LATER-LIFE FILIPINO IMMIGRANTS IN THE GREATER TORONTO AREA:
A Case Study of Health Status and Utilization of Services

by

JANETTE JOYCE BRUAL

A thesis submitted to the Department of Geography
in conformity with the requirements for
the degree of Doctor of Philosophy

Queen’s University
Kingston, Ontario, Canada
July, 2014

Copyright © Janette Joyce Brual, 2014
Abstract

This research contributes to the growing field of ethnogerontological research in Canada offering insights into the health and aging experiences of immigrants, with specific reference to the Filipino immigrant community. The two-fold purpose of this study was to first examine how ethnicity and immigration operate within various settings of senior-centered community and health care services. Secondly, this study examined the role of place and how it shapes health and age identities among later-life Filipino immigrants. In total 37 semi-structured interviews (22 key informants and 15 later-life Filipinos) and a survey of 138 questionnaires were collected for analysis. Results from key informant interviews support current literature which suggests that immigrant seniors experience significant barriers to services, such as language, economic difficulties, immigrant family conflict and social and cultural isolation. Sharing from their working and personal experiences, key informants expanded on their own views about cultural and ethnic diversity describing the intersectionality of immigrant, ethnic and social identities, as well as their experiences of health and aging in Canada. They also discussed the predominance of monocultural views of aging and the limitations of multicultural and culturally competent senior care services. Compared to research on other Canadian immigrant populations, later-life Filipinos reported high levels of physical and mental health and described very few barriers to health care access in Canada. In-depth analyses of later-life Filipinos’ narratives on their aging and migration experiences revealed culturally-informed views, expectations and understandings of what it means to age in a foreign land. Older Filipinos shared their ideas on the meaning of place, perceptions of aging and age identity, such as place-making and a sense of belonging in older age. This research considers the significance of ethnicity and migration as important social determinants of health and advocates for more life-course analyses on the health and aging experiences of the older immigrant. This research was built from a conceptual framework that incorporated concepts from life course theory and social determinants of health approaches in
providing a critical perspective and examination about the role of place, culture and migration on normative views of the aging experience.
Acknowledgements

There are many people I want to thank without whom this research would not have been completed. Firstly, I want to extend endless gratitude to my doctoral supervisor and mentor, Mark Rosenberg, for believing in me and offering your unwavering support and encouraging advice during this long process. Thank you for taking a chance on me.

I offer my humble appreciation to my examination committee; Audrey Kobayashi, Beverly Mullings, Lucie Lévesque, Philip Kelly and Thorsten Koeppel, thank you for your participation, sharing your time, energy and feedback on my research. To the ladies in the geography department office – Sheila MacDonald, Joan Knox, Kathy Hoover, and Sharon Mohammed – thank you for your warmth, welcoming cheerfulness and administrative support. Thank you to my peers and colleagues in the geography department and to all the friends I’ve met while in Kingston; so many of you have offered me great support, camaraderie, shared expertise, inspiration, and friendship that I won’t soon forget.

I will forever be grateful to my family and extended family for their loving support, constant patience and encouragement. Mom and Dad – thank you for keeping my spirits buoyed and for your unconditional love and guidance. To my sisters, Trish and Chris, for keeping me properly distracted with your boundless energy, loving antics, sisterly support and for putting up with me. Thank you to Rich and Jere for your friendship, support and for keeping me balanced. Thank you Tita Coco, Tito Dards and the Diaz clan for sharing your enthusiasm and for cheering me on.

And finally, thank you to all my participants for generously giving your time and energy to my research. It was such a great privilege to do this project. This learning experience has been wholly educational, yet satisfyingly enlightening.
# Table of Contents

Abstract ........................................................................................................... ii
Acknowledgements ........................................................................................... iv
List of Tables ...................................................................................................... x
List of Figures ..................................................................................................... xi

## Chapter 1: Introduction ................................................................................. 1

1.1 Introduction .................................................................................................. 1
1.2 Health and Aging among Older immigrants: An Ethnogerontological Study ....... 3
   1.2.1 Later-life Filipino Immigrants: An Ethnogerontological Case-Study ............ 7
1.3 Significance of Research ............................................................................. 10
1.4 Research Goals and Broad Research Questions ............................................ 14
1.5 Chapter Outline ......................................................................................... 15

## Chapter 2: Literature Review ...................................................................... 20

2.1 Introduction: Immigration and Canada ....................................................... 20
2.2 Immigrant Health ....................................................................................... 22
   2.2.1 Quantitative Research: Large-Scale Studies on Immigrant Health .......... 25
   2.2.2 Qualitative Research on the Health of Immigrant Populations ................. 29
2.3 The Aged and Aging Immigrant: Health Trajectory Hypotheses .................. 33
   2.3.1 Healthy Immigrant Effect Hypothesis ..................................................... 34
   2.3.2 Double Jeopardy Hypothesis ................................................................. 40
   2.3.3 Age as Leveller Hypothesis .................................................................. 42
   2.3.4 Cumulative Disadvantage or the Matthew Effect .................................... 45
   2.3.5 Buffer Hypothesis or the Stress Process Model ........................................ 47
2.4 Health Transitions of an Aging Immigrant: A Question of Age, Illness or Ethnicity? .... 49
   2.4.1 Crosscutting Aging and Migration: Theoretical Considerations ................. 50
   2.4.2 Research on Aging Immigrant Populations in Canada .............................. 55
2.5 Research on Aging Ethnocultural Groups in Canada ..................................... 59
   2.5.1 Aging Chinese Canadians ..................................................................... 59
   2.5.2 Aging South Asian Canadians ............................................................... 60
   2.5.3 Other Aging Ethnocultural Groups in Canada .......................................... 61
2.6 Research on Filipino Immigrants ................................................................. 62
   2.6.1 Filipino Migration to Canada ................................................................. 63
Chapter 3: Research Design and Methods ................................................................. 78

3.1 Introduction ........................................................................................................... 78

3.2 Conceptual Framework ....................................................................................... 79

3.2.1 Life Course Theory ......................................................................................... 80

3.2.2 Social Ecology Theory and the Social Determinants of Health among Aging Immigrants .......................................................................................................................... 83

3.2.3 Andersen’s Behavioral Model of Health Services Utilization ......................... 87

3.2.4 Dimensions of Place Experiences .................................................................. 87

3.3 Methods ................................................................................................................ 89

3.3.1 Study Site ....................................................................................................... 90

3.3.2 Recruitment and Data Collection .................................................................. 91

3.3.3 Key Informants .............................................................................................. 92

3.3.4 Later-Life Filipinos ....................................................................................... 94

3.3.5 In-depth Semi-Structured Interviews ............................................................. 97

3.3.6 Survey Questionnaire .................................................................................... 99

3.4 Analysis ............................................................................................................... 104

3.4.1 Semi-structured Interview .......................................................................... 104

3.4.2 Survey Data Analysis ................................................................................... 106

3.5 Limitations, Challenges and Ethical Issues ......................................................... 109

3.5.1 Use of Retrospective Data, Study Design and Data Collection ....................... 111

3.5.2 Ethical Considerations ................................................................................. 114

3.6 Chapter Summary ............................................................................................... 116

Chapter 4: Understanding Health and Aging of Immigrants in the City: A Key Informant’s Perspective ............................................................................................................. 118

4.1 Introduction ........................................................................................................... 118

4.2 Key Informants .................................................................................................... 121

4.3 Describing Immigrant Seniors in Toronto and the GTA: A Key Informant’s Perspective 124

4.3.1 Describing the Role of Immigrant Seniors in the Family Unit ....................... 126

4.3.2 Describing the Role of Immigrant Seniors in the Community ....................... 129

4.3.3 Describing the Role of Immigrant Seniors: Contrasting Key Informant Views .... 134

4.4 Challenges of Working with the Older Immigrant Populations ....................... 138
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.4.1 Theme 1: Funding Challenges and Lack of Financial Resources</td>
<td>140</td>
</tr>
<tr>
<td>4.4.2 Theme 2: Establishing and Working with Community Partnerships</td>
<td>147</td>
</tr>
<tr>
<td>4.4.3 Theme 3: Service Provider-Client Relationships</td>
<td>149</td>
</tr>
<tr>
<td>4.4.4 Theme 4: Senior/Client Issues</td>
<td>156</td>
</tr>
<tr>
<td>4.4.5 Theme 5: Mainstream Societal Views</td>
<td>161</td>
</tr>
<tr>
<td>4.5 Chapter Summary</td>
<td>165</td>
</tr>
<tr>
<td>Chapter 5: Ethnic and Cultural Diversity of Aging Immigrant Populations: A Key Informant’s Perspective</td>
<td>168</td>
</tr>
<tr>
<td>5.1 Introduction</td>
<td>168</td>
</tr>
<tr>
<td>5.2 Migratory Experiences: Different Trajectories in Life</td>
<td>171</td>
</tr>
<tr>
<td>5.3 Processes of Immigration</td>
<td>180</td>
</tr>
<tr>
<td>5.4 The Structure of Immigrant Families</td>
<td>185</td>
</tr>
<tr>
<td>5.5 Migration, Place and Aging</td>
<td>190</td>
</tr>
<tr>
<td>5.5.1 Risks of Social Isolation (n=11)</td>
<td>192</td>
</tr>
<tr>
<td>5.5.2 The Need to Find Community (n=8)</td>
<td>194</td>
</tr>
<tr>
<td>5.5.3 Sense of Belonging (n=4)</td>
<td>195</td>
</tr>
<tr>
<td>5.5.4 Fear (n=4) and Lack of Trust (n=8)</td>
<td>198</td>
</tr>
<tr>
<td>5.5.5 The Importance of Social and Community Supports (n=10)</td>
<td>199</td>
</tr>
<tr>
<td>5.6 Exploring the Social Determinants of Health among Aging Immigrants</td>
<td>201</td>
</tr>
<tr>
<td>5.6.1 Economic Barriers (n=11)</td>
<td>204</td>
</tr>
<tr>
<td>5.6.2 Housing Issues (n=7)</td>
<td>205</td>
</tr>
<tr>
<td>5.6.3 Poor Access to Transportation (n=9)</td>
<td>207</td>
</tr>
<tr>
<td>5.6.4 Language Barriers (n=20)</td>
<td>209</td>
</tr>
<tr>
<td>5.7 Health and Aging among Immigrants in Toronto and the GTA</td>
<td>211</td>
</tr>
<tr>
<td>5.7.1 Immigrant Health Issues</td>
<td>212</td>
</tr>
<tr>
<td>5.7.2 System-level Issues</td>
<td>219</td>
</tr>
<tr>
<td>5.7.3 Cultural Competent Care</td>
<td>226</td>
</tr>
<tr>
<td>5.7.4 The Future of Population Aging on Immigrant Seniors</td>
<td>234</td>
</tr>
<tr>
<td>5.8 Chapter Summary</td>
<td>237</td>
</tr>
<tr>
<td>Chapter 6: Exploring Health, Place and Aging among Later-life Filipinos in Toronto and the GTA: A Cross-sectional Study Using Survey Data</td>
<td>241</td>
</tr>
<tr>
<td>6.1 Introduction</td>
<td>241</td>
</tr>
<tr>
<td>6.2 Demographics of Filipino Survey Respondents: Data and Definitions</td>
<td>244</td>
</tr>
<tr>
<td>6.3 The Health of Older Filipino Immigrants: Question #1</td>
<td>247</td>
</tr>
</tbody>
</table>
6.3.1 General Health ........................................................................................................ 248
6.3.2 Mental Health ......................................................................................................... 250
6.3.3 Chronic Health Conditions ................................................................................... 251
6.3.4 Use of Mobility Assistive Devices ....................................................................... 252
6.3.5 Health Behaviours ................................................................................................. 253
6.4 Health Care Use of Older Filipino Immigrants: Question #2 ................................. 259
6.4.1 Health Care System Satisfaction .......................................................................... 260
6.4.2 Health Care Utilization ........................................................................................ 262
6.4.3 Contacts with Health Professionals ...................................................................... 262
6.4.4 Home Care Services ............................................................................................. 263
6.4.5 Community-based Care ......................................................................................... 264
6.4.6 Access to Health Services .................................................................................... 264
6.4.7 Insurance Coverage ............................................................................................. 268
6.5 The Role of Place in Health and Aging: Dimensions of Place Experiences: Question #3 272
6.5.1 Life after migrating to Canada .............................................................................. 273
6.5.2 Health Care Use in the Philippines ..................................................................... 277
6.5.3 Health Measures .................................................................................................... 280
6.5.4 Psychosocial Measures of Health, Place and Aging ........................................... 286
6.6 Summary .................................................................................................................... 292

Chapter 7: Health, Place and Aging in Multicultural Toronto: An Ethnogerontological
Case-study of Aging Filipinos ...................................................................................... 301
7.1 Introduction ................................................................................................................ 301
7.2 Later-Life Filipinos .................................................................................................... 303
7.3 Health and Aging Trajectories in the Context of Migration ...................................... 304
7.4 Reasons for Migrating ............................................................................................... 305
7.5 Perceptions of Health and Aging ............................................................................. 310
7.5.1 Self-perceptions of Health and Aging: Retirement, Aging and Social Wellbeing ..... 312
7.5.2 Aging in Canada: In Sickness and In Health ......................................................... 319
7.5.3 Health Care and Aging: A Matter of Life and Death ........................................... 330
7.6 Aging and Attachment to Place ............................................................................... 338
7.6.1 Adjusting to Life in Canada .................................................................................. 338
7.6.2 At “Home” in Canada but Longing for “Back Home” .......................................... 341
7.7 Chapter Summary ...................................................................................................... 347

Chapter 8: Discussion and Future Directions ................................................................. 349
8.1 Introduction

8.2 Successful Aging versus Active Aging among Older Immigrants: Exploring Key Informant Perspectives and Filipinos’ Understanding of Aging in Canada

8.3 Re-visiting the Research Goals and Questions

8.4 Immigration and Aging in Canada: Experiences and Meanings of Place in Later Life

8.5 Key Challenges and Limitations

8.6 Future Directions

Bibliography

Appendix 1: Key Informants In-depth Interview Guide

Appendix 2: Survey Questionnaire for Later-life Filipinos

Appendix 3: Later-Life Filipino In-depth Interview Guide

Appendix 4: Letter of Information – Key Informants

Appendix 5: Letter of Information – Later-Life Filipinos: Survey

Appendix 6: Letter of Information – Later-Life Filipinos: Interview

Appendix 7: Informed Consent Form for Key Informant Interviews

Appendix 8: Informed Consent Form for Later-life Filipinos – Survey

Appendix 9: Informed Consent Form for Later-life Filipinos – Interview

Appendix 10: Table 4-1: Characteristics of Key Informants

Appendix 11: Table 7-1: Later-Life Filipino Interview Participants

Appendix 12: Table 7-2: Later-life Filipino Interview Participants Characteristics

Appendix 13: Ethics Certificate
List of Tables

Table 1-1: Immigrants by Country of Birth According to 2011 National Household Survey (Statistics Canada, 2013) ............................................................................................................. 8
Table 2-1: Summary of Recruitment, Data Collection and Analysis for all Three Phases of Field Research ........................................................................................................................................ 91
Table 4-1: Characteristics of Key Informants ............................................................................................................. 454
Table 4-2: Key Informant Characteristics ...................................................................................................................... 122
Table 4-3: Describing the role of immigrant seniors in Toronto and the GTA ........................................ 1255
Table 4-4: Summary of Themes on the Challenges of Working with Older Immigrant Population ........................................................................................................................................ 1399
Table 5-1: Themes of Migration, Place and Aging ........................................................................................................ 192
Table 5-2: Exploring Social Determinants of Health among Aging Immigrants ........................................ 204
Table 5-3: Issues of Health and Aging among Immigrants ......................................................................................... 212
Table 6-1: Later-life Filipinos Survey Respondents Demographics ........................................................................ 2455
Table 6-2: Later-life Filipinos Survey Respondents Migration Characteristics ........................................... 247
Table 6-3: Health Scale Ratings by Age Group Cohort ............................................................................................ 249
Table 6-4: Non-weighted and Weighted Duke Activity Status Index (DASI) Scores by Age Group Cohorts ........................................................................................................................................ 254
Table 6-5: Descriptive Statistics for Non-weighted and Weighted Duke Activity Status Index (DASI) for Dimensions of Place Experiences ................................................................................................. 2866
Table 6-6: Descriptive Statistics for the Geriatric Depression Scale – Short Form (GDS-SF) .. 287
Table 6-7: Descriptive Statistics for the Multidimensional Scale of Perceived Social Support (MSPSS) ........................................................................................................................................ 2899
Table 7-1: Later-Life Filipino Interview Participants .............................................................................................. 458
Table 7-2: Later-life Filipino Interview Participants Characteristics ..................................................................................... 459
List of Figures

Figure 2-1: Diagrammatic Representation of Successful Aging .......................................................... 56
Figure 2-2: Percentage of later-life Filipinos within the total Filipino population in the Toronto CMA (N= 185,085) and in Ontario (N= 218,660) ........................................................................ 71
Figure 3-1: A conceptual model of health and health care use of older Filipino immigrants in Canada. ......................................................................................................................... 81
Figure 4-1: Health and age-related domains identified through key informant interviews ...... 1244
Figure 6-1: Self-rated health by sex (N=138) ..................................................................................... 2488
Figure 6-2: Percentage of respondents, by sex, rating their current health to their health from one year ago (N=138) ............................................................................................... 2499
Figure 6-3: Self-reported stress experienced most days, by sex (N=138) ....................................... 25050
Figure 6-4: Self-reported stress experienced most days, by age group cohort (N=138) ............ 25151
Figure 6-5: Number of chronic conditions experienced by sex (N=138) ................................. 2522
Figure 6-6: Self-report frequency of engaged leisure-time activity reported over the last three months (n=125) ........................................................................................................ 2555
Figure 6-7: Self-reported time spent on each occasion of leisure-time activity over the last three months (n=126) ........................................................................................................ 2555
Figure 6-8: Respondents who self-reported that they consider themselves physically active (n=133) ............................................................................................................................ 2566
Figure 6-9: Number of respondents reporting on current diet since migrating from Canada (n=88) ........................................................................................................................................... 2577
Figure 6-10: The frequency that respondents report drinking alcoholic beverages by sex (n=85) ............................................................................................................................................. 2588
Figure 6-11: Number of respondents reporting alcoholic drinking behaviour since immigrating to Canada (n=66) ............................................................................................................... 2599
Figure 6-12: Rating the perceived availability of health care services by sex (N=134) ............ 26161
Figure 6-13: Rating the perceived quality of health care services by sex (N=134) .................... 26161
Figure 6-14: Percentage of respondents who visited health professionals in the past twelve months ............................................................................................................................................. 2633
Figure 6-15: Number of respondents (n=24) reporting on the types of difficulties experienced in receiving specialist care ........................................................................................................ 2655
Figure 6-16: Number of respondents (n=6) reporting on the types of difficulties experienced in receiving tests such as MRIs, CAT scans or angiographies .................................................. 2666

Figure 6-17: Number of respondents (n=8) reporting on the types of difficulties experienced in getting routine or on-going care .................................................................................. 2677

Figure 6-18: Number of respondents (n=6) reporting on the types of difficulties experienced in receiving immediate health care .................................................................................. 2688

Figure 6-19: Percentage of respondents who reported having insurance that covers prescription medications (n=119) .................................................................................................. 2699

Figure 6-20: Percentage of respondents who reported having insurance that covers all or part of their dental expenses (n=94) .................................................................................................. 27070

Figure 6-21: Percentage of respondents who reported having insurance that covers all or part of the cost of eye glasses or contact lenses (n=91) .............................................................................. 27070

Figure 6-22: Percentage of respondents who reported having insurance that covers all or part of the hospital charges for a private or semi-private room (n=103) ...................................................... 27171

Figure 6-23: Respondents on whether they considered themselves to be regular visitors to the Philippines, by Migration and Aging Dimensions (N=136) ...................................................................................... 2755

Figure 6-24: Respondents on whether they considered themselves to be regular visitors to the Philippines, by Health Care and Place Dimensions (N=137) ...................................................................................... 2766

Figure 6-25: Respondents beliefs about their health if they had not moved to Canada and were still living in the Philippines (n=78) .................................................................................................. 2777

Figure 6-26: Number of health care services received in the Philippines (N=16) .......................................................................................................................... 2788

Figure 6-27: Rating the quality of health care in the Philippines prior to migrating to Canada (n=132) .......................................................................................................................... 2799

Figure 6-28: Level of satisfaction with health in the Philippines prior to migrating to Canada (n=131) .......................................................................................................................... 2799

Figure 6-29: Self-rated health by Dimension One, Two and Three (n=137) .......................................................................................................................... 28181

Figure 6-30: Self-rated mental health for Dimensions One, Two and Three (n=137) & Dimensions Four and Five (n=138) .................................................................................................................. 2822

Figure 6-31: Mean number of chronic conditions for the total sample and by sex for Dimensions One, Two and Three .................................................................................................................. 2833

Figure 6-32: Mean number of chronic conditions for the total sample and by sex for Dimensions Four and Five .................................................................................................................. 2844

Figure 6-33: Mean scores for non-weighted DASI for Dimensions One, Two and Three by sex (n=137) .......................................................................................................................... 2855
Figure 6-34: Mean scores for non-weighted DASI for Dimensions Four and Five by sex (n=137)

Figure 6-35: Mean scores for Geriatric Depression Score-SF for the total sample and by sex for Dimensions One, Two and Three

Figure 6-36: Mean scores for Geriatric Depression Score-SF for the total sample and by sex for Dimensions Four and Five

Figure 6-37: Mean scores for multidimensional scale of perceived social support (MSPSS) total and subscales by Dimensions One, Two and Three

Figure 6-38: Mean scores for multidimensional scale of perceived social support (MSPSS) total and subscales by Dimensions Four and Five
Chapter 1

Introduction

“An awareness of the age dimension of migration sensitises us to movement over time as well as over space.”

(Biggs and Daatland, 2004: 4)

1.1 Introduction

With an increasingly aging population globally and medical advances increasing life expectancies, devising strategies to maintain optimum quality of life and positive health outcomes for all seniors are important research and policy considerations. In Canada, reductions in program funding, hospital and health care restructuring have serious implications on the health and well-being of seniors at all stages of later-life aging. Current policies in aging and health care for the elderly have often been more focused on normative ideas of aging and concepts of aging-in-place, which emphasizes the importance of positive aging experiences. Strategies and programs promoting positive aging (similar terms include successful aging or active aging) support the same overall goal, which is to endorse policies, strategies and outcomes that slow down or stave off the negative and adverse effects of growing older. The promotion of positive or successful aging has grown increasingly popular from both political and economic perspective where fears of an aging population are believed to have potentially devastating impacts on the health care and welfare systems.

Addressing the health and health care concerns of Canada’s aging population is a complicated issue. Population aging in Canada, and in much of the world, has been a consequence of increasing life expectancies resulting in a large proportion of seniors living well into their 70s and 80s (Chen and Shields, 1999). In Canada, as with other industrialized nations, immigration is commonly viewed as an important strategy not only to bolster a flagging economy
but to also deal with the pressures of an aging population and supplement fragile health care and social welfare systems. As well, changes in immigration policy over the last 20 to 30 years have seen a greater emphasis on independent (e.g., economic class) immigrants resulting in fewer later-life immigrants arriving in Canada (Moore and Rosenberg, 2001). Most recently, economic downturn and immigration policy reforms have had severe consequences for immigrant populations settling and living in Canada, especially newcomer immigrants. Despite the fewer numbers of later-life immigrants entering Canada through sponsorship applications i.e., family reunification, it is important to acknowledge that immigrants who entered Canada after the Second World War are now entering retirement and later life stages (Newbold and Felice, 2006). When compounded with issues of aging immigrant seniors are especially at risk.

As a result of immigration, often with the goals of stabilizing population growth and meeting local and regional labour pool demands, the senior population has grown in ethnic and racial diversity. This diversity has seldom been addressed in the literature and in particular, much of the research that has addressed issues of aging have rarely acknowledged the migrant factor (Durst, 2005; Durst and MacLean, 2010). For example, in a Statistics Canada report entitled A Portrait of Seniors in Canada it was acknowledged by the authors that age-related issues among immigrant seniors were grouped alongside issues of non-immigrant seniors throughout most of the report (Turcotte and Schellenberg, 2007, p.271). While Turcotte and Schellenberg dedicate a chapter on immigrant seniors, it mostly reports on demographic variation and profiles of various immigrant populations and reviews studies that aggregate groups of immigrants in order to compare to non-immigrants populations. Much of Canadian research on aging has mostly been positivist in both their approaches and understandings on the implications of migration on the aged and aging communities, which has been a glaring oversight on the specific needs of Canada’s diverse elderly population.
Even among long term immigrants who may be more established and settled in Canada, often their diverse cultural and ethnic backgrounds are overlooked as the experience of aging is treated as a monocultural process. As immigrants live and age in Canada, often building families and communities, their early migration experiences in addition to their political and economic circumstances from their birth country all contribute to and shape their current personal, working and social lives. These early migrant experiences and ongoing experiences of place-making and settlement will invariably influence their health and aging. In order to explain and describe the diverse geographies of older immigrant populations with respect to their health and aging experiences it is equally important to acknowledge the global context of migration and the significance of the migration experience itself. Such an approach not only recognizes the cultural aspect of health but also necessarily invokes discussions around how global forces shape migration and settlement experiences along the lines of gender, class and race. An intersectional understanding of migration, ethnicity and health is important to understand how to address the health and aging issues of older immigrant seniors.

1.2 Health and Aging among Older immigrants: An Ethnogerontological Study

Ethnogerontology has emerged as a new sub-field in social gerontology that focuses on the process of aging and the aging experiences of later-life adults who identify having a distinct ethnic or racial background (Crewe, 2004; Torres, 2004; Durst and MacLean, 2010; Koehn, Neysmith, Kobayashi and Khamisa, 2012). Research in ethnogerontology examines the influence of ethnicity, race and culture on individual and population aging\(^1\), using a multitude of

\(^1\) The terms “ethnic” or “ethnicity” used here include both individuals of white ethnic origin as well as people of colour and mostly refer to people who belong to a minority ethnic groups (Brotman, 2003), for instance, in the case of one key informant who at times spoke about her work with Russian-Jewish immigrant seniors. In common usage, ethnicity refers to individuals who identify with each other on the basis on cultural sameness or shared cultural values, geographical location, ancestry and even language (Brotman 2003; Henry and Tator, 2006). The terms “race” and “racial”, while widely recognized as social constructions, rather than biological or genetic constructions, have no true empirical value, these terms are often used to categorize a particular group of people of a common ancestry and of certain phenotypic or physical characteristics. As social categories, the terms “race” and “racial” emphasize the hierarchical
approaches and theoretical lenses and often bridges multiple disciplines (Koehn, Neysmith, Kobayashi and Khamisa, 2012). The breadth of ethnogerontological research has mostly been concerned with issues of ethnic seniors and mainstream services (Brotman, 2003). Brotman (2003) identifies four specific areas of study concerning the needs of ethnically and racially diverse seniors. The first area is the role of ethnicity and/or race and the connection to wealth and associated class structures of society. The second area involves the ethnic subculture thesis, which explains ethnic seniors’ use of health care services and the influence of family and ethnic communities which informs their own cultural caregiving practices. The third area of study is examining ethnic and cultural practices and beliefs and how these are related to perceptions of health, as well as how they may influence their own self-care practices, behaviours and patterns of health care use. The fourth important area of ethnogerontological study involves examining the various barriers and enablers of service utilization among ethnic seniors (Brotman, 2003).

