

MEDICAL PRACTICE

Contemporary Themes . . .

Health and social status of elderly Asians: a community survey

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Abstract

A sample based on general practices was the starting point for a community survey of Asians aged 65 years and over to describe: family structure and social contact; aspects of lifestyle; language and communication; capacity for self care; and knowledge about and use of services. A total of 726 (95% of those approached) old people were interviewed in their own languages. Almost all had been born in India, mainly in Gujarat or the Punjab, but most had come to Britain via east Africa. Over half of the over 75s were not fully independent in basic activities of daily living, and a fifth were occasionally or often incontinent of urine, though these levels of incapacity were little different from those found in the indigenous elderly.

Few elderly Asians were aware of social services, such as meals on wheels, home helps, social workers, and particularly chiropody. Language also excluded them: 37% of men and only 2% of women could speak English. Moreover, two thirds of elderly Asian women were illiterate in all languages.

Health education initiatives directed at these people must understand these cultural and language barriers and perhaps use alternative methods, such as Asian radio programmes and home videos, in providing information on health and welfare services.

Introduction

The demographic shift in the age structure of Britain's population has led, particularly over the past 10 years, to a growing realisation that many sections of our health and social services will be preoccupied with the needs of elderly and very elderly people. Simultaneously, the

main ethnic minority populations have consolidated in British cities. In contrast with the indigenous group, at present they are a young population; this will not always be the case, and as the population ages there will be a need to try to anticipate its health needs.

If there is a commonly held view of the needs of this group of the elderly it is probably that Asian families care for their older members in such a way that outside intervention or special consideration is unnecessary. Some recent commentators, however, have taken a more pessimistic view, pointing to the potential impact of old age, racial discrimination, and inaccessibility of services, factors which are said to put an elderly person belonging to an ethnic minority group in a state of "triple jeopardy."¹

Without adequate information it is impossible to assess the relative contributions, on the one hand, of Asian culture with its respect for the aged and, on the other, membership of a minority group, to the planning of services for these populations. With this in mind, I set out to provide basic descriptive data relevant to health and social service provision for an elderly Asian community in a defined geographical area, including those who were not necessarily in contact with services.

Methods

For the purposes of this study, an Asian was defined as a person not of United Kingdom descent originating from India or Pakistan or of Indian or Pakistani descent originating from east Africa. The study population included all men and women aged 65 years and over who were of Asian origin and living in the City of Leicester. The Asian population of Leicestershire is predominantly urban based within the city of Leicester and, to a much lesser extent, in Loughborough.

The sampling frame used was a list of those names which had an Asian appearance within the list of patients aged 65 years and over registered with general practitioners who had at least one of their surgeries in Leicester. The use of names in this way is a more reliable method of identifying a person of Asian ethnic origin than using country of birth.² It has been used to study the pattern of Asian and non-Asian morbidity in hospitals³ and the occurrence of cancer in the two groups.⁴ The possibility of serious underenumeration of Asian women by this method, due to cross cultural marriage, is unlikely because this is estimated to be low in Britain.⁵

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The sampling frame was assembled after seeking the cooperation of the family practitioner committee, to use its central patient register, and the local medical committee. The approval of the local ethical committee was obtained. Despite the known limitations of the family practitioner committee's lists, particularly in terms of inflation,⁶ this was thought to be the best choice of sampling frame. It was not considered feasible to search each general practitioner's records within the surgery premises, as few of them had age-sex registers. Individual practitioners were contacted, however, when members of the sample could not be traced. People who had died were removed after checking draft death returns for Leicestershire residents held by the health authority.

A total of 2312 names of Asian appearance occurred among people aged 65 years and over; when they were allocated to the main religious groups on the basis of name the sampling frame had the following composition: Hindus 1516, Sikhs 475, and Moslems 321.

