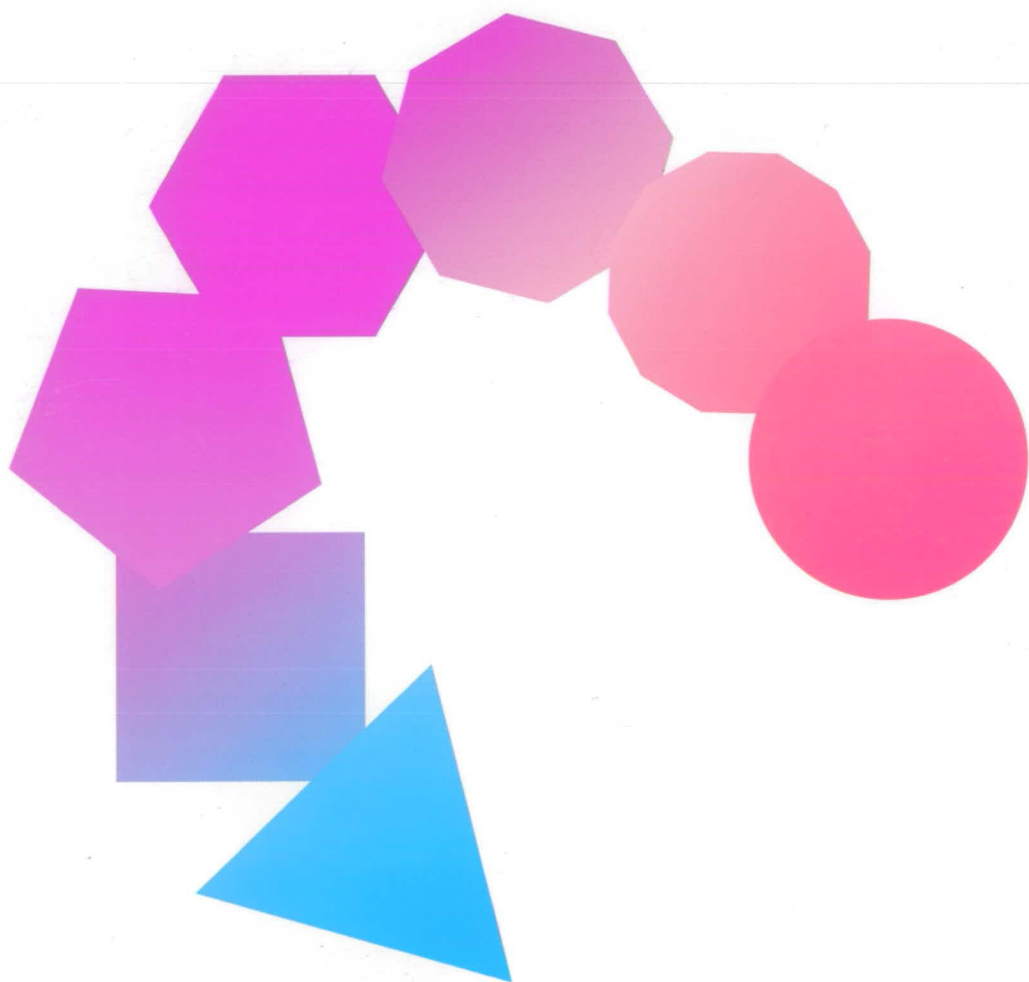


Health Systems & Aging in Selected Pacific Rim Countries: Cultural Diversity & Change

Edited by
Andrew V. Wister & Gloria M. Gutman



HEALTH SYSTEMS AND AGING
IN SELECTED PACIFIC RIM COUNTRIES:
CULTURAL DIVERSITY AND CHANGE

Edited by :
Andrew Wister, Ph.D. and
Gloria Gutman, Ph.D.

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The late Dr. Gene Yoon (1945-1997) received his Ph.D. at St. Louis University in 1978, and was a Professor in the Department of Psychology at Yonsei University, Seoul, Korea since 1982. He was the president of the Developmental Psychology Division of the Korean Psychological Association during 1992 to 1994, and the president of the Korean Gerontological Society from 1994 to 1996. The late Dr. Yoon also served as a consulting editor for the *Journal of Cross-Cultural Psychology*, and wrote numerous books including *Psychology of Adulthood and Aging*. His research interest was in life-span developmental psychology, motivation and emotion, and cross-cultural aspects of aging.

Chapter 1

Introduction

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BACKGROUND

Increases in population aging and concurrent changes in population health are having a profound effect on the organization and delivery of health care in many countries of the world. The growth in the relative and absolute numbers of elderly people coupled with changes in patterns of morbidity and mortality have drawn attention to issues of quality, efficiency, and efficacy of health care systems. Although many societies are engaged in health and health care transitions and reform, there exist considerable diversity in the current demographic, cultural, and economic contexts within which change is manifested. Dramatic shifts in values and beliefs within a particular country over time, and ethnic differences within a country at one specific time, represent important cultural elements having a significant impact on population health, health care organization, and health policy. However, these issues have yet to be adequately addressed in the literature, especially in a comparative context (Phillips, 1992).

This book addresses contemporary issues associated with the intersection of population aging, health care, and cultural diversity and change through an exploration of the experiences of selected countries from the Pacific Rim. Australia, China, Hong Kong, Japan, Korea, and

Canada, have been chosen because they represent countries that have distinct history, culture, and organization of health care. They are undergoing population aging and health transitions at different tempos. They also share a geographic connectedness because of their location on the Pacific Rim, that has facilitated trade and international migration among the countries.

One of the major transformations in patterns of population health is known as the "epidemiological transition," which refers to the long-term change in leading causes of death, from infectious and acute causes to chronic and degenerative causes (WHO, 1989). While the epidemiological transition has taken place in most industrialized nations, it is a more recent phenomenon in many developing countries. The population health experiences of mainland China and the Republic of Korea, for example, typify the latter (U.S. Bureau of the Census, 1996). Countries such as Japan and Hong Kong are experiencing rapid population aging and are therefore moving through the epidemiological transition at a faster pace than did Western countries. Table 1A shows that Australia and Canada have large proportions of persons aged 60 and over (16% and 16.5%, respectively), a corresponding high median age (34 and 35, respectively), and high percentages of their GDP supporting health care (9% and 10%, respectively). In contrast, mainland China has only 9.5% of its population aged 60 and over, a median age of 28, and spends only about 4% of its GDP on health care. Japan is undergoing rapid transitions with 20.9% of its population aged 60 and over, a median age of 40, and a GDP expenditure on health of 7%. Similarly, Table 1B shows that Hong Kong has a higher proportion of persons aged 65 and over than North or South Korea (9%, 4%, and 5%, respectively), but also has a higher life expectancy of its population as well as per capita GNP. The relationship between changes in the timing and causes of morbidity and mortality have considerable implications for population health and health care systems. A rise in the absolute number, as well as higher rates of older persons in states of disability and poor health, has been connected to increases in population aging and higher life expectancy (Verbrugge, 1984). Linked to this association is the finding that, even though women live longer than men, the proportion of disability-free remaining years at age 65 is lower for women than men (WHO, 1985). In addition, although controversy continues to surround the degree and dynamics of the rectangularization of the survival curve (Manton & Tolley, 1991), there appears to be agreement that emphasis needs to be placed on delaying the onset of chronic diseases and disability, in addition to retarding or

reversing the disease and disability process (Nusselder & Mackenbach, 1996).

TABLE 1A
Demographic Characteristics of Selected Pacific Rim Countries*, 1996

COUNTRY	POP. AGED 60+ (000'S)	% 60+	% 75+	MEDIAN AGE (years)	LIFE EXPECTANCY		% OF GDP SPENT ON HEALTH (1991)	% INCREASE IN 60+ POP. (1996 to 2025)
					Male	Female		
Australia	2,931	16.0	5.1	34	76	83	9	102
Canada	4,756	16.5	5.3	35	76	83	10	111
China	290,640	9.5	1.9	28	68	71	4	152
Japan	26,248	20.9	5.8	40	77	83	7	51

Source: US Department of Commerce, Economics and Statistics Administration, Bureau of the Census (1996)

* Data were not available for Hong Kong and Korea.

These changes in population health have resulted in restructuring of health care services, facilities, and health promotion efforts. In most Western countries, we have witnessed a movement from a medical model of health care to an integrative model that incorporates curative elements of modern medicine with preventive and health promotion approaches based on a holistic perspective of health, illness, and wellness. In contrast, many Asian societies (e.g., Hong Kong) have historically combined allopathic and naturopathic medicine, even though the formal system has tended to be responsive to the morbidity and mortality patterns associated with earlier stages of the epidemiological transition. It is interesting that, regardless of these differences, formal health care organization in all societies is undergoing scrutiny and reformulation in the face of population aging and its effect on population health. Thus, how such transitions occur against the distinct cultural and economic backdrops of Pacific Rim countries as we move into the next century is of considerable interest to researchers (Phillips, 1992), and comprises the principal theme of this edited monograph.

TABLE 1B
Demographic Characteristics of Hong Kong and Korea, 1993

COUNTRY	% OF POPULATION 65+	LIFE EXPECTANCY		GNP, 1991 (US\$)
		MALE	FEMALE	
Hong Kong	9	75	80	13,200
North Korea	4	66	72	—
South Korea	5	67	75	6,340

Source: Population Reference Bureau, 1993.

Origin and Aim of the Book

The majority of the chapters that comprise this book originate from papers presented at a workshop entitled, *Pacific Rim Health Policy and Practice* and those provided at a symposium titled, *Pacific Rim Research on Ethnic Elders* held October 26th and 27th, 1995 in conjunction with the 24th Annual Scientific and Educational Meetings of the Canadian Association on Gerontology. The workshop and symposium were organized by the editors of this book in collaboration with Dr. Victor Ujimoto, Sociology Department, University of Guelph, Canada. These special conference events were co-sponsored by the British Columbia Consortium for Health Promotion Research and the Gerontology Research Centre, Simon Fraser University, Canada.

The objectives of the workshop and symposium upon which this book is based were to: 1) bring together renowned researchers from Australia, China, Hong Kong, Japan, Korea, and Canada for the purpose of addressing contemporary health and aging issues from the perspective of diverse cultures and health care systems; and 2) foster comparative research and knowledge dissemination on health services and health policy as they relate to aging populations. Common themes underlying this volume are the development of services that are sensitive to diverse cultures; transition from primarily curative to combinations of allopathic, holistic, and health promotion models of health; and the interrelationship between formal and informal, especially family-based, care of elderly people.

Content of the Book

In Chapter 2, Kendig and Russell profile older Australians from different ethnic backgrounds and present health and aged care programs targeting these individuals, given their unique needs and resources. The current ethnic diversity of Australia is understood against historical patterns of migration and major events. It is estimated that by the beginning of the second millennium, one-fifth of older Australians will have been born outside of English speaking countries. Although health care services have begun to address the complexity of issues underlying significant ethnic diversity within Australia, the authors contend that there is a need to extend and fine-tune culturally relevant services. The means by which this is accomplished is dependent on additional health care resources devoted to ethno-specific health care and by cultivating stronger partnerships between ethnic communities and governments. For example, the Ethnic Aged Care Advisory Committee has initiated consultation processes with ethnic communities for the purpose of identifying needs and articulating best practices for health care strategies responding to the needs of ethnic groups. However, there are concerns about the degree to which Australia can make the necessary adjustments to its health system in order to respond to its multicultural aged population given the current limitations in government funding.

Chapter 3, authored by Wataru Koyano, details the rapid pace of population aging and the changing health status of Japanese seniors for the purpose of understanding the forces underlying the new direction of health services in Japan. In the Japanese studies reviewed, Koyano notes that level of functional capacity remains high among Japanese seniors even into very old age, in part because the very disabled tend to die earlier in life. Functional ability is also associated with larger social networks, active time use and life satisfaction, thus emphasizing the importance of preventive efforts to maintain functional ability at all ages of the life cycle. Turning to service models, Koyano shows that health services, medical services and social services are brought to bear on different stages and for different types of health problems (see Figure 11). For example, under the infectious disease model, medical services target the acute and, in part, the recovery stages; while under the chronic disease model, responses to the chronic stage mainly involve health and social services. The integration of health, medical and welfare services is viewed as an efficient way to deal with the health of Japanese seniors.

One problem identified is the overemphasis on services targeting

disabled persons and the neglect of preventive services for healthy persons. This gap in the current health care system is addressed by a series of recommendations dealing with issues of health education and promotion, illness prevention, and maintenance of healthy aging. Koyano strongly urges this shift in the current health service organization of Japan in order to deal with transitions in population health.

In Chapter 4, Wataru Koyano focuses on the cultural dynamics of intergenerational family relations rooted in changes in the *ie* ideology, and examines the effect of these transitions on Japanese elderly. Specifically, the gradual erosion of filial piety – social and family norms, attitudes and beliefs supporting the patrilineal, patrilocal stem family – is explained from a socio-historical perspective. The author elaborates the impact of these ideological shifts on coresidence and intergenerational solidarity. It is argued that a rise in the rate of elderly Japanese living alone has reduced the accessibility to instrumental forms of support, although affective forms of support remain strong. The implications of these patterns for health policy are also outlined.

Written by Iris Chi, Chapter 5 presents a portrait of population aging and health care policy and organization in mainland China and Hong Kong. Given the return of Hong Kong to mainland China in June 1997, it is appropriate for this chapter to juxtapose these two populations. Common to most countries, issues of equity, access, financing, and quality of care have dominated the health care arena. In addition, the integration of Western medicine and traditional Chinese medicine represents a distinct aspect of their health systems. However, a number of unique characteristics of health care organization are described for China and Hong Kong. For example, geriatric medicine has not developed as quickly in China as in Hong Kong. Furthermore, the economic restructuring within China may have far-reaching consequences for an elderly population that will be increasing rapidly over the next several decades. Conversely, the higher rate of population aging experienced in Hong Kong has led to much higher utilization rates of health care services than in China, and even compared to many other industrialized countries. Yet, the cost of health services is considerably lower in Hong Kong than in Canada, for example. Some of the major decisions facing Hong Kong policy makers in the near future are those related to the division of responsibility of health care delivery between the public and private sectors and their implications for cost-effectiveness, efficiency and quality of care for an aging population.

Chapter 6, authored by the late Gene Yoon, details the health status and health care of the elderly in the Republic of Korea. It is apparent from the data presented that the epidemiological transition is well under way in Korea. Cancer, cerebrovascular disease, heart disease, and hypertension are the major causes of death for Korean elderly, and the incidence of chronic illness has been on the rise between 1988 and 1993. In light of these changes in the health status of older Koreans, coupled with population aging, it is estimated that medical costs for the elderly will also inflate; in 1993 the proportion of medical costs for elderly persons was 10.3%, but this is expected to rise to 17.7% by the year 2000. One of the major problems is the lack of hospital beds for elderly Koreans. Another set of problems pertain to the rapid social change and industrialization experienced by older Koreans. The effect of these transitions on traditional family systems are beginning to have a profound effect on intergenerational relationships and patterns of support. The author states that, although the patriarchal-structured *Hoo-Joo* family inheritance system still exists in Korea, whereby family wealth and obligation for care of elderly resides with the eldest son and his wife, tensions often exist between Korean elderly and daughter-in-laws. These problems may become more frequent as Korean elderly live longer, but often in states of disability. The experiences of other countries suggests that preferences for coresidence among the elderly may change in tandem with developments in formal services targeting the elderly.

In Chapter 7, Andrew Wister and Caroline Moore examine health care issues specific to First Nations elders in Canada. They begin with a profile of the demographic and health characteristics of elders; cover cultural differences in definitions of what constitutes an elder; and provide a brief historical backdrop to contemporary issues. Indicators of health status clearly show that while improvements have been experienced among First Nations elders, there exists a significant gap between aboriginal and non-aboriginal Canadians. In the face of increasing population aging and a rise in life expectancy, the health experiences of First Nations elders have also been changing from mainly infectious diseases to chronic disease types. These transitions point to the need to rethink the way in which health policy has been shaped and implemented within First Nations communities. Using the experience of British Columbia, the authors address a selection of problems and issues underlying provision of care to First Nations elders, based on regional consultations with many urban, rural and remote communities. An integrated model is proposed, suggesting the support of a continuum of

services that combine available government sponsored services with culturally relevant ones developing from within communities. A number of innovative approaches to First Nations elder care are presented as examples of the proposed model.

Chapter 8, written by Gloria Gutman, Andrew Wister, Charmaine Spencer and Naomi Staddon, addresses the health and social service needs of older refugees entering Canada. The chapter begins with a demographic profile of refugees in which age, refugee type, region of origin, sex ratio, and education level are detailed. This section is followed by discussion of the specific circumstances and characteristics of older refugees that contribute to their health and social service needs. Selected areas of concern include: relocation, language, work, family support and living arrangements, transportation, and torture and post-traumatic stress disorder. Review of these areas show that older refugees living in Canada are distinct from the general older population in several important ways. A number of recommendations are discussed for the purpose of responding to problems associated with health and well-being of older refugees living in Canada.

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Chapter 2

Aging, Ethnicity and Health Policy in Australia

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INTRODUCTION

Australia has many similarities with other English-speaking countries on the Pacific Rim. As with Canada and the United States of America, Australia's mainstream society was founded by European colonialists who overran indigenous populations. Modern history has seen massive migration of Europeans to these new world nations, and each of them are moving uneasily from dominant British cultures to more multi-cultural societies.

The English-speaking countries of the Pacific Rim also have stark contrasts. French ships bypassed the harsh and strange Antipodes. A century after American pioneers began traditions of self-reliance and government distrust, Australian settlers arrived with near absolute dependence on government stores and forged myths of matesmanship and classlessness. Cheap labor was supplied originally by convicts rather than slaves. Contrary to its bucolic image, Australia is actually much more urbanized than North America and relatively few people live in remote hinterlands. While Canada and the USA also have experienced substantial Asian migration, only Australia is geographically in Asia.

Australia is facing difficult social and policy questions similar to those

of other developed countries. The broad political terrain is delineated by tensions between continuing expectations for the welfare state and resurgent electorates unwilling to increase taxes. Concerns about population aging have arisen at the same time as stagnation of real incomes. This political and economic context has generated substantial challenges to the foundations of universal health care and recent advances in comprehensive aged care services. Interlaced with these concerns is some questioning of hitherto bipartisan support for multiculturalism and international migration. In 1996 a conservative Coalition government was elected to national government, replacing the long-established Labor party.

This paper reviews for an international audience the circumstances of older Australians from different ethnic backgrounds and the response from health and aged care programs. Australian and Canadian experiences of aging and immigration have many parallels (McCallum et al., 1994). The next two sections explain the waves of migration which have formed contemporary Australia and consider the needs and resources of older people of varied cultural backgrounds. The discussion then turns to the Australian health and care systems and ways in which policymakers have attempted to provide for cultural diversity. The conclusion presents questions and directions for the future.

AUSTRALIA: A LAND OF IMMIGRANTS

Australia is among the most ancient of lands but it was the last continent to be populated. European migration to Australia did not begin until the late 18th Century, several centuries after European settlement of the Americas. Rapid migration occurred over the post war period. Among Australia's older people of non English-speaking background, most migrated to Australia while young, although a minority migrated late in life, usually either with adult children or to join them. The general history below is drawn primarily from Fraser (1983).

The First People

Aborigines walked and canoed their way to Australia more than 40,000 years ago when the first ice age dropped sea levels and formed shallow straits and land bridges with Asia. Unlike the warrior nations of some indigenous Americans, Australian Aboriginals generally formed small, nomadic groups. Their rich spiritual life and identity has been centred on ties to their ancestral lands. The Aboriginal population was

estimated at 750,000 by the time of European invasion in 1788.

European settlement has brought massive destruction for the Aboriginal people. Their numbers were rapidly reduced by epidemics, massacres, and displacement from ancestral lands. Governments located many in missions and settlements in order to 'civilise' them. Aboriginal numbers fell to only 60,000 in the 1920s, increased slowly until the 1950s, and has increased more quickly since the 1960s. At present nearly 200,000 people, just over one percent of the population, is of Aboriginal descent.

The 1960s witnessed the emergence of Aboriginal action for political and land rights. Not until the 1972 Whitlam Labor government, however, was responsibility for Aboriginal policy assumed by the national government and coherent policies put in place. But legacies of racial conflict, land dispossession and cultural destruction have left huge social, cultural and economic divisions between black and white Australia. In the 1990s Aboriginal people still have the lowest standard of living, the lowest life expectancy, the highest rate of imprisonment and the highest rate of unemployment of any group (Reid & Trompf, 1991).

Aboriginal people live on average 20 years less than other Australians and only a few percent of them are aged 60 and over. While aged care programs devote some attention to them, their needs are addressed primarily by specialized policies and services for Aboriginal people of all ages. Indigenous people are not considered further in this paper because their situations have few commonalities with those of migrants from non-English speaking backgrounds.

The Colonial Era

The first European arrivals were soldiers and convicts from overcrowded British jails, sent to Australia after the War of Independence stopped their passage to America. Nearly 160,000 convicts were transported to Australia from 1788 to 1868. Until the 1820s, other migrants consisted mainly of property owners and their families due to the distance and expense of the passage. However, labour shortages during the 1830s led to the introduction of assisted migration to encourage free labourers and 'artisans' from England, Wales, Ireland and Scotland. By 1840, the population of the fledgling colonies had risen to more than 400,000.

Gold rushes in California, Australia, and Canada were major factors in European settlement of Pacific Rim countries. The Australia gold rush during the 1850s depleted the supply of labour in the cities and led to

further assisted migration. Non-assisted migration from many different countries also flourished. The Chinese population increased sharply, leading to overt racism on the gold fields and then restrictions on their entry to the colonies. By 1860, the gold rush had swelled the population to over a million. Thirty percent were born in Australia, 60% in Britain and 10% elsewhere, including Italy, Hungary and Germany.

Federation and the War Years

In 1901, the six colonies federated to form the Commonwealth of Australia. The new Federal Parliament passed the Restricted Immigration Act, which had a language test that effectively excluded non-Europeans from permanent settlement. British subjects were granted assisted passage and automatic citizenship whilst other Europeans had to fulfill a qualifying period and take an oath of allegiance to the British Crown. The lead up to World War I and its aftermath saw massive migration, mainly from Britain but also from northern Europe, including Germans, Danes and Scandinavians. Italian migration increased dramatically during the inter-war period as a result of restrictive immigration policies in the USA. Australia also accepted European refugees in the late 1930s including a number of Polish Jews.

Post War European Migrants

The second world war brought new forces to migration policy. In the context of wartime attacks on northern Australia and resurgent nationalism in Asia, Australians felt highly vulnerable to being over-run by large Asian populations. The 'Populate or Perish' slogan, together with continuing labour shortages, led to more assisted immigration schemes which for the first time included non-British migrants. Australia also agreed to take large numbers of refugees and persons displaced by Soviet advances into the Baltic region and middle and eastern Europe. However, British migrants still predominated until the late 1950s when the restrictive language test was abolished.

During the 1950s and 1960s, assisted migration was extended to many European countries where standards of living had been severely set back by the slow post war recovery. From 1959 to 1973, nearly two million people migrated to Australia with Malta, Holland, Italy, Greece, Turkey and Yugoslavia all contributing substantial numbers. By the 1980s, for example, almost 250,000 Greeks had arrived in Australia. Although their numbers are now lower due to reverse migration on retirement,

Melbourne still has the largest Greek-speaking population of any city outside Greece (Bureau of Immigration and Population Research, 1994a).

The 1970s Onward

The election of the Whitlam Labor government in 1972 brought further change to immigration policy. The last vestiges of the White Australia era were removed in 1974 when immigration laws were applied equally without any racial discrimination. Increasing unemployment gave rise to continuing debate over the effects of migrants on the availability of jobs for those already in Australia. This led to immigration falling to a post war low in 1973.

European migrants have continued and there also have been new streams of refugees arriving from Vietnam, Laos and Kampuchea (Bennoun, 1984). On a per capita basis, Australia accepted more Indo-Chinese refugees than did any other country. During the 1980s there were arrivals from war-torn areas of the former Yugoslavia as well as large numbers from New Zealand. Over the 1990s there have been increasing numbers from Hong Kong and China, with many of the latter having arrived originally as students.

Over the last decade the mix of migrants has been roughly balanced between the family reunion, economic migration, and humanitarian (refugee) categories. Net migration has fluctuated widely since the 1970s, peaking at 173,000 in 1988 and falling to 34,000 in 1993. Since 1973, net migration has consistently contributed somewhat less to population growth than has natural increases through births over deaths (Shu, Khoo, Struik & McKenzie, 1995). Rates of immigration have been low over recent years partly because of political sensitivities concerning high levels of unemployment.

AUSTRALIA'S ETHNIC AGED

For most purposes in Australia, the ethnic aged are defined as older people born in a non-English speaking country (NESB). The inadequacies of the term, however, are well recognized (Rowland, 1991a; McCallum, 1990; Human Rights and Equal Opportunity Commission, 1994). Birthplace groupings conceal major differences in religion, language, customs and history. Further, some migrants from English speaking countries would argue that they also have different customs and history than do the Australian born population.

While this overview paper deals mainly with birthplace groupings, it is important to recognize that the 'ethnic aged' are not a homogenous group. There is considerable danger in applying ethnic stereotypes which obscure the character of cultural groups and misinterpret the needs of individuals.

Demographics Characteristics

Early in the post war years Australia had a young and rapidly growing population, partly because of immigration and the baby boom, but more recently the country has experienced modest population aging (Rowland, 1991a). The proportion of the population aged 65 years and over rose from 8% in the 1950s to 10% at present, and is expected to rise steadily to 15% in 2020. The numbers are increasing especially quickly for older women, widows, disabled individuals and older people living alone. The numbers of people aged 75 years and over is in the process of doubling over the 1980s and 1990s. Older migrants from non-English speaking countries will increase from 11% of the older population in 1981 to 22% in 2001.

Currently 23% of Australians were born overseas, 14% in a non-English speaking country and 9% in an English-speaking country. The largest overseas birthplace groups in 1991 were UK and Ireland (6.9%), New Zealand (1.6%), Italy (1.5%), former Yugoslavia (1.0%), Greece (.8%), Vietnam (.8%), Germany (.7%), the Netherlands (.6%), China (.5%), and the Philippines (.5%). Overall, approximately 40% of Australians are either post-war migrants or are children of these migrants.

There is a sense of urgency in Australia concerning the post war migrants now reaching old age. Brief waves of migrants from specific European countries, 30 to 50 years ago, are now rapidly peaking in old age. For example, demand for aged care among Polish-born people will peak after the turn of the century when most will enter the 75 years and over age group. Table 1 demonstrates the increase in the aged population of certain key birthplace groups between 1986-1991 compared to the equivalent group born in Australia. This situation, described by Rowland (1991a) as 'demographic shock waves', presents great challenges of rapid adaptation for Australia's aged care system.

At present, however, older people in most NESB groups are relatively younger than the Australian-born group. Overall, people from NESB backgrounds amount to 20% of the population aged in their sixties but only 12% of those in their eighties (ABS Catalogue No. 3412.0). The

proportion of people 65+ or over 80 varies greatly between birthplace groups.

TABLE 1
Increase in Proportion of 65+ Age Group for
Selected Birthplace Groups in Australia, 1986-1991

BIRTHPLACE	1986 no. 65+	1986 % 65+	1991 no. 65+	1991 %65+	% CHANGE 1986-1991
Australia	1,188,379	9.8	1,323,113	10.4	11.3
Italy	36,952	14.2	53,304	21.4	47.0
Poland	17,416	26.0	25,501	37.2	46.4
Netherlands	13,686	14.5	18,990	20.1	38.8
Greece	10,716	7.8	15,669	11.5	46.2

Source: Bureau of Immigration and Population Research, Community Profiles (1993, 1994a,b, 1995)

LANGUAGE

Difficulty with English is a major problem for ethnic elderly people. It can greatly limit access to recreational pursuits, transport, health services and heighten risks of isolation and loneliness (Kratiuk et al., 1992; Rowland, 1991a). Westbrooke and Legge (1993) suggest that good English language skills allow ethnic older people much greater freedom to control their own lives.

