Older people’s experience of proactive welfare rights advice: qualitative study of a South Asian community

Suzanne Moffatt PhD
Joan Mackintosh BSc

Institute of Health & Society
Newcastle University, UK

The definitive version of this article is published in:
Ethnicity & Health, Vol 14, Issue 1, pp5-25, 2009

Corresponding author:
Suzanne Moffatt
Public Health Research Programme
Institute of Health & Society
Newcastle University,
Medical Sciences
Newcastle upon Tyne, NE2 4HH, UK
s.m.moffatt@ncl.ac.uk
Older people’s experience of proactive welfare rights advice: qualitative study of a South Asian community

Abstract

Objectives Many older people in the UK require means tested and health-related benefits to supplement low incomes in retirement and pay for additional resources required to cope with ill-health. Ethnic minority older people have lower uptake of welfare services than white older people. This study investigated routes to the service, barriers to claiming and explored the impact of additional financial resources among ethnic minority elders by evaluating a novel welfare rights advice service which facilitated access to state benefit entitlements.

Design Qualitative study using data from one-to-one interviews with ethnic minority elders from Newcastle upon Tyne, UK analysed using the Framework method. Participants were recruited to this study from among ethnic minority elders attending a full benefits assessment offered by Newcastle Welfare Rights Service.

Results 22 South Asian participants aged between 50 and 81 were interviewed. 19 participants were above state retirement age, 15 of whom were on means tested state benefits. Knowledge of state entitlements was extremely low. 16 qualified for non means-tested health benefits; 6 qualified for further means-tested state benefits. Additional resources had a considerable impact on participants and their families. Participants could better afford essential items such as food, bills, shoes, clothes and ‘one off’ payments. Less stress, increased independence and better quality of life
were reported. Welfare rights advice also had a positive impact on carers, none of whom knew what they or their relatives were entitled to.

**Conclusions** As with older people of all backgrounds, Facilitating access to state benefit entitlements with appropriate services is an important way of increasing the resources of ethnic minority older people on low incomes and/or in poor health. Such services can also significantly improve quality of life for carers. Since the numbers of ethnic minority older people will rise over the next few decades, it is necessary to meet this need with linguistically and culturally appropriate welfare rights services. To do otherwise will exacerbate existing income and health inequalities.

Key words: Welfare benefits, welfare rights, inequalities, additional resources, South Asians, older people
Older people’s experience of proactive welfare rights advice: qualitative study of a South Asian community

Introduction

It is well established that many older people in the UK do not take up the state welfare benefits to which they are entitled (National Audit Office, 2002). The most recent estimates suggest that approximately £2.5 billion of state benefits was unclaimed in 2006, affecting up to 1.5 million people over the state retirement age (Mathiason, 2007). The relationship between socio-economic position and poor health is well-known (Townsend et al., 1988, Marmot and Wilkinson, 2000). However, studying the health impact of additional financial resources is methodologically challenging (Thomson et al., 2004) and studies have yielded equivocal results. A recent pilot randomised controlled trial investigating the impact of additional resources on older people found no measurable impact on a range of health outcome measures (Mackintosh et al., 2006), but a parallel qualitative study found improved ability to afford necessities, maintain independence and increased social participation. (Moffatt et al., 2006a) Ethnic minority older people have lower uptake of health and social services than white older people (Lindesay et al., 1997, Merrell et al., 2006) and have relatively little knowledge of welfare services, with correspondingly limited use (Ahmad and Walker, 1997, Rait and Illiffe, 2003). This is also the case for welfare benefits (Barnard and Pettigrew, 2003), which for many older people reliant on the state pension, are essential if their incomes are to be lifted above the poverty threshold of 60 per cent of the median income (the current EU and UK Government measure of relative poverty (Barnes, 2005)). There is a significant literature on benefit take-up among older people in the UK (Corden, 1999, Costigan et al., 1999, National Audit Office, 2002), which has largely ignored the dimension of ethnicity (Craig, 2004,
Salway et al., 2007). An exception is a study commissioned by the Department for Work and Pensions (Barnard and Pettigrew, 2003) examining the barriers to take up of means tested benefits (specifically, the Minimum Income Guarantee (now Pension Credit’)) among ethnic minority older people. Barnard and Pettigrew (2003) found that many of the barriers experienced were similar to those found among the white ethnic majority, these being, lack of knowledge about benefits or the workings of the system; literacy problems; apprehension about approaching, lack of trust in, and lack of comprehension of statutory services. Language barriers, concerns about the impact of claiming on residency status, and difficulties arising from not having a National Insurance Number, were issues that specifically affected some ethnic minority older people. The study presented here was part of an evaluation of a novel welfare rights advice service for ethnic minority elders which aimed to determine routes to services, barriers to claiming and ascertain the impact of welfare benefits on health and well-being. Important aspects of ethnic minority elders’ socio-economic context are highlighted in the next section.

**Background**

Currently ethnic minority older people are over-represented amongst the poorest pensioners in Britain. Evandrou (2000) constructed an index of multiple disadvantage which confirmed that just under half of Pakistani and Bangladeshi older people experienced medium or high levels of deprivation, compared with one fifth of the majority white population. An investigation of income, wealth and assets showed that Black-African, Black-Other, Pakistani and Bangladeshi families were disproportionately income- and asset- poor, were much less likely to have a safety net in times of economic adversity and concluded that this has significant ramifications for both their economic wellbeing in old age and the economic health of younger generations.
The cost of caring and providing for older family members is likely to be substantial and is generally considered a non-negotiable responsibility – particularly, but not exclusively, among South Asians. (Warren and Britton 2003:116)

Many people who migrated to Britain did so in the middle of their working lives and, as a consequence, had less time to build up pension rights in state or occupational/private schemes. The current emphasis on private pensions and savings to provide an income in later life, places many ethnic minority elders, particularly women, at a disadvantage (Ginn and Arber, 2000, Cooper and Arber, 2003). Current UK Government policy of targeting the poorest pensioners with means-tested benefits reinforces the need for the least well-off pensioners to be able to access the welfare benefits system.