The survey was a descriptive study intended to provide information which was not routinely available to help in the planning of services and possibly to generate hypotheses for further study. Sample size, therefore, was determined by the need to provide a sufficiently large number to enable comparisons between different subgroups and also by the resources available. The sampling frame was stratified by religious group, and within each stratum a simple random sample was drawn by computer to produce a total sample that comprised one third of the Hindus and one half of the Moslems. We also intended to interview half of the Sikhs, but during the course of the fieldwork it became apparent that experienced interviewers who spoke Punjabi were scarce and available only part time. A one in three sample of Sikhs was therefore arrived at.

A total of 763 elderly Asians were contacted and invited to participate in the survey. Those who had moved away from Leicester and who were not known at their last address (even after checking with the general practitioner) were deleted and replaced with other members of the sampling frame drawn at random. Of the total of 763, 21 were out of the house after several visits, five refused to be interviewed, and 11 were excluded because they were too ill to be interviewed or were in hospital. In all, 726 (95%) completed interviews were obtained. I wrote to those to be interviewed in their own language informing them of the nature of the survey, seeking their cooperation, and indicating that an interviewer would be calling.

THE QUESTIONNAIRE

The questionnaire covered the following areas of inquiry:

Demographic details—sex, date of birth, country of origin, religion, and current and past employment;

Family life and social contact—numbers and place of residence of children, household compositions, participation in household tasks and going out, and visits from others;

Aspects of lifestyle—smoking, diet, and chewing of betel;

Level of physical capacity—mobility, ability to wash and dress, whether incontinent of urine, and ability to prepare meals and do housework;

Language and communication—languages spoken, written, and read, use of English in everyday situations, and use of newspapers and radio;

Knowledge and use of health and social services—contacts with primary medical care, use of alternative healer, taking of medicines, knowledge and use of a range of services—for example, social workers, old people's homes, meals on wheels, day centres, and so on.

Data were collected using a standard interview schedule, administered by fieldworkers who spoke the person's language in the homes of the elderly people. Eleven interviewers were used who were fluent in the relevant Asian languages; most had already participated in surveys of other kinds in the Asian community. All interviewers were taught not only to administer the questionnaire but to understand the theory of structured interviewing when comparability in questioning, accuracy, and completeness were emphasised.

Each completed questionnaire was checked with the interviewer when it was brought into the survey office. It was hoped that this would maintain a high standard and that problems could be dealt with promptly and many systematic errors avoided. Many of the questions were derived directly or were modified from a community survey of the non-Asian elderly that the department of community health had carried out in Melton Mowbray, Leicestershire.⁷ In a survey of this kind there was no opportunity to undertake a detailed nutritional assessment. A brief dietary history was taken, however, using questions drawn from the Leicestershire perinatal mortality survey.⁸

Results and comments

The population included slightly more men than women but only for the youngest age group (table I); this pattern contrasted with that in the indigenous population, in which there are more elderly women than men,

TABLE I—Age and sex structure of population by number (%)

| Age group (years) | Men | Women | Both sexes |
|-------------------|-----------|-----------|------------|
| 65-69 | 210 (54) | 160 (48) | 370 (51) |
| 70-74 | 104 (27) | 102 (30) | 206 (28) |
| ≥75 | 75 (19) | 75 (22) | 150 (21) |
| All ages | 389 (100) | 337 (100) | 726 (100) |

especially among the very old. Two thirds of elderly Asian women and one fifth of men had no spouse (nearly always because of widowhood) and, as might be expected, these proportions were even higher for the over 75s.

Almost all the old people had been born in India, mostly in the state of Gujarat (78%) with a smaller proportion (11%) in the Punjab. Only a quarter, however, had been living in India immediately before entering Britain. Most came to Britain via African countries, particularly Kenya (31%), Uganda (23%), or Malawi (11%), where 37% had been employed in skilled jobs or exercised a craft and a further 39% had owned a shop or business (women were classified by their husband's occupation). Since coming to Britain 31% of old people had worked but 65% of these had done so in an unskilled manual occupation.

