TWELVE

# HEALTH AND HEALTH CARE UTILIZATION PATTERNS OF VISIBLE MINORITY SENIORS IN CANADA

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## INTRODUCTION

Peoples' perception of health may influence their health care utilization pattern, and visible minority immigrants are no exception. Coming to a new country and facing various challenges such as adjusting to a different culture, language barriers, economic disadvantage, less social support, lack of easy access to transportation, and lack of general and health information may make immigrants, especially senior immigrants belonging to a visible minority group, vulnerable to ill health. For these same reasons, they may be reluctant to use available health services. Identifying health services utilization behaviours and the health status of visible minority seniors will help policy planners understand the health and social needs of this particular group, and thus will eventually help planners better provide culturally appropriate health services and minimize the cost of health care at the same time. The health status and health care use of senior visible minority groups have not received much attention despite their growing

number in Canada. This study compares the health status of visible minority and White seniors in Canada, and analyzes the relationship between visible minority seniors' health services use and factors that may affect the use and non-use of available services.

### *Current Situation of Visible Minority Seniors in Canada*

Visible minorities are defined by the *Employment Equity Act* as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-White in colour" (Statistics Canada, 2001a). Until the 1950s, most immigrants to Canada were from European countries, whereas the trend has shifted to visible minorities since 1997 (Hyman, 2001). According to the 2001 census, 13.44% of Canada's population of 29,639,030 belong to visible minority groups. Of these visible minorities, 6.5% were seniors (Statistics Canada, 2001b). The census records also show that most members of visible minority groups (54.4%) live in Ontario, 21% live in British Columbia, 12.5% in Quebec, and 8.3% in Alberta; the lowest number (N = 210) live in Nunavut. Of all the visible minorities in the 2001 census, 70% were born outside of Canada; Chinese accounted for 26% and South Asians 23% (Statistics Canada, 2005). Canada's visible minority population is expected to increase to 7.1 million in 2026 from 2.7 million in 1996. Between 1996 and 2001, the rate of growth of visible minorities was noticeably faster than that of the total population of Canada—25% for visible minorities as compared to 4% for the whole population (National Advisory Council on Aging, 2005).

The population distribution of elderly immigrants will eventually change with a higher proportion of visible minority seniors than other immigrant seniors as a result of the continuous increase in visible minority immigrants. This trend will grow much faster as the visible minority baby boomers age. There were about 20% visible minorities in the age group 45–64 in the 2001 census (Statistics Canada, 2001b) who were about to become seniors in 2002 or in the coming years. Thus the planners in Canada will have to meet the health and social needs of the elderly as well as understand the socio-cultural norms of health concepts of visible minority groups.

Some social scientists argue that the elderly among visible minorities may be victims of so-called "double jeopardy," being old and belonging to a marginalized group (Dowd & Bengtson, 1978). However, other researchers have shown that this hypothesis is weak or that the difference in indicators between White and minority seniors narrows with age (Penning, 1983;

Rosenthal, 1983; Chan, 1983; Rosenthal, 1986). Furthermore, researchers also caution us to look at different socio-economic variables, such as education and income of visible minority groups, to investigate whether multiple or double jeopardy affects only those with low education levels and low income, and whether the effect is thus not due to belonging to a visible minority group (Durst, 2005). This study will shed light on some of these issues with empirical evidence using the current status of health and health care utilization of visible minority seniors in Canada.

***Perceptions on Health***

It is a well-established fact that the perception of health among different cultural groups around the world varies. As Lai, Tsang, Chappell, Lai, and Chau (2003) found, such perceptions vary even among the Chinese, depending on their country of origin. Immigrants may adhere to their traditional social norms and health perceptions in their new country. Age-related illness such as dementia is taken as a natural process of aging among the Vietnamese and the Hawaiians living in the United States, for example (Braun & Browne, 1998). Braun and Browne (1998) discussed cases among Chinese, Japanese, and Filipino immigrants, who believed in links between illnesses and wrongful acts in previous lives. Another study found that Chinese Americans hid persons with disability while Korean immigrants in that study group preferred to seek informal and formal help only if provided by Koreans (McCallion, Janicki, & Grant-Griffin, 1997). Even the choice of words to denote certain "diseases" should be selected carefully while dealing with seniors from visible minority groups. For example, mental health is a taboo subject among the elderly Chinese, and they may identify mental health "by referring to it as 'mood,' a word with fewer stigmas attached" (Lai, 2003).

***Health Status of Immigrants***

There have been a considerable number of research findings on the "healthy immigrant effect" in Canada recently. Normally, immigrants are healthy when they enter Canada, probably because of the health screening required in the immigration process (Dunn & Dyck, 2000). After being in Canada for more than ten years, immigrants' health status seems to converge with that of Canadians (Chen, Ng, & Wilkins, 1996; Newbold & Danforth, 2003; Dunn & Dyck, 2004; McDonald, Clarke, McLeary, George, & Marziali, 2006). By using the 2001 Canadian Community Health Survey,

Perez (2002) showed that Canadian immigrants had better health than non-immigrants in terms of chronic conditions as well. In addition, the results also revealed that recently arrived males had healthier heart disease outcomes than non-immigrants and that recently arrived female immigrants had fewer cancer problems than their non-immigrant counterparts. Similarly, Ali (2002) found that recent immigrants and immigrants from Asia and Africa had lower rates of depression and alcohol dependence than the Canadian-born population even after adjustment for age, gender, marital status, income, and education. This result held true despite immigrants' language barriers, higher unemployment rates, and lower sense of belonging to the local community. Furthermore, older ethnic minority persons, most of whom had immigrated to Canada "ten years or more" earlier, had poorer health status in comparison to the ethnic majority group (McDonald, Clarke, McLeary, George, & Marziali, 2006).