Proficiency in English varies enormously between NESB groups (Table 2). On the one hand, the Dutch and Indian communities have high proficiency and many speak English at home. On the other hand, over 60% of Vietnamese, Chinese, Greek and Italian born women have a poor proficiency in English, even after many decades in Australia. The extreme case is that of Vietnamese elderly women, 94% of whom speak English not well or not at all. Whilst this suggests a limited integration with the mainstream culture, it may also result from some reversion to native languages late in life (Ethnic Aged Working Party, 1987).

TABLE 2
Proficiency in English and Language Spoken at Home, 65+ Age Group, Australia

BIRTHPLACE	SPEAKS ENGLISH NOT WELL OR NOT AT ALL		LANGUAGES SPOKEN AT HOME	
	MALES %	FEMALES %	ENGLISH ONLY %	LANGUAGES OTHER THAN ENGLISH (EXCLUDING OTHER CAT.) %
Italy	43	61	6	Italian 94
Poland	15	24	20	Polish 62; German 7; Yiddish 7
Greece	52	72	3	Greek 90; Macedonian 5
Netherlands	3	6	39	Dutch 59; German 3
Germany	6	9	25	German 71; Polish 2
China	68	79	8	Cantonese 55; Mandarin 8.1; Russian 10
Malta	21	31	17	Maltese 80; Italian 2
India	3	6	87	Hindi 3; Tamil 1
Vietnam	86	94	1	Vietnamese 77; Chinese languages 21

Source: Bureau of Immigration and Population Research; Community profiles, 1991 Census.

Family support

Older people from NESB countries have a wide variety of family and household circumstances. A major effect of migration per se is that few older people have the support of locally available siblings or life-long friendships. Their extended families are focused very much down the generations through their children.

Rates of co-residency with children are relatively low for migrant groups which arrived many years ago for example, Italians (6.7%), Greeks (8.3%) and Polish (6.4%). These rates are close to those for the Australian-born (4%). Living with adult children is much more common among recently arrived Cambodians (23%), Vietnamese (23%) and Malaysians (17%) (ABS Queensland, 1994). Cultural factors are obviously important in these patterns but another major factor is economic hardship among recently arrived groups.

Older people with an NESB background are much less likely than other older Australians to live in residential care and they make relatively little use of community services (Rowland, 1991a). It is misleading, however, to assume that NESB families uniformly 'look after their own' as a matter of choice and cultural tradition (Kratiuk et al. 1992). As with the Australian born, most ethnic older people value independence from family and are determined to stay self reliant at home (Rowland, 1991;

Legge and Westbrooke, 1993; Kurowski, 1994). Further, older parents born in other countries and their Australian-reared children do not always share the same views on family responsibilities. Family care through co-residency can involve family tensions, restricted employment opportunities, and other problems which are as great for NESB groups as for the Australian born (Kendig, 1986).

A report on older Vietnamese found that major challenges to cultural meanings can arise within families as well as with respect to the Australian mainstream:

Younger Vietnamese in Australia do not appear to hold obligations to Vietnamese family to be unconditional, but rather subject to strategic and situational concerns. Older Vietnamese however came to Australia under the impression that the priority of kin relations would remain the same as it was while they were living in Vietnam. (Thomas & Balnaves, 1993, p. x)

There is a general tendency for immigrant groups to adapt their cultural beliefs and patterns over time in ways which become more similar to those of the mainstream. As with other English-speaking countries, Australian norms of family support are best characterized by strong emotional ties and financial independence between generations, which tend to live in separate households. Nonetheless, most frail older people live in the community with support only from family. High personal and social costs arise when traditional norms of family support confront economic realities, for example, two-thirds of women in middle-age are now in the workforce.

Cultural and Social Isolation

Involvement in the social mainstream is limited for many older NESB migrants. Most importantly, the values and ways of life in Australia differ substantially from those of their countries of origin. Other major barriers can include small family networks, economic and health restrictions, difficulty in getting around (inability to drive a car) and limited cultural expectations for community involvement by older people, especially women (Rowland, 1991). Geographic dispersion of small ethnic communities can accentuate loneliness, and isolation in residential care is a considerable problem for NESB older people (Ferguson and Browne, 1991; Kurowski, 1994).

As a result of these barriers, older NESB migrants have high rates of social isolation and dissatisfaction with their social relationships. People who have migrated to Australia late in life to live with adult children report the most difficulties on a variety of measures of social life and personal well being (Kendig, 1986; Rowland, 1991). Older NESB women born in Europe are four times more likely to report feelings of unhappiness than older Australian born women (Mathers, 1994).

Australia has an extensive Special Broadcasting Service which presents television and radio programs in a wide variety of languages. However, the mass media is not well equipped to meet the needs of small ethnic groups, and watching television of course does little in the way of providing meaningful activity.

Health Status

Overall, migrants have better health status than do the Australian born, due to both the self-selectivity of migrants and health standards required to gain entry. Mathers (1994) reports that these same trends apply equally to the 65 years and over age group. As compared to the Australian born, older men and women born overseas have lower death rates, although the differential reduces with length of residence in Australia. Older NESB migrants also report less recent illness than do the Australian born and people born in English speaking countries. Some illnesses, however, are reported more for the older NESB, notably diabetes for older women from Europe and heart disease for older men born in Asia.

Older NESB people generally have low rates of disability and handicap (Mathers, 1994). But the rates vary substantially between birthplace groups. For example, rates of disability are elevated among Greek and Yugoslavian born men. Greek, Italian and other European women have quite high rates of disability and handicap (Australian Institute of Health and Welfare, 1994). These summary figures are difficult to interpret because they do not adjust for ethnic differences in age ranges and in the cultural interpretations which affect these self-report data.

In terms of health habits, the older people from Europe and older Asian women are relatively more likely to be overweight and inactive. European men and Asian born men and women have higher rates of smoking than their Australian born counterparts (Mathers, 1994).

Contrary to the more objective measures of health status above, self-reported health is an area in which the older Australian born do better than those born overseas (Mathers, 1994). The Greek, Italian and Polish born have the lowest self assessed health status, possibly reflecting the high proportions of frail aged in these communities.

The experience of migration and acculturation can involve great emotional distress. The risks of mental illness include pre-migration difficulties, factors associated with migration itself and post-migration circumstances such as low socioeconomic status (Minas, 1990). People born in non-English speaking countries are more likely to report a mental disorder compared to Australian born and those born in English speaking countries, with Italian and Greek born having the highest rate (ABS Queensland, 1994).

It is difficult to establish whether or not there are any racial or cultural differences in the prevalence of dementia, largely because of measurement difficulties across cultures (Kратиuk et al., 1992). Generally NESB older people do not seek early help with dementia. Two reasons are suggested: firstly, NESB people are often uninformed of symptoms and secondly, because communication difficulties with health care professionals make it difficult to recognize the early signs of dementia (Ferguson & Browne, 1991).

Economic Resources

NESB older people generally have fewer economic resources than do the Australian born. Overall, the average weekly earnings of an NESB family is lower than for an Australian born family, but this varies substantially by country of birth. Approximately three-fourths of the ethnic aged, as compared to half of the Australian born, rely on the means tested aged pension. The proportions which have accumulated superannuation benefits is correspondingly lower. Home ownership rates, however, are higher for people born in NESB countries than in Australia (ABS Queensland, 1994).

Economic resources of individuals and families tend to be higher for groups which migrated relatively earlier in the post war period. Receipt of the pension and home ownership rates are highest for older people from Europe, especially Greece and Italy. Families which have newly arrived have high rates of poverty.

People who migrate late in life must prove that they have adequate

resources to support themselves or else have an Australian guarantor or assurance of economic support from their children (Ethnic Aged Working Party, 1987). Their exclusion from the old age pension, for ten years after arrival, can cause great stress within families. Special pensions are paid only if family support breaks down. Thomas and Balnaves (1993), in their report on older Vietnamese migrants, recommend that the Family Reunion Program include a small special allowance, payable to parents, to allow them to live in dignity with some economic resources of their own.

Multiple Jeopardy

Vulnerability among members of older ethnic groups is to a large extent concentrated among people who face multiple difficulties (Rowland, 1991a,b). Among those aged 75 years and over, there are close associations between lack of close relatives, private renting, low levels of education, and poor knowledge of the English language. Again, the difficulties are most pronounced among recent migrants.

AUSTRALIAN GOVERNMENT AND THE HEALTH CARE SYSTEM

The institutional framework for Australian government was established when the separate colonial governments formed the federal Commonwealth of Australia in 1901. The Constitution, with later amendments, has basically limited Commonwealth direct responsibilities in welfare areas to income support, direct payments for disadvantaged people, and grants to the States (Sax, 1993). State governments have responsibility for most service provision and regulation, but they rely primarily on Commonwealth income tax revenues. Overall, Australian federalism has many similarities with the Canadian system.

Funding income support, and for the most part health care, is principally the responsibility of the national government. Approximately two-thirds of older Australians now receive a modest, means-tested pension funded out of current revenue. Public housing serves only a minority of older people who do not own homes.

Mainstream Health Care

The foundation of Australian health care for people of all ages and incomes is the Commonwealth Medicare system of universal health insurance. Medicare is financed by a levy on income tax as well as

general revenue. It meets virtually all of the costs of non-hospital services provided by (mainly private) medical practitioners (Australian Institute of Health and Welfare, 1996). Approximately one-third of Australians also have private health insurance which pays benefits for services in private and public hospitals and additional services.

The Pharmaceutical Benefits Scheme, also funded by the Commonwealth, subsidizes a wide range of approved drugs. Holders of Pensioner Health Benefits cards pay especially low contributions for each approved item. After a given number of items pensioners receive all prescribed pharmaceuticals at no cost. Governments have been attempting to limit the escalating costs of pharmaceutical subsidies by increasing co-payment requirements.

Public hospitals, community health centres, and various other services are provided by State governments. They are funded jointly by the Commonwealth and State Governments under the Medicare Agreement. A number of State governments are attempting to limit expenditure on public hospitals and increase efficiency through the introduction of case mix funding. One of the concerns for these arrangements is that they increase incentives for hospitals to discharge older people before they have fully recovered.

Use of health services rises rapidly with advancing age and varies among birthplace groups. Average number of visits to the doctor and use of hospitals is several times higher for those over 75 years of age as compared to those in their twenties (Australian Institute of Health and Welfare, 1996). Age standardized figures for doctor consultations, for people 15 to 74 years, also vary greatly by birthplace and gender. For example, they are high for men from Malta and Vietnam but low for women from Asia (National Health Strategy, 1993). In the case of hospitals, virtually all of the overseas born groups have much lower utilization rates than do the Australian born.

The mainstream health system is not always geared to meet the needs of older people and NESB migrants. The Mid Term Review of Aged Care (Department of Community Services and Health, 1991) noted that acute hospital services devote relatively less attention to rehabilitation and there can be poor coordination between hospital discharge and community services. Relatively little emphasis is given to older people in health promotion and mental health; adverse reaction to medication is widespread. Access to hospitals and aged care services is heavily influenced by cost shifting pressures between levels of governments and

health and welfare agencies.

The National Health Strategy (1993) has documented the relatively poor access of NESB migrants to the mainstream health system. Language barriers and cultural differences are poorly recognized by many health agencies. The Commonwealth government provides telephone translations but agencies are charged a fee for these services. As with other older people, NESB migrants face elevated risk of problems with medication and poor access to mental health services. These difficulties are being addressed through better guidelines for interpreter services, education of health professionals, client rights mechanisms, and Commonwealth financial incentives for State Health Authorities.

The Costs of Health Care

Health costs amounted to 8.6% of Australia's national income in 1993-94 (Australia Institute of Health, 1996), as compared to about 10% for Canada and 14% for the USA. Approximately 40% of these costs are met by the Commonwealth government, a third by private sources, and a quarter by State governments. The major areas of expenditure are hospitals (\$12.2 billion), medical services (\$6.9 billion), pharmaceuticals (\$4.0 billion), dental and other professional services (\$3.1 billion), and nursing homes (\$2.6 billion).

Costs of an Aging Population

The report entitled *Australia's Aging Society* produced by the Economic Planning Advisory Council (Clare & Tulpule, 1994) goes a long way towards allaying fears concerning the costs of population aging. The projections show that population aging is likely to increase public expenditure steadily to the middle of the next century. However, these costs can be largely offset by more self-financing of income support in old age and by modest increases in economic productivity. As with other countries, there is little objective case for making older people the scapegoat of changing political priorities and poor economic performance.

AGED CARE SERVICES AND THE ETHNIC AGED

The Australian aged care system had its origins in disparate funding programs which arose separately for specific residential and community services (Sax, 1993). Until the early 1980s, aged care was largely driven by

voluntary agencies and private nursing homes, notwithstanding the funding from the Australian government. A perennial problem is the divided funding responsibility between levels of government. Residential care is funded by the Commonwealth, hospitals are funded by the State government (assisted by Commonwealth grants), and community services are cost-shared between the levels of government. Reform of aged care did not begin in earnest until the mid 1980s when the Commonwealth government was alarmed by rapidly escalating costs of residential care.

The development of the aged care system has coincided with increasing social and policy recognition of the ethnic aged. McCallum (1990) suggests that the group emerged as a social problem for three reasons: the demographic evidence showing a rapid increase in the number of ethnic elderly, the interest of policy makers in planning for the ethnic aged and the increasing pressure from within various ethnic groups on their own communities to heed the concerns and needs of their aging relatives.

The Ethnic Aged Working Party was established in 1985 to consult with ethnic communities and recommend proposals for enhancing the suitability and availability of services. The ensuing report *Strategies for Change* (1987) marked a policy watershed by recognizing the ethnic aged as a distinctive client group. The recommendations covered information collection and dissemination, needs based planning, access to services, funding for ethno-specific nursing homes and hostels and innovative models of care. These concerns have guided changes in the aged care system over the last nine years.

In 1995, the Commonwealth Government commissioned a review of these strategies and the extent to which they had produced equitable outcomes for NESB aged within the aged care system (Office of Multicultural Affairs, 1995). Findings from this review form the basis of much of the discussion below on the effectiveness and directions of aged care services for the ethnic aged in Australia.

Residential Care Services: Nursing Homes and Hostels

By international standards, a relatively large proportion of older Australians live in residential care. Among persons aged 70 years and over, approximately 5% live in a Commonwealth subsidized nursing home and 4% in a subsidized hostel (Australian Institute of Health and Welfare, 1996). Over the past decade there have been substantial

increases in the availability of hospitals and decreases in the availability of nursing homes. The changes were brought about by planning restrictions on new nursing homes, increased control on admission, and direction of subsidies more on the basis of relative need. Another major advance was the introduction of outcomes based regulation of the quality of nursing homes.

There is substantial under-representation of the ethnic aged in residential care (Department of Human Services & Health, 1992, 1995a). These low utilization rates appear to result from a number of reasons in addition to the relatively young age of most of the ethnic aged. Some are unfamiliar with hostels and nursing homes because they were not common in their countries of birth. As with many of the Australian born, there can be a reluctance to sell homes to pay the in-going contribution required for hostel entry. Further, the growth in the provision of ethno-specific residential care services has failed to keep pace with increasing demand.

Most of the ethnic aged in residential care live in mainstream facilities developed for the Australian born. This can cause severe problems of isolation. For example, a recent survey showed 41% of NESB residents in mainstream hostels and nursing homes were single representatives of their linguistic group in their facility (Kurowski, 1994). Particularly disadvantaged are small and emerging NESB groups and those in rural and remote areas. While many facilities aim to be sensitive to the needs of NESB residents, subsidies do not cover the extra cost of providing for cultural and linguistic diversity. The Community Visitors Scheme is one successful strategy for reducing isolation. This involves ethnic organizations working with volunteers to provide visitors to older ethnic people in residential care.

It is generally agreed that the best way of providing culturally appropriate residential care for elderly NESB people is through ethno-specific services (Human Rights and Equal Opportunities Commission, 1994, Kurowski, 1994). This approach is suitable mainly for larger, geographically concentrated ethnic communities which can generate the required funds. Bilingual staff are employed and appropriate food, religious and recreational activities are provided.

Other approaches fit midway between mainstream and ethno-specific provision. The Multicultural model aims to meet the individual cultural and linguistic needs of all residents through substantial input from ethnic communities. Under the partnership model, a mainstream provider joins

with an ethnic organization and provides a wing of beds for their community. The clustering model involves small groupings of particular ethnic groups within mainstream facilities and with delivery of specifically appropriate care through cross-cultural staff training. These latter approaches are particularly appropriate for smaller ethnic communities.

Formal clusters can be difficult to establish due to the financial imperatives on nursing homes to fill vacant beds as quickly as possible. Cross-cultural staff training and good data bases are essential to achieving the aims of the clustering model of care (Rhys Hearn et al., 1994). A less formal approach is the co-placement model, which matches new clients with existing residents or staff who speak the same language or have the same cultural background.

Home And Community Care

The provision of community services in Australia lagged behind residential care for many years. However, the Home and Community Care Act (HACC) in 1985 consolidated existing services, added to their scope and funding, and focused on the key objective of improving quality of life for carers as well as frail older people themselves. The Act also provides for younger people with disabilities and supports a range of services including home nursing, housekeeping, personal care, meal services, day care, home maintenance, and respite care. Older people with an NESB background are identified as a priority needs group.

Overall, only about one-third of frail older people in the community make use of any community services. The use of 'mainstream' services by people from non English-speaking countries is especially limited, due to language barriers and distinctive cultural preferences (Rowland, 1991b). HACC data has shown a steady increase in HACC service utilization by NESB older people (Department of Community Services and Health, 1993). However, much more progress is required. In particular, smaller ethnic communities often do not have access to translated information and still remain uninformed about the availability of such services.

Assessments of frail older people for aged care, in the State of Victoria, show that home help and delivered meals are used by the ethnic aged at approximately half the rate of the Australian born clients (Aged Care Research Group, 1995). NESB clients were more likely than the Australian born to be recommended for day hospital, home respite and more intensive services which tailor case management and specific

support to individual needs (Community Options and Community Aged Care Packages).

The use of community services by carers varies significantly across ethnic communities. Legge and Westbrooke (1991) found that Anglo-Australians were relatively high users of services, as were the Chinese, compared to Greek carers who were reluctant to use services. The study points to differences between ethnic groups in attitudes of caring for their aged. This suggests that under-utilization of services by NESB carers and clients may be the result of cultural attitudes as well as problems of access. Language is widely acknowledged as a major barrier to use of community services. Interpreters are an essential expense but governments do not specifically fund services to use them. Training in the use of interpreters is needed to appreciate the cultural dimensions of an assessment. This involves sensitivity to the particular family values, religious beliefs and practices, and sometimes the historical and political background of each NESB individual.

High levels of illiteracy among some NESB communities underscore the importance of information strategies targeted to specific communities. In 1996, the former Labor government committed funding to developing an information strategy which:

...will target ethnic older people, ethnic communities and aged care providers using a variety of media and information strategies....with less reliance on printed material... the purpose being to increase awareness of aged care services with the overall objective of assisting to increase access (Department of Human Services and Health, 1995, p. 9-10).

A needs study of the Filipino aged suggests disseminating information using native speakers at information sessions, audio visual displays and ethnic radio, dissemination of information through local Filipino venues eg. restaurants, surgeries, shops, churches and through networks such as priests and other community leaders (San Jose, 1995). Targeting general practitioners who work with ethnic communities is another potentially fruitful method of disseminating information.

Community Aged Care Packages (CACP), introduced in 1992, are particularly important in providing a home-based alternative to residential care for people who would otherwise be eligible for residential care. Fully 19% of these flexible services nationally are allocated to the NESB aged. Many are auspiced by ethnic organizations such as the Australian Greek Welfare Society, and the Jewish Welfare

Society. Butler (1996) found that aged care assessments were relatively more likely to allocate CACPs rather than hostel care to the ethnic aged. This suggests that older NESB older people, even more than the Australian born, prefer to remain at home where culturally appropriate supports are available.

Aged Care Assessment Teams

Aged Care Assessment Teams (ACATs) are central to Australian aged care because they recommend care plans for elderly people based on expert consideration of individual needs in the context of available services. For many people, the Teams are the critical first point of contact for learning about the range of residential and home care services. NESB people aged 70 and over are not underrepresented in the ACAT clientele; it is only in the NESB 'young old' population (age 60-69 years) that are under-represented (Aged Care Research Group, 1995). However concerns persist that ACATs do not always take account of cultural difference, lack awareness of ethno-specific services, and underutilize interpreter services (Law Reform Commission, 1995; Office of Multicultural Affairs, 1995). Further, birthplace is the only indicator of ethnicity in the Assessment data bases.

Assessment Teams responsiveness to their NESB clientele could be greatly improved through cross cultural training and the development of culturally sensitive assessment tools and protocols. Improving data collection to include language spoken at home, religion and need for an interpreter would inform needs based planning and assist in providing a culturally appropriate care plan. Dementia assessment is a particularly important area for ensuring cultural sensitivity and appropriateness. Ethnic Liaison Officers have recently been employed in some regions to work with assessment teams to raise their awareness of cultural issues and in some cases to carry out co-assessments with the ACAT worker.

FUTURE DIRECTIONS

Over the past decade, Australia has developed substantial experience in responding to increasing ethnic diversity of the older population. This effort must be accelerated, however, because the next decade will see the full arrival in old age of the substantial numbers of post war migrants of NESB background. Further, there will be substantial aging of recently arrived refugees and Asian migrants. As a result, up to one-fifth of older people will have been born outside English speaking countries.

Mainstream health and care services must increase capacities for meeting the particular cultural, language, and other needs of a wide range of groups.

The 'big' picture for the future requires strong partnerships between ethnic communities and governments (Office of Multicultural Affairs, 1995). This implies a move away from the simple dichotomy between mainstream and ethno-specific approaches. It further supports the ideas that a new level of understanding and respect and cooperation must be developed and cultivated by members of both the mainstream and ethno-specific services (ibid, 1995, p. 89). Provision of culturally appropriate services to the ethnic aged, in the context of mainstream service, will also require additional resources targeted specifically for NESB clients.

Mainstream services must incorporate the reality of a culturally diverse clientele and collaborate with NESB agencies which are keenly aware of local needs. These links must involve shared decisionmaking and planning, extending far beyond coordinating activities such as information, referral and interpretation. Equally, ethno-specific agencies must recognize the wider context of cultural diversity and the operations of mainstream services. Particularly with health care and community services, most of the ethnic aged will continue to rely on mainstream services.

National and state policies require expert implementation at the local level. In Victoria, for example, the Ethnic Aged Care Advisory Committee conducts intensive consultations with specific cultural groups. The Committee works with communities to develop a plan covering their particular ethno-specific needs and strategies to increase the sensitivity of mainstream providers. Best practice initiatives in aged care include the development of manuals on culturally appropriate care, community service models for small communities, and better dementia assessment for the NESB aged (Ethnic Older Person's Strategy, 1995). Better data systems, and culturally appropriate evaluations, also are necessary to monitor the effectiveness of service delivery.

Population aging and ethnic diversity are major aspects of social changes underway in Australian society. Multicultural policies have bipartisan political support but the underpinning values are being challenged by groups which scapegoat migration (and population aging) for poor economic performance. In times when the public sector is retracting, groups with growing needs, such as the ethnic aged, will confront entrenched interests which may be more powerful but less

needed. Proposed devolution of responsibility for health and welfare services, from the Commonwealth to the States, raises concerns for the adequacy of funding and protection of vulnerable groups.

In summary, Australia has evolved from its White Australia past into a multicultural society over a short period of history. There are racial and ethnic tensions but these have not coalesced into the deep social divides found in other countries. Australia has a history as a youthful nation but its population is increasingly demographically mature. As with many other countries, the most significant area of uncertainty concerns economic growth and the funding capacities of governments.

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Health Status of Japanese Seniors and the New Directions of Health Services

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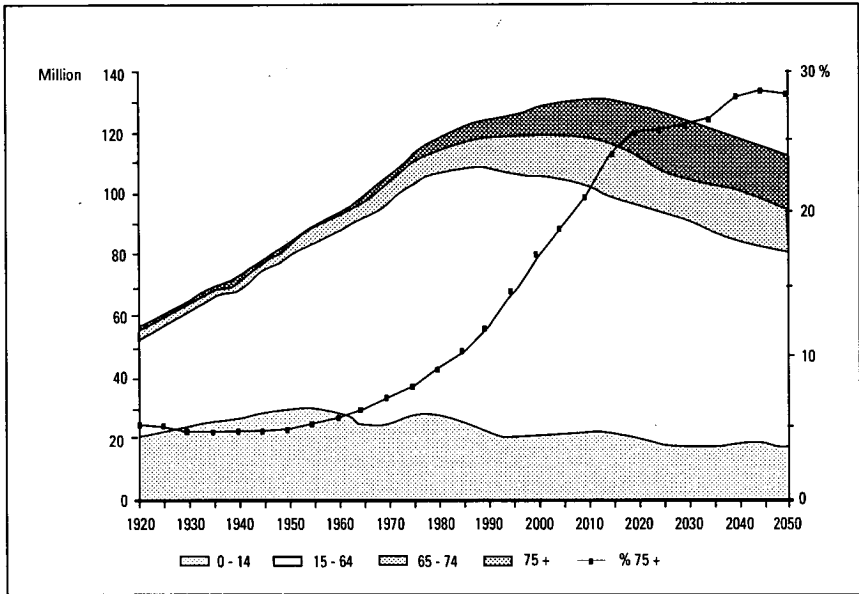
INTRODUCTION

Rapid population aging is one of the most salient social trends in today's Japan. In 1950, people aged 65 years and over accounted for only 5% of the total population. This percentage reached 7% in 1970, 14% in 1994, and is projected to increase continuously to 2050 (Figure 1). In particular, people aged 75 years and over will rapidly increase both in actual number and proportion; for the 25 year period from 1995 to 2020, the population aged 75 years and over is projected to increase from 7.1 million to 18.2 million or from 5.7% of the total population to 14.5%.

The projected increase of the "old old", people aged 75 years and over, will also result in a rise in the absolute, and perhaps relative, number of disabled persons. It is well known that the health status of the "old old" is worse than that of "young old" persons aged 65 to 74 years. For example, the 1990 *Health and Welfare White Paper* reported that the prevalence of bed-ridden people was 3.51%, and among the demented it was 0.95%. For the institutionalized population, the prevalence of bed-ridden people was 1.92% among the "old old", while the prevalence was only 0.69%, 0.19%, and 0.36%, respectively, in the "young old". The most serious problem of an aged society is care of the disabled. In fact, we

would argue that the core of societal preparation for population aging is considered to be an expansion of provision of services for disabled seniors. Compared with services for disabled persons, preventive health services have long been overlooked, although healthy seniors form the vast majority of the population.

FIGURE 1
Changes in the Japanese Population and Future Population Projected



Source: Population Census and Population Projections for 1991-2050

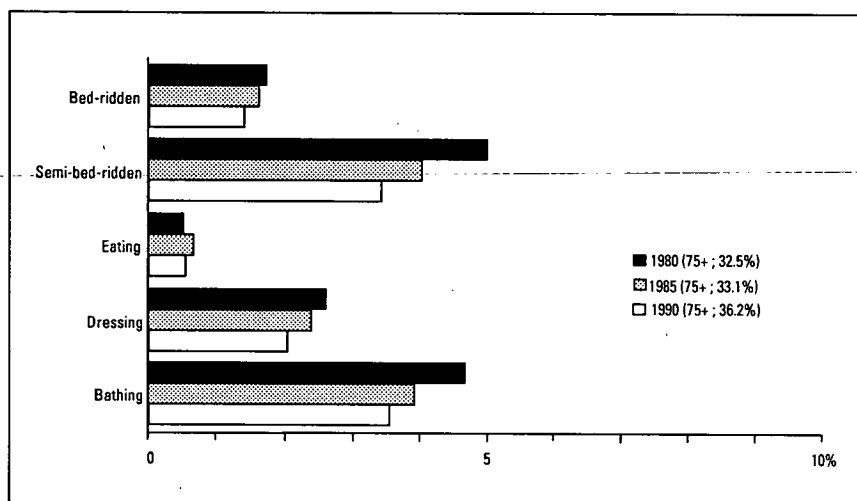
In this paper, the results of recent studies examining the health status of Japanese seniors will be presented. Also covered will be the definition of a target population of present health and welfare services in Japan, and new directions of health services bridging the next century.

