Changing Families as Societies Age : care, independence and ethnicity

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ABSTRACT

The UK's national population structure in line with most Western societies is ageing rapidly. The combination of falling fertility and increasing longevity is having an impact on family structures and resultant relationships, with the emergence of long vertical multi-generational families replacing the former laterally extended family forms. This is occuring at a time when UK government policy is placing increasing reliance on families to provide health and social care and support for the growing number of frail older people. While there has been extensive research on family care within the majority white population, there is less understanding of the elder family care provision for the UKs growing older ethnic population. This paper discusses the changing demographics, new government policy on promoting independent living and its implications for family care provision, and reviews our current understanding of family care and support for older people within the UK's varied ethnic minority families.

1. Demography

The UK national population age structure, in line with most Western countries, has aged continuously over the past century. The measure of ageing being an increase in the percentage of those over 60 years, and a decrease in those under 15 years. The 2001 Census noted the official *maturing* of the UK population, as the number of individuals aged over 60 was greater than those aged under 15. The proportion of the UK population aged over 60 had reached 21% by 2001. Of these, 36% were aged over 75, corresponding to 7.5% of the total population, and 9% were aged over 85, comprising 2% of the total UK population. However, the numbers of older people in the UK are predicted to increase significantly over the next 25 years. Growth will be particularly significant among the oldest old – by 2025 more than one quarter of the UK's population will be aged over 60, with more than a third of these aged over 75 (see tabel 1). These demographics have arisen through a combination of falling mortality, leading to increased longevity, and falling fertility, both resulting in a higher percentage of older adults within the population. Life expectancy rose from 70.8 years for males and 76.9 years for females in 1980 to 75 and 79.8 respectively in 1999. Alongside this, fertility has declined more or less continually from the mid 1960s falling from 2.95 in 1964 to 1.68 in 1999.

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Table 1.Census and projected population of the UK, 2001 and 2025. Thousands.

Age group	2001		2025	
	Number	Percentage	Number	Percentage
0-14	11,105	18.9	10,512	16.2
15-29	11,077	18.8	11,117	17.1
30-44	13,271	22.6	12,910	19.9
45-59	11,115	18.9	12,672	19.5
60-74	7,816	13.3	11,234	17.3
75 & over	4,405	7.5	6,392	9.8
Total	58,789		64,836	

Source : Census 2001 and National population projections 2000-based

Only eight per cent of the UK population registers itself of an ethnic (non white) minority status and 28% register themselves as non-Christian (2001 Census, see table 2). In the latter instance, the use of UK national census material is controversial as the religious question is voluntary – 23% state that they have no religion or do not state a religion. In addition, it is unclear as to the percentage who choose to identify themselves along ethnic lines. This is particularly the case, for example, with the Jewish population. Jewish scholars prefer to use their own estimates, due to being reliant historically upon their own communal figures partly because the religion question was not included in the census until 2001. The UK Jewish population is thus currently estimated to be around 280,000 based on data collected by the Board of Deputies of British Jews (Schmool and Cohen, 1998), as opposed to the 267,000 in the 2001 census. These figures also need to be put into perspective in that minority ethnic groups are frequently clustered together residentially. Thus, several of the large British cities may have up to 10% of their population of ethnic minority status, with Greater London registering over 17%, and individual boroughs in the capital up to 27%.

Table 2. Ethnicity and religion, 2001. Thousands.

Ethnic group	*Number*	*Percentage*
White	54,154	92.1
Other	4,635	7.9
Place of birth		
UK	53,884	91.7
Other EU country	1,307	2.2
Outside EU	3,598	6.1
Religion		
Christian	42,079	71.6
Buddhist	152	0.3
Hindu	559	1.0
Jewish	267	0.5
Muslim	1,591	2.7
Sikh	336	0.6
Other	179	0.3
No religion/not stated	13,626	23.2

