

## Quality of Life and Social Support Among Older People from Different Ethnic Groups

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This study set out to explore quality of life and social support among older people from different ethnic groups. We carried out in-depth interviews with 203 older people from Caribbean, Asian (including Chinese), African and white communities aged 55 and over. The study suggests that ethnicity influences both collective and personal responses to perceptions of quality of life.

### Summary of key findings

- Health, income and social support were generally agreed to be important components of quality of life but the importance participants assigned to each of these aspects varied.
- Expectations played a significant part in determining the extent to which people assessed their quality of life as being good. Past experiences, current and future prospects, and considerations about other paths that their lives might have taken were all used as ways of setting markers for assessing quality of life.
- Ethnicity appeared to have a significant bearing on quality of life. White participants tended to report better levels of health and higher incomes than participants from other ethnic groups. At the same time, participants from other ethnic groups tended to view the process of growing older more positively.
- More consideration needs to be given to the impact of discrimination upon quality of life. Just under half of the sample of minority ethnic people said that they had experienced racism with almost two-thirds of those who had experienced racism suggesting that they had done nothing about it. Almost one in five participants reported that ageism or being judged by their age had made their experiences of growing older more negative.

- Levels of social support were generally high across all participants but this may be experienced differently between different ethnic groups. For all older people practical and emotional support was most often provided by families and friends, but for minority ethnic older people voluntary organisations played a vital role in providing support in terms of information and advice.

### Exploring ethnicity, social support and quality of life

Gerontological research has increasingly recognised the diversity of older people's lives, highlighting the differing experiences of men and women, the impact of socio-economic status, as well as the diverging experiences of those aged 85 and over in comparison to their younger counterparts. Yet those wishing to explore the impact of 'ethnicity' have had to rely on small scale studies, often looking at the experience of a specific ethnic group, often in a single geographical location. This comes at a time when there are now over 350,000 people from minority ethnic communities aged 65 and over (White, 2002) – more than twice the number in 1991. This partly reflects the wider trend of an ageing population, but is mainly due to the post-Second World War generation of migrants from the Caribbean, Asia and Africa now reaching retirement.

The growth in numbers has been one factor in the belated interest policy makers and practitioners have shown in the support that minority ethnic older people need and in the efficacy of existing provision. It is in this context that we set out to explore quality of life and social support among older people from different ethnic groups.

## Quality of life

The concept of quality of life has entered every day usage, but there remains disagreement on what it means and how it should be measured. While there has been some move to measuring quality of life in both subjective and objective terms, there has still been criticism of existing quality of life measurement for its emphasis on health or economic related indicators. Our study attempted to explore both subjective and objective measures of quality of life.

Overall, less than a third of participants rated their health as good and over three-quarters reported that they had a longstanding illness or disability. Although there were no significant differences in self-reported health, limiting longstanding illnesses, or number of health problems between participants from different ethnic groups, Asian people tended to report the poorest health and their rates of diabetes, hypertension and coronary heart disease were high.

While health was often a component affecting how participants felt about their lives, their answers also suggested that ethnicity may play a role in influencing both collective and personal responses to perceptions of quality of life. First, the impact of migration may mediate individual components of quality of life, such as social support (Brockmann, 2002). Secondly, there may be more direct effects in that, for instance, different external events will influence collective experiences. The most vivid example of this was that of a Chinese woman who had lived through the Cultural Revolution. This provided her reference point for a time that was bad in her life.

Thirdly, differing religious and cultural practices appeared to affect the way in which participants were prepared to comment negatively on their current quality of life. This was especially noticeable among some Muslims who emphasised that there was a divine purpose behind what happened.

Different religious and cultural practices may also impact on the way in which people perceive their lives within the context of ageing. A Hindu man emphasised the cyclical nature of life. Chinese or Asian participants were more likely to report that

growing older had positive aspects, such as becoming wiser or more tolerant.

Here, the strongest contrasts were with white women, some of whom expressed negative ideas about ageing, either in terms of how they felt about themselves or how others reacted to them.

## Social Support

A useful way of describing social support is to see it as the interactive process through which assistance is obtained from our social network (our families and friends) (Bowling, 1991). Existing analysis (Helgeson, 2003; Newsom *et al*, 1997) has suggested this support can be categorised as: emotional (affection, sharing feelings, a sense of belonging); instrumental (tangible or material assistance); and informational (knowledge and advice from others). Furthermore, structural factors such as health, income, living arrangements and migration history may influence how social support is received and perceived.

Results from the study suggest that there is a trend towards increasing convergence in household living arrangements between different ethnic groups and that certain minority groups may be more, not less likely, to live on their own. The strongest contrasts were to be found among Asian participants. Taken as a whole Asians tended to live in larger households. However, multigenerational living patterns were stronger among Asian Bangladeshi and Asian Pakistani participants. Asian Indians showed greater similarities with their white counterparts in that they were more likely to live with just their spouse or with their spouse and children under the age of 18.

It was noticeable that more than half of Black Caribbean and Chinese participants lived in single person households. Nevertheless, the majority of participants from all ethnic groups were in regular contact with their family and friends.