Increasing attention is being paid to the role of socio-economic factors in the health experience and health outcomes of Britain’s ethnic minorities (Karlsen and Nazroo, 2002). According to Nazroo (2006), the available evidence linking health, age and socio-economic position suggests that ethnic inequalities in health and economic position are greatest for older people. A substantial proportion of ethnic minority older people will not, therefore, be in a position to fund the additional expenses which arise as a result of ill-health and/or ageing or to contribute financially to social care costs (Zaidi and Burchardt, 2004).

Much of the literature is critical of a great deal of ethnicity and health research for focusing on simplistic and decontextualised accounts of ‘culture’ as an explanation for particular health problems and downplaying the role of socioeconomic factors (Nazroo 1998). Atkin (2004) highlights the widespread nature of institutionalised
racism which affects service provision and experience of health, social and welfare services. One such stereotype is that the health and social care needs of ethnic minority older people are met by the extended family, thus negating the need for professional support. Assumptions that, ‘they look after their own’ are widespread, yet misguided and at worst a racist denial of their support needs Atkin (2004: 14)

Undoubtedly, there are much stronger expectations about caring for older generations among South Asians in comparison to the white majority. However, changing family structures are increasingly likely to make this more difficult at a practical level (Modood et al., 1997).

The overall picture suggests that particular groups of ethnic minority older people experience higher levels of economic hardship and poor health in comparison to the white majority, but that in spite of this, some disadvantaged ethnic minority older people draw considerable benefit from their social and community networks (Grewal et al., 2004)

Non take-up of welfare benefit entitlements is the main contributory factor towards pensioner poverty for older people (Goodman et al., 2002) and therefore has consequences for health and well being in later life. The account given in this paper makes an attempt to go further than a great deal of ethnicity and health research, which is predominantly descriptive and address Atkin & Chattoo’s (2006:101) point that there is,

…a need for more research that explores how services can best meet the needs of ethnic minority populations … it would be helpful to understand what constitutes good practice at local level and how such practice can be sustained and replicated in other localities.
**Demography and services in Newcastle upon Tyne, North East England.**

The City of Newcastle upon Tyne in North East England has a total population of 276,400. The proportion of people from ethnic minorities living in the city is relatively small and the largest groups are Pakistanis (1.9%), Indians (1.2%), Bangladeshis (1.0%) and Chinese (1.2%). Three electoral wards in the city have substantial ethnic minority communities: Elswick (18.4%), Wingrove (17.0%) and Fenham (7.6%). Elswick ward is in the highest deprivation quintile as defined by the Index of Multiple Deprivation (IMD) (Shaw et al., 2007) and Fenham and Wingrove are in the next most deprived quintile. The number of ethnic minority older people is small with fewest in the 65+ age group (Nomis 2006).

Newcastle City Council Welfare Rights Service has offered benefits assessments for older people for many years, and more recently provided a domiciliary service. However, it was recognised that there was low take-up by ethnic minority elders. Funding was obtained from a government funded fixed term initiative (Social Exclusion Unit, 2001) to establish a new service with specific provision for ethnic minorities. In 2005, two Welfare Rights Advisors (WRA) and one community worker who between them spoke all the South Asian community languages represented in Newcastle were appointed to facilitate state benefit uptake among ethnic minority older people. The voluntary organisation, Age Concern Newcastle, employed the community worker; the welfare rights advisors were employed by Newcastle City Council’s Welfare Rights Service, although both organisations and staff worked collaboratively throughout the project. The new initiative comprised three elements.

1. Community development work to raise general awareness about welfare benefits among ethnic minority elders by staging a number of information
events and developing appropriate information materials as well as outreach work with various established groups.

2. Actively seeking out ethnic minority elders via GP age-sex registers, contacting them and offering a full benefit check to establish whether they were claiming their full entitlement. This method of contacting older people was used in a recently completed local study (Mackintosh et al., 2006).

3. Offering active assistance to claim benefits: form filling; liaising with other professionals; and, attending appeals and tribunals.

**Methods**

We conducted a qualitative study using one to one interviews with ethnic minority elders in Newcastle who had been recruited to the new domiciliary welfare rights service. Permission to carry out the study was obtained from Newcastle and North Tyneside Local Research Ethics Committee and from Newcastle Primary Care Trust. The project was registered in accordance with the Data Protection Act.

**Recruitment to the new welfare rights service**

All general practices within the three wards with the largest ethnic minority populations were invited to participate. Five practices agreed to take part. Practice lists were hand searched for people aged over 60 with non-English names. Letters in English, Urdu, Punjabi, Hindi, Bengali and Chinese were then sent out from the practice offering individuals a full welfare benefits check in their own homes. Respondents to this invitation were visited in their home by one of the ethnic minority welfare rights advisors who conducted a full welfare assessment, actively assisted with claims and conducted any necessary follow-up work.
Recruitment to and conduct of the qualitative study

Following the outcome of their claim, recipients of welfare rights advice were contacted by the welfare rights officers and asked if they would be willing to take part in an interview with a member of the research team. Participants were asked whether they would like an interpreter to be present and this was arranged if requested.

Within the time and budgetary constraints of the study, it was not possible to recruit and train interviewers from the same linguistic backgrounds as the participants. Instead, the interviews were undertaken with professionally qualified interpreters from the Newcastle Interpreting Service (NIS), experienced in working within the health and social care sectors. In line with good practice guidelines, (Jones and Gill, 2003, Sanders, 2000 #2209) prior to the fieldwork, discussions were held with the NIS staff likely to work on the project, clarifying the study aims, the interview schedule and specific items within the schedule that it was anticipated might present difficulties with translation. Discussing the aims of the project fully with the interpreting team enabled them to suggest acceptable ways in which concepts related to welfare benefits could be translated. It was agreed that when there was no direct translation of items such as Attendance Allowance\(^1\), that an explanation of the term would suffice.

The interview schedule had a semi-structured format, providing flexibility to the interviewer and interviewee in terms of the order in which questions could be asked, and the depth to which they were covered. The topic guide covered the following areas: knowledge of welfare benefits; accessing benefits advice; impact of additional benefits (affordability, health, health behaviours, social factors) and, acceptability, at
which point interviewees were asked about any negative aspects of the service. Prior to the interview commencing, participants were informed about the study, given the opportunity to ask questions, after which they were given a copy of the consent form to sign. With the permission of the participants, all interviews were audio-recorded. The English translation of each interview was transcribed in full. Fifteen minutes prior to each interview, JM met with the interpreter to brief them fully about the individual case. Following the interview JM and the interpreter had a short de-briefing session to discuss any outstanding issues.

The interpreting service provides contemporaneous translation such that the closest approximation to the words and meaning of the researcher and participant are directly translated. During the fieldwork, the practice of contemporaneous translation appeared more varied than anticipated. Some interpreters appeared to translate what the participant meant rather than what they said. In the light of this, two of the Welfare Rights Officers undertook an independent quality check on two translations that had been of concern along with four others selected at random. This involved each independently listening to the full transcript, checking the translation and discussing discrepancies. Six out of the 14 transcripts which involved an interpreter were subject to this quality check. Although most interviews were not translated verbatim, the independent check revealed that the full meaning had been correctly conveyed.

**Analysis of interviews**

Data analysis followed the ‘Framework’ approach (Ritchie and Lewis, 2003), a content analysis technique widely used in qualitative research. Each of the transcripts was read and re-read by the authors, following which a coding framework was
devised. Coding was undertaken by one person (JM), but discrepancies discussed with SM. Thematic categories were applied to each transcript coded using the NVIVO software package (QSR International 2000) and then ‘charted’, a process by which key points of each piece of data were summarised and documented on a cross-sectional matrix. The derived categories were discussed by SM and JM, a ‘pragmatic’ version of double coding (Barbour 2003). The data were examined for deviant cases (Clayman and Maynard 1995), but none were found. Thus, a set of categories were obtained which described the main themes arising from the interviews.

**Results**

**Targeting strategies**

Eighteen community events took place between May 2005 and July 2006. In total, over 1200 people attended these events. Sixty-one people consulted with a welfare rights officer as a direct result of attending one of these community events. It is possible that more than 61 people actually received advice, but that this could not be directly linked with a particular event. Much more difficult to ascertain is the impact of awareness raising in the longer term a point we return to in the discussion.

**Characteristics of study population**

Table 1 summarises socio-demographic information on the 22 participants aged between 50 and 81, interviewed between October 2005 and May 2006. Most participants were from the Pakistani community. The most plausible reason why there were relatively few Bangladeshi participants is due to the younger age structure of this community within the city of Newcastle upon Tyne (Nomis 2006) although in other parts of the UK with longer established Bangladeshi communities, for example Oldham in North West England and Tower Hamlets in London, elders form a more sizable proportion of this community (Garbin 2005). As found elsewhere (Evandrou
the Indian community in Newcastle upon Tyne is more geographically dispersed with fewer individuals in poorer socio-economic circumstances, No Chinese elders participated, probably reflecting the fact that there was a gap in same-language services to the Chinese community. Most participants were above state retirement age, of these, only three had private or occupational pensions. Twelve retirees qualified for means-tested Pension Credit prior to the study and a further three obtained it as a result of this intervention, indicating that most of the participants were on low incomes. Few participants lived in rented housing, most lived in owner occupied accommodation usually owned by a family member. Accommodation for the majority was in the lower council tax bands, reflecting residence in less affluent areas of the city. It was relatively unusual for participants to live alone, and in all cases these were widowed women. Most, but not all of the participants were living on means tested benefits, in multi-generational households owned by another family member.

Table 2 summarises further relevant participant characteristics and indicates benefits received prior to and following welfare rights advice. All participants had at least one chronic health problem, but many suffered from several, most commonly diabetes and cardio-vascular disease. A number of participants were caring for ill relatives, reflected in the types of benefits obtained. Twenty out of the twenty-two claims were health, disability or carer-related claims. Prior to the intervention, six of the respondents were receiving a health-related benefit; a further 11 respondents received a health-related benefit as a result of the intervention with two appeals pending and two applications turned down.
Three of the participants were fluent in English; most of the sample, as we had anticipated, spoke little English. All participants were offered the option of an interpreter for the research interview, but some preferred to rely on a family member, often the main carer. Altogether, 14 interviews were carried out with an interpreter.

The interview data are organised around a number of themes which relate to routes to services, barriers to claiming, caring roles and impact of increased financial resources.

