Ethnic Minority Seniors Face a Double Whammy in Health Care Access

Summary

British Columbia is home to increasing numbers of seniors from ethnic minority (primarily Asian) backgrounds. Although health care providers commonly believe that family members usually provide care in the home for these seniors, a new study suggests that this belief needs to be reconsidered. Ethnic minority seniors describe many barriers to accessing health care, such as conflicting family values, language barriers, immigration status, and lack of understandings of the roles of the health authority and of specific service providers. These problems are further confounded by the configuration and delivery of health services and the limited awareness among health care providers of the seniors’ needs.

This summary highlights the key themes that emerged from focus groups conducted with seniors and their families and health and multicultural service providers, as well as two workshops with all of these stakeholders. Strategies and policy changes that might help increase the navigability and effective utilization of services for this substantial group of B.C.’s seniors are also described.

Issue: As a group, seniors have significantly greater health care needs than younger people and planning and delivery of health care services typically takes their needs into consideration. However, ethnic minority seniors face a double whammy. Not only do they have greater health care needs, they have greater difficulty accessing health care. The barriers to care identified for ethnic minorities are especially acute for ethnic minority seniors. And the problem is growing. British Columbia’s ethnic minority population is growing, and so are both the numbers and proportions of seniors.

Objective: The research study, Barriers to Access to Care for Ethnic Minority Seniors, set out to identify barriers to the effective utilization and navigation of the continuum of care offered by the regional health authority, as well as strategies to overcome them.

Researcher and organizations: Dr. Sharon Koehn conducted the research while at the Gerontology Research Centre, Simon Fraser University. Ted Bruce (Executive
Director, Primary Health Care Network, Vancouver Coastal Health) provided valuable guidance throughout the project, as did many other VCH employees. The research was funded by the Canadian Health Services Research Foundation and the Canadian Institutes for Health Research (PDA-0938-10).

**Data collection:** Focus groups were held with seniors and family members from the Vietnamese, Hispanic and Indo-Canadian communities of Greater Vancouver, as well as health care and multicultural service providers who work with them. Professional interpreters were used for all interactions with seniors.

After the focus groups, stakeholders from various sectors participated in two workshops. Participants included seniors, service providers from a broad array of health and social service professions, multicultural and community organizations, community advisory committees, seniors’ advocacy groups, non-profit organizations, academicians, and health authority administrators. Participants in the first workshop agreed that the themes that emerged from the focus groups were consistent with their experiences, and helped to interpret the results and identify workable solutions. In the second workshop, guest speakers from VCH, PLS and AMSSA described existing efforts to overcome the identified barriers, so that participants could prioritize action items that came out of the first workshop.

**Key Findings:** Ethnic minority communities, in which extended co-resident families are the norm, have traditionally provided the majority of care for the elderly in their homes. But these norms are rapidly being eroded, and—based on interviews conducted for this study—the beliefs among health care providers and administrators are increasingly lagging behind the changing circumstances of ethnic minority seniors. Seniors and service providers with extensive experience in working with ethnic minority families report that many families are not able to take care of their seniors without assistance.

The immigrant experience, the dependency relations that arise with sponsorship, and the differing adoption of Western cultural norms between generations can leave seniors feeling that they are a burden, or that their children have abandoned them. Health care providers interviewed for this study described families that do not uphold their traditional responsibilities toward their elders and, yet, interfere with the delivery of services that could be provided by health care personnel. For example, a case manager reported that in an 18 month period she had tried three times to place an elderly Vietnamese woman whose
needs exceeded the care that her family and in-home support could provide. However, “it always breaks down and she’s back [home]. ... It feels like we should place her but [the family] can’t let go because they can’t let go of the guilt.”

Misunderstandings between families and service providers also arise when the family is not aware of the full scope of the care providers’ role and hence does not seek help as needed. Immigrants who are accustomed to limited health services that are staffed only by physicians and nurses are often unfamiliar with the different types of community health care providers and paraprofessionals and the various ways in which they can assist families to care for seniors in their home. For example, even though she spoke the same language as her clients, a South Asian case manager explained that a family had not responded to her offers of assistance with their elderly father’s care because they did not understand that they could get help with incontinence management and other difficulties. Several health care providers concurred that they see these families all too often in crises that could have been avoided.

Most of the seniors interviewed for this study said they knew little about the health care services available to them. A common question was, “What is the health authority?” There are many reasons for their lack of understanding:

- their recent arrival in BC,
- lack of communication between family physicians and the health authority,
- inability to find a family physician who speaks their language,
- lack of knowledge about the availability of interpreters,
- scarcity of interpretation services and translated materials,
- insufficient English language skills to use the telephone or public transportation,
- reliance on family members for transportation and interpretation,
- restrictions on movement outside the home due to childcare responsibilities and/or cultural mores, and
- lack of access to the internet.

Seniors and care providers alike commented on the unsatisfactory consequences of relying on family members as interpreters. Previous studies have documented that information provided by families is often unreliable or inaccurate, as well as
raising ethical concerns. Targeted programs offered by VCH (e.g., Vietnamese diabetes program, Raven Song) and ethno-specific seniors programs have ameliorated the problem for some seniors. Immigration status also imposes a barrier. Many seniors are still under the ten-year sponsorship provision and do not have full access to health care services or financial assistance. Participants in this study and a previous study by the same author² provide examples of how sponsorship status isolates seniors and renders them vulnerable to abuse.

Seniors in each of the communities studied said that many of them may need residential care as their health fails, but they do not want to go into facilities unless they can speak their own language, eat their own food and observe their religion. Service providers and seniors alike gave examples of isolated seniors they knew who were like ‘fish out of water’ in Anglo-oriented facilities where they became very agitated or withdrawn. Some family members went out of their way to assist seniors by providing food, interpretation, or companionship in facilities, for example, but they ran into inflexible policies or managers who increased their burden. Some seniors who do not have access to their customary diet choose not to eat at all. Those interviewed for this study, particularly from the Indo-Canadian community, reiterated this stance. Access to religious programming on radio or television was described as very important for the peace of mind of most ethnic minority seniors, particularly Indo-Canadians.

Implications: In order for ethnic minority seniors to navigate the continuum of care, they will need targeted outreach, prevention and treatment services in their own languages or, at the very least, interpretation and translated materials to better link them to multicultural programs. Care providers may need to be better educated about the particular barriers ethnic minority seniors confront if they and their families are to receive the supportive services they need to support optimal health. A re-examination of policies such as the ten-year dependency period associated with sponsorship and with first-available bed policies that separate seniors from family supports that provide services that are otherwise not available to them should be considered.

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Literature Cited:
