

Brief to the Special Senate Committee on Aging: Second Interim Report by Dr. Sharon Koehn, Centre for Healthy Aging at Providence

This brief summarizes the contributions of ethnocultural minority seniors, service providers and academics who presented at *Speaking to the Interface: A Symposium on Access to Health Care for Ethnic Minority Seniors*¹ While their perspectives are diverse relative to their ethnic affiliation, the type of work they do and/or the focus of their studies, some key themes are apparent.

Family context of health care access

Several speakers mentioned the ideal of filial piety—the notion that children should look after their aging parents—as a common cultural belief in communities with origins in South Asia, China/Hong Kong/Taiwan, the Philippines, Vietnam, Japan and Latin America. It is true that children are more likely to provide care for aging parents if they subscribe to this ideal, but in reality many things can get in the way of fulfilling parents' expectations. Like all Canadians, adult children are often “too busy” to provide the necessary care at home. Also, the perception of what filial piety means can vary between and within generations; it is a multi-layered concept, and the understandings of caregiver and care recipient are not always the same. Finally, we see that the unrealistic desire to live up to the ideal on the part of some caregivers can result in delays in securing appropriate and timely care for the senior. Assessments of the need for home care should therefore take into account the level of the burden on the caregiver.

Family Class Immigration

During the first ten-years following immigration, between 25 – 40% of elders who arrive in Canada after the age of 60 have no source of income². This reflects the fact that almost 80% of this group came as Family Class immigrants. This fact increases their susceptibility to social isolation and/or workplace exploitation (e.g. as farm labourers). During the initial dependency period, seniors may not be eligible for public pensions such as the Allowance, Old Age Security or the Guaranteed Income Supplement, social services, subsidized housing or housing subsidies or other local benefits such as reduced fare bus passes.³ In addition many older immigrants remain economically disadvantaged even after sponsorship ends, because of the way the residency criterion for Old Age Security is calculated. However, seniors from

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some countries (e.g. Australia, New Zealand, UK) are protected by reciprocal agreements on social security with Canada.⁴ The agreement can have a beneficial effect on residency credits, which determine the eventual amount of Old Age Security the person will receive. As a result, they do not face the same burden as do immigrants from countries such as India, Pakistan, and Sri Lanka; this appears to violate equality protections of human rights law in many provinces as well as section 15 of the Canadian Charter of Rights and Freedoms.⁵

Sponsored seniors can be completely dependent on their sponsors for services such as transportation, including trips to the doctor, translation and interpretation, information about services and activities, spending money and housing. The vulnerability of sponsored seniors plays out in several ways: (1) With limited knowledge of available services and basic rights, language barriers, and social isolation, sponsored seniors are especially vulnerable to abuse; (2) If the sponsorship relationship breaks down, the family faces shame in the eyes of the community and seniors have a hard time securing adequate housing and food on a low income; (3) Efforts to offset their dependency can affect seniors' health and access to healthcare—for example, they may become too busy to go to the doctor; (4) Many work on farms for low pay and under poor working conditions; (5) Women are often expected to take care of grandchildren and do the housework and cooking; families can become angry when the senior is no longer able to do domestic work.

Stigmatized Conditions

Speakers and workshop chairs spoke about several conditions that are stigmatized within certain ethnocultural groups and prevent seniors or their families from taking the necessary steps to access appropriate care. The most commonly discussed example was mental illness. Simmons' discussion of clients with aphasia (the inability to speak, usually following a stroke), which is based on her PhD. research, confirms that other illnesses are also stigmatized. In addition, talking about terminal illness and death is avoided in many cultures.

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Speakers emphasized that for many seniors, migration to Canada is involuntary—refugees and sponsored seniors may have no other options. This can lead to low self-esteem and demoralization, and those who work and volunteer with ethnic seniors believe that many of them are depressed. Yet very few seek care for this condition and other mental illnesses because they are stigmatized and/or not recognized as illnesses within the community. Similarly, seniors with stigmatized illnesses may be kept away from others to “save face.” Seniors often rely on community organizations they trust for care, but these organizations are not designed or funded to provide mental health services. Family members may not have the time to provide appropriate care, but seniors and their families may prefer to keep the senior at home rather than place them in a mainstream facility.

An unwillingness to talk about and plan for death and end-of-life care is common in many Asian cultures (e.g. South Asian, Chinese) and has consequences for access: People avoid medical tests because they fear the results. Seniors seek out doctors trained in their own country who will not talk about death, but this does not guarantee that they get the best service.