**Routes to welfare rights advice**

Participants accessed the service via four different routes. Firstly, there were those who responded to the mailing from their general practitioner. Secondly, some participants were directly referred from other services or agencies, particularly health, for example, hospital social workers, community physiotherapists, district nurses and the diabetes service. The third route was via community networks, knowledge of a family member, or a chance occurrence at a community event. Fourthly, a number of participants had visited the Minority Ethnic Community Support Service resource centre, often for a reason other than specific welfare rights advice, and were directed to the welfare rights service. Routes to the service were therefore varied and often arbitrary.

**Views about welfare benefits**

None of the participants refused benefits once their entitlements were made clear and they were assisted to claim. However, some participants expressed negative views about claiming benefits, and it appeared that this was not a subject that was generally spoken about outwith the family. The impression conveyed was that families preferred to keep financial information private and would not discuss benefits with
friends as a result of the associated stigma of claiming benefits. Therefore, ‘word of mouth’ would be an unlikely route to expect welfare benefit information to permeate through these communities,

... most of our people are not on supplementary benefits or anything ... then we don’t know all these things you know, what the benefits are ... and those people who are claiming, they don’t tell other people ... they should but they don’t. (Case 3, Pakistani, male, aged 69, via interpreter)

A few participants expressed negative views about claiming benefits. But this was mainly among those who were younger and unable to work because of serious illness or caring responsibilities, and therefore related mainly to means-tested benefits,

I am really, really embarrassed in getting this support from the government ... the first time I had it like I cried because I have always worked, then I lost my husband, then I worked 50 hours a week in a rough area ... I did everything for eleven years. (Case 16, Pakistani, female, aged 50, in English)

However, none of these negative views were expressed by carers of older relatives in receipt of non means tested health and caring related benefits. The general view was that the additional resources were deserved,

I did not have any worries ... I never thought for one second that I wouldn’t get it or he wouldn’t get it. I think it is within yourself to tell the truth and if you tell the truth, you shouldn’t have any worries. (Daughter-in-law (carer) of Case 19, Pakistani male aged 81, in English)

No participants voiced any major concerns about the actual process of claiming, once the entitlement was confirmed and the applicant was assisted through the process.
Qualities of the Welfare Rights Service

The service was valued for several reasons. Firstly, the welfare rights advisors had the expertise to quickly assess situations and advise appropriately, secondly they were able to ask about personal issues in a sensitive manner and thirdly, because there were key factors which particularly appealed: its domiciliary nature; active assistance with form filling; and, shared language,

Although in a minority, there were some participants who were very isolated from family and friends and had no-one to turn to in a crisis, often brought about by illness and the ensuing financial implications of being unable to work. The Welfare Rights Service provided a lifeline.

*That time I had nowhere to go and nobody helped. Just them ... At first I did not think they would sort it out, that they would help like that and at the time I needed help and they helped me.* (Case 16, Pakistani, female, aged 50, in English)

Barriers to claiming benefits

Knowledge

Lack of knowledge about what benefits were available to older people living on low incomes with ill-health or with caring responsibilities was the main reason for the failure to obtain entitlements. Most participants had little or no knowledge of the benefits system and no idea of what they might be entitled to. Those who did have some idea that there might be some financial assistance had no idea how to go about obtaining help,
He knew he should be getting some help, but he didn’t know how to go about it. He thinks people who are entitled to help get it … wouldn’t know where to go. (Case 3, Pakistani, male, aged 69, via interpreter)

**Personal circumstances and expectations**

The underlying lack of knowledge was compounded by a number of assumptions relating to personal circumstances which some participants thought would preclude them from entitlement to further benefits. Already being in receipt of benefit, acted as a barrier for some participants who assumed that they would not be entitled to additional benefits, despite considerable deterioration in health,

*I thought because my father-in-law was living with me and my [severely disabled] husband, I thought we wouldn’t be entitled to anything else. So we never bothered claiming and nobody came round to say. Yet he [father-in-law] has been in and out of hospital so many times, and I would have thought that sometimes they give you advice.* (Daughter-in-law (carer) of Case 19, Pakistani male aged 81, in English)

In some cases, the family, rather than the individual, viewed themselves as the unit of assessment. Therefore, if one family member was already in receipt of another, unrelated benefit, this was thought to rule out entitlement to any further benefits. This was found to be the case for carers, usually a younger family member supporting older relatives and often experiencing considerable financial hardship as a result.

Although most participants had lived in the UK for many years, for some, fewer years of residence and immigration rules acted as barriers. For example, Case 18 assumed he would not be entitled to any additional benefits once his family joined him since his wife was told, on arrival in the UK, that she could not claim any benefits. The
family were, however, entitled to child tax credit. Length of residence was thought to impact on entitlement,

*My mother-in-law she doesn’t even know that she is entitled to this money because she has been abroad all her life. She doesn’t understand that you can get money here, whereas in Pakistan you are not entitled to anything there anyway and she thinks it’s the same here.* (Daughter-in-law (carer) of Case 4, female, Pakistani, aged 61, in English)

**Language**

Lack of fluency in English operated as a barrier to both knowing about and claiming benefits. This was particularly the case for older women, many of whom were reliant on their husbands or other family members for their contacts outside the home. However, even for those whose spoken English was good, dealing with officials over the phone could prove to be difficult and sometimes led to mistakes being made, such as, when information needed to be verified, and could lead to benefits being stopped or claims rejected. Even when spoken English was adequate, for the older participants in this study, this was rarely accompanied by competency in reading or writing.

