after adjusting for age and sex, elderly Londoners are 8 percent less likely to report limiting long-standing illness compared to the whole population. Elderly Londoners are also 12 percent less likely to report acute ill health (Figure 2) and 14 percent less likely to describe their general health status in the last year as not good (Figure 3). These difference are particularly marked when compared to the health of elderly persons living in other Metropolitan areas.

Elderly people living in Metropolitan areas *outside* Greater London are more likely to report both acute ill health or injury in the last two weeks (Figure 2), and poor general health over the last year (Figure 3). It should be noted that these other metropolitan areas include Glasgow and Edinburgh as well as Merseyside and Tyneside - areas which other work has shown to have higher than average standardised mortality rates (Black Report).

As well as varying with age, health amongst elderly Londoners varies by socio-economic status. Tables A.1.3a to A.1.3c in Appendix 1 show the proportion who report ill health by socio-economic characteristics within regions.

- **Health and Londoner's socio-economic characteristics**

A number of indicators of economic and social well-being are used - socio-economic group, housing tenure, overcrowding and income distribution[1]. The proportion of elderly Londoner's reporting ill health tends to increase with higher levels of socio-economic deprivation. This is true for all three indicators of health.

For example, of those elderly Londoners in the bottom quintile of the income distribution, 42 percent report limiting long-standing illness compared to 33 percent of those in the top fifth of the income distribution (Table A.1.3a). Similarly, of elderly persons living in accommodation with one than one person per room (generally taken to be an indicator of overcrowding), 27 percent report an acute illness in the last two week compared to only 17 percent of those residing in condition with under 0.5 persons per room (Table A.1.3b). Finally, 31 percent of elderly Londoners living in local authority or housing association accommodation reported poor general health in the last year, compared with only 13 percent of owner occupiers without mortgages (Table A.1.3c). These socio-economic differentials are not, however, adjusted for age and gender.

Comparing Londoners with elderly persons with similar socio-economic characteristics in other parts of the country, again Londoners appear healthier than their counterparts. However there are several interesting exceptions to this, which deserve further investigation.

Elderly Londoners from socio-economic groups I and II (Professional and Managerial occupations) are *more* likely to report limiting long-standing illness than persons from the same socio-economic groups elsewhere in the country e.g. 40% in London, compared to 32% in Other Metropolitan areas. The same 'relative' ill health is observed for those Londoners in the top quintile, with 33 percent reporting limiting long-standing illness compared to just 21 percent in Other Metropolitan areas and 25 percent in Britain as a whole (Table A.1.3a). Thus more affluent Londoners seem to be disadvantaged in terms of health compared to their affluent counterparts elsewhere in the country. This could be due to a variety of influences, including environmental, psycho-social and lifestyle factors.

There are some indications that elderly Londoners at the other end of the social spectrum are also relatively disadvantaged in terms of acute ill health. Of persons living in overcrowded conditions, we have already noted that 27 percent of Londoners report acute ill health. In addition 46 percent report their health as not good, in contrast to only 36 of elderly people living in overcrowded conditions in Other Metropolitan areas (Table A.1.3c). These differentials must, however, be treated as only indicative as again the figures are not adjusted for differences in age and sex composition between the two groups.

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[1] The income measured used in this analysis refers gross monthly income of the family unit, adjusted for family size and composition using the McClements equivalence scale.

1.2 **Dependency**

Functional capacity and ability to perform activities of daily living in later life is strongly associated with living independently in the community. The OPCS surveys of disability estimated that 6.2 million persons in Britain are disabled, of which two thirds (4.2 m) are aged 60 and over (Martin et al, 1988). Severity of disability was found to be marked at ages of 70 and also 80 plus. Thirty-seven percent of persons aged 60 plus are disabled, a rate which rises to 59% among those 80 plus (McGlone, 1992).

The proportions of elderly persons who, in 1994, reported that they were unable to carry out selected activities of daily living unaided are shown in Figures 4 and 5 (and in Appendix Tables A.1.4). The vast majority of elderly people have no difficulty in undertaking basic domestic and personal care tasks for themselves.

Functional capacity is related to both age and gender. The proportion reporting inability to perform tasks rising with age and a higher proportion of women report that they are unable to perform these tasks on their own than that men. For example, 23 percent of elderly men are unable to cut their own toenails, as compared to 40% of elderly women; whilst 8 percent men are unable to walk outdoors unaided compared to 16 percent of women. In part these differences are explained by the greater proportions of very elderly women (over 85 years) in the '75 years and over' age group. However the gender differentials remain marked even when comparing between men and women amongst younger elderly (65-74 years).

Elderly persons living in London report *lower* levels of incapacity than in Great Britain in general. Comparing Figures 4 and 5 shows that this is particularly marked for men, with only 2 percent of men aged 75 plus in London unable to 'bath, shower and wash all over' unaided compared to 10 percent of men of the same age nationally.

These differences in functional capacity are summarised in the table below, which presents the rates for London and other areas adjusted for and age-sex composition and then standardised in relation to Great Britain (taken to be 100).

Table 1: Functional capacity and daily living activities: age-sex standardised ratios for persons aged 65 and over by region, 1994/5

	Region			
	Greater London	**Other Metropolitan**	**Non-metropolitan**	**Great Britain**
Get up & down stairs and steps	73.0	100.0	106.7	100
Walk out of doors	77.3	112.5	95.3	100
Bath, shower, wash all over	56.8	101.2	108.6	100
Cut Toenails	79.7	102.6	102.6	100
(N)	(363)	(1385)	(1702)	(3450)

Source: GHS 1994/5

Elderly people in London are 21 percent *less likely* to be unable to cut their own toenails; 23 percent less likely to be unable to walk out of doors; 27 percent less likely to be unable to negotiate stairs or steps; and 43 percent less likely to be unable to bath, shower or wash all over than the average for Great Britain. As well as being lower than the national average, the likelihood of being unable to perform these tasks unaided for London is also lower than in other Metropolitan areas, particularly with regard to mobility out of doors.

Once again there is socio-economic variation in the ability to perform activities of daily living within London; as well as variation across regions within a particular socio-economic group (Table A.1.5 in Appendix 1). Amongst elderly Londoners, 11 percent of people from manual occupational backgrounds could not manage to walk out of doors unaided compared to 7 percent of non-manual. Similarly, ten percent of Elderly Londoners in the bottom fifth of the income distribution could not manage this activity compared to five percent of those in the top income quintile group.

2. Sources of support and social isolation

• Who helps?

Assistance with domestic tasks and activities of daily living comes from a variety of sources, including the State, private agencies, the voluntary sector , the informal sector and the family. The main source of support for people living in private households is the family and informal sector. However, sources of help reflect the living arrangements of the elderly person and their household composition.

For mobility and self-care tasks, elderly people living with their spouse only were most likely to receive support from their spouse; persons living alone were most likely to be supported by NHS or personal social services or an outside relative outside; amongst elderly living in other household types the main form of support is another household member or their spouse (OPCS, 1996).

The strength of social networks, social support enjoyed by elderly people varies with age and with region. The level of social contacts enjoyed by elderly people has been found to be of importance for health (refs) .

• Social contact

With increasing incapacity in advanced old age, the risk of social isolation and loneliness is heightened. Four out of five elderly people (65 and over) reported going to visit relatives or friends and over nine out of ten reported that friends or relatives come to see them. Only 3 percent reported that they did not see relatives or friends *at all* nowadays. There was no significant difference between people living in London and the national average.

However, there were differences in the *frequency* of social contacts outside the household between elderly persons living in London and elsewhere. Figure 6 shows that 56 percent of elderly Londoners visited friends or relatives at least once a week, compared to 63 percent in

other metropolitan areas and 69 percent in non-metropolitan areas. There is a similar pattern observed in the frequency reported by elderly persons of *being visited* by friends or relatives, with a higher proportion of elderly Londoners being visited less than once a month (Figure 7). This is despite the fact that contact tends to decrease with age, and that the elderly in London tend to be younger than in other metropolitan areas and non-metropolitan regions.

Furthermore, of those who are visited less than once a month by friends or relatives, nearly half (46.5%) reported that they themselves had gone to see relatives less than once a month. For London that proportion rises to 52.9 percent, indicating that social isolation is likely to be a greater danger.

Social contacts are related to household composition. Overall, people living alone are more likely to see relatives or friends at least weekly than those elderly who live with their spouse or others, with almost a third reporting that they saw them everyday or nearly every day compared with only a fifth of those who reside with others (OPCS, 1996). This makes the lower frequency of social contacts in London more striking; a high proportion of elderly people live alone (32%) and there is greater need for social contact outside the household among those living alone.

3. Service use

3.1 Social services

Although the majority of support is provided by the family, personal social services remain an important provider - enabling people to continue to live independently in the community. Overall, six percent of elderly people had seen a district nurse, health visitor in the previous month, eight percent had received support from a local authority home help or home care worker and seven percent has used private domestic help. In London, the proportion in receipt of services is slightly lower.

Reported receipt of social services increases with age. Three percent of young elderly in London (65-74) received a local authority home help in the previous month compared to 14 percent of older elderly (75 and over) (Table A.1.6).

The fact that London's population is slightly younger may, in part, account for the lower service utilisation rates observed compared with those for Britain. However even after allowing for differences in age, persons in London were less likely to be in receipt of a service than elsewhere. Table 2 shows that after controlling for both age and sex composition, London's elderly were 18.5 percent less likely to receive a meals on wheels in the previous month, 9 percent less likely to attend a day centre or receive support from a local authority home help and nearly a third less likely to have private domestic help than would be expected according to the national average.

Interestingly, London's elderly were *more* likely to attend a lunch club than elsewhere in the country.

Table 2 Use of health and personal social services: by persons aged 65 and over, age-sex standardised ratios for regions

	Region			
	Greater London	**Other Metropolitan**	**Non-metropolitan**	**Great Britain**
Personal social services in the last month				
Home Help (LA)	90.9	105.2	97.4	100
Private domestic help	71.0	94.2	110.1	100
Meals on wheels	81.5	92.6	107.4	100
Day centre	90.6	128.1	78.1	100
Lunch Club	112.1	97.0	97.0	100
District nurse	86.4	93.2	110.2	100
Health services in the last three months				
Doctor at surgery	105.7	99.8	98.9	100
Doctor at home	67.5	108.8	100.9	100
Doctor at hospital	108.5	105.5	94.5	100
Nurse at surgery/ health centre	89.3	92.3	108.3	100
Social worker	66.7	95.2	109.5	100
(N)	(363)	(1385)	(1702)	(3450)

Source: GHS 1994/5

Although these figure standardise on age and sex, which are associated to dependency, this is not the same as taking into account 'need', as defined by ability to carrying out daily living activities. Table 3, therefore, shows the proportion of elderly Londoners who used a personal social service in the last month *amongst* those who were unable to walk out of doors unaided and amongst those were not able to bath, shower or wash without help.

Receipt of personal social services is markedly higher amongst those in need of support of daily living activities than for all elderly - indicating that services are generally targeted to those in greatest need. There appears to be a strong relationship between need for assistance with mobility and self acre activities and visits from local authority home helps and the district nurse.

Elderly people in Greater London who were unable to walk outdoors unassisted, were

- six times as likely to receive meals on wheels compared to others;
- four and a half times as likely to receive a local authority home help;
- over five times more likely to see a district nurse, and
- two and half times as likely to have private domestic help.

Table 3 Use of personal social services in the last month by functional capacity: among persons aged 65 and over, by region 1994/5 (%)

	Region			
	Greater London	**Other Metropolitan**	**Non-metropolitan**	**Great Britain**
Unable to walk outdoors on their own				
Home Help (LA)	32.4	26.1	29.3	28.1
Private domestic help	13.5	12.1	11.1	11.7
Meals on Wheels	13.5	7.9	10.1	9.2
Day Centre	2.7	10.6	7.2	8.4
Lunch Club	5.4	5.0	5.3	5.2
District Nurse	30.6	17.6	26.0	22.6
(N)	(37)	(199)	(208)	(444)

Source: GHS 1994/5

Once 'need' is allowed for, the relative disadvantage in service receipt by London's elderly compared to elderly living elsewhere diminishes, and in fact the proportion of people requiring assistance with walking in receipt of services is now *higher* in London than elsewhere for all personal social services except 'Day Centre'. Just under 14 percent receive meals on wheels in London compared with only 8 percent in other Metropolitan areas and 10 percent in non-metropolitan regions

Elderly people living alone were found to be twice as likely to use a local authority home help or private domestic help than elderly people living with other household members. However, it is worth pointing out that one third of elderly people residing alone and unable to manage, bathing, showering or washing had not been visited by either a local authority home help or a district nurse in the previous month (in Britain) (OPCS, 1996 p.150). Thus although services are targeted to those in greatest need there still appears to be a shortfall in provision.

In fact receipt of local authority home help amongst elderly living alone *and* unable to walk out of doors unaided, has fallen over time, from 62.3% in 1980 to 55.3% in 1985 and 45.1% in 1994/5 (Table 4). At the same time private domestic help may have risen in response to this, although data is not available to confirm this. Proportions receiving a visit from a district nurse or health visitor in the last month have also fallen from 33.1% tp 29.7% between 1980 and 1994/5.

Table 4 Use of personal social services in the last month by functional capacity: among persons aged 65 and over, 1980-1994/5, GB (%)

	Year		
	1980	**1985**	**1994/5**
Of all persons aged 65 and over Percentage unable to walk out of doors unaided	12	12	13
Home Help (LA) Lives alone Lives with others	 62.3 14.9	 55.3 16.5	 45.1 15.1
Private domestic help Lives alone Lives with others	 -	 -	 19.2 6.0
Meals on wheels Lives alone Lives with others	 17.7 4.3	 18.0 2.9	 16.6 3.6
District nurse/ health visitor Lives alone Lives with others	 33.1 24.4	 30.4 18.0	 29.7 17.7
(N)			

Source: GHS 1980, 1985, 1994/5

3.2 **Health care use**

In 1994, 18.8% of all persons 60 and over consulted a doctor in the two weeks prior to interview; 21.3% attended an outpatient or casualty department in the previous 3 months; 13.3% had an inpatient stay during the last year and 5.0 % attended hospital as a day patient. Within London, the corresponding proportions were 19.9% GP consultation; 21.9% outpatient visit ; 12.7% inpatient stay and 4.9% day patient visit.

Detailed information regarding the proportion of elderly people (60 and over) reporting use of a health service by age, sex and region are presented in Table A.1.7 in the appendix. There are some differences in the pattern of health service use by the elderly across Britain and these differentials summarised by age-sex standardised ratios in Table 5 below.

Table 5 Use of health services by persons aged 60 and over: age-sex standardised ratios for regions

	Region			
	Greater London	**Other Metropolitan**	**Non-metropolitan**	**Great Britain**
GP in the last 2 weeks	105.3	100.5	98.9	100
Outpatient in the last 3 months	103.3	107.5	93.4	100
Inpatient in the last year	94.7	100.8	100.8	100
Day patient in the last year	98.0	108.0	92.0	100
(N)	(487)	(1875)	(2326)	(4689)

Source: GHS 1994/5

The elderly population in Greater London is more likely to have consulted a GP in the last 2 weeks or to have attended an outpatient or casualty department in the last three months, and is less likely to have stayed in hospital either overnight or as a day patient than elsewhere in Britain. However the differences are not great.

The key question is whether use of services is related to morbidity. As we have seen in section 1 above, elderly Londoners tend to be healthier than persons of the same age and sex group living in other parts of the country. Below we look at use of services *within* morbidity groups by persons aged 60 plus living in London and elsewhere, controlling for differential age and sex composition.

- Is there equal use for equal need?

3.2.1 *Use of GP services*

GP consultation is associated with both chronic and acute ill health. Of London's elderly

reporting an acute illness in the last two weeks, 34.5% had consulted a GP during this period compared to only 16.8% of those with no acute illness. Similarly, 28.4% of those reporting a limiting long-standing illness *and* acute ill health consulted the GP in the previous fortnight compared to 11.9% of those with no long standing illness and no acute ill health (Table A.1.8). However, although ill health is associated with higher consultation rates, 12.2% of those with good general health saw a doctor. This reflects the variety of reasons people consult their GP.