Most elderly Asians had large families: all but 2% had at least one child, and 73% had four or more living children. Most had at least one child living with them, and this was reflected in the multigenerational households in which the elderly Asians lived (table II). Of those who did live in multigenerational households, 22%, whether they were married or widowed, shared a bedroom with someone else, most commonly grandchildren.

TABLE II—Composition of households in which elderly Asians lived according to religion by number (%)

| Household composition | Hindu | Sikh | Moslem | Other | All religions |
|-----------------------|-----------|----------|-----------|---------|---------------|
| Lived alone | 25 (5) | 3 (4) | 6 (4) | | 34 (5) |
| One generation | 69 (13) | 14 (19) | 12 (9) | | 95 (13) |
| Two generations | 117 (23) | 12 (17) | 42 (31) | 2 (40) | 173 (24) |
| Three generations | 285 (56) | 41 (56) | 68 (49) | 3 (60) | 397 (55) |
| Four generations | 13 (3) | 3 (4) | 10 (7) | | 26 (3) |
| With non-relatives | 1 | | | | 1 |
| All households | 510 (100) | 73 (100) | 138 (100) | 5 (100) | 726 (100) |

The main languages spoken reflected the religious composition of the population—almost all Hindus (97%) were most familiar with Gujarati, and almost all Sikhs (98%) with Punjabi. Moslems exhibited greater diversity in terms of first language. Many old people, however, could speak more than one language: 52% could speak a second language and 29% a third. Twenty one per cent of people said that they could speak English in addition to their main Asian languages, although there was a notable difference between the sexes: 37% of men reported an ability to speak English, but only 2% of women did so. In a further exploration of their proficiency in English, over half of the 145 old people who said that they could speak it said that they would have difficulty in communicating (or would require an interpreter) in four out of six suggested social situations (table III). The situation judged by respondents to be most difficult to conduct in English was the explanation of problems to a doctor.

TABLE III—Elderly Asian's assessment of their own ability to use English in a range of everyday situations expressed as a percentage

| Situation | Ability to make themselves understood | | | Total (n=145) |
|---|---------------------------------------|-----------------|-----------------------|---------------|
| | Easily | With difficulty | Only with interpreter | |
| Asking for cost of fare on a bus | 68 | 22 | 10 | 100 |
| Asking for goods in English shop | 64 | 27 | 9 | 100 |
| Returning faulty goods to English shop | 47 | 31 | 22 | 100 |
| Telephoning to rearrange outpatient appointment | 43 | 23 | 34 | 100 |
| Giving directions to an English person | 52 | 31 | 17 | 100 |
| Explaining a problem to a doctor | 41 | 21 | 38 | 100 |

Of the study population, 35% said that they could not read (in any language). This proportion was higher for older people and for women of all religious groups: 63% of women could not read compared with 11% of men.

About half the old people never ate meat, a proportion which showed notable variation between Hindus (63%), Sikhs (48%), and Moslems (2%) and, although a high proportion of the non-meat eaters also did not eat fish, eggs, or cheese, they could not be regarded as vegans as they often ate dairy products such as yoghurt, butter, and ghee.

One fifth of those interviewed reported that they chewed betel nuts or leaf, although the proportion was much lower in Sikhs (3%) than among Moslems (21%) or Hindus (22%). For most people it was clearly a long standing habit: over 80% had chewed betel for more than 20 years. About half those who chewed it did so in combination with other substances, most commonly slaked lime or tobacco. Moslems showed the highest proportion of current cigarette smokers (49%) compared with Hindus (40%) and Sikhs (8%).

