

***PRIAE*** *Policy Research Institute on Ageing & Ethnicity*

Registered Charity no. 1081930

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**PRIAE POLICY RESPONSE  
to the Healthcare Commission's  
*Gender Equality Scheme***

**Submitted to the  
Healthcare Commission**

**April 2007**



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## **PRIAE Response to the Healthcare Commission's *Gender Equality Scheme***

PRIAE is the leading organisation specialising in ageing and ethnicity in the UK and across Europe. Established as an independent charitable institute in 1998, PRIAE seeks to improve health, social care, housing, income and pensions, employment and quality of life for current and future generations of black and minority ethnic (BME) elders at the national and European level. For this submission we use in most cases the term 'minority elders' to refer to those who have worked, lived, aged and are ageing in Europe due to being a traditional/national minority; as a result of economic migration within the Union; as a result of colonial connection and/or refugee background.

Discussion of the needs of BME elders cannot be undertaken without reference to the voluntary organisations based in these communities. They play a crucial role in identifying the concerns of BME elders, and in raising awareness of and communicating possible solutions. PRIAE as a national umbrella body represents their issues and views and as these organisations are voluntary and exist often on temporary and short-term budgets, PRIAE has proposed that they should be adequately supported to carry out such a function. (Further information about PRIAE is detailed at the end of this document.)

In submitting this response, our aim is to draw attention to the particular position of BME elders, focusing on gender equality and its interrelationship with ethnicity and age. We do however recognise that these concerns are also of relevance to other disadvantaged groups where inequalities also persist. During this response, unless otherwise stated, the examples mentioned and recommendations refer to policy in the UK.

## **Introduction**

PRIAE welcomes all measures to promote equality, including the Gender Equality Duty, although we argue that there is an important interrelationship between gender, ethnicity and age (and undoubtedly other aspects of identity and socio-economic status) that must be given due care and attention by policy makers and service providers. Policies and services must be neither 'age blind' nor 'race blind'.

The Gender Equality Duty comes into force on 6<sup>th</sup> April 2007 and the Healthcare Commission, as a public authority, is required to have due regard to:

- Eliminate unlawful discrimination
- Eliminate harassment
- Promote equality of opportunity in all its functions

Specific duties include:

- Gather information on how its work affects women and men
- Consult employees, service users, trade unions and other stakeholders

- Assess the different impact of policies and practices on both sexes
- Identify priorities and set gender equality objectives
- Plan and take action to achieve those objectives
- Publish a gender equality scheme and review progress every three years

The Healthcare Commission's Gender Equality Scheme, based on the Healthcare Commission's operating plan 2006/07, outlines a number of specific measures to be taken to ensure that the Healthcare Commission complies with the Gender Equality Duty and, more importantly, the purpose of the Gender Equality Duty i.e. the elimination of unlawful discrimination, harassment, and the promotion of equality of opportunity.

PRIAE welcomes the measures although emphasises that gender equality cannot be promoted in isolation from tackling age and 'race' equality as, for many individuals, it is the multiple impact of gender, age and 'race' which is most significant.

PRIAE also argues that effective implementation, monitoring and evaluation of the measures are essential if the Gender Equality Duty is to be more than a framework and an effective driver for change.

PRIAE in particular welcomes a number of measures proposed in relation to (1) training; (2) data collection, monitoring and analysis; (3) engagement; and (4) communication<sup>1</sup>; all of which are key issues identified by PRIAE, including work specifically on women from black and minority ethnic communities.

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<sup>1</sup> Categories defined by PRIAE

These measures are outlined below:

### **Training**

- All members of the investigations team to attend training in diversity, which includes consideration of gender equality
- All members of the operations team to attend training in diversity, which includes consideration of gender equality

### **Data collection, monitoring and analysis**

- Data on complaints analysed to identify trends and learning relating to gender equality
- Assess the design of all national surveys of patients and staff in terms of gender
- Assess the conducting of all national surveys of patients by reference to gender
- Ensure that any significant variations in response by gender are identified in the reporting surveys
- Report on differences in the experiences of patients by age, gender, ethnicity and disability
- Assess by reference to gender, the design of Information/data collection from the independent healthcare sector
- Include an element in the collection of data for asylum seekers and refugees that can be aggregated against gender for these groups when they are seeking access to primary care
- Black and minority ethnic groups census and seminar *Count Me In* to explicitly address gender equality relating to mental health inpatients