The Morbidity Statistics from General Practice 1991-1992 indicated that among elderly persons, a higher proportion consulted the GP or practice nurse for diseases of the circulatory system and respiratory system than for any other group of illnesses (McCormick et al, 1995). Other major reasons for consultations concerned immunisation for influenza or tetanus, and for general medical examinations.

- How does London compare with the rest of Britain?

Figure 8 shows the age-sex standardised ratios for GP consultations in the last 2 weeks, controlling for acute ill health or injury in the last two weeks.

Among elderly people reporting acute ill health, Londoners consult in similar proportions to the average for Great Britain. However, amongst those reporting no acute ill health, elderly Londoners are over ten percent more likely to consult more. A similar pattern is seen using long standing illness as the morbidity indicator with a higher proportion of those with no long-standing illness consulting a GP than elsewhere.

The venue of where consultations take place has changed over time, with a fall in home visits and an increase in telephone consultations. Elderly people along with children are most likely to receive home visits. Nearly one third (31%) of GP consultations among those aged 75 and over in 1994, took place within the person's own home. This compares with nearly two-thirds (61%) in 19971 among the same age group (OPCS, 1996; p49).

3.2.2 *Use of hospital services*

Use of hospital services (outpatient attendance or visit to Accident and Emergency department in the last 3 months; inpatient stay or day patient visit in the last year) was markedly higher amongst those who reported ill health than those who did not (Table A1.8).

Figure 9 shows the age-sex standardised ratios for outpatient attendances in the last 3 month, controlling for limiting long-standing illness *and* acute ill health. Elderly Londoners reporting ill health are 11 percent *less likely* to attend as an outpatient compared to the national average. But amongst those with no long-standing and no acute ill health, London Elders were a third more likely to use hospital outpatient services.

Figure 10 and 11 shows the age-sex standardised ratios for inpatient stays in the last 12 months. Figure 10 controls for general health status over the past year, while Figure 11 standardises on limiting long-standing illness. On both measures of morbidity, London elders with ill health are about six percent less likely to have had an inpatient stay in the last 12 months than in Britain

generally. This is also true for Other Metropolitan areas.

The two different indicators of morbidity show different trends in use for the 'not sick'. Those London elders with 'good' health are slightly more likely to have had an inpatient stay than elderly in good health in Britain as a whole, but those in London who report no long standing illness are less likely than the average.

Finally, Figure 12 presents the age-sex standardised ratios for day patient attendance in the last 12 months, controlling for general health status over the past year. Londoners are about ten percent more likely to have a hospital day patient visit than elsewhere.

The fact that in London 'not ill' consult GP more and use outpatients more than on average suggests that either morbidity is not a good indicator of need for health services or that people are using primary health care when they may best be catered by community services.

Part II: Health status and health care utilisation amongst black and minority ethnic elders in London and Britain

Introduction

There are over 3 million individuals belonging to black and minority ethnic communities in Great Britain, with more than 200,000 aged 60 or over. Of these around 50,000 (a quarter) live in London.

Great emphasis has been placed upon locating information, both nationally and locally, regarding socio-economic positions, particularly since the implementation of the NHS & Community Care Act. Purchasing authorities, along with other bodies, need information concerning the health, current utilisation patterns, social and economic circumstances of black and minority ethnic elders in order to further develop, purchase, and deliver appropriate services.

The ethnic dimension of health and health care use among elderly people in Britain has been under-researched. Where it has received attention, the focus has been on smaller locality surveys (Pilgrim et al, 1993; Blakemore and Boneham, 1994; Askham, 1995), or of particular ethnic groups (Ebrahim et al, 1991), which have provided very useful insights. The limited large scale analysis has been largely due to a lack of sufficiently large samples within national surveys to allow detailed analysis. A recent study based upon nationally representative figures is the Health Education Authority's report on the health and lifestyles of black and minority ethnic groups in England, although this study only goes up to the age of 75yrs.

The analysis in this section of the report is based upon the Ethnicity Multiyear GHS (1984-1994) which combines data for minority ethnic groups over a 11 year period. The Multiyear Ethnicity Database was specifically constructed within the King's Fund Policy Institute in order to provide a sufficiently large pooled sample base to facilitate analysis of a wider range of ethnic groups and to enable more detailed analysis to be carried out.

In this section of the report we focus on the following questions:

- How do patterns in self-reported morbidity and also health care use vary with ethnicity?
  Is this different within London?

- Are differential levels in health care utilisation amongst black and minority ethic elders accounted for by morbidity patterns?
  Is there equal use for equal need among ethnic elders in London and Britain?

5. **The size and composition of the minority ethnic population**

- How representative is the Ethnicity Multiyear GHS?

A comparison of the composition by ethnic origin from the Ethnicity Multiyear GHS (1984-1994) with the 1991 Census and the Labour Force Survey (1989-91), Great Britain is presented in Appendix 2, table A.2.1

Using the Ethnicity Multiyear, black and minority ethnic groups constitute 5.2 percent of the total sample. An additional one percent refused to answer the question. This compares closely with the 1991 Census (5.5%) and with figures from the Labour Force Survey taking '89-91 (4.9%).

Ethnicity Multiyear GHS 1984-1994

- combines 11 cross-sectional years of the General Household Survey
- sample of > 270,000 cases
  - includes all black & minority ethnic respondents (16,856 cases)
  - and a 10% random sample of the white respondents (ie 10% of 253,300)
- standardising upon the variables used

Advantages:

- unique database on individuals from a wide range of black & minority ethnic groups of different ages and socio-economic backgrounds.

Disadvantages:

- time effects are likely to impact upon the relationships under study
- changes in some questions & definitions

Figure 1a presents the ethnic composition of the whole sample i.e. for Great Britain. Nearly half of the black and minority ethnic population are of South Asian origin, and nearly a fifth (18%) are of Black Caribbean origin.

Figure 1b shows the ethnic composition among the elderly population aged 60 and over . Persons from black and ethnic minority groups constitute 1.4% of the total - a smaller proportion of the total elderly population than the population in general. Amongst ethnic elders, a greater proportion are Black Caribbean (29.2%) and Indian (35%) and a smaller proportion are African or of Mixed origin.

Figure 1c shows the ethnic composition among London's elderly population. London's ethnic elders constitutes 5.6% of the total elderly population of the Capital. Black Caribbean elders account for a third of black and minority ethnic elders, with Indian elders contributing another third.

The composition of the black and minority ethnic elders reflects the different age structures of the different groups (see Figure 2a -3b) both in London and Britain.

• Demographic
The proportion of black and minority ethnic elders is currently small, however policy planners and purchasers, in particular care managers, will face even more challenging times in service development and delivery, as the numbers will be increasing in the next two to three decades.

Most ethnic elders are younger, with the exception of Chinese elders, they reside in different household structures reflecting diverse kinship patterns, with Pakistani, Bangladeshi and Indian elders being most likely to live in three generational households with dependent children.

• What proportion of ethnic elders live where?

Table 6: Percentage of ethnic elders (60 plus) residing in different geographical regions

	Inner London	**Outer London**	**Other Metro**	**Non-Metro**	**All** 100% (N)
White	3	7	39	50	100 (55560)
Indian	7	35	37	21	100 (266)
Pakistani/Bangladeshi	15	11	57	17	100 (93)
Chinese	7	27	43	23	100 (30)
Black Caribbean	37	15	30	19	100 (222)
Black African	23	31	31	15	100 (13)
Mixed race	21	31	21	28	100 (39)
Other groups	23	32	23	22	100 (96)
Refused question	2	15	51	32	100 (253)

Source: Ethnicity Multiyear GHS (1984-94)

Over half of all Black Caribbean and Black African elders live in Greater London, compared to just one in ten of white elders. Most of the Black Caribbean elders live in Inner London, whilst nearly a third of black African live in Outer London.

Over four out of ten Indian elders live in Greater London and the majority of these live in Outer London.

6. **Socio-economic characteristics of minority ethnic elders in London and Britain**

• Socio-economic group (figure 4a for Britain, and figure 4b for London)
The majority of ethnic elders are from manual occupational backgrounds although there is enormous diversity between ethnic groups. Over half (57%) of Chinese elders are from non-

manual backgrounds (and in London this rises to 71%) compared to only 16 percent of Black Caribbean elders and 18 percent of Pakistani/Bangladeshi elders.

• financial resources

Figure 5a shows the proportion of elderly people in each quintile group of the income distribution of the total population within each ethnic group. Thirty percent of white elders are in the bottom fifth of the income distribution compared to 71 percent of Pakistani/Bangladeshi elder, 55% of Indian elders, 45% of Black Caribbean and 44% of Chinese elders. A similar picture is seen for London, although small cell counts only allow us to look at Indian and Black Caribbean elders.

Elderly people in London tend to be slightly better off, with a higher proportion located in the top quintile group for both white and minority ethnic elders than in the general population.

The predominance of ethnic elders in the bottom fifth of the income distribution has implications for their health and well-being. Majority are from manual backgrounds. many will not be in a position to contribute financially to health and social care support - although some will have the means to do so.

• overcrowding

Figure 6a, London figure 6b

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 36.8 percent living in households with more than one person per room. Within London this percentage rises to 42.8%. A lower proportion of Chinese elders experience overcrowding (13.8% in Britain as a whole), but again this rises in London, with 30% living in households with 1 person or more per room.

7. **The health of minority ethnic elders**

• Self-reported Morbidity

Elderly people from minority ethnic communities, particularly Pakistani and Bangladeshi elders, report higher levels of ill health compared to white elders, irrespective of the self-reported measure of morbidity examined. Table A.2.2 in Appendix 2 shows the proportion reporting ill-health amongst those aged 60 and over.

Limited long-standing illness

The ethnic differences in LLSI become more pronounced with increasing age, as can be seen by the fanning out of the lines in Figure 7a for men and Figure 7b for women. For example, Pakistani and Bangladeshi women report higher levels of LLSI, 61% at 60-74 years, compared to 37% of white elderly women, and 10% of Chinese women of that age group. Such broad relative patterns have also been shown by Haskey (1996) using the 1991 Census data which included both ethnicity and LLSI for the first time.

A similar pattern can be seen for black and minority groups living in London (Figures 8a and 8b).

Acute ill health (in last 2 wks)
There are marked differences in self-reported acute ill health among ethnic elders. Pakistani and Bangladeshi elders reporting higher levels of acute illness (ie 31%) than among white elders (ie 18%). Chinese elders report the lowest incidence of acute health (ie 6%).
Again within Greater London, there is a similar picture although Indian elders in London report lower levels of acute ill health (11%) compared to Indian elders in Britain generally (18%).

General health (in last year)
Looking at general health over the last year, ethnic elders are also more likely to report their health to be 'not good', compared to white elders (22%); for example, 53% of Pakistani and Bangladeshi elders, 43% of Black Caribbean/West Indian elders, and 32% of Chinese elders. However Chinese elders also report average levels of 'good health' (ie 42% compared to 41% of white elders). (Figure 9a)

Within London, again Indian elders report slightly better health than elsewhere. Chinese, however, report worse health although the numbers involved are small.

These self-reported morbidity patterns need to be interpreted within a wider context of cultural differences in health beliefs, health expectations, and how the GHS health questions would be interpreted by different elderly people.

8. **Service use**

8.1 Health care use

Table 7 shows utilisation rates for a range of health care services within ethnic groups for persons aged 60 and over, both within Greater London and for Great Britain as a whole. Comparable figures for health service utilisation amongst ethnic elders in Other Metropolitan and Non-metropolitan areas are shown in Table A.2.3 in Appendix 2.

Table 7 Use of Health Services: Proportion of persons aged 60 and over reporting use by black and minority ethnic group and region (%)

GREATER LONDON				
	GP	**Outpatient**	**Inpatient**	**(N)**
White	20.9	22.8	15.8	(5700)
Indian	25.7	23.4	15.1	(105)
Pakistani/Bangladeshi	33.3	20.8	12.5	(24)
Chinese	(1)	(1)	(1)	(9)
Black Caribbean	30.6	27.3	18.9	(111)
African	(3)	(2)	(1)	(7)
Mixed	75.0	10.0	5.0	(20)
Other groups	26.4	17.3	13.2	(53)
Refused question	17.1	12.2	7.3	(41)
GREAT BRITAIN				
	GP	**Outpatient**	**Inpatient**	**(N)**
White				(55330)
Indian				(257)
Pakistani/Bangladeshi				(91)
Chinese				(29)
Black Caribbean				(215)
African				(13)
Mixed				(39)
Other groups				(96)
Refused question				(241)

It is interesting to investigate whether these differentials in health service use by black and

minority elders remain after standardising for the differences in age structure between the ethnic groups.

8.1.1 *Use of GP services*

Nationally ethnic elders report higher levels of GP consultations, particularly Indian, Pakistani and Bangladeshi elders (standardising for age, sex and morbidity patterns) than their white counterparts. (Figure 10a). Indian elders are over twice as likely to have consulted a GP in the last two weeks than white elders; Pakistani and Bangladeshi elders are 90% more likely to consult a GP; and Black Caribbean elders are nearly half as likely more to consult. Chinese elders, however, are a quarter *less likely* to have consulted than the majority white elder population.

The differentials in consultation rates across ethnic groups are reduced within London, but nevertheless black and minority ethnic elders (with the notable exception of Chinese elders) remain more likely to consult than their white counterparts (Figure 10b.)

Higher likelihood of use amongst ethnic elders cannot solely be accounted for by higher levels of morbidity. Figure 11a indicates GP consultation patterns *within* morbidity groups; ie (I) those elders reporting both LLSI and acute ill health, which can be viewed as a proxy for 'need' to consult, and (ii) those reporting no LSI and no acute ill health. The relative differences in consultation rates among the ethnic groups remain after standardising upon both chronic and acute ill health.

For example, among elders with limiting long-standing illness and acute ill health, Indians are 90% more likely to have consulted a GP in the last two weeks than white elders; Black Caribbean elders are a third more likely to consult a GP; and elders categorised as 'other ethnic groups' are nearly three quarters more likely to consult a GP (Figure 11a). Pakistani and Bangladeshi elders, however, are 78% *less likely* to have consulted than the majority white elder population (low numbers? to check).

Although data is limited for London, for those groups where the sample size is sufficient, Black Caribbean elders who report such chronic and acute ill health are two fifths more likely to consult a GP than white London elders (Figure 11b).

It may be argued that there is an **ethnic patterning in severity of illness** within the experience of limiting long-standing illness or acute ill health. Thus higher use levels may not be accounted for by greater severity of long-standing illness. We cannot investigate this issue further within this particular data set.

However, examining GP consultations among those who reported ***no*** long-standing and ***no*** acute ill health, ethnic elders still report above average consultations; for example, Pakistani and Bangladeshi elders are two and three-quarter times more likely than white elders to consult; Indian elders are more than twice as likely to consult; lack Caribbean elders are 71% more likely and those elders in 'other ethnic groups' are nearly twice as likely to consult a GP compared to

white elders (Figure 11a). Similar patterns have been found using other proxy indicators for 'need'; ie acute illness only, and general health in the last year. This suggests that ethnic elders may consult the GP for reasons other than ill health. Similar patterns are found for London ethnic elders, although low numbers indicate the results should be treated with some caution (Figure 11b).

- Amongst those reporting both a limiting long-standing illness and acute ill-health, Black Caribbean elders in London are 39% more likely to consult the GP than their white elder counterparts.

- Amongst those reporting no long-standing illness or acute ill-health, Indian elders in London are a third (34 percent) more likely, and Black Caribbean elders twice as likely, to consult the GP than their White elder counterparts.

McCormick and Rosenbaum (1990) used the *GP Morbidity Study* 1981-1982 data, where ethnicity was composed from own or parents' country of birth information, to examine ethnic differences in consultation rates. They found high consultation ratios for serious conditions among Black Caribbean women and South Asian men and women.

One of the most nationally representative study carried out is the Health Education Authority's recent study of the health and lifestyles of black and minority ethnic groups in England (N=3,549 16-74yrs). They also found higher GP consultation rates among Black Caribbeans, and South Asians. They also found that 5% of the UK sample reported **physical access to GP surgery** as difficult. This proportion was much higher amongst Bangladeshis (17%) and also Pakistanis (11%).