The limitation of ethnogerontology as a substantive area of study stems from the inconsistencies with which ethnicity, culture and race have been defined and conceptualized. The category of immigrant has also been conflated with these terms, particularly in the context of immigration in Canada. As a hallmark of Canada’s multiculturalism policy, population growth as a consequence immigration has resulted in increasing ethnic and cultural diversity, which has important implications on how immigrant seniors are perceived and treated in clinical settings, within the community, in the broader society, and even within the family household. Findings from the most recent National Household Survey (NHS) reveal that 19 percent of Canada’s overall population reportedly belonged to a visible minority group and that one in five people in Canada’s population are foreign-born (Statistics Canada, 2013). In terms of Canada’s increasingly diverse population, ethnicity and race have become important determinants in health and aging for older immigrants. However, as demonstrated by the widely held hypothesis known

organization of people on the basis on these characteristics, often to reinforce unequal relations and power differentials between dominant and more subordinate groups.

4
as the healthy immigrant effect poor health outcomes including poor health care access for immigrants over time remain blights to immigration and health care policy in Canada (Chen, Ng, Wilkins, 1996; Chen, Wilkins and Ng. 1996; Perez, 2002; Newbold and Danforth, 2003; Ali, McDermott and Gravel, 2004; McDonald and Kennedy, 2004; Halli and Anchan, 2005; Newbold, 2005a; So and Quan, 2012).

There are a number of explanations that have been offered to account for the healthy immigrant effect. One such explanation is the positive self-selection of migration whereby only the healthiest migrants are likely to emigrate (Deri, 2004; Hyman, 2004; Kennedy, McDonald and Biddle, 2006). As well, most immigrant applicants to Canada are required to undergo a medical examination before their application is approved which ensures that the “healthy” are likely to be approved (Laroche, 2000). Another explanation offered for the healthy immigrant effect is the process of acculturation in which immigrants eventually adopt the lifestyle behaviours of the native-born population. Among these cultural and lifestyle behaviours include dietary practices (Varghese and Moore-Orr, 2002), physical activity behaviours (Tremblay, Bryan, Perez, Ardern and Katzmarzyk, 2006), alcohol-related and smoking behaviours (Millar, 1992), and obesity outcome measures (Setia, Quesnel-Vallee, Abrahamowicz, Tousignant and Lynch, 2009).

In terms of the acculturative effects, authors note that there are two possible healthy trajectories that may result. In one case health may decline among immigrant groups as they adopt negative lifestyle behaviours, which is the case often depicted with the healthy immigrant effect. On the other hand acculturative effects may actually result in health improvements resulting from successful public health campaigns or adoption of healthy behaviours (Chen, Wilkins and Ng, 1996). Few studies have actually verified positive health trajectories with large-scale data. Other explanations that are also offered include barriers to health care access relating to language or cultural barriers (Wu, Penning and Schimmele, 2005). There is also the notion that health and illness are subjective constructs and may vary greatly across different ethnic groups.
and influenced by cultural ideas (Kopec, Williams, To and Austin, 2001; McDonald and Kennedy, 2004).

However, recent studies have challenged the premise of the healthy immigrant effect thesis particularly examining whether it holds for older populations. In one study, recent immigrants aged 55 years and older were likely to rate their health similar to the Canadian-born population (Newbold and Filice, 2006), while another found that older immigrants reported poorer health and lower functional health status than non-immigrant populations (Gee, Kobayashi and Prus, 2004). Similar studies found mixed results among older immigrant groups and self-reports of health status (Kobayashi and Prus, 2012) and not surprisingly, perceptions of health varied among different age cohorts of immigrants where recently migrated older immigrants were more likely to rate their health more poorly than younger ones (Zhao, Xue and Gilkinson, 2010).

As an important facet of population change, migration is a factor worthy of study with regards to aging which as a social process results in spatial variability. Kobayashi and colleagues (2008) examined the extent that immigrant status influenced self-rated and functional health status by comparing immigrant and Canadian-born individuals who share the same ethnocultural background. They found that immigrant status and health differences varied among different ethnocultural groups, suggesting that immigrant status and ethnicity are important determinants of health. While current debates about population aging globally are dominated by issues on health care systems and support for the aging and aged, international migration should also be an important issue to consider. In particular, there has been a growing interest in the specific role of place, beyond locational migration, and its influence on the health and aging trajectories of immigrants. Equally important are the complex patterns of settlement and community integration to the changing family structure and geographies of families.

The growing concerns and responses towards to aging population projections and the implications of it have spurred local and regional agendas for aging-in-place initiatives and
planning strategies for age-friendly cities in order to provide older people the supportive environments and opportunities required for social participation and community integration (Plouffe and Kalache, 2010). However, as research has demonstrated some ethnoculturally diverse populations, including Aboriginal and immigrant communities, often fare poorly in terms of health as a result of their social, economic and cultural realities which are often shaped by ethnicity, race, gender, class and age (Brotman, 2003; Vissandjee, Desmeules, Cao, Abdool and Kazanjian, 2004; Tang and Browne, 2008).

1.2.1 Later-life Filipino Immigrants: An Ethnogerontological Case-Study

In addition to examining factors that influence the health and aging experiences of the older immigrants through the perspective of key informants, this research also examined the specific experiences of later-life Filipinos living in Toronto and parts in the surrounding GTA. The Filipino population in Canada has grown considerably in the last few decades and there is surprisingly little research on the health of Filipino immigrants. This noticeable gap in health research is remarkable considering that since the 1981 Census, the Philippines has remained within the top five source countries for immigrants to Canada (Chui, Tran and Maheaux, 2007). Since the 2001 census, and more recently the 2011 National Household Survey (NHS) as shown in Table 1-1, the Philippines has been the top third country for new immigrants landing in Toronto and fourth for all of Ontario.
Table 1-1: Immigrants by Country of Birth According to 2011 National Household Survey (Statistics Canada, 2013)

<table>
<thead>
<tr>
<th>Immigrants by country of birth</th>
<th>Toronto (CMA)</th>
<th>Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
</tr>
<tr>
<td>India</td>
<td>268,915</td>
<td>10.6</td>
</tr>
<tr>
<td>China</td>
<td>224,915</td>
<td>8.9</td>
</tr>
<tr>
<td>Philippines</td>
<td>173,495</td>
<td>6.8</td>
</tr>
<tr>
<td>Total immigrants</td>
<td>2,537,405</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The focus of much of the research on Filipinos in Canada has reflected on their role in the globalized economy and patterns of labour migration, which has greatly shaped the way in which Filipinos are perceived in Canada (Kelly and Lusis, 2006; Gardiner Barber, 2008). In reviewing literature on Filipinos in Canada, Lusis (2005a) identified three general trends within the research on Filipinos. Firstly, he describes that much of the research is urban biased focusing mostly on immigrant settlement in Toronto and Vancouver. With growing numbers of Filipino immigrants settling outside of the major gateway cities (Toronto, Montreal and Vancouver) he proposes that future research focus on second-tier cities and rural regions of Canada. The second trend Lusis identifies in the literature is the emphasis on economic issues, such as labour market issues of Filipino immigrants, such as labour market integration, deskilling of professionals and the associated transnational class identities (Lusis, 2005b). A significant portion of this research has also focused on the Filipinos involvement with the Live-In Caregiver program (formerly the Foreign Domestic Movement program, 1981-1992) and their economic and social experiences as consequences of their participation. The third trend in the literature has been the gender bias of research on Filipino immigrants where a bulk of the research has examined the social, cultural and economic conditions of Filipino immigrant women. Most often this research has centred on the experiences of Filipino women caregivers (Stiell and England, 1997). For example, Pratt
(1997; 1999) has explored the stereotypical and discursive identities of Filipino domestic caregivers working in Vancouver, B.C. Other research has also included nurse migration of Filipino women into Canada (Ronquillo, 2011).

Since Lusis has written his literature review on Filipino immigrant and Philippine migration to Canada (2005a), the literature on Filipinos (immigrant and non-immigrant) in Canada has grown. In an edited volume of essays Coloma and contributors (2012) discuss the relative obscurity or invisibility of Filipinos in Canada. More specifically, they write on the growing Filipino cultural consciousness, relating to concepts of agency and representation to debate constructs of visible and invisible identities. In the first part of this collection, the authors discuss the economic circumstances of Filipino migration, transnationalism, as well as their experiences and issues in the labour market. In the second part they explore gender and labour migration of Filipino immigrants, mostly Filipino women’s experiences in various occupational settings. The authors discuss issues of agency, activism and suggest future directions for the study of Philippine diaspora and transnationalism. The subsequent parts include discussions on Filipino representations in the literary and visual arts and even a section dedicated to the subjectivities of Filipino youth in Canada as second-generation immigrants. The various themes and concepts discussed throughout include community, identity, representation and citizenship, which the authors argue are fundamental to bringing the visibility of Filipinos to the fore of ethnocultural study of Canada’s diverse populations.

Most recently, Bonafacio (2013) has written on representation and identity of Filipino women who have chosen to reside in other parts of Canada, namely in the prairie provinces of Manitoba, Saskatchewan and Alberta. At the core of her analysis is the task of deepening the discussion on Filipino women’s identities away from stereotyped constructs of nanny, caregiver and domestic worker to more nuanced meanings of pinay – a common colloquialism for Filipino woman. She explores migrancy or migrant status as an important part of Filipino women’s sense
of belonging, identity and agency as she connects to place beyond labour migration. As she writes, “Being Filipino is ‘identity becoming’ beyond national borders – that distinct sense of who we are away from home.” (Bonafacio, 2013: 2). In her book she examines concepts of migration, identity and community through a feminist lens as she discusses Filipino women’s sense of place in the prairies, and their sense of belonging in connection to their multiple identities in the workplace, family and community.

These scholarly treatises on Filipino migration and settlement are significant and represent important contributions to the commentary of Filipinos in Canada. Both volumes give validity to the lived experiences and the realities to Filipino immigrants’ political, economic, social and cultural circumstances in Canada. My research proposes exploring another aspect of Filipino identity. More specifically, I look at experiences of migration, place and aging and how these shape health and age identities. My study contributes to the growing field of ethnogerontological research in Canada offering insights into the health and aging experiences of immigrants, with specific reference to the Filipino immigrant community.

1.3 Significance of Research

My research focuses on the specific needs of older immigrants by examining what factors influence their social, physical and mental health and wellbeing and builds from a conceptual framework that explores the concepts of aging, migration and place. By incorporating the life course theory perspectives, to examine the roles of place, culture and migration and how these inform current ideas on the normal process of aging. The need to understand how aging and migration interact in complex and varied ways to shape health of older immigrants living in a foreign land, in an increasingly globalized world, is not only a relevant issue but pressing one as well. The bulk of research examining the intersections of these two important processes remains a relatively specialized research interest within the broader discipline of social gerontology and
ethnogerontology and across a wide variety of disciplines (Koehn, Neysmith, Kobayashi and Khamisa, 2012).

My thesis will draw from existing research on cultural identities and transnationalism of Filipino Canadians, as well as the migration and labour experiences of Filipinos as they settle and create connections to Canada and in some cases to the Philippines. As a case study analysis based on the research goals and questions that are discussed I will investigate the health and health care experiences of aging and aged Filipinos in Canada. Additionally I will include data from key informant interviews, some of whom have worked directly with Filipino communities, in order to provide a broader context on the aging immigrant experience in the GTA. This data includes interviews from health and social service providers as well as key policy-makers. Taking a population health approach I will incorporate a social determinants of health framework by examining the social, geographical, cultural and economic factors that influence health for aging Filipinos, engaging with past and current research on the economic and spatial lives of Filipino immigrants. I will also draw from the social gerontology and in particular, ethnogerontology to further explore the role of culture and ethnicity in the health and aging experiences of immigrants in a post-migration context. Data for this thesis includes both qualitative and quantitative data which will allow for exploratory and descriptive analyses on the health of aging immigrants and in particular, aging Filipino immigrants. This ethnogerontological study and analysis on the

---

2 The population health approach in the context of my research views population health as important field of study that examines the health outcomes of groups of individuals as well as the relative distribution of these outcomes within these groups. Specifically, what are the factors that result in the varied health outcomes between various groups, such as immigrant populations and non-immigrant populations. Kindig and Stoddart (2003) suggest that the social determinants of health evolved from the population health approach as described in the seminal work of Evans, Barer and Marmor’s book, Why Are Some People Healthy and Others Not? The Determinants of Health of Populations (1994). The Public Health Agency of Canada (PHAC) adopts the population health approach uniting knowledge and action with a focus on the determinants of health, in order to improve the health of Canadians through health system interventions that engage prevention, health promotion and treatment. For more in-depth view of the key determinants of health as outlined by PHAC please see: http://www.phac-aspc.gc.ca/phsp/approach-apprache/appr-eng.php
health and aging experiences of Filipino immigrants will incorporate a number of theories, methodologies and health research approaches, including population health and health geography.

There were several objectives set out for my research project. The first objective was to explore and describe key informant perspectives from a diverse group of experts and service providers on aging immigrant populations. While my project is not unique from academic or service-level perspectives, as there have been a number of studies presenting the views of key informants and other key stakeholders on immigrant populations, the timing of my research is significant. Interviews with key informants unveiled narratives and perspectives that were reflective of the most recent 2008-2009 global economic recession regarded as the most austere and synchronized recession in economic history. In the planning stages and the early writing of the proposal, the government of Canada was currently reviewing and restructuring immigration policies, in particular elderly parent sponsorship, prompting many key informants to invoke the controversial statements and sentiments from then Minister of Citizenship and Immigration, Jason Kenney (2008-2013). These included changes to the family class or sponsorship immigration as well as drastic changes to immigrant worker programs.

At the same time there has been much political and academic attention given to population trends projected to occur across many industrialized nations including Canada. Thus, the purpose of these interviews was to provide context on the experiences of older immigrants living in an urban area where new immigrant settlement is higher. Various key informants from a variety of backgrounds were solicited, particularly in reference to their settlement issues, health and aging experiences. In exploring the expert views and opinions of key informants and stakeholder groups who have specific knowledge on the diverse and often marginalized aging immigrant groups this allowed for me to identify what the key issues were for immigrants with respect to their health and aging. Also important to this research is to determine what resources
are required to aid in the planning and provision of services to support all later-life adults including immigrants.

The second objective was to explore more specifically the aging and migration experiences among a particular population, namely Filipino immigrants living in Canada. As many key informants revealed, findings presented in scholarly research often relies on administrative data which rarely reflects the reality of aging immigrants situated in the community or subjective experiences and interactions with social and health services.

Given the lack of empirical research on older Filipino immigrants, two phases of research were employed to examine, quantitatively and qualitatively, their experiences of health and aging. The purpose for this stage was to provide insights on the health and wellbeing of aging Filipino immigrants living the GTA. Although Filipinos are a relatively new ethnocultural group in Canada’s immigrant history compared to other ethnocultural groups, such as Japanese and Chinese immigrants, they make up a significant proportion of newer immigrants in recent decades. Relatively little is known about their health outcomes and health care use, and in going beyond health and health care utilization my research also attempts to describe the aging experiences of older Filipino immigrants. Additionally, my research provides an alternative understanding of the Philippine migrant identity and counter-balances more prominent descriptions of Filipino immigrants’ migration and settlement experiences of in Canada, which often describes their economic and labour circumstances. A unique aspect of this study is the focus on the migration and place experiences of later-life Filipinos, namely in describing their plans for future aging including their understanding of active or successful aging, concepts of aging-in-place, retirement plans and even their thoughts about death and dying in a second homeland. In terms of health care utilization and elder care plans, I also describe their perceptions about health care and their use of health care systems outside of Canada. In addressing these two

3 A more detailed summary of research that explores the lives of Filipino immigrants in Canada are described in Chapter Two.
objectives, it is my hope that this research can contribute to a broader understanding of the challenges to and the perceptions of aging and health experiences immigrants in Canada.

1.4 Research Goals and Broad Research Questions

There were three main research goals guiding this study:

1. Describe how the complex processes and relationships of aging, migration and re-settlement influence the health experiences and social lives of later-life immigrants.

2. Describe the factors that influence health care seeking behaviours and decisions around issues of aging among later-life immigrants in Canada.

3. Describe the social determinants, migration and the role of place influence the health and aging experiences of later-life immigrants.

Additionally, there were six research questions developed for this study based on existing literature on older immigrants and the limited research on older Filipino immigrants in Canada:

1. What role does ethnic or racial background play in the health and wellbeing of aging immigrants? And how does this influence how key informants approach aging immigrants?

2. What are the implications of an ethnic and cultural background with respect to issues of access and availability of health and social services, particularly in a multicultural city like Toronto? How does this influence the health and social service seeking behaviours and decisions for older immigrants?

3. What is the general health of later-life Filipino immigrants?

4. Do later-life Filipinos experience any barriers in accessing and utilizing health care?

5. How do health and health care use vary among later-life Filipinos, based on the five dimensions of place experiences outlined in Chapter Three?

6. How do older Filipinos view their lives as they age in the context of globalization?
In answering the above research questions and guided by the overall goals of the study, my research seeks to analyze the complexity and interrelatedness of health, aging and place, as experienced by older immigrants though key informant perspectives and a case-study of later-life Filipino immigrants. This research also contributes to the growing field of ethnogerontological research in Canada offering insights into the health and aging experiences of immigrants, with specific reference to the Filipino immigrant community. I incorporate concepts of health geography and geographical gerontology to emphasize the importance of place and the meaning of place to older immigrants who are in-between being at home and being back home and the struggles to adapt and make sense of aging in a foreign-land. The two-fold purpose of my study was to first examine how ethnicity and migrancy operate within various settings of senior-centered community and health care services. Secondly, my study examined the role of place and how it shapes health and age identities among later-life Filipino immigrants. This research is important to researchers, policy-makers and practitioners who are interested in an ethnogerontological examination of place and migration of older immigrant populations. This study also contributes a much needed examination on the health and wellbeing of older Filipino immigrants in Canada.

1.5 Chapter Outline

In Chapter One the broad aims of this study are considered in terms of the growing field of ethnogerontology in Canada, including its importance and relevance to Canada’s increasingly diverse aging population. The proposed case-study on older Filipino immigrants is briefly explained arguing that given the breadth of research on Philippine migration in Canada including strong analyses on the economic, social and cultural experiences of Filipino immigrants and temporary migrant workers, there is little research that connects migration experiences to health and aging. The research goals and research questions are also discussed in connection to the overall study’s significance and rationale.
Chapter Two reviews current literature on aging immigrants in Canada including a description of immigration in Canada and what this has meant in terms of immigrants’ health and aging experiences. Identifying two paradigmatic views on immigrant health – the sick immigrant and the healthy immigrant – which have contributed to current perceptions of the immigrant population, both quantitative and qualitative research is discussed. Quantitative research provides broad and generalized descriptions on the health distributions within immigrant populations in comparison to non-immigrant populations and often these studies used large-scale survey or administrative data. Qualitative research is more focused on certain aspects of health and/or health care, specific ethnocultural groups or on gendered health experiences, such as immigrant women and health care access. A critical review of the key theories and hypotheses that attempt to explain health differences among immigrant populations are also discussed. Research on older immigrants or aging issues in health among immigrants are not as straightforward as there are few studies that explore these older immigrant populations. However, there is ample aging research on specific ethnocultural groups, such as aging Chinese and South Asian communities. Research on older Filipinos in comparison to other ethnocultural groups in Canada is scant, despite there being much attention paid to the labour migration experiences of Filipino immigrants. A review of the existing literature on Filipino immigrants is also discussed, including some studies outside of Canada that have examined health and aging among later-life Filipino immigrants.

Chapter Three describes the research design and methods, including a detailed description of the conceptual framework used in this study. This study utilizes multiple sources of data and methods to examine aging and health among immigrants from the perspective of key informants and from the later-life Filipino immigrants. Included in this framework are five dimensions of place experiences, which combine health, aging and migrant experiences. The conceptual framework illustrates the multiple influences and interactions which include the
dimensions of place experience, the social determinants of health and health care, health status, health attitudes and behaviours, as well as access to and utilization of health care services within the socio-ecological framework co-existing macro-level subsystems. Three distinct stages of the research are proposed and the various research methods and analyses are designed to capture complex health and aging experience of immigrants, both quantitatively and qualitatively.

Chapter Four and Chapter Five describe results from Phase one of the project – key informant interviews. The purpose of chapter four is to examine how key informants perceive immigrant seniors who are living in Toronto and the GTA. This chapter provides a description of the key informants that were recruited and who participated in this study. In setting the stage for the various themes about health and aging among immigrant seniors, this chapter describes the various roles that key informants attributed to immigrant seniors. Most identified roles both within the community and the family. Key informants were also asked to describe the various challenges they faced while working with older immigrant populations. Among the major challenges identified and described more in-depth issues around finances and funding for programming, the building of community partners to strengthen the supportive networks for immigrant populations, the sometimes difficult and sometimes rewarding relationships between service-provider and clients, senior/client issues specific to various ethnic groups and prevailing attitudes and other mainstream societal views that promote ageist and anti-immigrant sentiments.

In explaining the type of challenges they faced, key informants related these to the overall lack of support and barriers that many older immigrants encounter as they age in Canada.

Chapter Five describes in detail the recurring themes and issues brought up from key informant interviews relating to older immigrant populations. The purpose of this chapter is to provide a more focused examination of the migratory experience in health and aging, among both newcomer and more long-term immigrants. Although key informants shared their views about broader immigrant populations, with some specific examples of ethnocultural groups, they
discussed the common factor of the migrant experience resulting in different trajectories in health and social life of older immigrants. In particular, key informants shared their ideas about the impact of immigration the health and aging experiences of immigrants as well as the on the structure of immigrant families. Interrelated themes of migration, place and aging were discussed when speaking on the vulnerabilities of immigrant seniors such as the risks of social isolation, the significance of finding community, developing a sense of belonging, dealing with issues of fear and lack of trust in a foreign-land, and importance of creating and fostering ongoing social and community supports. Key informants also made reference to the social determinants of health among aging immigrants, bringing up issues stemming from economic barriers, various housing issues, poor access to transportation and language barriers. Among the health and aging experiences of immigrants, as described by key informants, they discussed specific immigrant health issues, system level issues, cultural competent care and the future of population aging on immigrant seniors.

Chapter Six analyses results of the survey completed by later-life Filipinos, which included demographic data, various measures of physical and psychosocial health, health care access and service barriers and measures of immigration and immigrant status. This chapter describes the general health of aging Filipinos, as well as their health care use in Canada and in the Philippines. Varied patterns of health and health care use are compared between gender (men versus women), among different age cohorts (pre-senior, young-old, old-old and very-old), and among the five dimensions of place experiences described in chapter three which capture migration, aging and health care experiences. The results from later-life Filipinos are also discussed in relation to those found from key informant interviews who shared their views on the health and aging experiences of immigrant seniors. Discussion of the results also observes and evaluates how older Filipinos compare to similar research on other ethnocultural groups in Canada. In view of the paucity of research on the health of aging Filipino immigrants in Canada,
this chapter provides insights into the health status and health care use of community-dwelling Filipinos who are either aging-in-place or who have arrived in Canada at a later age.

Chapter Seven reports on the results from phase three of the study involving a follow-up interview with a small sample taken from survey respondents. The purpose of this chapter is to qualitatively examine issues of health, place and aging as they relate to the migration experiences among later-life Filipinos. Reasons for migration and expectations of aging for this specific ethnocultural group are investigated and various themes are explored within broader topics that include describing Filipinos’ self-perceptions of health and aging in a second homeland, experiences of living and growing older while in Canada and experiences with health care systems both in Canada and the Philippines. This chapter also examines more closely how later-life Filipinos envision Canada and the Philippines, in terms of being at home in Canada and longings for being back home.

Chapter Eight provides the final conclusions that were drawn from this mixed method and multiple perspective study, including a critique on normative ideas of aging including the concepts of active or successful aging as they relate to older immigrants experience of health and aging. Discussion on the how each data set connected in terms of themes and concepts are explained as the research questions set out in Chapter One are re-visited. A final discussion on the dimensions of place experiences analyses on health, place and migration are described and connected to ideas and concepts found in ethnogerontology and geographical gerontology. Finally, the key challenges and limitations of this research are provided and recommendations for future direction in the study of the older immigrants and place are proposed.
Chapter 2

Literature Review

2.1 Introduction: Immigration and Canada

Immigration policy in Canada has undergone many changes in the last five decades. Shifts in immigration policy have been the result of labour market demands and harsh criticism of the policy as being racially discriminatory. In the 1960s when immigration policy had finally opened up to countries of Asia and Africa, new waves of immigrants had an enduring impact on the composition of Canada’s population. In both academic and public opinion, Canada’s immigrant population has garnered much socio-cultural and political attention. Compared to other industrialized countries Canadian views on immigration have more often been positive as they are frequently tied to references of Canada as a multicultural mosaic; a culturally and ethnically diverse population founded on a long history of immigration (Hiebert, 2006; Chiu, Tran and Maheux, 2007; Harell, Soroka, Iyengar and Valentino, 2012). The development towards a policy of multiculturalism had been a decade long debate that began with embracing increased ethnic and racial diversity leading to the passing of the Multicultural Act in 1988 (Berry, 2006; Dewing and Leman, 2006). Today it remains a guiding principle and abiding value within Canada’s political, economic, cultural and social fabric.

In a recent study, Bilodeau and colleagues (2012) examined the assertion that Canada, as a whole has been favourable towards immigration and racial minorities. They observed public opinion trends for all ten provinces using pooled data consisting of native-born White Canadians from the Canadian Election Studies of 1988 through to 2008. They observed an increasingly positive trend over 20 years and found that all provinces were equally as favourable in their views on immigration and that no single province drove the overall favourable impressions of immigration in Canada (Bilodeau, Turgeon and Karaoc, 2012). They conclude that although the
dynamics of public opinion on immigration are sensitive to provincial policy agendas as well as labour market and economic demands that there is no clear explanation as to why Canadians have generally maintained a positive view on immigration.

A number of studies have used realistic group conflict theory as a framework for understanding different attitudes towards immigration, increased diversity and demographic change, as well as the commonly perceived threats associated with them (Esses et al., 1998; Bilodeau et al., 2012; Harell et al., 2012). Realistic group conflict theory or group conflict theory was developed by Levine and Campbell in 1972, as elaborated in their book Ethnocentrism: Theories of Conflict, Ethnic Attitudes, and Group Behavior, and has become a mainstay in anti-immigration research. The theory holds that group competition for limited resources, such as housing, employment, economic benefits, health care and social welfare services results in increased negative attitudes towards the immigrant population (Esses et al., 1998; Esses, Dovidio, Jackson and Armstrong, 2001). Canada has remained an anomaly among many Westernized nations with their positive attitudes and views on immigration, while other countries, such as the United States of America (U.S.A.) view immigration with suspicion and even outright hostility (Esses, Jackson and Armstrong, 1998; Harell et al., 2012). Wary attitudes towards immigration are often framed as economic or material threats and/or threats to cultural or social identity.