Ng, Wilkins, Gendron, and Berthelot (2005) conducted a longitudinal study of non-European and European immigrants' health versus "other" Canadians' health by using all five cycles of National Population Health Survey data. Both recent and long-term (immigrated before 1981) non-European immigrants were twice as likely to report their health as poor or fair in 2002–2003, compared to Canadian-born individuals. However, these same non-European immigrants reported their health as excellent or very good in 1994–1995. As a result of deteriorating health, non-European immigrants also visited medical doctors more often than other Canadians in 2002–2003. Stress of immigration and gain in weight because of lack of physical activity were also found. Nonetheless, literature on senior immigrants' health status has mixed findings. Newbold and Filice (2006) found both immigrant and non-immigrant seniors rank their health in a similar manner. In contrast, Lai et al. (2003) found that Chinese seniors' health was poorer than those of the "other" population in Canada. The cultural norms and health care services use of a specific group among immigrants, perhaps, made the difference. This study will examine whether the healthy immigrant effect found among immigrants in Canada holds true in the case of senior visible minority population.

### *Health Services Utilization and Access to Services*

If individuals perceive their health condition as excellent, they may not seek medical help. Similarly, financial situations, language barriers, educational background, and other circumstantial factors may have an impact

on an individual's choice to seek preventative medical help. It is important to keep in mind that the perception of health and mental health of various cultures comes to play a big role in seeking any kind of medical help. Generally speaking, seniors may be physically challenged compared to younger people, and thus may tend to use health care more often. One recent study found that almost 90% of Canadian seniors consulted a family doctor, 14% were hospitalized, and 15% received home care in a year (Rotermann, 2006). The main reason for health care use by seniors was a chronic health condition. Not surprisingly, cultural factors were found to contribute to the health care utilization differential among seniors belonging to Asian Pacific Islander groups in the United States (Tanjasiri, Wallace, & Shibata, 1995). The elderly in this group delayed in seeking care, were confused in making appointments, had a language barrier, felt embarrassed and afraid while attempting to describe symptoms, and were confused, afraid, or angered at professional advice.

One recent Canadian study found that although visible minorities in general were more likely than White Canadians to have had contact with a general practitioner and were less likely to have contact with specialists, specific subgroups of visible minorities—such as the Japanese and the Koreans—used both general practitioners and specialists less frequently than their White counterparts (Quan et al., 2006). However, the empirical study by Jenkins, Le, Mcphee, Stewart, and Ha (1996) on Vietnamese immigrants in California demonstrated that it was accessibility to the health care system rather than cultural health beliefs and practices that determined preventive health care utilization among this group. Lai et al. (2003) found that Chinese seniors in Canada had a low level of home support services use compared to the general population despite the former group's poorer health status. They also found that Chinese seniors did not seek help from mental health care providers despite having poorer mental health than the general population.

Similar to other immigrants, visible minority immigrants, especially seniors, leave behind their close friends and relatives, a prestigious living style, name, and/or fame to come to Canada to join their children. For visible minority immigrant seniors in Canada, a feeling of loneliness and depression (Kinch & Jakubec, 2004; Acharya, 2004) and being in "golden prison" at home (Durst, 2005) are not uncommon; these feelings have been discussed in a number of qualitative and quantitative studies. Considering these facts, living in Canada for a long period may mean deterioration in

health for these seniors. Given other disadvantages they may face, such as discrimination (Neufeld, Harrison, Stewart, Hughes, & Spitzer, 2002; Ng, Northcott, & Abu-Laban, 2004) and low income (Harvey, Siu, & Reil, 1999), they may also become victims of double or multiple jeopardy. The purpose of this study is to unveil the demographic, socio-economic and health status, lifestyle, and health care service utilization patterns of visible minority seniors versus White seniors based on empirical analysis, with the objectives of: (a) examining the healthy immigrant effect, (b) revisiting the double/multiple jeopardy thesis, and (c) providing valuable policy implications for health and social policy planners in Canada.

## METHODS

The data source for this study was the Public Use Microdata File (PUMF) of the Canadian Community Health Survey Cycle 3.1 conducted in year 2005. This PUMF contains the regional, provincial, and national information on health services, health status, and health issues important to Canadians and disseminated to the public (Statistics Canada, 2006). The sample data contained 132,221 respondents aged 12 years and older. A Random Digit Dialing sampling frame was used to select the household sample for this survey. Individuals living on Indian Reserves and on Crown Lands, institutional residents, full-time members of the Canadian Forces, and residents of certain remote regions were excluded from the survey. The response rate was 78.9% (Statistics Canada, 2006).