HEALTH STATUS OF JAPANESE SENIORS

Recent studies have demonstrated that the vast majority of Japanese seniors are quite healthy. Although the operational definition and measurement of health in old age are difficult, the studies reviewed here employed measures of functional capacity, such as mobility, activities of

daily living (ADL), and instrumental activities of daily living (IADL), in accordance with the recommendation of the WHO Scientific Group on the Epidemiology of Aging (1984).

FIGURE 2
Prevalence of Disability in Mobility and ADL in the Metropolitan Surveys



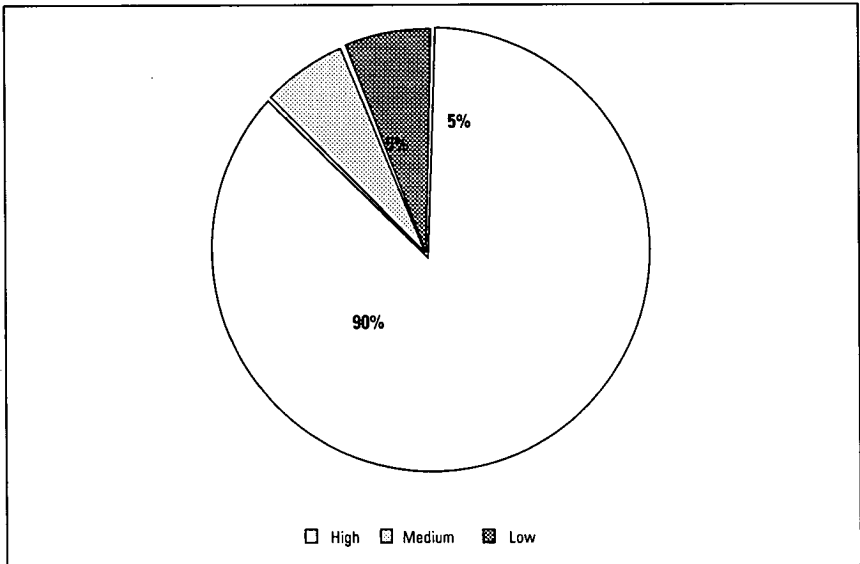
Source: Metropolitan Tokyo Government.

Figure 2 shows the prevalence of disability observed in large scale cross-sectional surveys conducted by the Metropolitan Tokyo government. The same set of variables at five year intervals have been collected since 1980. The data clearly indicate that the prevalence of disability in mobility and ADL is relatively low in the general aged population: the prevalence of bed-ridden individuals is less than 2%, and that of disability in ADL is less than 5%. Reflecting population aging, the percentage of persons aged 75 and over increased during the 10 year period. Given the increase of the "old old", some increase in the prevalence of disability might be expected. However, in spite of the increase in the size of this age group, the prevalence of disability did not increase, and in fact did not change over the full 10 year period.

Drawing from the results of a prospective study, Koyano et al. (1986) observed that the vast majority of seniors in their sample had high functional mobility. Figure 3 shows the distribution of mobility among

seniors living in Koganei City, Tokyo. A longitudinal interdisciplinary study on normal aging, named the Koganei Study, was carried out by the Tokyo Metropolitan Institute of Gerontology (see Shibata et al., 1988, 1993). The data shown in Figures 3 and 4 were part of this study. Mobility was classified into three categories: high, medium, and low. The category "high" indicates the normal condition of mobility; and the "low" denotes bed-ridden or semi bed-ridden conditions. As shown in Figure 3, about 90% of seniors were "high" in mobility, and the bed-ridden or semi bed-ridden persons accounted for only 5% of the total sample.

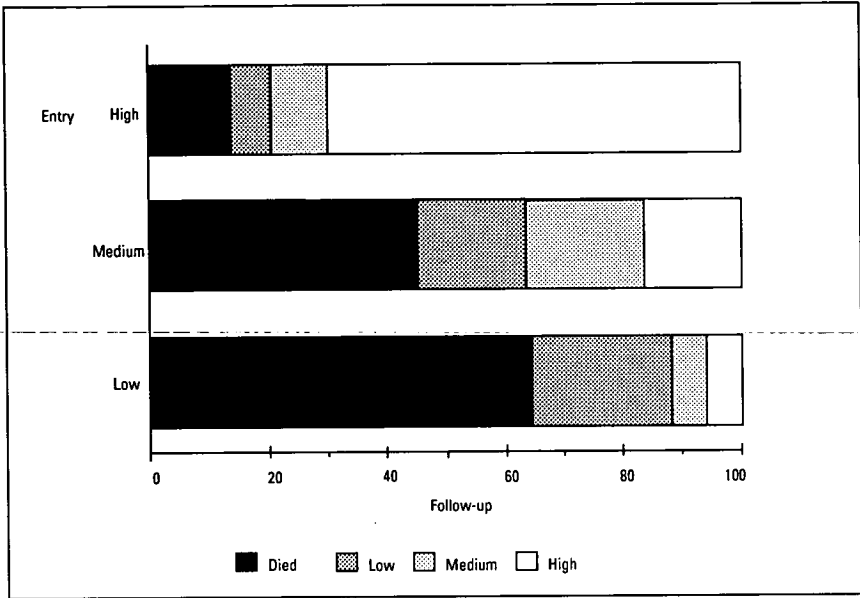
FIGURE 3
Distribution of Mobility (Koganei Study)



Source: Koyano et al. (1986).

The same persons were followed up five years later. Among the seniors who scored "high" in mobility at baseline, the majority maintained their function at follow-up. In contrast, the majority of seniors with "low" mobility at baseline died during the five year interval (Figure 4). The prevalence of disability in mobility was significantly higher among women than men and increased significantly with age. The association between disability and mortality did not disappear when the effects of age and gender were statistically controlled.

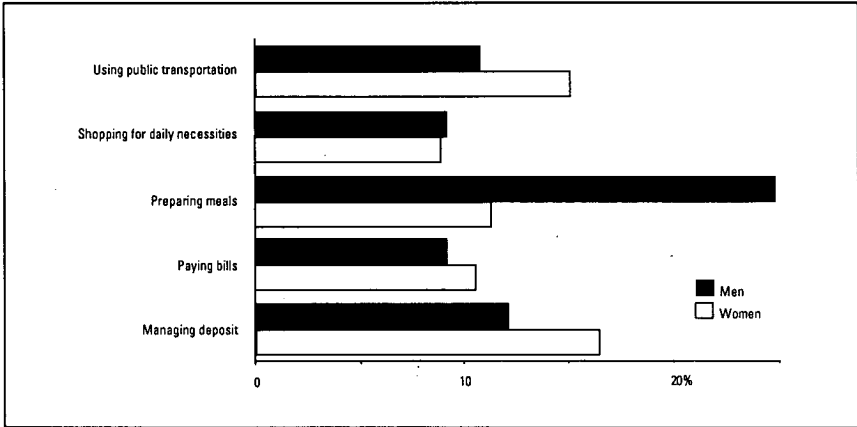
FIGURE 4
Five-year Changes in Mobility (Koganei Study)



Source: Koyano et al. (1986).

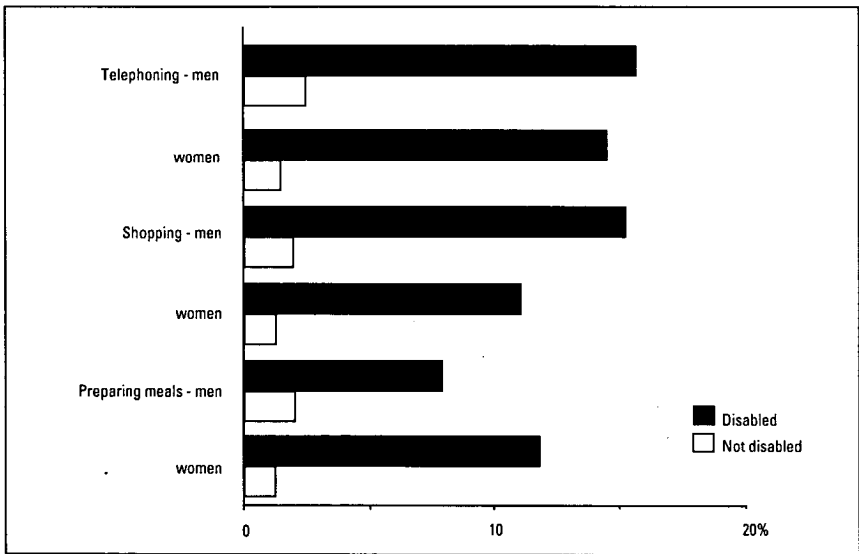
Prevalence of disability in IADL is reported to be higher than that in ADL, or mobility, but not high in the general aged population (Koyano et al., 1988). Figure 5 displays the prevalence of disability in IADL observed in a national representative sample of Japanese seniors (Koyano et al., 1993). The prevalence of disability varies across the items, but does not reach 20% except for "preparing meals" among men. The prevalence rates are similar to those found in the EPESE data book of NIA (Cornoni Huntley et al., 1986), except for shopping for daily necessities reported for American seniors. Inadequacies in public transportation and shopping facilities in the United States appear to be related to the higher prevalence rates of shopping disability in that country.

FIGURE 5
Prevalence of Disability in IADL (National Sample of Japanese Seniors)



Source: Koyano et al. (1989)

FIGURE 6
One-year Mortality in Relation to Disability in IADL (Koganei Study)

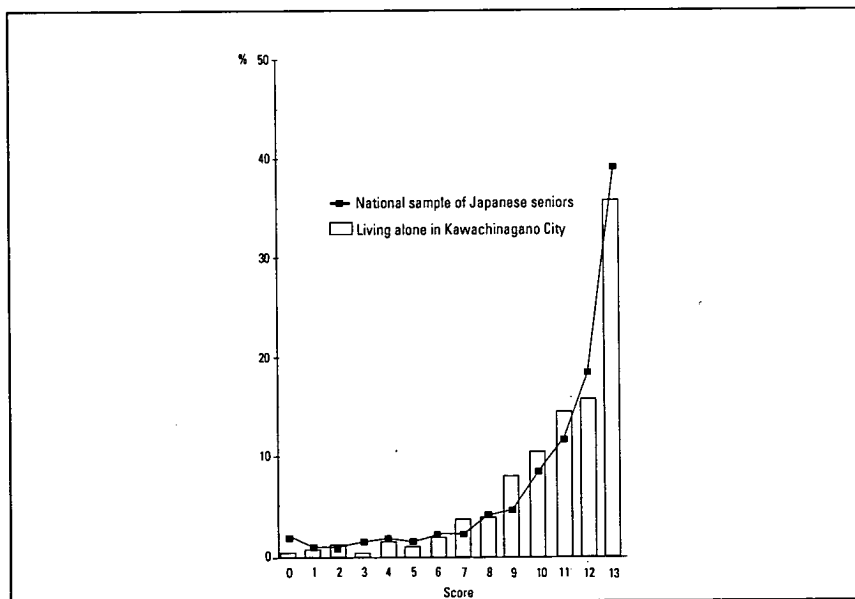


Source: Koyano et al. (1989)

A statistically significant association between disability and early death was also found for IADL. Figure 6 shows one year mortality in relation to IADL observed for seniors living in Koganei City, Tokyo. For all IADLs, and both for men and women, one year mortality was significantly higher in the disabled than in the non-disabled (Koyano et al, 1989). The association between disability and mortality remained statistically significant when the effects of age were controlled.

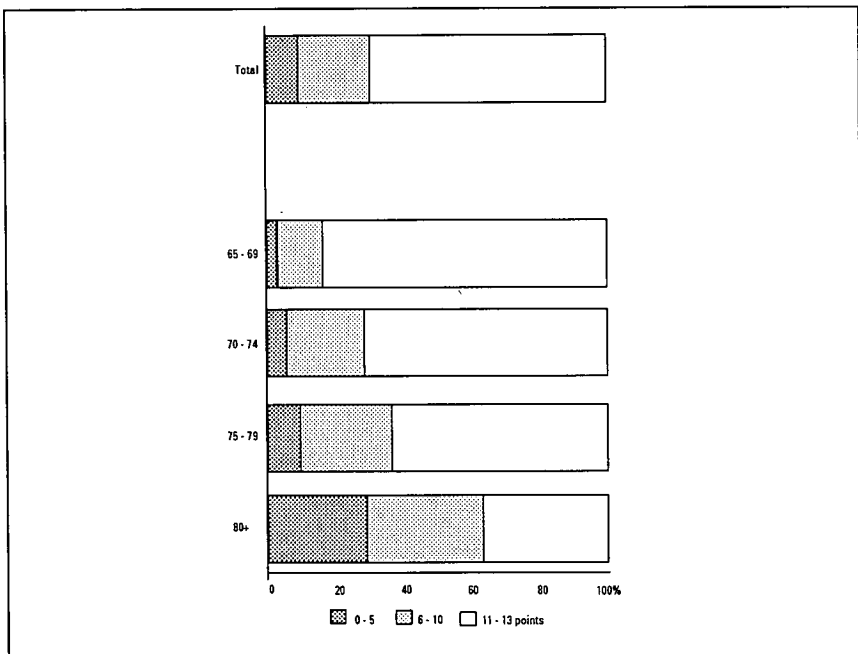
In order to measure functional capacity, a 13 item index of functional capacity (the TMIG Index of Competence) was developed and used in several settings (for a full description, see Koyano et al., 1991). The distribution of the score of the TMIG Index for a national representative sample of Japanese seniors (Koyano et al., 1993) and for seniors living alone in Kawachinagano City, Osaka Prefecture (Tokyo Metropolitan Institute of Gerontology, 1993) is presented in Figure 7. In the national sample, as well as among the seniors living alone, about 40% scored 13 points (full marks) on the TMIG Index, and another 30% scored 11 or 12 points. The negatively skewed leptokurtic distribution of the scores signifies the fact that 70% of Japanese seniors are functionally healthy.

FIGURE 7
Distribution of Scores on TMIG Index of Competence



Furthermore the mean score of the TMIG Index significantly decreases with age, whereas the standard deviation increases with age (Koyano et al., 1993). This implies a higher prevalence of subjects with low scores in older age groups and greater variation in disability among the old-old (Figure 8).

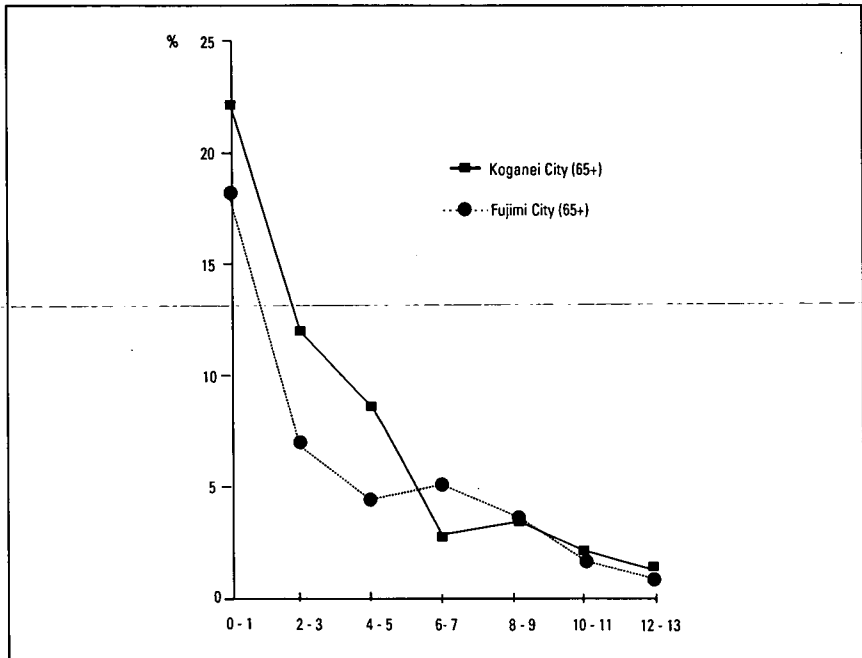
FIGURE 8
Distribution of Scores on TMIG Index of Competence
(National Sample of Japanese Seniors)



Source: Koyano et al. (1993)

As observed in the data reported earlier, low scores were correlated with early death. Figure 9 shows one year mortality in relation to scores on the TMIG Index among seniors living in Koganei City, Tokyo, and those living in Fujimi City, Saitama Prefecture. When the effects of age and gender were statistically controlled, we find that seniors with limited functional capacity, as indicated by low scores on the TMIG Index, were more likely to die younger than those with higher scores (Koyano et al., 1991).

FIGURE 9
One-year Mortality by Scores on the TMIG Index of Competence
(Kaganei Study)



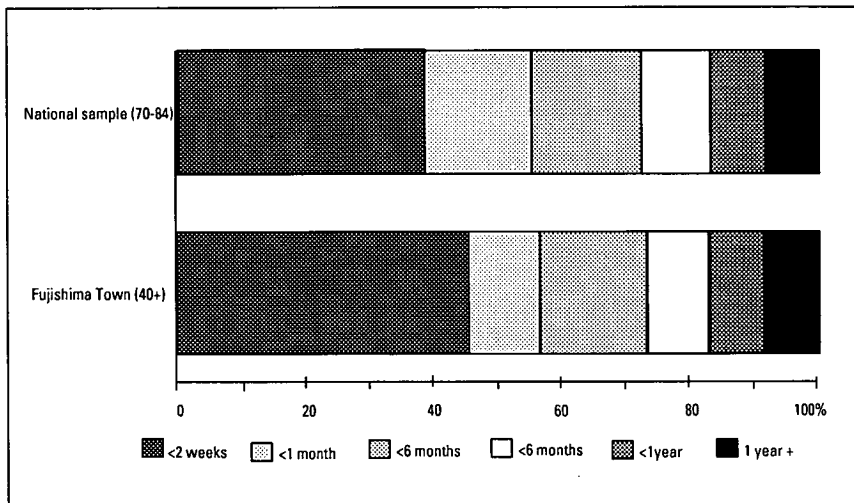
Source: Koyano et al. (1991)

Figure 10 displays the duration of bed-ridden days prior to death for a national representative sample of deceased, ranging in age from 70 to 84 years of age at the time of death, and for deceased persons aged 40 years and over in Fujishima Town, Yamagata Prefecture (Yasumura et al., 1990). For more than 70% of the deceased group, the bed-ridden period was shorter than 3 months.

Contrary to the widespread myth, the prevalence of disability is relatively low in the general aged population, because the majority of seniors maintain their functional capacity until very old ages and because seriously disabled persons are likely to die earlier. Further, Koyano et al. (1995) found that functional capacity as measured by the TMIG index had significant positive effects on quality of life, including self rated health, going out, leisure activities, emotional supports, social network, and life satisfaction. Functional capacity is a prerequisite for large social networks

and intimate interactions with others, active time use, and high life satisfaction. Thus, research findings underline the importance of prevention of functional decline at all ages of the life cycle.

FIGURE 10
Duration of Bed-ridden Period Before Death



Source: Yasumara et al. (1990)

ELIGIBILITY FOR HEALTH AND WELFARE SERVICES

In Japan, since 1989, health services for senior citizens have been regarded as being integrated with welfare services. The integrated provision of health and welfare services appears to be desirable for the recipients of these services. However, integration seems to have attenuated the effectiveness of health services through overemphasis on services targeting disabled persons and negligence of preventive health services for healthy persons.

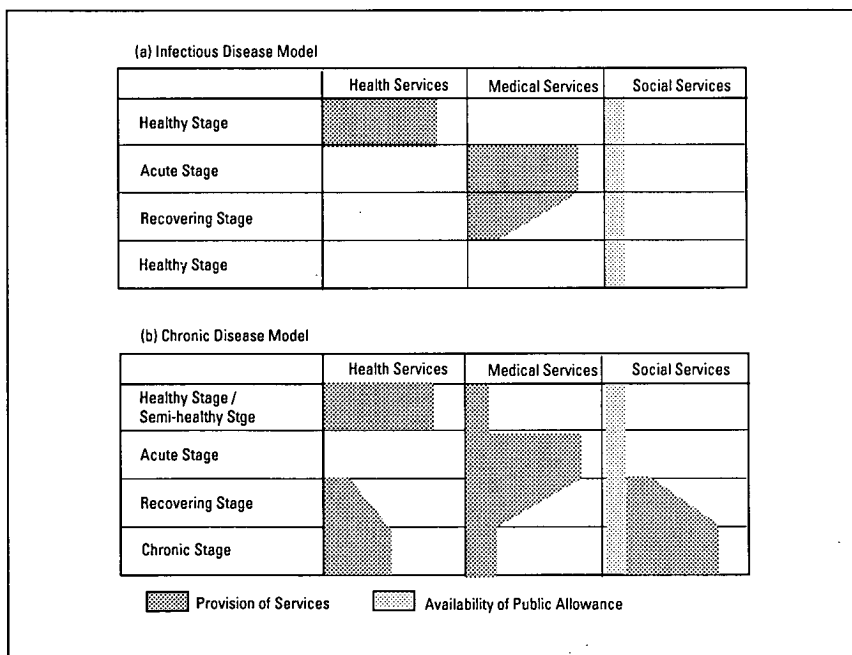
One example of this inherent contradiction is the definition of eligibility found in the Plan of Health and Welfare Services for the Elderly. According to Japanese government regulations, all municipal and prefectural governments had to make a plan defining the future provision of health and welfare services for seniors. The guideline for making the plan, issued by the Ministry of Health and Welfare, stated

that “bed-ridden” and “semi-bed-ridden” persons would be eligible to receive services described in the plan.

Such a restricted definition of eligibility seems suitable for the services in the plan because almost all of them are targeted for disabled persons, such as home help/home maker service, day-care, short-term institutional care, rehabilitation, and home visiting nursing. According to the traditional bureaucratic distinction between health and welfare services in Japan, home help/home maker service, day-care, and short-term institutional care are welfare services, while rehabilitation and home visiting nursing are health services. Therefore, the plan is called a “plan of health and welfare services”. Whatever the bureaucratic distinction, these services are not readily available to all persons, but only to the disabled. Referring to the prevalence of disability (see Figure-2), eligible persons constitute only 5% of the general aged population, and the remaining 95% fall outside of the plan.

FIGURE 11

Schematic Model of the Provision of Health, Medical, and Welfare Services



Source: Koyano & Shibata (in press)

In contrast to welfare services that are essentially *post hoc* coping methods for disability or dependency, a distinctive feature of the organization of health services in Japan is prevention. Figure 11 illustrates the array of services provided as health, medical, and welfare services in relation to stage of illness. Different models are necessary for infectious diseases and chronic diseases. Within the "Infectious Disease Model", health services have charge of preventive services for healthy people; medical services deal with treatment of patients in acute conditions, but neither of them is necessary for recovered patients. The only welfare service provided for this group is the public allowance for eligible persons.

Within the "Chronic Disease Model", the stages should be different from the "Infectious Disease Model": because of the gradual progression of diseases, "semi-healthy stage" needs to be included in "healthy stage". Also, "chronic stage" should be added because complete recovery from any chronic condition can hardly be expected. For example, a sequence of hypertension, cerebrovascular stroke, and disability in ADL seems well illustrated by this model. "Semi-healthy" people, such as patients with hypertension, not only need preventive health services but also have to utilize medical services. People with chronic conditions, such as those disabled in ADL, should continue to have medical services, but also need health and welfare services.

Integration of health, medical, and welfare services is needed primarily among the aged for whom chronic diseases are the major health concern. However, the emphasis on services for disabled persons may lead to a neglect of prevention.

Services for healthy seniors are much more ambiguous than services for the disabled in their task, method, and definition of target populations. However, in an aged society, such as within Japan in the early 21st century, a strategy to keep seniors independent will have to be undertaken. Preventive health services for healthy seniors are an important part of the strategy.

NEW DIRECTION IN SEARCH

Health education is an essential part of preventive health services for healthy seniors. However, when we try to develop a new health education program there are two major types of difficulty. Firstly, the contents of health education are not certain. The prevention of functional decline is much more complicated and difficult than that of specific

diseases. Therefore, the information to be provided in health education is likely to be complicated, and has not been clearly formulated, and tested on Japanese elders.

Secondly, effective ways of communicating health information are not clear. In Japan successful models of health education for seniors are almost exclusively disease prevention undertaken in local communities, in which the mobility of residents is low, neighborhood relations are close, health and medical facilities are rare, and the community is geographically isolated. Under such conditions, approaches through voluntary or semi-voluntary groups in the community or neighborhood supported by governmental agencies are reported to be quite effective. However, in urban areas, conditions are completely different: the mobility of residents is relatively high, neighborhood relations are weak, the proportion of residents belonging to community groups is quite low, and people can utilize many health and medical facilities almost freely. Under such conditions, approaches through community groups or neighborhood relationships are unlikely to be as effective. Further, participants in health education programs provided in these environments are likely to be health conscious people with good health habits, since participation in such programs is a kind of health behavior in itself.

To overcome these difficulties, the following were proposed as preliminary ideas to a governmental task force (Koyano & Shibata, 1996).

1. EDUCATION WITH BOOKLET

Since community based interpersonal channels seem ineffective for community residents in general, another way of sending information is needed. As Japanese seniors living in urban areas are literate and generally interested in health promotion or health maintenance, it seems possible to use written materials as a medium of information transmission, assuring that the booklet is adequately prepared and distributed.

2. APPROACHES THROUGH COMMUNITY GROUPS, NEIGHBOURHOOD RELATIONSHIPS, AND TRADITIONAL HEALTH EDUCATION PROGRAMS

Programs delivered through community groups, neighbourhood relationships and traditional health education programs can still be effective for a limited number of residents. Therefore, such approaches should be continued, but without exaggerated expectations of their

effectiveness. The booklet mentioned above can be used as one of the teaching materials.

3. TRAINING OF PRACTITIONERS

Practitioners currently involved in health and welfare services, including physicians, public health nurses, and social workers, have not been well-trained in gerontology. Because of a lack of knowledge of normal aging, practitioners are likely to think and behave in a disease-centred or problem-centred way, and are likely to overlook the importance of maintaining functional capacity. Thus, on-the-job gerontology training programs that stress normal aging and health promotion is necessary for practitioners.

4. CURRICULA AND TEACHING MATERIALS OF HEALTH EDUCATION

The range of knowledge to be provided through health education, as well as through retraining of practitioners, should be delineated according to the range of knowledge, curricula, and teaching materials available through the field of gerontology.

Traditionally, disease-related medical knowledge is the core of information provided in health education. However, in health education as a preventive health service for healthy and/or semi-healthy seniors, information about normal aging should be at the centre, surrounded by information about diseases and risk factors that negatively affect quality of life in old age, physical and social environments, knowledge of health and welfare services, etc.

Unfortunately discussion and examination of these ideas has just begun. Although they seem suitable to preventive health services in the near future, their implementation has yet to be realized. Hopefully, the years that bridge the 21st century will mark a period of significant change in Japanese health policy aimed at older persons.

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Filial Piety and Co-residence in Japan

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INTRODUCTION

The traditional living arrangement of Japanese seniors is the patrilineal, patrilocal stem family. Today, about 60% of Japanese seniors are co-residing with their adult children in the same household. Although the percentage has been gradually decreasing, it is still high compared with other developed countries.

In sociological studies of family life of Japanese seniors, co-residence with an adult child, especially with the eldest son, was frequently taken as an indicator of acceptance of the Confucian norm of filial piety. This is understood to represent the moral aspect of co-residence under the *ie* ideology which was established and propagated through legislation and education, by the Imperial Government in pre-war Japan.

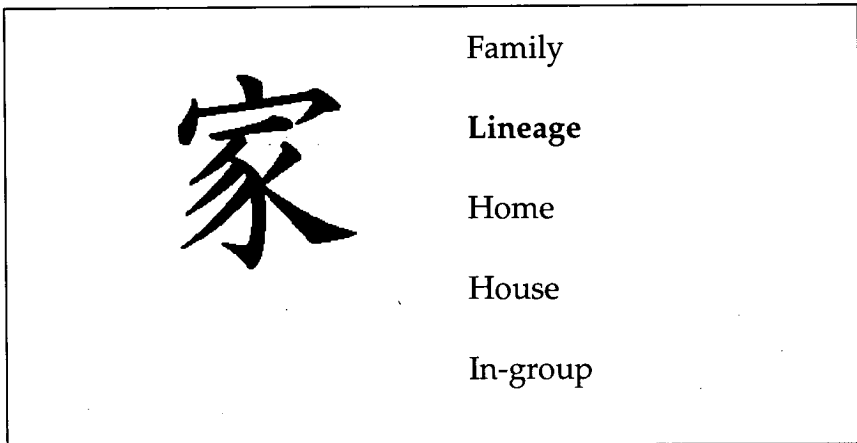
This chapter outlines and discusses the implication of filial piety, informal support for elderly parents, and co-residence under the *ie* ideology, and changes occurring since World War II.