Source : Census 2001

Estimating the age profile of these minority groups from census data is thus equally problematic, in particular as younger ethnic minorities are most likely not to register an ethnic affiliation. There is also considerable difference between the age profiles of minority groups. Within Asian and Black communities, for example, there is a clustering at young old – those between age 50 and 75. This is in part due to the migration of large numbers of young Asians and Blacks in the immediate post-war period. However, the age profile of UK Jews (Board of Deputies of British Jews Statistics and Census 2001), for example, is older than that of both the national population, and Asian and Black ethnic groups. While 22.3% of the Jewish population is aged over 65 and 12.5% aged over 75 - comprising 56% of older Jews - and 6% aged over 85 - comprising 27% of older Jews – the corresponding figures for the UK population as a whole are 15.9% aged over 65, 7.5% aged over 75 (47% of the older UK population) and 1.9% aged over 85 (12% of the older UK population). This appears mainly due to the high socio-economic class of the Jewish population, with over half professional and managerial workers, as compared with around 10% of the UK population (Miller et al, 1996). These socio-economic groups within the majority white population have a longer life span on average than lower socio-economic groups. However, it should also be noted that such percentages are not comparable between the different ethnic and majority groups. Thus, most ethnic minorities have poorer health profiles than the majority white population, making them more similar in many ways to the age 75 and over white population. Secondly, there may be an under-estimation of age, with respondents in both community and census surveys, under-estimating their true

ages. All ethnic populations are affected, however, by two demographic factors. Firstly, while the percentages of older people within these groups vary, all are experiencing increased longevity; secondly, all groups are being affected to some degree by increased exogenous marriage. Thus, the absolute number of frail older people within these groups is increasing at a time when traditional family structures are changing.

A final demographic aspect worthy of note relates to the population of foreign citizenship resident in the country. In 2000, 4.1% of the UK population corresponding to almost 2.5 million persons were foreign citizens (Eurostat, 2001). This figure is, however, an underestimate of the stock of foreign population as it does not include naturalisations.

II. UK Policy Initiatives for Care of Older People

The changing demographics of the UK population has been reflected in considerable developments over the past two decades in health and social care policy for older people. As Harper and Leeson's (2002; 2003) recent review and evaluation of current government policy promoting independent living for older people, argue, a shift has occurred with regard to both the health and social care policy agendas. With the rejection of institutional solutions comes the focus on independence and the provision of necessary care close to home. Some of the central concerns of policy development are to increase individual citizen input into this development, increase choice, increase diversity and increase inclusion, with self-reliance remaining one of government's key objectives. The concepts of active ageing, social inclusion and independence are complex concepts relying on a wide range of diverse but interrelated factors, and this has been reflected in recent policy developments in this area. Current Government policies for older and disabled people thus aim to promote health and independence, provide person-centred services to meet individual needs, help people remain in the community, support carers, modernize and integrate service, and deliver value for money. Such policies are very heavily reliant on the availability of unpaid informal, typically family care from within the community (Harper and Leeson, 2002), and indeed current models for service distribution specifically factor in available family care (Harper and Leeson, 2003)

The White Paper on Community Care in 1989 emphasized the need for older people to stay at home for as long as possible (Department of Health, 1989). The resultant NHS and Community Care Act of 1990 aimed to encourage the development of community care provision, enabling older people to remain at home. In 2001, the *National Service Framework for Older People* (NSF) became the main policy instrument through which the government works to modernizing health and social care services for older people (Department of Health, 2001). The goals of the NSF for older people include promoting independence and person-centred care; improving the quality and consistency of services*;* expanding

service capacity and the reform of long-term care. In July 2000, the Government announced in the *NHS Plan* (Department of Health, 2000) the development of services for older people. Intermediate care services between hospital and home were to be introduced to prevent loss of independence. By placing the focus on policies that enable older people to stay in their own homes while receiving care, the NHS Plan places independence as central, importantly supported by joined up thinking: "*housing, primary care, community health services and social services, together need to provide effective support*". A major stated objective is to ensure that older people can "*secure and sustain their independence in a home appropriate to their circumstance*". The government here emphasizes the inclusion and evaluation of the needs of vulnerable groups and the provision of guidance on good practice in healthcare delivery and support for *minority ethnic groups.*