For the current study, visible minorities and Whites aged 65 and over were selected for analysis, using the "cultural/racial" question. Unfortunately, cultural/ethnic groups were not specified by each cultural group in the PUMF data as they were in the original data file. The total sub-sample turned out to be 19,146 cases, of which 1,625 seniors belonged to visible minority groups (8.5%) and 16,781 were White (87.6%); the rest (3.9%, N = 739) did not specify their cultural status. The data were analyzed by using Pearson's chi-square test. The variables selected for analysis were cultural identity (visible minority seniors versus Whites); demographic and socio-economic (gender, job status, education level, language proficiency, living arrangement, household size, personal income, length of stay in Canada); health status (chronic condition, arthritis/rheumatism, high blood pressure, heart disease); perceived health and perceived mental health; health care services utilization (has regular medical doctor, number of visits to a doctor, reasons for not

having a regular doctor, consulted alternate health care provider, had flu shot, had eyes examined, visited dentist, overnight patient, required home care provided by the government, required home care not covered by the government). Comparative analyses were performed by cultural/racial group (visible minority or White) and by gender, education, income, language proficiency, and years of stay in Canada among visible minority seniors.

## RESULTS

### *Demographic Characteristics*

Among the visible minority seniors, 81.0% were immigrants, whereas 21.5% of White seniors were immigrants. Of those visible minority senior immigrants, 88.2% had lived in Canada for ten or more years and the rest less than ten years, whereas almost all (99.0%, N = 3,564) White seniors who self-identified as immigrants had lived in Canada for ten or more years (table 1). In both visible minority and Whites groups, female seniors were represented more than males. Some visible minority and White seniors were still working full-time or part-time. Most visible minority seniors had either "less than secondary" education or were "post-secondary" graduates, similar to those belonging to the White group. Although a large percentage of visible minorities reported that they spoke either English or French or both, with or without other languages, 27.2% (N = 440) of these seniors did not speak either of the official languages.

The "living arrangement" and "household size" results from table 1 confirm that one-third of visible minority seniors lived in "other" arrangements rather than alone or with spouse, or in parent-spouse-child or parent-child arrangements, possibly in large households with four or more persons. Half as many visible minority seniors as Whites lived alone, and two-thirds as many lived with a spouse only, compared to Whites. Personal income showed that 61% of visible minority elderly earned below $15,000 or none at all, almost double the proportion of low-income Whites.

### *Health Characteristics*

A large proportion from both groups (about 90%) had a chronic health condition. Relative to visible minorities, a significantly higher proportion of White seniors had arthritis or rheumatism and heart disease. A significantly higher proportion of visible minority elderly were suffering from high blood pressure relative to Whites (table 1).

### *Perceived Health Status*

About one-third of visible minority elderly said their health was in excellent or very good condition (table 2). About the same proportions indicated their health as good and as fair or poor. A higher percentage of White seniors (40.6%) than visible minorities confirmed their health as excellent or very good. Most seniors from both groups (62% of visible minority and 69.5% of White seniors) perceived their mental health to be excellent or very good. Relative to general health, substantially low percentages from both groups expressed their mental health as fair or poor. However, a higher percentage of visible minority seniors (8.4%) reported their mental health as fair or poor compared to Whites (4.7%).

### *Health Services Utilization*

Most seniors from both groups had a regular doctor: 96.3% of visible minority versus 95.2% of White respondents (table 2). Nevertheless, the former group visited their doctors more often than their White counterparts. A significantly higher proportion of White seniors reported that the doctor they saw had either left or retired, among other reasons for not having a doctor. About 10.7% of visible minorities and 6.3% of Whites consulted alternate health care providers.

A significantly higher proportion of White seniors were overnight patients compared to their visible minority counterparts. A higher proportion of White seniors than visible minority seniors also needed home care provided by the government as well as that not covered by the government. The differentials between the groups of those who responded to flu-shot questions and those who responded to eye-examination questions were narrow. Nonetheless, the proportion of visible minority elderly who visited the dentist less than a year ago was fairly low (48.5%) relative to Whites (56.1%).

The lifestyle factor measured by smoking and drinking was also examined for both groups. Most seniors from both groups were non-smokers. Compared to visible minority seniors, almost double the proportion (9.0%) of White seniors smoked daily. More than one-half of White seniors were regular drinkers in comparison to one-third of visible minorities. Among the visible minority elderly, 29% never drank liquor as opposed to 7.9% Whites. Almost the same proportion of seniors from both groups (about 7%) also indicated unmet health care needs.

### *Perceived Health Within Visible Minority Group by Different Characteristics*

A lower percentage of female visible minority seniors indicated both their general health (30.5%) and mental health (61.4%) as excellent or very good compared to males (38.3% and 64.6% respectively) (table 3). Within the three education levels, the highest proportion of visible minority seniors with university degree (40.5%) reported having an excellent or very good health and the lowest proportion (20.8%) as fair or poor health (table 3). In contrast, most of those who had less than high school education (40.9%) reported their health as fair or poor. Reports on mental health are consistent across every education level, the highest proportions reporting as excellent or very good and the lowest proportions as fair or poor in each category of education. However, visible minority seniors with a university degree mostly (75.1%) reported having excellent or very good mental health, with few (3.3%) reporting fair or poor mental health.

The haves and have-nots among the visible minority seniors reported very different levels of self-perceived health, especially self-perceived mental health: more than one-third of those with less than $30,000 annual income reported their health as fair or poor, compared to one-tenth of those whose income was $30,000 or more. Less than 27.5% of low-income seniors perceived their health to be excellent or very good relative to 58.4% of high-income seniors. Similarly, 59.3% of seniors with low income perceived their mental health as excellent or very good, whereas 80.6% of seniors belonging to the high-income group perceived the same.