Family decision-making

Family-based decision-making is the cultural norm in Chinese, Punjabi and many other Asian communities: decisions are often not made unless the oldest child is present. In addition, decisions are made in a way that ensures the family does not “loose face.” Sometimes collective decision-making can be accommodated, but there are times when it has important consequences for care. For example, the patient may miss out on some aspect of treatment that requires immediate attention if the appropriate person is not present or the family is trying to reach a consensus.

Disincentives to exercise

Following two separate racially motivated incidents resulting in the death of Punjabi Sikh seniors in Surrey, B.C. over the past few years, many ethnic minority seniors in Surrey are afraid to engage in

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healthy activities such as walking in the park or to the temple. Women in some cultures are forbidden from leaving the home and many are unable to do so because of childcare and housekeeping responsibilities (often associated with their dependency and sense of obligation as sponsored immigrants).⁶

Communication – Language

Punjabi and Vietnamese seniors and caregivers identified the language barrier as the major problem seniors face in trying to access services. This was less true of Filipino seniors who are more likely to speak English. Language barriers prevent the senior from (a) Speaking with healthcare providers and getting appropriate treatment (e.g. it's easier to write a prescription than refer people for psychotherapy or other appropriate psychological or emotional supports when language is a barrier); (b) Accessing information about healthcare and related services such as housing options via written or electronic means; (c) Understanding medication information; (d) Using public transportation.

As a result, language barriers reinforce social isolation and reduce access to the healthcare system. The problem is twofold: (1) there are not enough healthcare providers who speak minority languages or interpreters to meet everyone's needs; and (2) important information, for example, about medications and other treatments, is not presented in a way that is easy to understand, even by English-speaking clients.

Communication – Interpreters

Interpretation services are provided in many hospitals and clinics, but there are many situations for which they are not readily available, sometimes because clinicians do not make use of existing services.

Speakers also noted some populations do not trust professional interpreters and need to be educated about professional standards in Canada. Interpretation services are not adequate for all types of treatment, for instance, mental health services for the elderly, but neither are family members. While they are commonly used for interpretation, family members often do not have the necessary language skills to interpret

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medical information accurately, their presence may prevent the senior from speaking openly and they sometimes withhold information from the senior. One reason for withholding information might be to “protect” a senior from a diagnosis. In some cases, such as therapy or rehabilitation, however, use of family interpreters is unavoidable because funding and the dispatch of interpreters makes it difficult to ensure that the same interpreter can assist a client on an ongoing basis.

Communication – Translated Materials

Some resources are available for larger minority language groups. For example, the B.C. Health Guide has been translated into Chinese and Punjabi, but there are still very few materials translated into the languages of immigrant communities with smaller and more dispersed populations, such as the Vietnamese. Moreover, many seniors are not literate in their own language, so health information materials need to be tailored to each population using the most appropriate media. Even so, materials in the language of the illiterate senior can be read to them by others in the community who may not be able to read English.

Cultural Communication Styles

In addition to language, there are other kinds of cultural barriers to care when caregivers do not share the ethnic background of their clients. In hierarchical societies, such as the Chinese and Punjabi communities with which they are familiar, people fear and respect doctors. This can be especially true of seniors. As a result, the seniors and/or their families may not openly talk about their dissatisfaction with care, may not ask questions about treatment and often say “yes” as a form of deference, rather than understanding. Health service providers must be aware of this possibility when working with ethnic minority senior clients.

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Communication Between Service Providers

Canada's healthcare system is complex, with services and policies influenced by all decisions made at regional, provincial and federal levels. Ensuring "seamless service" or a better flow of communication and referrals is a priority of many regional health authorities. However, others who do not work for the health authority, such as physicians and multicultural service providers, are also critical to care. A lack of communication between these different care providers limits access for ethnic minority seniors.

Ambrosini's position as a pharmacist who links acute and community care is a good example of how important it is to connect different parts of the health care system. Meier also spoke to the potential value of using community service workers who are trusted by ethnic minority seniors for mental health follow-up. Privacy laws and non-existent links between community services and physicians nonetheless limit this possibility.

Patient Education

The need for age- and culture-appropriate education targeted at ethnic minority seniors was made by several presenters. This is especially true in the area of medications. Multicultural service providers working with South Asian and Latin American populations, as well as a physician with South Asian patients said that seniors in these populations commonly share medications. Another problem that Ambrosini spoke about was the use of medications from the home country in addition to medications prescribed in Canada. Patel emphasized that information about services is not reaching the minority elderly. The problem, she said, lies not only with language barriers. Much of this information is not widely available to the public, even if they speak English, or is too complicated to understand.

Comparative studies of Anglo-Canadian seniors and different ethnic groups would help us to better understand the scope of the problem and how best to communicate important health information to Canada's diverse senior population.