FILIAL PIETY AND INFORMAL SUPPORT UNDER THE *IE* IDEOLOGY

The Japanese word *ie* has several meanings, including family, lineage, home, house and in-group (Figure 1). However, when talking about the

ie ideology, the word exclusively means lineage, which is conceptualized as the essence of family connectedness succeeding from generation to generation.

FIGURE 1
Meanings of *ie*



The *ie* ideology consists of two elements: the conception of *ie* (lineage) and paternalism within the family (Figure 2). Since the currently existing family is conceived of as a small link in the long chain of lineage, factors such as family name, assets, social status, and occupation were expected to be inherited by the eldest son. Tomb and home Buddhist altar (in which mortuary tablets of ancestors were placed) were also deemed to be succeeded to the eldest son in order to continue the ancestor worship of lineage. If there was no son, but only daughters, adoption through marriage with the eldest daughter was arranged. Adoption was the alternative method of securing a successor.

Thus, marriage was conceived as a means of continuation of lineage. Therefore, a marriage should be carefully arranged in order to fit the main purpose of marriage: maintenance of lineage, and should not be made freely by the couple without the permission of the heads of both families.

FIGURE 2
Components of *IE* Ideology

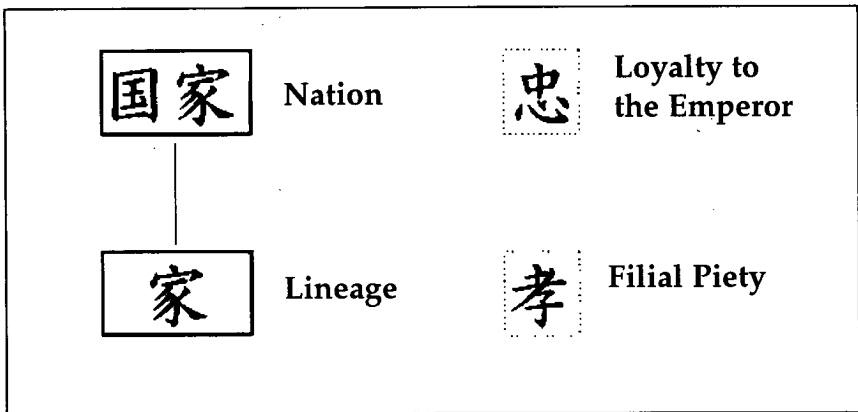
<p>Lineage</p> <ul style="list-style-type: none">Succession<ul style="list-style-type: none">By Eldest Son or Adopted SonFamily Name, Assets of Lineage, TombOccupation/Social StatusMarriage for the LineageAncestor Worship
<p>Paternalism</p> <ul style="list-style-type: none">Predominance of Household Head (Father)Obedience of Family Members (Children) — Filial Piety

In the currently existing family, inequality among family members, in terms of their importance, power, and privilege, was taken for granted. There was an order of importance and power among family members. Typically, the father acted as the household head, having the supreme position and legal power to predominate over other family members. The position, power, and privileges of the household head were the means to fulfilling his obligation: to maintain family name, social status, and all assets of the lineage, and to pass them over to the household head of the next generation (ideally, his eldest son). The wife of the household head was expected to serve and be obedient to her husband, but could have a superior position in the role of a parent. Among children, the eldest son was afforded the highest status as the future household head.

The obedience of children to their parents or parents-in-law was regarded as an expression of filial piety. Filial piety was therefore an extremely important moral virtue corresponding to the infinite grace of parents, including the grace of bearing, nurturing, and allowing marriage. Filial piety was repeatedly taught in moral education; for example, children were instructed to obey parents in everything and never to resist them. They were not even to stretch their foot in the direction of parents while sleeping.

The norm of filial piety was propagated by the Imperial Japanese Government in combination with loyalty to the Emperor. Ideally, only family and nation were regarded as "formal" organizations, and the nation was conceptualized as a big family, consisting of real families headed by the Emperor. Prior to World War II, filial piety and loyalty to the Emperor were tightly interwoven in the Imperial Japanese ideology (Figure 3).

FIGURE 3
Combination of Filial Piety and Loyalty to the Emperor



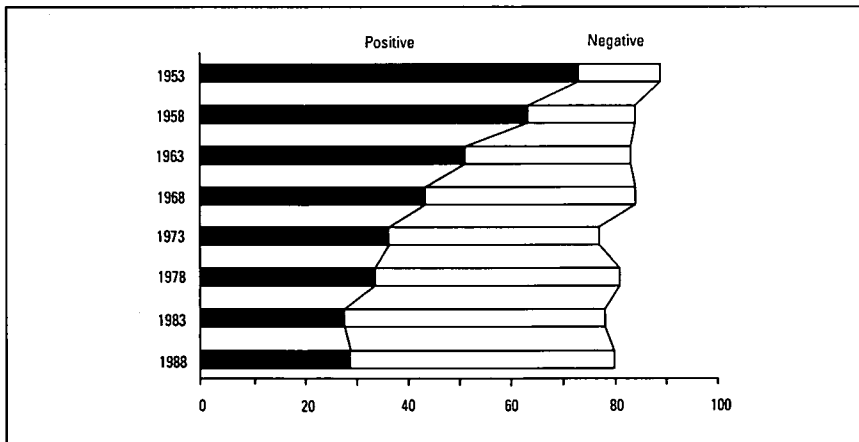
The life of seniors under the *ie* ideology was typically found for a retired household head, who had already transferred the headship to his eldest son, his wife, or the widow of the household head. The senior lived with the successor's nuclear family within the same household, and was given every kind of support by the successor, his wife, and children. For the successor, co-residing and sharing all assets with elderly parents were legal, as well as moral, obligations. Further, providing support to elderly parents was not only an obligation but also an actualization of filial piety. Therefore, the successor and his nuclear family should provide support with gratitude and respect for elderly parents. In the moral education in pre-war Japan, it was praiseworthy to serve parents while neglecting wife and children.

CHANGES IN ATTITUDES TOWARD THE IE AND FUYO

After World War II, as a part of the democratization of Japan, the *ie* ideology was officially renounced, and the conception of *ie* was completely removed from the constitution and civil law. For example, the constitution declares that agreement between the couple is the only basis of marriage, and civil law gives the highest priority of support to wife and children rather than elderly parents. During this period filial piety has never been taught in classrooms, at least, not in its original and extreme form found in pre-war Japan.

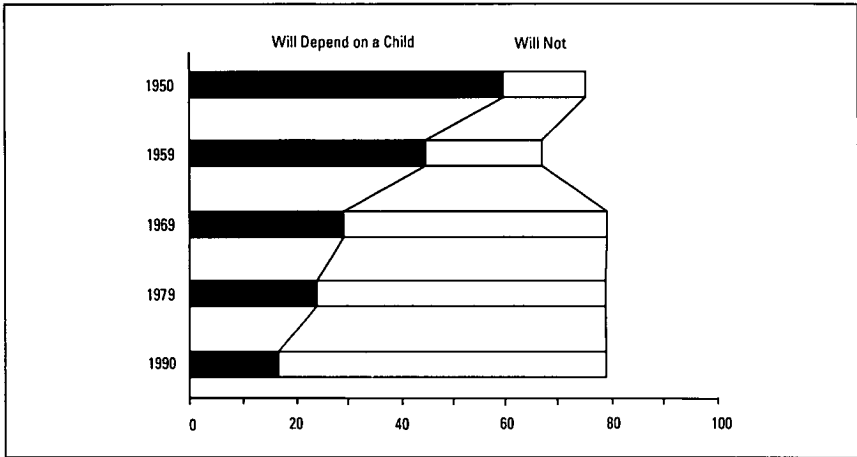
Alterations in people's attitudes toward the conception of *ie* and support for elderly parents can be traced in opinion polls. Matsunari (1991) reviewed nation-wide opinion surveys and found a gradual decline of positive attitudes toward the *ie* ideology. Figure 4 shows the changes in attitudes toward the adoption of a successor. The percentage of people showing positive attitudes decreased from 73% in 1953 to only 28% in 1988. Also, concerning dependence on children in old age, the percentage of people with positive attitudes decreased from 59% to 18% (Figure 5). For dependence on children in old age, Matsunari commented that, interestingly, the percentages of people with positive and negative attitudes reversed in the 1960s when the old age pension became effective.

FIGURE 4
Changes in Attitude toward Adoption of Successor



Source: Matsunari (1991)

FIGURE 5
Changes in Attitude toward Dependence on a Child in Old Age

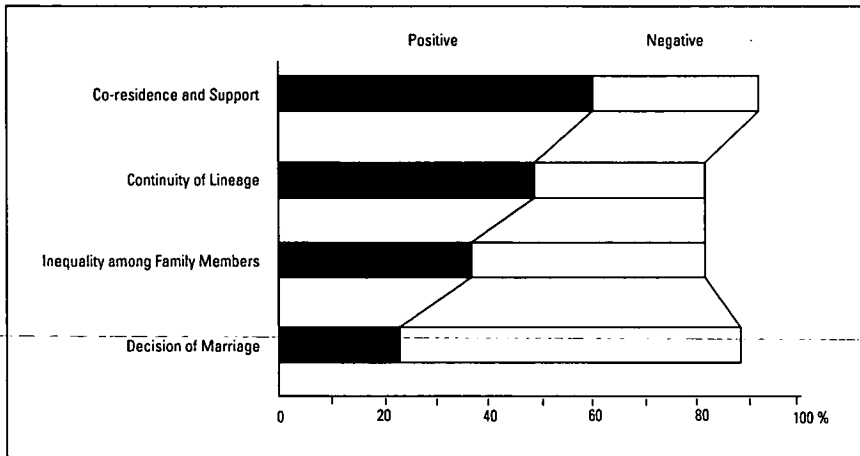


Source: Matsunri (1991)

In the later half of the 1980s, Takahashi (1987) scrutinized the factorial structure of attitudes of seniors toward the *ie* ideology and detected four factors. He reported that, “decision of marriage made by the household head” and “inequality among family members” were no longer accepted even by seniors who had been socialized in pre-war Japan, while “co-residence and support provided by children” was still widely accepted (Figure 6). For the contents of support and intergenerational solidarity in old age, an opinion poll conducted in 1986 found that a relatively small portion of the Japanese people preferred to have economically close ties with children. The percentage of persons willing to have economically close but not emotionally close ties was only 4%, and 19% preferred to have both emotionally and economically close ties. The remaining 37% preferred to have emotionally close but not economically close ties, and 31% preferred to maintain full independence.

The Japanese word used to describe the informal support provided by adult children to elderly parents is *fuyo*. Although *fuyo* may include any kind of support, the nuance of the word suggests instrumental support, especially financial aid and long-term care. It was the instrumental support that was stressed as the actualization of filial piety in pre-war Japan. Gratitude and respect were therefore attached to instrumental support, rather than to emotional closeness or affection.

FIGURE 6
Attitude Toward *ie* Ideology Among Seniors



Source: Calculated from Takahashi (1987)

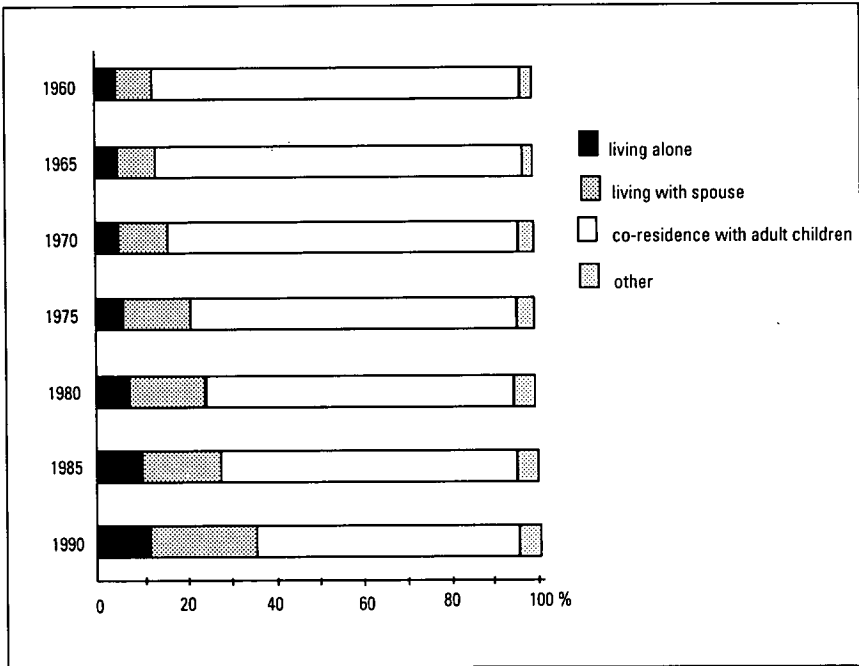
The life of seniors in pre-war Japan described above is an ideal type deduced from the *ie* ideology. Since there is no empirical data indicating the actual lives and attitudes of people during this time, reality might have been different from the ideal type. However, during several decades after the war, the Japanese people surely changed their attitudes toward *ie* ideology and intergenerational solidarity. Looking at the end of the 20th century, the majority of Japanese elderly prefer to keep emotionally close ties with their adult children, but they do not want to depend on children. It is the emotional closeness that is the essential part or basis of intergenerational solidarity, while filial piety has been superseded by emotional closeness, and instrumental support has been reduced in importance.

CO-RESIDENCE AND INTERGENERATIONAL SOLIDARITY IN THE STEM FAMILY

Since the elimination of the concept of *ie*, co-residence with elderly parents has no longer been an obligation of children. Nevertheless, the percentage of seniors co-residing with adult children was very high for several decades, and only started to decrease in the 1960s. During the 30-year period from 1960, the frequency of co-residence decreased from 87% to 61%, while that of living alone and living only with spouse increased from 4% to 11% and from 7% to 24%, respectively (Figure 7). The

frequency of co-residence is generally lower in urban areas, among employees, and among younger generations, and is expected to decrease further in the near future.

FIGURE 7
Changes in Living Arrangement of Japanese Seniors



Source: Population Census.

Apparently, the decrease of co-residence was not brought about by the separation of co-residing households but by the low frequency of co-residence within younger generations coming into old age. Because of the large generational differences produced by the drastic social changes following the World War, today's young-old are significantly different from older generations in many ways. Compared with the old-old, they are much more healthy, wealthy, well-educated, and as a result, are also more functionally, economically, socially, and psychologically independent. Thus, the reduction in co-residence may simply reflect a decreased frequency of seniors needing to co-reside in order to receive

instrumental support. However a lower rate of co-residence is suggestive of a weakening of the informal support system and of filial piety.

For seniors living during pre-war Japan, co-residence was not only the normatively approved way of living under the *ie* ideology, but also the only possible way to sustain their lives through receiving instrumental support from children. For some of the today's seniors, co-residence is also the only and most reliable method to secure levels of instrumental support necessary to remain living in the community. Family members living together are the most dependable source of instrumental support, but it may place heavy burdens on providers (Koyano, et al., 1994). A detailed survey of social relationships of Japanese seniors suggests that co-residence has significant negative effects on emotional closeness with children though it significantly enhances exchanges of instrumental support. Further, co-residence with a married son, still the preferred type of co-residence, is likely to bring harmful interactions with daughters-in-law living together, characterized by frequent exchanges of instrumental support without emotional closeness (Koyano, 1996). Therefore, for seniors without immediate need of instrumental support, avoiding co-residence with children might be a meaningful choice.

The decrease in co-residence coupled with the erosion of the norm of filial piety affect the availability of instrumental informal support in old age among Japanese elders. Research shows that living arrangement, in particular co-residence, is the key factor in determining caregiving (Tennstedt et al., 1993). The availability of a caregiver associated with co-residence directly shapes patterns of instrumental support. These associations have important implications for health policy and for the development of formal support systems.

Including choices for co-residence, intergenerational relationships between elderly parents and their adult children become more affection-based, convenience-oriented, irrelevant to the *ie* ideology, and free from the norm of filial piety than they used to be (see Naoi, et al., 1984; Sakamoto, 1996). For most of today's Japanese, filial piety and the conception of *ie* sound old-fashioned, feudalistic, and unimportant to their everyday lives. Yet, this is not indicative of a weakening, but rather a reconstruction of intergenerational solidarity. An old thesis of family sociology known as "from institution to affection" seems appropriate to describe the changes in intergenerational solidarity that have occurred in Japan.

IMPLICATIONS FOR HEALTH POLICY

In Chapter 3, the increase in population aging in Japan and the rise in the rate of functional impairment associated with extended longevity were documented. The author contends that future health policy must consider both services targeting prevention among healthy elderly, as well as those aimed at assisting disabled, ill, or chronically impaired seniors. Among the well-elderly, changes in patterns of co-residence and instrumental assistance may inhibit the dissemination of health knowledge, since family members often play a role in health education and changing health behaviours, such as quitting smoking or increasing exercise. For the physically or mentally disabled, alterations in family caregiving may shift the responsibility of care from the family onto the government.

Over time, it is possible that changes in family norms and the availability of instrumental support will magnify the need for community-based formal services, health promotion efforts, and self-care practices. Individuals and communities may have to rely on the state and/or become more self-reliant to a greater degree than in the past, assuming that instrumental support declines. However, more research is needed on the interrelationship between informal and formal care, especially given the current climate of health policy reform in Japan.

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Chapter 5

Health Care in China and Hong Kong

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AGING POPULATION IN CHINA AND HONG KONG

The world's elderly population (aged 60 and over) in 1991 numbered nearly half a billion persons. China has more than 20% of the global total. In 1991, China still had a relatively "young" population with only 8.9% of the total population aged 60 and above. However, given its rapidly declining fertility, China is expected to have a substantially older population in the twenty-first century. According to a number of projections, the proportion of the Chinese population who will be elderly will be 17% by 2020. In absolute terms, the elderly population in China will be growing from 102 million in 1992 to 254 million by 2020 (Liang & Gu, 1989). At the same time, the age 75 and over population is projected to increase from 1.9% of the total population in 1991 to 4.1% by 2020 (U.S. Department of Commerce, 1992).

Hong Kong, a British colony until June 1997, was returned to China to become a special administrative region. Since over 98% of the population in Hong Kong are ethnic Chinese, it has been dominated by the Chinese culture, although western practices have also been prevalent, especially among the young and the educated. This encounter of different cultures is most apparent among the elderly because most of them have come from an agrarian social and economic background and are now the first

generation to grow old in a highly industrialized city (Chow, 1994). In the 1991 Census of Hong Kong, 13.5% of the total population, or 772,400 out of 5,674,114 persons, were found to be aged 60 and over, and 8.7% of the total were aged 65 and over (Census & Statistics Department, 1992). It is projected that by the year 2000, more than 15% of the population of Hong Kong will be aged 60 and over and the actual number will approach one million (Health and Welfare Branch, 1994).

As a result of population aging, the demand for elder health care in China and Hong Kong is expected to increase considerably (China Daily, 1989; Chi & Leung, 1995). Since the elderly are particularly prone to illnesses, many of which are chronic and degenerative in nature, they have utilized most of the available health care services. In China, however, geriatric medicine has not yet been developed as a standard medical care specialty. Elderly sick patients are still admitted to general medical units with younger patients. This has placed the elderly sick at a particular disadvantage in receiving the appropriate health care. In Hong Kong, geriatric medicine started about 20 years ago. However, the number of geriatric beds is far from satisfactory for providing services to its elderly population.

Relatively little is known about the influence of traditional culture on health-related behaviours. For instance, what impact does the traditional Chinese medicine (TCM) have on an elder's health? Most of the western-trained doctors have encountered Chinese patients mixing a prescription of Western-style drugs with Chinese herbal medicines. This is especially common among Chinese elderly patients (Tjam, Hirdes & Chi, 1996).

An important starting point in an attempt to gain some insight into what kind of health care older Chinese are likely to be receiving in China and Hong Kong is to examine their health policies and health care systems. Although Hong Kong and China share the same culture, the former is more Westernized and modernized. In addition, Hong Kong adopts a mainly Western health care model while China has both Western and traditional Chinese medicine. How would these differences affect the health care for their senior citizens? This chapter will first report on the health and vital statistics of China and Hong Kong. Demography and health data will be used to describe and assess China's health care system. The chapter will then discuss health care policy, health care organization and system (including the role of TCM), health insurance, and health care expenditures for the mainland and Hong Kong.

HEALTH CARE IN MAINLAND CHINA

Health and Vital Statistics

The history of health care since the founding of the People's Republic of China (PRC) in 1949 has been characterized as an expansion of services to benefit as far as possible the entire Chinese population. In 1949, China was known as the sick man of Asia, with a life expectancy of 32. The population of China reached 1.2 billion in 1995 at which point the birth rate was 1.7, the mortality rate was 6 deaths per 1,000, and life expectancy was 69 years (71 years for women and 68 years for men) (Ministry of Public Health, 1996).

Health Care Policy

Chinese health policy evolves within the same general framework that shapes every national health policy, including political ideology and economic resources. As these have changed, health policy has been transformed but always with roots in previous historical and cultural patterns. Like many other developing countries, China has struggled to deal, often in unique ways, with the same problems facing all health care systems, such as: equity, access, uniform financing, distribution of resources, and quality of care (Ron, Abel-Smith, & Tamburi, 1990).

It was clear to the PRC government that improving the nation's health could not be done solely by providing expensive curative health facilities. In 1950, the Ministry of Public Health called the First National Health Conference, which laid down the principles that still guide the provision of health services today. These were (Rosenthal, 1987):

- (1) medicine should serve the entire population, including workers, peasants and soldiers;
- (2) preventative health care should take precedence over curative medicine;
- (3) traditional Chinese medicine should be integrated with Western scientific medicine; and
- (4) health work should be combined with mass movements.

Achievements following these precepts have been remarkable, to the extent that China's health profile looks increasingly similar to those in the more industrialized countries of the West.

Health Care Organization

China organizes its health care system with relationships to important political units. These encompass its twenty-one provinces, three centrally governed large cities and counties within the provinces and villages (World Bank, 1984). Each has various health-related responsibilities that reflect general health policy which is formulated by the National Ministry of Health in Beijing. Health care facilities are owned by different government organizations in China, with wide variations throughout the country, in both the organization of medical care and types of resources available. It is a relatively decentralized system with financing and delivery left to local political units on the country and village levels. The decentralized nature of funding and administration means that services and facilities are unevenly distributed around the county. The problems of distribution of services and health personnel have been chronic and constitute the single most difficult challenge to Chinese health policy to this day (Rosenthal, 1987).

One of the characteristics of the health care system on the mainland is that it integrates TCM with Western medicine. All levels of the health care delivery system adopt both medical models. Specialized Western health care systems, such as hospitals and clinics, co-exist with specialized Chinese health care institutes. In 1995, there were 2,482 specialized Chinese hospitals (Ministry of Public Health, 1996). However, the number of specialized Chinese hospitals is relatively small in terms of the total number of hospitals. Also, many health care systems operate with both specialties, that is the TCM is accessible through other health care organizations. Therefore, most of the time patients could choose which medical care model they would like to have for the treatment of their illness.

Although some westerners doubt the efficacy of Chinese herbal medicine, it has a 5,000 year history of evaluation and use. Emperor Shen Nung is said to have started herbal medicine by testing the healing effects of various herbs. Another Emperor, Huang Ti (2,600 B.C.), laid the framework for Chinese medical science. His studies were focused on physiological and pathological problems and were compiled into a book entitled "Internal Medicine" about 25 centuries later by Han Dynasty scholars. "Internal Medicine" is understood as the oldest treatise on medicine in the world; even today it is the most valuable Chinese medical text which outlines the basic principles of Chinese medical practice.

The main difference between traditional Chinese medicine (TCM) and

Western medicine is that the latter treats symptoms, while TCM looks at the underlying problem and targets the whole body system. Chinese medicine treats the sick first by restoring the patient's inner strength, and then treating the disease; Western drugs cure certain diseases without knowledge of the underlying cause of the disease.

In earlier times, naturopathic and homeopathic medicine were practiced in Europe and North America along with herbal medicines. However, extracting the active components from plants led to the development of synthetic drugs in the early 19th century, and herbal drugs in their original forms have largely disappeared from Western drug stores. With the increased development of synthetic drugs, Western medicine has mainly focused on curative (allopathic) medicine rather than holistic or naturopathic medicine. Curative medicines such as antibiotics and steroids are used to treat thousands of diseases. It is interesting to note, however, that naturopathic medicine, and the use of herbs is again on the rise. The Chinese, however, have maintained the knowledge of herbal medicine throughout the centuries since 3500 B.C.

By the turn of the 20th century, although the flood of Western civilization challenged traditional Chinese culture, Chinese medicine continued to advance. Even in the face of Western medicinal miracles, it survived because the concept of holistic treatment constitutes the core of Chinese medicine. In 1978, the production of medicinal herbs in China reached 1.3 million tons, twice the amount produced in 1955. Then, in 1982, over 800,000 acres of land were put to use for the production of medicinal herbs. Today in China, traditional Chinese medicine is practiced by doctors who receive intensive training in Chinese medicine and additional training in basic Western medical sciences. The combined use of Chinese and Western techniques is encouraged: Western medicine has been providing good support for Chinese medicine.

HEALTH INSURANCE

Various forms of health care schemes have developed over the past 45 years in China, with wide variations by province and between urban and rural areas (Xin, 1985). However, from a financing point of view, the PRC does not have a unified insurance system but rather three major separate insurance funds that cover targeted populations. About two percent of the population is covered by a "public medical insurance"; this includes government workers and political cadre. A second plan covers an additional 10% to 12% of workers in government-owned factories and

farms. The rural population is covered by the "cooperative medical service" set up on a local basis but subject to the exigencies of crop failures and success (Ron et al., 1990). About 87.7% of the villages are thought to have service in place in 1991. It is quite obvious that medical service in China is characterized by a close relationship between health planning and economic development, that is, it has a strong emphasis on urban workers' health (Leung, 1992).

HEALTH INSURANCE FOR WORKERS IN CHINA

In China, workers can enjoy the necessary medical services for illness, injury and childbirth in accordance with the state provisions. This is the basic right of workers stipulated by the Constitution and laws. The medical coverage usually implemented for state-owned enterprise workers and retired persons is called "labour insurance medical coverage". Another system carried out for workers and retired persons of government agencies, political parties and groups, non-profit institutions as well as for university students and disabled soldiers is referred to as a "public medical service". Most of the items and standards under labour insurance medical coverage and public medical service are the same with a few exceptions. By the end of 1987 about 180 million persons were covered by these systems in urban areas. Among them 94.11 million were in service enterprises or government workers, about 50 million were direct dependents of workers, 14.24 million were retired workers and 20 million were workers from large collective enterprises (Ron et al., 1990).

When enterprise and government retired workers go to the appointed medical institutions for their illness, they have to pay a nominal registration fee, nutrition, and board expenses during hospitalization, while enterprise and government will bear their therapy, medications, operation, examination and hospitalization fees. One special feature in Chinese health care is that patients pay one fee for both outpatient consultation and medication.

Health Care Expenditure

Resource funds and administration systems are different between labour insurance medical coverage and the public medical service. Funds for medical coverage for enterprise workers are taken from costs according to a certain ratio of total wage and paid from a "welfare fund of enterprise workers". The total expenditure on health in 1990 was 2.3% of China's total GNP. About 40% of the amount was government

expenditure, and about 35% was borne by private households (Zhong-guo Wei Sheng Nian Jian, 1992). Experts from the World Bank estimate that the PRC will have to spend between 3% to 4% of GNP on its health care system in the coming years, a percentage somewhat higher than its Asian neighbours (World Bank, 1984).