The *Better Care, Higher Standards* is a joint measure from the Department of Health (DoH) and the Department of the Environment, Transport and the Regions (DETR), acting to inform those in receipt of care of the standards they can expect. Recognising the particular difficulties of older people, local authority strategies have shifted focus from simply protecting people to also protecting/adapting their properties, the idea being that more and better advice on home maintenance will help older people to plan their housing future as they grow older and face the possibility of frailty. Extra government funding for Home Improvement Agencies (HIA) has enabled many older people to stay in their own homes for longer periods. The *Supporting People Programme* will provide housing-related support for vulnerable people from April 2003, such as information services and access to wider web services (DETR, 2001). *The Better Government for Older People Programme* and the *Interministerial Group* for older people also recommend measures which would decrease dependency, by providing more independent living opportunities, better quality provision of sheltered housing, and clear information and advice on what is available.

The cross-departmental initiative *Modernising Government* underlines the importance of the Department for Work and Pensions (DWP) strategy for alleviating poverty and promoting independence in retirement by means of increasing the take-up of existing services, including financial services as well as health and social care. One of the Department's key components for improving the delivery of benefits and information to pensioners is the *Pension Service*, which is delivered through 26 pension centres and is supported by a local service working with a range of partner organisations. At the same time, DWP together with a number of other government departments is developing *Third Age Services (TAS)*, a holistic and joined-up model of service delivery for older people providing an integrated gateway to access benefits, health, housing and social care, in the first instance via inter-agency working. The development of TAS is part of a widespread growth in initiatives designed to facilitate the independence of older people by improving access to services. Others include *Care Direct,* a service led by the Department of Health but linked to NHS Direct and run locally by local authorities in partnership with other government and non-government organisations. Finally, *Sheltered housing* is the primary housing-based way of helping older people to maintain independence. It is available in the public or private

sectors to rent, purchase or through shared ownership. Approximately ½ million older people live in rented sheltered housing accommodation in England with an additional 100,000 living in private sheltered housing otherwise known as retirement housing or leasehold schemes. The majority of sheltered housing residents have low incomes and are therefore dependent on income support or housing benefit to pay their rent, other essential housing costs and for housing support services, which are valued by residents as enabling them to live active and independent lives in the community.

III.. Kinship structure, roles and elder care

Current government policy thus sees an essential role for informal carers, in particular the family, (Milne et al, 2001; Twigg, 1998; Dalley, 1996). Indeed, it has been estimated that the value of the care provided informally by family and friends amounts to some £33.9 billion annually (Nuttall et al, 1993). However, the changing demographics are also impacting upon these families and their capacity to provide care. The shift from a high-mortality/high-fertility society to a low-mortality/low-fertility society results in an increase in the number of living generations, and a decrease in the number of living relatives within these generations. Within the white majority population we are thus seeing the emergence of long vertical multi-generational families replacing the former laterally extended family forms (Harper, 2003a). Increased longevity may increase the duration spent in certain kinship roles, such as spouse, parent of non-dependent child, sibling. A decrease in fertility may reduce the duration of others, such as parent of dependent child, or even the opportunity for some roles, such as sibling. A combination of forces are also resulting in the ageing of some life-transitions, with these ageing societies also displaying an increase of age at first marriage and at remarriage, at leaving the parental home, at first childbirth. While public and legal institutions may be lowering the age threshold into full legal adulthood, individuals themselves are choosing to delay many of those transitions which demonstrate a commitment to full adulthood – full economic independence from parents, formal adult union through marriage or committed long-term cohabitation, and parenting. The ageing of family transitions in younger life leads to subsequent transition delay for both the individual and other kin members. For example, delayed birth of first child may lead to long intergenerational spacings, and a transition to both parenthood and grandparenthood at a later age than has been the recent historical norm.

While the changing structure of families in ageing societies has been well documented (Harper 2003b), this does not mean that the role of families in supporting older people is decreasing in importance (Harper, 2003a). Indeed, recent longitudinal work suggests that the family does in fact seem to be more important today for middle aged and older generations than was the case 10-15 years ago (Leeson, 2001). In contemporary society, there are, however, many competing demands on and roles for family members – one of which is care-giving, for children, spouses, parents, parents-in-law, and perhaps even other family members or friends. Comprehensive European studies of the family care of older people (Le Bris,

1993; Leeson & Hoffmann, 1993) reveal the complex aspects of this phenomenon both for the caregiver and the cared-for and the cultural settings. In considering the multifaceted role of social and familial networks in caring for and supporting older people, it is important to recognize the cultural context of care-giving changes over time, as the family structure and inter-familial relationships change over time.