8.1.2 *Use of hospital services*

Hospital Outpatient Attendance

Figures 12a and 12b indicate the relative ethnic differences in outpatient attendance in Great Britain and London. The ethnic differences in outpatient and A & E attendance are less marked once morbidity is taken into account (Figure 13). For example among those reporting limiting long-standing illness and acute ill health, there is little difference in outpatient attendance patterns between Pakistanis and Bangladeshis, Indians, and white elders. However Black Caribbean elders do report above average outpatient attendance; ie one quarter more likely to attend compared to white elders.

Interestingly, outpatient visits are also the most likely among Black Caribbean elders who report no long-standing illness and no acute ill health; ie 91% more likely to attend than white elders. Pakistani and Bangladeshi elders are 23% more likely to attend, Indian elders are 10% more likely to attend outpatient services. Chinese elders tend to go to attend much less (60%less in Figure 12b) however when morbidity is taken into account, they are half as likely to attend outpatient services.

Hospital Inpatient Stays

Ethnic differences in hospital inpatient stays are less marked (Figures 14a and b). Within Britain, most ethnic groups report slightly higher inpatient attendance, standardising on age, sex, than white elders. Pakistanis and Bangladeshis elders are 35% more likely to have had an inpatient stay, Black Caribbean elders are 28% more likely compared to that of white elders (Figure 14a).

In London, however, apart from Black Caribbean elders (where they are 16% more likely), ethnic elders appear to be less likely to experience an inpatient stay than white London elders; for example, 10% less among Indian elders, and one third less likely among Pakistani and Bangladeshi elders (Figure 14b).

Controlling for ill health, Figure 15 shows relative use of inpatient hospital services within morbidity groups in Britain. Pakistani and Bangladeshi elders, and also Black Caribbean elders report higher likelihood in inpatient stay than white elders. Higher inpatient stay levels among ethnic elders are also found among those reporting no longstanding illness and no acute ill health.

Discussion

- Higher GP consultations among ethnic elders
- Higher outpatient attendance among Black Caribbean elders
- With inpatient use, ethnic differences are less marked

However, this higher use cannot be accounted for by higher levels of acute or chronic indicators of self-reported morbidity. These trends are combined with consistently low take of preventative and screening services. High frequency of health care use may be indicative of a lack of an effective consultation, thus requiring further visits, or lack of patient satisfaction with the consultation outcome (ie no prescription or, referral or certificate. Lack of sufficient information, appropriate care or sensitive response to the particular needs of ethnic elders may stimulate further consultations. The evidence thus far tells us nothing of the quality of service received. The role of ethnic monitoring is of crucial importance here.

8.2 Social services

Previous studies found a low take up of community health and personal social services (Boneham, 1989; Blakemore, 1982; Askham, 1995; Askham et al, 1995). The key issues which were raised then, and remain on the agenda today, was the general lack of contact between clients and community health services, and also the lack of knowledge amongst the ethnic communities about their availability and access pathways. Furthermore, Evers, Badger, Cameron and Atkin (1988) found that low referral rates by GPs was one of the main factors related to low use of district nursing services by disabled people from black and minority ethnic groups.

Investigation of personal social services utilisation among black and minority ethnic elders using this data is limited due to the low cell counts. However, what is clear is that in 1994/5 21% of white elders aged 65 plus received at least one personal social service in the previous month (using the 1994/5 GHS). The proportion averaged for all black and minority ethnic groups was 19%. Clearly further research on national scale is required.

Informal sources of support

The different patterns of household composition among ethnic elders in Britain and London are referred to in Figures 16a & b. Nearly one third (31%) of white elderly live alone, 1% reside in three generational households, with the overwhelming majority (68%) residing as couples only/ singles or couples living with other adults (of whom some are adult children). What is clear is that black and minority ethnic elders are much less likely to live alone, especially South Asians, and are more likely to live in multi-generational households with dependent children. For example 54% of Pakistani and Bangladeshi elders live in three generational households. Of Black Caribbean elders, 25% live alone, and only 4% reside in multi-generational households, reflecting different kinship patterns.

36% of white London elders compared with 31% of white elders in Britain live alone; Figure 16b indicates that this tendency towards 'solo living' in London is not found amongst black and minority ethnic elders. For example only 21% of Black Caribbean elders reside alone compared to 25%of those elderly in the population in general. (How does the cost of housing in London impact upon such patterns?).

Ethnic elders in London are more likely to likely to live in extended families; for example, 32% of Indian elders live in three generational households in GB, whereas this rises to 38% in London; similarly, 54% of Pakistani and Bangladeshi elders live in these multi-generational households in Britain, compared to 58% of this group in London. However, given these differences, it would be erroneous to assume that informal care would be automatically be available for these ethnic elders residing in multi generational households. The view that the black and minority ethnic communities 'tend to look after their own' is a myth.

(refer to Mike Murphy's chapter in OPCS Ethnicity volume)

Part II Summary

The findings from the Ethnicity Multiyear database have emphasised the heterogeneity of social and economic positions of ethnic elders in Britain, although some key patterns have emerged which have relevance for policy development.

□ Demographic and Social
The proportion of black and minority ethnic elders is currently small, however policy planners and purchasers, in particular care managers, will face even more challenging times in service development and delivery, as the numbers will be increasing in the next two to three decades. Most ethnic elders are younger, with the exception of Chinese elders, they reside in different household structures reflecting diverse kinship patterns, with Pakistani, Bangladeshi and Indian elders being most likely to live in three generational households with dependent children.

□ Economic
The predominance of many different ethnic elders groups located in the bottom quintile of the income distribution has implications for their health and well-being. Many are from manual backgrounds and will not be in a position to contribute financially to health and social care support - although some will have the means to do so.

For London, small cell counts only allow us to look at Indian and Black Caribbean elders. Elderly people in London tend to be slightly better off, with a higher proportion located in the top quintile group for both white and minority ethnic elders than in the general population.

Black and minority ethnic elders in London are more likely to experience overcrowded conditions; only 1% of white elders reside in accommodation with 1 person or more per room. Pakistani and Bangladeshi elders are particularly prone to living in more crowded conditions, with 36.8 percent living in households with more than one person per room. Within London this percentage rises to 42.8%. A lower proportion of Chinese elders experience overcrowding (13.8% in Britain as a whole), but again this rises in London, with 30% living in households with 1 person or more per room.

□ Health
Elderly people from minority ethnic communities report higher levels of ill health compared to white elders. For example, the ethnic differences in limiting-longstanding illness (LLSI) become more pronounced with increasing age; 61% of Pakistani and Bangladeshi women 60-74 years report higher levels of LLSI, compared to 37% of white elderly women, and 10% of Chinese women of that age group. A similar pattern is observed in London.

□ Ethnic elders report higher levels of GP consultations, particularly Indians, Pakistani and Bangladeshi elders (standardising on age, sex & morbidity patterns). However, this higher use cannot be accounted for by higher levels of acute or chronic indicators of morbidity.

For example, among elders in Britain with limiting long-standing illness and acute ill health, Indians are 90% more likely to have consulted a GP in the last two weeks than white elders; Black Caribbean elders are a third more likely to consult a GP; and elders categorised as 'other ethnic groups' are nearly three quarters more likely to consult a GP. Although data is limited for London, for those groups where the sample size is sufficient, Black Caribbean elders who report such chronic and acute ill health are two fifths more likely to consult a GP than white London elders.

In order to take on board possible ethnic patterning in the *severity* of illness within the experience of limiting long-standing illness or acute ill health, GP consultations can be investigated among persons who reported *no* long-standing and *no* acute ill health. The analysis shows that ethnic elders still report above average consultation rates; for example, Pakistani and Bangladeshi elders are nearly three times as likely than white elders to consult; Indian elders are more than twice as likely to consult; Black Caribbean elders are 71% more likely and those elders in other ethnic groups are nearly twice as likely to consult a GP compared to white elders. As similar patterns have been found using other proxy indicators for 'need' (ie acute illness only, and general health in the last year), it suggests that ethnic elders may consult the GP for reasons other than ill health. Similar patterns are found for London ethnic elders, although once more, low numbers indicate that broad relative patterns should be taken rather than absolute proportions.

For example, amongst those reporting both a limiting long-standing illness and acute ill-health, Black Caribbean elders in London are two-fifths more likely to consult the GP than their white elder counterparts; also amongst those reporting no long-standing illness or acute ill-health, Indian elders in London are a third more likely, and Black Caribbean elders twice as likely, to consult the GP than their White elder counterparts.

□ Higher outpatient attendance among Black Caribbean elders.

Among elderly persons in Britain reporting limiting long-standing illness *and* acute ill health, there is little difference in outpatient attendance patterns between Pakistanis and Bangladeshis, Indians, and white elders. However Black Caribbean elders do report above average outpatient attendance; that is, one quarter more likely to attend compared to white elders. Interestingly, outpatient visits are also the most likely among Black Caribbean elders who report no long-standing illness and no acute ill health; ie 91% more likely to attend than white elders. Pakistani and Bangladeshi elders are 23% more likely to attend, Indian elders are 10% more likely to attend outpatient services. Chinese elders tend to go to attend much less (60%less) however when morbidity is taken into account, they are half as likely to attend outpatient services. These national patterns are not consistently replicated for London, although Black Caribbean elder Londoners who report no long-standing illness and no acute ill health are slightly more likely to attend outpatient services (standardising for age and sex). Clearly more research is needed on this and also referral patterns, which have been found in smaller scale studies to be fewer among ethnic elders than their white elder counterparts (refs).

□ With respect to inpatient use, ethnic differences are less marked although present.

Within Britain, most ethnic groups report slightly higher inpatient attendance than white elders; Pakistanis and Bangladeshis elders are 35% more likely to have had an inpatient stay, Black Caribbean elders are 28% more likely compared to that of white elders. In London, however, apart from Black Caribbean elders (where they are 16% more likely), ethnic elders appear to be less likely to have a hospital inpatient stay than white London elders; for example, 10% less among Indian elders, and one third less likely among Pakistani and Bangladeshi elders.

Taking health status into account, the national analysis shows that among those who have a long-standing illness and acute ill health, Pakistani and Bangladeshi elders, and also Black Caribbean elders report a higher likelihood in inpatient stay than their white elder counterparts. Furthermore,

higher inpatient stay levels among are also found among ethnic elders reporting *no* longstanding illness and *no* acute ill health. The patterns for London do not follow the national trends, indicating a lower than average inpatient stay among ethnic elders as compared to white elders.

- Social services

Previous research has found a low take up of community health and personal social services and a general lack of contact between ethnic elder clients and community health service professionals. Using the 1994/5 General Household Survey, 21% of white elders aged 65 plus received at least one personal social service in the previous month. The proportion averaged for all black and minority ethnic groups fell to19%.

- Informal sources of support

Patterns of household composition among ethnic elders in Britain and London differ; nearly one third (31%) of white elderly live alone, 1% reside in three generational households, with the overwhelming majority (68%) residing as couples only/singles or couples living with other adults (of whom some are adult children). What is clear is that black and minority ethnic elders are much less likely to live alone, especially South Asians, and are more likely to live in multi-generational households with dependent children. For example 54% of Pakistani and Bangladeshi elders live in three generational households. Of Black Caribbean elders, 25% live alone, and only 4% reside in multi-generational households, reflecting different kinship patterns.

36% of white London elders compared with 31% of white elders in Britain live alone. This tendency towards solo living in London is not found amongst black and minority ethnic elders. For example only 21% of Black Caribbean elders reside alone compared to 25%of those elderly in the population in general. (Discuss migration to the coast).

Ethnic elders in London are more likely to likely to live in extended families; for example, 32% of Indian elders live in three generational households in GB, whereas this rises to 38% in London; similarly, 54% of Pakistani and Bangladeshi elders live in these multi-generational households in Britain, compared to 58% of this group in London. However, given these differences, it would be erroneous to assume that informal care would be automatically be available for these ethnic elders residing in multi generational households. The view that the black and minority ethnic communities tend to look after their own is a myth.

Many of these findings are not new, other studies have shown similar results, however these trends are based upon **national representative data** with over 14,078 ethnic respondents, of whom 1,265 are elderly.

BUT

□ Is self-reported morbidity an appropriate indicator of need? Which self-reported morbidity? These morbidity indicators may not be the most appropriate indicators of need for GP, outpatient and inpatient.

□ What of mental health and wellbeing?

They do not directly take into account depression or mental health in general. General health over the last year may to some extent account for mental and physical well-being, but it really depends upon the interpretation made by the respondent.

Defining 'need' is complex.

□ What does higher utilisation reflect?

The higher utilisation of health care, esp GP use, may be indicative of lack of an effective consultation, or lack of a satisfactory consultation from the patients' view. Lack of sufficient info, appropriate care or sensitive response to the particular needs of ethnic elders may stimulate further consultations.

□ What is the quality of the health care service used?

The evidence tells us nothing of the quality of service used. The role of ethnic monitoring is particularly important here.

□ Further Research needed

Eg Separate out Irish elder groups.

□ Improved data sources

Encourage producers of statistics (eg OPCS), all survey collectors to consider where appropriate to over-sample black and minority ethnic groups, given that the enormous cost of setting up the survey and collecting the info would be already committed.

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Appendix 1

Table A.1.1a
Proportion reporting **limiting long standing illness** by age and gender, 1994 General Household Survey

Age group	London			Britain			
	Men	Women		Men		Women	
All 60+ (N)	34.7 (213)	39.5 (276)		40.1 (2003)		40.4 (2712)	
60-64	35.3	35.6		38.4		30.2	
65-69	33.3	28.3		38.8		35.8	
70-74	36.2	38.7		37.5		42.3	
75-79	34.0	44.2	48.0	41.7	45.4	44.3	48.7
80-84		46.4		51.1		48.1	
85+		54.0		43.5		56.4	

Table A.1.1b
Proportion reporting **acute illness** in the last two weeks by age and gender, 1994 General Household Survey

Age group	London		Britain			
	Men	Women	Men		Women	
All 60+ (N)	16.9 (213)	18.6 (274)	18.2 (2003)		21.3 (2710)	
60-64	22.1	15.3	20.2		15.4	
65-69	14.6	15.1	18.8		20.1	
70-74	17.0	16.1	15.6		22.6	
75-79	12.0	24.0	17.9	18.1	24.0	24.8
80-84			19.9		25.6	
85+			15.2		25.3	

Table A.1.1c
Proportion reporting **'not good' general health** by age and gender, 1994 General Household Survey

Age group	London		Britain			
	Men	Women	Men		Women	
All 60+ (N)	20.8 (207)	18.7 (267)	22.3 (1935)		22.0 (2619)	
60-64	28.8	10.3	23.8		16.3	
65-69	12.8	5.9	20.6		17.9	
70-74	17.8	21.3	20.3		23.6	
75-79	20.4	28.9	22.3	24.5	26.5	27.2
80-84			30.9		25.8	
85+			19.2		30.1	

Table A.1.2 Health status: percentage of persons aged 60 and over reporting ill health by sex, age group and region, 1994/5 General Household Survey

GREATER LONDON				
	Men		Women	
	60-74	75+	60-74	75+
Limiting long standing illness	35.0	34.0	34.5	48.0
Acute ill health	18.4	12.0	15.5	24.0
'Not good' general health	20.9	20.4	12.9	28.9
(N)				
GREAT BRITAIN				
	Men		Women	
	60-74	75+	60-74	75+
Limiting long standing illness	38.2	45.4	36.2	48.7
Acute ill health	18.2	18.1	19.4	24.8
'Not good' general health	21.6	24.5	19.3	27.2
(N)				

Table A.1.3a: Health status amongst persons aged 60 and over: proportion reporting **limiting long standing illness** by socio-economic characteristics and region