### *Language Proficiency*

The percentages of those who perceived their health, especially mental health, as excellent or very good were significantly lower for those who could not converse in English or French as opposed to those who could converse in one of the official languages (table 3). The percentages of seniors who reported their health and mental health as fair or poor were significantly higher if they could not converse in English or French than those who could converse in one of the official languages. A significantly higher percentage of visible minority seniors who could not converse in English or French had a regular medical doctor, visited a doctor more than seven times a year, consulted an alternate health care provider, and had a flu shot within the past year compared to those who could converse in one of the

official languages (table 4). A significantly lower percentage of visible minority seniors who could not speak either of the official languages had had their eyes examined and visited a dentist within the past year, compared to those who could speak English or French.

Apart from these findings, chronic conditions and health services utilization of visible minority seniors by gender and income were also examined. A higher percentage of female visible minority seniors reported having a chronic condition and a regular doctor than their male counterparts. However, a higher percentage of male visible minority seniors saw their doctors more than 19 times compared to females. Having a flu shot and eye examination were not very different for males versus females. A moderately higher percentage of females visited a dentist within the past year than their male counterparts.

A remarkably high percentage of visible minority seniors from low-income group saw the doctor more than 7 times and as high as 19 times or more, compared with those from the high-income group. Interestingly, a significantly higher percentage from the low-income group had a flu shot in the past year compared to those in the high-income group. In contrast, only 55.8% of those coming from the low-income group had visited a dentist in the past year, in comparison to 86% from the higher income group.

### *Healthy Immigrant Effect*

Although there was some indication that recent arrivals among visible minority seniors had better health and mental health compared to those who had been to Canada for ten years or more, length-of-stay in Canada results were not significant (table 3). A remarkably higher percentage (91.0%) of earlier arrivals reported having a chronic illness as opposed to 74.5% of recent arrivals (table 4). Similarly, 34.8% of earlier arrivals saw the doctor more than six times a year, whereas 24.3% recent arrivals reported the same. Almost the same percentage (about 58.0%) of both early and recent arrivals visited a dentist in the past year.

## DISCUSSION

Unlike the findings of Newbold and Filice (2006), in which native- and foreign-born people aged 55 and over ranked their health in a similar manner, we found differences in perceived health, perceived mental health, chronic conditions, lifestyle, and health care service use between visible

minority and White seniors in Canada. We also found differences in these factors by gender, education levels, language proficiency, income levels, and length of stay in Canada within the visible minority group.

What is also clear from this study is that more White seniors live alone, and they make more money than their visible minority counterparts. One-third of visible minority seniors live in large households with four or more people. This may be because most seniors from visible minority backgrounds come to Canada to look after their grandchildren (National Advisory Council on Aging, 2005) or to join their adult children (Behjati-Sabet & Chambers, 2005; Dinh, Ganesan, & Waxler-Morrison, 2005). This could also be one of the reasons why their individual income is less than that of White seniors.

It is a matter of concern that a lower percentage of visible minority seniors than Whites perceive their health and mental health as excellent or very good, and that a higher percentage of visible minority seniors report their health and mental health as fair or poor. Regardless of race or ethnicity, most seniors had some kind of chronic health problem. The chronic conditions could be the reason why such a high percentage of seniors from both groups had a regular medical doctor. Given the high prevalence of chronic illnesses reported by seniors, the remarkable proportion having fair or poor health, and their high utilization of health care facilities, increased health care costs could be expected in the coming years. High blood pressure was more prevalent among visible minority elderly, but the direction of prevalence changes favouring them over the Whites in such chronic conditions as heart disease and arthritis/rheumatism.

The healthy immigrant effect that most researchers have found was not fully confirmed in the case of visible minority seniors. However, there was a suggestion of healthy immigrant effect for visible minority seniors in relation to their chronic condition and doctor's visits.

While comparing the health and health care services utilization pattern, we had an opportunity to revisit the "double jeopardy/multiple jeopardy" thesis for visible minority seniors. There were some suggestions that visible minority seniors may have been disadvantaged to some extent because of their minority status apart from belonging to a low-income group. Language proficiency proved to be very important in having excellent health, especially mental health. More importantly, the findings also suggest that it is their lack of language proficiency that poses a barrier to

health care services use, such as seeking eye and dental care. Language proficiency was also related to fewer visits to a doctor. The language barrier, of course, is connected to their status as minority senior immigrants.

Visible minority seniors' lower utilization of health care services such as eye examinations, dentistry, being an overnight hospital patient, and having government-provided home care may also depend on culture, perception of health, and lifestyle, along with language barriers and personal income. A low percentage of visible minority seniors reporting excellent or very good health may be a result of the types of food they consume in Canada, their economic condition, the difficulty of coping with the harsh winter (Dinh et al., 2005), the stress of leaving their friends and relatives back home to come to a new place and unfamiliar culture, and loss of social status. Similarly, visible minority seniors' higher number of visits to the doctor could be the outcome of their poor health.