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Time Crunch

A common theme was the lack of time healthcare providers have to spend with their clients. Healthcare professionals need to spend larger amounts of time with ethnic minority seniors in order to meet their needs. In some cases, this involves finding out what their experiences have been, what they value, and what they really need. Interactions between health professionals and other team members, such as interpreters, also benefit greatly when service providers take the time to discuss the needs of their patient and what they hope to achieve in a session in advance.

Housing Options

The relative merits of housing and care options that are aimed at a specific ethnic group versus integrating seniors into existing, mainstream facilities was debated. Those who argue against ethno-specific housing say they fear segregation or ghettoization. Those who support ethno-specific housing relate many success stories in which seniors who were previously withdrawn or diagnosed with dementia, for example, did very well (sometimes requiring re-diagnosis) when they were moved into an ethno-specific care environment. Care homes that cater to seniors from a particular area (e.g. South Asia, the Caribbean) can still be multiethnic, catering to many languages and religion). Ultimately, speakers and participants agreed that what is most important the provision of choices: ethno-specific homes should exist for those who need them, but seniors of a particular ethnic group should not be automatically streamed into these facilities. Even more important is that the options provided are of good quality, which may require governmental support of community-based organizations eager to provide care but without the necessary resources to do so.

Culturally Sensitive Care

A very important feature in any care home where ethnic minority seniors are clients is the delivery of service in a culturally sensitive manner. Staff who are from ethnic minority backgrounds are not

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necessarily more sensitive to the needs of the residents, although this is often thought to be the case.

While it is useful to have staff that can speak the same language as the client or patient, their cultural sensitivity is more important. One way to address this is by providing cultural competency training of staff. This training needs to be at all organizational levels and should be offered on an ongoing basis.

Observation of food preferences and religious practices are extremely important to some groups.⁷ Staff also need to understand the barriers that ethnic minority seniors face in their efforts to access care.

Recommendations

This material has numerous implications. The recommendations that follow are specifically responsive to the second interim report of the Special Senate Committee on Aging to whom this brief is addressed.

Their relevance to the themes identified by the committee is denoted in column 2 of the table below, as follows: A = Active aging and ageism; B = Older workers, retirement and income security; C = Healthy aging; D = Aging in Place of Choice.

<p>1. The dependency period associated with sponsorship of parents or grandparents should be reduced from ten years to three in the face of evidence that the policy creates power imbalances and dependency, and increases the risk of social isolation, abuse or exploitation, and in alignment with regulations pertaining to conjugal sponsorship.^{3, 8}</p>	<p>A, B, C</p>
<p>2. Public awareness campaigns against ageism need to include a component on racism; the real or perceived threat of racist violence limits the mobility and use of public spaces by visible minority seniors. The seniors' experience with discriminatory attitudes from officials or service providers also represents a barrier to access.</p>	<p>A, C</p>
<p>3. Education of ethnocultural seniors about the benefits of physical health and other topics) and of family care providers of the immigrant elderly intended to offset caregiver burnout requires (a) the mobilization of ethnocultural community resources (trusted gatekeepers,</p>	<p>A, C</p>

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<p>religious organizations, settlement agencies etc.), (b) the translation of written materials into different languages and (c) the use of non-written media to connect with seniors who are illiterate.</p>	
<p>4. Services offered to ethnocultural older adults may be rejected on the grounds that (a) the recipients' immigrant status precludes their eligibility for subsidized services; (b) they are culturally insensitive (inappropriate food in care homes, no interpreters available etc.); (c) the family and/or care recipient is concerned that doing so will bring shame (either due to stigma or norms of filial piety) on the family and/or family members feel 'guilty' because they are not fulfilling their duty to the elder; (d) the appropriate family member(s) were not available to make the decision or amenable to the treatment plan; or (d) the family does not understand fully the service offered or its benefits due to unfamiliarity. It should NOT be assumed that immigrant families can always "take care of their own." This knowledge should be incorporated into education campaigns and practice guidelines.</p>	<p><i>C,</i> <i>D</i></p>
<p>5. The proposed extension of CPP dropout provision to caregivers of ailing seniors is even more salient for immigrants who may have had less time to accrue benefits and should therefore be supported.</p>	<p><i>D</i></p>
<p>6. Support at the policy level for centralized interpreter services in each province that are uniform in terms of availability and standards of training across the country is recommended. Appropriate and accessible interpretation services are central to the provision of quality health care, particularly to recent immigrant seniors who are least likely to speak an official language.</p>	<p><i>C,</i> <i>D</i></p>
<p>7. Policies that allow for alternative billing structures to fee-for-service by family physicians are recommended in order to facilitate longer appointment times with complex</p>	<p><i>C</i></p>

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patients (such as ethnocultural older adults) and greater integration of family practices and services offered by regional health authorities.	
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