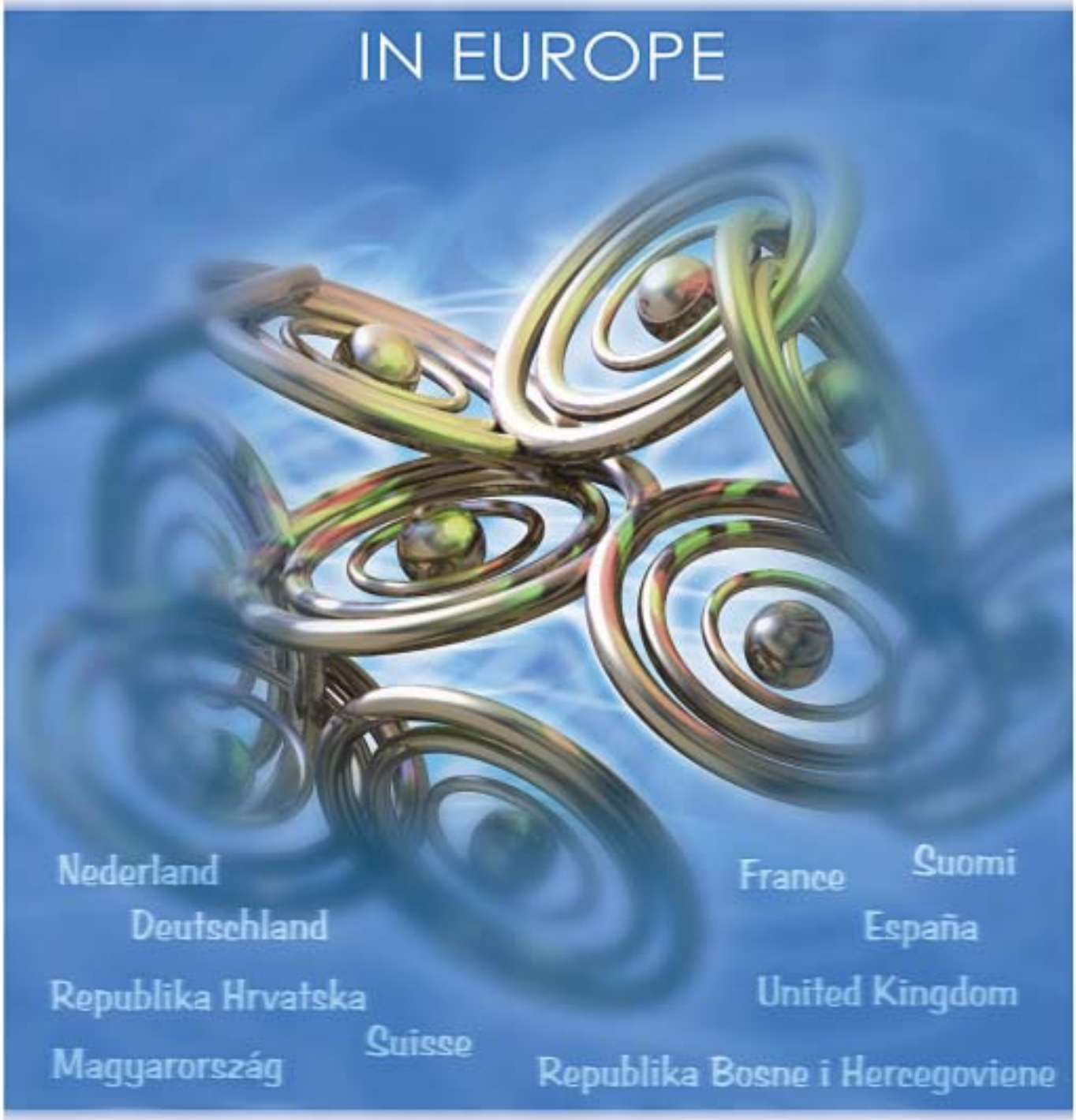
Minority

ELDERLY HEALTH & SOCIAL CARE

IN EUROPE



PRIAE RESEARCH BRIEFING

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MINORITY ELDERLY HEALTH & SOCIAL CARE IN EUROPE

PRIAE RESEARCH BRIEFING

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SUMMARY FINDINGS OF THE MINORITY ELDERLY CARE (MEC)© PROJECT

In the United Kingdom, France, Germany, Netherlands, Spain, Finland, Hungary, Bosnia-Herzegovina, Croatia and Switzerland

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Introduction

Take 10 countries, 30 or more researchers, 3277 minority ethnic elders, 901 health and social care professionals and 312 voluntary organisations; add to that 3 years, many questions and a lot of analysis and you have the final results of the MINORITY ELDERLY CARE (MEC) project.

This Research Briefing provides an overview of the key results from the MEC study across the 10 participating countries (UK, Finland, France, Netherlands, Spain, Germany, Hungary, Bosnia-Herzegovina, Croatia and Switzerland). We highlight some of the key findings and present recommendations for action across the region. A research series will be published – further details at the end of this summary.

The MEC project was conceived and designed by Naina Patel at PRIAE and submitted as a research proposal in year 2000 under the EC 5th Framework. The proposal set out the objectives and expected achievements of the research and a detailed work plan of how the study was to be conducted. The original design of the study, which consists of the production of 4 cross-country research reports, has been maintained throughout the project. The goals set in the proposal have all been achieved from its start date in June 2001 to end August 2004.

The purpose of the MEC research is to inform and help plan the nature and direction of provision of health and social care services now and in the years to come. The project has the explicit intention of seeking to draw attention to the needs of minority ethnic (ME) elders and thereby improve the provision of services for them throughout Europe.