Theoretical and conceptual grounding for research in the field of family obligation and informal care-giving has been primarily undertaken for the UK white population. Here care-giving within the family is found to be negotiated within a context of norms, obligations and reciprocities (Stein, 1992 ; 1993). **Felt obligation**, for example, has been defined by Stein et al (1998) as: '*expectations of appropriate behaviour that are perceived within the context of specific personal relationships with kin across the life course'* . He idenfies five basic dimensions of felt obligation, namely expectations about contact and participation in family rituals, assistance, avoiding conflict, personal sharing and self-sufficiency. Research indicates that the norms associated with obligation run along *gender* lines (Bahr 1976), it being higher among women than men. Research conducted into the perceptions of felt obligation have also been found to differ as a function of ethnicity but not social class (Stein et al 1998). Stein et al (1998) also reports work that examined views of parental obligation and caregiving among adults. In that work, views of felt obligation were investigated as a function of gender, generation and parental status. Adults with one living parent expressed higher felt obligation than adults with both parents alive, and younger children expressed higher felt obligation than older children.

As Stein et al (1998) also reveals, an alternative approach is **relational** where the assistance provided by older children is pay back for the effort of child rearing. It has been suggested this may serve to alleviate the child's sense of guilt. The assumption is as younger members have not yet had time to engage in reciprocal exchanges they will exhibit a greater degree of filial obligation. Within the UK white population, Qureshi and Walker (1989) found that, irrespective of the quality of familial relationships, decisions about who should take up the burden of caring for an older relative are made in accordance with a hierarchy of obligation, which runs from spouse (first choice) through daughters (second choice) to other close relatives, although there may be a variety of reasons regarded as legitimate for failure to conform to this. Finch and Mason (1990; 1993) suggested that while there are no clear rules about the kinds of responsibilities people should adopt towards their relatives, there are widely accepted normative 'guidelines'.

Filial responsibility incorporates the understanding that obligation '*comes from societal expectations that older parents have a right to be taken care of and adult children have a duty to do so'* (Stein, et al 1998). Past research into family obligation has operationalised obligation either as an attitudinal construct or societal norm. Expectations of kinship may include the maintanenace of contact, communication and the provision of assistance. Other research into the duty to care reconfigures filial responsibility as an attitudinal construct. By measuring this construct the extent to which an individual is prepared to provide care can be elicited.

Recently, studies have explored in some depth the complex interactions faced by family carers. These carers, for example, are often coping with older people's (severe) medical conditions and the older person's feelings of loneliness and depression, which then put strain on the carer (Herlitz and Dahlberg 1999). A key study in this area is by Twigg and Atkin (1995) which considers the factors mediating the relationship between carers and service provision in relation to the service given to carers. The authors identify a number of significant factors: the attitude of the carer and the views of the person being cared for and the views of other family members, family relationships and the moral status of the person being cared for, and gender, age, class and race. The singularity and the interaction of the factors is underlined. In their study, Twigg and Atkin find that assertive carers who push for help end up getting help, something confirmed by the service providers in the study, who explained that they did not generally seek out cases and that help was to some degree determined by factors extraneous to 'need'. Clearly, the person being cared for also plays a role when services are negotiated, although for some this is difficult because of their frailty. This is important as service providers respond to the person being cared for and his/her needs and actively encourage their right to play a central role in negotiations. However, despite this acknowledgment, service providers varied in the degree to which they were willing to compromise that right in the interest of the carer. There was some evidence in the study that some forms of support were given more often to male carers than to female carers, something found in earlier studies too (Arber et al, 1988). It seems that social care assistance is more often denied if there is a female family member nearby.