In conclusion, health statistics on the population speak for themselves in terms of how well the Chinese health care system is performing but health care problems remain enormous and will continue, especially when its population is aging. Furthermore, China is undergoing major economic re-structuring, many health insurance providers are facing financial difficulties and they are reducing the coverage of medical care. Retired workers tend to suffer the most from these changes.

HEALTH CARE IN HONG KONG

Vital and Health Statistics

Based on available vital and health statistics, Hong Kong people appear to be in good health. Statistics collected in 1991 show that life expectancy for women was 82 years and for men 75. This was second to Japan and was better than in most developed countries. The infant mortality rate is 6.9 per 1,000 live births and the crude death rate is 4.9 per 1,000 population (Health & Welfare Branch, 1994). These figures are among the best in the world. Rates of cardiovascular and cerebrovascular disease are extremely low. So what causes such a successful health record in Hong Kong? Some speculate that it is the result of improvement in the overall standard of living of the people in Hong Kong. Others points to the lifestyle and family structure characteristics, particularly as reflected in the low rates of tobacco use, alcohol dependency, hospital admissions, low rates of family dissolution and infant mortality, factors which imply that Hong Kong residents have maintained healthy aspects of traditional culture and have adjusted to the health impacts of industrialization as well or better than most of the world's population (Hay, 1992).

Health Care Organization

Health care is provided by a two-tier public and private funding system. Patients are free to choose to go to whichever sector for whatever illness, and to move back and forth from one sector to the other. The public funded sector is administered under the Department of Health and a new quasi-nongovernmental agency, the Hospital Authority (HA),

to manage and operate all government and subvented hospitals in Hong Kong (WONCA, 1992). The Department of Health is mainly concerned with primary care services including general outpatient clinics, family health services (maternal and child health centres), social hygiene clinics (venereal disease), chest services (tuberculosis and other chest diseases) and public health services such as port health. The Department of Health has 54 general outpatient clinics which provides 17% of primary medical care in Hong Kong. It has 44 family health services centres taking care of over 90% of preventive care for children under 5 years old (WONCA, 1992). The HA was formed in 1991 and controls the government and subvented hospitals and the specialist outpatient clinics. The Government funded services have a total of 38 public hospitals (five regional, 15 general, three chest, three mental, one maternity, and the others convalescent or rehabilitative) providing over 90% of hospital care (WONCA, 1992).

The private sector consists of private general practitioners, specialists, and hospitals. About 50% of registered doctors in Hong Kong work in the private sector. Seventy percent of the primary medical care is provided by private doctors. There are 11 private hospitals providing under 10% of all hospital care in Hong Kong (WONCA, 1992). Only Western medicine is recognized by the government in Hong Kong. However, traditional Chinese medicine (TCM) has been practiced all along. Alternative medicine provides a significant 13% of primary medical care. It is mainly in the form of traditional Chinese herbal medicine. A recent study in Hong Kong showed more than 30% of adults use TCM. There are numerous Chinese doctors and herbal shops in Hong Kong. Chinese drugs are readily available in stores, people of all ages can self-administer Chinese medicines, with or without a prescription. Moreover there is no means of quality assurance because people can practice any form of alternative medicine without the need to provide evidence of competence. Two years ago, the Hong Kong government established a working group to review the regulations pertaining to traditional Chinese medicine. Before 1997, new legislation will be set up to include TCM in the mainstream health care system (Tjan, Hirdes & Chi, 1996).

Government funded health care allows direct access to primary care by anybody, including the very rich, but the service is limited by a quota system. There is a strict referral system from primary to secondary or tertiary care. The private funded system allows direct access to all levels of care with absolutely no control on what type of patients or problems are presented to what discipline of doctors.

Health Care Utilization and Expenditures

Nevertheless, the overall levels of health care utilization, both inpatient and outpatient, are substantially higher in Hong Kong than in other industrialized countries. The rates of minor illness leading to a doctor visit or to some restrictions in daily activities appear higher than in North America. It is not clear what accounts for these differences, although cultural differences and the relatively low cost of many medical care services in Hong Kong probably play some role.

The health care system in Hong Kong is characterized by being relatively inexpensive. According to official statistics, Hong Kong health care expenditures for the public sector are quite low by international comparison. The average cost of \$10 Canadian per bed day in public hospitals and \$8 for each general outpatient consultation is very low. These fees include professional service, all necessary investigations, treatment and medications. Hong Kong's public sector health care expenditure is around 2.5% of Gross Domestic Product (GDP), which is lower than most of the industrialized countries with a spending level of 4% to 6% of GDP (Hay, 1992). The public funds cover 90% of the inpatient (hospital) services and approximately 10% of the primary health care (WONCA, 1992). That means the majority of outpatient primary health care in Hong Kong is carried out by private doctors and private doctor fees in Hong Kong vary. The average private general practitioner consultation fee including medications is 12 Canadian dollars. However, the private specialist's fees are among the highest in the world. Only a small proportion of people can afford care in a private hospital because a fee is charged for every item of service, for example, the charge for one day of hospital stay is \$60 Canadian at the minimum and there are additional charges for the doctor's service, investigations and medications.

Elderly persons are a major user group of hospital services. They occupy on average 37% of bed-days in public hospitals and constitute an estimated 21% of patients at specialist clinics of the Hospital Authority. In addition, elderly persons constitute about 30% of patients at the general out-patient clinics of the Department of Health (Health & Welfare Branch, 1994).

Health Insurance

No public health insurance exists in Hong Kong. All health insurance schemes are run by private profit-making organizations and the private

medical insurance market has been growing at about 40% annually. Even so, less than 20% of the population are covered by health insurance. Those insured are most likely to be male, better educated, employed and with relatively higher income. In general, the level of medical benefits coverage is limited. A catastrophic medical event would quickly put the beneficiary of private insurance back into the government hospital system. In addition, medical insurers, have almost no ability to check the appropriateness of fees and services provided by doctors or to exclude or limit excessive fees or unnecessary claims from abusive doctors, hospitals or other providers. The Hong Kong Medical Council has insisted that medical insurers must cover services provided by all licensed Hong Kong doctors. This prohibition by the Council, against the formation of closed panels of doctors by medical insurers is the biggest barrier to enhancing the quality and efficiency of private medical care. It bars the development of any form of managed care which could correct the knowledge imbalance between the doctor and the consumer regarding appropriate fees and quality of medical care services.

Health Services for Elderly Persons

The Hospital Authority provides four types of medical services to elderly persons in Hong Kong. They are: (1) geriatric services; (2) infirmary service; (3) outreach medical service; and (4) psychogeriatric service. The geriatric services include geriatric in-patient, day patient and out-patient services that provide different levels of curative treatment to elderly persons who require acute medical care. Infirmary service is provided for patients who no longer require intensive medical treatment, but who are still in need of long term hospitalization. It enables elderly patients with unstable physical and mental conditions to be cared for in an institutional setting outside an acute hospital environment. Outreach medical services are provided through community-based geriatric teams to provide better interface between medical and welfare facilities. The teams undertake geriatric assessment to ensure proper placement of elderly patients who need residential care. Psychogeriatric teams provide early assessment and appropriate treatment for elderly persons with mental illness (Health & Welfare Branch, 1994).

The Department of Health operates four Elderly Health Centres that aim at promoting the health and well-being of elderly persons in the community. These centres offer physical examinations, simple screening

tests and special investigations for at-risk groups. Health education programmes aim not only at older people but also at their caregivers and volunteers. The emphasis is on the promotion of a healthy lifestyle, early detection of disease and self-care. Community participation in the promotion of health among elderly persons is encouraged (Health & Welfare Branch, 1994).

Health Care Policy

There has been a nearly total lack of discussion of the overall objectives of Hong Kong government health care policy. Perhaps the single most important reason for health policy stasis in Hong Kong is the fact that health care did not matter much until relatively recently. Health care is consumed in increasingly greater amounts as disposable per capita income rises. Hong Kong started the post World War II era with an income per capita of a poor third-world country and has risen to the middle ranks of the developed industrialized economies (Hay, 1992). The improvement in the living standard of the people in Hong Kong has made them demand better health care. As consumer expectation increases, the problems of the health care delivery system have become very obvious. The most fundamental issue is the overemphasis on hospital care with very little development in primary health care since the second world war. Health care policy has therefore developed at a very slow pace in Hong Kong. This has resulted in rapidly escalating costs in government health expenditures (WONCA, 1992).

Furthermore, abuse of services is common in the public sector because of the low cost. For instance, many people seek treatment at Accident and Emergency Departments for non-emergency cases; another example is hospitalization for problems that can be better dealt with in the community. As a result overcrowding in public hospitals has become intolerable. There is a long waiting time for public funded specialist service; on average, it takes three months to obtain an appointment to attend the medical specialist clinic (WONCA, 1992). There is increasing dissatisfaction from both consumers and providers who are urging the government to improve the situation. The establishment of a Hospital Authority is a major innovation to correct several health care problems that include: a sharp rise of government taxation revenues to match the growing demand for health care services; discontent with the overcrowding in government hospitals and outpatient clinics; problems of hospital administration and management; and problems with a rigid

system due to the inflexibility of management within a Civil Service structure of employment regulations (Hay, 1992).

Currently in Hong Kong, there is a clear conflict between the desire to have government ensure health care access for all and the recognition that the private market often provides goods and services more effectively and efficiently than does government. However, the division of responsibilities in health care delivery between the public and private sectors is ill-defined. This duplication of efforts and wastage of resources can lead to long-term systemic problems. The foremost objective of government health policy is to determine what is the most cost-effective funding system for effective health care in Hong Kong, given future patterns of population aging and increased demand on the system.

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Chapter 6

Health Care for the Korean Elderly: Emerging Trends and Issues

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Successful aging and life satisfaction in old age can be measured objectively through various criteria. This is especially true in Korea. There seems to exist four major issues concerning elderly life: 1) poverty and economic difficulties, 2) physical and mental health problems, 3) social isolation and alienation, and 4) loss of role in the family and in society. Of these central issues, 'health' is the most urgent and important issue of interest according to the Korean Gallup Poll.

The national medical insurance system in Korea is just 15 years old. Following the traditional way of elderly care by the extended family, the Korean people are largely expected to take care of their elderly parents within the family. Therefore, the Elderly Welfare Law (or, the Older Korean Act) implies that the primary responsibility of elderly care lies not with the government nor in society but in the family itself.

Government policy for the elderly tends to address concerns of low-income or no-offspring-elderly. Therefore, many elderly dementia and chronic disease patients do not receive appropriate medical care and health maintenance services from hospitals, nursing homes and other

professional institutions. In this chapter, the specific trends and related issues concerning Korean elderly health care will be discussed. The implication of changing patterns of family support and social change will also be addressed.

A. CURRENT SITUATION OF ELDERLY CARE IN KOREA

1. Statistics of the Korean Elderly

According to Government statistics, the elderly population is growing rapidly (Table 1). The ratio of persons aged 65 and over is currently 5.2% and the ratio of persons aged 60 and over is 9.0%. By the year 2000, these figures will increase to 6.8% and 10.7%, respectively. Even though the proportion of elderly in the population (5.2%) is not high compared to many countries, the mandatory retirement age is 55, and it is 58 years old in most of the private corporations. Therefore, the ratio of 'functional or social elderly' is close to 12%.

TABLE 1
Elderly Population Growth and Average Life Expectancy, 1960-2020

YEAR	PERCENTAGE OF ELDERLY (%)		AVERAGE LIFE EXPECTANCY		
	60+	65+	Mean	Male	Female
1960	5.5	3.3	55.3	53.0	57.8
1970	5.4	3.3	63.3	59.8	66.2
1980	6.1	3.8	65.9	62.7	9.1
1985	6.7	4.3	68.0	64.9	71.3
1990	7.7	5.0	70.2	67.1	73.6
1995	9.0	5.2	71.2	68.2	75.0
2000	10.7	6.8	72.6	69.3	76.2
2020	17.7	13.1	77.0	74.9	79.1

Source : Korean Institute for Health and Social Welfare (1992)

Furthermore, with the recent trend of restructuring and downsizing in the business circle, 'involuntary retirement with honour' or 'early retirement' is encouraged and covertly advised to middle-aged workers by management. Therefore, the exact number of retirees in Korea cannot be determined.

Another issue affecting the elderly population stems from the discrepancy between average life expectancy of males and females. As of 1995, the average life expectancy is 71.2 years for both sexes; however a difference of nearly seven years exists between the two sexes (male, 68.2 years and female, 75.0 years). Furthermore, the husband is about four years older than the wife in a first marriage. In the face of Asian cultural norms and customs, it is virtually impossible for middle-aged or elderly widows to remarry.

We observe that approximately 75% of women aged 65 and over are widows. As with many other countries, one significant issue among the elderly in Korea is the problems facing elderly widows who live alone or live with their children.

As Table 2 shows, the ratio of the elderly population to the remaining population is growing rapidly. In particular, the sex ratio for persons aged 65 and over will become 62.5 by the year 2000. Data for the annual growth rate by age group also indicate rapid growth for the 65 and over age group (4.0% in 1990, and 3.9% in 2000) relative to the negative rate of growth in the 0-14 age group (-1.3% in 1990, and -1.2% in 2000). Thus, while the dependency ratio of 'youth' is decreasing, that of the 'aged' is steadily increasing.

2. Mortality, Morbidity and Health Status

As Table 3 and Table 4 indicate, the mortality rate decreased from 1970 (9.4%) to 1988 (5.9%). However, it will increase from the year 1990 (5.8%) through the year 2000 (6.3%), extending to the year 2020 (10%). For the category of age 65 and over the male mortality rate is twice as high as the rate for females (Moon, 1995).

TABLE 2
Population Trends and Major Demographic Indices of the Elderly,
Republic of Korea (1960 – 2020)

AGE/YEAR	1960	1970	1980	1990	2000	2020
NO. OF POPULATION (thousand)						
Total Population	24,989	31,435	38,124	43,390	46,789	50,578
0 - 14	10,938	13,241	12,951	11,134	9,917	8,098
15 - 64	13,260	17,155	23,717	30,094	33,705	36,147
65 +	791	1,309	1,456	2,162	3,168	6,333
Sex ratio (65+)	76.3	62.1	59.5	60.0	62.5	78.5
PROPORTION BY AGE-GROUP (%)						
0 - 14	43.8	42.1	34.0	25.7	21.2	16.0
15 - 64	53.1	54.6	62.2	69.3	72.0	71.5
65 +	3.2	3.3	3.8	5.0	6.8	12.5
ANNUAL GROWTH RATE BY AGE-GROUP (%)						
Total population	—	2.4	1.9	1.3	0.8	0.4
0 - 14	—	2.0	-0.0	-1.3	-1.2	-1.0
15 - 64	—	2.7	3.3	2.4	1.1	0.4
65 +	—	2.8	3.4	4.0	3.9	3.5
DEPENDENCY RATIO (%)						
Total dependency ratio	88.5	83.8	60.7	44.6	38.8	39.9
Youth dependency ratio	82.5	78.2	54.6	37.4	29.4	22.4
Aged dependency ratio	6.0	5.7	6.1	7.2	9.4	17.5
Aging index	7.2	7.2	11.2	19.4	31.9	78.2

Source: National Office of Statistics, Census Reports, respective census years.

TABLE 3
Change of Mortality Rate (per thousand) by Year

	1970	1975	1980	1985	1988	1990	2000	2020
Mortality	9.4	7.6	7.4	6.5	5.9	5.8	6.3	10.0

Source: Office of Statistics, ROK (1990)

TABLE 4
Mortality by Age: Sixty Years and Over (60+) (per 1,000)

AGE RANGE	MALE			FEMALE		
	1970	1980	1990	1970	1980	1990
60 - 64	40.0	37.9	27.3	18.7	15.7	11.3
65 - 69	66.9	63.7	45.3	30.2	26.4	20.0
70 - 74	96.3	92.0	68.1	49.1	50.6	35.7
75 - 79	151.0	144.0	113.1	82.3	77.1	60.8
80+	228.2	222.6	228.9	177.4	170.3	142.6

Source : Office of Statistics, ROK (1990)

TABLE 5
Top Five Causes of Death and Mortality Rate Per 100,000 Persons (by age)

RANK	1st	2nd	3rd	4th	5th
TOTAL	Cancer(110.9)	CD(80.4)	AD(69.1)	HD(43.5)	CLD(28.6)
Male	Cancer(136.9)	AD(100.3)	CD(75.4)	CLD(45.7)	HD(42.8)
Female	CD(86.9)	Cancer(83.6)	HD(44.7)	AD(35.9)	HT(29.2)
50-59	Cancer(289.8)	CD(116.9)	AD(106.4)	CLD(93.9)	HD(62.2)
60-69	Cancer(588.3)	CD(366.8)	HD(148.4)	HT(121.9)	AD(120.9)
70+	CD(1531.2)	Cancer(998.1)	HD(764.5)	HT(542.8)	AD(223.6)

CD=Cerebrovascular diseases; AD=Accidental death; HD=Heart diseases; CLD=Chronic liver diseases; HT=Hypertension

Source: Office of Statistics, ROK (1994)

According to Table 5, cancer ranks first as a cause of death. While accidental death, malignant neoplasms, and suicide are the major causes of death in the younger generations (age ranges 10-19, 20-29 and 30-39), cancer and cerebrovascular diseases are the major causes of death in old age.

The cause of death in the elderly population (age 65 and over) is changing. In 1993, malignant neoplasms and diseases of the circulatory system were the chief causes of death (Table 6). In 1966, the major causes were infectious and parasitic diseases, and symptoms, signs and ill-defined conditions.

TABLE 6
Change of Cause of Death in the Elderly Population (65+) (%)

YEAR	1966	1980	1984	1993
Infectious and Parasitic Diseases	14.6	2.4	3.0	2.7
Malignant Neoplasms	5.9	10.4	7.8	22.2
Endocrine, Nutritional, Metabolic Diseases, Immunity Disorders	0.1	1.2	0.9	4.6
Mental Disorders	—	0.7	0.3	1.0
Diseases of the Nervous System and Sense Organs	1.6	0.6	0.3	1.3
Diseases of the Circulatory System	10.8	39.1	31.6	38.2
Diseases of the Respiratory System	16.0	7.2	4.3	8.1
Diseases of the Digestive System	7.0	7.7	4.8	5.7
Diseases of the Genitourinary System	1.5	0.8	0.6	1.4
Diseases of the Skin and Subcutaneous Tissue	—	0.1	—	0.2
Congenital Anomalies	—	—	—	—
Certain Conditions Originating in the Perinatal Period	—	—	—	—
Diseases of the Musculoskeletal System and Connective Tissues	—	0.4	0.4	1.3
Symptoms, Signs and Ill-defined Conditions	37.4	26.9	45.2	5.5
Injury and Poisoning	4.5	2.3	1.7	7.6
Total	100.0	100.0	100.0	100.0

Source: Office of Statistics, ROK (1994)

TABLE 7
Morbidity Rate, Sick Days, Sick Days in Bed in Elderly (Population (in 2 wks.))

	AGEYEAR MORBIDITY RATE (%)			SICK DAYS			SICK DAYS IN BED		
	1986	1989	1992	1986	1989	1992	1986	1989	1992
total	12.0	16.6	18.5	6.2	6.4	5.9	2.0	1.0	0.9
65+	18.2	25.0	26.5	8.6	8.3	8.1	3.9	2.2	1.9

Source: Office of Statistics, ROK. Social Index (1990)

TABLE 8
Immobilized Elderly (Bed-ridden)

AGE	PARTICIPANT	IMMOBILIZED ELDERLY	RATIO (%)
60 and over	3,704	132	3.6
male	1,471	53	3.6
female	2,233	79	3.6
65 and over	2,422	110	4.5

Source: Lim (1985)

The morbidity rate among persons aged 65 and over increased from 18.2% in 1986 to 26.5% in 1992. However, the statistics for sick days and sick days in bed decreased slightly. Even though the sick days of the elderly decreased slightly, the morbidity rate, frequency of sick days, and the sick days in bed of the elderly is still the highest among all age groups (Table 7).

The proportion of immobilized elderly (bed-ridden) is 3.6% for persons aged 60 and over, and 4.5% of those 65 and over (Table 8). The average daily activity level (ADL) criteria for immobility include the following five items: washing face and hands, bathing, changing clothes, indoor mobility, and using restrooms. This proportion is similar to the figure for Japanese elderly (4.6% of the elderly age 65 and over were bed-ridden in 1986).

As Table 9 indicates, medical examinations have increased tremendously, particularly for the elderly (3,321,000 in 1988 compared to 10,067,000 in 1993). The annual growth rate is 24.8%, with annual growth for the total population standing at 17.4%.

The number of chronic disease cases in the total population has also risen, more than doubling from 11,090 in 1988 to 29,964 in 1993. The number of chronic disease cases among the elderly has also increased about four times, with an annual increase of 28.5%.

In addition, all three ratios in the bottom section of Table 9 reveal annual increases in chronic diseases among the elderly. The ratio [D/B = number of elderly cases with chronic disease/incidents of elderly examination] has especially increased, from 38.3% in 1988 to 44.2% in 1993. This implies that the morbidity rate of the elderly is high in comparison to the general population (C/A).

TABLE 9
Chronic Diseases in Elderly (age 65 and over)

YEAR	1988	1990	1992	1993	AVERAGE ANNUAL INCREASE (%)
No. of examinations					
total population (A)	69,622	125,678	141,088	155,492	17.4
(Unit: 1000) elderly (B)	3,321	6,506	8,567	10,067	24.8
No. of cases of chronic diseases					
total (C)	11,090	20,647	25,336	29,964	22.0
elderly (D)	1,271	2,550	3,583	4,451	28.5
Ratio (C/A)	15.9%	16.4%	18.0%	19.3%	
Ratio (D/B)	38.3%	39.2%	41.8%	44.2%	
Ratio (D/C)	11.5%	12.4%	13.2%	14.9%	

Source: The Korean Medical Insurance Association Statistics, (1988-1993)

According to Table 10, the major prevalent chronic diseases are hypertension, chronic respiratory diseases, chronic digestive diseases, arthralgia, and lumbago. However the degree of interference in daily living across the diseases is variable. In rank order, these are hypertension, stroke, arthralgia, lumbago, and dementia.

TABLE 10.
Prevalence of Chronic Diseases, Degree of Interference in
Daily Living and Treatment Group

	PREVALENCE OF CHRONIC DISEASES	RATIO OF EXAMINATION BY PHYSICIAN	DEGREE OF INTERFERENCE IN DAILY LIVING	CURRENT RATIO OF TREATMENT
Malignant neoplasms	1.0	100.0	52.0	28.6
Diabetes mellitus	6.4	96.6	70.1	77.3
Hypertension	18.8	90.1	69.4	67.4
Stroke	6.1	85.7	94.3	61.9
Chronic respiratory disease	12.0	73.4	75.0	59.4
Tuberculosis	1.5	100.0	47.3	33.4
Chronic digestive disease	18.7	70.0	76.4	76.7
Arthralgia	57.8	69.1	88.8	61.2
Lumbago	32.6	66.2	91.0	57.5
Fracture, Dislocation	4.7	96.9	84.2	43.8
Cataracts	9.1	93.6	74.8	38.4
Dementia	2.0	60.4	95.5	27.3

Source: Rhee (1994)

Several major characteristics distinguish patterns of caregiving for elderly patients (see Table 11). It should also be noted that:

- 1) Elderly with multiple limitations showed a high rate of 'no care'. For example, 80.9% of the elderly with high ADL limitations (5-6 types) do not receive any care.
- 2) The older the elderly, the lower the care-receiving rate. For example, compared with the age group of 65-69, of whom only 42% do not receive care, 75.4% of the elderly age 80 and over receive no care.
- 3) 26% of the elderly living alone and 50.6% of those with spouses do not receive any care.

The major factors are living arrangements, age and activities of daily living.

TABLE 11
Presence of Caregiver in Daily Living for Elderly Patients (65 and over)

	RECEIVING CARE	RECEIVING NO CARE	TOTAL
Total	54.1 %	45.9 %	100.0
Limitations on activities of daily living			
1-2	59.1	40.9	100.0
3-4	39.5	60.5	100.0
5-6	19.1	80.9	100.0
Area			
city	41.8	58.2	100.0
rural	47.4	52.6	100.0
Gender			
male	48.8	51.2	100.0
female	47.4	52.6	100.0
Age			
65-69	58.0	42.0	100.0
70-74	53.1	46.9	100.0
75-79	42.8	57.2	100.0
80+	24.6	75.4	100.0
Total number of co-habitants			
1-3	54.1	45.9	100.0
4+	33.8	66.2	100.0
Form of family unit			
single	73.8	6.2	100.0
with spouse	49.4	50.6	100.0
with children	35.7	64.3	100.0
other	45.1	54.9	100.0

Source: Rhee (1994).

3. Medical Cost and the Insurance System

As Table 12 shows, the ratio of medical costs for the elderly to total population is estimated to increase from 12% in 1995 to 17.7% in 2000, while the actual cost of medical fees for the elderly (B) will increase from \$839 million US in 1995 to \$2,351 million US in 2000.

TABLE 12
Estimate of Medical Costs for the Elderly

YEAR	TOTAL MEDICAL COST (A)	MEDICAL FEE FOR ELDERLY (B)	B/A (%)
1993	43,025 (5,378)	4,441 (555)	10.3
1994	48,692 (6,089)	5,457 (682)	11.1
1995	55,719 (6,965)	6,708 (839)	12.0
1996	63,408 (7,926)	8,244 (1,031)	13.0
1997	72,158 (9,020)	10,132 (1,267)	14.0
1998	82,116 (10,265)	12,452 (1,559)	15.2
1999	93,448 (11,681)	15,304 (1,913)	16.4
2000	106,345 (13,293)	18,808 (2,351)	17.7

Unit: 100 Million Won (Million \$ US)
Source: Moon (1995).

There are three different types of medical insurance systems in Korea:

- 1) Employment medical insurance (for private companies or organizations)
- 2) Government employees (for civil servants, military and public school teachers) and teachers' medical insurance
- 3) Regional medical insurance (for small scale businesses and self-employed individuals in urban and rural areas)

Between 1985, 1990 and 1993, the total number of persons aged 65 and over increased in all of the three insurance systems (Table 13).

TABLE 13
Number of Examinations in the Medical Insurance System

	1985	1990	1993
Employment medical insurance			
Total	34,223	54,855	63,536
60 +	1,649 (4.8)	4,498 (8.2)	6,848 (10.8)
65 +	890 (2.6)	2,644 (4.8)	4,113 (6.5)
Government employees & teachers' medical insurance			
Total	—	16,633	19,170
60 +	—	1,950 (11.7)	2,711 (14.1)
65 +	—	1,224 (7.4)	1,721 (9.0)
Regional medical insurance			
Total	—	54,188	72,685
60 +	—	4,244 (7.8)	6,757 (9.3)
65 +	—	2,629 (4.9)	4,223 (5.8)

Unit: thousand, () = % of total population

Source: Korean Medical Insurance Association. Medical Insurance Statistics, 1985, 1990, 1993.

Table 14 presents the ratio of elderly population costs to total costs of medical insurance payment.

TABLE 14
Ratio of Elderly Population Cost to Total Cost of Medical Insurance (allowance) (%)

	1985	1990	1993
Employment medical insurance			
60 +	8.9	14.1	17.0
65 +	4.8	8.5	10.5
Government employees & teachers' medical insurance			
60 +	12.3	19.3	22.1
65 +	7.5	12.5	14.5
Regional medical insurance			
60 +	—	12.2	14.3
65 +	—	7.6	9.1

Source: Korean Medical Insurance Association. Medical Insurance Statistics, 1985, 1990, 1993.

As observed, the ratio is increasing annually in all three insurance systems. For example, in the case of Government employees and teachers' medical insurance, the cost of the elderly (age 65+) increased from 7.5% in 1985 to 14.5% in 1993. Therefore, the insurance burden for the elderly is becoming heavier. The trend of medical cost increment for the elderly has also recently become significant (Table 15). While total medical costs per person in the general population have increased by 214.2% between 1985 and 1993, the cost per elderly person has increased 298.2%.

Similarly, the cost per elderly person increased 325.2% for government employees and teachers' medical insurance, and 406.9% for regional medical insurance over the same period. Therefore, the growth in the elderly population is making medical insurance coverage considerably more costly for the Korean government.