For the first time statistically significant research evidence is now available on the circumstances and opinions of more than 20 different ethnic groups across Europe. The MEC project is unique in that it addresses service issues from three dimensions: ME elders, health and social care professionals (including managers and planners) and the ME voluntary sector, which provides a significant amount of social care to ME elders.

Minority ethnic populations tend to be younger than the indigenous populations within a country, reflecting the tendency for people to migrate in the early part of their working lives and the main periods of settlement in the various countries of Europe. Yet it is apparent that in many countries the proportion of ME elders within the elderly population as a whole is set to increase quite dramatically over the next few decades (PRIAE, 2003 Country Profiles – details at the end).

The ageing of the general population is a well known demographic trend throughout Europe. Three driving forces are behind the ageing of the population: fertility below replacement levels, a fall in mortality and the approach of the 'baby boomers' to retirement age. Between 1960 and the present day, the proportion of people 65 years and older in the population has risen from 11 per cent to 16 per cent. By 2010 there will be twice as many older people (69 million) than in 1960 (34 million) (European Commission, 2003).

This International Executive Summary is prepared with the context of an ageing population in mind and seeks to provide insight into the situation facing different minority ethnic groups in different countries throughout Europe. The age of the informants is from 50 years upwards of whom 54% are women and 46% are men. The location and ethnic group of the elders surveyed is shown in Table 1.

Table 1: surveyed minorities by region

Country	Region	Ethnic group			Total
United Kingdom		**African-Caribbean**	**South Asian**	**Chinese/Vietnamese**	
	Yorkshire	41	62	33	
	London	46	84	30	390
	Scotland	5	64	25	
France		**Algerian**	**Moroccan**	**South East Asian**	
	Ile-de-France	48	45	54	
	Rhône	48	62	25	390
	Isère	60	40	8	
Germany		**Turkish**	**Italian**	**Russian Repatriates**	
	Berlin	50	31	54	
	Munich	50	40	50	394
	Augsburg	50	19	50	
Netherlands		**Moluccan**	**Turkish**	**Surinamese**	
	Alphen aan den Rijn/ Leiden	48	75	75	
	Amsterdam Nieuw-West	45	75	77	391
Spain		**Moroccan**	**Latin American**	**Roma**	
	Catalonia	50	46	50	
	Andalucia	52	45	50	293
Finland		**Russian**	**Vietnamese**	**Sami**	
	Capital area	119	50	0	
	Lapland	0	0	126	295
Hungary		**Roma**	**Germans**	**Croatians**	
	Nógrad	35			
	Baranya	35	100		
	Borsod-Abauj-Zemplen	30			290
	Vas			90	
Bosnia and Herzegovina		**Hungarians**	**Czechs**	**Roma**	
	Federation of BiH	90	91	71	
	Republika Srpska	0	0	21	273
Croatia		**Hungarians**	**Czechs**	**Bosniaks**	
	Zagreb region	20	0	51	
	Slavonia-Baranja	70	91	0	271
	Istria-Primorje	0	0	39	
Switzerland		**Italians**	**Spaniards**	**Former- Yugoslavians**	
	Geneva	49	51	45	290
	Basle	50	50	45	

Figure 1. Methodology

A Methodology Sub-Group was created to undertake the detailed design of the research for each of the three dimensions: ME elders, health and social care professionals and managers/planners, and ME voluntary organisations. In keeping with the design of the original proposal, three ethnic groups and three geographic regions were targeted. Several focus groups were held in each country and the critical incident technique was used to aid the design of the survey instruments. Extensive reviews of literature, past survey instruments, clinical instruments, including an emphasis on examining service quality were also used to guide the topics investigated in the surveys. Survey instruments were piloted before being finally approved. Most of the surveys in all three dimensions were completed by face to face interviews using a structured questionnaire. Only in a small number of situations were self-administered interviews used – these applied when geographic distance or interviewee time meant this was a more practical approach. Survey questionnaires were translated into all relevant languages for the different ethnic groups and interviews were held in the language of choice of the respondents. The method of sampling used was quota sampling based on ethnic group and region for the ME Elders dimension, job title, sector and region for the Professionals and Managers/Planners' dimension, and target ethnic group and region for the ME Organisations dimension. Gaining the trust and confidence of community groups was essential for gaining access in the first and last dimensions in particular. The main data analysis techniques used were frequencies, cross-tabulations and associated chi square test, T-tests and one-way ANOVA. Quality control procedures were adhered to at all times.

Dimension 1:
Minority Ethnic Elders

While each country has its individual and specific findings we can identify a number of common themes across different countries:

Family
Family was very important to ME elders in all countries and not surprisingly, most elders preferred to be looked after by their family in their own home. Yet, despite a strong desire for independence it was apparent that family circumstances are changing and there are many elders, especially women, who live alone. More than 30% of the women in the UK, Netherlands, Finland, Bosnia-Herzegovina and Switzerland lived alone. The highest proportion was in Switzerland with 47% of women living alone. In France more men (36%) than women (7%) lived alone. Family size varies across the ethnic groups with some of the poorest groups having large extended families. Although family were an important part of care and support for elders, there were many who had no one to turn to when ill or in need of emotional support.