Researchers acknowledge the fact that the study of immigrants is complex (Durst, 2005), and the complexity may become greater when the study is that of senior visible minority immigrants for several reasons. First, some visible minority seniors were born in Canada or had resided in Canada for decades, obviously with more acculturation, while others were recent immigrants (possibly facing various challenges). Second, visible minority groups have complex cultures and different norms related to aging and health compared to other immigrants. Third, despite their growing numbers in Canada, relatively little research has been conducted on this segment of the population, and thus detailed medical and health-related information about this population has not been known.

From the findings of this study, there arise a number of medical and health-related research questions that are worth exploring in the future. A relationship between the higher percentage of visible minority seniors suffering from high blood pressure and the stress related to large family households, the depression of being left alone with small children or infants in the house, and/or loneliness (while sons, daughters, and daughters-in-law are at work) may unveil a number of answers for these seniors' health outcomes and challenges they face. Similarly, a relationship between visible minority seniors' high blood pressure and their changed lifestyle and/or changed diet in Canada could be worth examining. Another interesting study could be to investigate the factors influencing the use of alternate

health care providers. What could be done to improve the double or multiple jeopardy situation of senior visible minority population in Canada may be yet another research question for future researchers to explore.

## LIMITATIONS

A larger sample size and including specific visible minority groups in the PUMF data would be useful for researchers interested in these groups. Not all visible minority groups have similar cultures, neither do they come to Canada with similar reasons for migration, nor do they have homogenous perceptions of health and aging. A multiple regression analysis may reveal relationships between predictor variables selected and visible minority seniors' health and health care utilization outcomes. Apart from empirical analysis, qualitative research may expose a number of hidden causes of deterioration of health and mental health over time for visible minority seniors in Canada.

## CONCLUSION

Given that most (75%) of the recent immigrants to Canada belong to a visible minority group (Ng, Wilkins, Gendron, & Berthelot, 2005), studies of visible minority seniors, their health, mental health, and health care use become more important as their numbers keep growing. Furthermore, general health and mental health become fragile as people age, needing more health care services use in the future. Thus, keeping track of visible minority seniors' health and mental health, use of health care services, and access to preventative health services will help Canadian health policy planners tremendously in the process of health provision, health-related infrastructure building, and training of health professionals in dealing with culturally sensitive "elderly health" related issues, especially focused on visible minorities. Such processes will eventually be beneficial in maintaining the health of visible minority seniors for a healthier Canada, while at the same time in reducing health care costs.

## AUTHOR'S NOTE

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## REFERENCES


Acharya, M.P. (2004). *Constructing the meaning of "mental distress": Coping strategies of elderly East Indian immigrant women in Alberta*. PHD thesis, Department of Sociology, University of Alberta, Edmonton, AB, Canada.

Ali, J. (2002, ). Mental health of Canada's immigrants (catalogue no. 82-003). *Supplement to Health Reports, 13*. Ottawa: Statistics Canada.

Behjati-Sabet, A., & Chambers, N.A. (2005). People of Iranian descent. In N. Waxler-Morrison, J.M. Anderson, E. Richardson, & N.A. Chambers (Eds.), *Cross-cultural caring: A handbook for health professionals* (pp. 127–61). Vancouver: UBC Press.

Braun, K.L., & Browne, C.V. (1998). Perceptions of dementia, caregiving, and help seeking among Asian and Pacific Islander Americans. *Health & Social Work, 23(4)*, 262–74.

Chan, K.B. (1983). Coping with aging and managing self-identity: The social world of the elderly Chinese women. *Canadian Ethnic Studies*, *15(3)*, 36–50.

Chen, J., Ng, E., & Wilkins, R. (1996). The health of Canada's immigrants in 1994–95. *Health Reports, 7(4)*, 33–45.

Dinh, D.K., Ganesan, S., & Waxler-Morrison, N. (2005). People of Vietnamese descent. In N. Waxler-Morrison, J.M. Anderson, E. Richardson, & N.A. Chambers (Eds.), *Cross-cultural caring: A handbook for health professionals* (pp. 247–87). Vancouver: UBC Press.

Dowd, J.J., & Bengtson, V.L. (1978). Aging in minority populations: An examination of the double jeopardy hypothesis. *Journal of Gerontology*, *33(3)*, 427–36.

Dunn, J.R., & Dyck, I. (2000). Social determinants of health in Canada's immigrant population: Results from the National Population Health Survey. *Social Science & Medicine, 51*, 1573–93.

Durst, D. (2005). *Aging amongst immigrant in Canada: Policy and planning implications*. Paper presented at the 12th Biennial Canadian Social Welfare Policy Conference: Forging Social Futures, Fredericton, NB.

Harvey, E.B., Siu, B., & Reil, K.D.V. (1999). Ethno-cultural groups, period of immigration and socioeconomic situations. *Canadian Ethnic Studies*, *31(3)*, 95–103.

Hyman, I. (2001). *Immigration and health* (No. 01–05). Health Policy Workshop Paper Series. Ottawa: Health Canada.

Jenkins, C.N.H., Le, T., Mcphee, S.J., Stewart, S., & Ha, N.T. (1996). Health care access and preventative care among Vietnamese immigrants: Do traditional beliefs and practices pose barriers? *Social Science & Medicine*, *43(7)*, 1049–56.

Kinch, J.L., & Jakubec, S. (2004). "Multiple margins" (being older, a woman, or a visible minority) constrained older women's access to Canadian health care. *Canadian Journal of Nursing Research, 36*, 90–108.