TABLE 15
Trend of Increase in Medical Cost per Elderly

YEAR	1985	1990	1993
Employment medical insurance			
Total	100.0	157.8	214.2
60 +	100.0	191.3	289.3
65 +	100.0	191.3	298.2
Government employees & teachers' medical insurance			
Total	100.0	160.5	217.0
60 +	100.0	201.0	309.5
65 +	100.0	206.0	325.2
Regional medical insurance			
Total	100.0	248.8	363.7
60 +	100.0	235.2	391.4
65 +	100.0	235.8	406.9

Source: Korean Medical Insurance Association. Medical Insurance Statistics, 1985, 1990, 1993.

B. HEALTH CARE POLICY FOR THE ELDERLY IN KOREA

The major health care policy framework for the elderly is not very different from other major developed or Western countries (Moon, 1995).

The general programs are as follows;

1. Health maintenance services:

- (1) health examination
- (2) health counseling
- (3) health education
- (4) ADL, competence training and rehabilitation
- (5) home visiting health services

2. Home health and medical services:

- (1) home visit nursing services
- (2) day care and night care services
- (3) short-stay services
- (4) home helper services
- (5) equipment supply services

3. Medical treatment and nursing care services:

- (1) special hospital for the aged
- (2) skilled nursing home
- (3) general care facility for the disabled and ill elderly
- (4) private sector investment (e.g. Samsung Life Insurance Welfare Foundation is currently constructing a large facility for healthy and ill elderly).

Even though only 5.7% of the total population was age 65 and over in 1995, 10% of the total hospital beds were occupied by the elderly (Table 16).

Furthermore, the percentage of hospital beds occupied by the elderly will reach 10.3% in 1997, and about 7,500 new beds will be needed to meet the demand. However, hospital beds are in short supply.

TABLE 16
Estimated Number of Hospital Beds for the Elderly and Present Percentage of Beds Occupied by the Elderly

YEAR	ELDERLY POPULATION (THOUSAND)	% OF POPULATION ELDERLY	NO. OF HOSPITAL BEDS	% OF HOSPITAL BEDS OCCUPIED BY ELDERLY	ESTIMATE NO. OF BEDS NEEDED
1993	2,362	5.4	125,102	9.7	
1994	2,450	5.5	135,102	9.8	3,240
1995	2,543	5.7	145,102	10.0	4,510
1996	2,643	5.8	155,102	10.1	5,665
1997	2,760	6.0	165,102	10.3	7,006

Source: Moon (1995).

The number of professional and skilled nursing homes and hospitals and their budgets will need to be drastically increased. There were only 10 professional nursing homes in Korea as of 1996, and only 3 are special medical centers for the elderly. By 1998, the number of professional nursing homes will reach 20 and the budget estimate will be \$50.3 million US, and 15 special medical centers for the elderly will spend \$468.8 million US (Table 17).

TABLE 17
Plan for Financial Support for Professional Nursing Homes and Hospitals for the Elderly

YEAR	PROFESSIONAL NURSING HOMES			SPECIAL MEDICAL CENTRES FOR ELDERLY		
	NUMBER	BUDGET ESTIMATE	(%)	NUMBER	BUDGET ESTIMATE	(%)
1995	6	3,869	(4.9)	—		
1996	4	9,008	(11.3)	3	75,000	(93.8)
1997	5	12,304	(15.4)	3	75,000	(93.8)
1998	5	15,040	(18.8)	9	225,000	(281.3)
Total	20	40,221	(50.3)	15	375,000	(468.8)

unit : Million Won (\$ Million US)

Only three kinds of nursing care facilities exist for sick elderly in Korea, and this number cannot accommodate the current demand (Table 18).

- (1) Free nursing homes (n=34) in which only the elderly under the poverty level with senile or chronic diseases can be admitted;
- (2) Minimum fee nursing homes (n=14) for the persons aged 65 and over from low income families who are required to pay a nominal fee for admission and care; and
- (3) Full expense paying nursing home (n=1)

This third system has been recently initiated in Korea and residents are required to pay the full cost of facility expenses. Since 1995, many big business groups and individuals have begun to build such types of facilities throughout the nation.

In order to enhance the welfare status of Korean elderly in the upcoming 21st century, beds for sick elderly will need to be drastically expanded.

TABLE 18
Nursing Care Facilities for the Sick Elderly (3 kinds)

TYPE	QUALIFICATION FOR ADMISSION	NUMBER OF FACILITIES	NUMBER OF PERSONS
Free	65 + Poverty level Government life-protecting family Senile, chronic disease	34	2993
Minimum fee	65 + Low income family chronic disease	14	897
Full expense	60 + Paying Chronic disease	1	67

C. HEALTH CARE ISSUES FOR THE KOREAN ELDERLY

Korean elderly have had unique historical experiences. They experienced 36 years of Japanese rule (1910-1945) as well as political and social turmoil after the country's liberation (1945). In addition, they have survived the Korean War (1950-53) either as military personnel or as refugees. Several million people suffered separation from close families

who could not flee from the North (Yoon, 1995a). They have also experienced rapid social change and industrialization. The country has rapidly transferred from an agricultural society to an industrialized one. The current high-tech society in which we are living is uncomfortable to many Korean elderly. Rapid development of transportation, telecommunication, and the influence of mass-media have exposed Korean elderly to significant social change, making their adjustment process difficult.

In addition, social values and family life have changed drastically. The nuclear family appears to be replacing extended family systems over time. Therefore, expectations for the care of the elderly and the reality of the elderly situation are not congruent. The collectivistic way of thinking is diminishing and is being replaced by individualism. These changes have led to a weakening of instrumental support originating from the family network (Yoon, 1995b).

The psychological adjustment of the elderly depends on the kinds of resources and stress-coping mechanisms available. For example, according to the phenomenological model for stress-coping behavior (Folkman & Lazarus, 1980), the elderly can appraise possible resources and experience their chronic illness and symptoms differentially. If they have adequate coping resources – physical, psychological, social and material – to confront poor health condition and diseases, they may avoid depressive mood or exhaustion.

Among the social resources available for most ill elderly in Korea, family support is probably the most important factor for health maintenance and treatment of disease. The economic stability and high income level of the family provide especially strong support during poor health.

The traditional family inheritance (The *Ho-Joo*) system still exists in Korea. Through this system, family name can be passed from generation to generation without disruption. In most cases, the eldest son plays the role of transmission. In addition to carrying the family name of the extended family, division of wealth favors the eldest son. Even though the law specifies equal division between children, it is customary for the eldest son to take a larger portion of family wealth compared with other sons and daughters (Yoon, 1995c).

The emotional care provided by the immediate family is often deemed more important than physical and financial care. Emotional ties or conflict between a Korean elder and his/her daughter-in-law is a key factor in elder care in the home. Usually, some tension exists between the

two parties. Emotional warmth and family harmony will often depend on the level of psychological and interpersonal tension.

In summary, Korean elderly wish to be cared for by the eldest son's family at home rather than at a modern nursing facility. In addition, the older generation in Korea prefer living in their older houses or single units rather than in large-scale apartment complexes or group homes. However, increasing rates of chronic illness, in tandem with shifts in family structure and values surrounding care of elderly, are changing the face of health care and aging in Korea.

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Chapter 7

**FIRST NATIONS ELDERS IN CANADA:
ISSUES, PROBLEMS AND SUCCESSSES
IN HEALTH CARE POLICY**

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INTRODUCTION

First Nations elders in Canada have faced a range of problems that reflect the special circumstances of life both on and off the reserve. Widespread discrimination, a severe shortage of housing, high unemployment, the residential school system, high rates of dependency on social assistance, and limited access to preventive and reactive health care have contributed to an intensely severe life course for many older Natives. The consequences of these conditions have placed Native elderly at the centre of policy discussions around population health. However, until recently, a major impediment to discussing formal service options targeting First Nations elders, either from within or in

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partnership with Native communities, has been the lack of attention to population aging.

The field of gerontology has only begun to devote attention to the specific problems faced by First Nations elders in Canada. In 1993, the Canadian Association on Gerontology developed a brief to the Royal Commission on Aboriginal Peoples entitled *Older Aboriginal People in Canada*. A document entitled *Aboriginal Seniors' Issues* was released by the National Advisory Council on Aging in 1994. These reports represented the beginning of a burgeoning substantive field within gerontology. This chapter aims to: 1) provide a demographic and health profile of Native elders in Canada using data from the 1991 Aboriginal Peoples Survey conducted by Statistics Canada, as well as from other federal and provincial sources; 2) address a selection of underlying problems and issues that communities face in the provision of care for Native elders; 3) cover changes in health policy from the perspective of Native communities and from various levels of Canadian government; 4) propose a health policy strategy for the impending transition to self-government; and 5) describe several innovative formal care options developed in response to current and future social change. British Columbia is selected as a case study because the authors draw, in part, from their participation in eight provincial workshops and consultations on Native adult care. Diverse provincial experiences in the dynamics of elder care issues are also presented.

BACKGROUND

Based on the 20% sample of the 1991 Canadian census, it is estimated that there were 470,610 Canadians who selected as a single ethnic origin. North American Indian, Metis and Inuit. A further 575,275 Canadians claimed one of those same ethnic groups as a multiple origin, summing to 1,045,885 people (Statistics Canada, 1993a). In Canada, about 37% of on-reserve status Indians live in urban areas, 39% in rural areas, 19% in special access (fly-in) areas, and 5% in remote areas (Department of Indian Affairs and Northern Development, 1990).

British Columbia is home to approximately 17% of all status Indians in Canada. However, 33% of all bands can be found in B.C., totalling 197. Due to its mountainous geography, the relatively small and isolated First Nations communities in British Columbia are constrained in the development and implementation of elder care programs. Approximately 53% of status Indians live on reserves in British

Columbia. In this chapter, the terms "communities" and "reserves" will be used interchangeably in an attempt to transcend the legal description under the Indian Act. In addition, focus will be placed on reserve communities rather than non-reserve Native elders, given their unique factors that determine health policy.

It is well recognized that there is a severe lack of services in First Nations communities across Canada. Until recently, First Nations elders and disabled persons living on reserves were provided limited services within the policy and funding constraints of the Department of Indian Affairs Social Development. Although there is considerable variation in the service infrastructure within First Nations communities, policy and funding have mainly been restricted to the provision of homemaker services. Based on the communities' specific priorities and resources, some communities provide care outside of departmental policy. Provincial continuing care services afford little assistance to Natives living on reserves, especially if they live in non-urban areas. For example, the Ontario Ministry of Health reports that its Home Care Program is available in only 16 of the 128 First Nations reserves in that province. There are only three long term care facilities built on reserve lands in the province of British Columbia. These problems will be compounded by future increases in population aging within Native communities on and off reserve lands.

Another problem is that, generally, elder care issues have not been high on the political agenda of First Nations. Furthermore, as stated by Frideres (1994), "elderly Native people have experienced double alienation, as they have remained outside the mainstream Canadian institutional structure as well as outside the changing Native community" (p. 30). The present situation is, in part, the result of historical patterns of racism and inequality. However, the strength of cultural heritage in First Nations communities is a testimony to the courage, wisdom, and resilience of Native elders.

PROBLEMS IN DEFINING NATIVE ELDERS

In Canadian society, definitions of "old age", "senior" and "elderly" have been, at least in part, influenced by social policy. Typically, the arbitrary age of 65 has been used as a systematic designate of old age for the purpose of distributing public pensions. While this chronological marker is increasingly being questioned as a useful definition of old age for all Canadians, it is particularly problematic for Aboriginal Peoples of

Canada. Native culture uses the term elder to describe an individual who has gained wisdom from life and who uses that wisdom to educate others in their community (Ontario Advisory Council on Senior Citizens, 1993, p. 19). For some Native communities, elders may be as young as 45.

An additional issue underlying the use of the 65 and over selection criterion for Native Canadians is that their life expectancy is considerably lower than non-Natives. Although the gap is narrowing, the life expectancy of status Indians was approximately 10 years lower than the national average in 1981, while in 1991, it was approximately 6 and 7 years lower for men and women respectively (Frideres, 1993). This mortality differential reflects past and current inequalities in the health status and the quality of life of Natives compared to non-Natives. It is also indicative of a different tempo of aging, what is termed asynchronization in the gerontological literature. This has been shown to be associated with one's ethnic status (Bienvenue and Havens, 1986).

In comparison to non-Natives, the socio-economic conditions on reserves have restricted the ability of the current cohort of elders to prepare for retirement. Some of the socio-economic factors that appear to affect earlier life and quality of life as an elder include a lack of economic opportunities, high unemployment, and the absence of adequate preventative health care services. Given that Native culture defines elders in terms of accrued wisdom and that Aboriginals have a significantly lower life expectancy than non-Natives, the typical selection criterion used to define elderly is not appropriate for Natives. Assuming that social policy in modern democratic states is predicated on fairness, equity and need, policy makers need to rethink the use of age 65 as a starting point for the distribution of public pensions in the case of Native Canadians. Armstrong-Esther and Buchignani (1987) propose using 55 and over as a more useful age criterion in their study of health care utilization among the Blood Tribe. In the document entitled, *Denied Too Long: The Needs and Concerns of Seniors Living in First Nation Communities in Ontario*, it was also suggested that 55 and over be used (Ontario Advisory Council on Senior Citizens, 1993). Regardless of the age criterion, it is important to document the extent of population aging among Native populations.

POPULATION AGING OF NATIVE COMMUNITIES

The age structure of the Native population is young relative to the total Canadian population. The median age of the total status Indian

population was 19 in 1981 and 23 in 1991 compared to 30 and 33 for the total Canadian population (Indian and Northern Affairs Canada, 1989). In 1981, only about 3.5% of the Native population was aged 65 and over compared with 9.1% of the total population (Statistics Canada, 1984). In 1991, the percentages were 4.5% for the Aboriginal population (Statistics Canada, 1993b) and 11.6% for the total population (Statistics Canada, 1992).

However, the Native population is expected to age rapidly into the next century. It has been estimated that the proportion of Natives aged 65 and over will double between 1981 and 2001 from about 3.5% to 7% (Department of Indian Affairs and Northern Development, 1990). The projected percentage of First Nations peoples aged 55 and over is approximately double that for the 65 and over group. This pattern is expected because both fertility and mortality rates have been dropping significantly for Natives. In fact, the rate of population aging among First Nations is approaching that experienced by the Canadian population during the 1960s and 1970s. However, the implications of population aging are even more far-reaching for Natives than for the rest of the country because of the absence of a comprehensive service delivery system in First Nations communities. This problem is magnified by the fact that the health status of Native peoples is significantly lower than the rest of Canadian society. We turn now to a profile of Native health status.

COMPARATIVE HEALTH AND DISABILITY

A considerable literature has accumulated that documents the poor level of health experienced by Aboriginal Peoples compared to other Canadians (see for example, Siggner, 1986; Indian and Northern Affairs Canada, 1989; Department of Indian Affairs and Northern Development, 1990; Health and Welfare Canada, 1991a; Health and Welfare Canada, 1991b; Frideres, 1993; Statistics Canada, 1993c). These publications have tended to use measures of mortality (combined and by cause of death), the incidence and prevalence of diseases, and utilization of health services.

Although it has been demonstrated that the health status of Native Canadians is improving, there continues to be a significant gap between Natives and non-Natives. One important measure of community health status, and social development more generally, is infant mortality. The infant mortality rate (number of infant deaths per 1,000 live births) for the registered Indian population was 33.6 in 1977, 17.0 in 1982 and 13.7 in 1987 (Health and Welfare Canada, 1991a). The respective figures for the

Canadian population were 12.4, 9.1 and 7.3. This represents a differential in the infant mortality rate that is almost three times the national average in 1977 and about two times the Canadian average in 1987. A similar gap is observed for the age standardized mortality rate for status Indians in British Columbia compared with the provincial rate between 1987 and 1992 (Health Canada, 1993).

The leading causes of death for middle-aged Native Canadians (aged 15 to 44) are external causes of death. Deaths by injury and poisoning accounted for 87% of all deaths among status Indians aged 15 to 24 and 64% of all deaths among those 25-45 between 1986 and 1988 (Health and Welfare Canada, 1993a). For status Indians aged 45 to 64, the proportions were: injury and poisoning (21.5%), neoplasms (18.6%), diseases of the circulatory system (17.9%), and diseases of the respiratory system (6.7%). Among those aged 65 and over, the leading causes of death during this period were: diseases of the circulatory system (40.7%), neoplasms (16.7%), diseases of the respiratory system (6.8%) and injury and poisoning (4.4%) (Health and Welfare Canada, 1993a).

Specific comparisons have been made between Status Indians and non-Natives in British Columbia for the leading causes of death using age-standardized mortality rates (ASMR) by cause (Medical Services Branch, 1993). Standardizing for age statistically controls for the differences in age structure between the two populations. These comparisons demonstrate a clear pattern of mortality inequality between Natives and non-Natives. In British Columbia between 1987 and 1992, the greatest differences between the Status Indian ASMRs and the provincial ASMRs were for the following causes of death: alcohol-related death (six and a half times higher); medically treatable diseases (five times higher); digestive system diseases (four times higher); all external causes of death (more than three times higher); motor vehicle accidents (three and a half times higher); suicide (over three times higher); respiratory diseases (two times higher); and circulatory system diseases (almost one and a half times higher).

Considerably higher rates of diabetes (prevalence as high as 40% among those 45 years of age and older compared to 5% in the Canadian population), osteoporosis, arthritis, heart disease, stroke, and hypertension have also been documented (e.g., Frideres, 1993; Ontario Advisory Council on Senior Citizens, 1993). These specific problems are especially common among older adults and have contributed to hospitalization rates among Natives that are estimated to be at least twice the national average.

Less attention has been devoted to disability, with two notable exceptions: 1) a recent document based on the 1991 Aboriginal Peoples Survey (Statistics Canada, 1993c), and 2) a report produced by the British Columbia Aboriginal Network on Disability Society (BCANDS, 1993). Table 1 shows comparisons of disability for Aboriginal and non-Aboriginal populations based on the 1991 Aboriginal Peoples Survey (APS) and the 1991 Health and Activity Limitation Survey. Overall, a striking 31% of the total Aboriginal population (n=373,785) reported some disability compared to 15% for the non-Aboriginal population. Also, 33% of Natives living on reserves reported some disability.

The distribution of disability types among those who have some disability provides some additional comparative information (see Table 1). Whereas small differences between the groups are observed for mobility and agility disabilities, and level of severity, significant differences arise for hearing and seeing. About 35% of disabled Aboriginals included in the survey report a hearing problem compared to only 23% of disabled non-Aboriginal. In addition, approximately 24% of all Aboriginals who were disabled and 32% of disabled North American Indians living on reserve report a seeing disability. This can be compared to only 9% of disabled non-Aboriginals. Further, 88% of all disabled Aboriginal people and 90% of those living on reserves who identify themselves as North American Indians, reported that they receive assistance with everyday housework, compared to 81% among disabled people who are non-Aboriginal. These latter differences would be expected to be even more substantial if we compared only older disabled people because of the greater propensity for non-Natives to live alone. Surprisingly, few differences between the disabled groups arise for several other dimensions of support. These include: need for heavy housework, receipt of assistance for heavy housework, need help for everyday housework, difficulty taking short trips, and in ability to leave the residence.

Comparisons of disability for Aboriginal and non-Aboriginal populations are shown by age group in Table 2. Among the 55 and over age group, the rate of disability is 66.5% for all Aboriginal people, 70.1% for North American Indians living on reserves and only 37.4% among non-Natives. Furthermore, since 1972-73, the proportion of adult registered Indians in Type I and Type II residential care for elderly and disabled persons has nearly doubled (Department of Indian Affairs and Northern Development, 1990). By 1988-89, 8.4 out of every 1,000 adult registered Indians were in residential care.

TABLE 1
Disability Among Aboriginal and Non-Aboriginal Populations, Canada, 1991

	NON ABORIGINAL*	TOTAL ABORIGINAL**	NORTH AM. INDIAN***	N. AM. ON RESERVE	N. AM. OFF RESERVE	METIS	INUIT
DISABILITY TYPE	% —	% (n) (373,785)	% (n) (277,650)	% (n) (100,440)	% (n) (177,210)	% (n) (81,650)	% (n) (18,805)
Some disability	15% —	31% (117,090)	31% (87,210)	33% (33,155)	31% (54,055)	32% (26,030)	29% (5,445)
Mobility ¹	45% —	45% (52,430)	45% (39,735)	47% (15,520)	45% (24,215)	44% (11,505)	44% (2,395)
Agility	44% —	35% (41,335)	35% (30,665)	39% (12,820)	36% (19,465)	38% (9,925)	36% (1,940)
Hearing	23% —	35% (41,135)	35% (30,450)	34% (11,195)	33% (17,625)	34% (8,735)	26% (1,430)
Seeing	9% —	24% (28,560)	25% (21,865)	32% (10,555)	21% (11,310)	22% (5,745)	24% (1,310)
Mild ²	60% —	66% (77,005)	65% (57,090)	65% (21,415)	66% (35,675)	65% (16,930)	74% (4,055)
Severe	12% —	12% (14,020)	12% (10,760)	14% (4,545)	11% (6,210)	12% (3,095)	8% (415)
Need help for heavy housework	31% —	32% (35,560)	32% (28,015)	33% (10,815)	32% (17,200)	33% (8,730)	25% (1,380)
Receive help for heavy housework	89% —	87% (32,740)	88% (24,525)	87% (9,385)	88% (15,145)	86% (7,495)	92% (1,265)
Need help for everyday housework	18% —	17% (19,430)	17% (14,320)	20% (6,725)	15% (8,230)	15% (3,955)	17% (945)
Receive help for everyday housework	81% —	88% (17,070)	88% (13,200)	90% (6,045)	94% (7,775)	85% (3,350)	96% (910)
Difficulty, short trips	12% —	10% (11,160)	10% (8,460)	10% (3,275)	10% (5,185)	9% (2,275)	11% (600)
Unable to leave residence	41% —	29% (3,255)	30% (2,550)	35% (1,160)	27% (1,390)	25% (580)	32% (195)

Notes: 1. Percentages for disability types (mobility, agility, learning and seeing) do not sum to 100% because individuals may suffer from more than one type; mobility and subsequent questions are only asked of persons with some disability;

2. Moderate disability is the remaining category.

* These are disability rates showing percentages adjusted for differences between the 1991 Health and Activity Limitation Survey (HALS) and the Aboriginal Peoples Survey (APS). The subgroup n sizes are unavailable.

** People who identify themselves with an Aboriginal group.

*** People who identify themselves as North American Indian.

N. Am.=North American Indian.

Source: Statistics Canada. (1994). *Disability and Housing: 1991 Aboriginal Peoples Survey*. Catalogue No. 89-535. Ottawa: Minister of Industry, Science and Technology.

TABLE 2
Disability Rates for Aboriginal and Non-Aboriginal Populations by Age,
Canada, 1991

	NON ABORIGINAL*	TOTAL ABORIGINAL**	NORTH AM. INDIAN***	N. AM. ON RESERVE	N. AM. OFF RESERVE	METIS	INUIT
Age Group							
15-24	6.4	27.7	21.7	21.7	21.7	21.9	21.0
25-34	9.4	23.6	23.7	23.3	23.9	23.1	23.2
35-54	14.0	35.5	35.4	35.5	35.3	37.2	33.3
55+	37.4	66.5	66.4	70.1	63.3	68.1	62.5

Notes:

* Based on the 1991 Health and Activity Limitation Survey, The Daily: Statistics Canada. Catalogue No. 11-0001E. October 13, 1992

** People who identify themselves with an Aboriginal group.

*** People who identify themselves as North American Indian.

N. Am.= North American Indian.

RECENT CHANGES IN FUNDING AND SERVICE DELIVERY

Prior to the 1990s, the majority of First Nations communities generally provided a limited range of homemaking services to elders and disabled persons. A small number of communities expanded on homemaking services to include, for example, personal care attendants. However, these services were provided on a case by case basis. In addition, a lack of funding further constrained the development of a continuum of care that is comparable to services available to the majority of off-reserve residents living in British Columbia.

In British Columbia, since the 1990s, there have been significant developments in the delivery of on-reserve community-based services to elders and disabled persons. These changes can be attributed to two factors. First, a Department of Indian Affairs and Northern Development (DIAND) national paper entitled, *Management Framework for Community Care and Support Services* was distributed to all regional districts in the early 1990s. And second, increased funding by DIAND was provided to the British Columbia region to support new initiatives in service development coinciding with the distribution and consultation process built around the national policy framework document. This policy paper was originally developed by a DIAND working group comprised of First

Nations and federal government representatives. The primary objectives of this process are to: 1) empower First Nations to design and deliver a range of community-based social services, which will assist persons with functional limitations or social needs resulting from conditions of frailty, disability or illness to live independently in their home and community; and 2) empower First Nations to develop holistic services that are culturally appropriate, and which are co-ordinated with other components of the health and social services continuum. The policy paper introduced a set of potentially useful services such as: respite care, personal care attendants, companion services, adult day care programs, meal programs, fostercare/adult family care homes, and new case management methods.

The B.C. Region implemented a formula-based funding model for the Adult In-Home Care program in 1993, which coincided with the distribution, consultation and discussion of the national policy framework. The formula for the increase in funding was comprised of two components: a base amount of \$2,000 plus a per capita component derived from the on-reserve adult population aged 19 and over, using the status population as a base. Of this amount, 15% is identified as service delivery program dollars; the remaining 85% is for community-based home care support services. Funding for eligible First Nations facility care is provided by DIAND from the regional budget. An increase in the absolute number of eligible on-reserve residents could impact the community service budget. The formula funding approach resulted in approximately 90% of the communities experiencing an increase in their funding. Furthermore, the additional monies were specifically earmarked for new initiatives in order to stimulate service development.

THE CONSULTATION PROCESS

The geographical distribution and the variation in service development of the 196 First Nations Bands in British Columbia led DIAND to initiate a series of eight regional consultations between September and December 1993. Chiefs and Councils, First Nations Social Development Workers, Community Health Representatives and Native elders were invited to the sessions to discuss the national policy framework. The purpose was to facilitate discussion and information sharing around the topic of adult care. Some of the topics presented for discussion included: responses to the Management Framework; ideas relating to the development of alternative programs using adult care funding; and the organization of program management infrastructures.

Presentations were made by representatives of the British Columbia Continuing Care Division (Ministry of Health), Medical Services Branch (Health Canada), the British Columbia Aboriginal Network on Disability Society, and the authors of this paper. Several innovative service options and community-driven programs were discussed at the meetings, including: volunteer recruitment and management, meals programs, homemaking, home maintenance, personal care attendants, respite care, companion care, day support for elders, adult family care homes, case management, self-help groups, and long term care facilities.

SERVICE DELIVERY ISSUES

A number of generic problems and issues were identified during the eight regional interactive workshops. It is argued by the authors that these need to be recognized and addressed in order to successfully develop services for Native elders in Canada and other countries. It should also be noted that several of the workshop themes led to debates by the participants. The following represent some of the principal issues discussed during this process.

The interface of family and formal care. One of the impediments to developing comparable services for First Nations elders appears to be the perception that reliance on formal services, such as home care or adult day care, will deteriorate traditional culture, especially as it relates to family relationships. Interestingly, the 'breakdown of the family' as the result of modernization processes, has been debated for many decades in the family and gerontological literatures with the conclusion that the concept of the isolated nuclear family is largely fiction (e.g. Sussman, 1959). In fact, considerable support has been found for a hierarchical compensatory model of support, which postulates that frail older adults rely first on a spouse for support, followed by children, other family, and finally and only if necessary, formal sources of support (Cantor, 1979). Among Natives living on reserves, fears of dependency on formal services and isolation from family and community are often strong. Since residential care is rarely found in close proximity to Native elders living on reserves, institutionalization frequently results in large physical distances between elders and their extended family. The preponderance of negative experiences associated with the residential school system voiced by some Native elders magnify this problem. For these reasons, it may be necessary to change negative attitudes about the consequences of formal service provision in tandem with the development of services that can be accessed close to one's community. However, it may be equally

important to support the tradition of family members caring for their elders in order to re-balance the recent shift towards formal services.