	Greater London	**Other Metro**	**Non-Metro**	**Great Britain**
Socio-economic group				
I & II	40.0	31.9	35.4	34.5
III N/M	32.8	39.2	35.6	36.6
III M	35.8	44.7	42.8	42.8
IV & V	41.7	42.5	45.8	44.1
Non Manual	34.6	36.8	35.5	35.9
Manual	38.9	43.3	44.6	43.6
Income Quintile				
Bottom	42.4	47.9	44.7	45.7
2	41.5	44.3	44.6	44.2
3	34.4	39.8	43.2	40.8
4	28.0	32.4	29.0	30.3
Top	32.5	20.6	27.5	25.4
Tenure				
Owns outright	32.2	35.5	35.3	35.1
Owns mortgage	40.0	42.7	39.8	41.1
Local Authority	48.6	50.9	52.7	51.5
Other	25.0	38.1	43.5	38.7
Persons per room				
Over 1	54.5	63.2	62.5	60.9
0.5-1.0	40.0	46.3	43.0	43.9
under 0.5	35.5	38.4	39.3	38.6

Table A.1.3b: Health status amongst persons aged 60 and over: proportion reporting **acute illness or injury in the last 2 weeks** by socio-economic characteristics and region

	Greater London	**Other Metro**	**Non-Metro**	**Great Britain**
Socio-economic group				
I & II	18.3	19.4	16.2	17.5
III N/M	18.1	20.5	19.7	19.8
III M	15.1	19.3	16.4	17.4
IV & V	21.0	22.4	23.2	22.7
Non Manual	18.2	20.1	18.4	19.0
Manual	18.2	21.2	20.5	20.6
Income Quintile				
Bottom	18.1	23.2	23.1	22.6
2	21.1	23.1	20.0	21.4
3	12.9	22.1	19.7	19.9
4	14.0	15.7	16.3	15.8
Top	20.0	14.0	13.8	14.6
Tenure				
Owns outright	14.3	18.7	17.0	17.4
Owns mortgage	25.0	20.4	16.6	19.2
Local Authority	23.6	26.9	27.0	26.6
Other	17.7	17.5	18.5	16.5
Persons per room				
Over 1	27.3	25.0	25.0	25.5
0.5-1.0	18.2	22.0	17.7	19.4
under 0.5	17.4	20.7	20.2	20.1

Table A.1.3c: Health status amongst persons aged 60 and over: proportion reporting **'not good' health** in the last 12 months by socio-economic characteristics and region

	Greater London	**Other Metro**	**Non-Metro**	**Great Britain**
Socio-economic group				
I & II	23.3	18.1	17.1	17.9
III N/M	17.9	22.4	15.9	18.7
III M	19.6	26.1	23.6	24.1
IV & V	20.7	27.4	26.3	26.3
Non Manual	19.2	21.0	16.3	18.4
Manual	20.2	26.9	25.2	25.4
Income Quintile				
Bottom	15.3	25.4	24.4	23.7
2	26.1	29.0	24.3	26.4
3	20.2	21.5	20.1	20.7
4	16.3	17.9	12.3	15.0
Top	7.5	8.0	9.0	8.4
Tenure				
Owns outright	12.8	19.6	16.5	17.3
Owns mortgage	21.1	24.9	19.9	22.3
Local Authority	31.0	35.0	31.7	33.0
Other	17.5	13.8	22.7	18.6
Persons per room				
Over 1	45.5	35.7	38.5	39.5
0.5-1.0	22.9	28.6	24.8	26.0
under 0.5	17.0	22.5	19.3	20.4

Table A.1.4 Functional capacity and daily living activities: percentage of persons aged 65 and over unable to manage on their own by age and sex, 1994 General Household Survey

GREATER LONDON				
	Men		Women	
	65-74	75+	65-74	75+
Get up & down stairs and steps	2.2	4.1	5.4	15.6
Walk out of doors	2.2	10.2	4.5	26.0
Bath, shower, wash all over	1.1	2.0	2.7	13.5
Cut Toenails	4.4	30.6	18.8	51.0
(N)	(92)	(49)	(112)	(96)
GREAT BRITAIN				
	Men		Women	
	65-74	75+	65-74	75+
Get up & down stairs and steps	4.8	6.7	7.1	17.0
Walk out of doors	5.2	13.3	9.2	25.3
Bath, shower, wash all over	3.8	10.3	5.4	14.4
Cut Toenails	15.1	38.0	24.7	51.0
(N)	(937)	(504)	(1164)	(872)

Table A.1.5: Functional capacity: percentage of persons aged 65 and over **unable to walk out of doors on their own** by socio-economic characteristics and region

	Greater London	**Other Metro**	**Non-Metro**	**Great Britain**
Socio-Economic Group				
I & II	7.3	9.7	5.3	7.1
III N/M	7.5	15.6	9.9	11.9
III M	10.8	11.3	9.0	10.1
IV & V	10.3	15.6	18.2	6.4
Non Manual	7.4	13.7	9.1	10.2
Manual	10.6	13.9	14.5	13.9
Income Quintile				
Bottom	10.1	12.1	9.3	10.5
2	10.7	15.0	13.4	13.8
3	10.9	15.3	16.4	15.3
4	3.1	8.5	7.6	7.5
Top	5.3	7.1	6.6	6.7
Tenure				
Owns outright	7.4	11.2	10.1	10.3
Owns mortgage	20.7	14.6	12.2	14.2
Local Authority	12.7	19.4	15.4	16.8
Private Rent/Other	11.8	16.0	15.5	15.1

Table A.1.6 Use of Health and Social Services: percentage of persons aged 65 and over reporting receipt by age group and region, 1994/5 General Household Survey

	Greater London		Great Britain	
	65-74	75+	65-74	75+
Personal social services in the last month				
Home Help (LA)	2.9	13.8	3.1	14.7
Private domestic help	3.4	7.6	3.8	11.5
Meals on wheels	0.5	4.8	0.9	5.4
Day centre	1.5	4.8	2.1	4.9
Lunch Club	1.0	7.6	1.7	5.6
District nurse	2.0	10.3	2.6	11.0
Health services in the last three months				
Doctor at surgery	52.5	46.2	48.4	46.0
Doctor at home	4.4	13.8	6.7	18.5
Doctor at hospital	20.1	23.4	19.0	21.5
Nurse at surgery/ health centre	14.2	15.9	15.8	18.5
Social worker	0.5	26.7	1.2	3.3
(N)	(204)	(145)	(2101)	(1375)

Table A.1.7 Use of Health Services: percentage of persons aged 60 and over reporting use by sex, age group and region, 1994/5 General Household Survey

GREATER LONDON				
	Men		Women	
	60-74	75+	60-74	75+
GP in last 2 weeks	18.4	18.0	21.3	21.0
Outpatient attendance in last 3 months	20.9	26.0	22.4	20.6
Inpatient stay in last year	11.7	24.0	9.2	14.7
Day patient visit in last year	8.0	8.0	2.3	3.9
(N)	(163)	(50)	(174)	(100)
GREAT BRITAIN				
	Men		Women	
	60-74	75+	60-74	75+
GP in last 2 weeks	16.9	18.3	20.0	19.8
Outpatient attendance in last 3 months	20.8	22.4	20.9	22.4
Inpatient stay in last year	12.9	18.1	9.8	17.9
Day patient visit in last year	5.9	5.0	4.4	4.9
(N)	(1487)	(518)	(1789)	(923)

Table A.1.8 Use of Health Services: Amongst morbidity groups, percentage of persons aged 60 and over reporting use of a health service by region, 1994/5 GHS

GREATER LONDON					
	GP	Outpatient	Inpatient	Day patient	(N)
LLSI & acute	28.4	34.3	34.3	7.5	(67)
No LSI and no acute	11.9	14.2	6.9	3.2	(218)
Acute	34.5	29.9	28.7	8.0	(87)
No acute	16.8	20.0	9.3	4.5	(399)
LLSI	25.8	29.0	19.1	7.1	(182)
Non-Lim LSI	21.1	27.8	13.9	5.6	(71)
No LSI	15.0	14.5	7.3	3.4	(234)
'Not Good' general health	31.2	39.8	24.7	10.8	(93)
Fair general health	22.5	19.7	13.1	4.4	(182)
Good general health	12.2	15.7	5.6	2.5	(197)
GREAT BRITAIN					
	GP	Outpatient	Inpatient	Day patient	(N)
LLSI & acute	32.8	38.5	27.7	7.2	(748)
No LSI and no acute	10.1	10.9	7.1	2.9	(1867)
Acute	33.8	36.0	26.6	7.2	(941)
No acute	15.1	17.6	10.0	4.5	(3773)
LLSI	26.7	32.3	20.2	7.2	(1898)
Non-Lim LSI	17.0	19.2	10.1	4.5	(814)
No LSI	12.1	11.1	8.2	3.2	(2000)
'Not Good' general health	29.4	39.0	27.5	9.2	(1006)
Fair general health	20.7	21.2	12.4	5.3	(1690)
Good general health	11.1	11.7	5.2	2.2	(1885)

Appendix 2

Table A.2.1

Comparison of ethnic origin from the Ethnicity Multiyear GHS (1984-1994) with the 1991 Census and the Labour Force Survey (1989-91), Great Britain

	Ethnicity Multiyear GHS (1984-1994)	1991 Census	Labour Force Survey (1989-91)
White	**94.3**	**94.5**	**94.2**
Minority ethnic groups	**5.1**	**5.5**	**4.9**
Black	1.4	1.6	1.1
Indian	1.5	1.5	1.4
Pakistani	0.8	0.9	0.9
Bangladeshi	0.2	0.3	0.2
Chinese	0.2	0.3	0.3
Other groups	0.9	0.9	1.0
Refused question	**0.6**	**n/a**	**0.9**

Source: Ethnicity Multiyear GHS 1984-1994; figures for 1991 Census and the Labour Force Survey (1989-91) taken from Table 4, p. 17 *Population Trends 72*.

Table A.2.2 Morbidity: Percentage of persons aged 60 and over reporting ill health by black and minority ethnic group and region (%),

GREATER LONDON				
	Limiting LSI	**Acute ill health**	**'Not good' health**	**(N)**
White	43.2	14.9	22.7	(5700)
Indian	45.8	11.4	21.7	(105)
Pakistani/Bangladeshi	56.5	29.2	43.5	(24)
Chinese	(1)	-	(3)	(9)
Black Caribbean	46.4	27.3	41.0	(111)
African	(5)	(4)	(3)	(7)
Mixed	25.0	15.0	10.0	(20)
Other groups	58.5	19.2	30.6	(53)
Refused question	34.1	17.1	18.9	(41)
GREAT BRITAIN				
	Limiting LSI	**Acute ill health**	**'Not good' health**	**(N)**
White	42.0	17.8	21.8	(55330)
Indian	51.0	18.4	32.3	(260)
Pakistani/Bangladeshi	57.1	30.8	52.6	(92)
Chinese	20.7	6.9	31.6	(29)
Black Caribbean	44.9	24.2	43.0	(216)
African	(7)	(5)	(4)	(13)
Mixed	33.3	12.8	10.5	(39)
Other groups	58.9	26.6	37.5	(96)
Refused question	46.3	21.8	28.1	(241)

Table A.2.3 Use of Health Services: Proportion of persons aged 60 and over reporting use by black and minority ethnic group and region (%)

OTHER METROPOLITAN AREAS				
	GP	**Outpatient**	**Inpatient**	**(N)**
White	17.8	17.8	13.0	(21710)
Indian	42.7	22.7	12.4	(96)
Pakistani/Bangladeshi	49.0	26.9	21.2	(51)
Chinese	15.4	7.7	15.4	(13)
Black Caribbean	27.3	26.2	13.6	(66)
African	-	-	-	(4)
Mixed	-	-	12.5	(8)
Other groups	22.7	50.0	18.2	(22)
Refused question	22.2	23.4	12.7	(126)
NON METROPOLITAN AREAS				
	GP	**Outpatient**	**Inpatient**	**(N)**
White	19.3	16.4	12.5	(27920)
Indian	57.1	16.7	17.9	(56)
Pakistani/Bangladeshi	31.3	18.8	31.3	(16)
Chinese	14.3	42.9	14.3	(7)
Black Caribbean	15.8	18.4	13.2	(38)
African	-	-	-	(2)
Mixed	18.2	18.2	-	(11)
Other groups	52.4	14.3	47.6	(21)
Refused question	16.2	16.2	10.8	(74)

Part I: Health status and health care utilisation amongst elderly Londoners

Graphics

Figure 1

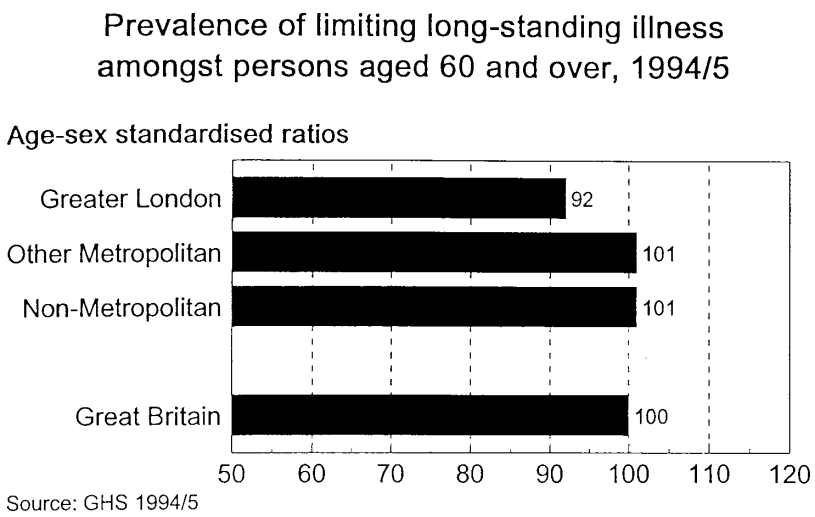


Figure 2

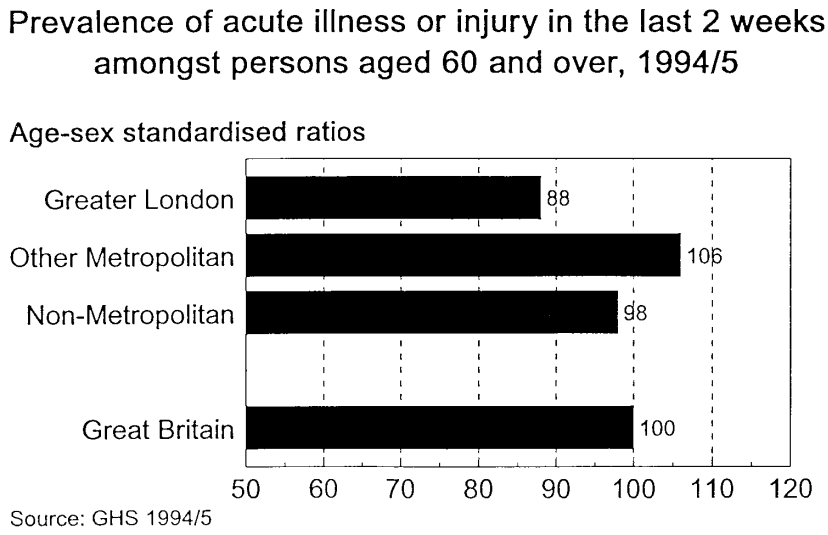
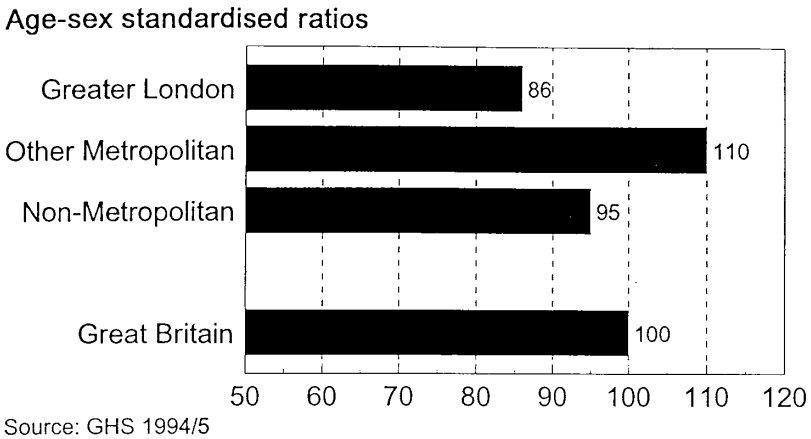