In Canada, at least in political and economic matters, immigration is often pitched as a key strategy to boost the slowed natural birth rate, bolster a flagging economy and to deal with the pressures of an aging population on Canada’s already fragile health care and social welfare systems (Mérette, 2009; Kustec, 2012). However, a number of researchers are cautioning that it is important to understand the long-term impacts of immigration from all angles and not just in terms of economic and cultural impacts (Beaujot and Matthews, 2000; Bourne and Rose, 2001). For instance, Moore and Rosenberg (2001) consider not only the short-term effects but also the long-term effects of immigration on the aging population and Canada’s demographics. Changes
to immigration policy in the last 40 to 50 years have resulted in significant changes to the overall composition of Canada’s populace, many of which have manifested (and will continue to manifest) through the ethnic, cultural, geographic and social characteristics of the aging population. Despite incoming immigrants tending towards younger age cohorts, the re-settled immigrant population across all age groups will be expected to live longer and healthier lives which will stifle the intended efforts of immigration in slowing population aging (Moore and Rosenberg, 2001: 146).

The purpose of this literature review is to provide a background into how immigrant health is approached from a Canadian perspective. From large scale population based studies to more subjective and culturally informed understandings of health, studies on immigrant health in Canada are numerous and wide-ranging. In introducing approaches to immigrant health overall I will present the growing body of research on the aging experience of Canada’s immigrant populations as well as some of the current hypotheses that attempt to explain health among an aging immigrant population.

2.2 Immigrant Health

The health and wellbeing of Canada’s immigrant population is often not an important discussion point in political and economic discourses. However, it is becoming increasingly evident that in order for immigrants to be successful in the ways that immigration policy expects them to be it would seem logical that their health and wellbeing should also be a priority. While earlier studies have tended to view immigrants as a monolithic category, literature of the last decade has since pointed to the limitations of such a view. This is especially true when considering measures of health and health care use. Health, in general, has been of particular interest as it has become well recognized that immigration and re-settlement have considerable implications on the health and well-being of Canada’s immigrant population.
Research on the health and health care use of immigrants is positioned within one of two broad views; the sick immigrant paradigm or the healthy immigrant paradigm. Early research and commentary about the immigrant population have often tended towards the sick immigrant paradigm, where it was widely believed that newly arriving immigrants posed significant threats to public health as carriers of disease and imposing significant burdens on Canada’s social and health systems (De Maio, 2010). The view of immigrants as a health burden had dominated much of the thinking on immigrant populations in North America until the 20th Century where public health concerns were focused on European immigrants bringing with them infectious disease such as cholera and smallpox (Beiser, 2005). Although this view is less common, current immigration policy in Canada still mirrors this paradigm, namely with the legislated health screening required by all immigrants before entry status into Canada (Laroche, 2000; DeMaio, 2010; Gushalak, Pottie, Roberts, Torres and DesMeules, 2011). Not to undervalue the importance of protecting the health of the population through surveillance measures and border security, often such tactics veil anti-immigration and racist sentiments (Beiser, 2005). More recently, concerns about our increasingly globalized world and highly mobile populations have compelled most industrialized nations towards decisive disease surveillance and prevention measures (Boyle and Norman, 2009). For instance, the SARS outbreak in 2003 demonstrated the vulnerabilities of even the most industrialized and medically advanced societies to disease transmission and mobility. When the outbreak reached Toronto, Ontario, panicked response framed SARS as a “Chinese disease” contributing to anti-immigrant sentiments fueled by the sick immigrant paradigm (Keil and Ali, 2006).

Discourse eddying on themes of migration and disease often positioned immigrants, most especially racialized immigrants, as scapegoats for global disease outbreaks through variant processes of “othering” (Boyle and Norman, 2010). A highly socio-politically informed idea, the sick immigrant paradigm not only proposes that immigration will challenge an already
overburdened social and health care system as well as it paints immigrants as carters of illness and disease, this view is also intermingled with sentiments of the stealing of jobs from the native-born population or even the loss of Canadian culture (De Maio, 2010). The assertion that immigrants pose an undue strain on the health care system, however, has been refuted by a number of studies (Wen, Goel and Williams, 1996; Laroche, 2000).

The contrasting view of the healthy immigrant paradigm see immigrants as healthy upon arrival in part due to a number of factors such as self-selection and immigrant policies such as pre-admission health screening (De Maio, 2010). This has been the more dominant view guiding much of the research on Canada’s immigrant population. Research dedicated to Canada’s immigrant population is considerable but also widely diverse and it would be a nearly impossible task to attempt to track and catalog all the studies that have been done. Part of the reason is that the immigrant population in Canada is so highly diverse with one in five people in Canada being foreign-born and over 200 countries of origin reported in the 2006 Census (Chiu, Tran and Maheux, 2007). Over the last five decades of immigration into Canada there has been a significant increase in ethnic and religious diversity (Reitz and Bannerjee, 2007). Research has reflected that diversity from a wide variety of methodological and theoretical approaches. The decision to choose quantitative or qualitative methods for investigating immigrant health is highly dependent upon the questions asked, the availability of data and the scope and magnitude of the migration event. The migration experience may be quantified as years since migration or categories of recent or longer term migration or it may be viewed as an individual experience or a population group phenomenon. Many of contributions to immigrant health research discussed here are situated within the healthy immigrant paradigm and range from positivist views of health and health care towards more post-positivist understandings on the experiences of immigrants with respect to health and patterns of health care use.
2.2.1 Quantitative Research: Large-Scale Studies on Immigrant Health

A common assumption made in the migration experience is that it is often supposed that once an immigrant arrives in their new host country they adopt the health behaviours and patterns of the native-born population and leave their old ways behind (Chen, Ng, Wilkins, 1996; Torres, 2004). This has been the premise adopted by earlier studies on the health of immigrants; however, as Boyle and Norman (2010) note culture is not the only import with international migration but that immigrants also bring with them their own health characteristics and practices. It has been well documented that immigrants have different health outcomes and experience the Canada’s health care system differently than their non-immigrant counterparts but these studies often ignore the ways in which immigrants meld their old and newly adopted health behaviours and patterns.

Using large scale data has been useful in identifying trends in health and health care use among immigrant populations over time. Whether research has compared foreign-born and native born populations or examined the differences within sub-groups of the immigrant population, it is clear that once an immigrant arrives in their new host country their health is likely to change. Moreover, despite most immigrants arriving relatively healthy due to self-selection and the required health screening exam research has consistently shown that immigrant’s health tends to decline over time (Chen, Wilkins, Ng, 1996; Gushalak, Pottie, Roberts, Torres and DesMeules, 2011). This observation is widely known as the healthy immigrant effect (Deri, 2004; Gushulak, 2007).

Research on the health of Canada’s immigrant populations has drawn from large Canadian survey data ranging from cross-sectional studies to time-series analysis. For instance the National Population Health Survey (NPHS), first launched in 1994/95 is a longitudinal household survey covering a comprehensive list of health-related topics. The NPHS has since collected data from the same panel of respondents biennially (Béland, Bailie, Catlin, and Singh, 2000). A significant proportion of research on immigrant health in Canada has made use of the
NPHS, with a number of them assessing the healthy immigrant hypothesis (Chen, Ng and Wilkins, 1996; Dunn and Dyck, 2000; Newbold and Danforth, 2003; McDonald and Kennedy, 2004; Newbold 2005a; 2005b; So and Quan, 2012). Using longitudinal data such as the NPHS allows for a more accurate measurement of temporal health changes within a population.

Another widely used survey is the Canadian Community Health Survey (CCHS), a cross-sectional survey developed as part of a federal initiative to provide health information at regional and provincial levels (Beland, 2002). Like the NHPS it is administered biennially with the purpose of health surveillance in the collection of data relating to health status, health care utilization and health determinants. However, unlike the NHPS, the CCHS collects cross-sectional health estimates and offers more detailed information on immigrants groups in Canada, such as immigrant class category (Béland, Bailie, Catlin, and Singh, 2000). A number of studies have analyzed CCHS data making use of the comprehensive set of health and health-related measures (Perez, 2002; Halli and Anchan, 2005; Wu, Penning, Schimmele, 2005; Kobayashi, Prus and Lin, 2008; Veenstra, 2009) and some researchers have even combined data from the NPHS and CCHS (McDonald and Kennedy, 2004). Although there has been considerable research on the healthy immigrant effect that utilizes the NPHS and CCHS for analyses, these surveys have been criticized for their limited use in immigrant research particularly in their inability to capture more cultural aspects of health (Dunn and Dyck, 2000; Halli and Anchan, 2005). As well, mixed results in the testing of the healthy immigrant effect calls for a more in-depth investigation on the health transitions of immigrants (DeMaio and Kemp, 2010).

The Longitudinal Survey of Immigrants to Canada (LSIC) differs from the NPHS and CCHS in that it focuses on a cohort of recent immigrants to Canada. The LSIC was first conducted in 2000/01 and completed its final cycle in 2005 and allowed for a closer examination on the health trajectories and transitions of immigrants over a specified period of time (Chui and Tran, 2005). A smaller number of studies have utilized these data as it is limited in scope in
providing more direct comparisons with Canadian-born populations or to more longer term immigrants (De Maio and Kemp, 2009; Newbold, 2009b). On the other hand, because of its broad coverage on the social, economic and migration experiences of new immigrants it has been highly useful for the study of immigrant health in Canada.

While a majority of research has used survey data for exploring the health of immigrant populations, there are a number of studies that have opted to use less common datasets or have combined different types of data in order to provide a broader scope of analysis. One of the earliest studies on the health of immigrants was conducted by Chen, Wilkins and Ng (1996), who combined census data, vital statistics, and survey data from the Health and Activity Limitation Surveys. They assessed life expectancies, as well as disability- and dependency-based health expectancies, among three broad groupings: Canadian-born, European immigrants and non-European immigrants. This was one of the earliest studies to categorize non-traditional immigrants and traditional immigrants to distinguish the racialized identities of visible minorities and non-visible minorities in Canada. The flow of non-European immigrants is reflective of the relatively newer evolution to Canada’s demography when shifts in immigration policy in the 1960s opened immigration to countries outside of Europe (Chen, Wilkins and Ng, 1996). Chen et al. reasoned that European immigrants were more likely to have cultural backgrounds and lifestyles similar to the Canadian-born. Their overall findings show that immigrants had better life and health expectancies than the Canadian-born population and these differentials were especially more favourable for non-European immigrants.

Wen, Goel and Williams (1996) focused their analysis on immigrants and ethnocultural groups in Ontario, based on data from the Ontario Health Survey (OHS). The OHS, conducted in 1990 consisted of two sections to assess the health utilization patterns of ethnic and immigrant groups. They found that immigrants and other ethnocultural groups had similar access to health care but had less utilization than the Canadian population overall. In a later study examining
health and health care use among immigrants Laroche (2000) used pooled data from two cycles of the General Social Survey (GSS). The GSS captures data on social trends in Canada (e.g., time use or social identity) in order to monitor changes in living conditions as well as the overall wellbeing of Canadians. In her study, Laroche found that there were no statistically significant differences in health status between immigrants and Canadian-born and that health care use was similar between the two groups.

There are a number of limitations in using large-scale survey data for the study of immigrant populations. Many of these studies rely heavily on the assumption that data collected are representative of the true population of interest and it explains why much of the recent studies utilize survey data. While quantitative methods on immigrant health using large datasets have been heavily favoured for statistical rigor and greater explanatory power others have argued that large-scale, generalizing studies reduce the subject down to mathematical equations in which case we can only know insofar what the data sets out to describe. As well, given the ethnic and culturally diverse immigrant population in Canada and the need to preserve large sample sizes there is the tendency in quantitative research to group immigrants under single category of foreign-born (Wen, Goel and Williams, 1996). This generalized category of immigrant or foreign-born is often designated for comparisons to the broader native-born or Canadian-born population, which is also a problematic and assumptive category. Because immigrant groups are aggregated to form one singular group many of these studies do not account for within group variations such as age and ethnicity. Moreover large-scale studies ignore the varied subjective and qualitative experiences that may stem from the process of immigration itself or the experiences of being a racialized or visible minority group where the dominant population by and large has been a non-visible minority. In doing so, this also assumes that the immigrant population is similar across different racial and ethnic groups.
Another important limitation to quantitative survey data is that immigrant health studies often use cross-sectional data and therefore only captures one point in time. This overlooks the fact that immigration and resettlement is a temporal and spatial process that occurs over most of an immigrant’s lifetime (Koehn, Neysmith, Kobayashi and Khamisa, 2012). Furthermore quantitative studies are often charged with conforming to a more biomedical or medicalized view of health (Dyck, 2006). Often the operationalizing health or determinants of health do not consider the cultural perceptions of health and illness or consider the migrant experience as a social determinant. More recent studies on immigrant health are opting to use a population health approach in examining health differences between immigrants and Canadian-born population (McDonald and Kennedy, 2004). For example, instead of using quantitative measures of migration (e.g. years-since-immigration [YSM]) effects on health, Newbold (2005a) emphasizes the importance of other factors relating to social determinants. Newbold argues that the perception of health among immigrants may be influenced by acculturative processes in the migration experience, in addition to other cohort effects in the observation of health status change. He suggests that reasons for the health status declines may be related to changes in perceived health rather than real changes particularly for those immigrants who, as a result of longer residence in Canada, identify more with their Canadian-born counterparts shifting their perceptions of health (Newbold, 2005a: 1368).

2.2.2 Qualitative Research on the Health of Immigrant Populations

Considering the limitations of quantitative studies to generalize immigrant health, qualitative researchers have taken up the task to more closely examine and uncover the nuances of immigrant health. Presenting case study research such as the health of a specific ethnocultural group provides a more nuanced understanding of the health experiences of the group. Qualitative methodology differs from quantitative in that it allows for more insights into the specific health and health care experiences of the immigrant population. These studies may address a small but
diverse sample or focus on a culturally specific population and are often more exploratory rather than descriptive and predictive and are often not generalizable to the broader immigrant populations. Some of the literature may range from a focus on a particular place or scale of place or may explain a specific ethnic settlement, such as Murdie and Ghosh (2010) who examine the perceived relationship between ethnic concentration and integration. As well, researchers may choose to focus on an aspect of health or health care, such as the prevalence of depression or use of mental health services.

Qualitative health research on immigrant populations in Canada cross-cuts many sub-disciplines including the areas of health geography, cultural anthropology, social work and nursing, to name a few. Researchers may adopt a number of guiding theories ranging from feminist theory to embodiment theories of the habitus while other studies may choose to situate their methodology within a broader theoretical or conceptual framework, such as population health or socio-ecological approaches. Often this research takes a pragmatic turn by developing strategies for eliminating barriers, increasing uptake of health and social services or challenging the discourse of health and immigration policy in Canada. Because of the wide variety of approaches to qualitative research on immigrant health, specific theoretical and conceptual understandings of immigrant health have yet to be fully developed. What follows is a sample of the type of qualitative research that has grown substantially in recent years and is not in any means an exhaustive list. As described previously considering the diversity of the immigrant population in Canada and the wide variety of health topics and issues regarding the immigrant population it is difficult to capture all the research that has been conducted.

Qualitative research has either focused on a particular ethnocultural group or a locally situated group of diverse immigrants. For instance Asanin Dean and Wilson (2008; 2009; 2010) employed focus groups to explore various determinants of health within an ethnically and socially diverse sample of immigrants residing in a suburban city in the Greater Toronto Area. In one
paper, they describe how immigrants perceive their access to health care in their community citing various geographic, socio-cultural and economic barriers (Asanin and Wilson, 2008). Also from the broader study they investigated the link between employment and health (Asanin Dean and Wilson, 2009) and the factors that can be attributed to declining health status over time as hypothesized by the healthy immigrant effect. Leduc and Proulx (2004) qualitatively assessed health services utilization among 20 newly arrived (less than eight years since immigration) immigrant families in the Côte-des-Neiges neighborhood of Montreal. The authors were interested in the challenges often faced by new immigrants in obtaining health information and health services. They found that for most families, their health seeking behaviours evolved based on their perceived needs and systematic barriers of the health care system. It has been addressed elsewhere that recent immigrants face a multitude of barriers when trying to access health services for themselves and/or their family (Zanchetta and Poureslami, 2006).

Qualitative research on immigrant health has also tended towards engendered experiences of health and health care in Canada. In one study Meadows et al (2001) sought to capture the heterogeneity of immigrant women’s health experiences. In addition to understanding how immigrant women managed chronic illness and poor health, they explored the varied ways that women defined health as well their interactions with the health care system (Meadows, Thurston and Melton, 2001). Other studies that analyzed immigrants’ experiences with Canada’s health care system include, Weerasinghe and Mitchell (2007) who explored the patient-provider relationships in a diverse sample of immigrants in order to understand how they perceived and defined health and illness. Similarly, some qualitative studies have focused on other aspects of the health and health care use among immigrant populations such as breast health services (Bottorff, Johnson, Bhagat, Grewal, Balneaves, Clarke, and Hilton, 1998; Choudhry, Srivastava, and Fitch, 1998), mental health (Ahmad, Shik, Vanza, Cheung, George, and Stewart, 2005; Wong and
Tsang, 2004), health promoting behaviours (Choudhry, 1998), and diabetes self-care and cardiac rehabilitation (Neilson et al., 2012).

Beyond health care system or health behaviours other research has focused on the actual experiences of immigrant women, such as gendered experiences of migration, the role of places and their impact on health. Much of research has tended to concentrate on immigrant women’s personal health experiences. For instance, Dyck (1995) explores immigrant women’s experiences with the health care system to understand and describe the ways in Chinese and South Asian Women in Vancouver managed their illness. She also considers the racialized experience of place and how these experiences influenced their perceptions of and access to health care services. In a separate study where she explores spatiality of South Asian women’s lives as they connect meanings of health, culture and the body in the various places of their day-to-day activities. Here, she defines place according to Gesler and Kearns (2002) who describe place as not static but always in flux “…with culture and identities fluid and complexly bound up with place.” (Dyck, 2006: 3). Similarly, Elliot and Gillie (1998) examine the interrelatedness of the migration experience and the meanings of health in South Asian Fijian women residing in lower mainland British Columbia.

In the interest of immigrant populations, some researchers have focused on the views of service providers and policy makers. For instance, Steele et al. (2002) qualitatively assessed the impact that policy changes would have on immigrant and refugees. In their study they sought the views of service providers who worked with the immigrant and refugee communities in inner-city Toronto (Steele, Lemieux-Charles, Clark and Glazier, 2002). In a later study, Simich et al. (2005) conducted a large-scale qualitative study in three large Canadian cities that consisted of interviews and focus groups with service providers and policy makers as well as immigrants and refugees. During the period of 2000 to 2003 they sought various viewpoints and explored systemic issues and challenges faced by both immigrants/refugees and service providers and the
role of social support (Simich et al., 2005). The authors confirmed the importance of social support for positive health and the vital role it played in immigrant settlement. In particular, they wanted to understand social support in a cultural context and the various multicultural meanings attributed to it (Stewart et al., 2008). In the case of mental health care use among immigrant women, O’Mahony and Donnelly (2007a; 2007b) sought the perspectives of health care providers to share their insights on the barriers faced by immigrant women in seeking mental health services. Health care providers were asked to comment on the intersecting influences of gender and race on how immigrant women perceive and dealt with mental illness (O’Mahony and Donnelly, 2007a). The authors argued that the current Western model of mental health care in Canada does little to address the culturally and ethnically diverse experiences of mental illness of immigrant women (O’Mahony and Donnelly, 2007b). In another study that focused on language barriers in health care use, Guruge et al. (2009) included data from focus groups with key informants including community leaders such as settlement workers and other stakeholders to share their views on successful English as second language classes and the barriers to learning English. Guruge and colleagues discussed how both key informants and immigrant women felt language proficiency or lack of language proficiency greatly influenced how immigrant women received and experienced care (Guruge et al., 2009).

2.3 The Aged and Aging Immigrant: Health Trajectory Hypotheses

Under the healthy immigrant paradigm has been the development of several hypotheses in explaining the health trajectories of immigrants upon arrival in a host country; the more relevant ones are explained below. Understanding why and how the initial health advantages of immigrants deteriorates the more time they spend in their host country are important questions for health researchers, policy-makers and service providers. The most notable among these hypotheses within Canadian research is the healthy immigrant effect, whereby upon arrival immigrants see their health deteriorate the longer they stay in their adopted country. Another
common view is the multiple jeopardy hypothesis or the closely related intersectionality thesis. Less common hypotheses include the age-as-leveler, the cumulative disadvantage effect and the buffer hypothesis or stress process model.

2.3.1 Healthy Immigrant Effect Hypothesis

The healthy immigrant effect hypothesis argues that on first arrival immigrants tend to have better health status, and consequently consume less health care services, than the native-born population (Deri, 2004; Gushulak, 2007). Framed within a healthy immigrant paradigm, research comparing immigrant and native-born populations typically invoke this hypothesis to explain the health advantage and subsequent declines of immigrant populations either to the levels of or worse than the native-born population. In the U.S. this effect is sometimes referred to as the healthy migrant phenomenon or immigrant paradox and has been used to describe the social and economic status of immigrant populations (Koya and Egede, 2007; Uretsky and Mathiesen, 2007). It has often been applied, with contradictory results, among Latino populations in the U.S., such as Mexican Americans (Markides and Coreil, 1986; Abraido-Lanza, Dohrenwend, Ng-Mak and Turner, 1999; Rubalcava, Teruel, Thomas and Goldman, 2008).

In Canada a substantial portion of research studying immigrant populations in Canada have identified the healthy immigrant effect with differing results (Chen, Ng, Wilkins, 1996; Chen, Wilkins and Ng, 1996; Perez, 2002; Newbold and Danforth, 2003; Ali, McDermott and Gravel, 2004; McDonald and Kennedy, 2004; Halli and Anchan, 2005; Newbold, 2005a; So and Quan, 2012). Beiser refers to this hypothesis as immigrant overshoot based on what he terms the convergence premise, which calls attention to the unique risk factors associated with resettlement in addition to those that immigrants may share with other members of the native-born population but may be intensified by the resettlement experience (Beiser, 2005: S33). Many of these studies, which utilize large-scale survey data, have well established that recent immigrants tend to be healthier than their native-born counterparts. But not all studies have demonstrated the
convergence of health between immigrants and non-immigrant populations that is said to occur over time.

In the studies by Chen and colleagues (Chen, Ng and Wilkins, 1996; Chen, Wilkins and Ng, 1996) both study samples compared Canadian born and foreign-born populations and found evidence of the healthy immigrant effect. In particular, they noted that non-European born immigrants had experienced greater health over the Canadian-born population than did European-born immigrants. Although later research identifies the healthy immigrant effect to encompass the premises of healthy on arrival and deteriorating health status the longer one resides in a host country, Chen et al. distinguishes between the “the healthy immigrant selection effect” and the “residence effect”. The “healthy immigrant selection effect” explains why immigrants tend to be healthier than the overall Canadian-born population (e.g., it is believed that only the most healthy and resilient are likely to migrate given the stressful process of migration and settlement). The “residence effect” describes post-migration health declines that occur over time due to lifestyle changes usually in the adoption of health attitudes, lifestyles and behaviours as the host society (Chen, Ng and Wilkins, 1996).

In addition to understanding why this effect occurs, researchers are also interested at what point does this effect occur from the time of first arrival and have offered some approximations of when health declines begin to occur. In finding evidence of the healthy immigrant effect, Newbold and Danforth (2003) noted that ten years of residence in Canada is when health convergence can be observed between immigrant and Canadian-born populations. Newbold and Danforth found that for more long-term immigrants they reported even poorer health statuses than Canadian-born. Other studies have also verified this time frame for when health declines can be seen (Chen, Ng and Wilkins, 1996; Perez, 2002; Newbold and Danforth, 2003; McDonald and Kennedy, 2004; Halli and Anchan, 2005; Kennedy, McDonald and Biddle, 2006). The actual time frame is unknown and most research provides an inaccurate depiction of the true time-path of
immigrant health decline resulting from definitions that identify recent immigrant as having lived less than ten years in a new country. Depending on the type of analysis, researchers may group years since migration into five or even ten year categories (Wen, Goel and Williams, 1996; Ali, McDermott and Gravel, 2004; Perez, 2002). A study by McDonald and Kennedy (2004) also points to recent immigrants being healthier on arrival and a decreasing health gap between immigrants and the Canadian-born population over time but they observed that this occurred over a much longer period than the ten years identified in earlier studies. In the case of chronic disease, health declines among immigrants were observed at 20 years after immigration. However, temporal health trends can only be inferred and the direction of causality cannot be certain since most survey data testing the healthy immigrant effect are cross-sectional in scope, such as the CCHS, which provides only a snapshot of the immigrants’ health at one point in time.

Newbold (2009b) provided a more accurate measure of health decline among immigrant populations in his study using longitudinal data from the LSIC. Although studies utilizing the LSIC often do not include data from the Canadian-born population to test the convergence premise of the healthy immigrant effect, results using this data offer time trend characterizations of recent immigrant health transitions. Newbold found declines in self-assessed health in as little as two years since time of arrival. Similarly, DeMaio and Kemp (2010) found health declines among the immigrant sample in the short span of time that the LSIC took place.

While there are a number of studies supportive of the healthy immigrant effect among Canada’s foreign-born and native-born populations there are some studies that demonstrate very mixed results. For instance, Newbold (2005a) assessed self-rated health with conflicting results. He found that health status was not statistically different between immigrants and Canadian-born. Other variables such as being of younger age, having higher income, non-smoking status, being married status and being employed were seen as stronger predictors for reporting healthy status. Following this study, in a more focused testing of the healthy immigrant hypothesis Newbold
examined health care use and utilization patterns (Newbold, 2009a) and chronic health conditions in another study (Newbold, 2006). Newbold reasoned that as immigrant health status converges with the Canadian-born population over time, there should be a concomitant increase in health care use (Newbold, 2009a). While health care use has been shown to be lower among recent immigrants, especially when making first contact with a physician (Sanmartin and Ross, 2006) it has been argued that as immigrants become more familiar with the health and social systems of Canada and adopt Canadian lifestyles and behaviours, they are more likely to use services (Perez, 2002). In terms of physician visits and hospitalization, Newbold found that health care use between immigrants and Canadian-born was in fact equal. Laroche (2000), in her study using the GSS, found similar results, in which health care use was similar between the two groups and remained unchanged over time. Newbold cautions though that the apparent equality of services may not be reflective of actual health care use as the literature has pointed to significant barriers in accessing health care (e.g., not knowing where to go or language and communication problems) (Steele, Lemieux-Charles, Clark, and Glazier, 2002; Wu, Penning and Schimmele, 2005).

In terms of chronic disease, Newbold (2006) found that the healthy immigrant effect held with more recent immigrants having a lower prevalence rate for chronic diseases. This finding is similar to Perez (2002) who also observed a worsening of health over time due to chronic diseases with long-term immigrants demonstrating similar health outcomes as the Canadian born population. Where there were dissimilarities between immigrant and Canadian-born populations was with specific chronic diseases such as cancer, which was found to be a rare outcome among the immigrant group overall. In a more recent study using NPHS data, So and Quan (2012) analysed longitudinal data over 10 years to track both health declines and improvements of the immigrant population. Four measures of health were incorporated in their analyses including overweight/obesity measures using body mass index (BMI), perceived self-rated health, HUI and
self-reported chronic conditions. An important observation the authors noted was that health changes that occurred between immigrants and the Canadian-born population were dependent on the health measure used. For instance, time trends of declining health trajectories of immigrants were not found for self-rated health, the HUI and chronic conditions, which do not support earlier studies’ findings of a healthy immigrant effect. So and Quan cite inconsistent reporting by immigrant groups including dichotomous reporting of health, where one group of immigrants report health declines while another group report improvements (So and Quan, 2012: 898). The authors also note that health status is not static and may not necessarily follow a linear progression, either in declines or improvements, such that the reporting of health from one cycle to another may be reflective of their health status at that particular time rather than time-related trajectories of health.