Culturally sensitive and culturally sensible services. A related challenge to developing comparable services in First Nations communities is to make them culturally relevant, that is, implement programs that do not seriously conflict with traditional values. Although there are diverse and unique cultural elements among Aboriginal groups, several broad cultural differences between Natives and Whites have been identified. Natives tend to highly value their ancestry and social group, cooperation more than competition, age and wisdom, nature, the extended family, and religion; whereas Whites tend to have an individual orientation, and value competition, youth, conquest of nature, and the immediate family (Frideres, 1993). In addition, the propensity for older adults in Canada to live alone in separate and independent living styles in Canadian society has not been embraced by Native communities to the same extent. However, it is not clear whether the higher rates of co-residence among Native elders living on reserves is because of a desire to live with family members, whether there are limited options (such as adequate housing or alternative models of residential care), or whether older Native people value institutionally-based services to the same degree as non-Native elders (Armstrong-Esther, 1994). These cultural differences need to be recognized, better understood, and integrated into service delivery models and programs developed for Native seniors.

For example, many First Nations communities are comprised of large extended family units who live in close proximity to each other. It is common for elders to play an essential role in the maintenance of culture. They advise family, leaders and other community members on issues and responsibilities for preserving and teaching cultural traditions, such as holistic medicine as taught using the Medicine Wheel and language. In some groups, it is only the elders who can transfer language to younger members. The loss of elders to the community, due to relocation to a long term care facility outside of the community, actually threatens the reproduction of culture.

A recurring theme throughout the consultation process was the identified need for long term care facilities on reserves. Within the gerontological literature, research has begun to demonstrate the importance of cultural context for ethnic elderly living in institutional settings (Pereira, 1991). For Aboriginal peoples, this might entail services

provided within lodge-like residential homes that are designed in a meaningful way, and which are proximate to the reserve. It might also be accompanied with traditional food and language, and combined with leisure activities that involve traditional activities such as weaving, carving, sewing, sweat-lodges, healing circles, potlatches, and so on.

Variability in funding and programs. There is wide variability in both the level of funding received by bands and the types of services provided in First Nations communities across Canada. For example, the Homemaker Program in Ontario ranges between a \$28 per diem for the 173 elders over 65 in the Wikwemikong Unceded First Nation to \$9,258 for the 19 elders over 65 in the Pic Mobert First Nation (Ontario Advisory Council on Senior Citizens, 1993). Part of the reason for this discrepancy is the size and location of the community. However, there are instances of overuse of the homemaker program because there is an absence of other support services, such as adult day care, as well as few long term care facilities built within close proximity to First Nations communities. Inconsistent government funding, by both provincial and federal sources, also contributes to differences in average per diem. The jurisdictional conflicts surrounding responsibility for Native health services between the provincial and federal government often result in added bureaucracy to an already complicated health and social service system. Provincial-Federal debates over the responsibility for Native health continue without resolution. In B.C., the already underfunded Continuing Care Program under the Ministry of Health lacks resources to provide more than a minimal amount of assessment and home care support for Native communities that are not proximate to urban centres.

Provincial Community Home Care Nursing services provided by health units and municipal health departments are available for use by First Nations people who can access them, as they are for other residents of British Columbia. And even though B.C. First Nations peoples living on reserves in remote areas have recently been allocated \$832,000 annually as part of the Medical Services Branch Home Care Nursing Initiative, these funds are relatively small.

In addition, there is an inhibition among the more remote communities to accept and to implement formal services. In British Columbia, where there are proportionately more small bands that are geographically separated by mountainous terrain, service delivery barriers are of a greater magnitude. Economies of scale are but one problem. More isolated communities tend to be slower to adopt services

that appear to threaten traditional culture. Also, there is a relationship between the stage of economic, political and social development of a community, and the degree of fragmentation of services. For many communities, the needs of elders are not made a high enough priority during Council meetings because issues of treaties, self-government and larger band expenditures take precedence. However, political processes and those concerned with the provision of services must evolve together.

Empowerment. It has become evident that a fundamental assumption that should guide service development in First Nations communities is the empowering process. Clark (1989) discusses four interpretations of empowerment relevant to the participation of elderly in the health care system. These include: empowerment as political activism and social process; empowerment as effective deliberation and moral reflection; empowerment as personal process; and empowerment as balance and interdependence. For Native communities, the concept of 'empowerment as political activism and social process' is closely tied to the notions of self-determination, self-government and Nation building (Frideres, 1993). At the individual level, 'empowerment as personal process' connotes a proactive approach to planning and decision-making for health contingencies (Clark, 1989, p. 275). The importance of the process is the involvement of the individual in reflecting on personal histories and life plans.

Research in the field of health promotion and aging shows that health outcomes are affected most significantly and permanently when a community helps itself and involves those for whom the change is intended (Wechsler & Minkler, 1986). For Native elders, empowerment requires participation in the decision-making process that underlies the development of services in a community. This process necessitates that the opinions and preferences of Native elders are respected and acted upon. Successful program development in First Nations communities must also involve extended family, leaders, and the community as a whole to ensure that programs reflect community, as well as personal needs. What works in one community may not work in another, since there may be differences in culture, available resources, geography, level of services already in place, health characteristics, and so on. Furthermore, program planning and implementation decision-making should also be guided by discussions between government representatives and community members in order to bridge the gaps in service delivery and to distribute resources efficiently.

Training issues. There is an urgent need for training and upgrading of the qualifications of community workers who provide services in First Nations communities, in particular, those working in the more isolated and remote communities. Many of these individuals are required to perform tasks that are beyond their level of expertise (Ontario Advisory Council on Senior Citizens, 1993). For example, it is well known that the duties of the homemakers working in First Nations communities typically include: meal preparation, light cleaning and housekeeping, laundry, and assistance with dressing and bathing. However, it also often includes rehabilitation, administering of medication, and other tasks usually performed by a physiotherapist, occupational therapist or a community nurse (Ontario Advisory Council on Senior Citizens, 1993). In the same report, it was recommended that the Medical Services Branch of Health Canada take immediate steps to improve the training of community health representatives currently working in First Nations communities, especially in the area of diabetes awareness (p. 55). There is an urgent need for persons trained in rehabilitation medicine, including physicians, nurses, physiotherapists, occupational therapists, and so on.

Furthermore, the training needs of health and social workers may vary from community to community. For example, services may focus on diabetes in one community, but may be directed at depression, alcohol and drug problems, and abuse in another community. The lack of resources and the requirement to spend the additional funds from DIAND within a relatively short period of time were also identified as major impediments to support the training of 'front line' workers within First Nations communities, as well as many forms of long term strategic planning. There is therefore a need for both investment of money and ideas into the long-term advancement of training.

A PROPOSAL FOR SERVICE DEVELOPMENT

It can be argued that the successful transition of First Nations communities, from a fragmented and underfunded service model to one that more closely approximates the configuration of service available to most Canadians, necessitate several steps. An initial phase in facilitating service development might begin with the establishment of links with off reserve providers. Off reserve policies can be a starting point from which Native programs are modelled, recognizing the problems and issues discussed in the previous section. These can be added to the small but growing number of innovative approaches to servicing Native elders occurring across Canada.

Yet the development of new services requires integration within the current system. Services on reserves need to be coordinated with other federal and provincial services to provide an integrated model that focuses on a continuum of services targeting older adults living in First Nations' communities. In B.C., Health Canada funding to urban bands can be used to hire a nursing coordinator or other nursing services. The provincial Ministry of Health will also provide some nursing services in support of specific health initiatives, such as diabetes programs. In conjunction with these services, adult in-home care funding from DIAND can be used to fund a range of support services related to activities of daily living. Furthermore, there is a need to connect home nursing care to long term care in order to deal with the problem of large gaps in the continuum of care.

Given limited resources in most communities, the shift from competition to cooperation must take place among funders and service providers to enhance the capacity of First Nations communities. Interfacing community programs with federal and provincial services would maximize the range of potential services based on economies of scale. However, it is unlikely that linkages with off reserve programs will incorporate a holistic approach to services as reflected in the Medicine Wheel. The majority of mainstream programs do not provide services that deal with the physical, spiritual, emotional, and mental aspects of an individual's life. Nor will the programs include cultural aspects such as language or alternative healing, such as herbal medicine, sweat lodges, etc. Therefore, programs need to be adapted in culturally sensitive and meaningful ways to meet the unique constellation of needs reflected in First Nations culture.

INNOVATIVE APPROACHES TO SERVICE DELIVERY IN BRITISH COLUMBIA

Five innovative residential care facilities and service programs found in British Columbia will be highlighted. These service delivery models represent successful projects that have arisen in quite diverse First Nations communities, in terms of culture, size, location and resources. They also provide working examples of the general points raised in the previous section.

The North Thompson Band has five reserves in the south central area of British Columbia approximately 80 kilometres north of Kamloops. The band has an on-reserve population of 232, 10% of whom are elders. During the late 1980s, the band was spending a significant proportion of

their Adult In-Home Care budget to send homemakers from the main village to the outlying communities. After two years of community discussion and planning, a six unit residence (three two bedroom and three one bedroom suites) was constructed on the main Chu Chua reserve in May 1989. Although there was considerable resistance to the idea of a home for seniors originally, the lengthy community discussions dealt with most of the concerns. Funding for the project originated from two sources. The Canadian Mortgage and Housing Corporation provided a \$240,000 low interest loan and DIAND contributed \$120,000.

The residence has a central shared living area constructed around a large fireplace with kitchen and washroom facilities, an arts and crafts room, an office and common laundry facilities. Two of the six suites are designed to be barrier free. Additional storage areas for personal belongings were constructed based on the preferences of elders about to move into the residence. The support needs of the residents are assessed regularly by a nurse. Homemaker hours are then adjusted to meet the residents' changing requirements. The band's Adult In-Home Care budget pays for these services. Residents pay 25% of their Old Age Security pension for rent and heat, and their remaining income is used for the cost of food, and other household items.

Another unique feature of the home is that a public lunch is served every Thursday evening for other elders from the community, family, and friends. This affords an opportunity for continuous community involvement. Several other native communities have expressed interest in the Chu Chua model.

The Skidegate-Masset Adult Program. The Queen Charlotte Islands are situated approximately 75 kilometres south of the Alaskan panhandle and about 100 kilometres west of the mainland of British Columbia. There are two main islands, Graham and Moresby, and about 150 small surrounding islands. The inhabitants of the islands, comprised of several Haida and White communities, are geographically isolated. The Old Masset Haida community is located at the northern end of Graham Island and the Skidegate band is located at the southern end. Based on 1993 data, Old Masset has an on-reserve population of 727 with 6% over age 65, while Skidegate has an on-reserve population of 449 with 12% over the age of 65.

When first established, the Skidegate-Masset Adult Day Program was funded by the provincial Ministry of Health and delivered through contract with the Queen Charlotte Islands General Hospital. Currently, it

is jointly funded by the B.C. Ministry of Health Continuing Care Division and DIAND, B.C. Region. It is one of only two licensed adult care programs targeting First Nations communities in B.C. The program is offered three days per week, and is located at sites within the two communities. Approximately 85% to 90% of the Skidegate program users are Natives, whereas all of the participants of the Masset program are Native. The services offered at the two sites include: structured exercise periods, healing circles, hot meals, community outings, music, story telling (including intergenerational programs), and arts and crafts. One unique activity has been the gathering of cedar bark and its use for the weaving of traditional hats for Haida dancers. The participants also receive regular visits from a podiatrist, physiotherapist and massage therapist. In addition, each program has a full-time registered nurse.

A number of other features make this program different from those typically offered in the province. Although there are between 9 and 15 clients served per day for each of the two sites, there is a low staff/client ratio. Skidegate has two full-time staff, including a nurse co-ordinator and an activity worker. Masset has three full-time staff positions and is therefore able to divide the nurse co-ordinator into two positions. It is common for volunteers to subsume key roles in the programs being offered. Furthermore, in contrast to other provincially funded centres, where a daily fee is levied, the Skidegate-Masset Adult Day Program covers its costs by means of fund raising events within the two communities. Both the events and the program have met with initial success. Part of this success can be attributed to the charismatic leadership shown by one of the local nurses in the initiation and development of the program. The considerable degree to which the Skidegate and Masset communities have embraced the program has also contributed to its success.

For obvious reasons transportation has, and continues to be, a significant barrier for the running of the Skidegate-Masset Adult Day Program. The Skidegate Band has donated a wheelchair access van for their site. However, the smaller Masset community relies on taxis, which sharply increase the costs associated with the program. Partly because of the high cost of transportation, the Masset component of the program has been temporarily halted for periods of low funding. This particular problem is faced by many First Nations communities attempting to initiate services for their population.

Cowichan Elder's Program. Known as S'ulhween Khowutzun, the

Cowichan Elder's Program is another example of an adult day program that has been organized and implemented in a Native reserve community to meet the health, social and cultural needs of Native elders. The program is situated on the Cowichan reserve near the town of Duncan on Vancouver Island, in space located adjacent to the Cowichan Health Centre Building. The proximity to the community nurse housed at the health centre affords opportunity for health assessment and health promotion activities. Diabetes, arthritis, and foot care are some of the health problems that are being targeted. Regular trips to an urban swimming pool, exercise classes, and visits by a podiatrist twice a month represent some of the health promotion efforts. Lunches are provided every Wednesday and Friday, and relatives and visitors are encouraged to spend time with the elders. It is estimated that approximately 200 individuals participate in the Elder's Program for an average of 11 visits per person. An interesting feature is that the elders organize themselves, administer their own funds, and have an elected chairman, two directors, and a secretary/treasurer. They also organize an Elders Conference on a regular basis, which is sometimes held at other Native communities.

Tsawaayuus. Translated to English, Rainbow Gardens is a one-storey 30-bed Multi-Level Long Term Care facility located in Port Alberni on Vancouver Island. It is funded by the Continuing Care Program, B.C. Ministry of Health, and is licensed under the Hospital Act. Both the design and the operation of the facility are based on West Coast Native culture. Although the majority of the beds (about two-thirds) are filled by non-Natives, elderly of Native ancestry receive priority placement. The constellation of services available within the facility are similar to those found in major Canadian cities. For example, there is 24 hour professional nursing care, direct personal care, therapeutic nutritional care, medical supervision, physical and recreational therapy, housekeeping, and health promotion consultations. The inclusion of Native cultural activities and foods, as well as the employment of Native workers within the facility, have made Tsawaayuus a useful model for other communities. This success is largely due to the commitment and compassion of a group of women who contribute to the administration and running of the facility. However, there is the problem of both physical and social distance between Native elders and their communities that occurs when relocating to Rainbow Gardens.

A Q'Am Community Care Home. This is one of the two long term care facilities located on Native reserve lands in the province and was built by the St. Mary's Band. It is located about 5 miles from the town of

Cranbrook in the interior of British Columbia near the boarder of Alberta. A Q'Am Community Care Home is a 16 bed Intermediate Care facility on the St. Mary's Band reserve that was built in 1993. One of the beds is a swing bed for seriously disabled clients. The funding for the project came from DIAND and the Canada Mortgage and Housing Corporation. What is unique about this facility is that it provides comparable services to Native elders in a culturally rich environment. Native foods, rituals, and recreational activities are part of the daily routine. Also, many of the staff are First Nations peoples from the community. Again, several communities have expressed interest in developing a long term care facility that models the St. Mary's home.

FUTURE DIRECTIONS

Interest in the development of services in First Nations communities to support Native elders has been growing. The concerns of elders have been placed on the political agenda of most First Nations Bands and Regional Councils. However, to a large degree, the problems and issues discussed in this paper require the attention of those who make the financial decisions before they can be addressed in a concerted fashion. This includes the jurisdictional complexities faced by bureaucrats within DIAND, the Medical Services Branch, and the provincial ministries of health, as well as Native organizations and communities.

In the face of these impediments, there have been a number of service developments that have been innovative, effective, and well-received by Native elders and their communities. The North Thompson Group Home, Haida Adult Day Care Program, the Cowichan Elder's Program, Rainbow House and the A Q'Am Care Home represent five innovative projects. Their success has, in part, been realized because of the commitment of community leaders and a small core of individuals who have championed the cause. However, the variability in the characteristics of First Nations communities (i.e. culture, size, location, number of elders, financial resources, etc.) make the diffusion of these service models difficult, and not feasible in certain instances. In fact, the development of self-government within Native communities may result in alternative approaches to elder care that are not based on a service delivery model. The challenge that lies ahead requires as a first step the realization that elder care issues for First Nations communities are a priority concern. Only then will Natives and non-Natives recognize the common problems that are faced and bring together the social, cultural and financial resources needed to solve these problems.

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Chapter 8

**OLDER REFUGEES IN CANADA:
PROFILE, HEALTH NEEDS AND
SOCIAL SERVICE ISSUES**

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INTRODUCTION

Over the past few decades, we have witnessed a significant increase in the number of immigrants entering Canada on social and humanitarian grounds as Convention or Designated Classes refugees¹. This pattern has contributed to a growth in research, policy and programs targeting persons entering Canada under refugee status. However, the older refugee (defined here as any refugee aged 55 or over)

¹ The term 'Convention' refers to the United Nations' 1951 *Geneva Convention Relating to the Status of Refugees* and 1967 *Protocol* to which Canada is a signatory. Convention refugees are defined by Citizenship and Immigration Canada (1997) as: "...persons who by reason of a well-founded fear of persecution based on race, religion, nationality, political opinion or membership in a particular social group, are: (i) outside their country of nationality and are unable or, by reason of that fear, are unwilling to be protected by that country; or (ii) not having a country of nationality, are outside of their former habitual residence and are unable or, by reason of that fear, are unwilling to return to that country." (p. 28). Canada also operates an overseas resettlement program in which the Governor in Council designates classes of persons, other than Convention refugees, who may be admitted to Canada on humanitarian and compassionate groups (e.g. currently, political prisoners and oppressed persons; Indochinese; self-exiled persons).

has been relatively ignored in the literature, and furthermore, has not been the subject of direct research in Canada. Evidence is accumulating from several sources (Beiser, 1990; Godziak, 1989; Tran, 1990) suggesting that older refugees are marginalized in a number of ways. There are indications that poverty, cultural barriers, illiteracy, changes in status, fear of bureaucracy, and for some, physical and psychiatric problems linked to torture, contribute to poor health, low community integration, and low health service utilization among older refugees.

In Part I of this chapter, a demographic profile is presented for all adult refugees but with a focus on the older refugee. Part II provides a review of the limited literature concerned with health and social services needs targeting older refugees. The chapter concludes with some recommendations based on gaps in research and policy.

PART I: A DEMOGRAPHIC PROFILE

The following demographic profile of refugees is based on data obtained from the Immigration Statistics Division, Employment and Immigration Canada. The data cover a 12 year period, from January 1980 to September 1992.

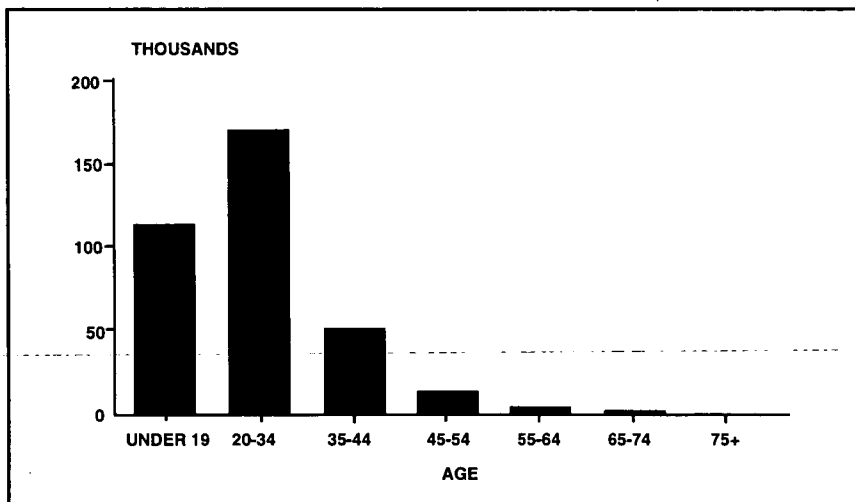
1. Refugee Type

In the 12 year period, a total of 350,546 refugees became permanent residents of Canada. Of these, 98,567 (28.1%) were Convention refugees and 251,979 (71.9%) were Designate refugees.

2. Age Distribution

Of all refugees admitted to Canada over the 12 year period under investigation, 112,191 or approximately one-third (32.0%) are children under the age of 19 years. The largest group are those aged 20-34 totalling 168,760, representing almost one-half (48.1%) of all refugees entering the country. Persons aged 35-44 (49,043) accounted for 14.0% of all refugees, while those aged 45-54 (13,470) made up 3.8% of all refugees. Persons 55 years of age and over totalled 7,082 and accounted for 2.0% of all refugees and 3.0% of all adult refugees (persons over age 19). The relatively small proportion of older refugees can be observed in Figure 1, which shows the total number of refugees by age group for Canada, 1980 - 1992.

FIGURE 1
Total Refugees by Age, Canada, 1980-1992*



* 1992 Includes only Jan. to Sept.

3. Refugee Type and Age

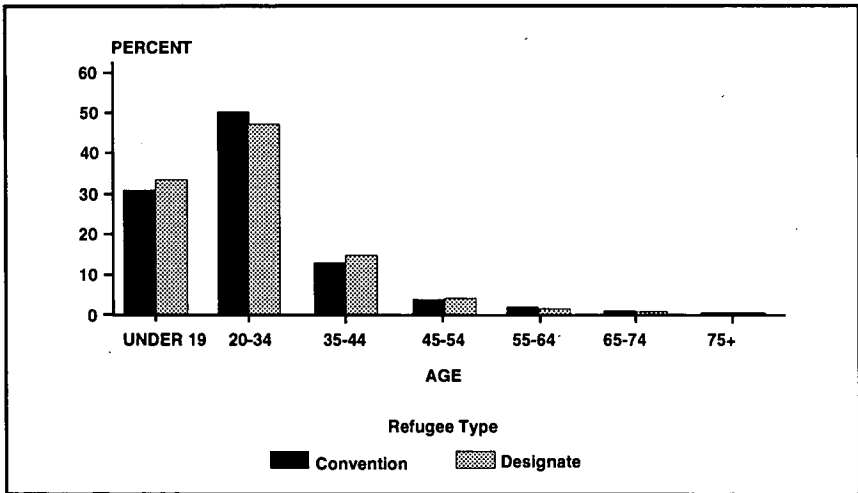
Table 1 shows the number and percent of refugees entering Canada by refugee type (Convention and Designate status) and by age. It is apparent that the majority of refugees of both types are relatively young. Table 1 also shows that the pattern of 1/4 Convention to 3/4 Designate refugees occurs across all age groups.

TABLE 1
Convention and Designate Refugees by Age, Canada, 1980-1992

AGE GROUP	CONVENTION		DESIGNATE		TOTAL	
	N	%	N	%	N	%
0-19	30,306	30.7	81,885	32.5	112,191	32.0
20-34	49,615	50.3	119,145	47.3	168,760	48.1
35-44	13,035	13.2	36,008	14.3	49,043	14.0
45-54	3,743	3.8	9,727	3.9	13,470	3.8
55-64	1,347	1.4	3,560	1.4	4,907	1.3
65-74	417	0.4	1,327	0.5	1,744	0.5
75+	104	0.1	327	0.1	431	0.1
TOTAL	98,567	100.0	251,979	100.0	350,546	100

Figure 2 presents the proportion of Convention and Designate refugees by age category. It clearly demonstrates that the age distribution is similar for the two types of refugees.

FIGURE 2
Convention and Designate Refugees by Age, Canada, 1980-1992*

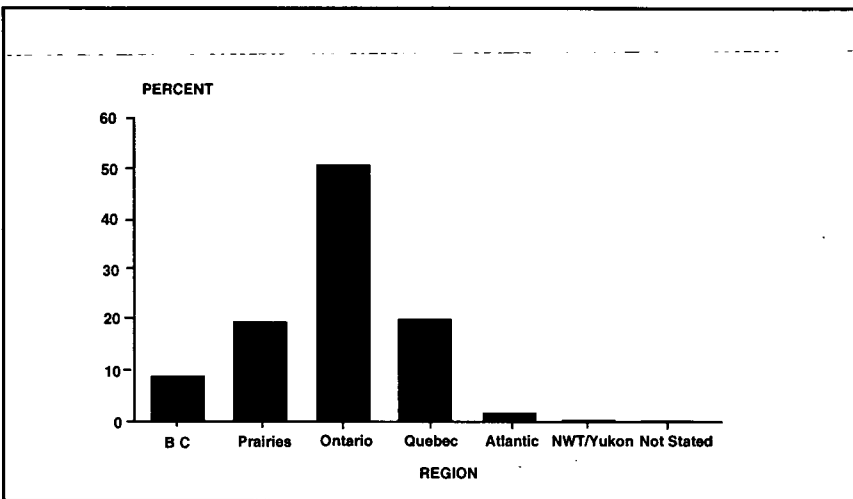


* 1992 includes only Jan. to Sept.

4. Geographic Distribution of Adult Refugees

The remaining sections of this descriptive profile includes only adult refugees 20 years of age and over. Slightly more than half (51.9%) of all refugees aged 20 and over selected Ontario as their destination, 19.0% went to the Prairie provinces, 18.8% to Quebec, 8.3% to British Columbia, 2.0% to Atlantic Canada and 0.04% to the Yukon/Northwest Territories. This distribution is shown in Figure 3.

FIGURE 3
Total Adult Refugees by Destination, Canada, 1980-1992*



* 1992 includes only Jan. to Sept.

Of the prairie provinces, Alberta received the highest number of adult refugees. Those with Alberta as their destination constitute 11.0% of all adult refugees compared with 5.2% going to Manitoba and 2.9% to Saskatchewan.

a) Refugee Type and Geographic Distribution

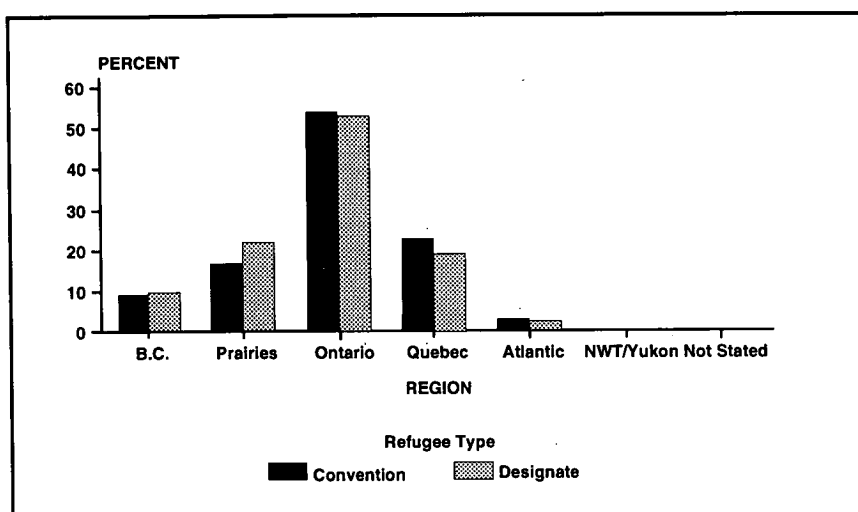
As shown in Figure 4, the geographic distribution of Convention and Designate refugees is similar — i.e. approximately half of both refugee types (52.8% and 51.6%, respectively) went to Ontario. The proportion going to the Prairies is slightly higher among Designate refugees as compared with Convention refugees (20.4% and 15.3%, respectively). On the other hand, a slightly greater proportion of Convention (21.1%) than Designate refugees (17.8%) went to Quebec.

b) Age and Geographic Distribution

When those aged 20-54 are compared with those aged 55 and over, a higher proportion in the older group chose Quebec as their destination (25.5% versus 18.6%). Younger refugees, on the other hand, were more likely than older refugees to select Ontario (52.1% aged 20-54 versus 44.5% of those 55+). Proportions choosing the other three regions were very similar for adult refugees under and over the age of 55.