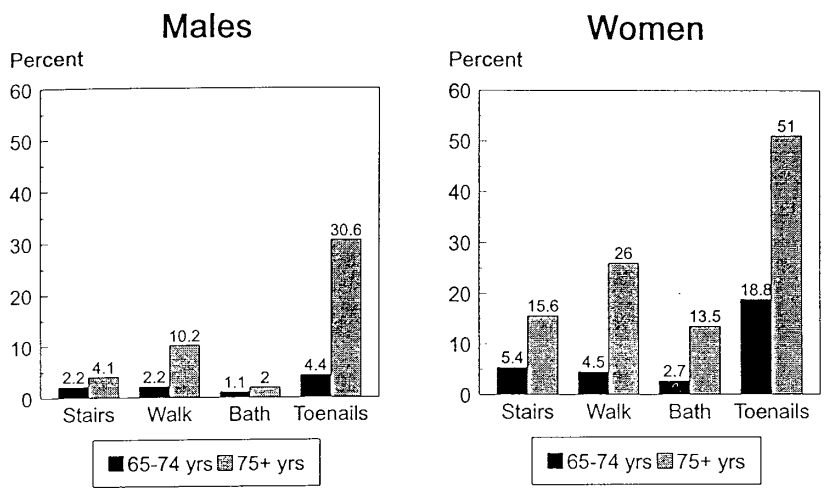
Figure 3

Prevalence of 'not good' general health in the last 12 months amongst persons aged 60 and over, 1994/5



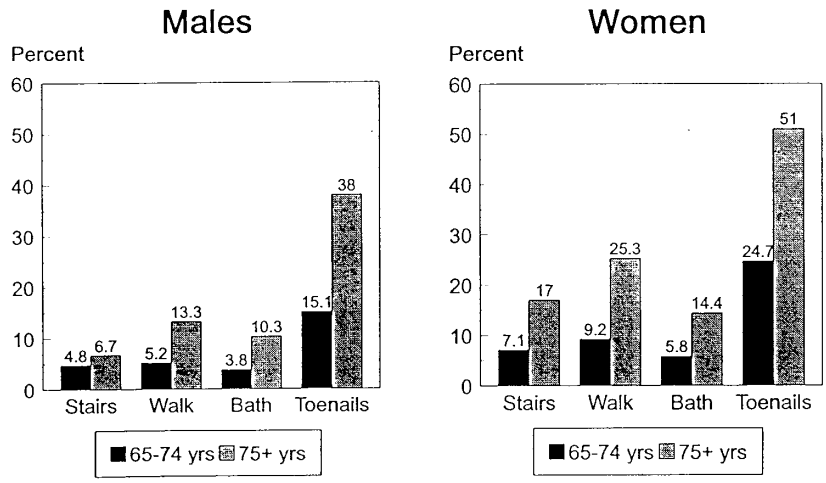
Source: GHS 1994/5

Figure 4: Functional capacity and daily living activities, 1994/5 Greater London



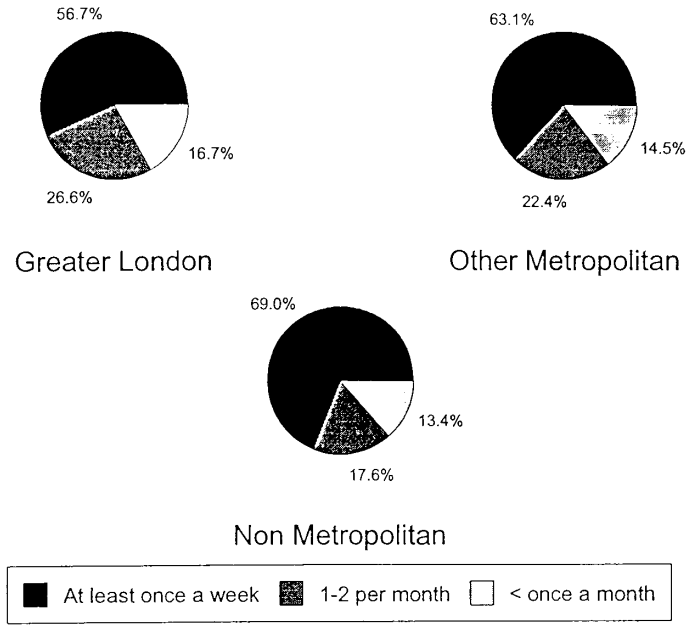
Source: GHS 1994/5

Figure 5: Functional capacity and daily living activities, 1994/5 Great Britain



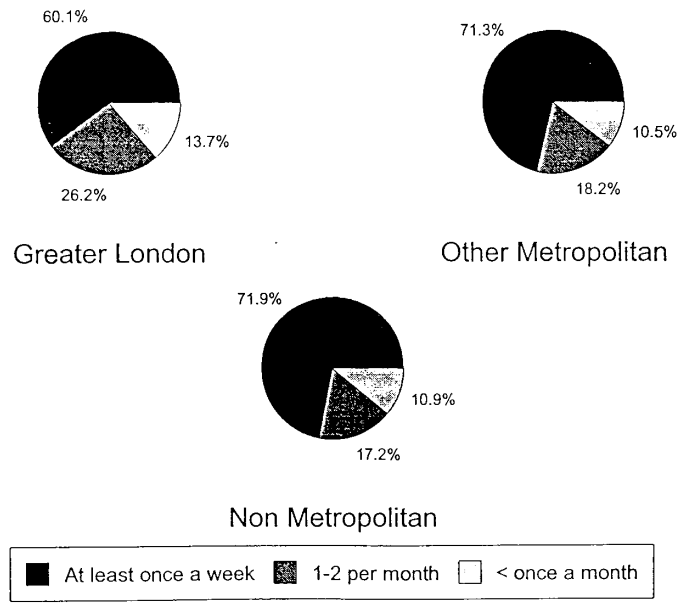
Source: GHS 1994/5

Figure 6: Frequency of elderly person visiting friends or relatives



Source: GHS 1994/5

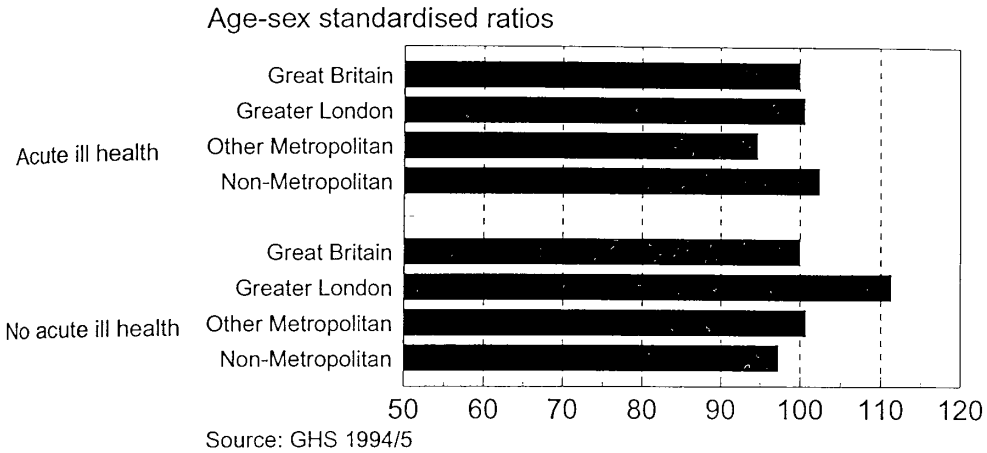
Figure 7: Frequency of elderly person being visited by friends or relatives



Source: GHS 1994/5

Figure 8

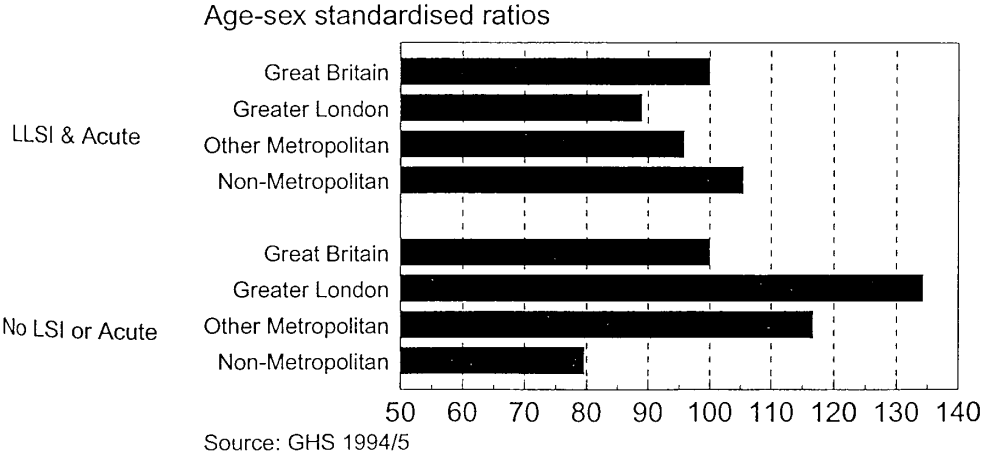
Consulting a GP in last two weeks by persons aged 60 and over within morbidity groups, 1994/5



Source: GHS 1994/5

Figure 9

Outpatient attendance in the last 3 months by persons aged 60 and over within morbidity groups, 1994/5

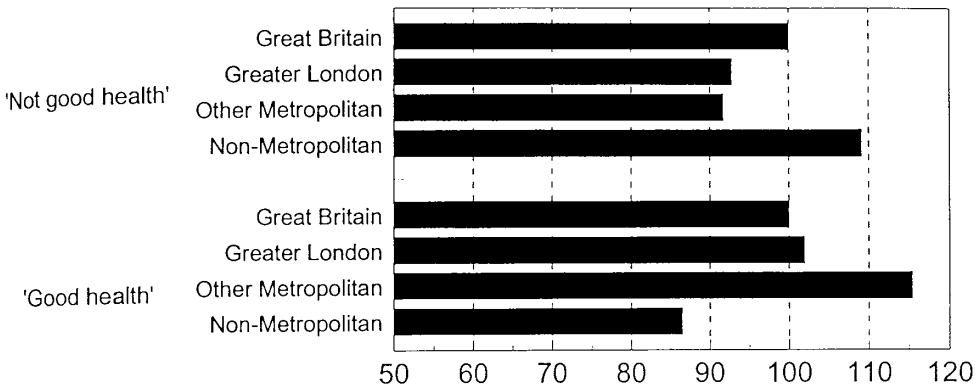


Source: GHS 1994/5

Figure 10

Inpatient stay in the last 12 months by persons aged 60 and over within morbidity groups, 1994/5

Age-sex standardised ratios

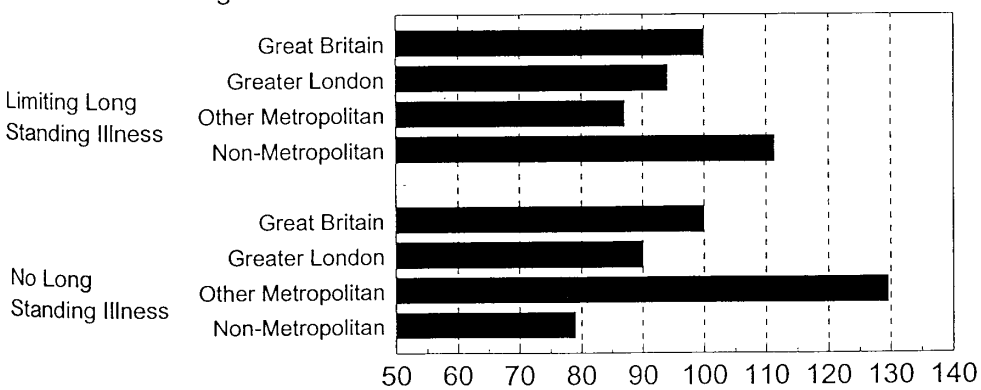


Source: GHS 1994/5

Figure 11

Inpatient stay in the last 12 months by persons aged 60 and over within morbidity groups, 1994/5

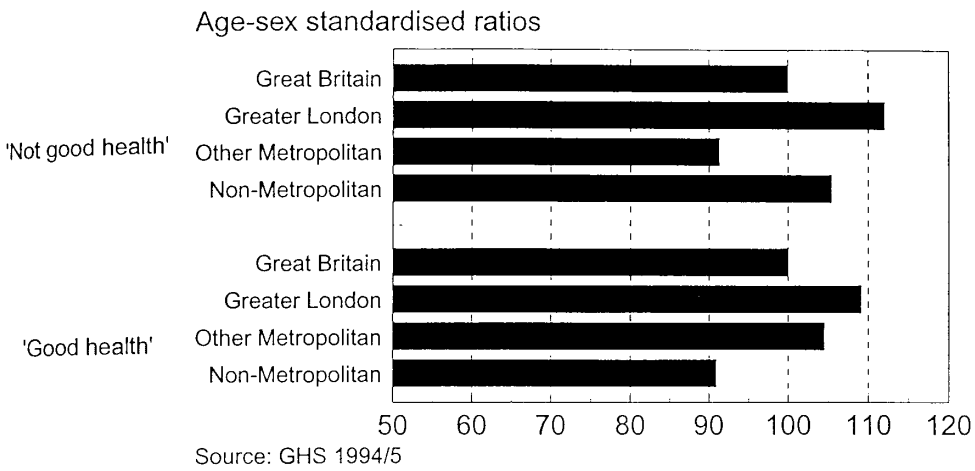
Age-sex standardised ratios



Source: GHS 1994/5

Figure 12

Daypatient attendance in the last 12 months by persons aged 60 and over within morbidity groups, 1994/5



Source: GHS 1994/5

Part II: Health status and health care utilisation amongst black and minority ethnic elders in London and Britain

Graphics

Figure 1a

Composition of the total sample and minority ethnic groups, all adults & children: Ethnicity Multiyear GHS (1984-94)

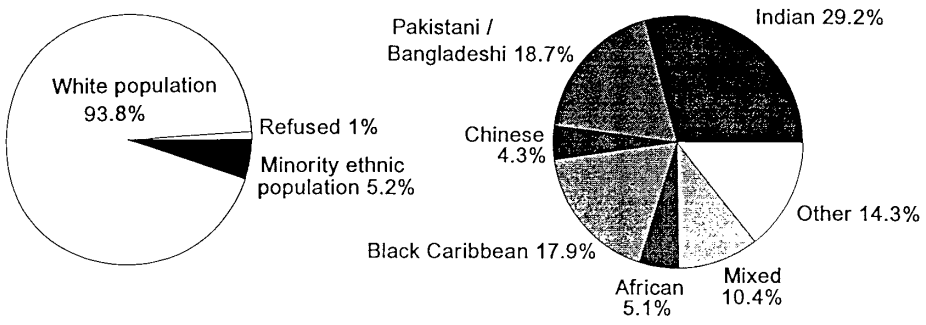


Figure 1b

Composition of the elderly population (60 plus) and minority ethnic elders: Ethnicity Multiyear GHS (1984-94)

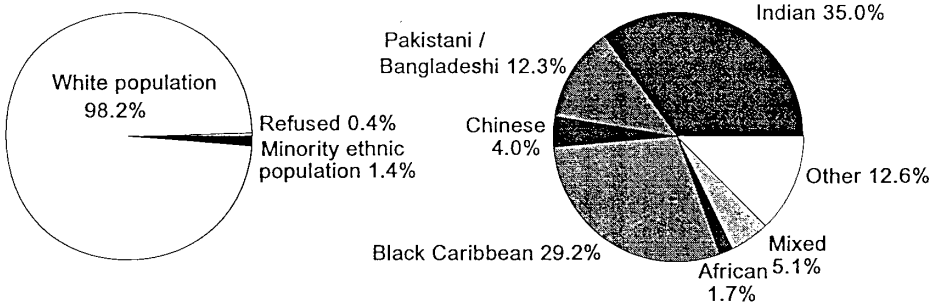


Figure 1c

Composition of the elderly population (60 plus) and minority ethnic elders: Ethnicity Multiyear GHS (1984-94)