Lai, D.W.L. (2003). Measuring depression of elderly Chinese Americans: A replication study. *Home Health Care Services Quarterly*, *22(2)*, 69–85.

Lai, D.W.L., Tsang, K.T., Chappell, N.L., Lai, D.C.Y., & Chau, S.B.Y. (2003). *Health and well being of older Chinese in Canada*. Calgary: Centre on Aging, Faculty of Social Work, University of Calgary.

McCallion, P., Janicki, M., & Grant-Griffin, L. (1997). Exploring the impact of culture and acculturation on older families caregiving for persons with developmental disabilities. *Family Relations*, *46(4)*, 347–57.

McDonald, L., Clarke, D., McLeary, L., George, U., & Marziali, E. (2006). *Health disparities in older visible minorities in Canada*. Paper presented at the Meeting the Challenge: Research in and with Diverse Communities Conference, Society for Social Work and Research, January 2006, San Antonio, TX.

National Advisory Council on Aging. (2005). *Seniors on the margin: Seniors from ethno-cultural minorities*. Ottawa: National Advisory Council on Aging.

Neufeld, A., Harrison, M.J., Stewart, M.J., Hughes, K.D., & Spitzer, D. (2002). Immigrant women: Making connections to community resources for support in family caregiving. *Qualitative Health Research*, *12(6)*, 751–68.

Newbold, B.K., & Filice, J.K. (2006). Health status of older immigrants to Canada. *Canadian Journal on Aging*, *25(3)*, 305–19.

Newbold, B.K., & Danforth, J. (2003). Health status and Canada's immigrant population. *Social Science & Medicine, 57*, 1981–95.

Ng, C.F., Northcott, H.C., & Abu-Laban, S.M. (2004). *The experiences of South Asian immigrant seniors living in Edmonton, Alberta: Report to the community*. Edmonton: Alberta Centre on Aging, University of Alberta.

Ng, E., Wilkins, R., Gendron, F., & Berthelot, J. (2005). *Dynamics of immigrants' health in Canada: Evidence from the National Population Health Survey* (catalogue no. 82-618-MWE2005002). Ottawa: Statistics Canada.

Penning, M.J. (1983). Multiple jeopardy: Age sex, and ethnic variations. *Canadian Ethnic Studies*, *15(3)*, 81–105.

Perez, C.E. (2002). Health status and health behaviour among immigrants (Catalogue no. 82-003). *Supplements to Health Reports, 13*. Ottawa: Statistics Canada.

Quan, H., Fong, A., De Coster, C., Wang, J., Musto, R., Noseworthy, T.W., & Ghali, W.A. (2006). Variation in health services utilization among ethnic populations. *Canadian Medical Association Journal*, *174(6)*, 787–91.

Rosenthal, C.J. (1983). Aging, ethnicity and the family: Beyond the modernization thesis. *Canadian Ethnic Studies*, *15(3)*, 1–16.

————. (1986). Family supports in later life: Does ethnicity make a difference? *Gerontologist*, *26(1)*, 19–24.

Rotermann, M. (2006). Seniors' health care use (Catalogue no. 82-003). *Supplement to Health Reports, 16*. Ottawa: Statistics Canada.

Statistics Canada. (2001a). Definition: Visible minority population by age, provinces and territories (2001 Census). Accessed November 27, 2007, at http://www.statcan.ca/english/Pgdb/defdemo50a.htm

————. (2001b). Visible minority population by age (2001 Census). Accessed December 3, 2006, at http://www.statcan.ca/english/Pgdb/demo50a.htm

————. (2005). Study: Canada's visible minority population in 2017. *Daily*, March 22. Accessed November 27, 2007, at http://www.statcan.ca/Daily/English/050322/d050322b.htm

———. (2006). *Canadian Community Health Survey (CCHS) Cycle 3.1, 2005; Public Use Microdata File (PUMF) Use Guide*. Ottawa: Statistics Canada.
Tanjasiri, S.P., Wallace, S.P., & Shibata, K. (1995). Picture imperfect: Hidden problems among Asian Pacific Islander elderly. *Gerontologist, 35(6)*, 753–60.

