Collaboratives on addressing racial inequity in covid recovery

Older People

Briefing Paper

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Contents

Introduction

The onset of the Covid-19 pandemic in early 2020 has highlighted the effects of contemporary and historical racism on health. In the UK ethnic minority people are one of the worst affected groups, with higher mortality and infection rates.[20,32] Many ethnic minority groups have been disproportionately affected by the lockdowns (local and national) and associated restrictions, which have further hampered their health.[29,33] The evidence to date shows that the ethnic minority groups (Pakistani, Bangladeshi, Black African and Black Caribbean) that are most likely to suffer higher rates of mortality and poorer health outcomes due to Covid-19, are also those that have been persistently shown over the last few decades to be suffering with the worst health and are the most disadvantaged socially and economically.[5] However, the way in which ethnic minority older people specifically have been affected by the pandemic has not been the focus of much research, although the disadvantages facing ethnic minority older people have moved up the agenda for many think tanks (e.g. Centre for Ageing Better, Institute for Public Policy Research (IPPR)) and organisations working in the voluntary, community and social enterprise (VCSE) sector.

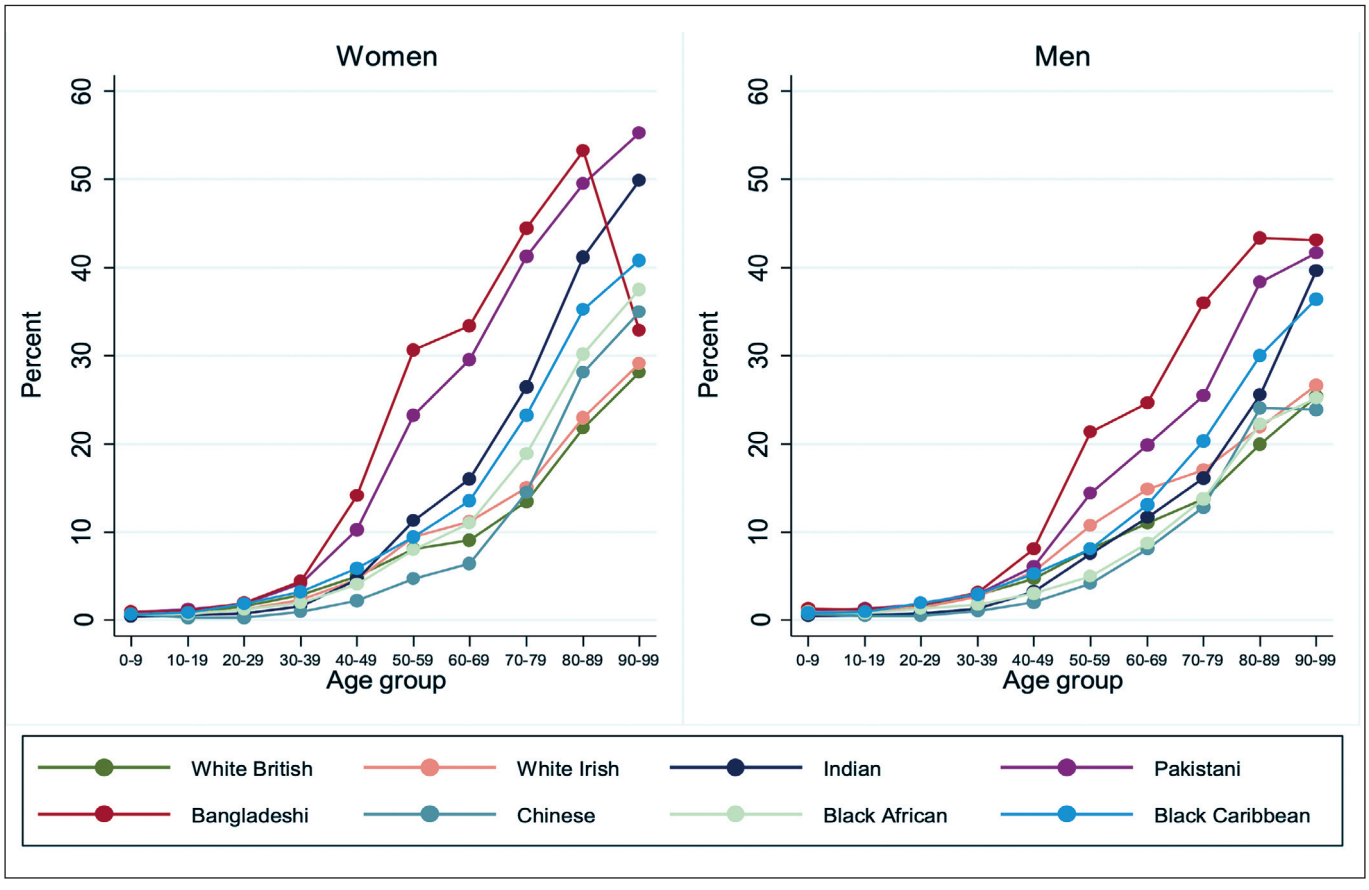
1. What was already known before the pandemic?