GREATER LONDON

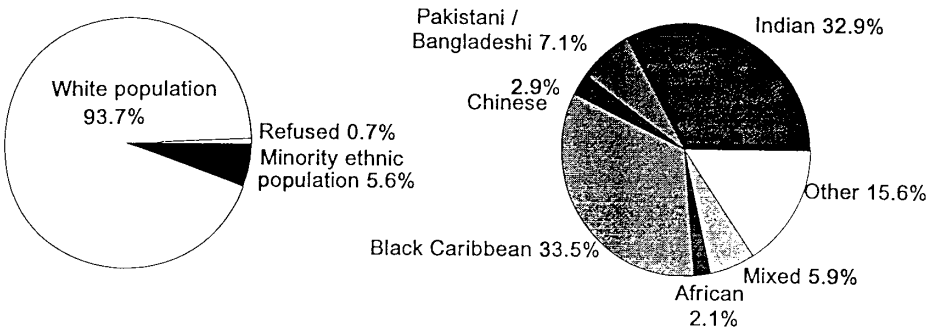
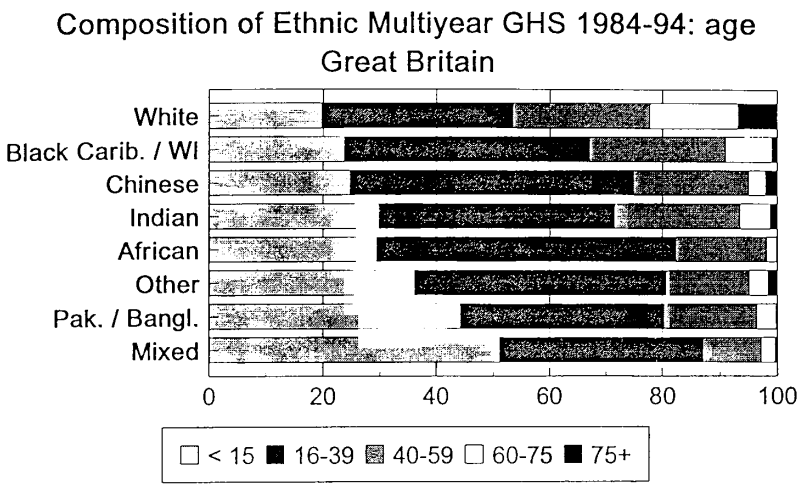
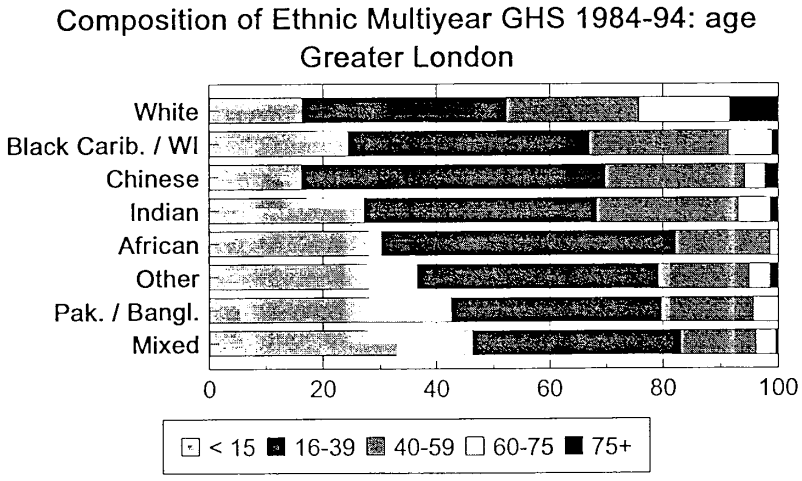