While there is no unanimity on how and why this effect is seen across immigrant populations and despite mixed results, the healthy immigrant effect remains a widely accepted explanation for health declines among immigrant groups. Despite the number of studies that reference the healthy immigrant effect less is known about whether this effect is seen among immigrants in later-life irrespective of time of arrival, country of birth or length of time since immigration. Moreover, research that has assessed later-life immigrants have tended to group all ethnocultural groups together under a single category of immigrant or foreign-born (Gee, Kobayashi, Prus, 2004; Newbold and Felice, 2006). With regards to the healthy immigrant effect the results from these studies depict a considerably different picture of the health of mid- to later-life immigrants in Canada. For instance, Gee, Kobayashi and Prus (2004) assessed the health status and patterns of health care use of mid-life immigrants (45 to 64 years of age) and later-life immigrants (65 years and older). Based on data from the CCHS, the authors found that the healthy immigrant effect was present among the mid-life immigrant cohort and that health deterioration occurs as time since migration progresses. However, for the later-life cohort, recent
immigrants tended to report much poorer health status and lower health functionality than the Canadian-born.

Newbold and Filice (2006) also used CCHS but limited their sample to immigrants over 55 years of age. In their analysis they found that older immigrants reported their health equal to the Canadian-born overall and by age-group for a variety of health measures including self-assessed health status, HUI and reported chronic conditions. In another study, Zhao, Xue and Gilkinson (2010) used the LSIC to examine health status and social capital among recent immigrants. Separating the population by age group Zhao and colleagues found that immigrants in the older age groups were more likely to rate their health as fair or poor compared to the younger immigrant cohorts. For all recent immigrants, compared to the reference age group (15 to 19 year olds), the oldest age groups were less likely to report their health as healthy. Although they made no comparisons to the Canadian-born populations to comment on the healthy immigrant effect, their results are consistent with Gee, Kobayashi and Prus (2004) and Newbold and Felice (2006) for later-life immigrants.

In a more recent study Kobayashi and Prus (2012) return to consider the dimensions of gender, ethnicity and age of the healthy immigrant effect using 2005 CCHS data of immigrant and Canadian-born populations. Similar to an earlier co-authored study, they separate immigrants into two groups of mid-life and later-life. There were differences found between genders as well as by age group. Recent (0 to 9 years) mid-age immigrant men were less likely to report fair or poor health. As for mid-life immigrant women, the authors found that regardless of time since immigration, they were likely to report fair and poor health compared to Canadian-born women. Kobayashi and Prus argue that the health disadvantages of women within this age cohort may be reflective of the differences in immigrant status (e.g., entering Canada through family reunification). Turning to the older age cohorts of immigrant and Canadian-born they found opposite results. More recent later-life immigrant men, particularly non-White, were more likely
to rate their health poorly whereas recent later-life immigrant women were less likely to rate their health as poorly when compared to the Canadian-born.

These mixed results which test for the healthy immigrant effect using the NPHS and CCHS certainly raise demands for more in-depth investigation on the health transitions of immigrants particularly among older age groups (DeMaio and Kemp, 2010). Although most of the support for the healthy immigrant hypothesis has consisted of mostly quantitative analysis, more recently, qualitative methods have been utilized to explore the healthy immigrant effect phenomenon providing more subjective accounts of changes in health status among immigrants in Canada (Dean and Wilson, 2009).

Contradictory results of the healthy immigrant effect in terms of gender, age and race illustrate that the healthy immigrant effect is a convenient but inadequate measure of health transitioning among immigrants in Canada. Kobayashi and Prus (2012) point to immigrant class as an untested factor in the measuring differences in health advantage and/or health advantage or disadvantage over time. Many of the studies on the healthy immigrant effect point to issues in the operationalizing of health and immigrant class group as well as inconsistencies with what constitutes recent and longer-term immigrants. Additionally many of these studies have taken to treating immigrants as a monolithic category while those that separate immigrants into groups tend organize them based on dichotomous categories of European or non-European, visible minority or non-visible minority or categorical groups according to regional birthplace (i.e., Asian, African, Latin American, etc.).

2.3.2 Double Jeopardy Hypothesis

A growing interest in immigrant and aging research is the issue of compounding identities along with age in influencing health. The double jeopardy hypothesis, as is often applied as a means of demonstrating health and health care needs among aging populations, contends that disadvantages in old age accrue with other positions of disadvantage (McColl,
This accumulation of disadvantage along with older age results in greater use of health and social services. When one adds the disadvantage of immigrant status or race/ethnicity as applied to aging immigrants, the double or even triple jeopardy hypothesis argues that multiple identities of being an immigrant and as an older adult act cumulatively giving rise to negative outcomes in health status and health care use. A similar concept on the influence of multiple identities or statuses is the intersectionalities of influence, one that Guruge and Khanlou (2004) apply to the study of immigrant and refugee women’s health. Studies that examine the health of aging immigrant women may also refer to this phenomenon as triple jeopardy in which the intersectionality of three stigmatized statuses result in combined negative effects (Havens and Chappell, 1983: 119). As noted in the previous section, Kobayashi and Prus (2012) examined the role of gender, age and ethnicity as dimensions of the healthy immigrant effect with conflicting results among mid- to later-life immigrants. They argue that in order to assess appropriately the needs of immigrants, policymakers should consider the intersections of identities across the life course. Similarly Vissandjée Weinfeld, Dupéré and Abdool (2001) examined the intersections of gender and ethnicity of immigrant women and how this affects their access to health care services. In their examination of immigrant women’s health care use they advocate for the sex and cultural matching of users and providers for more gender sensitive and culturally competent care. The authors argue that although the healthy immigrant effect has been well established in the literature it may not be a question about whether immigrants arrive in better health but rather is a question of what are factors that influence health once they arrive (Vissandjée, Weinfeld, Dupéré and Abdool, 2001). This is also echoed by Newbold (2009a) who discusses how family, job or cultural expectations and roles of immigrant women may hinder their access to health care services.

As Kobayashi (2003) also explains health inequities “…are shaped by the intersection of multiple identity markers of diversity” (p.94). In her study on multiple identities and health, she
notes that when socio-demographic and socio-economic factors are controlled for the differences that occur in health status and health care use between immigrant and Canadian-born populations may be rooted in cultural and ethnic dimensions of immigration such as country of birth, length of time since immigration and language. Furthermore she argues that addressing the impact of identity markers of diversity on health is a key issue that needs to be discussed in follow-up research where ethno-cultural values and beliefs of immigrant populations, as well as other Canadian minorities, such as French-speaking Canadians and First Nations/Aboriginal populations conflict with Canada’s health care system.

2.3.3 Age as Leveller Hypothesis

An alternative to the multiple jeopardy hypothesis is the age as leveller hypothesis. With respect to older immigrant populations, it argues that the health differences that diverge at young and middle-age begin to narrow as one grows older (Beckett, 2000) and that the social and economic disadvantages that exert the most influence among the working age population are cancelled out in older age (McColl, Shortt, Gignac and Lam, 2011). Thus the convergence of health for immigrant and Canadian-born can be attributed to age-related health decline which occurs across all racial and ethnic lines (McDonald, 2011). This argument presupposes that aging levels out social differentials in health as biological processes overtake more social determinants factors (Hoffmann, 2011). As an example of this, a number of studies have examined whether the socioeconomic effects on health decline with older age. In the U.S., this hypothesis is often tested in comparisons with White and Black populations, which seeks to determine whether or not there is decreasing racial disparity over time among older cohorts (Ferraro and Farmer, 1996; Kim and Miech, 2009). Social position, in terms of income and education, has been commonly used as a proxy for race and ethnicity particularly in the U.S. where the burden of racial and ethnic inequalities is in large part due to the “racialized nature of socioeconomic disadvantage” (Haas and Rohlfsen, 2010: 241). Further studies have included Hispanics in their race/ethnicity
comparison groups to test this age-as-leveller hypothesis (Brown, O’Rand and Atkins, 2012). While in the U.S. socioeconomic status has often been used as a surrogate for race/ethnicity in some instances (Haas and Rohlfsen, 2010; Whaley, 2003) in Canadian research the categories of race and ethnicity have not been used in the same way. A number of key criticisms in the use of ethnicity or race as proxies of socioeconomic position is that it inappropriately assumes that all members of a particular ethnic or racial group may all be socioeconomically disadvantaged as well as disregarding the socioeconomic differences of health within an ethnic or racial grouping (Smith, 2000).

A number of researchers caution against this narrow view of age-related converging health status. From an epidemiologic standpoint, one explanation offered for why age is viewed as a leveller of health status is due to mortality selection bias (McMunn, Nazroo and Breeze, 2008). The relative decline in morbidity may be due to survival effects, which results in a compositional change of the surviving population (Hoffmann, 2011). In other words, those who are socially disadvantaged tend to die younger leaving behind stronger survivors resulting in a narrowed gap between the advantaged and disadvantaged groups in both mortality and morbidity measures (Benzeval, Green, Leyland, 2011). As described by Hoffmann (2011) the resulting surviving population is less heterogeneous and results in a downward bias of mortality differences as the mortality of the socially disadvantaged becomes similar to the more socially advantaged. Earlier studies which have controlled for mortality selection bias have found that it has little impact on the convergence of health status in older age (Beckett, 2000; Kim and Durden, 2007).

Another explanation cited is the role of welfare state policies in some industrialized countries such as Canada that reduce the “differences in socioeconomic status in old age through social policy and benefits that favor the elderly population, thereby contributing to some redistribution between social groups” (Hoffmann, 2011: 374). Other explanations are the
experiences encountered with social stratifying systems experienced at a younger age where the “impact of earlier stratifying and relevant health experiences (e.g., working conditions) fades out at old age” often as people age they start to disengage from the main stratifying social systems (Hoffmann, 2011; McDonald, 2011).

An important critique of the age-as-leveller hypothesis is that it assumes that older populations exist within the same social environments, exposed to similar social situations, and in doing so this ignores the various social and economic circumstances observed between senior immigrant newcomers and long-term immigrants who arrived when younger and have aged in place. Although this hypothesis has mixed results with regards to socioeconomic effects on age-related health decline (Mustard, Derksen, Berthelot, Wolfson and Roos, 1997) it has proven to not be a valid hypothesis with respect to ethnicity/race and the declines seen in the health and functioning of older immigrant groups (Durst, 2005). Part of the reason for this is that it tends to ignore potential carry-over effects of health experiences at a younger age (i.e., pre-migration experiences). This is an important limitation of much of the cross-sectional studies that are conducted on the health of immigrants and why the healthy immigrant effect hypothesis is so widely adopted: because current health status is the baseline at which subsequent health is assessed. Recent studies that have examined weak or contradictory observations with the healthy immigrant effect among older age groups (Gee, Kobayashi and Prus, 2004; Newbold and Felice, 2009; Kobayashi and Prus, 2012) have suggested that there may be other confounding variables relating to immigrant status that result in the differences in health status between older foreign-born and Canada-born populations. It is perhaps for this reason that studies that examine the health of immigrant populations tend to explore axes of race and ethnicity as they intersect other markers of identity such as gender and age. Durst (2005) argues that life experiences and more subjective, qualitative experiences among diverse older populations equally influence integration, resettlement and overall health experiences of aging immigrants. Quantitative empirical studies
are not able to factor in qualitative experiences which are equally important in determining and understanding the health of aging immigrants. Although the healthy immigrant effect may be relevant in immigrant health research it may require revision, particularly given the growing diversity of Canada’s older population and the overall population in general where immigration in the last few decades have resulted in a greater numbers of visible minorities than ever before (Durst, 2005; McDonald, 2011).

Another challenge to the age-as-leveller hypothesis is the notion that illness, not age is the leveller of health. Hoffmann’s study on Danish men showed that mortality differences between income groups were stable across age but poor health was seen as levelling out mortality differences (Hoffmann, 2011). In a Canadian study, testing the age-as-leveller hypothesis on health care use, McColl and colleagues (2011) examined the role of disability, a related determinant of older age. Although research demonstrates that age and disability both are predictors of increased health care use, often seniors with a disability are more likely at risk for hospitalization and report higher levels of unmet needs (McColl, Jarzynowska and Shortt, 2010). The results from their study suggest that seniors attributed their poorer health status to disease or illness rather than age (McColl, Shortt, Gignac and Lam, 2011).

2.3.4 Cumulative Disadvantage or the Matthew Effect

Cumulative disadvantage theory explains that socio-economic health inequalities will increase and persist into older age due to an early-life of accrued exposures to risk factors and having poor access to resources (Seabrook and Avison, 2012). This may explain why at later life stages the immigrant population’s health tends to converge and in some cases become worse than some Canadian-born populations. As described by Prus (2004) socio-economic health inequalities are reflective of disadvantaged socio-economic status stemming from differential social circumstances divided along class lines as a result of the interactions of material, lifestyle, and psychosocial factors (p.5416). Cumulative disadvantage, sometimes referred to as the Matthew
Effect, is premised on the idea that although health tends to decline as one gets older, there are important individual and socio-demographic groups differences that further delineates health outcomes in older age. The Matthew effect as it relates to population and public health stems from sociologist Robert K. Merton’s (1910 – 2003) observations on the social world that “…initial advantage tends to beget further advantage, and disadvantage further disadvantage, among individuals and groups through time, creating widening gaps between those who have more and those who have less” (Rigney, 2010: 1). Thus the cumulative effects of having a healthier lifestyle over time for persons of higher socioeconomic status delay or reduce morbidity and disability in older age, whereas those persons of lower socioeconomic status who experience early-life disadvantages have less healthier lifestyles overall (Roos and Mustard, 1997; Prus, 2004).

In the U.S., cumulative disadvantage is often used to explain the Black-White health gap often seen across all age groups across all social status groups. A related idea is the weathering hypothesis which suggests that health declines faster among those disadvantaged groups as a result of their accumulated disadvantage across the life course and was first hypothesized to describe the experiences of African-Americans who demonstrated greater health deficits during their reproductive stages as a consequence of prolonged disadvantaged with social, economic and political exclusion (Geronimus 2000; Shuey and Willson, 2008; Taylor, 2008).

In Canada, the relationship between socio-economic variables – income and education – with mortality and morbidity has been well documented (Roos and Mustard, 1997; Veugelers, Yip and Kephart, 2001; Roos, Magoon, Gupta, Chateau and Veugelers, 2004). One of the earliest examples was a study conducted by Mustard et al. (1997) on a representative Manitoba sample incorporating census data, vital statistics and health records. There was an inverse association with mortality and income and education quartile ranking. They found the greatest concentration of mortality differentials relating to education and income among the young and middle-age
group but among the older age cohort, the only significant relationship found was an inverse association between education and mortality once income was controlled for. However, Mustard and colleagues did not expand their analysis to discuss the role of race, ethnicity or immigrant status. In Canada, there are few studies that have examined the role age, race and ethnicity in socioeconomic health inequalities over the life course. The use of race and ethnicity as categories in health research, particularly race, has been a contentious issue, especially in the context of Canada’s multiculturalist society. While it is important to recognize the limitations of such a category, as studies from the U.S. have demonstrated that race/ethnicity are sociologically important because they illustrate the ways in which people are treated and positioned in society (Wu and Schimmele, 2005).

Generally, the cumulative disadvantage hypothesis is not common within immigrant health research. It seems a relevant hypothesis to apply, however, to aging immigrant populations considering that the early stages of resettlement among newly arrived immigrants are important in determining their social positioning in a new country. Moreover more recent immigrants often require more social resources, such as newcomer services, to enable them to navigate their host country’s system. The de-skilling of immigrants or immigrants in marginalized labour may maintain immigrants’ poorer socio-economic standing and their ability to accrue certain rewards and benefits as their native-born counterparts. Whether an individual or community is able to access resources may imply that certain systemic barriers contribute to diverging social inequalities that manifest in health inequalities over time (Singh-Manoux, Ferrie, Chandola, and Marmot 2004).

2.3.5 Buffer Hypothesis or the Stress Process Model

Originating in social psychology, the buffer hypothesis argues that psychosocial factors such as social support, ethnic support and social networking buffer the stress that is often experienced during significant life change events such as resettlement and life as an older
immigrant in a new country (McDonald, 2011). Migration itself can be a stressor and it has been discussed by a number of researchers that recent immigrants are more likely to experience more emotional problems and mental health issues than their Canadian-born counterparts (Noh and Avison, 1996; Wu and Hart, 2004). A related concept to the buffering hypothesis is the stress process paradigm which has its roots in the sociology of mental health (Noh and Avison, 1996). Within immigrant health research, the resettlement stress paradigm describes how certain stressors such as unemployment, poverty and lack of access to health services can adversely affect most people but during the process of migration and resettlement the likelihood of experiencing these stresses increase significantly (Beiser, 2005). Both the buffer hypothesis and the stress process model refer to the role of social support as a protective against health reducing stress associated with life change. In the case of aging immigrants, social support is especially important in ameliorating the effects of stress (Wu and Hart, 2004). Another concern among immigrants in adjusting to life in Canada is understanding the cultural norms and social contexts of a new country or coping processes in dealing with perceived racial discrimination (Noh and Kaspar, 2003).

Despite many recent immigrants arriving in good or better health than their Canadian-born counterparts (i.e. the healthy immigrant effect) this health advantage may deteriorate as a result of acculturative stress (Berry and Annis, 1974). Acculturative stress often occurs as new immigrants try to adapt to their new culture. For instance, DeMaio and Kemp point out that adjusting to life in Canada and the associated worry about family and the future in a new country may be considered chronic stressors that may influence health later in life (DeMaio and Kemp, 2010). Occurrences of racism and discrimination as experienced by immigrants have also been studied (Noh, Beiser, Kaspar, Hou and Rummens, 1999; Noh and Kaspar, 2003). Research on stress and coping has well established that personal coping strategies adopted by immigrants (and refugees) may ameliorate the harms of stress (Simich, Beiser and Mawani, 2003; Simich, Beiser,
Stewart, and Mwakarimba, 2005) but chronic stress may result in a decline in overall health status.

Social support theories and models have mostly dominated research on stress and health issues among immigrants groups. However, research on aging immigrant groups or immigrant seniors in Canada is not as widely studied. There are a few exceptions including a quantitative study by Wu and Hart (2004) who examine three different measures of social support with data from the NHPS. There has also been research on specific ethnic groups and the effects of stress and coping on health and wellbeing, such as Wong and Reker (1985) who compared Anglo-Canadian and Chinese populations on their perceptions of coping and experiences of stress. Similarly Hwang (2008) explored experiences of aging-in-place among Chinese and Korean immigrant seniors and the coping strategies and social networks in which they engaged. Other related research on aging immigrants and the stress process model include studies that explore cultural experiences of depression (Lai, 2000) and measures of life satisfaction among immigrant seniors (Lai and McDonald, 1995). Often a critique of this approach to immigrant health is that while this hypothesis describes how the stress of migration and resettlement can be ameliorated or intensified by psychosocial factors it does little to address the stress itself (McDonald, 2011).

2.4 Health Transitions of an Aging Immigrant: A Question of Age, Illness or Ethnicity?

As current research on immigrant health has demonstrated, immigration is a process that can be evaluated from a broad-based demographic perspective to a personal and subjective experience. It is a fact of population growth in Canada and its importance is beyond discussions of economic and health care policy. As a dynamic and continuing process immigration has many direct and indirect impacts on the health of individuals and communities consisting of both immigrants and non-immigrants. Immigration also has important implications on research among the foreign-born elderly. While immigration has been discussed as a way to deal with the
increasingly aging population there are two important consequences of immigration to Canada with regards to aging. First, while a majority of newly arrived immigrants are representative of a younger working-age cohort many who obtain permanent residency in Canada will eventually grow old. Second, there are a proportion of immigrants who arrived in Canada at a later age as sponsored parents of children who arrived before them.

Immigration results in a widely diverse aging population and research and policy dialogue about immigration and aging will necessarily challenge current understandings of aging demographics in Canada. For instance, the notion of “living alone” which is widely documented in aging research (Porter 1994; McDonald, 1997) may not be applicable for a majority of elderly immigrants where there is a higher incidence of inter-generational families and living arrangements of immigrant seniors living in more family settings (Boyd, 1991). Such arrangements may influence decisions around health and health care which are likely to be informed by the family values, roles and obligations (Grewal, Bottorff and Hilton, 2005). For example, recent studies suggest immigrants that originally come from countries where the elderly are often cared for by the family are now living alone (Lai, 2007; Lai and Leonenko, 2007a).

2.4.1 Crosscutting Aging and Migration: Theoretical Considerations

Much has been written on the controversial terminologies of “race”, “ethnicity” or “visible minority” as categories for health research (Vissandjee, Desmeules, Cao, Abdool and Kazanjian, 2004; Tang and Browne, 2008; Veenstra, 2009). While some health researchers strive to distinguish these terms, others have noted that they are often used interchangeably depending on the country or discipline of the originating study (Koehn, Neysmith, Kobayashi and Khamisa, 2012). The concept of “race” which historically was related to the presumption that sub-groups

---

4 Recently, at the 15th National Conference of Metropolis, held March 14–16, 2013 in Ottawa, discussions leaned heavily on recent changes to Canada’s immigration policy that will discourage mid- to later-life migration. The “new” immigrant is envisioned as younger (in their 20s) with fluency in English or French and with advanced degrees from international and/or Canadian universities. (Source: http://newcanadianmedia.ca/index.php?option=com_k2&view=item&id=4265:cherry-picking-the-best-and-the-brightest-for-canada)
of the population were genetically or biologically distinct has little credence in most academic circles. Accordingly a racialized identity refers to a “…(group) of people that have been socially and politically constructed as ‘racially’ distinct” (Veenstra, 2009: 538). To be sure the category of “race” in much of the social science world recognizes it as a socially constructed term that is linked to power structures and the hierarchical organization of social position on the basis of physical features or traits (Brotman, 2003; Koehn, Neysmith, Kobayashi and Khamisa, 2013). The term “visible minority” has also been referred to in the literature, particularly in Canadian research which is based on the government definition as people who are “…non-Caucasian in race or non-White in colour and who do not report being Aboriginal” (Statistics Canada, 2009). The term has also been deemed problematic as categories of race, ethnicity and nationality may be confounded (DeMaio and Kemp, 2010). In reference to Canada and the role of immigration, Dyck refers to the term “visible minority” as the leitmotif for the shifting complexion of Canada’s demography (Dyck, 2001: 417).

Ethnicity in contrast is an all-encompassing term made in reference to heterogeneous populations often sharing in similar cultural features. According to Cool (1981) ethnicity can be seen as a source of community esteem based on the idea that ethnicity allows for one to self-identify based on common cultural connections with others to create a sense of belonging or the establishment of an ethnic community founded on a shared history or common birthplace. While having an ethnicity can occur among non-visible minorities, such as Anglo-Canadians who are often seen as the majority, the term ethnicity it is often linked to racialized people or “people of colour” (Brotman, 2003). For the purposes of this research, I too will be using this definition of ethnicity.

On the topic of immigrant health, outside of a racialized identity, research tends to characterize ethnicity in a number of ways including broader categories of age of migration, years since migration, source country or language (Vissandjee, Desmeules, Cao, Abdool and Kazanjian,
A number of researchers have noted that the migration experience itself should be conceptualized as a determinant of health (Vissandjee, Desmeules, Cao, Abdoool and Kazanjian, 2004). In terms of aging research, Torres makes a similar claim with regards to social gerontology’s lack of interest with international migration as a determinant of health or a factor in the aging process (Torres, 2004). She argues this by citing Castles and Miller (2009) who emphasize that migration cannot be viewed as a single event or a simple process of uprooting and resettlement. They argue that migration is not as straightforward as an individual deciding to move from their home country in search of a better life but rather that migration and resettlement plays itself out for the rest of an immigrant’s life (Torres, 2004: 126). Similarly, Kelly and Lusis (2006) argue that one does not simply begin life as an immigrant but that there are strong connections to their country of origin that are sustained and even woven into their lived experiences.

In much of the literature that utilizes large-scale data to assess the health and health care use of immigrant populations, the category of immigrant is applied regardless of ethnicity, race, country of origin or languages spoken. An implied notion of this generalization of the foreign-born population is that all immigrants are the same and as such, have the same experiences. Immigrants as a population remain a category with regards to analyses on health care, public health and social policy. The label of immigrant in Canada is most often associated with legal status terminology, referring to a person born in any country outside of Canada and who has either obtained permanent residence status or become a Canadian citizen. Immigrants who have acquired this status can expect to freely enjoy the same rights and benefits as Canadian born citizens; however, as Miediema and Tastsoglou (2000) argue, an immigrant’s social status is often an entirely different matter. Although they make specific reference to immigrant women’s experiences the same premise can be applied for immigrant groups broadly.
As Miediema and Tastsoglou (2000) argue, the term “immigrant” is socially constructed and based on the economic and legal processes of political structures and institutions and therefore is reflective of the many race, class and gender biases that are entrenched within the dominant culture. As well, label of immigrant versus non-immigrant also result in the discursive construction of the ethnic or cultural other set against notions of what it means to be Canadian (Dyck, 2001). More commonplace associations with the term immigrant have tended to refer to people of colour, people who limited English or French language proficiency, who speak those languages with an accent, excluding British, American or French accents, or people holding lower status occupational jobs such as domestic and other migrant workers (Miediema and Tastsoglou, 2000; Vissandjee, Desmeules, Cao, Abdool and Kanzanjian, 2004; Henry and Tator, 2006). These ideas are perpetuated not only through systemic economic and occupational barriers but also barriers within the health and social care systems (Lai and Chau, 2007). The diverse backgrounds of older immigrants, particularly women, with respect to employment, family roles and cultural expectations can also act to hinder their ability to access health and social services (Dyck, 1995), similarly the social support networks within the family or among friends have been shown to influence perceptions of illness and actions or behaviours towards healthcare seeking (Cook, 1994). Thus, the label of immigrant should be understood beyond the legal and economic definitions to the wider social constructions and embodiments of power relations between minority cultures and the dominant culture. Viewed in these wider contexts, immigrants’ social experiences, as well as experiences of health and social care can reveal how cultural identities and personal narratives rooted in ‘difference’ shape their health and aging trajectories.

With respect to aging, research has been slower to address the role of race and/or ethnicity with experiences of aging in a post-migration context. Literature on the intersections of aging and migration remains a specialized interest within the broader discipline of social gerontology. A number of potential sub-fields that explore race/ethnicity and aging have
developed from various disciplines. For instance cross-cultural gerontology which is rooted in anthropology seeks to explore how different cultures view and understand the process of aging as well as how these influence how one ages as well (Torres, 2011). The *Journal of Cross-Cultural Gerontology*, an international peer-reviewed journal first published in 1986 by Springer, explains that the field is timely and appropriate as the world has become increasingly multicultural with many Western and non-Western societies greying on a grand scale (Springer, 2013). Other branches of social gerontology concerning culture, race and ethnicity are the related fields of minority gerontology and ethnogerontology. Minority gerontology or minority aging was thought to originate in the U.S. in response to growing diversity that occurred with immigration and it was during the 1980s when ethnogerontology first arrived as a field although minority aging still exists as a general label (Crewe, 2004).