- Collect data that will be sensitive to determining differences in outcomes by gender, and data sensitive to scoring and analysis and report on these differences
- Surveys commissioned on behalf of the Healthcare Commission will address issues relevant to promoting gender equality

### **Engagement**

- Ensure that men and women are represented in our engagement exercises
- Ensure that men and women are enabled to express their views in equal proportion to their numbers in all engagement exercises

### **Communication**

- Take into account the impact of our findings on any particular groups and put into place appropriate communication strategies

Engagement is a key mechanism for improving health and social care services. Good communication can facilitate effective engagement, while bad communication will hinder it.

PRIAE recently launched the **Minority Ethnic Elders' Policy Network (ME<sup>2</sup>PN)** in April 2006. This National Policy Network, funded by the UK's Big Lottery Fund, is developing an information link between BME elders, BME age organisations, mainstream age organisations and policymakers. ME<sup>2</sup>PN aims to empower BME elders and age organisations and will work to normalise BME elders' issues in the mainstream policymaking process.

Many of the above measures show that the Healthcare Commission is well aware of the significance of the relationship between gender, age and 'race' equality. PRIAE would argue however that multiple discrimination as key issue should be made more explicit by the Healthcare Commission and targeted measures to tackle multiple discrimination should be developed.

Much of PRIAE's work draws attention to the relationship between age, ethnicity and gender. We therefore provide information below which we feel will be informative to the Healthcare Commission on these interrelationships and the effects of multiple discrimination to help guide future Healthcare Commission equality strategies. The relationship between health, care and socio-economic status are well documented and therefore we focus on socio-economic issues as well as health-specific evidence. Evidence on information and communication strategies is also provided.

### **Health and social care**

In 2005 PRIAE completed its Minority Elderly Care (MEC) research project, a three-year project covering 10 European countries<sup>2</sup>, 26 ethnic minority backgrounds, 901 health and social care professionals, 312 voluntary organisations and which employed 30 or more researchers.

MEC was supported by the European Commission (EC) under its Fifth Framework Research Programme. The MEC proposal was awarded the highest research rating in its stream and remains the first and only research project to be supported in ageing and ethnicity in the EC's 24 years of Framework funding.

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<sup>2</sup> France, Germany, the Netherlands, Spain, Finland, Hungary, Bosnia-Herzegovina, Croatia, Switzerland and the UK

In the UK, 390 face-to-face interviews were conducted with BME elders from three different ethnic communities<sup>3</sup>, 101 health and social care workers were interviewed using a face-to-face, structured questionnaire, and representatives from 50 BME voluntary organisations were interviewed in total. The interviews were conducted in London, West Yorkshire and Scotland.

MEC UK (2005a) findings highlight a number of health inequalities relating to BME elders and also that there are a number of differences by ethnic group, gender and age.

### **Health inequalities by ethnic group**

- African-Caribbean elders had a higher incidence of high blood pressure than South Asians who, in turn, had a higher incidence than the Chinese/Vietnamese elders.
- African-Caribbean and South Asian elders had a higher incidence of diabetes than the Chinese/Vietnamese.
- Heart disease and lung/breathing conditions were highest amongst the South Asians.
- Osteoporosis and memory problems were highest amongst the Chinese/Vietnamese.

### **Health inequalities by gender**

- Men had a higher incidence of diabetes compared to women (men 42%, women 26%). Women had higher incidences of arthritis/rheumatism, musculoskeletal disorders, osteoporosis and constant headaches/migraine. The differences between men and women with regard to muscle and bone disorders are quite marked: arthritis and rheumatism – women 63%,

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<sup>3</sup> African-Caribbean, South Asian, Chinese/Vietnamese

men 46%; osteoporosis – women 17%, men 8%;  
musculoskeletal disorders – women 46%, men 29%.