FIGURE 4

Convention and Designate Refugees by Destination, Canada, 1980-1992*

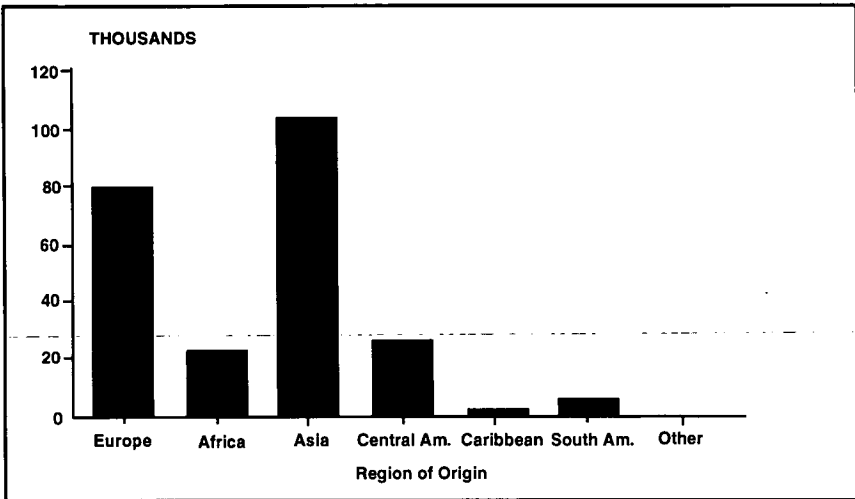


* 1992 includes only Jan. to Sept.

5. Region of Origin

When the region of origin of all refugees aged 20 and over (n= 238,355) was examined, it was found that 103,611 (43.5%) were from Asia, 79,563 (33.4%) were from Europe, 25,980 (10.9%) were from Central America, 22,112 (9.3%) were from Africa, 4,984 (2.1%) were from South America, 1,097 (0.5%) were from the Caribbean and the remaining 1,008 (0.4%) were from Australia, the U.S.A., Mexico and several countries in the South Pacific (e.g. Fiji). This distribution is shown in Figure 5.

FIGURE 5
Total Adult Refugees by Region of Origin, Canada, 1980-1992*



* 1992 includes only Jan. to Sept.

a) Refugee Type and Region of Origin

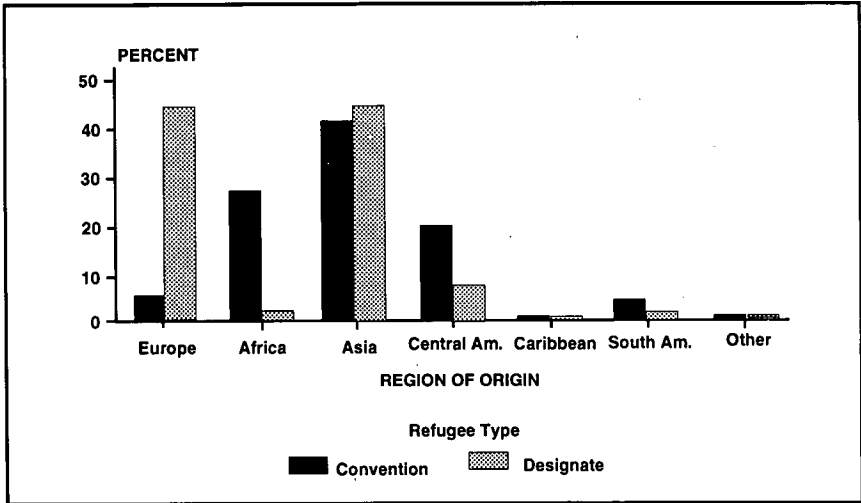
When the regions of origin of Convention and Designate refugees are compared, several noticeable differences become apparent. While similar percentages are found from Asia (41.3% Convention and 44.3% Designate), a much higher proportion of Convention than Designate refugees originate from Africa (27.4% versus 2.0%) and Central America (19.3% compared to 7.5%). The proportion from Europe, on the other hand, is much higher among Designate refugees (44.3% and 6.2%, respectively). These patterns are clearly shown in Figure 6.

It is interesting to note that most (96.5%) European refugees are from the six Eastern European countries of Poland (67.9%), Czechoslovakia (8.4%), Romania (7.4%), USSR (6.0%), Hungary (5.5%) and Bulgaria (1.3%). Most (83.0%) African refugees originate from Ethiopia (47.8%), Somalia (25.1%), Ghana (13.8%) and Sudan (3.2%).

In the case of Europe, Africa and Central America, the countries contributing the most refugees are the same for Convention and Designate refugees. That is not the case with respect to Asian refugees. While 82.4% of Designate refugees from Asia are from the three South East Asian countries of Kampuchea, Laos and Vietnam, these three countries accounted for only 5.6% of Convention refugees. Most Asian

Convention refugees originate from Lebanon, Iran and Iraq (52.9%) and from the South Asian country of Sri Lanka (17.6%).

FIGURE 6
Convention and Designate Refugees by Region of Origin, Canada, 1980-1992*



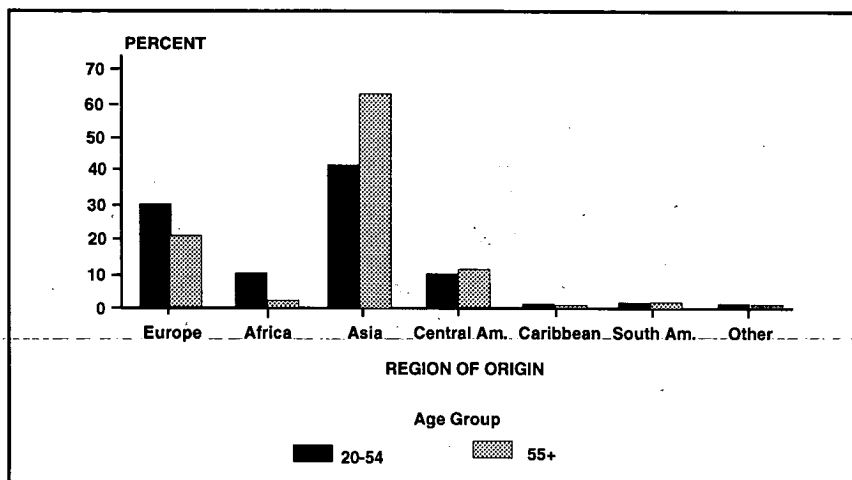
* 1992 includes only Jan. to Sept.

b) Region of Origin and Age

Figure 7 shows the distribution of adult refugees by region of origin and age group. Among older refugees (55 and over in age), approximately two-thirds (65.7%) originated from Asia, 18.1% from Europe, and 11.7% from Central America. While the proportion of refugees aged 20 - 54 from Central America (10.9%) is similar, Asia contributes proportionately fewer younger refugees (only 42.8%). Compared with those aged 55+, there is a greater proportion of younger refugees from Europe and Africa.

FIGURE 7

Adult Refugees by Region of Origin, and Age Group, 1980-1992*



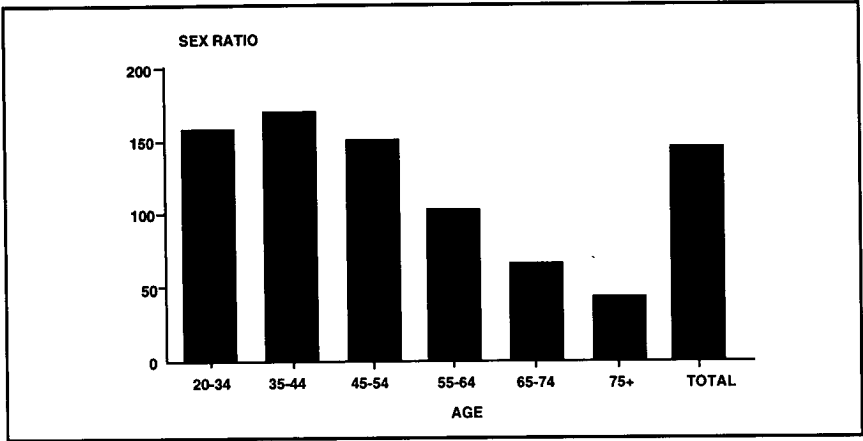
* 1992 includes only Jan. to Sept.

6. Sex Ratio and Age

The sex ratio is defined as the number of males per 100 females in a population. A sex ratio of 200 indicates that there are two males for every female, whereas a sex ratio of 50 shows the opposite relationship. Figure 8 presents the sex ratio for the total adult refugee population by age. There is a preponderance of males in the younger refugee age groups. The sex ratio for the 20-34 age group is 163, for the 35-44 group it is 172 and for the 45-54 group, 145. The sex ratio drops to near equality (100) for the 55-64 age group. By comparison, in the Canadian population as a whole, the sex ratio for persons aged 20-64 is between 97 and 105 (Statistics Canada, 1992).

Among older refugees, the 65-74 and 75 and over age groups display sex ratios of 72 and 53, respectively. This indicates that there are substantially more women than men in these upper age groups. The sex ratios observed for older refugees approximate those observed for the Canadian older population (Statistics Canada, 1992).

FIGURE 8
Sex Ratio of Total Adult Refugees by Age, 1980-1992*

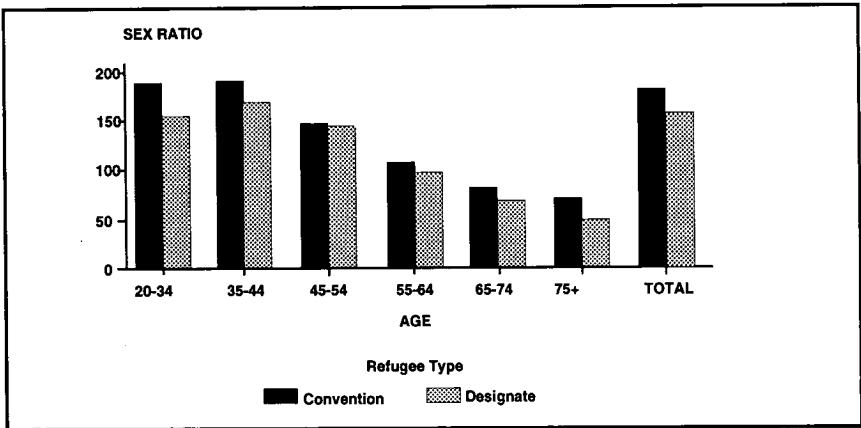


* 1992 includes only Jan. to Sept.
Sex ratio # of males per 100 females

a) Refugee Type, Sex Ratio and Age

Sex ratios are provided for Convention and Designate refugee types in Figure 9. A clear pattern emerges across all ages, showing a higher sex ratio (indicating more males) for Convention refugees.

FIGURE 9
Sex Ratio of Convention and Designate Refugees, 1980-1992*



* 1992 includes only Jan. to Sept.
Sex ratio # of males per 100 females

7. Education

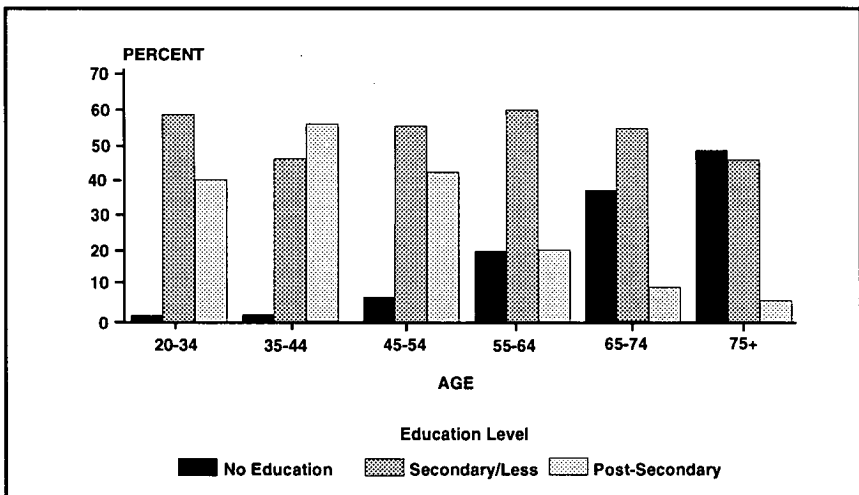
Of all adult refugees, 2.1% had no education, 56.1% had secondary or less, 41.1% had some post-secondary, and 0.6% did not state their education. This distribution is fairly similar to the Canadian population, except that the percentage with no education approaches zero in Canada as a whole.

a) Education and Age

As shown in Figure 10, younger refugees were considerably better educated than older refugees. The percentage of adult refugees with no education rises sharply, in a linear fashion, from 1.1% for the 20-34 age group to 47.8% for the 75 and over age group. The proportion of adult refugees with no education increases dramatically after age 55. Conversely, the percentage of adult refugees with post-secondary education is 39.8% for young adult refugees (20-34) but only 5.3% for the 75 and over age group.

FIGURE 10

Total Adult Refugees by Age and Education, Canada, 1980-1992*



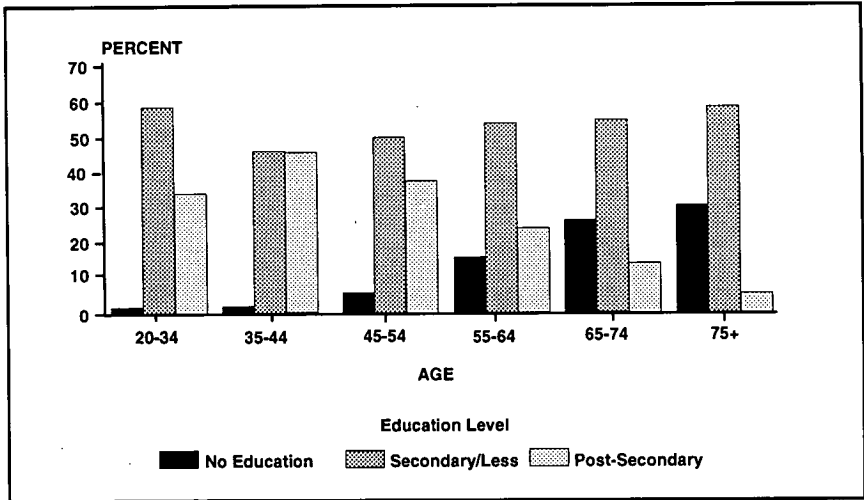
* 1992 includes only Jan. to Sept.

b) Refugee Type, Age and Education

Interestingly, Convention refugees are better educated than Designate refugees in the older ages but more poorly educated than Designate refugees in the younger ages, as observed by comparing Figures 11 and 12. For example, the percentage of refugees 75 years of age or over who have no formal education is approximately one-third (32.7%) for Convention refugees compared with over one-half (52.6%) for Designate refugees. The percentage of younger adult refugees aged 20-34 with post-secondary education is 35.6% for convention refugees but 41.6% for Designate refugees.

FIGURE 11

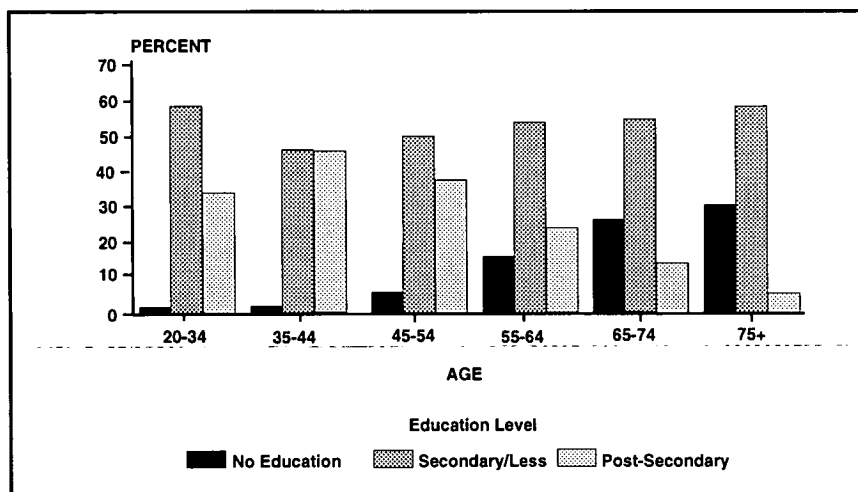
Convention Adult Refugees by Education and Age, Canada, 1980-1992*



* 1992 includes only Jan. to Sept.

FIGURE 12

Designate Adult Refugees by Education and Age, Canada, 1980-1992*



* 1992 includes only Jan. to Sept.

PART II: HEALTH AND SOCIAL CONCERNS AND SPECIAL CONSIDERATIONS

In many ways the older refugees have much in common with other older people, in that they share concerns about health, adequate housing, family relationships and avoiding social isolation. However, there are a number of special circumstances facing the older refugee that have direct bearing on health and social issues.

1. Relocation

Relocation is experienced as problematic by some older people and may be a source of special difficulty for older refugees. In the case of a move from home to a nursing home or for one nursing home to another, the types of relocation that are most commonly studied, data show that if the event is voluntary, planned, and there is minimal change in the psycho-social environment, even when there is major change in the physical environment, morbidity and mortality rates remain in the normal range (Bourestom & Tars, 1974; Grant, Skinkle & Lipps, 1992; Gutman & Herbert, 1976; Rutman & Freedman, 1988).

For the refugee, relocation may mean moving to a place without war, which may reduce the person's fear and anxiety level. However, being a

refugee means, by definition, that the relocation is not a matter of choice and invariably involves loss of the familiar and the stress associated with such a displacement. Current research on refugee relocation shows that the more dissimilar the host culture is from the culture of the country of origin, the greater the difficulties in adaptation (Kuntz, 1981).

It should also be noted that for many refugees displacement often involves an arduous journey, in some cases on foot. The physical demands of the journey, as well as the mental sequelae, may have long lasting effects. Further, not all refugees' displacement experiences are the same. For example, Vietnamese "boat people" experienced a 50% death or return rate. In other words, only half remained as refugees in a host country.

In refugee camps, the elderly often deny themselves food so that nursing mothers and children can be fed (Tout, 1990). This may have adverse consequences on the health of the older person. Also, older refugees who face the death of relatives and friends are often unable to provide funerals and burials that are culturally specific (Hayes, 1987).

Further, countries offering resettlement to refugees sometimes restrict their offers in ways that force younger people to abandon older relatives (Tout, 1990). This means that some older refugees who enter the country will suffer from survivor guilt.

2. *Language*

Language facilitates social adaptation. However, a significant proportion of refugees (85-90%) do not speak either official language (Canadian Task Force, 1988). The rate is estimated to be even higher for older refugees. Older refugees frequently report that not having adequate language skills causes considerable problems and frustration (Canadian Task Force, 1988). For example, it interferes with their ability to take buses, visit friends, go to the doctor, and to shop. Language difficulties also affect their utilization of available health and social services (Godziak, 1989).

Research also shows that being older, female or having less formal education has negative effects on language acculturation (Tran, 1990). In particular, older immigrant females are less acculturated than older males. Social, economic and cultural norms may explain the difference. Men attend language classes more regularly than women (Tran, 1990). Fifty or sixty years ago, formal education was a privilege that principally

males enjoyed. Currently, older refugee women are also often expected to care for the grandchildren at home while their sons and daughters work.

With a few notable exceptions, such as the Second Language Training Program pilot project, almost all language programs are tied to employment (Canadian Task Force, 1988). However, the older refugee is often unable to enter the workforce for various reasons, including the existence of an expectation that people over the age of 65 do not work in Canada. This does not reflect the economic or cultural reality of some older refugees. Additionally, ESL programs assume that the person is literate, however, significant proportions of older refugees have no formal education, which is correlated with illiteracy.

Research on language acculturation shows that the successful programs are those that 1) capitalize on the older adults' strengths; 2) use adult learning strategies; 3) make the learning situation and materials relevant to their needs and desires; and 4) tap the goals of the refugee community (Grognet, 1989). If language lessons can be imbedded into another culturally acceptable and culturally useful activity, the chances of successful acculturation increases. The location of the class may also be important. Language classes taught inside the refugee's home, in place of a formal school setting, may be more culturally and socially acceptable (Henkin, 1989).

Current research on ethnic family violence suggests that as younger members of an ethnic group move toward Canadian styles and values, the older person's dependence on others for translation may be seen as excessively demanding (Dhaliwal, 1991). They lose their privileged status within the family and the ethnic community and their authority and wisdom are questioned by the younger generation. These research findings may also be relevant for the older refugee.

3. Work

In the country of origin, work often has a central place in the life of the older person. However, during the rehabilitation process, refugee relief programs operate on the assumption that it is difficult and pointless to retrain older people (Tout, 1990). Unemployment or disemployment carries the message that whatever they did before in life is of no value, creating status loss or status inconsistency (Tran, 1991).

Losing that opportunity to work creates substantial difficulties for the

older refugee. Relocation usually entails a loss of possessions and personal savings and older refugees often find it hard to regain their former financial status (Godziak, 1989). In Canada, older refugees who secure employment typically work in low paying manual labour positions and have not worked long enough to build up pension benefits, personal savings, etc. needed for a comfortable retirement. Further, older refugees and immigrants must meet a 10 year residency rule to be eligible for Old Age Security and the Guaranteed Income Supplement.

There have been some employment projects for older refugees that show promise. The ones that are successful emphasize traditional skills, create new jobs that would not normally exist, and are organized to meet service and/or production needs of the public and private sectors (Kerschner & Coombs Ficke, 1989).

4. Family Support and Living Arrangements

Research shows that the older refugee's adaptation to the new society is facilitated by the presence of family members (Tran, 1991). Those living in a nuclear or extended family show better adjustment than those living alone or with non-relatives. However, elders living in overcrowded households or in households with children under the age of 16 appear to have poorer adjustment (Tran, 1991).

Older refugees with family often live in their children's houses. This living arrangement is often a reverse of the situation of the country of origin and can create difficulties. Who is living with whom partly determines power and control in family relationships and decision making. Some older refugees come to Canada alone and, by necessity, live with non-relatives. The potential for conflict is also present within these living arrangements. When there are serious disagreements in either situation, the elder is at a disadvantage due to financial constraints, restricted mobility, lack of access to transportation and possibly poor English language skills. In addition, rent subsidy programs such as British Columbia's Shelter Aid for Elderly Renters frequently are tied to the 10 year residency requirement of Old Age Security benefits. This further restricts the older refugee's option of moving.

Both self help approaches and collective housing are possible ways of dealing with the aforementioned problems. Collective housing is often espoused by ethno-specific agencies. However, it is important to recognize that this approach can unintentionally separate the older refugee from the host society.

5. Transportation

It is widely understood that access to transportation is a key need for many seniors. For the older refugee, lack of transportation may lead to a separation from the host society. A 1991 Seniors and Ethnicity Workshop concluded that financially accessible transportation is a key requisite for supporting the refugee's receptivity to the host culture in the period immediately post-migration. Financially accessible transportation increases mobility, provides access to services and to the society as a whole. Without inexpensive transportation, older refugees may become dependent on others for their transportation needs. Since this group tends to have a truncated support network, the needs may go unmet.

In British Columbia, bus passes are available for seniors who receive the federal Guaranteed Income Supplement or provincial Guaranteed Annual Income for Need benefits. However some refugees, particularly those whose status has not been determined, may be ineligible for a transportation subsidy. Refugee claimants who receive welfare benefits are not eligible for bus passes.

6. Health and Well-being

Age related health issues such as hearing loss or diminished mobility are a reality for all seniors. In addition to these losses, refugees face special mental and physical difficulties. An extensive literature exists that underlines the importance of social support for psychological well-being in later life (e.g. Cantor, 1980; McPherson, 1990). The older refugee tends to have few friends and sometimes few or no family. It is for this reason, among others, that the mental health of older refugees has become an issue (Canadian Task Force, 1988).

a) Torture

It has been estimated that a minimum of 10-30% of refugees will have experienced torture and will need to deal with the aftermath of that experience (Jacobson & Vesti, 1990). Torture obviously involves physical abuse. Without appropriate treatment at the time of the incident, broken shoulders, bones or fingers will not properly heal, leading to chronic pain and possibly poor mobility. These conditions often worsen with age. For example, falanga - beatings of the feet, may result in difficulties in walking which tend to worsen with age, and marino torture often leads to acute bronchitis.

Examples of psycho-social sequelae include: anxiety, depression,

gastro-intestinal problems, memory difficulties, and sleep disturbances. Because these symptoms are experienced by many seniors, careful medical assessment is needed for the older refugee to uncover the etiology of the problem. It has been suggested that a standard question in any initial interview should probe for possible indications of torture. One challenge is that refugees tend not to volunteer this kind of information easily.

b) Post Traumatic Stress Disorder

Post traumatic stress disorder occurs after a person has experienced a traumatic event. "A trauma (such as torture) may be a psycho-social event, and it can be described as a generalized social, political violence and systematic violations towards people causing damaging effects on bio-physical development and also having an effect on the community at large" (Staddon, 1991). Sometimes, long after the event, the person re-experiences it. The disorder can manifest itself by intrusive symptoms (e.g. recollections, nightmares, hallucinations, etc.), numbing/denial (e.g. avoidance of thoughts or feelings, inability to recall aspects, detachment, restricted affect), hyperarousal (e.g. sleeping difficulties, irritability, difficulties concentrating, hypervigilance) or even self injury (Blau, 1997). This change in reaction patterns may create difficulties for the person and within the family.

Research shows that better educated persons seem to make a better adjustment following disaster (Green, Wilson & Lindy, 1985). However, as the earlier discussion on refugee demographics has shown, the elderly tend to have low levels of education. There are several reasons for this, including the systematic targeting and killing of better educated people as enemies of the new society.

DISCUSSION

In considering the demographic information presented above, it should be recognized that at any point in time, there will be two distinct sub-types of older refugees. The first type consists of those who arrived in the host country in their later years (i.e. at age 55 or older). The second group are refugees who arrived when younger. At present, research on older refugees does not appear to have drawn this distinction. Distinctions between the two groups are important, as length of residence in the host country has been shown to be positively related to level of adjustment (Montgomery, 1991).

Current research on older refugees has been limited in several ways.

Most of it has been conducted in the United States, which has substantially different approaches and services for refugees than Canada. Research tends to be limited to particular ethnic groups, such as the Vietnamese and tends to focus on the broader category of immigrants (Litwin, 1995). Research tends to focus on younger or middle-aged refugees (Yee, 1989). Each of these limitations affects the generalizability of the research.

Between January 1, 1980 and September 1, 1992, a total of 7,082 refugees over the age of 55 came to Canada. This group can be considered as the first type of refugee. They tend to be female, large proportions originate from Asia, Europe and Central American countries, and they have significantly lower education than their younger adult refugee counterparts. The gerontological literature would identify these refugees as individuals exposed to "multiple jeopardy," defined as a person who has a devalued status in two or more stratification systems, for example old, female, poor, and a member of a racial or ethnic minority (McPherson, 1990). They are prone to be marginalized. The relatively small number of this type of refugee should not be viewed as reducing the need for program and policy development, but rather pointing to the challenge of identifying, contacting and meeting their special needs.

The 13,470 refugees who arrived in Canada at the ages of 45 to 54, comprise the second type of refugee. This group will grow old in Canada. It is made up of slightly more males compared to the same age group in the Canadian population, large proportions are from Asian, eastern European, Central American and African countries of origin, and they have higher level of education than the first type. Although these refugees have fewer attributes contributing to multiple jeopardy, they may face considerably more difficult conditions than the general Canadian population when aging.

At this stage in our knowledge of older refugees, we are constrained in the number and specificity of recommendations that can be put forward. However, four recommendations are supported in the literature. First, a pilot project should be supported that provides innovative approaches to language and literacy training, such as one-on-one, home-based training by bilingual volunteers. Second, we recommend that older refugees who want to engage in "useful work," be given the opportunity. This might be accomplished by retraining or skills training programs specifically tailored to the older refugee. A third recommendation is that government and community agencies should

continue to encourage and enable the development of ethno-specific support groups for older refugees. Links must also be built between the ethno-specific groups and mainstream agencies so that the person has access to the advantages and services of both. Fourth, transportation subsidies should be expanded to cover older refugees not presently covered. Overall, we must involve older refugees in the development and implementation of all programs addressing their needs.

What is most obvious is that more research concerning older refugees is urgently needed. This can help in the development of additional programs to meet their special needs. In particular, primary data collection is warranted so that information can be accumulated to better evaluate the health, social, and economic needs of the older refugee. The demographic profile and literature review of this chapter should be viewed as an initial step towards the development of a rigorous research and policy agenda for the turn of the century.

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