The proportion of old people who could undertake basic activities of daily living unaided varied between activities. In situations that necessitated physical mobility fewer old people could undertake the activity without difficulty or without the help of a mechanical aid or another person than was the case for dressing or bathing (table IV). Of the 7% of old people who did not

TABLE IV—Extent to which elderly Asians could perform various activities of daily living expressed as a percentage (n=726)

| Ability to perform activity | Going out doors | Mobility around house | Climbing stairs | Dressing | Bathing |
|-----------------------------|-----------------|-----------------------|-----------------|----------|---------|
| Alone without difficulty | 71 | 78 | 60 | 88 | 81 |
| Alone but with difficulty | 12 | 12 | 27 | 7 | 11 |
| With aid or assistance | 10 | 9 | 8 | 5 | 8 |
| Did not undertake it | 7 | 1 | 5 | | |

go out of doors at all, most attributed this to some kind of disability, and this proportion increased to 17% in those aged over 75 years. A similar increase in dependence with age occurred for each of the other activities studied. The proportion of over 75s who were fully independent in each of the activities shown in table IV was as follows: mobility outdoors (41%), mobility indoors (61%), climbing stairs (41%), dressing (76%), and washing (61%). In response to separate questions about incontinence 14% overall and 18% of over 75s reported experiencing some degree of urinary incontinence; this was commoner in women than in men.

Since they had been living in Britain, most old people had consulted their general practitioner, 92% within the previous six months (table V). If the indigenous elderly population is taken as a reference point, elderly Asians had generally consulted their doctor more often. The proportion of old people who had consulted alternative healers was quite small (6%).

TABLE V—Time of last consultation with general practitioner: elderly Asians compared with non-Asian elderly in Melton Mowbray (cumulative %)

| Last consultation | Elderly Asians n=723* | Melton elderly n=1047 |
|------------------------|-----------------------|-----------------------|
| Within past week | 29 | 9 |
| Within past month | 67 | 30 |
| Within past six months | 92 | 63 |
| Within past year | 95 | 80 |
| Within past five years | 100 | 96 |

*Three people had not visited their doctor at all and were therefore excluded.

Of three domiciliary services—meals on wheels, home helps, and contact with a social worker—a fairly small proportion of elderly Asians (1-3%) were receiving them, although 12% were attending a day centre. Appropriate uptake of services may depend on the person's awareness of the service and what it can accomplish. When the interviewer mentioned each of these three services and gave a definition or description of it over half had not heard of the service. A similar question was also asked about the chiropody service, which only 3% were receiving: overall 88% had not heard of this service. Elderly people who were not using these services were asked whether they had difficulty that warranted help—for example, with cooking meals and so on. Although such an assessment of need is subjective, it is consumer defined. The greatest perceived need appeared to be for access to a day centre: 94%

indicated that they would like to use a centre. Seven per cent expressed a need for meals on wheels, 8% for a home help, and 18% for a chiropodist. To explore attitudes to residential care, the interviewers asked who should look after elderly people when they become old; 92% of respondents replied "the family."

Discussion

The determination of service needs among the elderly largely depends on an assessment of people's capabilities to undertake those activities of daily living necessary to maintain an independent existence, together with the level and strength of family support and social networks.

Data presented here show that elderly Asians, like their indigenous counterparts, become frailer as they grow older, with levels of incapacity rising sharply for the over 75 age group. Over half of them were not fully independent in relation to mobility indoors or outdoors, climbing stairs, bathing, and dressing, and almost a fifth were occasionally or often incontinent of urine. With the exception of bathing, which more Asian over 75s (82%) reported being able to accomplish unaided than non-Asians (64%) in a comparable study in Leicestershire,⁷ the Asian elderly were similar to their indigenous counterparts in terms of their capacity to perform basic activities of daily living unaided.