**TABLE 1:** *Demographics of Visible Minority and White Seniors, 2005*

| Indicators | Seniors aged 65 and over | | |
|---|---|---|---|
| | Visible minorities N (%) | Whites N (%) | p-value |
| **Demographics** | | | |
| Status: Immigrant | 1,299 (81.0) | 3,601 (21.5) | 0.000 |
| Length of stay in Canada: | | | |
| 0–9 years | 153 (11.8) | 37 (1.0) | 0.000 |
| 10 years or more | 1,146 (88.2) | 3,564 (99.0) | |
| Gender: | | | |
| Male | 706 (43.4) | 7,472 (44.5) | 0.209 |
| Female | 919 (56.6) | 9,310 (55.5) | |
| Job: | | | |
| Full-time | 70 (61.4) | 744 (56.9) | 0.354 |
| Part-time | 44 (38.6) | 563 (43.1) | |
| Education: | | | |
| Less than secondary | 705 (44.2) | 6,973 (42.2) | 0.008 |
| Secondary grad/other post-secondary | 264 (14.3) | 3,185 (19.3) | |
| Post-secondary graduates | 627 (39.3) | 6,352 (38.5) | |
| Language (can converse): | | | |
| English/French | 1,179 (73.8) | 16,536 (98.6) | 0.000 |
| No English/French | 440 (27.2) | 224 (1.4) | |
| Living arrangement: | | | |
| Unattached/alone | 253 (15.6) | 5,078 (30.3) | 0.000 |
| With spouse/partner | 545 (33.7) | 8,961 (53.5) | |
| Parent, spouse, child | 207 (12.8) | 893 (5.3) | |
| Parent and child | 63 (3.9) | 634 (3.8) | |
| Other | 550 (34.0) | 1,176 (7.1) | |
| Household size: | | | |
| 1 person | 253 (15.6) | 5,078 (30.3) | 0.000 |
| 2 persons | 642 (39.5) | 9,888 (58.9) | |
| 3 or more persons | 730 (45.0) | 2,327 (10.8) | |
| Personal income: | | | |
| < 15,000 | 760 (61.4) | 4,384 (32.9) | 0.000 |
| 15,000–49,000 | 397 (32.1) | 7,561 (56.6) | |
| 50,000 and over | 80 (6.4) | 1,409 (10.6) | |
| **Health Characteristics** | | | |
| Has chronic condition (yes) | 1,459 (89.8) | 15,259 (91.1) | 0.055 |
| Has arthritis/rheumatism (yes) | 609 (37.6) | 7,853 (46.9) | 0.000 |
| Has high blood pressure (yes) | 781 (48.1) | 7,375 (44.0) | 0.001 |
| Has heart disease (yes) | 204 (12.6) | 3,301 (19.7) | 0.000 |
| Total N | 1,625 | 16,781 | |

Source: Computed from the Canadian Community Health Survey, Cycle 3.1, Public Use Microdata File.

Note: Percentages in each cell show those who responded to that particular question.

**TABLE 2:** *Health Care Utilization and Health of Visible Minorities and Whites, 2005*

| Indicators | Seniors aged 65 and over | | |
|---|---|---|---|
| | Visible minorities N (%) | Whites N (%) | p-value |
| **Perceived Health** | | | |
| Self-perceived health: | | | |
| Excellent/very good | 549 (33.8) | 6,785 (40.6) | 0.000 |
| Good | 565 (34.9) | 5,679 (33.9) | |
| Fair/poor | 507 (31.3) | 4,278 (25.6) | |
| Self-perceived mental health: | | | |
| Excellent/very good | 891 (62.8) | 11,005 (69.5) | 0.000 |
| Good | 408 (28.8) | 4,075 (25.7) | |
| Fair/poor | 119 (8.4) | 747 (4.7) | |
| **Health Services Utilization** | | | |
| Has regular medical doctor (yes) | 1,565 (96.3) | 15,973 (95.2) | 0.025 |
| Reasons for not having a regular doctor: | | | |
| No doctor available | — (—) | 108 (13.4) | 0.113 |
| Not taking new patients | — (—) | 117 (14.6) | 0.522 |
| Not tried to contact one | 22 (36.7) | 217 (27.0) | 0.074 |
| Doctor has left/retired | — (—) | 266 (33.1) | 0.002 |
| Other | 15 (25.0) | 208 (25.9) | 0.510 |
| Number of visits to a doctor: | | | |
| 1–6 times | 1,013 (67.7) | 11,175 (73.6) | 0.000 |
| 7 times or more | 484 (32.3) | 4,005 (26.4) | |
| Consulted alternate health provider (yes) | 174 (10.7) | 1,060 (6.3) | 0.000 |
| Last time had flu shot: | | | |
| < 1 year | 967 (88.1) | 11,314 (88.6) | 0.021 |
| 1–2 years | 54 (4.9) | 439 (3.4) | |
| 2 years or more | 76 (6.9) | 1,022 (8.0) | |
| Last time eyes examined: | | | |
| < 1 year | 492 (66.8) | 4,090 (69.0) | 0.070 |
| 1–2 years | 130 (17.7) | 964 (16.3) | |
| 2 years or more | 112 (15.3) | 841 (14.2) | |
| Last time visited dentist: | | | |
| < 1 year | 364 (48.5) | 3,709 (56.1) | 0.000 |
| 1–2 years | 57 (7.6) | 497 (7.5) | |
| 2 years or more | 296 (39.4) | 2,308 (34.9) | |
| never | 34 (4.5) | 96 (1.5) | |
| Overnight patient (yes) | 166 (10.4) | 2,390 (14.3) | 0.000 |
| Required home care provided by govt. (yes) | 92 (5.7) | 1,597 (9.5) | 0.000 |
| Required home care not covered by govt. (yes) | 138 (8.5) | 1,549 (9.2) | 0.325 |
| Total N | 1,625 | 16,781 | |

Source: Computed from Canadian Community Health Survey, Cycle 3.1, Public Use Microdata File.

Note: Percentages in each cell show those who responded to that particular question.