Figure 2a



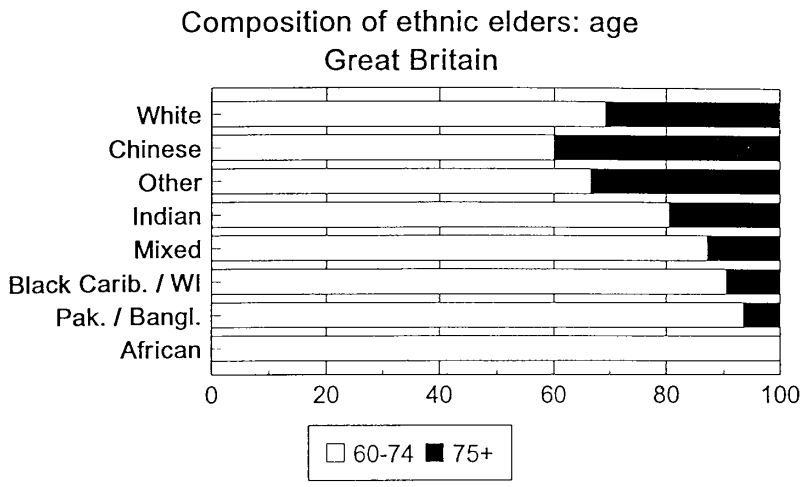
Source: Ethnicity Multiyear GHS 1984-94

Figure 2b



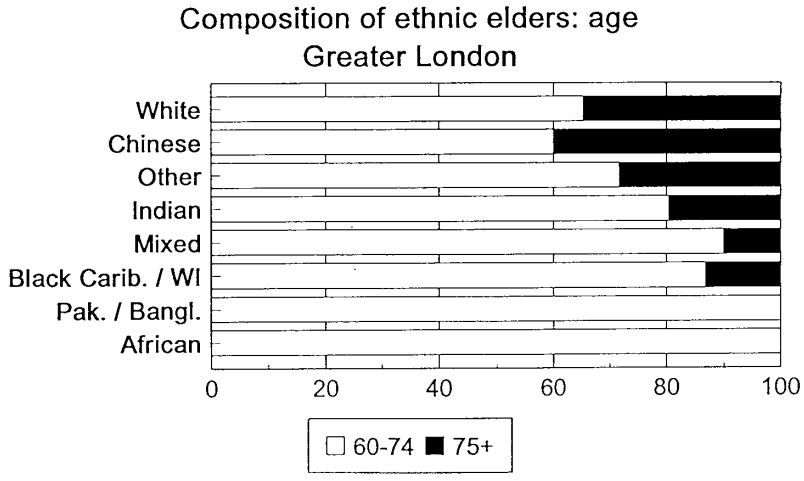
Source: Ethnicity Multiyear GHS 1984-94

Figure 3a



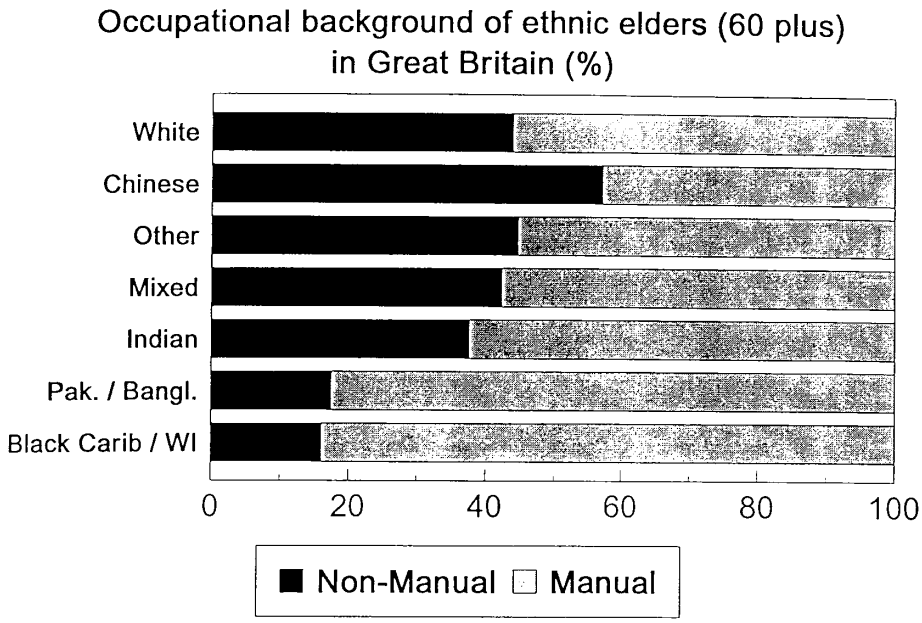
Source: Ethnicity Multiyear GHS 1984-94

Figure 3b



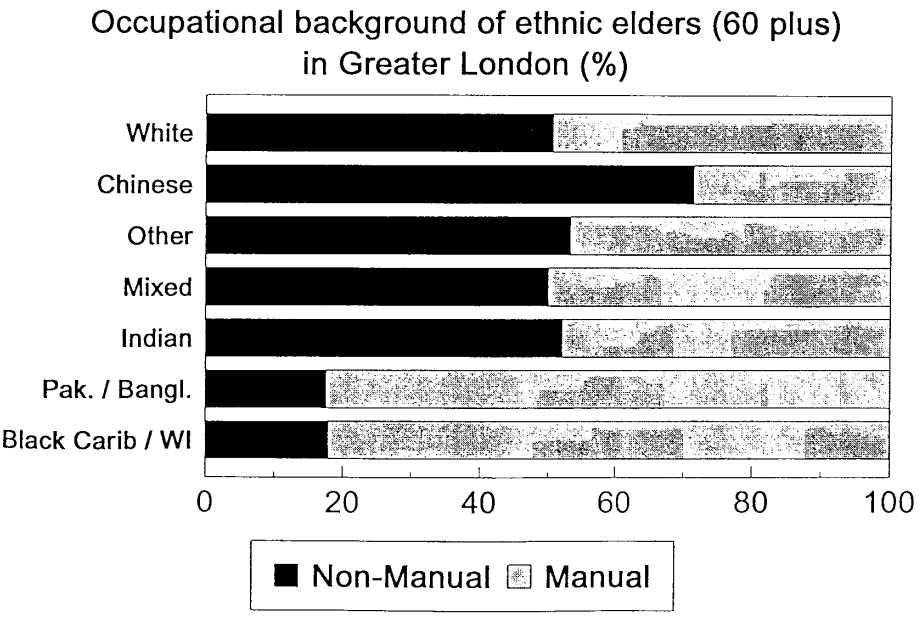
Source: Ethnicity Multiyear GHS 1984-94

Figure 4a



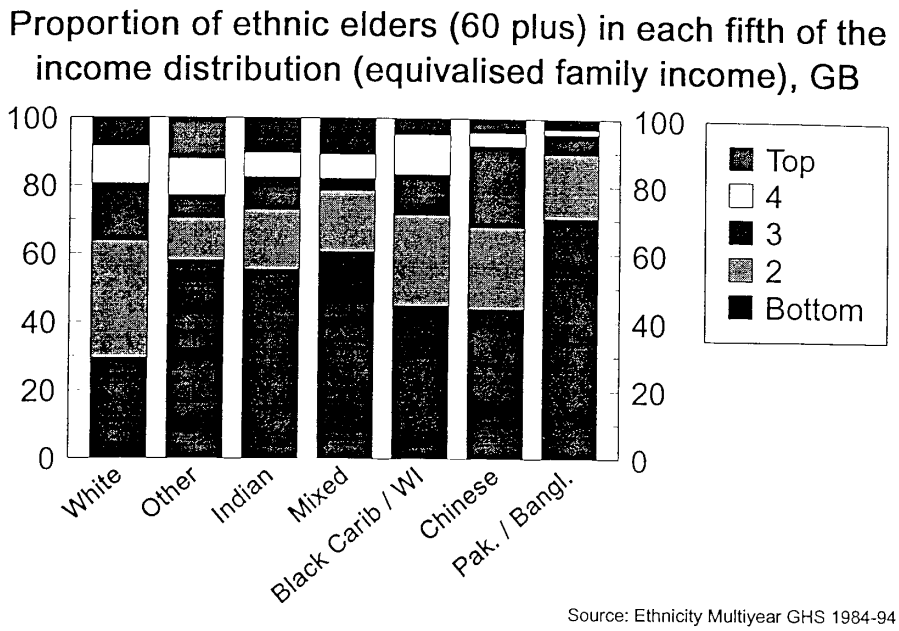
Source: Ethnicity Multiyear GHS 1984-94

Figure 4b



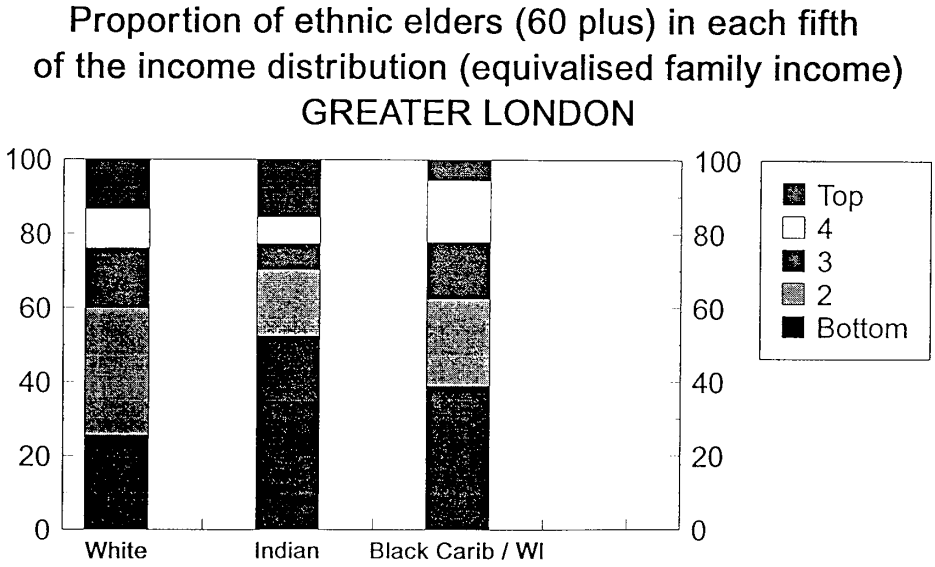
Source: Ethnicity Multiyear GHS 1984-94

Figure 5a



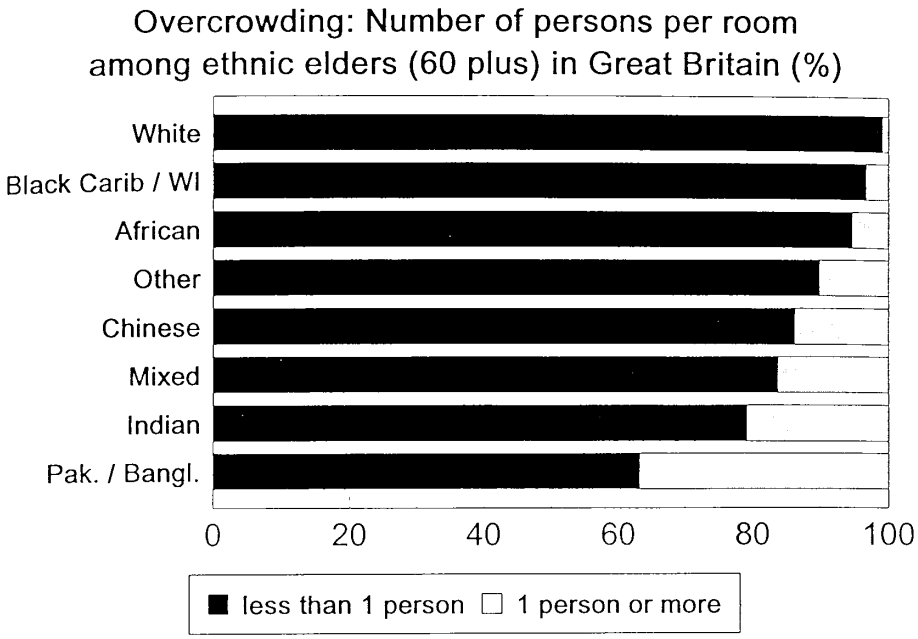
Source: Ethnicity Multiyear GHS 1984-94

Figure 5b



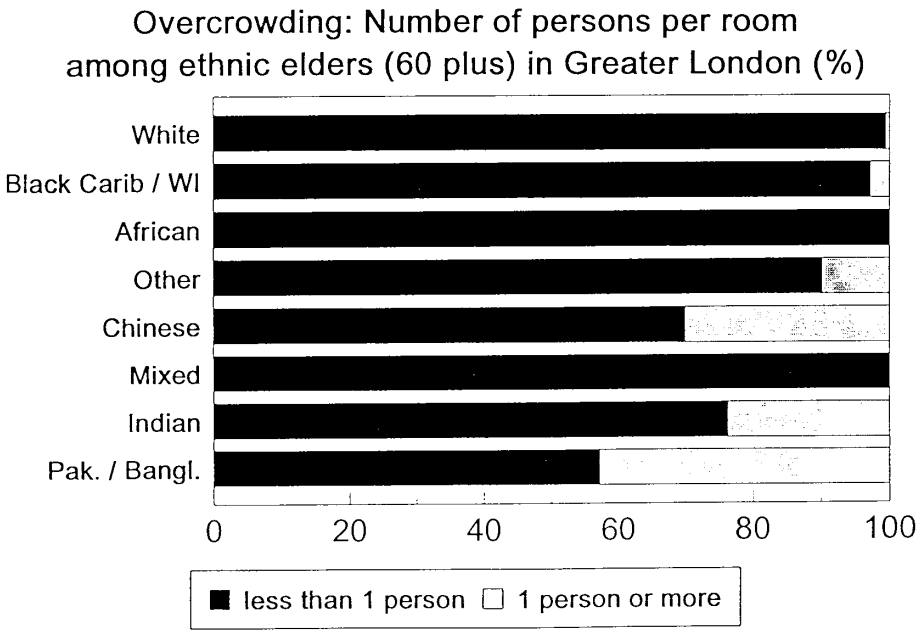
Source: Ethnicity Multiyear GHS 1984-94

Figure 6a



Source: Ethnicity Multiyear GHS 1984-94

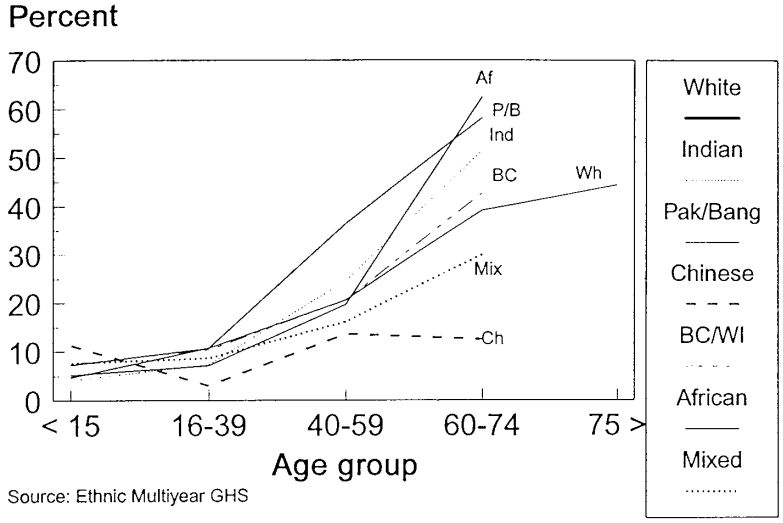
Figure 6b



Source: Ethnicity Multiyear GHS 1984-94

Figure 7a

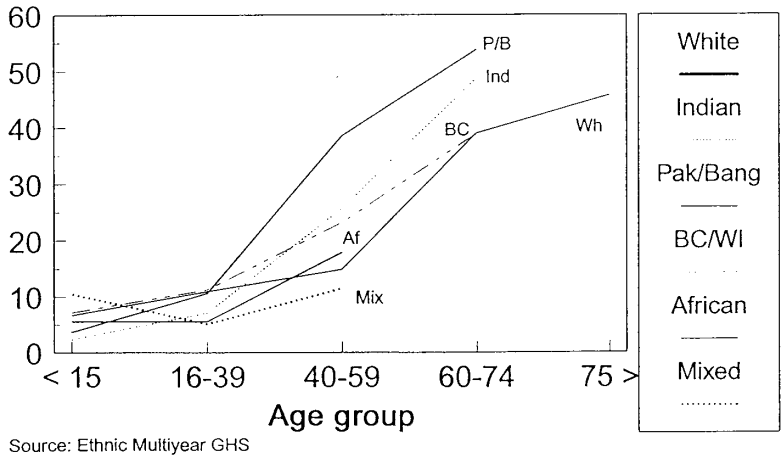
Percentage reporting limiting long standing illness by ethnic origin, Great Britain: Men



Source: Ethnic Multiyear GHS

Figure 8a

Percentage reporting limiting long standing illness by ethnic origin, Greater London: Men

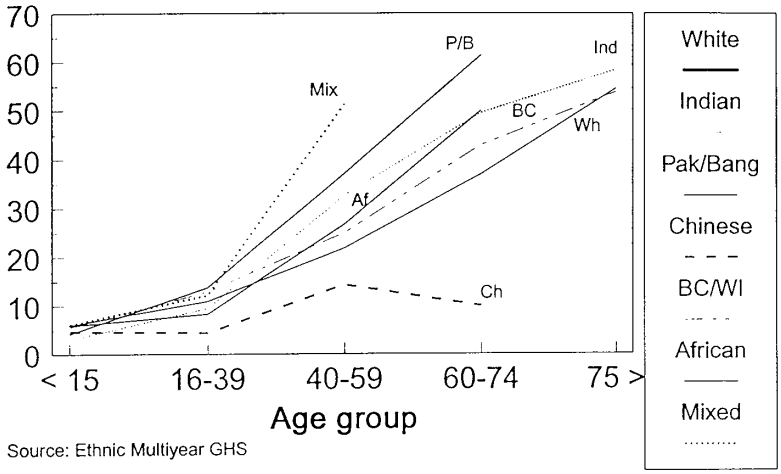


Source: Ethnic Multiyear GHS

Figure 7b

Percentage reporting limiting long standing illness by ethnic origin, Great Britain: Women

Percent

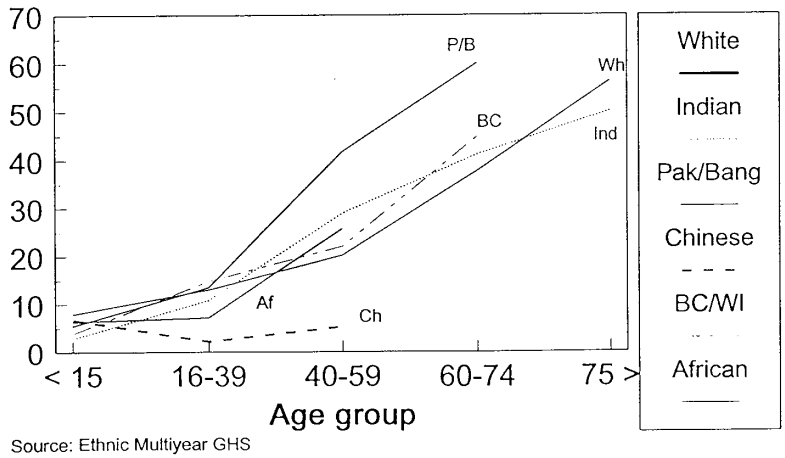


Source: Ethnic Multiyear GHS

Figure 8b

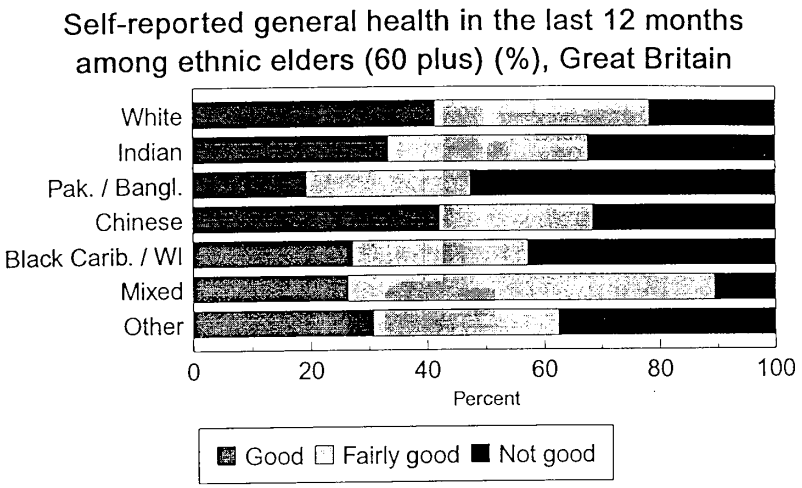
Percentage reporting limiting long standing illness by ethnic origin, Greater London: Women