Socio-Economic Situation
It is apparent that in every country there were significant proportions of ME elders on low incomes which were substantially less than the average incomes for elderly in the country concerned. The proportions with less than €750 per month were UK 35%, France 20%, Germany 25%, Spain 36% and Finland 48%. In the CEE countries, 78% in Hungary, 81% in Bosnia-Herzegovina and 59% in Croatia had less than €500 per month. It was apparent that many were reliant on social benefits and allowances. In the UK, France, Germany and Finland 40% or more were in receipt of social benefits or allowances. There were variations in socio-economic status by ethnic group – some groups had prospered more than others and had better employment histories; others had a history of work in poorly paid, unskilled jobs or had been unemployed. In many of the countries one or two groups stand out as being in a worse socio-economic situation than the rest and in a much less favourable situation than the population of the country as a whole. Examples include the Turks in Germany and the Netherlands, the Roma in Bosnia-Herzegovina and Spain, the Moroccans and Algerians in France and the Chinese/Vietnamese in the UK.

Language
For some of the ME groups their first language was the same as their country of settlement or residence – this was particularly the case with regard to indigenous minorities and repatriates. However, for many others the language of their country of settlement was not their first language. There were considerable variations with regard to the ability to speak the language of the country. For example, in the UK 36% of South Asians and 82% of Chinese/Vietnamese did not speak English; in Germany 23% of Turks and 22% of Russians did not speak German; in Netherlands 42% of Turks did not speak Dutch and in Switzerland 41% of former-Yugoslavians did not speak either French or German.

Health
In all countries there were quite significant proportions who described their general health as poor or very poor and these elders needed more medical treatment. There are striking differences in the incidence of various serious diseases and conditions across the ethnic groups. In particular, diabetes and cardio-vascular disease have alarmingly high rates in certain groups. Musculoskeletal disorders, as one would expect, are much more prevalent for women than for men. In some situations there was evidence of premature ageing due to past life experiences and socio-economic factors. For example, the Turks in Germany and Netherlands, the Roma in Bosnia-Herzegovina and Spain, and the North Africans in France had poorer health records than other ME groups despite, in some cases, having a younger age profile.

Use of Services
The use of different health and social care services is not uniform across the different ethnic groups and countries. While each country has its own systems and procedures it is apparent that in all countries there are some elders who are failing to gain access to services. Satisfaction levels with services overall tend, on average, to be good but there are variations by country and by ethnic group. The results show that some groups face more barriers than others. There is clearly a strong desire in every country for culturally sensitive care and for service providers to understand their needs and be willing to understand their preferences. The most frequently used services are GPs and they are often an important access route to other services.

Service Quality - Expectations And Perceptions

As an indication of service quality, ME elders were asked about their service expectations and perceptions of health and social care services. In every country there were gaps between what the elders expect of service providers and the perceptions of how services are delivered (on most of the variables). There are, of course, variations by ethnic group and by country, but two themes which emerge particularly across countries are that ME elders wish to be treated with respect and for staff to behave with integrity; and that, in many cases, there is a lack of information on the services available and how to access them.

Country highlights

United Kingdom

Diabetes was most prevalent among African-Caribbeans and South Asians; heart disease and lung/breathing conditions were highest amongst the South Asians; and osteoporosis was highest amongst the Chinese/Vietnamese. Men had a higher incidence of diabetes compared to women; and women had a much higher incidence of musculoskeletal disorders such as osteoporosis.

Table 2: Incidence of Specific Medical Problems in the UK

	African-Caribbean %	South Asian %	Chinese/Vietnamese %
Arthritis/rheumatism	45	61	55
High blood pressure	64	57	38
Diabetes	40	38	17
Heart disease	24	33	10
Lung/breathing problems	14	26	15
Osteoporosis	5	13	21
Kidney problems	4	18	15
Note: numbers refer to per cent of each group referring to a particular problem			

The Chinese/Vietnamese used many health and social services less than the other two ethnic groups and while this may be, in part, due to better health this does not explain the full situation. Overall, satisfaction with health and social care services was good. The South Asians tended to be less satisfied with various services compared to the other two ethnic groups.

It is clear that there is an information gap in health and social care. The biggest gaps between expectations and perceptions relates to information about services, and the availability of information in one's own language. Other significant gaps related to waiting lists and delays and staffing levels to provide good services for elders.

Having staff of the same ethnic group was a high expectation for the South Asian and Chinese/Vietnamese elders and the provision of places of worship, being able to talk freely about religious needs and having staff of the same gender was most important for South Asians.

Finland

Despite their younger average age, Vietnamese elders rated their health worse than the other two groups, the Russians and the Sami. 46% of the Vietnamese rated their health as poor or very poor compared to 12% of the Russians and 8% of the Sami. Yet there is evidence that this group use both health and social care services less than the other two ethnic groups. The Sami, an indigenous minority living mainly in Lapland, rated their health most positively, as almost half (49 per cent) rated it as good or very good. The Russian respondents were situated in between these two groups, with a majority of them (70 per cent), rating their health as average.

With regard to specific health problems the Vietnamese were more likely to suffer from musculoskeletal disorders and arthritis compared to the other two ethnic groups. Diabetes, high blood pressure, hypercholesterolaemia, heart disease and lung/breathing related problems were more common among the Russians elders.

There was very little difference among the ethnic groups in their perceptions of the services but the Russian group had, on average, a higher level of expectations than the Sami and Vietnamese.

France

The Algerians, Moroccans and South-East Asians (Vietnamese/Cambodians) have different histories of migration: that of the North Africans was an economic, colonial and postcolonial migration, while for the South-East Asians it was a political and postcolonial migration. Their experiences of growing old in France are also different, for example, while the income of the South-East Asians falls mostly into our survey's average to high categories, the North Africans' income ranges from low to average.