As a Western pursuit, ethnogerontology was first referred to by Dr. Jacqueline Jackson, a term thought to be more acceptable as it does not conjure up the same stereotypical images as the term “minority” (Crewe, 2004). For the most part it has remained a relatively underdeveloped field in terms of theory (McDonald, 2011; Torres; 2011; Koehn, Neysmith, Kobayashi and Khamisa, 2012). As noted by a number of social gerontologists the field as a whole has been criticized for being atheoretical with an emphasis on informing health promotion and health care activities rather than contributing to a wider body of knowledge of the impact of race and ethnicity on aging. Torres outlines the current developments or rather comments on the sluggish developments in ethnogerontology and refers to the double jeopardy hypothesis and age-as-leveller as the two most prominent theoretical perspectives in ethnogerontological study but neither have been cemented as keystone theories given the difficulty to test them empirically (Torres, 2011). Even in Canadian research, there is less engagement with ethnogerontology as a branch of social gerontology. The challenges of a largely underdeveloped theory in
ethnogerontology may be due to the inconsistent use of the terms “race”, “ethnicity” and “culture”.

The profusion of studies in social gerontology, some situated in ethnogerontology, in Canada is certainly noteworthy but they often remain disengaged from one another and from a broader theory engaging age and ethnicity. Koehn et al. comment that despite the overall proliferation of studies on aging in Canada it has done so in a society that undervalues older age in the way other societies do not (2012). Similarly, invocations of a sick immigrant discourse or anti-immigration sentiments amid a declining economy, low natural birth rate, an increasingly aging population and immigrant policy restructuring have hindered developments in immigrant health research.

Sandra Torres (2004) in particular, calls upon ethnogerontology to fill in the research and theoretical gaps within social gerontology with respect to aging immigrants. In much of her research on aging and the migrant experience, she argues that the immigration experience has rich potentiality in reframing current views on the processes of successful aging. The uniqueness as well as the ubiquitous nature of the aging immigrant experience in this age of globalization makes it a valuable source in understanding the context and strategies in which people strive to age successfully (Torres, 2004).

2.4.2 Research on Aging Immigrant Populations in Canada

Figure 2-1 illustrates the concept of successful aging in accordance with Rowe and Kahn, whereby improved psychological adaption to the often negative aspects of aging can delay the physical and mental declines as one ages:
Rowe and Kahn describe three main components to successful aging which include having a low probability of disease and disability, having a high cognitive and physical functionality and an active involvement or engagement in life (Rowe and Kahn, 1997). Accordingly, while being disease-free and maintaining high cognitive and physical functional capacity are paramount to aging well, being actively engaged with society is characteristic of successful aging. The concept of successful aging differs from the concept of active aging in its tendency towards a person-centred focus on the engagement with society in older age or old age as a lifestyle, as argued by Katz (2013). Critiques on the concept of successful aging argue that the aging process is viewed as deterministic and unrealistically implies an outcome, in terms of a culmination or overlapping of all components outlined by Rowe and Kahn, that very few individuals can actually achieve (Bowling and Dieppe, 2005; Hank, 2011). In a number of studies that compared lay views of aging, both qualitative narratives of aging to rankings in self-rated health, to more theoretical definitions of successful aging found that while many older adults may consider themselves to be successfully aging, they were not necessarily disease or disability-free.
(Strawbridge, Wallhagen and Cohen, 2002; Bowling and Dieppe, 2005; Hank, 2011; Romo et al., 2013). Many of these studies reflect the empirical challenge of defining the aging process. More specifically, studies have noted that while concepts of positive aging have a number of theoretical and conceptual bases that define the aging process, more subjective accounts of aging or how an older persons view positive aging in their own personal lives and concepts of aging may be different (Tate, Lah and Cuddy, 2003; Phelan, Anderson, Lacroix and Larson, 2004; Romo et al., 2013).

While the successful aging concept assumes that one should engage in an involved lifestyle in order to age well, it does so without considering the means or conditions in which one is capable or aging fully. Active aging as a model for positive aging have a number of concepts similar to successful aging, with the one exception that there is also a focus on active improvement on the environments and opportunities that encourage and support active aging, one that is guided by a population health approach (Paul, Ribeiro and Teixeira, 2012). The World Health Organization defines active aging as “…the process of optimizing opportunities for health, participation, and security in order to enhance quality of life as people age” (WHO, 2002: 12). The component of improved quality of life is also a key difference between successful aging and active aging concepts, with the explicit goal of developing aging policy that targets of health promotion initiatives through health and social policy designed to support older adults. Within this framework, strategies for positive aging are often linked with policy initiatives, for example, Ontario’s Aging at Home Strategy initiative which was implemented in part to respond to the aging population that is expected to increase the next few decades.

There are only a few studies that have attempted to examine the health status and health care patterns of the broader aging immigrant population and fewer have considered active aging or successful aging outcomes among them. The results from these studies are incongruent with what is already well known about the health of immigrants in general. This is especially true with
the widely cited healthy immigrant effect. This phenomenon is well known in immigrant health research although the underlying causes that have been accounted for this pattern of health vary widely. As indicated previously, there are few studies that have assessed this hypothesis among an older population (Gee, Kobayashi and Prus, 2004; Newbold and Filice, 2006; Kobayashi and Prus, 2012). In fact in some studies on the health of immigrants, older cohorts are lost or diluted in analysis. For instance, many studies that have tested the healthy immigrant effect using large-scale cross-sectional survey data often excluded older age cohorts. In their analysis McDonald and Kennedy (2004) excluded respondents over the age of 65 in order to eliminate “heterogeneity in health outcomes by broad age group” (p.1615). Similarly Newbold (2009b) whose study found health declines in as little as two years of first arrival combined individuals in middle age and later into a single category with the oldest age cohort representing immigrants 45 years and older. In a similar fashion, some researchers do not distinguish between two major groupings of immigrants: i) those immigrants (and refugees) who have aged while in Canada and, ii) those immigrants who arrived as seniors. Current understandings of migration, aging and health among Canada’s immigrants are best represented in qualitative studies.

Despite numerous studies on the health of the general immigrant population in Canada as well as research dedicated to the general older population there is a lack of research that addresses both these aspects within the broader population. Perhaps the near absence of older and aging immigrants within the broader immigrant health research stems from the wide-use of large-scale studies on immigrant populations, most of which ignore the diversity of Canada’s immigrant groups. Much of the research addressing aging immigrants in Canada has focused on a specific ethnocultural community itself. While there are numerous studies researching the health of specific ethnic groups in many settings across Canada, the range of health and health care related topics have also been broad and diverse. Adding to this complex body of literature on aging
immigrants in Canada has been the varied use of theoretical and methodological approaches crossing over from multiple fields and disciplines.

Health care research on aging immigrants can be divided into two broad categories. The first category includes those studies that examine the ways in which the health care system imposes barriers to a racially and ethnically diverse population and explores the challenges of providing culturally competent and sensitive care to these underserviced communities. The other category of research consists of studies that take a more population health approach to health which seeks to examine factors that influence health unrelated to medical inputs and utilization (McDonald and Kennedy, 2004). In this approach, the interest is in exploring the more social and cultural factors of health among immigrants and aging minorities and how these influence the ways in which they experience health care services (Masi and Disman, 1994). Within these two broad categories of research on aging immigrants studies on Chinese and South Asian immigrants have dominated much of the both quantitative and qualitative health research on aging immigrants (Koehn, Neysmith, Kobayashi and Khamisa, 2012).

2.5 Research on Aging Ethnocultural Groups in Canada

2.5.1 Aging Chinese Canadians

In terms of health care utilization of older Chinese in Canada, research has ranged from general use of the health care system (Chappell and Lai, 1998), the barriers to health care services (Lai and Chau, 2007a; Lai and Chau, 2007b), use of annual physical examinations (Lai and Kalyniak, 2005); use of home care services (Lai, 2004); dental care use (Lai and Hui, 2007) and even use of traditional Chinese medicine and therapies (Lai and Chappell, 2007). There has also been research on various aspects of the role of Chinese culture and ethnicity on health, including examining the influence of cultural health beliefs (Lai and Surood, 2009), the impact of cultural factors on health status (Lai, Tsang, Chappell, Lai and Chau, 2007), the effect of ethnic identity on the well-being of aging foreign-born Chinese (Gee, 1999) as well as its role in the access to
services and care (Lai, 2012). The cultural aspect of filial piety among Chinese elders in Canada and the caregiving practices while living away from their homeland has also been studied (Chappell and Kusch, 2007).

In the geographies of aging Chinese living in Canada, topics ranges from preferred living arrangements (Lai, 2005) who were either living alone (Lai and Leonenko, 2007b) or living with children (Pacey, 2002); the relationships between living arrangements and quality of life (Gee, 2000) as well as to their general health and well-being (Lai, 2004; Chow, 2010), to the intention to use long-term care facilities (Lai, 2004). Most recently, the size of the ethnic community related to health has been explored, which suggests that within group dynamics and settlement patterns of immigrant groups need to be considered to understand health disparities among aging immigrants (Chau and Lai, 2010). More recently Zhou (2012) explored the contexts of immigration and transnationalism regarding elderly caregiving arrangements in Chinese immigrant families and how examining these experiences extends the conversation of aging and ethnicity by rethinking the aging process in an era of global aging.

2.5.2 Aging South Asian Canadians

South Asians represent the second largest visible minority group in Canada (Tran, Kaddatz and Allard, 2005). Although not as vast as research on Chinese populations studies on aging South Asian groups has also dominated much of the literature in ethnogerontology. For instance, Olliffee et al. (2007) have explored elderly men’s immigration experiences as it relates to their perceptions of health and illness. Olliffee and colleagues explored identities of masculinities as they are shaped by their health practices (Oliffe, Grewal, Bottorff, Luke and Toor, 2007) as well as how they connect cultural ideas of health and exercise in a post-migration context (Oliffe, Grewal, Bottorff, Hislop, Phillips, Dhesi, and Kang, 2010). Other research explored processes of immigration and resettlement experiences and discussed the associated sense of loss and lack of social support among older women leading to loneliness and depression (Choudhry, 2001). Lai
and Surood (2008) also explore predictors of depression among Canadian South Asian immigrants. With respect to health care utilization, research on South Asian populations have studied the role of barriers to health care on health status and health seeking behaviours (Lai and Surood, 2010; Lai and Surood, 2013), including the role of cultural factors on health care use (Surood and Lai, 2010). The housing and living arrangements of aging South Asians have also been studied (Ng, Northcott and Abu-Laban, 2007).

2.5.3 Other Aging Ethnocultural Groups in Canada

While the Chinese and South Asian elderly populations are well represented in Canadian research, studies on the aging experiences of other immigrant groups are sparse and disparate. They are often found in disciplines outside of gerontology with wide-ranging research foci and adopting a wide variety of methodologies and theoretical frameworks. For instance, Shemirani and O’Connor (2006) used semi-structured interviewing to explore the personal stories shared by Iranian women who immigrated to Canada at a later age. Their qualitative study which utilized a phenomenological-hermeneutic approach examined the narratives and lived experiences of Iranian women as they considered aging in Canada. Though their sample was small (five) the authors noted how the women spoke of aging while connecting to their experiences of immigration and resettlement. In a similar study on aging experiences in a post-migration context, Lagacé, Charmarkeh and Grandena (2012) used focus groups to examine the views of Somali immigrants living in Ottawa. They also explored the inter-generational and cross-cultural aspects with the challenges of aging (Lagacé, Charmarkeh and Grandena, 2012). Hwang (2008) studied aging-in-place among Chinese and Korean seniors. Drawing from semi-structured interviews, group comparisons between these two groups in British Columbia were based on characteristics around housing, neighbourhood and community and use of local housing amenities.
Van Dijk (2004) applied the sociological theory of cultural continuity to describe the important role of religion and ethnicity of Dutch immigrants in providing and maintaining social support and ties with other seniors sharing the same ethnic background. Using survey data, van Dijk concludes that many ethnic or minority seniors may benefit from long-term homes that are developed around their specific cultural and religious needs. Other ethnocultural-specific research around health and aging includes intergenerational support structures among Japanese and Japanese-Canadian families (Kobayashi, 2000), around obligation (Kobayashi and Funk, 2010) and choice in filial care work (Funk and Kobayashi, 2009).

However, despite the slow progress in developing research in the area of health in later-life among immigrants, there is still a significant gap in the knowledge and literature on the role of ethnicity and other culturally-specific factors in the context of health and aging among Canada’s immigrant populations. Health researchers studying race and ethnicity argue that there needs to be more focus on disaggregated immigrant data in order to truly understand and explore health differences within the ethnic and visible minority ethnic groups (Rodney and Copeland, 2009; LeBrun and Shi, 2012).

### 2.6 Research on Filipino Immigrants

There is a surprising lack of health research on Filipino immigrants to Canada. This gap in health research literature is especially astounding if one considers that since the 1981 Census, the Philippines has been among the top five source countries for immigrants to Canada, occupying the third spot in the 2001 and 2006 Censuses (Chui, Tran and Maheaux, 2007). In 2010 and 2011, a large proportion of Canada’s permanent residents were from the Philippines, which topped the list of all source countries for permanent residency. Temporary foreign workers, in comparison, were sixth among all source countries for the same years (Citizenship and Immigration Canada, 2012). Notwithstanding the lack of health research on Filipinos in Canada much has been written about the social, economic, labour and spatial contexts of Filipino
migration to Canada. The migration trends of skilled (nurses) and unskilled (caregivers) migrant workers dominate much of the literature on Filipino immigrants. Filipino migration in Canada has often been characterized under the historical labour demands of Canada and has persisted as a case study for understanding class and the creation of transnational spaces (Kelly, 2012). For instance Kelly and Lusis (2006) used Pierre Bourdieu’s habitus as “a framework for understanding the value assigned to economic, social, and cultural forms of capital” in describing the transnational experiences of Filipino immigrants.

2.6.1 Filipino Migration to Canada

Filipinos are a relatively recent immigrant group in the history of migration in Canada. Prior to the 1970s they represented a very small proportion of immigrants entering Canada, mostly recruited to fulfill labour shortages in health care although they were also recruited as teachers and garment workers (Velasco, 2002; Kelly, 2006). Under the Marcos martial law declared in 1972, an important component to the Philippines’ economic policy was the export of labour namely as overseas contract workers with North America as a popular destination (Kelly, 2006). In reference to Philippine migration, Gardiner Barber (2013) offers the idea that “migration engages local and global spaces, and produces multiple and mobile attachments to place…” (p.41). Dubbed “national heroes” by the Philippine state Filipino migrants have come to represent the epitome of flexible labour migration with foreign remittances supporting the Philippines economy – a product of globalization and transnationalism (Stiell and England, 1997; San Juan Jr., 2000; Rodrigues, 2002; Velasco, 2002; Ramamurthy, 2003).

In the 1980s and 1990s, many Filipino women arrived in Canada as domestic workers under the Foreign Domestic Movement (FDM) Program, now currently the Live-In Caregiver (LIC) Program (Velasco, 2002)\(^5\). The FDM program (1981-1992) was established which

\(^5\) While the focus of this research is not solely on domestic workers it is reasonable to consider that a number of currently aging Filipinos came through the Live-In Caregiver or the previously named FDM
recognized the prior abuses and exploitation experienced by migrant caregivers which denied them citizenship and a host of social, economic and political rights. During this time most of the immigrants who arrived through domestic worker migration were women of colour and were unable to receive permanent residency. As well their low wages prevented them from achieving the minimum economic independency based in immigration criteria (Khan, 2006). With the development of the LIC program formed in 1992, conditional permanent residency status was now afforded to migrant workers. A number of researchers, however, doubt the promise of permanent residency as the LIC program also devised tougher barriers for entry such as strict education and other training criteria (Stasiulis and Bakan, 1997). With more well-educated migrant workers entering through the LIC into fields of domestic labour considered by the government as unskilled, it resulted in the overall deskilling of many migrant workers, including a majority of Filipinos. In fact, a very large proportion of migrant workers through the Live-In Caregiver program in 1993 to 2003 were from the Philippines and overwhelmingly women (Kelly, Park, deLeon and Priest, 2011).

Much of the emphasis has been reflective of their role in the globalized economy which have also shaped the way in which Filipinos are perceived in Canada as well as identity formation and transformation (Kelly and Lusis, 2006; Gardiner Barber, 2008). As McElhinney and colleagues (2012) offer in the first chapter of a recently published book on Filipinos in Canada, most of the circumstances written on the Filipino population have been very specific to stereotyped notions of the Filipino immigrant as a nurse or health care aide, live-in caregiver or troubled youth. As reflected in the title Filipinos in Canada: Disturbing Invisibility other aspects

program. Although research on Filipino domestic workers dominates much of the Canadian literature on Philippine migration, another predominant research focus has been on Filipino nurses as is the case of the foreign migration nurses, mostly Filipino, in the 1960s and 1970s and the current deskilling of nurses as health care aides.
and experiences of Filipinos living in Canada have been ignored and remain invisible (Coloma et al, 2012).

In a study that explored the relationships between immigrant care givers and older adults receiving home and long-term care Bourgeault et al. (2010) interviewed both care workers and residents/patients about their perceptions of care. When speaking with older adults the authors noted that when references were made to care workers from the Philippines they would generalize their comments about the personality traits and quality of care. Included in their paper were quotes that referred to an “ethnicized” sense of care where Filipinos were thought to be culturally better equipped to care for the elderly or Filipinos seen as a “caring people” (Bourgeault, Atanackovic, Rashid and Parpia, 2010: 110). Although this study is important for its discussion on the challenges of elderly care in times of labour shortages and high migration of care workers from the Caribbean or the Philippines, it does inadvertently reveal the persistent perception of the Filipino immigrant, particularly women, as nurturing and obedient – the ideal domestic worker (Khan, 2006).

Gardiner Barber (2008), in particular, discusses how Filipino migrant flows, the migrant worker experience and the struggle to adapt to the changes in the immigration and labour policies of Canada, creates new class identities and subjectivities among Filipino immigrants. As with other research on Philippine migration, a lot of the focus tends to the gendered, racialized and deskilling patterns of Filipino migration and the capacity for Filipino immigrants to adapt or conform to the desired characteristics of the ideal immigrant, a process Gardiner Barber refers to as “performances of subordination” (2008; p.1268). Part of the reason for this, Khan (2009) explains, is the strong preference of Canadian employers and recruitment agencies for Filipino caregivers over other countries based on enduring stereotypes of Filipino women as mentioned above in addition to the Philippine state’s labour-export policy and the use of foreign remittances to fuel the economy. Pratt (1997) discusses the stereotypical images and racialized differences of
the Filipina⁶ nanny and the British nanny in conversations with nanny agents in Vancouver. As Pratt encountered, British nannies were perceived as professionals and Filipino nannies were seen as servants. Similarly, in response to limited labour and housing opportunities, other researchers have noted similar traits of flexibility and resiliency to characterize Filipino immigrants to Canada (Thomas, 2011).

Harell et al. note that Canadians’ favourable attitudes towards immigration are based on the type of immigrant admitted and the context in which immigrants integrate (Harell, Soroka and Iyengar, 2011). In effect, by characterizing the process of immigration as a sole means of meeting labour demands immigrants are sorted into labels of desirable and undesirable immigrants. For both the Philippines and Canada, Filipinos may represent the ideal immigrant but a closer look reveals more about the character of Filipinos as flexible and adaptable in a post-migration setting. As argued by Gardiner Barber, the concept of the ideal immigrant ignores all notion of agency of the Philippine migrant with research on Filipino immigrants, particularly caregivers, who are portrayed as victims (Gardiner Barber, 2008). The reasons for migration are so varied and complex both in the decisions to migrate and the desire to maintain connections with the Philippines.

2.6.2 Geographies of Filipino Immigrants

The Philippines have been referred to as a country of emigration (Castles, 1998). In terms of the migrant flow and settlement patterns of Filipinos in Canada, they have had distinctive patterns of entry resulting in a dispersed pattern of settlement across the country. One

⁶ My preference for choosing to use “Filipino women” over the term Filipina is based on my reading of a number of accounts on the shift of meaning. Barber (2002) in her chapter entitled Envisaging Power in Philippine Migration: the Janus Effect discusses how Filipina is now associated with negative connotations with paid domestic labour. Other researchers, such as Lynn Farrales (1999) have documented the objections she encountered among her sample of young Filipino women in Canada (See Filipino Women Living in Canada: Constructing Meanings of Body, Food and Health). Filipina is a resisted term because as some women explained to Farrales it is synonymous with a maid or had derogatory meanings. For more further discussion on this Geraldine Pratt’s (1999) From Registered Nurse to Registered Nanny: Discursive Geographies of Filipina Domestic Workers in Vancouver, B.C. which describes the discursive constructions of Filipina and how it shapes the Filipino women’s migrant labour experiences.
aspect of migration settlement has been the level of racial segregation between a racialized group and the White majority. The level of racial segregation of an immigrant group indicates how well or how poorly that group has integrated into mainstream society (Balakrishnan, Ravanera and Abada, 2005). Darden and Kamel explain that racial segregation as a measurement, called the index of dissimilarity, determines the spatial unevenness in the distribution of population subgroups. For their study, Darden and Kamel (2004/5) measured the level of racial segregation of Filipinos in the Toronto Census Metropolitan Area (CMA) noting that Filipinos tend not to encounter more serious issues in integration following migration due to a number of factors including their knowledge of the English language, Western culture and democratic ideals. Among the ten racialized groups included in their study Filipinos were the fourth least segregated group (Darden and Kamel, 2004/5). Only Aboriginal, Japanese and Black Canadians were less segregated than Filipinos when compared against a White Canadian majority.

Other studies on spatial concentration of racialized groups have noted that immigration to Canada from less developed countries results in a chain migration where new immigrants tend to settle where sponsoring immigrants already reside (Balakrishnan, Ravanera and Abada, 2005). The assumption behind racial segregation and societal integration implies that more isolated groups are less engaged or do not participate fully in the housing and labour markets. A similar study to the Darden and Kamel study which measured spatial concentration and segregation of Filipino groups was extended to six major Canadian cities. Balakrishnan and colleagues found that while Filipino immigrants tended to settle in larger cities, they do not follow any settlement pattern and their dispersion is not generalizeable across all cities in Canada (Balakrishnan, Ravanera and Abada, 2005). They note that because of Filipinos overrepresentation in the health care and service sectors that they are likely to reside in cities where the greatest employment opportunities reside.
Racial segregation or spatial concentration measures are often used to test the success of Canada’s Multiculturalism Policy (Darden and Kamel, 2004/5; Balakrishnan, Ravanera and Abada, 2005). Bauder and Sharpe explain that ethnic identities in Canada’s urban areas are ever-changing and spatially contingent. In their study comparing visible minority groups and various measures of racial segregation among Canada’s major gateway cities (Montreal, Toronto and Vancouver) there were no distinct settlement patterns among Filipino immigrants. Filipinos’ levels of segregation, using the dissimilarity index as Darden and Kamel do, varied where in Montreal segregation measures were the highest but moderate in Toronto and Vancouver (Bauder and Sharpe, 2002).

In addition to Filipino re-settlement and racial segregation studies, other research has explored transportation and housing behaviours. For instance, Thomas (2011) who, in examining the transportation and housing choices of Filipinos living in Toronto makes specific reference to immigration and integration patterns of Filipinos. Thomas notes that despite Filipino immigrants’ English proficiency and higher educational attainment, they still struggle to find employment commensurate with their skills, which limits their transportation and housing choices. This she argues is indicative of the general problems faced by immigrants in the country as a whole (Thomas, 2011: 17). As Bauder and Sharpe (2002) note that the spatial patterns of visible minorities are strongly influenced by housing types and argue that “…(c)ircumstances of immigration, federal and provincial settlement policies, geographical and historical situations of the city all shape the residential patterns of visible minorities” (p.219).

Despite most of the discussion on Filipino labour falling into categories of nurses or live-in caregiver, one exception was a study by Wang and Sangalang (2005) who examined the workplace experiences of Filipino migrants. Research has indicated that employment is related to health which has also been demonstrated among immigrant populations (Dean and Wilson, 2009). In particular, employment with favourable work conditions, which includes job satisfaction, has
been known to influence health positively (Lavis, Mustard, Payne and Farrant, 2001). Assuming the premise that recent migration can be a stressful event as a result of having to leave behind established social networks the authors observe the individual-level determinant of social support as it relates to job satisfaction. Filipinos tended to find social support among their immigrant peers rather than from Canadian-born workers and management; however, Wang and Sangalang found that there was some indication that Canadian-born support may be more positively correlated with job satisfaction. It should be noted that this particular sample of Filipinos consisted of mostly blue-collar workers who were employed in assembly line jobs from a variety of industries and which may not be reflective of the overall labour patterns of Filipinos in Canada. As such this study may have discounted Filipinos in health care, caregiving or other service industries – sectors that most other research on Filipinos has discussed exclusively. Although this study did not make direct references to health, the authors note that increasing social support and employee interaction is important for job satisfaction and a work adjustment.

2.6.3 Research on the Health of Aging Filipino Immigrants

One of the more seminal works on Philippine migration to Canada is a book written by Anita Beltran Chen (1998) entitled From Sunbelt to Snowbelt: Filipinos in Canada, a collection of conference papers which discusses the history of Filipino migration in numerous communities across Canada. She reasons that the changing socio-demographics of the Filipino population in Canada is the result of Canada’s immigration policies which evolved to the shifting labour and economic needs of the country and provisions for family reunification. As a result of the immigration policy of 1976, during the late 1970s well into the late ’1980s the country received large numbers of older Filipinos arriving to join their adult children who had already settled and established their lives in Canada (Chen, 1998).

Overall, the senior Filipino population in Canada is relatively young compared to the overall senior population. Using 2001 census data to report on the profile of Filipinos in Canada,
Lindsay (2007) found that Filipino seniors aged 65 and older represented less than six percent of the total Filipino community compared to the rest of Canada where the senior population represented 12 percent of the total population. Notably the proportion of Filipinos in Canada representing mid-age adults, (i.e., 45 to 64 years) was reported to be less than 22 percent (Lindsay, 2007). To date this has been the only account of the older age group composition of Filipino immigrants in Canada. As these data are over ten years old it would be reasonable to assume that a sizeable proportion of the Filipino population are now starting to reach mid- and later-life ages.

Most recently ethnicity data from the 2011 National Household Survey (NHS) have reported that the Philippines was the leading country of birth among people who had immigrated to Canada between 2006 and 2011, with 152,300 newcomers reporting that they were born in the Philippines, which was 13.1 percent of all newcomers (Statistics Canada, 2013). The age structure of Filipinos in Canada has shifted since the 2001 census. Based on calculations from the data tables available for the 2011 HNS, the percentage of Filipinos aged 65 years and older was eight percent of the total Filipino population (including all Filipinos with or without Canadian citizenship) in Canada, which is a small increase from the report from 2001 census data (Lindsay, 2011). The percentage of mid-life Filipinos, aged 45 to 64, was found to be 32 percent for all Filipinos in Canada, which also represents an increase from 2001 census data. Of those eleven percent were representative of the pre-senior age cohort group.

In Figure 1-1 it shows the percentage of seniors and pre-seniors for the Toronto CMA and Ontario based on 2011 NHS data, which are both slightly higher than the percentage of Filipino seniors and pre-seniors for all of Canada. A breakdown of the senior age group cohorts is not available as the NHS combines all old-old (75 to 84 years) and the very-old (85 years and older) seniors but these figure demonstrate that the number of Filipino seniors have grown in the
last decade, that the need to study this under-researched population is timely and greatly important.