**TABLE 3:** *Perceived Health and Mental Health of Visible Minorities by Gender, Education, and Income, 2005*

| Indicators | Perceived health (visible minority seniors) | | |
|---|---|---|---|
| | **Excellent/ very good** | **Good** | **Fair/poor** |
| Gender:** | | | |
| Male | 269 (38.3) | 239 (34.0) | 195 (27.7) |
| Female | 280 (30.5) | 356 (35.5) | 312 (34.0) |
| Education:*** | | | |
| Less than high school | 202 (28.6) | 215 (30.5) | 288 (40.9) |
| High school + some university | 86 (32.6) | 98 (37.1) | 80 (30.3) |
| University graduates | 253 (40.5) | 241 (38.6) | 210 (20.8) |
| Personal income:*** | | | |
| Less than $30,000 | 290 (27.5) | 397 (37.7) | 366 (34.8) |
| $30,000 and over | 108 (58.4) | 58 (31.4) | 19 (10.3) |
| Language proficiency:** | | | |
| English/French | 427 (36.3) | 401 (34.1) | 347 (29.5) |
| No English/French | 119 (27.0) | 164 (37.2) | 158 (35.8) |
| Years of stay in Canada: | | | |
| < 10 years | 54 (35.5) | 59 (38.3) | 39 (25.7) |
| 10+ years | 373 (32.5) | 394 (34.4) | 379 (33.1) |
| **Indicators** | **Perceived mental health (visible minority seniors)** | | |
| | **Excellent/ very good** | **Good** | **Fair/poor** |
| Gender:* | | | |
| Male | 418 (64.6) | 189 (29.2) | 40 (6.2) |
| Female | 474 (61.4) | 219 (28.4) | 79 (10.2) |
| Education:*** | | | |
| Less than high school | 295 (51.0) | 206 (35.6) | 77 (13.4) |
| High school + some university | 150 (64.1) | 65 (27.8) | 19 (8.1) |
| University graduates | 437 (75.1) | 126 (21.6) | 19 (3.3) |
| Personal income:*** | | | |
| Less than $30,000 | 528 (59.3) | 276 (31.0) | 86 (9.7) |
| $30,000 and over | 145 (80.6) | 27 (15.0) | — |
| Language proficiency:*** | | | |
| English/French | 710 (67.4) | 280 (26.6) | 64 (6.1) |
| No English/French | 178 (49.6) | 126 (35.1) | 55 (15.3) |
| Years of stay in Canada: | | | |
| < 10 years | 95 (68.8) | 35 (25.4) | — |
| 10+ years | 601 (61.6) | 284 (29.1) | 91 (9.3) |

Source: Computed from Canadian Community Health Survey, Cycle 3.1, Public Use Microdata File.

Note: Percentages in each cell show those who responded to that particular question; *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$; "—" denotes "cases less than 15, not appropriate to report."

**TABLE 4:** *Health Care Utilization and Health of Visible Minority Seniors by Language Proficiency and Years in Canada, 2005*

| Indicators | Can converse in English/ French N (%) | Cannot converse in English/ French N (%) | p-value | Less than 10 years in Canada N (%) | 10 years or more in Canada N (%) | p-value |
|---|---|---|---|---|---|---|
| Has chronic condition: | | | | | | |
| yes | 1,050 (89.1) | 404 (91.8) | 0.103 | 114 (74.5) | 1,042 (91.0) | 0.000 |
| no | 129 (10.9) | 36 (8.2) | | 39 (25.5) | 103 (9.0) | |
| Has regular medical doctor: | | | | | | |
| yes | 1,124 (95.3) | 435 (98.9) | 0.001 | 150 (98.0) | 1,112 (97.0) | 0.482 |
| no | 55 (4.7) | — | | — | 34 (3.0) | |
| Number of doctor's visits: | | | | | | |
| 1–6 times | 762 (71.3) | 248 (58.4) | 0.000 | 112 (75.7) | 691 (65.2) | 0.000 |
| 7 times or more | 306 (28.7) | 177 (46.6) | | 36 (24.3) | 369 (34.8) | |
| Consulted alternate health provider: | | | | | | |
| yes | 92 (7.8) | 81 (18.5) | 0.000 | — | 137 (12.0) | 0.052 |
| no | 1,087 (92.2) | 357 (81.5) | | 141 (93.4) | 1,009 (88.0) | |
| Last time had flu shot: | | | | | | |
| < 1 year | 693 (85.2) | 272 (96.8) | 0.000 | 92 (90.2) | 647 (86.8) | 0.052 |
| 1 year or more | 120 (14.7) | — | | — | 98 (13.2) | |
| Last time eyes examined: | | | | | | |
| < 1 year | 383 (70.7) | 108 (56.5) | 0.000 | 67 (67.7) | 329 (63.5) | 0.700 |
| 1–2 years | 92 (17.0) | 39 (20.4) | | 16 (16.2) | 100 (19.3) | |
| 2 years or more | 67 (12.4) | 44 (23.0) | | 16 (16.2) | 89 (17.2) | |
| Last time visited dentist: | | | | | | |
| < 1 year | 334 (61.1) | 84 (50.3) | 0.045 | 48 (57.1) | 295 (58.8) | 0.017 |
| 1–2 years | 91 (16.6) | 37 (22.2) | | — | 104 (20.7) | |
| 2 years or more | 122 (22.3) | 46 (27.5) | | 27 (32.1) | 103 (20.5) | |

Source: Computed from the Canadian Community Health Survey, Cycle 3.1, Public Use Microdata File.

Note: Percentages in each cell show those who responded to that particular question; "—" denotes "cases smaller than 15, not appropriate to report."