Few elderly Asians were receiving community services, and the evidence from the sample interviewed here was that services such as meals on wheels, home helps, social workers, and particularly chiropody were not generally known to them. This is in contrast with the non-Asian elderly, where 21% of over 75s had a home help and 37% had chiropody services.⁷ Yet 46% of the indigenous elderly in this age group lived alone, compared with only 4% of Asian old people studied here. It seems therefore that the special importance of the extended family in the lives of most of the Asian old people is the major factor explaining the low uptake of these services. Clearly, although living within the extended family provides considerable social support for elderly people, it may not fulfil all needs. In relation to services over 90% indicated that they would use a day centre, perhaps reflecting a desire to spend time out of the home and socialise with their peers.

In contrast, elderly Asians seemed to be fairly high users of general practitioner services: 67% had seen their doctor within the last month, a similar figure to that found by Blakemore who studied elderly Asians and other ethnic groups living in the West Midlands.⁹ In both cases, the figures were appreciably higher than for the indigenous elderly. In view of the data on activities of daily living, it is unlikely that this higher use of general practitioner services by elderly Asians is entirely explained by a higher level of morbidity, although Blakemore has pointed out the need to consider the background of poor health in developing countries and problems of adjustment after migration.⁹ Both may genuinely lead to more ill health among the Asian elderly. The data thus seem to confirm the anecdotal impression of cultural differences in illness behaviour and attitudes towards medical services, and indicate scope for health education. Perhaps surprisingly not many elderly Asians reported using alternative healers.

The data on language also indicate the extent to which the elderly may depend on others for their contact with the world outside their own community, particularly in health settings. The finding that nearly two thirds of elderly Asian women are illiterate in all languages, however, is of immediate importance, as it suggests that simply translating leaflets on health education or welfare benefits may not be adequate. Living within the extended family also reduces the opportunity for privacy, as the data relating to sharing of bedrooms indicate. There is no way of knowing how harmonious life is in these large multigenerational households. Organisations such as the Asian Sheltered Residential Accommodation speak of increasing instances of family conflict leading to rejection of the elderly members.¹⁰

Participation and acceptance within the family, however, probably remain a key feature of old age in the Asian community. This was certainly the overwhelming expectation of the elderly people interviewed here, but if kinship patterns change then the elderly person's source of primary help will be removed. Services will then be

faced with a considerable and unexpected demand without the types of provision that are adapted to the needs of the elderly Asian population.

When considering the health needs of this population it is important to remember that the Asian populations in different parts of Britain—for example, Leicester, Birmingham, Southall, Tower Hamlets, and Bradford—will vary, both in the relative constituents of the main cultural and religious groups and also in the origins and status of the people before migration. In this study, data for the three main religious groups showed no notable differences in family patterns but did for certain behavioural factors. For example, the proportion of vegetarians was much higher in Hindus and Sikhs than Moslems, although the mix of grains and pulses probably ensured an adequate quantity and quality of protein, and, as some animal products were also being eaten, some vitamin B12 was also probably being taken in.

The prevalence of betel chewing and cigarette smoking was higher for Moslems and Hindus than for Sikhs. Betel chewing is of concern especially in view of my earlier finding of an apparent excess of oral cancer in Asians compared with non-Asians in Leicestershire,⁴ the suggestion that betel may cause this excess,¹¹ and the possibility of its more widespread use in the Asian community among younger people. These cultural factors suggest scope for health education initiatives, but the problems of skills in communication and general literacy seem to militate against conventional measures such as posters or leaflets. A useful alternative for circulating health education information might therefore be Asian language radio programmes (which were listened to by a high proportion of old people interviewed in this survey) and home videos. Ownership or renting of video recorders is thought to be high in the Asian community and watching Asian films is a popular pastime.