![Graph showing percentage of later-life Filipinos within the total Filipino population in the Toronto CMA (N= 185,085) and in Ontario (N= 218,660) (Statistics Canada, 2013)](image)

**Figure 2-2:** Percentage of later-life Filipinos within the total Filipino population in the Toronto CMA (N= 185,085) and in Ontario (N= 218,660) (Statistics Canada, 2013)

Compared to the wealth of research that can be found on the health of Chinese and South Asian seniors the dearth of research on Filipino seniors is conspicuous and not reflective of their increasingly demographic and cultural representation over the last five decades. In searching for any studies or papers that addressed the health of the Filipino immigrant population in Canada, the only one that was found was a study by Farrales and Chapman (1999). They explored cultural meanings of food in connection to body perception and health among a young group of women ranging in age from 19 to 30 years. In particular they were interested in how Filipino women living in Vancouver dealt with body image issues and their relationships with food amid conflicting Canadian and Filipino meanings of body (thinness versus fatness) and diet (restricting fatty foods and rice versus freely eating fatty foods and rice), as well as differing cultural perceptions about health. Although, this study is not related to the issue of aging, it does offer
some insight into how Filipino immigrants think about their health in a post-migration context and the tensions in acculturating to mainstream society and holding to Filipino tradition (i.e., dietary practices and perceptions of female body image).

In another study, Pasco and colleagues (2004) explored the role of culture in the perceptions of care in a hospital setting. Also not entirely focused on an elderly group, with participants ranging in age from 33 to 86 years they examined patient-provider relationships of Filipino patients and nurses in a Canadian hospital where they examined the culturally distinct ways in which Filipino patients perceived of their caregivers. Pasco et al. were also interested in the various ways that Filipino patients communicated their needs and concerns to nurses based on the degree to which they felt that nurses were either “one of them” or “not one of them”. The Pasco et al. study provides some insight into the cultural aspects of the Filipino community with regards to their health care needs but offers little in terms the relational power dynamics in intercultural patient-provider relationships. In a similar study on First Nations patients and their interactions with nurses in a hospital setting, Browne (2007) noted that the patient-provider relationships were not only shaped by cultural characteristics and perceptions of First Nation patients themselves but were also the result of nurses’ perceptions and care responses towards their patients. Browne discusses the relationship dynamics in terms of four themes which include cultural differences, construction of the “Other”, cultural assumptions which influenced clinical practice and response to patients (Browne, 2007).

The studies by Pasco et al. and Browne are part of a growing interest in cultural and ethnic identity within clinical settings in a pluralistic society like Canada. Concerned with issues of marginalization and systemic discrimination among ethnic groups and the significant role they play in poor health, there have been a number of studies that have explored issues of cultural sensitivity training (Majumdar, Browne, Roberts and Carpio, 2004), cultural othering and self-identity in health care research (Dyck, 2001), and racial/ethnic matching in patient-provider
Alongside an increasing concern about the lack of cultural sensitivity and awareness in clinical care practices, viewed as contributing to poor health status and poor health care access among Canada’s ethnocultural and visible minority groups, there is also concern about the lack of data on race and ethnicity in public health and biomedical research (Rodney and Copeland, 2009). This is especially true of research on Filipinos in Canada and even more so on aging Filipinos in Canada.

Much of the research on the health of older Filipino immigrants can be found in the United States. It was not until after World War II when Philippine migration to Canada and the US was first recorded and a greater percentage of Filipinos as a total of the immigrant population opted to settle in the US. In a report compiling data from the Canadian and US census, Darden reported on the migration trends of Filipinos to Canada and the US using level of incorporation as a measure of Filipino integration and host society acceptance and tolerance. Using an index of dissimilarity and simple ratios Darden compared the levels of incorporation between the two migrant groups of Filipinos in similar societies as being “…predominantly White, multi-racial societies with a history of racial/ethnic discrimination against non-white, non-European groups”. Additionally, he used socioeconomic indicators of occupational inequality, poverty, and median income to compare the groups and concluded that Filipinos in the US had greater levels of incorporation and socioeconomic equality compared to Filipinos in Canada (Darden, 2009).

Historically, the US has had a larger number of Filipino immigrants settle for a longer period of time than Canada and as such most of the research reported here on aging Filipino immigrants and health has come from the US. One of the earliest comprehensive studies to examine the health of Filipino Americans was by Anderson (1981). At the time the paper was published it was estimated that the Filipino immigrant population would reach the 1 million mark and become the largest Asian-American minority group in the US. In this paper, he not only provides a survey of the common health problems of Filipinos but he also discusses the culturally
informed notions of health and illness (Anderson, 1981). Anderson emphasizes that clinicians should consider the sociocultural aspects of Filipinos’ lives to be able to better understand and treat Filipino patients.

On the health of senior Filipinos in the US, DiPasqualie-Davis and Hopkins (1997) provided a descriptive analysis of the health behaviours adopted by Filipino immigrants aged 55 years and older. In this study, the researchers looked at specific health behaviours relating to lifestyle factors such as diet, physical exercise, alcohol consumption, smoking behaviours and attitudes on health. A strong theme in their analysis was that many seniors attributed their healthy behaviours as being common to their culture despite the suggestion that among immigrant populations older cultural patterns eventually give way to newly adopted behaviours.

Other studies that examined how older Filipinos perceived and self-managed their health and health care needs includes a study by Becker (2003a) and her discussion on the cultural expressions of later life (47 to 97 years of age) Filipino immigrants in how they manage chronic illness. In particular, Becker identifies the same cultural concept of maintaining balance in the body or timbang that Anderson also refers to as an indigenous concept of Filipino perceptions of health and illness. An example of this concept of balance is changing climates from the hot weather in the Philippines to colder temperatures in North America. Anderson explains an imbalance in temperatures such as “rapid shifts especially from ‘hot’ to ‘cold’ cause illness and disorders” (Anderson, 1983: 815). In order to remain healthy one must maintain a "warm" condition in the body.

Becker has also contributed to other studies on the migration experiences of aging Filipino Americans. In particular, Becker et al. describe the decisions and motivations for later-life migration of aging Filipino men who served in World War II with the U.S. military. With the Immigration Act of 1990 allowing WWII veterans to obtain American citizenship, the U.S. saw large numbers of Filipinos migrating to their country (Becker, Beyene and Canalita, 2000).
Becker (2002) also explored the decisions of death and dying in a second homeland of Filipino Americans (aged 59 to 97 years). Included in her study were Cambodian Americans although Filipinos made up the majority of the sample. She incorporated used a cultural phenomenological theoretical perspective to connect ideas about bodily awareness to death and dying decisions. For example, a portion of her sample were WWII veterans who connected their bodily experiences with war in discussions around death and future plans and arrangements for when they do die (Becker, 2002). In addition to cultural phenomenology as a theory and methodology she also brought in concepts such as transnationality, place, ethnic identity and continuity to explore the question of migration and death with the body as a locus for these constructs.

In terms of studies on the direct relationship between health and place among Filipinos Becker (2003b) again turns to Filipinos in the US to discuss the meaning of place for older Filipinos living in an inner city. In her overall study she looks at three older immigrant groups which including Latinos, Cambodian Americans as well as Filipino-Americans. She explores how older people cope with a chronic illness as part of their daily lives. Through qualitative interviews participants discuss their living arrangements, as well as negotiations with place in the context of their current living environments when compared to what they perceive their lives to be like if they were “back home”. Becker adopts a theoretical framework which includes the concept of space and place in which she incorporates ideas from Massey (1993) and Lefebvre (1974/2000). She argues for their greater use in gerontology, which is not a tendency, as it may help to advance the study of aging and ethnicity.

2.7 Summary

This chapter reviewed the broad literature on the health immigrants and the existing literature on age-related issues of immigrants and on the Filipino populations in Canada and the U.S. The research demonstrated two paradigmatic views on immigrant health – the sick immigrant and the healthy immigrant. While most of this research has leaned towards the healthy
immigrant paradigm, both views have contributed to current perceptions of the immigrant population. Much of the quantitative research on immigrant health provides generalized descriptions on the health distributions and health profiles of immigrant populations and often these comparisons are made to non-immigrant populations. A significant limitation of these studies are the use of large-scale survey or administrative data such as the CCHS, LSIC or NPHS, which often aggregate immigrant populations and do not distinguish ethnicity, immigrant status and even age. On the other hand, qualitative research tends to focus more on certain aspects of health and/or health care, on specific ethnocultural groups or on specific health experiences, such as gendered experiences of immigrant women and health care access. A critical review of the key theories and hypotheses that attempt to explain health differences and health trajectories of older immigrant populations discuss both the strengths and limitations of each of the five hypotheses. The healthy immigrant effect is the most common hypothesis within Canadian research; however it does not appear to hold for older immigrant populations.

The lack of research on aging Filipinos in Canada is bewildering given the depth and range of research on other aging ethnocultural groups in Canada. Compared to other ethnocultural groups in Canada, such as aging Chinese and South Asian communities, there are only a handful of studies that examine the health of Filipino Canadians (Chen, 1998; Farrales and Chapman, 1999; Pasco, Morse, Olsen, 2004). Most of these are outdated and do not engage with research on the labour and economic circumstances of Filipino migrants. The breadth of research on Filipinos in Canada has often fixated on the labour exploitations and subjectivities of the Filipino migrant worker, namely the experiences of Filipino nannies or caregivers (See Pratt, Kelly, Barber, McElhinny, Bakan.) and often does not examine the impacts on health of Filipinos, particularly the long-term effects on health as a result of their migration experiences. This study attempts to explore the relationship of migration, aging and health and the literature reviewed in this chapter aids in developing the methods and conceptual framework guiding this research. The research
considers the significance of ethnicity and migration as important social determinants of health and advocates for more life-course analyses on the health and aging experiences of the *older immigrant*.
Chapter 3

Research Design and Methods

3.1 Introduction

This research attempts to understand how the processes of aging and immigration interact and give rise to intersectional experiences of health and health care along the lines of ethnicity, race, gender and class. While most studies examining aging and migration adopt macro-level analysis to understand and explain institutional factors of demographic change, this study examines the less considered meso- and micro-level analyses which considers community, household and individual factors of immigrants’ health and aging experiences. The study used qualitative data from key informant interviews to understand the broader issues of aging and immigration at the community level (meso) as well as second-hand experiences about household or family level factors that influences immigrant populations’ health and aging in the city. Additionally, the study used a case-study analysis of aging Filipino immigrants, incorporating qualitative and quantitative data to explore their individual (micro) experiences of health, health care and aging in a post migration context and multicultural setting. More specifically, I explored Filipinos’ various experiences of health and aging in Canada at different stages of migration or migration status. I examined the transnational nature and activities of Filipino lives such as the regular visit “back home” or the keeping of Philippine property, the use of health care abroad, the geographies of families, obligations of senior care and perceptions of “Filipino elders”, perceptions of the aging self, retirement and aging expectations in a second homeland.

This chapter describes the methods used for the overall study as well as the conceptual framework guiding this research. The chapter is organized into three main sections. The first section explains the overall conceptual framework as well explanations on the separate theories, concepts and models included within the overall framework. The second section describes the
overall methodology of the study including sampling strategies, survey items and interviewing documents. The third section provides a brief discussion of the analyses for each data set and how they will be used in conjunction with each other. The chapter concludes with a discussion on the limitations and challenges of the research and study methods as well as some ethnical issues that arose throughout the research.

3.2 Conceptual Framework

With respect to aging and immigration in health research there is a considerable lack of theory that engages in both these issues simultaneously. Although theory is integral to understanding cultural and social phenomena, current understandings of aging and immigration in the fields of social gerontology and ethnogerontology remain atheoretical. In a recent paper, noted social gerontologist Lynn McDonald argues no clear theory has yet been described and she maps out the development or lack of development of theory in aging and immigration research, (McDonald, 2011). As described in Chapter 2, current research on the health of aging immigrants offers a number of hypotheses or chains of hypotheses to describe the health trajectories of aging immigrants. Most notable are the healthy immigrant effect and the multiple jeopardy hypotheses which receive much of the attention in Canadian research on immigrant health. Research on the older cohorts of immigrants (mid-life to later-life) shows there is little evidence to strongly support either of these hypotheses (Gee, Kobayashi, Prus, 2004; Newbold and Felice, 2006). Population aging is currently occurring in Canada, as well as globally, which will cause unprecedented changes to the age structure of Canada’s populations and pose significant challenges as well as opportunities for health and social policy in Canada. Additionally, international migration has been a significant factor in population growth and increased diversity in Canada, as census data have shown that over the last ten years two-thirds of Canada’s population growth can be attributed to net international migration (Statistics Canada, 2012). Understanding the health issues of aging immigrants is important because of its timeliness and its
relevance to Canada’s current immigration, health and social policies. As a result of the mixture of methodologies and theories used by others with targeted meso- and micro-level factors, this research necessarily relies on a number of theoretical and conceptual frameworks. See Figure 3-1 for an illustration summarizing the overall conceptual framework which guides this research. The components of the framework are described below.

3.2.1 Life Course Theory

Life course theory was applied to this study for its usefulness as a framework for understanding the social and cultural realms of aging in terms of both material and experiential circumstances leading to positive or negative health situations in later life. Early in the development of this perspective, Glen Elder pioneered some of the initial writings of the life course perspective which considers how “historical time, social location and culture affect experience” (Hutchinson, 2007: 11). By using this perspective in aging research gerontologists seek to understand later life or old age and how it is influenced by events that are experienced earlier in life (Browne, Mokuau & Braun, 2009; Ferraro & Shippee, 2009). As such, the concept of “life course” has been defined as a stage-like, interdependent set of sequences which are characterized by age-related social roles throughout one’s life (Crosnoe and Elder, 2002). For instance, within the domains of family, education, work, or leisure, individuals experience domain-specific experiences and enact certain social roles which in turn have an impact on subsequent life events.
Figure 3-1: A conceptual model of health and health care use of older Filipino immigrants in Canada.
Research using life course data or that have applied a life course approach consistently demonstrate that persistent stressors experienced in early life often result in cumulatively disadvantaged situations and circumstances that may lead to further stressors in later life phases (Holland et al., 2000). In this sense, life course theory argues that early stressors in life may lead to increasing health disparities along a temporal continuum. Because of its wide spread use in the wider field of gerontology many researchers also advocate for its use in research on the aging immigrant populations (Durst, 2005; McDonald, 2011). Aging and migration can be viewed as contingent upon each other and for this study I view the event of migration as a significant life event and potential stressor, which may have an impact on an immigrant’s health and aging experiences. As advocated by McDonald (2011), I use life course perspective theory as the overarching framework upon which I anchor three theoretical and conceptual perspectives.

As I only focused on later-life Filipinos aged 55 and older this study is not an analysis across the life course of Filipino immigrants in Canada. Instead the life course framework was used to develop the semi-structured interview script and to guide the actual interview with later-life Filipinos. During the interviews respondents were asked to recall and retrospectively discuss important key life events, such as first migration to Canada, marriage and family life, occupation history and retirement or planned retirement.

In particular, McDonald also argues that the life course perspective can be used in tandem with other theoretical frameworks and refers to life course theory as the scaffold upon which other lenses or perspectives can easily align. Together, the life course perspective and life course theory inform my broad research methodology in order to understand health and aging in the context of the material, social and cultural processes inherent in the migration experience. My research also seeks to understand not only physical, mental and social health status but also seeks health care behavior patterns and decision making all within the context of a post-migration, secondary home experience.
3.2.2 Social Ecology Theory and the Social Determinants of Health among Aging Immigrants

To understand health among the aging immigrant population I incorporate a population health approach with a focus on the social determinants of health and a socio-ecological framing of my research aims and questions. More broadly I am interested in untangling the factors that contribute to the established consensus in immigrant health research which asserts that foreign-born populations tend towards poorer health status, as noted by the healthy immigrant effect, when compared to native born populations (Newbold and Danforth, 2003; De Maio and Kemp, 2009; Newbold, 2009a). In applying social ecology theory, there exist distal social causes in the person-environment relationship which accounts for the health disadvantages and health differences seen among immigrant groups (Bookchin, 2009). The social determinants of health framework is important to this research in identifying distal determinants, also referred to the “cause of the causes” (Marmot and Wilkinson, 2005), that influence the poor health and aging trajectories for immigrants. Using the social ecological approach as a framework for this study emphasizes the significance of the interactions between these health determinants across different settings and within different contexts of the lives of older immigrants.

As a widely used framework in health research and health promotion initiatives across many disciplines, social ecology theory is noted for its usefulness in explaining health as influenced by numerous factors, within various domains and levels of the social ecology (Green, Richard and Potvin, 1996; Grzywacz and Fuqua, 2000). Early work by Bronfenbrenner in developmental psychology observed the development of the person with the environment. In the tradition of social ecological theory, proponents emphasize the mutual role of the person and the

---

7 Bookchin discussed the importance of social ecology as a critical approach to issues of the environment, which recognized that much of the ecological disasters in the natural environment were born out of social conflicts. He argues for the importance of the “social” factor by citing major ecological problems of the 20th Century, for example the 1989 Exxon Valdez oil spill disaster and the James Bay Hydroelectric Project, stating: “to make this point more concrete: economic, ethnic, cultural, and gender conflicts, among many others, lie at the core of the most serious ecological dislocations we face today—apart, to be sure, from those that are produced by natural catastrophes.” (Bookchin, 2009:285).
environment, as well and the mechanisms underlying person-environment interactions in human development (Berry, 1995; Grzywacz and Fuqua, 2000). In his later work, Brofenbrenner applies ecological systems theory to the process of human development within various contexts of interacting systems, for example, child development in which he identified the varying influencers on a child’s development through interactions with various structures of the environment, namely those external and nested structures (Brofenbrenner, 1986). Diagrammatical representations of nested structures illustrate concentric circles, where the individual is positioned at the centre with outward rings representing various systems of interacting influence, labelled micro-, meso-, exo- and macro-systems (Berry, 1995).

There are a number of key features of the ecology of health theory which guides understanding about how illness and disease may be treated, as well as how to promote good health. The following sections identify some of these features with an explanation of how this will serve within the framework of this research. Firstly, the ecological perspective adopts different dimensions of health and wellbeing, which in turn are linked to different conditions found in the socio-physical environments (Grzywacz and Fuqua, 2000). For this study, I explore these various dimensions of health and wellbeing, for example physical health, psychosocial health, social and civic wellbeing, through semi-structured interviews with key informants and later-life Filipinos. As such, this study aims to understand how these different dimensions of health among older immigrant populations are reciprocally related to the various environments within the community and broader society. Results from later-life Filipinos focus on the interpersonal and individual-level factors within the ecological model to explore experiences of health and aging, which in turn shape health care use. For these interviews I intentionally chose one-on-one interviews rather than focus groups in order to allow for participants to share their personal experiences without prompting and influence from other participants, as would be the
situation in a focus group setting which tends towards the dynamic and social transformative nature of group conversations (Barbour, 1999).

The second feature relates to the idea that the individual and community components within the social ecology are contingent upon various aspects of the person/population interaction as well as the multiple dimensions of the socio-physical environment (Grzywacz and Fuqua, 2000). For instance, key informants discuss the challenges that they face in their roles meeting the needs of immigrant populations, as well as those of individual clients. They often referred to specific populations within the broader community and would also speak to the how community and individual lives are affected by public and health policy, which impede or encourage good health and positive health behaviours.

A third principle is based on the assumption that health is viewed as an outcome of the person-environment fit (Grzywacz and Fuqua, 2000). Recognizing that person-environment interactions at different levels produce different experiences of health and wellbeing, in the case of older immigrants, I am interested in how experiences migration and aging, as well as other determinants of health, operate within different levels of the person-environment interactions (e.g., community, family) to influence health in a post-migration context.

Another important dimension of ecology theory is acknowledging that individual or environmental conditions may exert a disproportionate amount of influence on the health and wellbeing of certain individuals (Grzywacz and Fuqua, 2000). For the key informant phase of my research, I focus on the organization, community and public policy component of the socio-ecological model. Thus, social contexts and structural factors are equally important determinants of an individual’s health status, access and use of health care services, for example the role of race, where racialized immigrant populations will experience racial discrimination or systematic racism in ways that non-racialized immigrant populations will not. It is for this reason that I analyzed data from key informant interviews in order to understand the wider social and cultural
contexts of aging immigrants living in an urban area and to examine how these factors are interrelated with determinants of health.

Additionally, another dimension of the ecological perspective is in acknowledging that the physical and social environments are interdependent (Grzywacz and Fuqua, 2000), for instance, I also explore various place dimensions in the physical environment in connection to ideas of isolation, migration settlement and a sense of belonging, attachment to place and access to health care and social services. In the case-study of later-life Filipinos, I do not focus exclusively on the factors involved in individual health-seeking behaviours but examine the interaction of these factors with family, community, institutional and state level factors, as well as observe the ways that the physical environment may also interact to influence behaviour. Rather than looking at the later-life immigrant as a passive agent that is influenced solely by the social and physical environment I incorporate the important component of individual agency in health-related behaviours, decisions around migration and especially decisions around aging and retirement (Forde and Raine, 2008).

The final key feature of the socio-ecological model, relevant to this study, is the idea that in order to fully understand health and wellbeing requires a multidisciplinary approach (Grzywacz and Fuqua, 2000). To speak more broadly about my overall research aim I sought to bring together the often disparate literatures of aging and immigration through a population health approach. Having drawn from concepts, theories and methodologies from a variety of academic disciplines including geography, gerontology and social epidemiology I also incorporated various sub-disciplines within geography to help to inform my research at all stages of the study. I included literature from social, cultural, population, medical and health geographies which allowed me to gain a better insight and understanding of how social and cultural processes of aging and immigration influence the health status and health care use of later-life immigrant populations in Canada.
3.2.3 Andersen’s Behavioral Model of Health Services Utilization

Also embedded within the conceptual framework guiding this study is the Andersen’s Behavioral Model of Health Services Utilization (herein referred to as Andersen’s Behavioral Model), to examine issues of health care access among older immigrants. Andersen’s Behavioral Model was first proposed in the 1960s by Andersen but has since undergone a number of phases; the fourth phase which incorporates additional measures of effective and efficient access to evaluate perceived health status and consumer satisfaction (Andersen, 1995). It has since been a widely applied model in understanding health care use and access among various populations and across several units of analysis, for example the family unit, in which Andersen explains that “because the medical care an individual receives is most certainly a function of the demographic social and economic characteristics of the family as a unit” (Andersen, 1995; 1).

To demonstrate the pervasiveness of this theory, a recent systematic review conducted by Babitsch, Gohl and von Lengerke (2012) details the extent to which Andersen’s Behavioral Model is used to describe and explain the factors that influence health care use and access. Identifying articles in both English and German languages that specifically applied Andersen’s Behavioral Model from 1998 until March 2011 their initial search yielded 328 articles. The authors note the wide-ranging application of the theory to various aspects of health care encompassing a diverse array of services in the treatment of chronic disease and illnesses. The authors also describe the diversity of populations and the different variables measured such as ethnicity, gender and age, with varying results. The Andersen Behavioural Model informs the quantitative phase of the study in which I distribute a survey questionnaire to later-life Filipinos, a large component which queries their various measures of health as well as their use of formal and informal care services.

3.2.4 Dimensions of Place Experiences
Gesler and Kearns (2002) describe places as fluid and dynamic, where culture and identities are in flux and bound up in place. As such, place can manifest itself in the physical, social and cultural contexts that immigrants must navigate to negotiate and make important decisions about their health. Also important are the structural and relational forces that are inherent within the social and physical spaces. For example, place may involve a new immigrant’s experiences of physical isolation in tandem with the cultural and social isolation of arriving in a new country, which may influence their access to timely and culturally appropriate health care. The elderly are especially vulnerable to geographic isolation linked to social isolation, which may result in lower social support networks (Cloutier-Fisher & Kobayashi, 2009).

Place, comprised of the material and social conditions that affect immigrants’ health behaviours and health care use, can significantly affect their health and social outcomes. In Canada, immigration, as a force of unstable population growth when compared to birth and death rates, will also impact the social geography of Canadian cities. As such, place is especially important in understanding the health and well-being of aging immigrant populations, as this influences their spatial distribution, access to health and social services and housing experiences. Health outcomes have been linked to neighbourhood attributes for their promotion of health behaviours and accessibility to health and social services. Minority group enclaves or immigrant enclaves as they are referred to in the U.S. are neighbourhoods containing high proportions of immigrants and visible minorities and have been associated with lower levels of acculturation compared to those immigrants in neighbourhoods with lower proportions of immigrants. These places may be associated with varying health outcomes or health behaviours among immigrant populations (Osypuk, Diez Roux, Hadley and Kandula, 2009). Public health and social policies, as well as the various forms of health care management within Canada’s health care system and what these mean for later-life immigrants, may vary according to place.
Central to the temporal approach of aging and migration, within the broader ecological framework of this study in understanding health experiences, is the role of place. As an important theme in health geography, the concept of place is conceptualized as being either good or bad for health and that its importance lies in the attachments that people have with a particular place or places (Gatrell and Elliot, 2009). With respect to place and immigration some questions to consider within this study include: Does birthplace matter? Does the city or neighbourhood type of settlement matter? For instance, while the number of immigrants arriving as seniors has been relatively small over the years, over the last few decades a significant number of immigrants that had arrived at a younger age and are in the process of aging or are aged in (a post-migration) place (Turcotte and Schellenberg, 2007; Ng, Lai, Rudner and Orpana, 2012). Although the circumstances of immigration may differ, as with the immigrant class, the process of migration itself is considered a life transitional event that may have considerable influences over health in mid to later life. The time of first landing to Canada also matters, as the economic and social contexts of migration shape the relative “success” of immigrants having secured regular employment. Because the Filipino population in Ontario, in particular the City of Toronto and the surrounding region of the Greater Toronto Area, is highly diverse and given the limited scope of this study, the concept of place is closely aligned with the processes of immigration and aging (Dimensions 1, 2 and 3) and with health care use and place (Dimensions 4 and 5). Because the broad aims of the study are health status and health care use of later life Filipinos operationalizing place in this manner allows for me to examine and explore the ways in which place affects the health and aging trajectories of aging immigrants, in addition to examining the processes of migration.

3.3 Methods

A mixed methodology was employed to include, examine and integrate the multiple perspectives and experiences about the health and health care needs of aging immigrants in an
urban setting. A number of strategies were employed in the collection, analysis and interpretation of the data in this study. As described by Creswell, a sequential explanatory strategy is used, characterized by the collection and analysis of quantitative data (survey questionnaire) in the first phase followed by the collection and analysis of qualitative data (in-depth interviews) in a second phase (Creswell, 2009).

Both quantitative and qualitative methods were used in conjunction to answer the main research questions as noted in Chapter 1 and involved three stages of data collection that included: i) key informant interviews with community leaders; ii) a population-based survey of later-life Filipinos; iii) and in-depth interviews with later-life Filipinos in the GTA. From a key informant perspective I examine the broad issues that affect health and aging among older immigrant populations as well as some of the challenges key informants may face in serving older immigrants. Key informants from a diverse background shared their specific knowledge and working experience on the family, work, social and health circumstances of aging immigrant groups, with immigration as a central event or life stressor that impacts their current health and aging experiences. I further explore the impact of immigration on the health and aging of Filipino immigrants in later-life, exploring both quantitatively and qualitatively their health and aging experiences. A survey questionnaire distributed to older Filipinos in Toronto and the GTA was used to gather descriptive and statistical information. Follow-up interviews with a sub-sample of older Filipinos who completed the survey were conducted to explain the results of the quantitative data in more depth.