Lack of competency in English, set alongside failing health, sensory problems and the necessity of completing complex forms all acted as additional barriers to obtaining benefits. In the few instances where participants had set about claiming a benefit themselves, they found it extremely difficult,

*I was going to the local Citizens Advice Bureau, and then it was shifted to [placename], which was a bit hard to get to. We were sitting there three or four times ... for half an hour or an hour. Sometimes I don’t have some of the*
stuff that I should do and then they send me down to [city centre] and there again is loads of people in there and queues standing. We lost a couple of requests there and I have not heard about it ... I don’t know where to go, where to apply, you see? (Case 21, Indian, male, aged 74, in English)

Caring responsibilities

Few of the participants lived alone, most lived within an extended family. The caring responsibilities were often considerable, with family members, usually daughters or daughters-in-law caring for one or more older relatives while looking after children. This was not seen as a burden, but a community norm (Warren and Britton, 2003).

As well as being unaware of available benefits, many carers lacked either the time or the energy to negotiate the benefits system, and were isolated due to their caring responsibilities,

I am in the house all the time, all I do is look after my family, take my children to school, pick them up and help look after them, I do not have time to go out, I do not have time for myself ... I did not think that we were entitled to anything while we thought they [health care workers] knew that we were caring for my father-in-law and that they would obviously know what we were entitled to ... I did not know that everybody had their own rights or they were entitled to their own rights. It is difficult because when you are caring for somebody all you are doing is just trying to think of their comfort and what they need. You do not bother about going out and looking for extra income. (Daughter-in-law (carer) of Case 19, male, Pakistani, aged 81, in English)

Some participants were living with family members busy with work responsibilities, who themselves had neither the knowledge nor time to assist with benefit claims.

Although a minority within this sample of participants, there were some older people who were living without younger family members, either as a couple or alone. As has
already been pointed out (Atkin 2004) it is wrong to assume that family members will always be within the same household or nearby to take on caring responsibilities for older relatives.

**Impact of increased financial resources**

The additional resources obtained had a significant impact on the individual recipients. However, for those living with and/or being cared for by family members, the additional resources had an overall impact on the family unit in a number of important ways. It eased the financial pressure on the family and it gave the older person greater financial and overall independence within the family.

*We weren’t getting a lot of money to get them everything as well because my husband’s wages, it wasn’t enough, so it’s like we have children of our own as well and everything, we weren’t coping ... she thinks it’s less of a burden on us and ... she can go out a lot more and she can go to the town and she can go shopping, where before we didn’t have enough to give her.* (Daughter-in-law (carer) of Case 4, Pakistani, female, aged 61, in English)

For those with severe disabilities, or multiple chronic health problems who were being cared for by family members, the extra resources were used to pay for needs that arose from the illness, for example, to fund special dietary needs or help with transport and general mobility.

For the older people themselves, there were a number of ways in which the additional resources had a positive impact on their lives. Money was spent on necessities, such as food, paying household bills, heating the home adequately, affording taxis/petrol money, maintaining social activities and social contacts. Additional funds were also used to pay for occasional expenses such as clothes, shoes, furniture, gifts for family
or friends, often difficult or impossible to afford when living on a fixed income with little or no savings.

Additional resources were therefore spent on a wide number of different items. However, the overall impact was to reduce feelings of stress, anxiety and depression, increase the independence of the participants and increase their social participation. Thus, the help and additional benefits had an impact far beyond the particular ways in which the money was spent,

_This is a real blessing because I have been independent all my life and I would like to be independent in the future also as long as I live, I don’t want to depend on anybody else._ (Case 2, Indian, male, aged 71, in English)

_We are less worried and less anxious; this extra money can help us run our day to day life you know._ (Husband of Case 8, Pakistani, female, aged 71, in English)

**Discussion**

The aim of this qualitative study was to determine routes to services, barriers to claiming benefits and ascertain the impact of additional financial and material benefits among ethnic minority elders. It therefore enables us to explore the relationship between ill health, resources and quality of life among older people. The study revealed that participants were not claiming their full welfare entitlement. This was largely due to lack of knowledge about the welfare system, despite regular contact with health care professionals for most of the participants and/or their carers. Routes to welfare rights services were ad hoc and haphazard. Once in contact with services and assisted to claim, there was no resistance to claiming entitlements. There were no examples of individuals submitting successful claims on their own behalf without
specialist help, indicating the need for assistance in doing so. This picture is broadly similar to that found among white older people living in the same locality (Moffatt et al., 2006a) with some important caveats. It appears that the process of application is more time-consuming and requires bi- or multi-lingual welfare rights advisors or access to a high quality interpreting service; accessing appropriate services is more difficult for ethnic minority older people. Additionally, as Salway et al. (2007:55) point out the extent to which the benefits assessment process has ‘cross-cultural validity’ is an important one and may mean that certain groups are ‘less likely to produce the ‘right’ answers and thus receive awards’.

Across the UK population as a whole, there are low levels of awareness about health-related benefits. Among those below state pension age, it is estimated that the take-up rate of Disability Living Allowance is just 40%-60% of those eligible (Wayne, 2003)) and Salway et al. (2007) confirm low levels of awareness (and uptake) of health related benefits among Pakistanis, Bangladeshis, Indians and Ghanaian’s living in the UK; and Moffatt and Higgs (2007) found that older white people in North East England had very little knowledge about health-related entitlements. This study confirms that picture for South Asian older people and their carers.