Family life also differs – while 18.3% of North Africans live far from their families in immigrant workers' hostels, none of the South-East Asians do. The South East Asians have higher levels of education and better housing conditions. These differences are generally detrimental to the Moroccan and Algerian elders. Their conditions are poorer than those of the South-East Asians and sometimes even rather precarious.

The Algerians were most likely to describe their health condition as poor or very poor, followed by the Moroccans. The South-East Asians are more likely to participate in ethnic and economic networks, whereas the North Africans tend to form 'communities of values' that are less dynamic from an economic point of view.

Netherlands

Turkish migrants came to the Netherlands in the 1960s as guest workers and, as their stay was intended to be only temporary, little effort was made to integrate them into Dutch society. Among the elders surveyed in the Netherlands the Turks have the lowest socio-economic status and greater health problems compared to the Moluccans and Surinamese. This is despite their younger age profile. Particularly worrying is the high proportion of Turkish elders reporting musculoskeletal disorders and mobility problems.

The Moluccans have lived longest in the Netherlands and, like the Turks, expected their stay to be temporary and therefore settled in separate Moluccan residential areas. Their age distribution keeps pace with that of the total Dutch population and in terms of income, employment history, socio-economic position they are comparable with the total population and have significantly fewer health problems than the Turks or the Surinamese.

The Surinamese migrated to the Netherlands for various reasons and at different time periods. In terms of both socio-economic situation and health condition they occupy the middle position. However, they have a rather worrying high prevalence of cardiovascular conditions and diabetes.

Spain

On average, the Latin Americans had the highest self-assessed health condition followed by the Gypsies[1] and the Moroccans. 37% of the Moroccans rated their health condition as poor or very poor compared to 28% of the Gypsies and just 5% of the Latin Americans.

With regard to health problems, the Moroccans were more likely to have diabetes, musculoskeletal problems and kidney/urinary tract disorders compared to the Gypsies and Latin Americans. The Gypsies were more likely to have high blood pressure/hypertension, arthritis or rheumatism, heart disease, osteoporosis, hypercholesterolaemia and lung/breathing related problems. The Latin Amercans were more likely to have gastric/intestinal complaints and thyroid disorders.

Service expectations were higher among the Latin American group than the other two ethnic groups in Spain (the Gypsies and the Moroccans). However, the Gypsies reported the biggest gaps between expectations and perceptions. Overall, the service dimensions with the greatest gaps were concerned with: waiting lists and delays, amount of paperwork, friends/family being able to visit without problems, convenient opening hours, professionals' understanding of the needs of elders, and the provision of simple and understandable information (in own language).

1. We are using 'Gypsies' as the preferred term used in Spain.

Germany

The Turkish elders were, on average, younger than the Italians and Russian repatriates, but their state of physical and emotional health was relatively poor: They reported the lowest general health status and the most health disorders. Their quality and enjoyment of their life was much less. The Turks needed, on average, more medical treatment, experienced more pain in their daily lives and had a lower level of well-being than the others. The Turkish women were the most disadvantaged of all in terms of socio-economic status, acculturation and health condition.

The Italian respondents' self-assessed general health was clearly better than that of the Turkish respondents and they had less specific health problems. They needed the least medical treatment and reported the lowest amount of pain in daily life. While many Italians reported having emotional problems, their self-esteem was still slightly higher than that of the other groups.

The majority of Russian-speaking elders, who had an older age profile, rated their general health as average. They mostly needed a moderate amount of medical treatment and experienced a moderate amount of pain in their daily lives. However, they assessed their quality and enjoyment of life clearly more positively than the other ethnic groups.

Hungary

In Hungary, the Roma elders were in a worse socio-economic and health condition than the other two groups (the Croats and the Germans). The Roma had the poorest self-rated health condition compared to the Croats and Germans. The women generally suffered more illness than the men. Musculoskeletal problems were experienced by women in all three groups.

There were striking differences in the prevalence of various health conditions by ethnic group. The German elders had higher incidences of poor eyesight, arthritis/rheumatism, heart disease, hypercholesterolaemia, kidney problems, memory problems, and thyroid disorders. The Roma had higher incidences of dental problems, musculoskeletal problems, gastric/intestinal complaints, and tuberculosis. The Croatians and Germans had higher incidences of high blood pressure and mental problems, the Roma and Croatians had higher incidences of strokes/paralysis, and the Germans and Roma had a higher incidence of lung/breathing problems.

All the elders regard themselves primarily as Hungarian citizens, and hope and expect to be treated as such when making use of health and social care services. The Roma elders had the greatest difference between expectations and perceptions with regard to gaining access to services.

Bosnia-Herzegovina

The Czechs and the Roma are traditional historical minorities in Bosnia-Herzegovina whereas most of the Hungarians are economic migrants who came during the era of the former Socialist Federal Republic of Yugoslavia. Some 30% of the interviewees' families lived on a monthly income of less than €100 and among the Roma this proportion rose to 53%. Furthermore, the Roma had the worst housing conditions and by far the worst general health and quality of life.

Table 3: Percentage Rating General Health and Quality of Life As Poor or Very Poor (Bosnia-Herzegovina)

	Czechs	Roma	Hungarians
General health condition	25	77	34
Quality of life	36	88	38

The prevalence of diseases and chronic conditions were found extremely high in all three groups, in particular the Roma. The Roma were far more likely to suffer from diabetes, high blood pressure/hypertension, heart disease, musculoskeletal disorders, hypercholesterolaemia, headaches, gastric/intestinal disorders, mental problems, memory problems, kidney disorders, lung/breathing related problems, sleeping problems, and poor eyesight and hearing problems. The Hungarians were more likely to suffer osteoporosis, arthritis/rheumatism, foot problems and dental problems than the other two groups. The Czechs have a higher incidence of strokes/paralysis than the Hungarians and the Roma.