3.3.1 Study Site

The City of Toronto is one of three major destinations for newly arrived immigrants with the others being Montreal and Vancouver. In the 2006 Census, Toronto was the first choice landing city for over 40 percent of all recent immigrants (Chui, Tran and Maheux, 2007). It is a desirable location for immigrants due to its large urban population, high density of health care
and social services, higher levels of economic activity and development, its connections to large suburban centres and a relatively reliable public transportation system. These features make it an ideal setting to optimize recruitment and achieve an adequate sample size for this research. Although census data (2006) has shown that most immigrant seniors remain in one of Canada’s thirty-three census metropolitan areas (CMAs) as compared to Canadian-born residents, research has also suggested the outward migration of immigrants from CMAs and establishing communities in the surrounding areas (Ng, Lai, Rudner and Orpana, 2012). Based on this trend, recruitment for both key informant and Filipino participants was expanded to the surrounding Greater Toronto Area (GTA).

3.3.2 Recruitment and Data Collection

The sampling and recruitment strategies used for each phase of the research are summarized in the table below (See interview guides and detailed questionnaires for the all participants in Appendices 1-3):

**Table 2-1: Summary of Recruitment, Data Collection and Analysis for all Three Phases of Field Research**

<table>
<thead>
<tr>
<th>Phase 1: Key Informant Interview</th>
<th>Phase 2: Survey Distribution</th>
<th>Phase 3: Follow-up Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Sample:</strong></td>
<td>Key informants working with immigrant/newcomer communities and/or diverse older adult groups living within Toronto and the GTA.</td>
<td>Older (55+ years) Filipinos living in Toronto and the GTA who were born in the Philippines.</td>
</tr>
<tr>
<td><strong>Sampling Strategies:</strong></td>
<td>Recruited through purposive sampling, and through snowball sampling.</td>
<td>On-going recruitment through convenience and targeted sampling.</td>
</tr>
<tr>
<td><strong>Recruitment Settings:</strong></td>
<td>Key informants from settlement agencies, community health centres,</td>
<td>Settlement agencies, community health centres, home care and</td>
</tr>
</tbody>
</table>
Data Collection: In-depth semi-structured interviews in person.

Final Sample: 22

Analysis: Conventional and summative content analysis.

3.3.3 Key Informants

Key informants are often used in qualitative research because they are believed to be an expert in a topic being explored. Originating in cultural anthropology, the key informant technique involves the strategic selection of individuals in consideration of their position within the structure of society and the specific interest of the researcher (Tremblay, 1957; Marshall, 1996). They are often chosen because of their position in society and because of their personal and professional skills in their interactions with individuals in that community. The main advantages being that they have a distinct role in the community and have specific knowledge of the information that is desired by the researcher (Marshall, 1996). Hughes and Preski (1997) make a case for key informants as a useful resource to measure contextual variables at the macro- and meso-levels, which are difficult to obtain through direct measuring techniques. Key informants then can act as proxy measures to account for organizational processes and to provide expert knowledge about the features and characteristics of an organization (Marshall, 1996). The purpose of using key informant interviews in this study was to provide context for the social,

<table>
<thead>
<tr>
<th>Data Collection</th>
<th>Final Sample</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-depth semi-structured interviews in person.</td>
<td>22</td>
<td>Conventional and summative content analysis.</td>
</tr>
<tr>
<td>Mail or hand-delivered survey with a pre-paid return envelope.</td>
<td>138</td>
<td>Descriptive statistics and regression analysis.</td>
</tr>
<tr>
<td>In-depth semi-structured interviews in person and over telephone.</td>
<td>15</td>
<td>Conventional and summative content analysis.</td>
</tr>
</tbody>
</table>
political and economic environments of immigrant populations in an urban and multicultural setting.

With respect to key informants interviews I set out two broad research objectives. The first objective was to explore the expert views and opinions of key informants and stakeholder groups with specific knowledge of the diverse and often marginalized aging immigrant groups in Toronto and surrounding GTA. The first phase of data collection, semi-structured interviews with key informants took place in order to identify the key issues for immigrants with respect to their health and aging in a post-migration context. Also important to this phase of the research was determining what resources were required to aid in the planning and provision of services to support all later-life adults including immigrants. I also wanted to consider those factors that also may enable and constrain settlement and health care workers when working with aging immigrant populations. By addressing these two objectives, this research can contribute to a broader understanding of the challenges to and the perceptions of aging and health experiences immigrants in Canada. As well, key informants provided useful information on how to reach the older Filipino immigrant population and offered qualitative accounts on the key issues of concern and additional issues that had not been identified at the proposal stage. Letters of information and consent forms were provided prior to the interview taking place (See Appendix 4 and 7).

Key informant interviews (N=22) were conducted from May 2011 to September 2011. They were chosen based on their affiliations with organizations and groups in the Toronto and the surrounding GTA that serve later-life immigrant and newcomer populations. All key informants operated with the government definition of senior as 65 years and older but also served individuals younger than 65. As well, key informants that have specific work experience with Filipino communities were identified (n=2), although the majority of key informants (n=20) served multicultural communities. The final sample of key informants included individuals from all levels of management and front-line workers (e.g. social workers, nurses, etc.), board
members, executive directors, advocacy and social justice workers, managers and program
directors. Key informants who were interviewed provided services either directly through
programs or indirectly by way of planning, initiating and integrating health and social care
programs specific to the community and local neighbourhoods. They came from a variety of
settings including settlement agencies, community health centres, home care and supportive
housing services, community development agencies, seniors day centres, social civic clubs and
social recreation programs, mental health agencies, geriatric and long-term care facilities, local
public health units and regional health care services corporations.

3.3.4 Later-Life Filipinos

The population of Canada has changed considerably due to the influx of many
immigrants. In the 2006 Canadian Census, Canada experienced the highest proportion of foreign-
born individuals over the last 75 years, with one in five being foreign-born of the total population
(Chui, Tran and Maheux, 2007). This trend has persisted, with the data from the 2011 National
Household Survey (NHS) reporting that 20.6 percent of the total population represented
individuals born outside of Canada compared to 19.8 percent reported from the 2006 Census
(Statistics Canada, 2012). Among immigrants arriving in Canada between 2006 and 2011, the
leading country of birth was the Philippines, which represented 13.1 percent of all immigrant
newcomers (Chui, Tran and Maheux, 2007).

Various patterns of immigration in Canada have also impacted the economic
development and workforce composition of a number of municipalities in Canada. Immigration
patterns of Filipinos into Canada, as with a number of ethnic groups in Canada, are unique. Prior
to the 1970s they represented a very small proportion of immigrants entering Canada, mostly
recruited to fulfill labour shortages in health care although they were also recruited as teachers
and garment workers. Under the Marcos martial law declared in 1972, an important component of
the Philippines’ economic policy was the export of labour namely as overseas contract workers
with North America as a popular destination. Even before the enshrinement of this policy as early as 1967, Philippine immigration mostly reflected Canada’s labour demands such as the recruitment of nurses and medical technicians and domestic workers through the Live-In Caregiver Program (Darden and Kamel, 2004/5). In the 1980s and 1990s, many Filipino women arrived in Canada as domestic workers under the Foreign Domestic Movement (FDM) Program, now currently the Live-In Caregiver (LIC) Program (Velasco, 2002) Chen (1998) reasons that the changing socio-demographics of the Filipino population in Canada is the result of Canada’s immigration policies which evolved to the shifting labour and economic needs of the country and provisions for family reunification. As a result of the immigration policy of 1976, during the late 1970s well into the late 1980s, the country received large numbers of older Filipinos arriving to join their adult children who had already settled and established their lives in Canada (Chen, 1998).

Since the 1981 Census, the Philippines has been among the top five source countries for immigrants to Canada, occupying the third spot in the 2001 and 2006 Census. According to both the 2001 and 2006 Canadian Censuses, Filipinos represented the third largest non-European ethnocultural immigrant group arriving in Canada (Statistics Canada, 2007). The Filipino population in Canada is mostly concentrated in the provinces of Ontario and British Columbia. In 2001, it was estimated that just over 50 percent of the Filipino population resided in Ontario (Lindsay, 2001), with a majority of them choosing to live in Toronto. In 2010 and 2011, a large proportion of Canada’ permanent residents were from the Philippines, which topped the list of all source countries for permanent residency. Temporary foreign workers, in comparison, were sixth among all source countries for the same years (Citizenship and Immigration Canada, 2012).

Notwithstanding the lack of health research on Filipinos in Canada much has been written about the social, economic, labour and spatial contexts of Filipino migration to Canada. The migration trends of skilled (nurses) and unskilled (caregivers) migrant workers dominate
much of the literature on Filipino immigrants. Filipino migration in Canada has often been characterized as part of the historical labour demands of Canada and has persisted as a case study for understanding class and the creation of transnational spaces (Kelly, 2012). Dubbed “national heroes” by the Philippine state, Filipino migrants have come to represent the epitome of flexible labour migration with foreign remittances supporting the Philippines economy – a product of globalization and transnationalism.

For this study, later-life Filipinos aged 55 years of age and older were recruited from Toronto and the GTA. A wide variety of methods were used to recruit older Filipinos for participation in a survey questionnaire. From July 2011 to January 2012, early recruitment of survey respondents involved sending e-mails and a follow-up phone call to various Filipino leaders and community groups in Toronto and the GTA. These organizations and contacts were identified through internet searches using the Google search engine and “211Toronto” (http://www.211toronto.ca/index.jsp). Among the groups identified were Philippine heritage groups (for example the Magkaisa Centre, Philippine Heritage Band), alumni groups such as the Central Philippine University Alumni Association, religious groups (Filipino Baptist, Filipino Adventists, etc.), professional groups (teachers, accountants, etc.), fraternal organizations (Knights of the Rizal, Knights of Columbus) and Filipino community centres and clubs in different cities across Toronto and the GTA (Markham, Mississauga, Brampton, Toronto). Recruitment through these channels proved to be the least effective in accessing the community for recruiting later-life Filipinos. A number of these organizations were closed or were operating with limited hours due to the summer months and few contacts returned calls or responded to my repeated calls for opportunities to recruit survey respondents.

A majority of participants were recruited through Filipino seniors groups, church groups, approached in food court settings in local malls, and through organized house parties. I also relied heavily on snowball sampling techniques, which proved the most successful in distributing the
most surveys. Letters of information and consent form with instructions were sent with all individual surveys (See Appendix 4 and 8) along with a self-addressed return envelope with paid postage to ensure its return. In total 138 survey participants returned completed surveys. In the survey, the last page asked respondents if they would be interested in participating in interview at a later date and were asked to leave contact information if they were willing to participate. Letters of information and consent forms were provided prior to the interview taking place (See Appendix 6 and 9). Interviews with later-life Filipinos were conducted from January 2012 to September 2012. Fifteen later-life Filipinos in total were interviewed after completing the survey, consisting of four males and eleven females. While every effort was made to conduct interviews in person, three were conducted over the telephone which was the preferred choice for participants.

3.3.5 In-depth Semi-Structured Interviews

The semi-structure interview was the interview method chosen for both key informant interviews and interviews with later-life Filipinos. Semi-structured interviews, compared to the unstructured interview where observational data is also collected, is the main data source for qualitative analysis (DiCicco-Bloom and Crabtree, 2006). Although the advantages of group interviews allow for a great range of personal experiences the disadvantage is that the very public nature of the group interview process may not allow an individual to share the more deeply personal components of their experiences (DiCicco-Bloom and Crabtree, 2006). There were two types of semi-structured interviews that took place for this research. Prior to the interviews taking place, respondents were contacted in advance to determine an agreed upon time and location. As with the general format of semi-structured interviews, questions were organized around a pre-determined set of open-ended questions. A majority of key informant interviews were conducted well before interviews with later-life Filipinos.
One interview type was the key informant semi-structured interview. The purpose of using key informant interviews for my overall study was to provide a backdrop or some context into the social, political and economic environments of immigrant populations in an urban and multicultural setting. Twenty-one interviews were conducted with key informants, 20 of which were one-one-one interviews with key informant and one interview that consisted involved two key informants. Length of interviews with key informants ranged from 30 minutes to 97 minutes. Gathering qualitative accounts from key informants were valuable because it allowed me to identify the key issues of concern among a collective group of strategic and specialized individuals. And while the key informant interviews and interviews with Filipino seniors were first conceived to be analyzed separately, there were some themes of overlap and key informants discussions also opened up new points of inquiry for my study of the health and aging experiences of Filipinos. For key informant interviews, there were three main categories of topics of interest were: i) General description of organization/agency and professional experience of key informant; ii) Description of later-life immigrants in the community; iii) Description of health and aging among later-life immigrants.

The second type of interview was the case-study semi-structured interview which focused specifically on later-life Filipinos. Fifteen interviews were conducted with later-life Filipinos after responding to the final question in the survey inquiring if they were willing to participate in a follow-up interview. The purpose of conducting semi-structured interviews in addition to collecting survey data was to explore in more detail the health and aging experiences of later-life Filipinos. Since there has not yet, to my knowledge, been any research that explicitly focuses on the health and aging of older Filipino Canadians, the questions were exploratory and necessarily broad. I was interested also in how older Filipinos themselves interpreted their own experiences of health and aging in Canada. These interviews were performed one-on-one with later-life Filipinos in order to delve deeper into their personal experiences and issues, which may not have
been achieved in a focus-group or small group setting. There were four broad categories of topics set out for interviews with later-life Filipinos: i) Migration experiences; ii) Health and health services use; iii) Social support and active engagement; iv) Aging experiences.

3.3.6 Survey Questionnaire

The survey questionnaire was distributed to a broad sample of Filipinos aged 55 years and older (N=138) that were residing in the City of Toronto and the GTA which consists of the Regions of Halton, Peel, York and Durham. The survey was self-administered and consisted of survey-style, forced response questions querying Filipinos about their physical and mental health status, as well as their perceptions and experiences with health care services in Canada and in the Philippines. Because one of the broad aims of this research was to understand the health status of later-life Filipinos, it was important to gain as much health information as possible, for which survey research is the most practical. The advantage of survey research is to be able to generalize findings from a sample to a broader population (Creswell, 2009).

The questionnaire consisted of items which were adapted from the 2009 Canadian Community Health Survey including validated survey scales such as the Duke Activity Status Index, Geriatric Depression Scale, Multidimensional Scale of Perceived Social Support, and Unmitigated Communion (Interpersonal relations) Scale. Investigator-generated questions were also devised for use in the survey. Content for the survey questionnaire was sub-divided into various sections and are described below.

3.3.6.1 Canadian Community Health Survey [Sections A, B, D, E, G, H, I, J, K. L and M]

The Canadian Community Health Survey (CCHS) is a cross-sectional survey that was developed as part of a federal initiative to provide health information at regional and provincial levels, targeting individuals 12 years or older (Beland, 2002). Individuals who are members of the Canadian Armed Forces, living on Indian reserves or Crown lands, are institutional residents and who live in remote areas are excluded from the CCHS. The first cycle, consisting of two surveys
conducted over a two year period, began in 2000. Content of the CCHS consists of three components: i) core content, ii) theme content and, ii) optional content (Statistics Canada, 2009). The CCHS includes a wide variety of health topics assessing subjective health status, health behaviours, health care use and other dimensions of health, such as mental health or drug use (Beland, 2002).

Both common health and optional content topics were included in the survey that was used to assess Filipinos health status and health care use. Core content from the 2009 CCHS used in the questionnaire included chronic conditions, general health status, health care utilization, access to health care services, contact with health professionals and socio-demographic characteristics. Optional content used in the survey included health care system satisfaction, home care services, patient satisfaction with health care services, patient satisfaction with community-based care and insurance coverage.

3.3.6.2 Use of Mobility Assistive Devices [Section C]

In a longitudinal study that assessed the relationship between everyday activities and successful aging, Menec (2003) included a four-item checklist measure of physical difficulties, which was interviewer observed. The use of or expressed need for mobility assistive devices such as a wheelchair, cane, walker or crutches could indicate mobility difficulties for older populations within their community and may potentially influence their access to health care. To assess mobility difficulties, this section consists of two investigator-generated questions that ask respondents to indicate from a list the types of mobility assistive devices (e.g., cane, wheelchair, walker, crutches or other) that are used outside the home and inside the home.

3.3.6.3 Duke Activity Status Index [Section D]

The Duke Activity Status Index (DASI) is a 12 item self-administered questionnaire that assesses functional capacity and is a validated measure that has been correlated with peak oxygen uptake (Htlaky et al., 1998). Functional capacity is an indirect proxy measure of exercise capacity
and also provides some insight about a subject’s quality life. Items in the DASI consist of questions that determine a subject’s ability to perform a broad range of common daily activities. Subjects are asked to respond “yes” or “no” to a number of questions, such as “Can you take care of yourself, that is, eating, dressing, bathing or using the toilet?” and “Can you run a short distance?” The scoring of each item in the DASI is based on a total continuous score of each of the weighted items and can range from 0 to 58.2 METs. Items were weighted based on the known metabolic cost of each activity and rated in MET units (Htlaky et al., 1998). Moderate intensity activities, such as walking and some household activities have been estimated at 3.0 to 6.0 METs (Gunn et al., 2002). The DASI is an appropriate tool for measuring functional capacity of a large population of various health states because it poses no physical risk to the subject. The DASI has been used to measure the functional capacity for a number of clinical sub-populations, most notably among cardiac patients. DASI scores have been associated with other health measures, for example, in a study by Wessel et al. (2004) female cardiac patients who reported lower DASI scores (≤ 25 METs) were significantly more likely to have coronary artery disease risk factors.

3.3.6.4 Health Behaviours [Section E]

In this section both CCHS adapted and investigator-generated questions (6 questions) queries later-life Filipinos’ health behaviours related to cigarette smoking, alcohol consumption and physical activity. With regards to cigarette smoking and alcohol consumption, participants are also asked to assess whether or not their smoking and alcohol drinking behaviours have changed since immigrating to Canada.

3.3.6.5 Geriatric Depression Scale [Section N]

The geriatric depression scale (GDS) short-form is a 15 item scale that asks subjects to respond “yes” or “no” to a series of questions about how they felt over the past week. It was originally developed as a depression screening tool for use of all older adults (Yesavage et al., 1983). However, research on depression among ethnocultural groups has been undertaken to
reveal that standard depression scales may not detect depression equally among all seniors (Mui, Kang and Chen, 2003). Mui (1996) adapted the Yesavage short-form GDS (Y-GDS) to Chinese elderly immigrants (M-GDS). Subsequent testing of the M-GDS with other Asian subgroups found it to be a reliable tool for assessing depression among later-life Asians. The M-GDS was incorporated into the survey questionnaire with only 5 items differing from the Y-GDS. One point is assigned for each “yes” response and a total score is calculated. Scores between 0 and 5 are considered in the normal range. A score above 5 may indicate depression.

3.3.6.6 Multidimensional Scale of Perceived Social Support [Section O]

The Multidimensional Scale of Perceived Social Support (MSPSS) is a short 12 item self-administered questionnaire that subjectively measures a subject’s social support (Zimet, Dahlem, Simet and Farley, 1988). The 12 items can be subdivided into one of three factor groups that have been identified as a major source of social support: a) family, b) friends, and c) significant other. The MSPSS presents such statements as “I get the emotional help and support I need from my family” and “I can talk about my problems with my friends”. Subjects are asked to rate each of the 12 statements on a 7-point scale, with 1 being “very strongly disagree” and 7 being “very strongly agree”. A summation score can be calculated or sub-group factor scores can be calculated to assess perceived social support, such that the higher the score the greater the social support. The MSPSS has been validated for construct validity, internal consistency and test-retest reliability among younger adults and adolescents but has seen limited use in older populations. Stanley et al. (1998) assessed the validity of the MSPSS within an older population (aged 55 to 82 years) and found it to be a good measure of perceived social support.

3.3.6.7 Unmitigated Communion Scale [Section P]

The unmitigated communion scale (UCS) assesses unmitigated communion (UC), which describes an outward focus and concern on others at the exclusion of oneself (Fritz and Helgeson, 1998) and has been tested for high internal consistency and test-retest reliability. The UCS is a 9-
item scale where subjects are asked to rate each statement on their interpersonal relations on a 5 point Likert scale with 1 being “strongly disagree” and 5 being “strongly agree”. Scoring of each item is based on the 5 point scale with items #2 and #5 reverse scored. A summary score is calculated and a mean score is computed. High means scores on the UCS indicate a high level of UC. High levels of UC indicate that an individual puts the needs of others ahead of themselves often at the neglect of their own needs. Women tend to score higher on UC measures than men (Fritz and Helgeson, 1998) and according to census data, women make up a large proportion of the overall Filipino population. In 2001, they represented 65 percent of Filipinos who were over the age of 65 (Lindsay, 2001).

3.3.6.8 Immigration to Canada [Section Q]

This list of investigator-generated questions (8 items) queries about respondents’ past and current immigration experiences. Among the questions which ask later-life Filipinos’ immigrant status, these include if they are a regular visitor to the Philippines and whether they own property in the Philippines.

3.3.6.9 Health Care Use in the Philippines [Section R]

A list of investigator-generated questions (7 items) asks respondents about their use of and perceptions of health care services outside of Canada (e.g., health care in the Philippines). These questions explore transnational health care use on the part of Filipino immigrants and examines whether Filipinos actively seek health care services outside of Canada, particularly in the Philippines.

3.3.6.10 Sociodemographics [Section S]

A combination of investigator-generated and adapted CCHS items assessing basic sociodemographic data was collected for descriptive and inferential analysis and included such
variables as: sex, age, income, education, work status, marital status, immigration and citizenship status.

3.4 Analysis

In total 37 semi-structured interviews and 138 surveys were collected for analysis. There were three distinct phases of data collection with respect to the target sample and the methodology employed as described in the above section. Throughout the stages of data collection and analyses, overlapping of the phases occurred frequently resulting in a highly interconnected and conjoined data set. As a result, a number of common themes tended to emerge from the distinct and discrete data sets.

3.4.1 Semi-structured Interview

Twenty-one interviews with 22 key informants (one interview was conducted as a group interview with two key informants) and 15 interviews with later-life Filipinos were audio-recorded and individual field notes were collected. All key informant interviews were conducted in person at their place of work. For older Filipinos, a majority of interviews were conducted in person (n=12) unless the participant expressed preference for a telephone interview (n=3) for reasons of convenience, limited time or no agreeable meeting location could be decided upon. Shortly after an interview was audio-recorded it was transcribed verbatim except to preserve anonymity particularly for key informants who occupied higher-management positions. Names, organizations or programs titles were changed to maintain anonymity.

For both key informant and later-life Filipino interviews, themes and topics were coded and analyzed based on content analysis methodology. Content analysis techniques were developed from the early methods of quantifying qualitative data and have evolved to become a flexible method for analyzing data (Cavanagh, 1997; Hsieh and Shannon, 2005). The process of content analysis allows for a highly flexible, systematic method which specifies a set of coding procedures in order to distill meaning from textual data in a reduced form (Weber, 1990;
The forms of content analysis used in this study are conventional content analysis and summative content analysis methods.

Conventional content analysis has been described as an appropriate method when literature or theory is limited on the topic or phenomenon of interest (Hsieh and Shannon, 2005). The immersive technique of conventional content analysis allows for categories to emerge from the data itself allowing for new insights about a particular phenomenon (Kondracki, Wellman and Admunson, 2002). This method is also referred to inductive category development (Mayring, 2000) and was especially useful in the exploratory study on the health and aging experiences of later-life Filipinos immigrants.

The other form of content analysis used in this study was summative content analysis, which is described as the identification and quantifying of particular words or textual content (Hsieh and Shannon, 2005). This particular method is more concerned with the usage of certain words or terms known as manifest content analysis (Kondracki, Wellman and Admunson, 2002), which is chiefly concerned with frequencies and word counts. Summative content analysis moves beyond the word or text frequency counts to include more latent content analysis methods, where the focus is in uncovering the meaning behind the words or content but to also discover other alternative words with similar meanings or alternative interpretations of the same word (Hsieh and Shannon, 2005).

All interview transcripts underwent a number of iterative analyses including a precursory and careful reading of the transcripts to identify broad categorical themes, sub-themes and subject topics based on the semi-structured interview topic and question script. This initial reading and coding of the transcripts was done using a simple word processing software program (Microsoft Ltd, 2010). The transcription of data and analyses occurred concurrently as data were collected. Results from these initial readings of the interviews were recorded and noted in a spreadsheet program (Microsoft Ltd., 2010), coding tables, as well as the creation of detailed face-sheets for
all interview respondents, including demographic and organization information. Initial analysis or open coding of the data began with a careful line-by-line reading of each transcript to identify themes and sub-themes inductively as they emerged. Coding was also performed deductively based on themes identified a priori from the precursor readings of the transcripts, from the survey and interview design stages and from the results from the survey data. This first analytical and coding step allowed for greater immersion with and interrogation of the data.

Following open coding of the transcripts further analysis was conducted which involved a more focused coding, compressing related and repeating themes into more comprehensive themes or clusters of related topics subsumed under a broader theme. Analyses of the data involved cross-comparing key informants and later-life Filipinos interview data to identify analogous and dissimilar themes, sub-themes and topics regarding aging and health experiences in the context of immigration. The numbers of key informants and later-life Filipinos interviewed were finalized once saturation of themes was attained. The comparative and interactive nature of the analytical process adopted in this research and quantifying of categories and themes highlights one of the key features of the content analysis.

3.4.2 Survey Data Analysis

One hundred and thirty-eight survey questionnaires were collected. Surveys were entered into SPSS where all statistical analyses were performed (IBM Corporation, 2013). The dataset was cleaned and screened performing descriptive statistics to identify data errors in order to prepare data for analysis. A summary of the tabulated survey results are presented and organized based on gender (male or female) or age cohort (pre-senior, young-old old, old-old, very-old). A descriptive examination of the variables was performed using independent samples t-testing, one-way Analysis of Variance (ANOVA) and chi-square testing where appropriate. Analysis of the survey results were based on the following three research questions: 1) What is the general health of later-life Filipino immigrants? 2) Do later-life Filipinos experience any barriers in accessing
and utilizing health care? 3) How do health care status and health care use vary among later-life Filipinos, based on the five dimensions of place experiences?

Survey respondents were asked about their socio-demographic background information (age, gender, marital status, work status, education, household income and living status), immigration background (year of arrival in Canada, immigrant class category, immigrant class category) and the following dichotomous categories were created for descriptive analysis: gender (male versus female), marital status (married versus unmarried/divorced/separated/widowed), work status (retired/not working versus part- and full-time work) education (high school graduate and less versus some college to post-graduate), household income (less than $60K versus $60K or more) living status (alone versus living with spouse/extended family) and immigrant class category (family class versus skilled worker/education).

Other independent variables included insurance coverage (government, employer-sponsored or private) for prescription medication, dental and eye care. As previously discussed, independent variables on dimensions of place experiences were created to capture migration, aging-in-place experiences and multiple health care systems utilization. The first group of dimensions of place experiences (Dimensions One, Two and Three) characterized migration and aging-in-place experiences. Dimension One included those individuals who arrived in Canada before 1980, Dimension Two were those individuals who arrived in Canada after 1980 but did not arrive in later-life (55 years and older), and Dimension Three included later-life Filipinos who arrived in Canada in later-life. The second group of dimensions of place experiences (Dimensions Four and Five) represented health care systems use and place. Dimension Four included individuals who use health care in Canada only and Dimension Five is comprised of those who use health care in Canada as well as health care in the Philippines. In order to assess the role of place, migration experience and health care use of later-life Filipino
immigrants, chi-square tests were performed to assess group differences across both sets of dimensions of place experiences to sociodemographic characteristics of the sample.