Percent



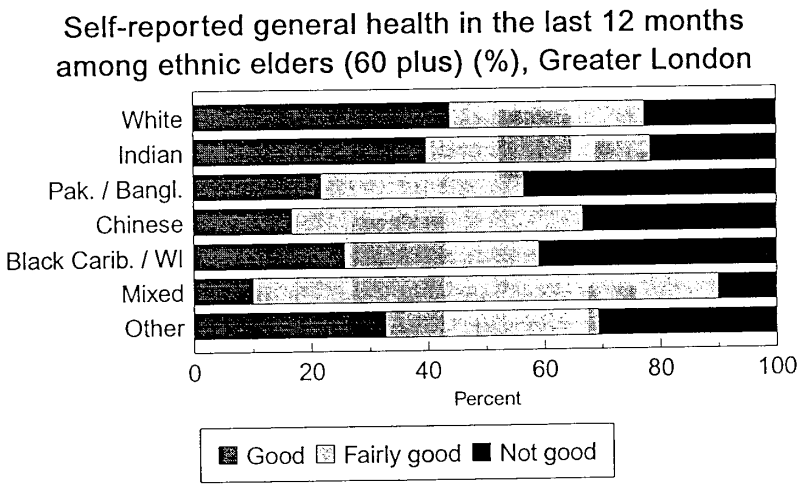
Source: Ethnic Multiyear GHS

Figure 9a



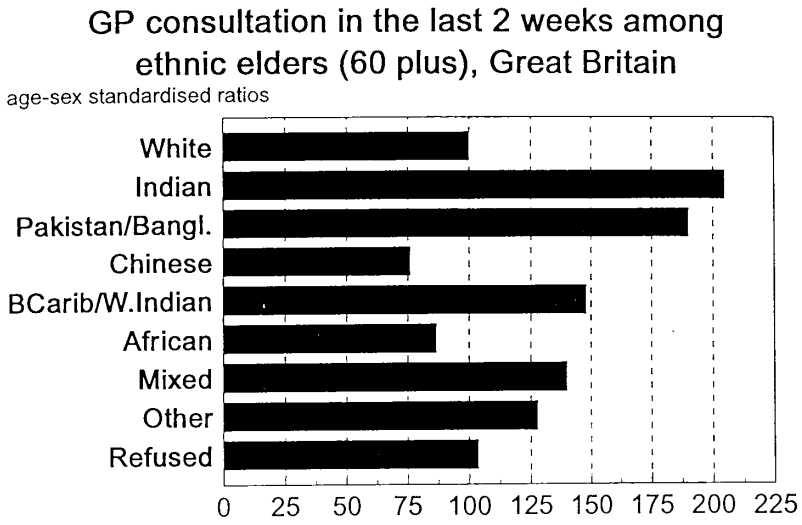
Source: Ethnicity Multiyear GHS 1984-94

Figure 9b



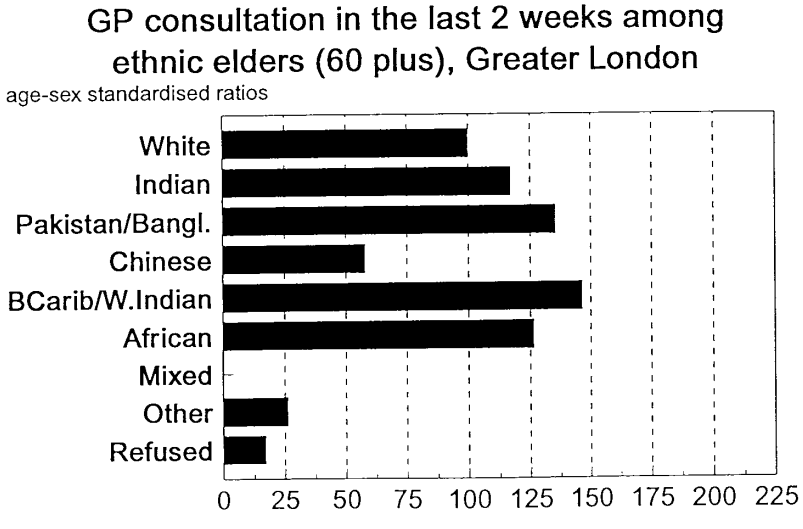
Source: Ethnicity Multiyear GHS 1984-94

Figure 10a



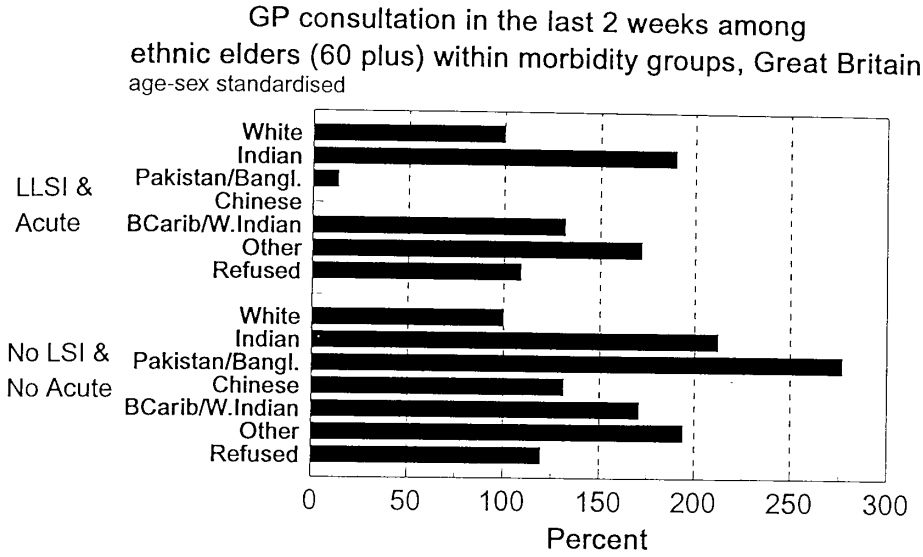
Source: Ethnicity Multiyear GHS 1984-94

Figure 10b



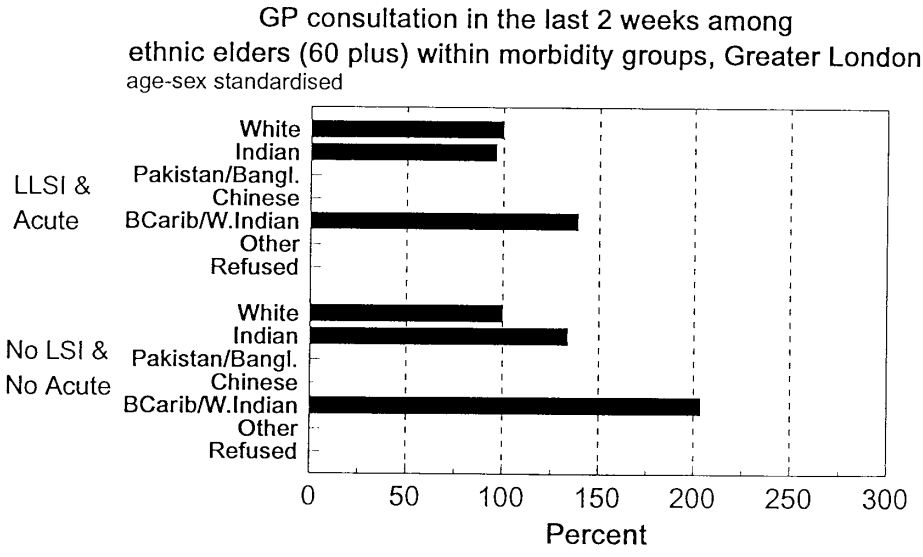
Source: Ethnicity Multiyear GHS 1984-94

Figure 11a



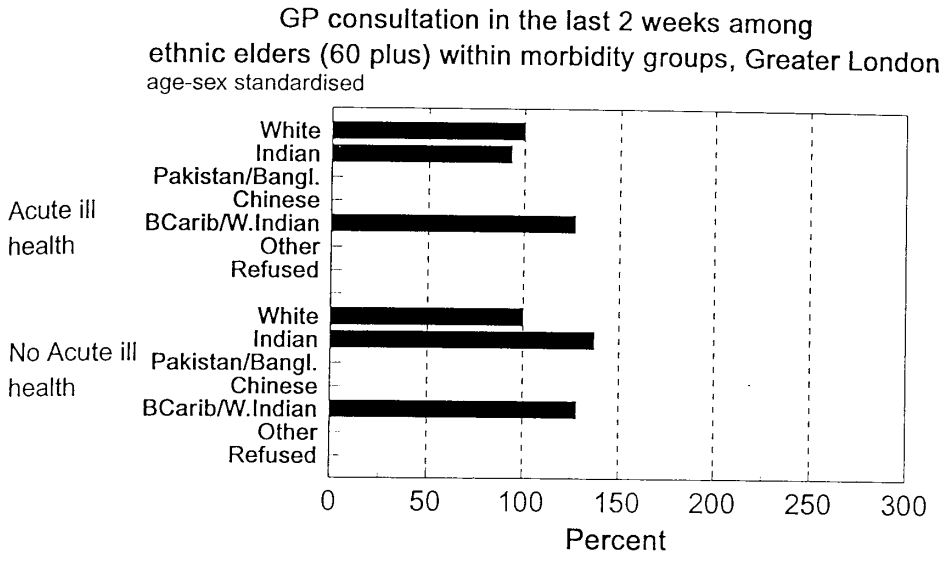
Source: Ethnicity Multiyear GHS 1984-94

Figure 11b



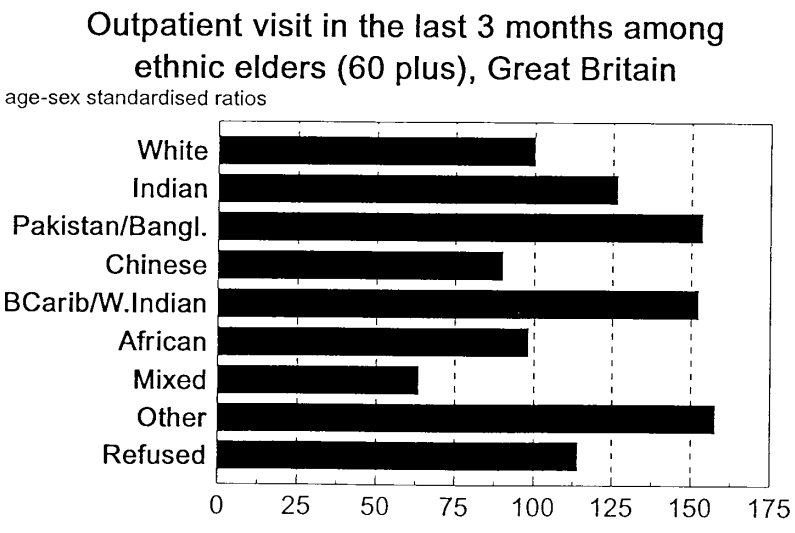
Source: Ethnicity Multiyear GHS 1984-94

Figure 11c



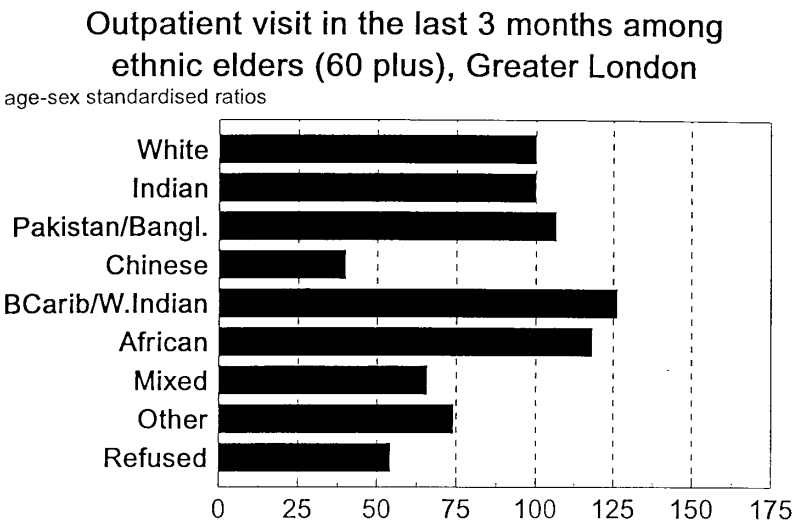
Source: Ethnicity Multiyear GHS 1984-94

Figure 12a



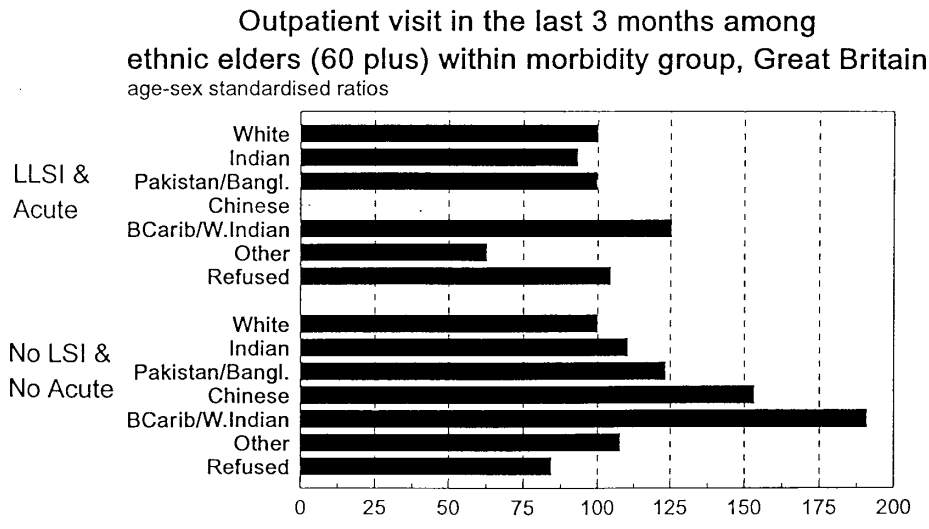
Source: Ethnicity Multiyear GHS 1984-94

Figure 12b



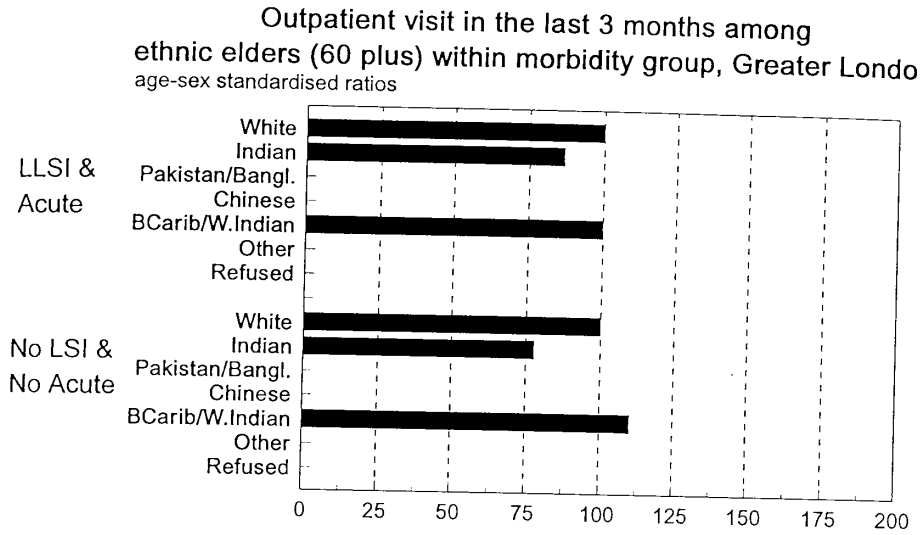
Source: Ethnicity Multiyear GHS 1984-94

Figure 13



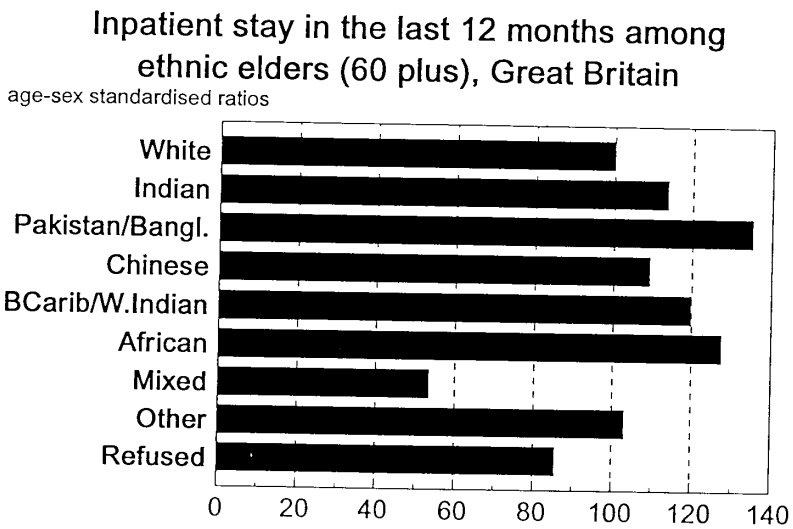
Source: Ethnicity Multiyear GHS 1984-94

Figure



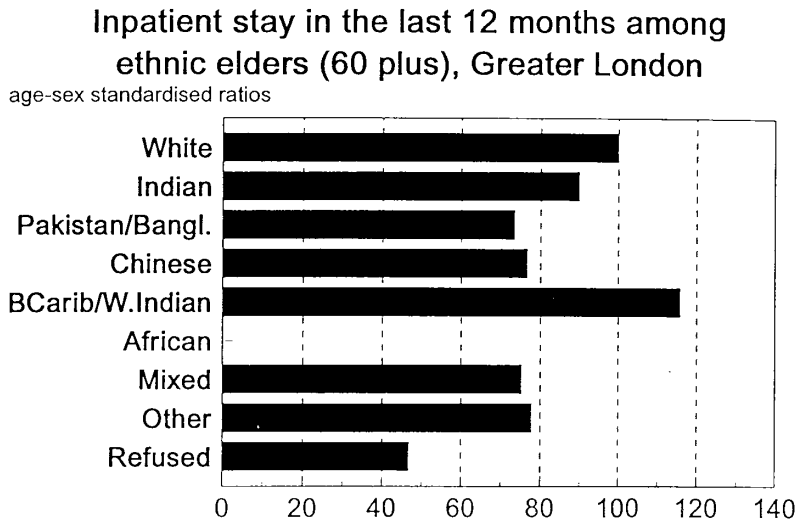
Source: Ethnicity Multiyear GHS 1984-94

Figure 14a



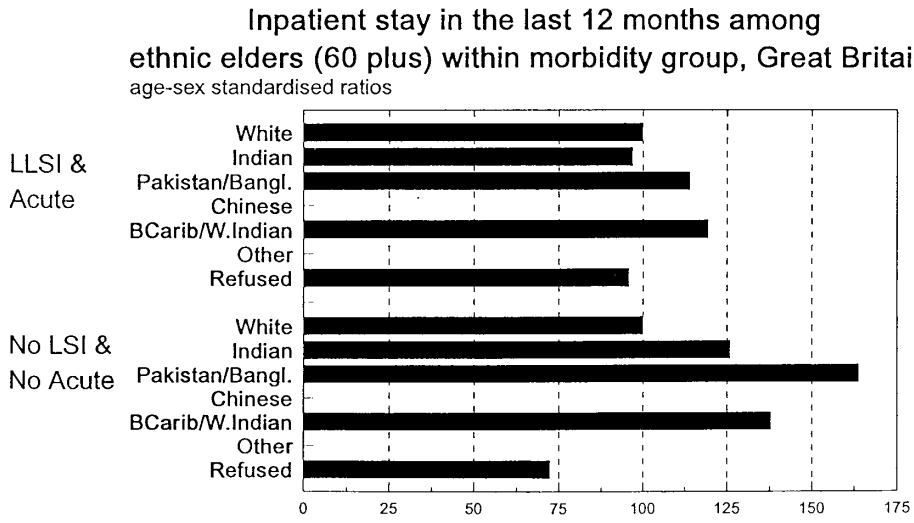
Source: Ethnicity Multiyear GHS 1984-94

Figure 14b



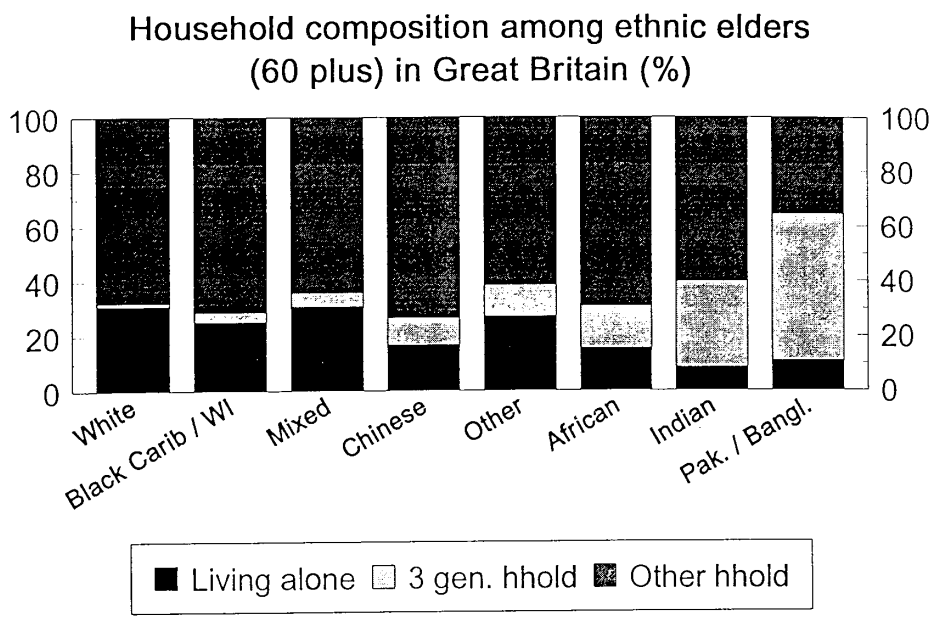
Source: Ethnicity Multiyear GHS 1984-94

Figure 15



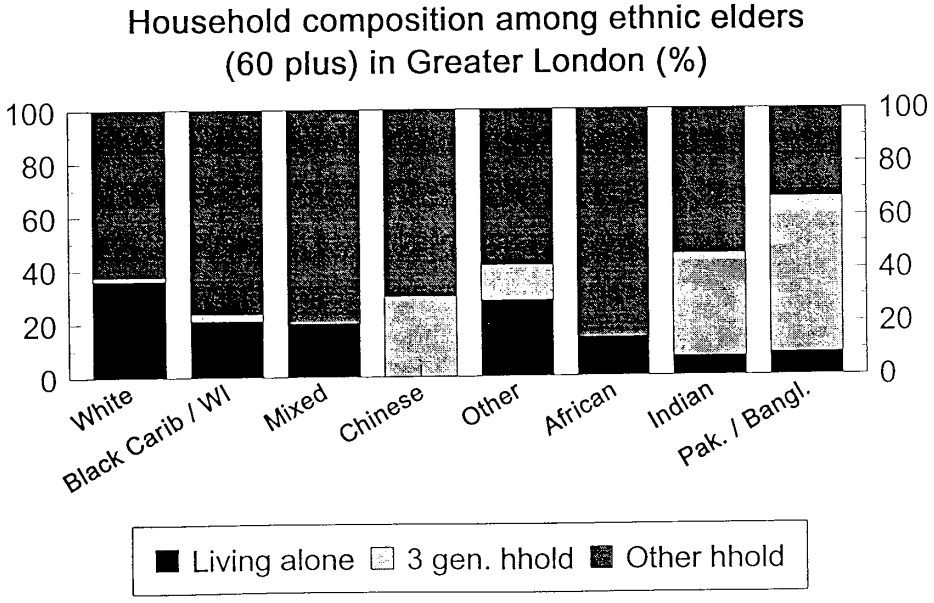
Source: Ethnicity Multiyear GHS 1984-94

Figure 16a



Source: Ethnicity Multiyear GHS 1984-94

Figure 16b



Source: Ethnicity Multiyear GHS 1984-94