This was a relatively small-scale qualitative study and we therefore need to exercise caution about the findings. How transferable these findings might be to other similar populations of ethnic minority older people in the UK, depends on the quality and consistency of the data and the existence of other confirmatory research (Hammersley, 1992, Seale, 1999). The impact of the additional resources was positive for all participants and these findings are confirmed by other research (Craig et al., Adams et al., 2006, Moffatt et al., 2006a). Despite being asked, no participants...
remarked on negative features of the service, although such aspects may emerge from a larger sample. We found that most participants were unlikely to discuss benefits outside the family, suggesting that among these communities, ‘word of mouth’ would not be a likely route to increasing awareness. This differs somewhat from Salway et al. (2007) who found particularly high levels of reliance on personal social networks for information and ‘know how’ on benefits information among Pakistanis and white English people of working age but much less among Bangladeshis and Ghanaians. We are therefore more cautious about drawing definitive conclusions about social networks and welfare benefits than we are about the positive impact of additional resources and appropriate welfare rights services.

The ideal in undertaking research with black and minority ethnic communities is to ‘linguistically match’ researchers and participants (Craig et al., 2003, Nazroo and Grewal, 2004). It is therefore preferable to conduct interviews in the language of the respondent’s choice, as this enables full expression of complicated ideas and emotions (Bajekal et al., 2004, Atkin & Chattoo 2006, Papadopoulos 2006). Because of the resource constraints, it was not possible to recruit and train interviewers to undertake fieldwork, which would have been the most desirable option. Instead, we opted to work with trained and fully briefed interpreters. Undertaking fieldwork in this way makes it more difficult to establish a rapport with participants as the researcher is not able to communicate directly with the participant. It is possible that participants interviewed with an interpreter were more reluctant to divulge personal information, particularly given the private nature of some of the subject matter. Those who requested an interpreter were used to communicating with people outwith their immediate network in this way, so it was not an unusual situation for them. The
analysis did not reveal different outcomes between those who were interviewed with an interpreter and those who were not. Six participants chose family members to interpret for them. While rightly, not regarded as good practice, this was the preferred choice of those individuals. Furthermore, our own experience was that the standard and quality of the interpretation service varied considerably. We accept that there are inevitably limitations with the methods used, but we would argue nevertheless, that careful checks on the data and adherence to the procedures which ensure rigour and quality in qualitative research (Barbour, 2001, Barbour, 2000) enables us to conclude that the findings reflect the experiences of participants who successfully accessed the service. The data do not include those who did not, or tried but failed, to access the service and this group poses a considerable challenge to practitioners and researchers. Accepting these caveats, we would suggest that these findings are likely to apply to ethnic minority older people in urban areas with limited knowledge of English who are in poor health.

The financial implications and pressures of caring full-time for older, ill relatives are well documented (Blakemore, 2000, Jones and Peters, 1992, Merrell et al., 2006) and material hardship is a generally accepted aspect of caring (Young et al., 2006) although this is often worse among ethnic minority carers (Atkin and Rollings, 1996). Most of the carers in this study were caring for older people and young children. Their opportunities to access services were curtailed by lack of knowledge and their time-consuming caring obligations which created a vicious circle of limited resources, stress and isolation (Jones and Peters, 1992, Merrell et al., 2006). However, participants’ accounts clearly showed how easing financial pressures made a considerable difference to their ability to carry out their caring role, particularly in
being able to afford essential items required as a result of health problems. Additional resources therefore also had a positive effect on carers. Given that Bangladeshis and Pakistanis are twice as likely to provide care for relatives as white groups, their information and support needs should be a priority for professionals.

Our findings confirm high levels of need among a small sample of South Asian older people and their carers and the narratives illustrate how lack of adequate income contributes to increased levels of stress and social isolation. Nazroo (2006:70) comments that,

> Ethnic inequalities in health and economic position are at their greatest for older people. The extent of the economic and health disadvantage faced by some ethnic minority groups is extreme and the significance of this cannot be overestimated. However, it is important to recognize that older ethnic minority people do not uniquely face these circumstances and that they are not uniformly experienced in ethnic minority populations, but they are far more common.

Although not focusing on ethnic minority older people, findings from the Poverty and Social Exclusion Survey highlight the links between poverty, deprivation and social exclusion for older people (Patsios, 2006).

The data from this study provides further empirical support for the findings of Nazroo and Patsios, and demonstrate how relatively small amounts of additional resources can have a positive impact on the lives of older people and their carers (Craig et al., 2003, Moffatt et al., 2006a). This study confirms important insights that are relatively familiar from the literature, and include: low uptake of entitlements; the many ways in which additional finances can help; the stigma associated with benefit claiming for
some individuals; the importance of keeping personal financial/benefit information private; and, the barriers of language and communication. However, this study generates other insights that are of value for practice and policy. Firstly, that a promising configuration for welfare and benefit services are those which are proactive and specifically target older people and have a domiciliary element; secondly, that many individuals hold assumptions that unhelpfully shape expectations about entitlements; and thirdly, that the context of caring needs to be identified and more actively supported, something that is increasingly recognised, but rarely takes into account those from ethnic minorities (Evans 2008)

**Conclusions**

We have shown that a dedicated welfare rights service can successfully increase welfare benefit uptake among South Asian older people and their carers. Strategies to connect with carers are also required. Once in contact with appropriate welfare rights services, older people are appreciative of the services, financial hardship is reduced and capacity to cope with ill-health improved. Increasing benefit uptake among ethnic minority older people is an important way of tackling poverty, discrimination and improving quality of life in the later years. What this, and other work demonstrates, is that services need to be proactive in connecting with older people and their carers, informing them of their rights and assisting them to claim their entitlements whilst taking account of specific barriers faced by ethnic minority older people. The type of service we have evaluated in this paper is an example of good practice at a local level which we would recommend elsewhere. Without such practices in place, many of the most vulnerable older people are at risk of remaining in poverty and losing out on benefits which are theirs by right.
Footnotes

1. Pension Credit (formerly Minimum Income Guarantee) – means-tested benefit with two components: Guarantee Pension Credit available to those over 60; Savings Pension Credit, available to those over aged 65.