IV.Intergenerational Relationships and Family Care in Ethnic and Faith Communities

Under current and future government policy for providing health and social support to its older population, older members of minority ethnic groups have in theory three broad options. They can draw on community based care provision developed by the ethnic community; on state provision, which may or may not be specifically developed and focused on their language and other needs; or on the informal support of family members. In practice, however, many communities are reliant either on standard state welfare provision or on family members. The limited research in this area has highlighted the inadequate and patchy provision of current health and social care services for these communities and has shown that uptake of services where they exist is low (Ahmad and Walker, 1997; Patel, 1990, 1999; Social Services Inspectorate, 1998). This cannot it seems be explained by health profiles (Lindesay et al, 1997) as several studies have reported relatively low uptake of social and community health services despite relatively high GP consultation rates (Atkin et al, 1989; Ritch et al, 1996; Bowes and Dar, 2000). Rather, as the Social Service Inspectorate (1998) suggests, there exists a common assumption that ethnic communities 'look after their own'. Indeed, Blakemore and Boneham (1994) have argued that the 'Jewish model of

care' has served as a prototype for other minority communities. Yet while the relatively large proportion of older Jews among this community has meant that issues of providing older care are salient and services have been well developed by the Jewish population themselves (Valins, 2002), this is not the case within other communities with a far lower proportion of older people. Paradoxically, however, in these communities ethnic service providers have sometimes adopted a view that they need not concern themselves with providing specific support for relatively few older people (Walker and Ahmad, 1994). Furthermore, this stereotype ignores the possible diversity of attitudes and behaviours both between and within such communities. It also ignores structural influences such as the fact that migrant families have often been divided by migration itself, resulting in changes in household structure and the geographical dispersal of kin, thus making it difficult for the extended family network to offer support, which may ordinarily have been provided, for older and disabled relatives (Atkin and Rollings, 1992). Increasingly, then, if older people desire ethnically appropriate care and support, religious or community based local services need to be developed to supplement the family based support and care.

Despite recognition of the importance of informal family care, research relating specifically to its role has tended to ignore ethnic and faith communities (Atkin and Rollings, 1992). It is, however, well documented that family and extended kin relationships have traditionally been valued in many of the home communities from which migrants have come and that caring for frailer family members has been seen as part of the fabric of social life (Chen and Silverstein, 2000; Kabir et al, 1998; Daatland, 1997; Knodel, Chayovan and Saengtienchai, 1994). Recent work by Leeson (2003), for example, indicates that within the Scandinavian population at least, ethnic minority families at second and third generation wish to play a full practical role in caring and supporting older parents.

In order to understand the contribution of family care within these communities, it is important to consider not only the availability of household and kin members to provide care, but also the concepts of obligation and reciprocity underlying this care.

Studies of minority ethnic communities which look at the **nature and provision of informal care** are generally small-scale and locally based (Centre for Research in Ethnic Relations, 1996; Farrah, 1986; McCalman, 1990). However, an early study of older Cypriots (Aloneftis, 1984) looked at the experiences of ageing in a foreign land. Adamson (1999) conducted a small exploratory study of African Caribbean and south Asian families looking at the uptake of services and awareness of dementia in these groups. A study of social change among people of Caribbean origin in Britain included an exploration of kin networks and family obligation and found a disproportionately heavy burden was placed on female members of families and households (Goulbourne and Chamberlain, 1999). However, as Goulbourne (1999) also points out, this Caribbean population has a strong tendency for exogenous marriage and this gives rise to less collective obligation.

Research on **household composition** among ethnic and faith communities has shown that older individuals from these groups are more likely than the white population to live with an adult child (Modood et a1, 1997). This may, however, be due to economic necessity (Warnes, 1996) rather than cultural preference. Butt and Mirza (1996), for example, sound a note of caution to those who might assume that living within an extended family means that all the needs of those being cared for are being adequately met. They conclude in fact that the evidence appears to suggest 'containment' rather than care within extended traditional families. It is important not to make simplistic assumptions about household structure and the extent of family support available within it; there is a need to make distinction between household structure and relationships within (and outside) that structure. Furthermore, the size and density of a social or familial network are not per se positively linked to perceived support and independence. Large, closely-knit families can be sources of intrusiveness, bad advice and conflict as well as support. Indeed, there may even be an inverse relationship between the size of the network and receipt of support (Pickett et al, 1993).