Croatia

The Hungarian and Czech elders in Croatia are indigenous whereas the Bosniaks are mostly post-1945 economic migrants following the creation of the former Socialist Federal Republic of Yugoslavia. The most distinctive group was the Bosniak elders, all of whom were Muslims, mostly living in urban areas, in larger families and who enjoyed better socio-economic conditions especially in comparison to the Hungarian elders. The Czechs had the highest average score on the self-rated health assessment followed by the Bosniaks and the Hungarians.

There were differences in incidences of various health problems by ethnic group. The Bosniaks had the highest incidences of poor eyesight, dental problems, arthritis/rheumatism, heart disease, constant headaches, kidney disorders, and memory problems. The Hungarians had the highest incidences of high blood pressure/hypertension, and hypercholesterelomia but considerably lower incidences of hearing difficulties, diabetes, osteoporosis, mental problems, thyroid problems, lung/breathing disorders, and sleeping problems. The Czechs had a much lower incidence than the Bosniaks and Hungarians with regard to foot trouble, musculoskeletal disorders, and gastric-intestinal disorders. The Hungarians, most of whom live in small scattered villages (rural settlements), were the most disadvantaged with regard to the services they receive.

Switzerland

The health situation of the former-Yugoslavian elders in Switzerland is particularly alarming when compared to the Italians and Spanish elders. A high proportion of the former-Yugoslavians assess their health as bad; there is a high level of registered disabled among them and of persons with functional limitations and mental health problems. Furthermore, half of the former-Yugoslavians had low scores on an Index of Well-being compared to a quarter of the Italians and Spanish and this was despite their younger age profile.

With respect to self-assessed health condition, we observed that 26% of the respondents considered their general health to be poor or very poor (average for population over 65 is 7-11%). There were differences between ethnic groups: 37% of the former-Yugoslavians considered their health condition to be poor or very poor compared to 22% of the Spanish elders and 21% of the Italian elders. As well as experiencing difficult working conditions, many of the former-Yugoslavians were either asylum seekers or refugees who had suffered situations of war and violence in their home country. The former-Yugoslavians were more likely to have used hospital emergency units and be kept in hospital overnight.

Dimension 2:
Professionals and managers/planners in health and social care

Information, promotion, diagnosis, treatment, assessment to services are important aspects of care for all elders, as for ME elders. So too are considerations about design, development and delivery of services which includes ME elders' specific cultural, faith and linguistic needs. In some countries, 'person centred care' is emphasised in which case such dimensions may be readily accessible to apply and adapt. In others, ME elders' 'specific' needs may not be recognised. We therefore researched such themes and interviewed nurses, social workers, geriatric practitioners, psycho-geriatricians, managers and decision makers in health and social care. Key themes in this survey are presented in this section:

Table 4. Sample Size for Dimension Two (Professionals and Managers/Planners)

Country	Sample size
United Kingdom	101
France	100
Germany	106
Netherlands	63
Spain	100
Finland	71
Hungary	98
Bosnia-Herzegovina	90
Croatia	91
Switzerland	81

Recognition of the 'specific' needs of me elders

In general, across the partner countries, there was something of a shortfall, by professionals and planners/managers in the recognition of the specific needs, problems and access barriers facing ME elders as users of their services. Several of the countries had only just over 50% of their respondents recognising that ME elders have specific needs problems and access barriers (France, Netherlands, Finland, Hungary, Spain). The UK and Germany had the highest level of recognition – over 80% of the UK and over 60% for Germany. 54% of the respondents in Bosnia-Herzegovina and over 40% of respondents in Croatia disagreed with the statement that 'ME elders have specific needs, problems and access barriers'. In Bosnia-Herzegovina, in particular, only 14% agreed with the statement and a high proportion of respondents did not answer this question[2].

Measures to encourage the take-up of services – service quality

There are several things an organisation can do to help ME elders to overcome barriers and gain access to services. For example, information can be provided in appropriate languages, staff can be given training in culture-specific care, or new services may be designed specifically to meet the needs of different ME groups. We asked respondents what actions their organisation takes to encourage take-up of services by ME elders. Then we grouped these 23 different possible actions into 5 service quality dimensions: collaboration[3], information/awareness[4], facilitation[5], adaptation/innovation[6] and human resources[7]. A pattern emerges in the responses. The UK and Germany were more likely to give higher priority to collaboration and information/awareness; France, Netherlands, Spain, Hungary and Finland were more likely to give higher priority to facilitation and information/awareness. In Bosnia-Herzegovina the majority of responses were that measures were planned, very few had progressed to the stage of effective implementation. In Croatia a very large proportion of responses indicated that measures were not considered and

2. As a caveat to these findings it is worth bearing in mind that the term "minority" is somewhat open to confusion in Bosnia-Herzegovina and Croatia since the populations as a whole are made up of several different minorities
3. Collaboration includes working and consulting with ME users ME organisations/associations
4. Information/awareness includes being proactive in disseminating information; encouraging response
5. Facilitation includes assisting ME elders and organisations with a range of services
6. Adaptation/Innovation includes assessing existing services for majority elders and seeing where changes need to be made
7. Human resources includes understanding & competence of existing staff to work with multi-ethnic elderly users; availability of interpreters; multi-ethnic workforce

only 2% at most had any measures in planning or implementation stages. These MEC findings suggest that there is a very strong need to place the issue of ethnic minority elderly care on the agenda for service providers in these countries.