- More women had physical problems and more men had emotional problems. There were slightly more men than women with no problems at all.

### **Health inequalities by age**

- The serious health problems were not related to age. The age-related conditions were problems with eyesight, high blood pressure, hypertension, dental problems, sleeping problems, hearing problems and kidney/urinary tract disorders.
- The Chinese/Vietnamese had a lower score than the other two groups on the index of physical limitation. This index was related to age, with the measure rising across all age groups. The South Asians had a lower score than the other two groups on the index of well-being. There were no differences in this measure by region, gender or age. The African-Caribbeans had a higher score than the other two groups on the index of self-esteem. Those aged 64 years or below had a higher score than the older age groups.

In 2000 between October and November PRIAE interviewed 32 elders from three ethnic groups (African-Caribbean, Asian and Chinese, with a number of them sharing sub-ethnicity, language, religion and social class) in England and Scotland for a joint report with Help the Aged *Dignity on the Ward* (2001).

The elders were aged 55-80 years and over. Twenty were women, twelve were men, and they came from East Scotland, Leeds and three London Boroughs.

PRIAE reports that the changes elders would make are:

- The availability of interpreters on the ward
- To be kept informed about their medical status and to be actively involved in any decisions about their care
- More nursing staff from ethnic minorities
- Nursing staff who have a sensitive approach and are aware of racial and cultural needs
- Measures to tackle rudeness and insensitive attitudes on the part of hospital staff
- Radical improvements in the type, quality and quantity of food
- Menus could be illustrated to overcome language difficulties
- To have religious needs met
- Care tailored to the individual's needs
- Better staffing levels
- Privacy and confidentiality on the ward
- Separate male/female wards
- Improved shower/washing facilities

### **Information and communication**

In PRIAE's MEC UK study, many of the biggest gaps between expectations and perceptions had to do with information and communication, which clearly suggests that there is an information gap in services provision. There are numerous things which can be done about this, for example: better use of the Internet as a patient source of information; hospital radio in minority languages; better liaison with BME voluntary organisations and use of social care institutions to provide information to users about other services and institutions.

Many organisations do provide translation or interpreter services and these must be considered important and essential. Advocacy is also an important mechanism for facilitating communication.

Furthermore, organisations should have a clear policy regarding provision of translation/interpretation services and the role of multi-lingual staff in providing a means of communication with patients/clients. Such a policy needs to be clearly communicated to BME communities (PRIAE, 2005a).

The 'hush-hush' system to information on services needs to now be vocalised with a planned strategy in marketing of services. Here good quality translated leaflets are only one part of the communication programme (PRIAE, 1999a: 259). It is important to explore other forms of media, including audio and visual.

### **Income security, employment and pensions**

While women are among the poorest pensioners, this income gap is arguably even more acute for ethnic minority women, many of whom have remained outside formal paid employment altogether. The industries where such women have worked, such as textiles, have often been in the black market, rendering them without National Insurance contributions or access to an occupational pension scheme (PRIAE, 2003a: 7).

We recognise that there is a diversity of female employment among different BME groups (Pakistani and Bangladeshi women have lower employment than Indian and African-Caribbean for example) – differences which need to be addressed in targeting information and measures. However we would maintain that the contributory nature of the state pension is key to the inadequacy of women's pensions

as women are unable because of lower earnings and unemployment to make the same contributions as men (PRIAE, 2005b: 9).

The higher prevalence of self-employment among Chinese and Pakistani communities also means that women do not have an income of their own, although they may work in the family business. This phenomenon has also masked under-employment within families.

Many parallels can be drawn between the experiences of the majority of women and ethnic minority groups in accessing pensions, in terms of fewer years worked, employment in lower paid industries and restricted access to private and occupational pension provision. This combination of factors during working life leads to lower pensionable income for these groups, translating into poverty in retirement (PRIAE, 2003a: 8).

### **Occupational and personal pensions**

Occupational and private pensions are important determinants of where older people appear in the income distribution. One of the Government's *Opportunity for All* indicators is therefore the proportion of working age people contributing to a non-state pension (Social Trends 36, 2001: 84).