PROBLEMS PRESENTED

There have been fairly few surveys that have set out to gather data directly from Asian people in the community and, in undertaking one, I encountered certain important practical problems that may be of general relevance to other workers and managers of services. Firstly, the elderly Asian population is a highly mobile group. Perhaps this reflects the behaviour of the Asian population as a whole, but it may also partly confirm the anecdotal impression that older people in this community tend to spend different periods of the year with each of their sons and daughters. This geographical mobility

means that there may be an under-representation of this most mobile group, who may differ from the rest of the population. It also poses a difficulty in the choice of the most appropriate sampling frame. The general practice register has the advantage over conventional alternatives—for example, electoral roll and lists of rate payers—in allowing identification of age groups, but there will necessarily be a degree of inflation for mobile populations. This may improve as more family practitioner committees become computerised, but in the interim it is necessary to search carefully within practice records to eliminate errors, despite it being time consuming.

Moreover, when conducting surveys within the Asian population it is important to seek fully the cooperation of community leaders to ensure success in the fieldwork. Finally, there must be available people skilled in interviewing in the Asian languages if valid information is to be obtained.

I warmly thank the Leicestershire Family Practitioner Committee and particularly its then administrator, Mr H Mallet JP, and its registrar, Mr L J Abbiss; the local medical committee, particularly its honorary secretary, Dr Gwilym Edmondson-Jones; the South Trent Division of the Overseas Doctors' Association, particularly its chairman, Dr A F A Sayeed. I also thank all the interviewers, Mr Tanu Masharani, who played a valuable part as coordinator, and Mrs Gulshan Ahmed, who willingly contributed her considerable experience of working in the Asian community in discussions about the study. Finally, I thank especially my research assistant, Aileen Odell, for all her dedication and hard work.

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A 67 year old patient with severe weakness of one leg after poliomyelitis in childhood complains of persistent tiredness and lack of energy. He has noticed this increasingly since he was about 30. Is this a generally recognised phenomenon?

Debility and weakness developing as a late sequel many years after acute paralytic poliomyelitis has long been recognised. It was rediscussed at the International Symposium on Poliomyelitis Control in 1983^{1,2} and in a recent article in *New Scientist*.³ Dalakas *et al* distinguished two groups of patients whose new neuromuscular symptoms appeared about 30 to 60 years after acute poliomyelitis.¹ Functional deterioration in one group affected only those muscles previously impaired; after compensatory adjustments it became restabilised and probably reflected the effects of wear and tear and aging. In the other group "late postpoliomyelitis muscular atrophy" affected previously unaffected or apparently recovered muscles, slowly progressing with new motor neurone signs, and investigations suggested that immunopathological processes were playing a part. Johnson reviewed evidence for persistence of polioviruses in the nervous systems of man and experimental animals² but, like the other writers, considered this an improbable cause of late recrudescence of paralysis. This seems more likely to result from degenerative and aging processes, the difficulty of maintaining compensatory mechanisms, and in some cases perhaps slow immunopathological processes.

During acute paralytic poliomyelitis some motor neurones are killed and others functionally impaired. Paralysis usually ceases to increase after about three days and a degree of improvement in neuromuscular function occurs,

mainly during the next month. This improvement is attributed partly to subsidence of acute inflammation in the central nervous system, which may temporarily impair the function of uninfected neurones, and partly to recovery of some infected neurones, probably mediated by the interferon response. Muscle fibres which have permanently lost their innervation atrophy with fibrous replacement. Others become reinnervated by sprouts from surviving nerve fibres, regain function, and may hypertrophy so that the affected muscle's function is partly or completely restored. These changes may affect many muscles not recognised as impaired during the acute illness. The reduced number of surviving motor neurones now supply more muscle fibres than before and may not permanently withstand the extra work load. It has even been suggested that too strenuous exercise may break some of the neuronal sprouts which then may not be efficiently reconstituted by the overstressed nerves.³ Bruno surveyed over 700 subjects who, usually about 20 years after acute poliomyelitis, developed new symptoms of tiredness, weakness, pains, breathing difficulty, and sensitivity to cold.³ He found that many showed higher psychological stress, which might enhance the deterioration, and suggested that circulatory impairment from nerve damage might also add to the problem.—N R GRIST, emeritus professor of infectious diseases, Glasgow.

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