Reasons for unmet needs

Respondents were asked what they think the reasons are for under-usage of services by ME elders. There is a pattern to the responses from the Western European countries. The main explanations given were language, lack of information, culture and lack of understanding of the complex service structure (by the users). Economic/financial problems also ranked high in France and both Germany and Switzerland referred to informal care by family or community (the idea that "they look after their own"). The responses from all of these countries suggest that the professionals and managers/planners attribute the under-usage of services to the inherent characteristics of the elders themselves and not to the nature of the organisation or the service provided.

The responses from Spain were somewhat different to the other countries. In Spain the reasons given were the authorities/organisations' image, fear of legal consequences for those without proper legal status and, like France, economic/financial problems.

In Bosnia-Herzegovina and Croatia the main reasons given are the ME groups are too small to be a relevant target group for our services; economic/financial problems and informal care by family or community. In Hungary there was a wide spread of different opinions and the explanations given included: lacking understanding of complex service structure, sense of non-belonging, shame of seeking formal help, economic/financial problems and informal help from family or community.

For all the countries the key issue is the agenda for ME elderly health and social care, the acceptance among service providers that there is a need, and that the service providers themselves need to adapt in order to become more accessible.

Collaboration

Collaboration or consultation with service users and with ME groups can help tailor services to more appropriately meet the needs of target populations. The overall effect can be a better quality service and at a pragmatic level simple problems and issues can be overcome through greater understanding from all parties involved. The level of involvement of users and ME organisations was much higher in the UK than the other countries. In the UK 31% of respondents indicated that their organisation involved ME users and 81% indicated that they collaborated with ME organisations. Table 5 shows the proportion of respondents and level of involvement by their organisation.

Table 5: Collaboration with ME Elders and ME Groups by Country

	Involvement of Elders %	Collaboration with ME groups %
UK	31	81
France	14	59
Germany	12	30
Netherlands	19	29
Spain	10	31
Finland	6	27
Hungary	13	46
Bosnia-Herzegovina	0	19
Croatia	<1	4
Switzerland	9	19

Columns show per cent of informants responding 4 or 5 on a 5-point scale

There is clearly scope for a lot of improvement across the region. Consultation with service users is one of the most basic principals in marketing and service quality management and there are obvious benefits which could be derived from talking to the ME elders. In the commercial world feedback from customers is often the most vital management tool. It is clearly important to encourage more collaboration and consultation with ME groups and especially ME elderly service users throughout the European Union. In Bosnia-Herzegovina and Croatia, especially, there is a need to increase awareness and recognition of the needs of ME elders.

Dimension 3:
Minority ethnic voluntary organisations

The key themes from the survey of ME voluntary organisations providing services to ME elders are presented here. This dimension has not been previously studied in relation to service provision, source and scale of resources and their relationship with users and mainstream providers. At the outset, it is necessary to state, that there are ME voluntary organisations in every country surveyed and that these take a proactive role in representing the interests of ME elders as well as providing services in many instances. In Finland the number of ME organisations is small since immigration is relatively a new phenomenon taking place for the most part since 1990, except for the traditional minority group: the Sami. In view of this, the researchers in Finland adopted a case study methodology, based on 4 organisations, rather than the survey approach. The sample size for each of the other countries is set out in Table 6.

Table 6. Sample Size for Dimension 3 (ME Voluntary Organisations)

Country	Sample size
United Kingdom	50
France	50
Germany	38
Netherlands	29
Spain	30
Hungary	19
Bosnia-Herzegovina	30
Croatia	30
Switzerland	32

Services and activities

All of the UK organisations provided services and most of them focused specifically on ME elders. The situation was not the same in the other countries where some of them provided services, but there was a stronger emphasis on the provision of information, cultural cohesion and lobbying/campaigning. Also not all of the organisations in countries other than the UK focused exclusively on older people. In Bosnia-Herzegovina and Croatia the organisations provided information and cultural activism, but were not involved in service provision as such. Across all countries it is apparent that acting as a bridge between mainstream institutions and service users is an important role for organisations, as well as enhancing cultural identity and cohesion. Many of the organisations had been set up to overcome communication problems, give advice and information, and address lack of cultural competence in mainstream provision.

Reasons for unmet needs

In most countries the majority of respondents thought that the needs of ME elders were only partly met. Regarding the reasons why needs were unmet, a very distinctive pattern emerges across the countries. In all Western European countries, language is given high priority as a reason. Lack of information, lack of understanding of the complex service structure (by users) and lack of multicultural competence of staff were very important reasons in most of the countries. Financial situation of the elders was cited as an important reason in France, Germany, Spain, Bosnia-Herzegovina and Croatia. Embarrassment of seeking formal help was given as an important reason in Hungary, Bosnia-Herzegovina, Croatia and Switzerland and legal barriers were important in Spain and Bosnia-Herzegovina

Funding and resources

We compared the level of funding of the organisations across the 9 countries (Finland is excluded, as this country did qualitative case studies). As the project used quota sampling rather than random sampling we cannot claim that these results are representative of all the ME voluntary organisations targeting elderly in each country, but they give an interesting indication of the level of resources. The organisations cover the whole range in terms of their resources from those with only small sums of money available to those with quite substantial amounts. It is perhaps not surprising that Hungary, Bosnia-Herzegovina and Croatia have the majority of their organisations with only a small amount of funding. However, what does stand out is that nearly 60% of the organisations in France have less than €5,000 funding per annum. Clearly for many of the organisations in France and the CEE countries there is a shortage of financial resources. It is also worth pointing out that while organisations in the other countries may have more funds at their disposal these are by no means secure and are often short term and in some situations there is the threat of cut-backs or non-renewal of grants.