Inequalities facing older ethnic minority people in the UK

In the UK, older ethnic minority people are among the most deprived and excluded groups in society. This is reflected in studies which show increased rates of poor health and wellbeing[1,15,26], and fewer socioeconomic resources, among migrant and ethnic minority older people.[14] Further, ethnic minority people have up to three years lower life expectancy and up to seven years lower healthy life expectancy (the number of years a person can expect to live in a healthy state) than their White counterparts[43], and report worse health-related quality of life.[41] Yet research specifically focusing on ethnic minority older people is relatively sparse, resulting in a lack of evidence from which to formulate adequate policy solutions for the ageing ethnic minority population.[27] A recent appraisal of the quantitative survey data available in the UK to document and understand ethnic inequalities in later life, concluded that the systematic exclusion of ethnic minority older people from population studies is a form of institutional racism.[2] Without high quality data, with large enough sample sizes to conduct robust analysis, the true extent of the inequalities facing ethnic minority people cannot be established.

The data that are available show that health inequalities become worse as ethnic minority people age. Figure 1 shows the percentage of men and women reporting self-rated poor health (bad or very bad) in the 2011 census, presented for eight ethnic groups and in 10 year age intervals between 0 and 99 years. The analysis shows that many ethnic minority groups have worse health than the White British group over the life course. But these inequalities become worse from the age of 30 onwards, with inequalities most pronounced at the oldest ages. For example, the rates of poor health for White British women in their 80s is equivalent to, or lower than, rates of poor

Figure 1. Percentage of men and women with poor self-rated health by age and ethnicity



Source: Census data, own calculations. Poor self-rated health aggregates 'bad' and 'very bad' health

health for Black Caribbean and Indian women in their 70s, and Pakistani and Bangladeshi women in their 50s. The rates of poor health for White British men in their 80s is equivalent to the rates of poor health for Black Caribbean men in their 70s, Pakistani men in their 60s, and Bangladeshi men in their 50s. Pakistani and Bangladeshi men and women are the most likely to have the worst health in almost every single age group, displaying levels of poor health up to double those of the White majority group at older ages. A more detailed analysis using national surveys from 1993 to 2017 shows that not only is ethnic minority older people's health worse at later ages, but this ethnic health inequality has persisted for more than two decades.[36]

The reasons behind these inequalities have shown to be rooted in racism and socioeconomic inequalities. There is a large body of evidence showing the association between experiences of racism and poor physical health[19,42], as well as effects of vicarious racism (racism experienced by family members) on ethnic minority people's health.[3,17] Due to earlier experiences of racism, and accumulated social and disadvantage over the life course, ethnic minority people's health starts to deteriorate in early adulthood as a result – a 'weathering effect'.[16] Further, research has also shown the cumulative effect of racist experiences on mental health i.e. more racist experiences have more of a negative effect.[40] This finding is particularly pertinent for the field of research with older ethnic minority people, as it adds to the evidence that inequalities become worse as people age, since they are more likely to have accumulated more incidents of racism by the time they reach older age.[11] However, it is not only evidence of interpersonal or individual experiences of racism that has to be taken into account when theorising the reasons for ethnic health inequalities at older ages. In addition, the structural and institutional racism[28] evident in UK society which gives rise to inequalities in health and many other life domains must also be addressed as part of the problem.

As well as the stark health inequalities that are evident for ethnic minority older people, there are severe inequalities in their social and economic circumstances. Socially, ethnic minority older people are more likely to be lonely[35,39,] leading to social exclusion. Economically, they are more likely to have had a history of insecure and precarious employment[10,24], more likely to have retired from the labour market due to poor health[18], less likely to be living in good housing[12], and less likely to have adequate pensions in later life[23], compared with their White counterparts. This suggests that poor Covid-19 outcomes are not only a result of contemporary conditions, such as elevated exposure to the virus through disproportionately high employment rates in occupations working with the public, but also historical deprivation and marginalisation. These socio-economic inequalities coupled with increased rates of poor health go some way to showing the extent of the vulnerable position that ethnic minority older people find themselves in.