While almost all the minority ethnic participants were born outside the UK, the majority had lived longer in this country (a mean length of 36 years) than in their country of birth. They were very settled in their neighbourhoods (mean length of 26 years) and there was some evidence that they quickly rebuilt their social support networks or had begun the process before leaving their country of origin.

A significant difference between participants was that white people tended to have lower expectations about the frequency and type of support that they received from their children. They felt that their chil-

dren would provide support in a crisis, but that they themselves would prefer to avoid such a necessity. A high proportion of Caribbean women in this age group have been employed in the health and social care sector. For these women, support from services rather than their family was often seen as not only more acceptable but also their right. By contrast, Asian participants often described a more intensive, system of reciprocal help. Thus, daughters or daughters-in-law usually provided practical help in the form of cooking, shopping or cleaning. In return, their parents looked after their grandchildren, thus enabling them to remain in paid employment. Although a minority of participants from minority ethnic groups expressed unhappiness about what they saw as a reduction in the support that adult children gave their parents, the majority were of the opinion that, while it may have been customary for older people in their country of birth to be supported by their children, this was not always possible in Britain.

Finally, existing research has highlighted how people from minority ethnic groups are less likely to use health and social care services and are less aware of what help is available (Ahmad, 2000). In our sample, while instrumental and emotional support was most often provided by families and friends, the vital role played by voluntary organisations in providing information and advice was especially striking. At one level, Black Caribbean, Chinese, and Asian community centres provided essentially social opportunities for people to share meals and the company of people from a similar background. At another, they were the link whereby people were helped to access health and social care services.

## Experience of racism

There are many forms of racism including personal insults, unfair treatment in the workplace, and racially motivated crime (The Commission on the Future of Multi Ethnic Britain, 2000). Just under half of the sample of minority ethnic people (defined here as 'Asian', 'Black', 'Chinese' and 'Mixed Heritage' participants) said that they had experienced racism. This is likely to be an underestimate as people are often reluctant to admit to being a victim of racism. It was a significantly higher proportion than that reported by white people, of whom just five had encountered it because they either came from a white minority or because their partner was Black.

Examples of racism ranged from verbal insults to physical assault. Almost two-thirds of those who had

experienced racism reported that they had done nothing. While a number of respondents noted that there had been a change in their experience of racism since their arrival in Britain, our findings nevertheless do suggest that racism continues to be a part of the lives of minority ethnic older people.

Our study does suggest that ethnicity plays a part in older people's perception of their quality of life. In terms of minority ethnic older people, there may be a positive or protective element in that they have a more positive view of the process of ageing and the social support they can draw upon. At the same time, as a result of the experience of racism or because of poorer health, ethnicity may also have a negative or risk element.

## Policy implications

Policy makers and practitioners need to ensure that when the diversity of experience of older people is addressed, ethnicity is part of the matrix. Equally when measuring quality of life, due attention should be paid to the experience of racism and its impact on the lives of minority ethnic older people. Furthermore, the complexity of how social support is organised and is actively shaped by older people should encourage us to avoid stereotypes at the same time as engaging older people in identifying for themselves how they wish their support needs to be met and by whom.

In terms of future research the methodological challenges faced by this study have several lessons, including the potential value of the Family Resources Survey (FRS) now that a new consent question is being asked. Furthermore, our success in identifying and using a team of interviewers who allowed us to match the ethnicity of participants should encourage other research teams and Government departments to consider this as achievable rather than settling for the second best solutions of using 'intermediaries' to interpret for the interviewers they employ.

## About the study

The complexities of generating a sample of minority ethnic communities that allows for comparison between minority ethnic communities and between minority ethnic communities and white communities have been widely acknowledged. A further layer of complexity is added when groups within minority ethnic communities are the focus of study (such as older people).



The Office for National Statistics (ONS) routinely undertakes a number of studies each year using nationally representative samples. This data has provided an important resource for researchers to use in secondary analysis. However, the feasibility of using participants in these surveys as a source for other primary research had never been attempted before. We were fortunate to be able to secure the agreement of the Department of Work and Pensions (DWP) for us to use the FRS) as a sampling frame. Unfortunately, the existing consent question in the FRS did not allow for names and addresses to be passed on to us until participants were contacted by the organisations carrying out the FRS to seek specific permission for their involvement in our study. This resulted in a smaller number of participants than we had envisaged and we had to increase the number of participants by snowballing and contacting community organisations.

A challenge for this project was to recognise that research interviews, in common with every other form of social interaction, take place in a context in which social and material differences exist, including racism. As researchers, we attempted to ensure that we did not replicate it. One way we addressed this was to attempt to match the 'ethnicity' of interviewers with that of respondents. We attempted to do this in terms of Asian older people, African and Caribbean older people as well as white older people.

## The research team

The original research team was made up of Professor Mike Fisher, Jabeer Butt, Jo Moriarty, Dr Chih Hoong Sin and Michaela Brockmann. The project began as a collaboration between the Research Unit at the National Institute for Social Work and the REU. The Research Unit transferred to King's College London in 2002.

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*Published by the*

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