Table 7: Funding of ME Voluntary Organisations

	Sample size	<€5,000	€5,000 to €50,000	>€50,000 to €200,000	>€200,000	Not answered question
UK	50	4	8	21	14	3
France	50	29	12	4	2	3
Germany	38	5	2	14	12	5
Netherlands	29	6	11	2	9	1
Spain	30	6	5	5	12	2
Hungary	19	9	6	—	—	4
Bosnia-Herzegovina	30	29	1	—	—	—
Croatia	30	16	7	3	1	3
Switzerland	32	5	9	2	12	4

The sources of funding are very varied. Generation of income from services, fees and donations is very common. Many organisations have local authority, State (central government) or project funding. However, in Bosnia-Herzegovina and Hungary a relatively small proportion has funding from either local or central government, although Bosnia-Herzegovina has a significant proportion with project funding (but presumably this is at quite a low level). Switzerland also has a rather low proportion with funding from central or local government.

Table 8. Sources of Funding

	Sample size	Services	Local authority	State	Project (eg EU)	Donations	Fees	Contracts	Public funding
UK	50	21	25	21	8	17	41	4	5
France	50	21	41	14	17	18	26	9	15
Germany	38	23	23	12	6	17	14	6	9
Netherlands	29	16	20	9	16	12	11	2	12
Spain	30	5	23	21	13	11	18	4	5
Hungary	19	13	3	5	8	10	15	1	13
Bosnia-Herzegovina	30	4	8	7	18	21	19	1	-
Croatia	30	5	17	23	9	13	19	3	2
Switzerland	32	13	12	8	13	18	12	2	6

In most of the countries, a very high proportion (over 80%) wished to expand their organisations' activities to meet the needs of new users or to expand their range of services for existing users but very few had any resources available to undertake expansion.

Service quality - expectations and perceptions

Each country team compared the service quality expectations and perceptions of service delivery for ME elders, health and social care professionals and managers/planners. While there are differences by country, a particular trend which appears is that in general the mainstream professionals and managers/planners have slightly higher service quality expectations than the users or the ME voluntary organisations but also that their perceptions are at a considerably higher level than the service users and the ME voluntary organisations. This results in there being a bigger gap between expectations and perceptions for the users and voluntary organisations than there is for the mainstream service providers. Graphs from the UK are shown as illustrative examples (see Figure 2).

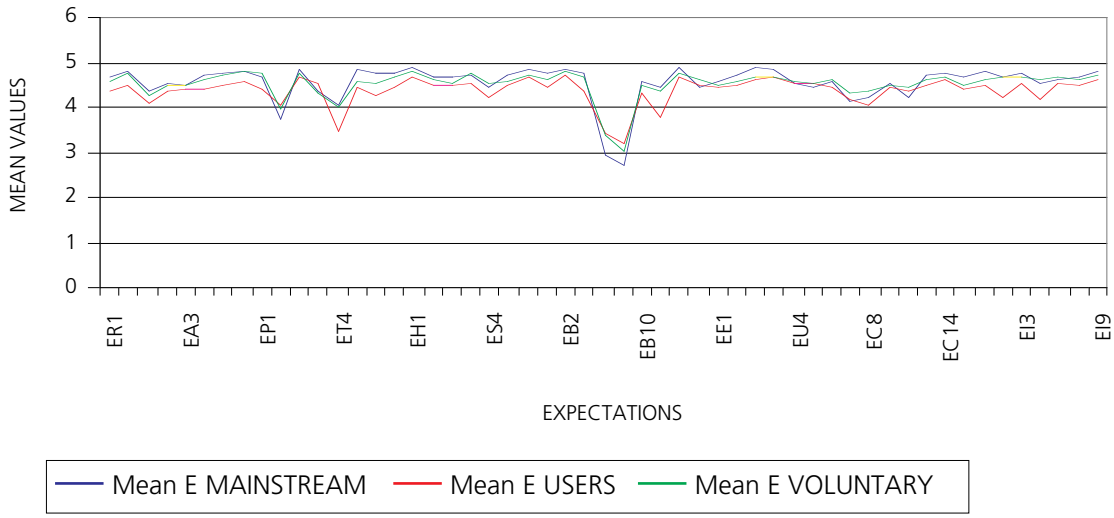
Service gaps

A number of common themes emerge as the biggest gaps in service provision across the 10 countries involved in the project. These are as follows:

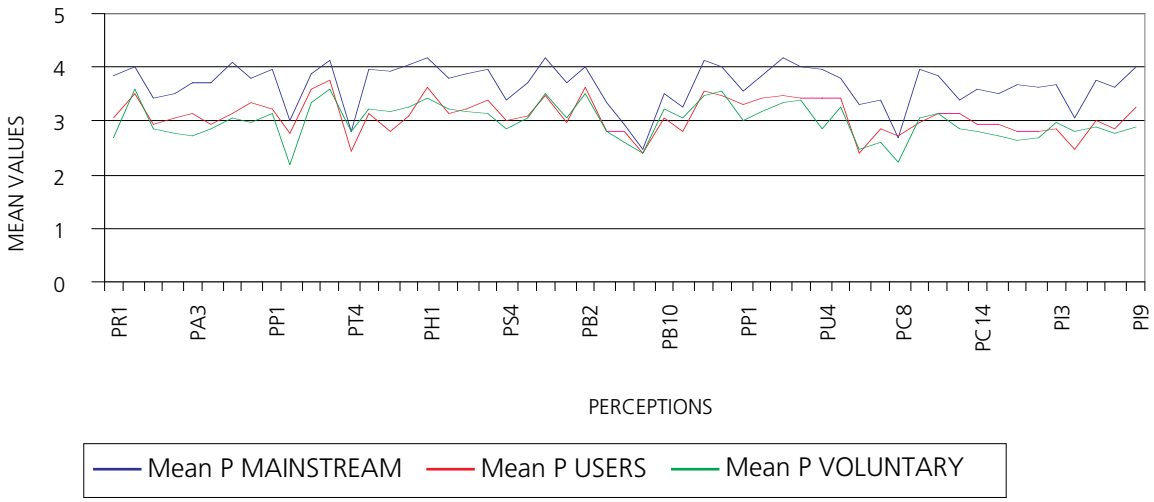
- Waiting lists and delays in service delivery
- Provision of information, especially in own language and concerning rights of the individual
- Communication between providers and service users and the provision of interpreters
- Understanding the culture of the users and having multi-cultural competent staff
- Having easy to understand procedures and practices
- Having equal access to services
- Use of alternative care methods along with Western medical practices

Figure 2

UK Comparison of Expectations: ME Elders, Professionals & Managers/Planners, ME Organisations.



UK Comparison of Perceptions: ME Elders, Professionals & Managers/Planners, ME Organisations



The first chart in Figure 2 shows the mean scores of expectations for 55 service quality measures. Examples of the measures are: ER1: I expect services to be provided by the time they were promised; EA3: I expect health and social care professionals to see me often enough to treat my problems; EP1: I expect health and social care professionals to want to help me; and ET4: I expect health and social care organisations to have places for worship. The corresponding perceptions, shown in the second chart, indicate whether in the view of the respondents these service quality measures actually happen in reality when the service is delivered.

Recommendations

Each country has their own particular recommendations arising from this major research project but we present here 12 recommendations which are common across all the countries involved in the MEC Project. These represent important strategic actions which organisations and institutions can use to improve and enhance their service provision for ME elders, as part of all elders.

1. Recognise that ME elders are included in the formulation and shaping of policies. They are patients, services users and people, and are a part of all elders, not apart. And that their needs are currently not being met by mainstream service providers. Therefore policies in social inclusion, health, social and housing need to reverse the saying that : ***in age, race is blind; in race, age is blind*** (PRIAE)

2. Provide clear information about the rights of the individual in accessing and using health and social care services and in different formats and languages

3. Adopt a person centred approach to patients and service users, abandon stereotypes and 'stagnant' ways of thinking. Recognise that needs vary from group to group but also within ethnic groups. Provide culture-sensitive care that acknowledges the users' ethnic background and the effect of disadvantage and discrimination

4. Improve the supply of information on existing and new services in appropriate languages. Use different media and communication channels to disseminate information

5. Recognise that certain ethnic groups face particularly strong access barriers for many reasons, not just language and culture, and plan measures for better access, increase supply and improve service delivery. Actively promote services to ME elders

6. Involve service users and ME voluntary organisations in the evaluation of service provision and the planning/design of future service provision on a regular basis.

7. Design service structures and access procedures with the user in mind so that they are not overly complex and difficult to understand – simplify the process at least from the user perspective

8. Make sure that interpreters are available when needed and don't over-rely on family members, especially where matters of privacy may be important. Make sure printed information and signs/notice-boards are provided in ways, including languages that facilitate usage, rather than hinder service use.

9. Recognise the differences in prevalence of different diseases and conditions among ethnic groups and seek to understand their underlying causes. Take action to reduce high incidences of a disease wherever possible through promotion, information, early referrals.

10. Implement a policy on race and age equality as part of human rights to ensure equal access and service excellence for all. Have procedures in place for dealing with racism and discrimination and make it clear this is not acceptable in modern times, whatever the source.

11. Recognise changing family structures and preferences among ethnic minorities as well as demographic trends and provide for greater demand for care services in the future

12. Initial professional training and continuing professional development must include training in cultural, age and race equality competence. This should include very practical guidance on how to care for patients and service users from very diverse ethnic and cultural backgrounds with diverse socio-economic conditions

13. Work in partnership to recognise the importance of ME voluntary organisations' role: as important contributors to the well being of ME elders, as effective providers of certain types of services and giving ME elders 'visibility'. Recognise the potential they have to do more, especially in service provision. There is a need for more funding and for strengthening of the infrastructure of the ME voluntary sector. Adopt a capacity building approach to increase service provision

PRIAE RESEARCH BRIEFING

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United Kingdom, France, Germany, Netherlands, Spain, Finland, Hungary,
Bosnia-Herzegovina, Croatia and Switzerland
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PRIAE is an independent registered charity working to improve pensions, employment, health, social care and housing, and quality of life for black and minority ethnic older people in the UK and across Europe. The Institute aims to influence national and European policy and increase and encourage good practice in work with black and minority ethnic elders. PRIAE does this through creating and leading on research projects like MEC, policy, information, service developments, training and consultancy. www.priae.org

Publications

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(c) MEC research report: minority elders perspectives of family, health and social care in Europe, to be released in 2005 – *register your interest*
(d) MEC research report: mainstream and minority organisations' provision of health and social care in Europe, to be released in 2005 - *register your interest*

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