### **Differences by age and gender**

In general older workers are more likely to have personal and/or occupational pensions than younger workers, and in general men are more likely than women to have personal and/or occupational pension arrangements (PRIAE, 2005c: 17).

## **Differences by ethnicity *with* gender**

In 2002 White British/Irish people of working age were more likely than any other ethnic group to have an occupational and/or personal pension and this applies to both men and women. Forty percent of White British/Irish women had an occupational/personal pension, followed by thirty-seven percent of Black-Caribbean women (reflecting the high numbers of these working in the public sector), twenty nine percent of Indian women and twenty five percent of Black-African women. By comparison, only nine percent of Pakistani and four percent of Bangladeshi women had an occupational and/or personal pension. There were also differences between men and women in ethnic minorities. Only Black-Caribbean and Black-African women were more likely than their male counterparts to have an occupational/personal pension, whilst Pakistani/Bangladeshi men were almost twice as likely as their female counterparts to have these products (PRIAE, 2005c: 17).

## **ENDS/PRIAE – PRIAE response to the Healthcare Commission's *Gender Equality Scheme***

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### **Further Information about PRIAE**

PRIAE is itself an international NGO set up to support grassroots minority age organisations in the civil sector, acting as an 'umbrella organisation'. The Institute therefore works with minority elders and age organisations, with clinical and non-clinical professionals and researchers, across sectors to influence, inform, develop and strengthen the knowledge base, capacity and practice in ageing and ethnicity.

PRIAE is recognised as having helped to increase awareness of policymakers on the combined effects of age and ethnicity. Claude Moraes MEP states 'PRIAE is the only body I know that looks at multiple discrimination brought about by age and ethnicity'.

Stephen Hughes MEP regards PRIAE's work as a 'wake up call for policymakers' (**MEC minority elderly care** launch, 2004). PRIAE carried out the largest European research into health and social care

of 26 ethnic groups in ten countries where 300 civil society organisations supplying age services were researched – a first of its kind research and provides European societies with important insights. The research award was given by DG Research at the EC – a first such grant to a civil society organisation in the area. The results were launched at the European Parliament ([www.priae.org](http://www.priae.org)).

PRIAE has undertaken a number of projects and initiatives which are relevant to gender equality:

(a) Patel, N. (1990) *A Race Against Time? Social Services Provision to Black Elders*. The Runnymede Trust

(b) Patel, N., Mirza, N., Lindblad, P., Amstrup, K. and Samaoli, O. (1998) *Dementia & Minority Ethnic Older People: Managing Care in the UK, Denmark and France*. Russell House Publishing Ltd.

(c) PRIAE (1999) *Black and Minority Ethnic Elderly: Perspectives on Long-Term Care: Extract from Royal Commission Research Volume 1*.

(d) PRIAE (2001) *Dignity on the Ward. Help the Aged*

(e) PRIAE (2005) *The Financial Well-being of Ethnic Minority Women Aged 40+ in the United Kingdom*. Part of the AGE+ project. The AGE+ project was part of the European Action Programme to combat Poverty and Social Exclusion and was co-financed by the European Commission. The project focused on the multiple discriminatory effects of age, gender and ethnicity. Organisations from five European countries – the United Kingdom, Germany, Austria, the Netherlands and Italy – worked together to investigate

the socio-economic position of older migrant women in their country.

(f) PRIAE (2005) *Black and Minority Ethnic Elders' in the UK: Health and Social Care Research Findings*.

(g) PRIAE (2007) *Summary of Results from the CEMESME (Contribution of Ethnic Minority Employees to Small and Medium sized Enterprises (SMEs))*.

## **References**

PRIAE (1999a) *Black and Minority Ethnic Elderly: Perspectives on Long-Term Care: Extract from Royal Commission Research Volume 1*.

PRIAE (2003a) *Simplicity, Security and Choice: Working and Saving for Retirement: Consultation Response*.

PRIAE (2005a) *Black and Minority Ethnic Elders' in the UK: Health and Social Care Research Findings*.

PRIAE (2005c) *The Financial Well-being of Ethnic Minority Women Aged 40+ in the United Kingdom*.

*Social Trends 36* (2006). National Statistics.