2. What impact has the pandemic had?

The impact on ethnic minority older people in the UK

Despite the vulnerable position of ethnic minority older people, there has been very little research in the UK focusing on how this group's health and socioeconomic circumstances have been affected by the Covid-19 pandemic and the associated lockdowns, from March 2020 to the present day. The stakeholder engagement held by Public Health England[34] showed the deep distrust of state institutions that exists for many ethnic minority groups, which plays a part in worsening health. For example, for many ethnic minority people "lack of trust of NHS services and health care treatment resulted in their reluctance to seek care on a timely basis, and late presentation with disease".[34] This distrust may be worse for older ethnic minority people due to a lifetime of racist experiences, and may also be a driving factor in the lower propensity for ethnic minority people aged 80 and over to have been vaccinated.[38] Although it must be noted that there are relatively few ethnic minority people aged 80+; they make up only 3% of this age group.[13] Additionally, as distribution of the vaccine to geographical areas was driven by age, ethnically dense areas where older ethnic minority people are more likely to live were less likely to receive vaccine doses. Hence, discussions around low 'vaccine uptake' for ethnic minority older people in early 2021 may have been better framed as poor geographical 'vaccine reach'.

There has also been a spotlight on the excess number of deaths in care homes[31], with a devastating number of deaths in these settings. By looking at deaths recorded in care homes between April and November 2020, it can be seen that Black (Black Caribbean, Black African and Other Black) and Asian (Pakistani, Bangladeshi, Indian and Other Asian) older people were more likely to have died from Covid-19 compared with their White counterparts[7]; 31% of Black care home residents' deaths and 30% of Asian deaths were due to Covid-19 compared with 23% of White residents' deaths. A subsequent publication by Care Quality Commission has shown that ethnic minority people are also dying at younger ages in care home compared with their White counterparts.[8]

Further, access to formal sources of support, including health services, might be even more difficult during the pandemic for older ethnic minority people, because they are more likely to face language barriers. For example, it is estimated that 60-70% of the older generation of Somali people speak little or no English.[37] A recent rapid review conducted on behalf of the Greater London Authority[29] reported that some older Somali people who had been admitted to hospital with Covid-19 had traumatic experiences, as they were unable to communicate with staff, could not use family members for translation as visitors on the ward were prohibited, and were at risk of dying alone, without being heard. There have been efforts to translate health information into a range of languages to ensure vital information about keeping safe in the pandemic is available to ethnic minority older people. However, these materials have not always been suitable due to being too long, complicated or difficult to understand.[9] This has meant that some ethnic minority older people with limited English skills have had to rely on family or friend networks for information.

A report by Camden Council[6] found that older Bangladeshi people found it hard to access social media and online tools due to a lack of digital skills, resulting in a lack of access to virus related guidelines and information. This is in line with previous research that shows that older people are less likely to be digitally connected[4], and this is particularly the case for poorer older people and for older women.[22] This undoubtedly exacerbated loneliness and social isolation at a time when socialising has been done mainly online. There have also been concerns that ethnic minority older people living in intergenerational households are at increased risk of catching the virus due to younger members of the family more likely to socially interact with others. Bangladeshi, Indian and Chinese people are more likely to live in this type of household[21] but there is limited evidence to suggest that household type increases the risk of transmission.[30]

Finally, it is important to point out the work that the VCSE sector has done during the crisis to support ethnic minority older people in terms of provision of advice, bereavement support, mental health services, alleviating isolation and providing an essential point of reference for information about the Covid-19 pandemic. However, despite this, evidence from The Ubele Initiative suggests that 9 out of 10 micro or small ethnic minority focused VCSEs did not have the financial reserves to last beyond three months [25].

3. Moving forward

How can inequalities for ethnic minority older people be remedied? Questions to aid formulation of recovery plans

1. What data are required to close the ethnicity data gap for ethnic minority older people?
2. What would a race equality strategy look like nationally and locally? How would ethnic minority older people be specifically addressed in such strategies?
3. How can we ensure vital information is accessible by ethnic minority older people?
4. What can be done to support the VCSE sector in their work with ethnic minority older people?

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Published March 2021

Race Equality Foundation