There is limited research on concepts of **obligation and responsibility** in relation to family care giving for older relatives among ethnic and faith groups. There is, however, substantive cross-cultural evidence that norms are important in establishing the status of older people and that this supports their receipt of familial care. As Pyke (1999) points out, in Asian families, religious and cultural traditions of filial piety and reverence confer power and status to elders, which underscores the practice of filial care (Abel, 1991; Aronson, 1992;). Lee, Peek and Coward (1998) investigated race differences in the degree to which parents endorse the view that they should receive support from their children. Results show that blacks have higher filial responsibility expectations than do whites and the difference is mildly altered by accounting for socio-economic factors. The authors argue this suggests evidence of a cultural difference between the two groups, the authors also suggest this is in accordance with the level of provision of support from kin. Furthermore, interestingly, they found that the use of formal services are not effected by levels of assistance provided. On the basis of a fourfold typology of intergenerational exchange, Lowenstein (1991) collecting data on Jewish elderly individuals showed the multidimensionality of intergenerational bonds, and that the amount of personal resources is positively related to expressive interactions and inversely related to instrumental aid.

Studies which have looked at the **expectations of older people** from ethnic and faith groups regarding care in later life have revealed conflict, anxiety and uncertainty about the future and the possibility that their old age might not be spent in the care of their children (Alibhai-Brown, 1998; Fenton, 1987; Qureshi, 1998). Fenton (1987) interviewed older south Asians who expressed fears that their children had or would become 'westernised' into the uncaring and individualistic attitudes of English people towards older people. Qureshi (1998), in a study of Bangladeshis living in Camden, north London, discovered that a great concern of older people in the area was the erosion of the 'customs' and 'tradition' of their joint Islamic and Bengali heritage because of the influences of British culture on their children and grandchildren. An alternative view is presented by Cohen and Eisen (2000) in their

investigation of American Jewish family life. They present evidence to suggest the symbolic significance of current Jewish rituals, festivals, and observance which actively strengthen family ties within the nuclear family and provide a role for the extended family also. The tradition of caring for older family members and filial piety in general can be traced back to Jewish family values reflected in Jewish law (Isenburg, 1992). Findings show relations to parents/ grandparents to be closely associated with feelings of Jewish identity. Observance and meaning become linked to the memory or the interaction with the Jewish family. Yet even these families are undergoing some of the changes identified above for the majority white population, and this tradition within both the US and UK Jewish population appears to be changing due low fertility and assimilation due to out marriage. This latter factor is of increasing importance, with currently over 40% of UK Jewish men under age 40 married to non-Jewish women, and with 50% of US Jewish marriages exogenous (Newman, 1999).

V. In Conclusion

As Harper and Leeson (2002) have argued, understanding the family is a key to current concepts of independence both in policy terms and in the statements of older people, in both the majority white and ethnic minority communities. What is clear from the above review on informal care provision for older people is that there is still a limited understanding of such care both in terms of its availability and of the changing attitudes of community members. More research is thus needed to explore in particular how attitudes towards family obligation in relation to care giving are changing in the context of changing family structures. Such attitudes towards family obligations in relation to care giving will differ between generations. Current stereotypes suggest that younger generations are less willing to provide personal care for older kin and more willing to accept services from the formal support system. There is also the perception that the attitudes of younger generations will have more in common with majority white population than with older ethnic minority generations. This view has been questioned, however, by recent research on new immigrants to Scandinavia (Leeson, 2003). We also need a greater knowledge of the extent to which attitudes towards caring for older relatives differ according to age, gender, and level of care required. Greater understanding is also required of the mechanisms within different communities for determining by whom this care should be provided in terms of which relatives are more likely to be carers and how is this decided; similarly, to whom should care be provided depending upon degrees of relatedness.

Even in those ethnic communities with a long and established history of providing care services for elderly and vulnerable members of their community, the changing demographics of all minority ethnic communities in the UK and the increasing out-marriage will have an impact on family obligations towards older relatives. It is therefore essential that the current growth and range of national state provided services emphasising independent living take these changing family dynamics into account, and

build ethnically appropriate service provision - services which are supportive to local family and community based support.

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