Non-means tested health related benefits obtained by participants:

Attendance Allowance (AA) - benefit paid to claimants over 65 who require frequent attention throughout the day or night (lower and higher rates depending on need)

Disability Living Allowance (DLA) – benefit paid to claimants under 65 who have either care or mobility needs. (Care component has 3 rates; mobility component has 3 rates)

Carers Allowance – paid to those who care for someone in receipt of AA or DLA

2. This was a result of the recent retirement of a liaison officer who spoke a number of Chinese languages and who provided welfare rights advice to the Chinese community. It illustrates the often precarious nature of services provided to ethnic minority communities, which frequently rely on one or two key members of staff.

3. The relatively high levels of means-tested Pension Credit received prior to this intervention resulted from a targeted Pension Credit campaign run by the local authority Welfare Rights Service
Acknowledgements
This study was made possible by the Neighbourhood Renewal Fund. We extend our thanks to all the participants and their families, Newcastle Interpreting Service, Shuhel Ahmed, Rosemary Bell, Shahanara Choudhury, Neal Heuchan, Fatima Khanom, Hameda Nisar and Imran Ul Haq at Newcastle City Council Welfare Rights Service, Meena Chopra, Tracy McIver and Sue Pearson at Age Concern Newcastle, Astrid McIntyre, Laura Stokoe and Martin White at the Institute of Health & Society, Newcastle University and two anonymous reviewers.
Table 1: Summary of socio-demographic information

<table>
<thead>
<tr>
<th>Sex</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>8</td>
</tr>
<tr>
<td>Women</td>
<td>14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakistani</td>
<td>17</td>
</tr>
<tr>
<td>Indian</td>
<td>1</td>
</tr>
<tr>
<td>Bengali</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>50-59</td>
<td>4</td>
</tr>
<tr>
<td>60-69</td>
<td>7</td>
</tr>
<tr>
<td>70-79</td>
<td>10</td>
</tr>
<tr>
<td>80+</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pension arrangements</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Private/occupational pension</td>
<td>3</td>
</tr>
<tr>
<td>Pension credit prior to study</td>
<td>12</td>
</tr>
<tr>
<td>Don't know</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Housing tenure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner occupier</td>
<td>7</td>
</tr>
<tr>
<td>Owned by relative</td>
<td>11</td>
</tr>
<tr>
<td>Council tenant</td>
<td>1</td>
</tr>
<tr>
<td>Private tenant</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Council tax band&lt;sup&gt;1&lt;/sup&gt; and full charge</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A (£904.27)</td>
<td>8</td>
</tr>
<tr>
<td>B (£1,054.99)</td>
<td>4</td>
</tr>
<tr>
<td>C (£1,205.69)</td>
<td>4</td>
</tr>
<tr>
<td>D (£1,356.40)</td>
<td>3</td>
</tr>
<tr>
<td>E (£1,657.83)</td>
<td>0</td>
</tr>
<tr>
<td>F (£1,959.25)</td>
<td>2</td>
</tr>
<tr>
<td>G (£2,260.67)</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living arrangements</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lives alone</td>
<td>3</td>
</tr>
<tr>
<td>With partner</td>
<td>5</td>
</tr>
<tr>
<td>Two generations</td>
<td>4</td>
</tr>
<tr>
<td>Three generations</td>
<td>9</td>
</tr>
<tr>
<td>Four generations</td>
<td>1</td>
</tr>
</tbody>
</table>

<sup>1</sup> Council Tax is the local authority domestic property tax and is calculated according to the estimated values of the property and the number of people living in it.
Table 2: Summary of participant characteristics and benefits received

<table>
<thead>
<tr>
<th>Case</th>
<th>Age</th>
<th>Competency in spoken English</th>
<th>Interpreter</th>
<th>Caring for relative</th>
<th>Being cared for</th>
<th>Health condition</th>
<th>Benefits received</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>70</td>
<td>basic</td>
<td>Y</td>
<td>Y</td>
<td>Multiple chronic health problems</td>
<td>Pension Credit</td>
<td>AA and Carers Allowance</td>
</tr>
<tr>
<td>2</td>
<td>71</td>
<td>fluent</td>
<td>N</td>
<td></td>
<td>Joint problems</td>
<td>State Pension</td>
<td>Higher rate AA</td>
</tr>
<tr>
<td>3</td>
<td>69</td>
<td>intermediate</td>
<td>Y</td>
<td>Y</td>
<td>Multiple chronic health problems</td>
<td>State Pension</td>
<td>Small private pension</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Higher rate AA and re-applying for AA for partner. Council tax reduction. Turned down for PC</td>
</tr>
<tr>
<td>4</td>
<td>61</td>
<td>basic</td>
<td>Daughter in law</td>
<td>Y</td>
<td>Joint problems</td>
<td>Nothing previously</td>
<td>PC and Carers Premium. AA and Pension Credit</td>
</tr>
<tr>
<td>5</td>
<td>67</td>
<td>basic</td>
<td>Husband</td>
<td>Y</td>
<td>Multiple chronic health problems</td>
<td>State Pension</td>
<td>DLA Middle Rate Care Component</td>
</tr>
<tr>
<td>6</td>
<td>79</td>
<td>basic</td>
<td>Nephew</td>
<td>Y</td>
<td>Multiple chronic health problems</td>
<td>Aids and adaptations Pension Credit (via WRO)</td>
<td>Higher rate AA and severe disability premium</td>
</tr>
<tr>
<td>7</td>
<td>66</td>
<td>intermediate</td>
<td>Y</td>
<td></td>
<td></td>
<td>State Pension</td>
<td>Couple had been living on £40 per week. Got Pension Credit of over £100/week. Lump sum backdated.</td>
</tr>
<tr>
<td>8</td>
<td>71</td>
<td>basic</td>
<td>Husband</td>
<td>Y</td>
<td>Multiple chronic health problems</td>
<td>Pension Credit</td>
<td>AA Carers Premium</td>
</tr>
<tr>
<td>9</td>
<td>73</td>
<td>intermediate</td>
<td>Y</td>
<td>Multiple chronic health problems</td>
<td>Pension Credit and State Pension</td>
<td>Turned down for AA</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>69</td>
<td>Intermediate</td>
<td>Daughter</td>
<td>Y</td>
<td>Multiple chronic health problems</td>
<td>Pension Credit</td>
<td>Turned down for AA</td>
</tr>
</tbody>
</table>
Table 2 (Continued): Summary of participant characteristics and benefits received

<table>
<thead>
<tr>
<th>Case</th>
<th>Age</th>
<th>Competency in spoken English</th>
<th>Interpreter</th>
<th>Caring for relative</th>
<th>Being cared for</th>
<th>Health condition</th>
<th>Benefits received</th>
<th>Benefits received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prior to intervention</td>
<td>As result of intervention</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>68</td>
<td>Intermediate</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td>Partner with multiple chronic health problems</td>
<td>Pension Credit</td>
<td>Higher rate mobility and higher rate care. Applying for Carer’s Allowance</td>
</tr>
<tr>
<td>12</td>
<td>70</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Cardio-vascular disease</td>
<td>Lower rate care and mobility DLA</td>
<td>Higher rate care and mobility, DLA. Carer’s allowance.</td>
</tr>
<tr>
<td>13</td>
<td>64</td>
<td>Almost fluent</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Multiple chronic health problems</td>
<td>Pension Credit, Widow’s Benefit (now ceased as of pensionable age), Higher rate care and mobility, DLA, Aids and Adaptations, Home care</td>
<td>Child Tax Credit overpayments being paid back. Pension applied for.</td>
</tr>
<tr>
<td>14</td>
<td>54</td>
<td>Intermediate</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td>Multiple chronic health problems</td>
<td>Income Support</td>
<td>Community Care Grant. Carer’s Allowance Disabled parking bay</td>
</tr>
<tr>
<td>15</td>
<td>75</td>
<td>Basic</td>
<td>Y</td>
<td></td>
<td></td>
<td>Multiple chronic health problems</td>
<td>State pension</td>
<td>AA turned down – gone to appeal.</td>
</tr>
<tr>
<td>16</td>
<td>50</td>
<td>Fluent</td>
<td>N</td>
<td>Y</td>
<td></td>
<td>Multiple chronic health problems</td>
<td>Middle rate DLA for son, lower rate for daughter (via NWRS)</td>
<td>Carer’s Allowance</td>
</tr>
<tr>
<td>17</td>
<td>77</td>
<td>Intermediate</td>
<td>Y</td>
<td></td>
<td>Y</td>
<td>Multiple chronic health problems</td>
<td>Pension credit (Daughter)</td>
<td>AA turned down (new application in progress)</td>
</tr>
</tbody>
</table>
### Table 2 (Continued): Summary of participant characteristics and benefits received

<table>
<thead>
<tr>
<th>Case</th>
<th>Age</th>
<th>Competency in spoken English</th>
<th>Interpreter</th>
<th>Caring for relative</th>
<th>Being cared for</th>
<th>Health condition</th>
<th>Benefits received Prior to intervention</th>
<th>Benefits received As result of intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>52</td>
<td>Basic</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td>Cardio-vascular disease</td>
<td>Blue Badge</td>
<td>Income Support, Incapacity Benefit, Child Tax Credit</td>
</tr>
<tr>
<td>19</td>
<td>81</td>
<td>Basic</td>
<td>Daughter in law</td>
<td>Y</td>
<td></td>
<td>Multiple chronic health problems</td>
<td>Pension Credit</td>
<td>AA, carer’s allowance</td>
</tr>
<tr>
<td>20</td>
<td>53</td>
<td>Intermediate</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td>Multiple chronic health problems</td>
<td>Income Support, Child Tax Credit, Council Tax Benefit, DLA LR Care for daughter</td>
<td>DLA Middle Rate Care and lower rate mobility, Carers Allowance</td>
</tr>
<tr>
<td>21</td>
<td>74</td>
<td>Fluent</td>
<td>N</td>
<td>Y</td>
<td></td>
<td>Multiple chronic health problems</td>
<td>State Pension, Savings Pension Credit</td>
<td>AA and carer’s allowance</td>
</tr>
<tr>
<td>22</td>
<td>69</td>
<td>None</td>
<td>Y</td>
<td></td>
<td></td>
<td>Joint problems</td>
<td>AA for husband (now deceased), Occupational Pension, Top Up Pension Credits (via WRO)</td>
<td>AA and Severe Disability Premium, Council Tax Benefit, Funeral Grant, Pension Credit</td>
</tr>
</tbody>
</table>
References