For measures of health status, dependent variables for chi-square testing included dichotomous variables for self-reported measures of health status: self-rated health (SRH) (excellent/very good/good versus fair/poor) and self-rated mental health (SRMH) (excellent/very good/good versus fair/poor). Descriptive statistics were also generated for related questions including comparisons of their health from one year before the time they completed the survey and various self-reported Likert-scale type measures of stress levels. Independent samples t-tests or one-way ANOVA were used to assess the following dependent variables: number of chronic conditions and the Duke Activity Status Index (DASI). Dichotomous variables were also created for use of mobility devices both inside of outside of the home (Y/N) as well as reports on the types of devices used. Other leisure-time physical activity behaviours captured in the survey included the frequency, duration and self-reported current physical activity status (physically active/no physical activity/ no, but I plan to be). Other health behaviours for analyses included dietary behaviours, smoking status (current smoker/former smoker/never smoked) and alcohol consumption. To assess change in lifestyle since migrating, respondents were also asked to retrospectively self-report on how these behaviours have changed (or not) from when they first immigrated to Canada.

In examining health care services access and use, respondents were asked to self-report on a variety of measures. Dependent variables included: availability of health services (excellent/good/fair/poor), quality of care (excellent/good/fair/poor), having a regular doctor (yes/no) and contact with other health professionals (list of 14 health professionals. Other dependent variables of health services access and use that were examined included home care services, health care services at a hospital and community-based care. Levels of satisfaction, ratings on the quality of care, as well as identification of difficulties from a predetermined list of
barriers were also examined for other health care services as self-reported by respondents. Examination of health service barriers were also examined from a series of questions that asked respondents to self-report on any difficulties they experienced for the following services: non-emergency services, receiving non-emergency tests (MRIs, CAT Scans or angiographies), health information or advice, routine or on-going care, and immediate health care.

Independent sample t-tests or one-way ANOVAs were performed on mental and psychosocial health measures including: geriatric depression scale short form (GDS-SF), multidimensional scale of perceived social support (MSPSS) and unmitigated communion (UC) using demographic characteristics variables and dimensions of place experiences. Preliminary descriptive analyses with the quantitative data also aided in identifying participants for a follow-up in-depth interview.

3.5 Limitations, Challenges and Ethical Issues

The main reason for conducting this study is to provide some insights into the health and wellbeing of aging Filipino immigrants permanently living in Toronto and the GTA. Although Filipinos are a relatively new ethnocultural group in terms of Canada’s immigrant history as compared to other ethnocultural groups, such as Japanese and Chinese immigrants, they make up a significant proportion of newer immigrants in recent years. As such, relatively little is known about their health outcomes and health care use. A unique aspect of this study was the focus on the place experience and transnational patterns of later-life Filipinos, particularly the potential use of other health care systems outside of Canada, all of which has the potential to influence policy and the provision of health and social care for ethnoculturally specific groups. All measures to ensure confidentiality and ease of comfort (e.g., desire to not be audio-recorded), as well as maintaining good researcher-participant relations for key informant and later-life Filipino interviews, was critical in attaining the desired sample sizes. This meant maintaining contact with a number of organizations who work with Filipino and later-life populations in the GTA.
The multiple-perspective nature of my mixed method study emphasized the nuanced power relations and dynamics of the researcher-participant relationship but also in my changing positionality with respect to my participants. For instance, in my interviews with key informants, who were sought specifically for their expert knowledge there was a clear power hierarchy between myself and my respondents as I ensured that I was respectful of the limited time that key informants offered me, often during their own work hours. One important limitation of key informants is in ensuring that the researcher has found the most appropriate and knowledgeable participant. To ensure this, I included multiple perspectives of key informants in varying positions and from different organizations in order to avoid one-sided or biased results. In conducting these “business” interviews with professionals there was the complex interplay of identities and power relations between myself, as a doctoral student researcher and the professional key informant. Mullings (1999) explains that there are distinct power relations at play among more elite key informants (policy-makers, managers, executive members) and among the non-elite (front-line workers and practitioners). As well, there were a number of potential informants who because of scheduling difficulties or their interpretations of the relevancy of their knowledge towards my own research goals that resulted in their exclusion in my study. This was in stark contrast to my positionality with regards to later life Filipinos.

Because I shared in the same cultural and ethnic background as the later-life Filipinos I interviewed, I was aware that this afforded me insider status. Having insider status according to Ganga and Scott (2006) grants researchers a “degree of social proximity” which increases an awareness of the social divisions that may structure the interactions of the researcher-participant relationship. However, there were instances throughout participant recruitment in which I was viewed as an outsider as I was not able to engage in conversations in Tagalog or some other Filipino language and it was clear that my status as a Canadian-born Anglophone conducting unilingual research positioned me as an outsider or “other” to some. In their attempts to make
sense of me as a Canadian-born Filipino I was often asked whether I had visited the Philippines (which I have not), what part of the Philippines were my parents from or reasons why my parents had not decided teach me the language. Additionally, because I was much younger than all of my Filipino participants interviews were thus, unavoidably conducted within an intergenerational context, where they had ideas and opinions about how younger Canadian-born Filipinos perceive older Filipino immigrants and the differences of intergenerational relationships in Canada versus the Philippines.

In conducting the primary research – in-depth interviews – I was made acutely aware of my approaches to limit potential researcher bias or biased responses from respondents. I was cognizant of the ways in which having a shared cultural and ethnic background resulted in being viewed as an outsider within and highlighted the reflexive nature of the researcher-participant dynamic. As argued by England (1994), reflexivity is integral to conducting fieldwork not only in achieving research that is ethically sound but that also enhances the relationship between theory and inquiry.

3.5.1 Use of Retrospective Data, Study Design and Data Collection

Qualitative and quantitative data were cross-sectional in scope and interviews in particular the Filipino immigrant interviews and some items in the survey questionnaire relied partly on retrospective data. Although, longitudinal studies are advantageous for tracking cohorts of individuals over time for greatest accuracy of life course data, they are timely and require many resources to execute (Blane, 1996). Given the scope and parameters of this research I used a cross-sectional design study with the use of retrospective data. The challenge with obtaining retrospective data from older adults is to minimize recall bias as much as possible. Developments in qualitative research have considered the difficulties of collecting retrospective data among subjects of older age in order to determine what items could reliably be recalled with the greatest accuracy (Berney and Blane, 2003). An example of this type of potential bias within this study is
dietary behaviours in the survey questionnaire. In an attempt to avoid potential recall bias with inaccuracies of food reporting, rather than discussing specific food groups or food types, survey questions refer to changes in traditional diet, (i.e., Filipino food) or changes in diet regarding consumption of dietary fat intake or fruit and vegetable. Similarly, recall bias may arise in the misreporting of behaviours that may hold certain significance. For instance, participants may be subject to recall bias about certain items or events that carry some moral significance such as the underreporting of smoking behaviour because of the changing status of smoking behaviour or related smoking bans (Berney and Blane, 2003). As well, the survey questionnaire specifically asked about certain health behaviours (e.g. smoking behaviours, dietary changes, physical activity level) and respondents may inadvertently be influenced to report what they consider “good behaviours” so as to appear in a favourable standing. This type of bias referred to as social desirability bias may be difficult to reduce particularly in health and behavioural studies. Unless a validated measure is used in the survey data, investigator-generated questions may be subject to potential bias.

Additionally, many of the participants in the qualitative interview were asked to recall some early experiences of their migration which may have spanned a few decades. For interview results, biographical data for later-life Filipinos, particularly date of first immigration may be subject to some inaccuracies, but similar data were also collected in the survey and can be cross-referenced and checked for accuracy from the survey. However, survey data for the quantitative analysis cannot be verified for inaccuracies. While it is impossible to eliminate bias fully, some measures were taken to ensure that the data gathered were as accurate as could be known. In the case of interviews with later-life Filipino immigrants, I was interested in triggering what I considered to be major life events, such as motivations for migration, family decisions such as marriage or jobs seeking when immigrants first arrived in Canada. Other aspects of their experiences were sought in connection to these life events. The health and aging experiences may
be subject to recall bias since a majority of senior Filipinos have lived in Canada over 15 years and some have lived in Canada longer than they have lived in the Philippines. The process and temporal nature of the immigration process and its effects on health and aging experiences among aging Filipinos may need to be understood in the wider social contexts of health, public and immigrant policy in Canada. Because this could pose a potential bias in how aging immigrants may interpret and discuss their health and aging experiences, interviewing techniques were developed to minimize this bias.

In one instance, aiding in recall for later-life Filipino interviews involved connecting certain mundane activities with temporal landmarks. For example, I was interested in knowing what difficulties and challenges were experienced by Filipino immigrants in Canada and prefaced, this inquiry with “when you first arrived in Canada” or “after you emigrated from the Philippines”. The use of these temporal landmarks or time cues have often been used in life history calendars and proven to be effecting in minimizing bias by aiding recall (Nelson, 2010). Similar research has supported the use of a “temporal reference system” where the mundane activities of daily life are connected to more easily recalled events such as marriage, birth and death (Berney and Blane, 2003). During the interview process I relied heavily on the audio-recorder to capture the interview in its entirety, which allowed me to make notes about significant life events that participants recalled and then linked them to follow-up questions in the interviewer guide. A new interview guide was used for each interview, where notes were made directly on the guide and in particular time cues relevant to the participant’s experiences were noted.

With regards to the survey data, I am unable to test the healthy immigrant effect because I was only able to collect data for Filipinos immigrants and thus, no comparisons can be made to native-born population survey data or cross-cultural comparisons with other immigrant populations. As well, because of the general lack of research on the health of Filipino immigrant
populations in Canada, this research is exploratory in nature. In particular, the health and aging experiences of Filipino Canadians in connection to their migration experiences is a relatively uncharted area in immigrant health research. Because of small sample sizes the views of key informants and later-life Filipinos are not generalizeable to broader immigrant populations or Filipino populations throughout Canada. The inability to validate or confirm findings with similar studies has been a strong criticism of case-study results using interview data (Coughlin, 1990).

3.5.2 Ethical Considerations

Ethics approval was granted and obtained through the General Research Ethics Board of Queen’s University (See Appendix 13). The decision to choose a specific immigrant ethnocultural group (Filipino immigrants) rather than comparing multiple ethnoculturally or linguistically diverse groups is in part due to the number of challenges that this type of research poses. The growing diversity among older immigrant ethnic groups in Canada and elsewhere around the world, present significant challenges to health and social systems for multicultural communities but at the same time there is limited research on certain minority groups, including Filipinos. The exclusion of elder minorities result from a number of challenges including lack of language expertise, financial costs of the research or simply the challenge of including multiple language groups is too great (Matsuoka, 1993; Adamson and Donovan, 2002; Lie, 2006) . The researcher is in a privileged position, particularly when dealing with culturally and emotionally vulnerable ethnic groups with regard to aging and health. Some authors have noted that qualitative research engaging in ethnic minorities or in portraying the voices of ethnicities as not belonging to the dominant cultural group results in the “othering” of these particular groups (Adamson and Donovan, 2002). Similarly, Ong’s work on cultural citizenship and the process of “subject-ification” amid power relations between the nation-state and the “subject” consisting of minorities of colour and from different classes suggest the power dynamics between researcher and subject (Ong, 1996). Yet, qualitative research is one of the most flexible and suitable methods
for accessing these new frontiers of ethnicity, health and aging while also having the potential to empower individuals (Matsuoka, 1993). Ethical considerations for including ethnically diverse populations include providing equal access to participate in qualitative research, the policies of funding governmental and non-governmental bodies and recognition for the under-researched older minority populations (Fryer et al, 2012). As Fryer et al. argue: “(t)he lack of linguistically diverse participant samples acutely limits the relevancy and application of new health knowledge to contemporary multicultural communities.” (2012, p.23) Moreover, they further state that unless researchers are aware of and more willing to deal with these challenges then the routine exclusion of elder people in in-depth qualitative research will continue.

For this particular study, it should be noted that despite my in-depth study of the Filipino elderly in Canada that there still remains an important segment of the later-life Filipino population that was excluded from recruitment and analyses. Because I am unable to speak any languages of the Philippines nor was I able to provide the survey in a Filipino language translation, such as Tagalog, I was limited in my reach of certain sub-populations of Filipino immigrants. However, many of the Filipinos recruited were able to speak English fluently and there were only a small number of instances during recruitment where communication posed a challenge and resulted in my not being able to include them in my research study. While the option to have a family member interpret for a willing participant was a consideration, the intention of my study was to explore the personal experiences of Filipino immigrants without the influence of other family members’ conversations. As confirmed by a number of key informants in my study, when describing the language barriers between service-provider and clients, they noted that family members often selectively translate or communicate ideas or questions as they have interpreted which may be different than what may have originally been intended or how the senior may have interpreted the question.
Another issue with regards to population recruitment and sampling is that I also excluded individuals who were currently experiencing cognitive issues such as dementia or Alzheimer’s disease. Given that the targeted population was for later-life Filipino immigrants, across all older age cohorts, there is the likelihood that some individuals may be experiencing significant cognitive issues and are therefore excluded from the sample. Their exclusion is mostly because this study relies on the recall of retrospective data about their migration and early health experiences in order to reconstruct a life course timeline of the health and aging trajectories for Filipino immigrants.

3.6 Chapter Summary

This chapter introduced the conceptual framework guiding the research design and methods for this study. This multidisciplinary study uses mixed methods and multiple perspectives to examine how migration and resettlement experiences of older immigrants give rise to varied experiences of health and aging. Also described in this chapter are the multiple concepts, theories and methodologies used in the overall study, which draw on those used in social gerontology, including ethnogerontology, social epidemiology, as well as a number of sub-disciplines within geography. Life course theory, social ecological theory, and Andersen’s Behavioral Model of Health Services Utilization are the key theories that structure the conceptual framework for examining health, aging and health care use among older immigrants. Embedded within this framework are the five Dimensions of Place Experiences, which incorporate migration, aging and health care use to describe later-life Filipinos. Literature from social, cultural, population, medical and health geographies assisted in building the dimensions of place experiences to analyze how social and cultural processes of aging and immigration influence the health status and health care use of later-life immigrant populations in Canada.

The advantages of using a cross-sectional design and in using both in-depth interviews and surveys to examine the health and aging experiences of older immigrants in Toronto and the
GTA were further explained. The three phases of recruitment, data collection and analysis were also described including a description of the study site and the subjects targeted for study. Rationale was provided for why key informants were used for this study, as well the significance for exploring the health and aging experiences of older Filipino immigrants. A detailed description of the analyses for all three data sets collected was discussed including the various software programs and methods used. A final discussion in this chapter includes the challenges, limitations and ethical considerations for this research project. In particular, this chapter explained some of the issues that arose from recruitment and the collection of data, mostly for the under-researched aging Filipino population and the necessary exclusion of specific individuals from this study.
Chapter 4

Understanding Health and Aging of Immigrants in the City: A Key Informant’s Perspective

4.1 Introduction

Much has been written on the impact and consequences of immigration on the economic, political, social and cultural systems in Canada. Researchers studying the effects of immigration often consider the push and pull factors of international migration, often relating demographic shifts to the economy and labour demands of receiving and sending countries. Despite increasing rates of immigration to Canada, it has been observed that most recently immigrants have experienced declines in employment opportunities and earning potentials (Reitz, 2007). Research has also been keen to examine immigrants’ health outcomes and experiences with health care, especially in comparison to non-immigrant populations (Chen, Wilkins, Ng, 1996; Deri, 2004; Gushulak, 2007; Gushalak, Pottie, Roberts, Torres and DesMeules, 2011). However, far less researched are those circumstances of immigrants as influenced by the direct and indirect impacts of the economy, more notably the effects of a declining economy, on their health and aging experiences.

With the lengthy history of immigration in Canada it is surprising that it is relatively unknown what the implications of a declining economy have on aging immigrant populations. While changing immigration policies of Canada in the 1980s and 1990s shifted from an emphasis on family reunification towards one emphasizing economic credentials, this has meant a decrease in the proportion of elderly immigrants entering the country. However, the senior immigrant population is still an important population to consider from both a public and health policy standpoint. Recent census data demonstrate that there are significant numbers of older immigrants in Canada and in particular, a sizeable proportion of immigrants reside in either Vancouver or
Toronto (Ng, Lai, Rudner and Orpana, 2012). With respect to Toronto, the setting for this study, it was reported in 2001 that 62% of seniors living in Toronto were immigrants. Even though changes to immigrant policies have discouraged family reunification that brings senior immigrants into the country to join their own adult children, a large segment of immigrants, many of which are part of the baby boomer cohort, are now growing older.

The implications of a declining economy may include health and social policy changes, which for immigrants may pose significant challenges in their ability to access social services and the health care they may require. Canada’s universal health care system by its very nature as a publicly funded system is highly vulnerable to the shifts and transitions of dynamic global, national and local economies. The nature of these changes often includes reductions in health and social program funding and health care restructuring. Steele et al. (2002) examined the impact of health and social policy changes in Ontario on the health of newcomer immigrants and refugees and found that such changes had negative repercussions on their overall health. Newcomer immigrants may be especially vulnerable to these changes which include reductions in services or cancellation of essential programs to help them to integrate within a new country as well as affecting their knowledge of what resources are available to help them to navigate social and health care systems. Among the problems faced by newcomer immigrants are precarious job status, lower income and lack of health and social services.

Additionally, the scaling back of social and health services may contribute to disruptions in social support systems which may threaten the health outcomes of immigrant populations, most especially newcomer immigrants and refugees. It has been argued that social support factors prominently in improving newcomers’ overall health and wellbeing as well as positive settlement experiences. Social support has been the focus in a number of studies on immigrants (Simich et al. 2005; Stewart et al. 2008) and refugee populations (Simich, Beiser and Mawani, 2003). Among those immigrants who arrive in Canada already as seniors or in later-life they may be
especially vulnerable as they tend to have lower incomes than their Canadian-born counterparts, will have less time to accumulate wealth for retirement and are likely to be ineligible to receive a pension or their pensions from their birth country are not transferable (Grant and Townsend in Durst and MacLean, 2010).

In Canada, immigration is seen as an important strategy to bolster a flagging economy, to deal with the pressures of an aging population and to supplement Canada’s already fragile health care and social welfare systems. With an increasingly aging population globally, with medical advances resulting in longer lives and increasing life expectancies, devising strategies to maintain optimum quality of life and positive health outcomes for all seniors are important research and policy considerations. Reductions in funding as well as hospital and health care restructuring have severe consequences for newcomer immigrant populations in Canada and when compounded with issues around aging, immigrant seniors are especially at risk. For long-term immigrants who may be more established and settled in Canada often their diverse cultural and ethnic backgrounds, which influence much of their social, political and economic experiences are overlooked when considering aging and health. Coincidentally, the processes of aging among immigrants, recent and long-term, are confined to more normative and singular experiences where the measure of the aging experience is linked to chronological age. Also important is acknowledging the diversity of seniors not only in terms of age but to also acknowledge the rich diversity of the older population in terms of chronic health status, culture, race, ethnicity and language.

This chapter will focus on discussions from the semi-structured interviews with key informants (n=22), throughout Toronto and the GTA, on their experiences working with older immigrant populations. As well, it addresses the following research goal from a key informant perspective:
• Describe how the complex processes and relationships of aging, migration and re-settlement influence the health experiences and social lives of later-life immigrants (Research Goal 1)

4.2 Key Informants

A total of twenty-two key informants were interviewed based on their affiliations with organizations, agencies and groups in Toronto and the surrounding GTA. For details on each key informant please see Table 4-1 (See Appendix 10). Twenty-one of the key informants were female, with one male (#20) participating in interviews. Their working experiences with aging and immigrant communities varied widely and are summarized in Table 4-2 below.

Among the sample of key informants interviewed most were service providers, who were involved in providing and delivering services directly to seniors and/or immigrant groups through programs and services they developed, oversaw, and monitored (n=18). The services provided by key informants included programs through settlement agencies (n=2), a geriatric centre (n=1), supportive housing/home support agencies (n=3), an adult day centre (n=1), social and recreational centres (n=4), social services agencies (n=2), a community health centre (n=1), a social civic club (n=1), a community support agency (n=1), a mental health and community centre (n=1) and a multi-service support agency (n=1).

Key informants who did not provide services directly to seniors consisted of policy-makers, advocates and system planners, who were involved in the planning, initiating and integrating of health and social care programs specific to neighbourhood and community needs (n=4). Among those key informants were a health care policy-maker, a health care and senior coalition advocate, a public health planner and a newcomer settlement project coordinator. Among those, only one key informant (#17) identified being involved in overlapping aging and immigrant communities. Two key informants (#11, #21) specified working with immigrant groups broadly and having some involvement with aging immigrant groups through various projects or other partnership agencies. The fourth key informant (#05) expressed that most of her
experience was specific to older populations and that her involvement in immigrant senior groups was through coalition partners or community projects.

Most key informants (n=19) worked in agencies and organizations that were open to a multiethnic population within designated service catchment areas and sometimes, even beyond those areas. Among the key informants who worked in agencies that served broad multiethnic, older populations, two were focused on a specific language and ethno-cultural group such as Russian-speaking Jewish seniors (#04) and Spanish-speaking seniors (#09). The remaining three key informants worked in agencies or organizations whose overall service focus was on a specific ethno-cultural group, which included a Filipino seniors group (#03), Chinese-speaking multi-service agency (#14) and a South Asian community and social services agency (#19). Their experiences working with either immigrant populations and/or senior populations varied.

Table 4-2: Key Informant Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total (N=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (Female)</td>
<td>21 (95%)</td>
</tr>
<tr>
<td>Experience with older populations (Years)</td>
<td>14.7</td>
</tr>
<tr>
<td>Range (Years)</td>
<td>2 – 30</td>
</tr>
<tr>
<td>Experience with immigrant populations (Years)</td>
<td>14.4</td>
</tr>
<tr>
<td>Range (Years)</td>
<td>2 – 30</td>
</tr>
</tbody>
</table>

Reflecting a population health approach in my research, results from interviews revealed that key informants also approached the older immigrant population from a holistic or social determinants of health framework. I identified seven health and/or aging-related domains from the interviews, which characterized the type of service that key informants were engaged in. The domains were based on their descriptions of what their involvement was with the aging immigrant community as well as their descriptions of what services or activities they were involved in at their agency/organization. The specific domains were identified and were perceived to have an impact on the health and health care access of aging immigrant groups in
Toronto and the GTA. The services or programs offered to immigrant seniors were within one or more domains which included:

a. Social and Recreation
b. Health and Wellness
c. Health Care
d. Supportive Housing/Home Supports
e. Outreach and Community Supports
f. Mental Health and Counseling Services
g. Newcomer Settlement

Participating key informants had various roles and occupied all levels of management. Many had full oversight over the programs offered within their respective agencies or organizations. Figure 4-1 demonstrates the breadth of services and involvement in health related domains among the key informants for this study. It was not uncommon that key informants discussed offering a wide-range of services and programs to support immigrant seniors and many of the programs offered occupied multiple domains.
Figure 4-1: Health and Age-Related Domains Identified through Key Informant Interviews

The wide-ranging and varied work experiences, as well as personal backgrounds of key informants provided rich narratives where they reflected on the challenges as well as the joys of working with vibrant and diverse aging immigrants in Toronto and the GTA. The collective sample was also an ethnically diverse group of individuals who spoke passionately and frankly about their experiences and perceptions about the struggles and successes of aging immigrant communities and their families, often making reference to very specific examples including some rare and extreme cases in some very common place situations.

4.3 Describing Immigrant Seniors in Toronto and the GTA: A Key Informant’s Perspective

Key informants within the study sample consisted mostly of service providers but was representative of individuals in different occupational positions at various levels of management. The diversity of key informants enabled me to maximize the level of expertise and working experiences with an equally diverse group of aging immigrants and their families. In particular, key informants were asked to describe what role they felt aging immigrants occupied within the
broader Toronto/GTA communities or to simply describe older immigrants in relation to their work experiences. In posing these questions to key informants I wanted to understand how they perceived older immigrant populations and how these perceptions guided their planning and provision of services to older immigrant populations. In the case of those key informants who did not provide services directly, how they viewed aging immigrant populations in relation to the broader population may be reflective of how they strategize and plan health and social care at the policy level. Among the responses given by key informants there were two broad categories of descriptions that were identified. The first being the roles that immigrant seniors had within the family or household unit and the second category were the various roles within the community. While nineteen key informants specifically described the various roles that immigrant seniors had either in the family or in the community, the remaining three approached the question differently. Table 4-3 summarizes the results of key informant interviews in which they were asked to describe the role(s) they view older immigrants as having with the community and broader society.

**Table 4-3: Describing the role of immigrant seniors in Toronto and the GTA**

<table>
<thead>
<tr>
<th>Roles within the Family: (n=13)</th>
<th>Specific Role:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social relations within the family unit</td>
<td>Caring for children and home (n=7)</td>
</tr>
<tr>
<td></td>
<td>Sponsorship (n=6)</td>
</tr>
<tr>
<td></td>
<td>Intergenerational relationships (n=7)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Roles in the Community: (n=14)</th>
<th>Specific Role:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement in social and public life</td>
<td>Volunteer (n=11)</td>
</tr>
<tr>
<td></td>
<td>Peer support (n=6)</td>
</tr>
<tr>
<td></td>
<td>Intergenerational support (n=3)</td>
</tr>
<tr>
<td></td>
<td>Building community (n=11)</td>
</tr>
<tr>
<td></td>
<td>Maintaining cultural values (n=6)</td>
</tr>
</tbody>
</table>

No role specified (n=3)
Their perspectives resulted in a contrasting view about immigrant seniors from a majority of the key informants. Detail results of the interviews are described below.

### 4.3.1 Describing the Role of Immigrant Seniors in the Family Unit

Being an integral part of the family or household was referred to quite frequently as key informants discussed the role of older immigrants (n=13). The home space for immigrant seniors was seen as a site of important social relations as well as a site of familial conflict. As family relations and informal domestic activities factored prominently in the lives of older immigrants according to key informants, there were three main roles identified by key informants that relate to the family or household unit. The first role that immigrant seniors are often seen occupying is the role of caregiver in the caring for grandchildren and keeping up household chores, and this was especially true for newer immigrant families (n=7). The second was the role of sponsorship or the related responsibilities and conflicts that arise out of the sponsorship relationship (n=6). Finally, the intergenerational relationships within families were widely recognized among key informants as having a positive influence on the seniors and their grandchildren (n=7).

Key informants who discussed immigrant seniors as caregivers for their grandchildren often made reference to the newcomer immigrant seniors who arrive in Canada through family class sponsorship. In their experiences working with immigrant seniors, key informants discussed the difficulties that these seniors experienced having to adjust to a new country as well as changing dynamics that occur within the family structure. More often these two experiences of adjustment and shifting family dynamics often result in situations that are stressful and create difficult circumstances for immigrant seniors to properly adapt to and integrate with the broader community:

06: It’s children who are currently here, living here and maybe have been here for not even a long time, but a short time and are now wanting to bring the rest of their family over here, and it becomes really difficult because they are not the wellest sort of individuals and also, their family members are extremely stressed too. Because they’re trying to make a new life for themselves, they’re trying to, you know, burn the candle almost at both ends, you know, looking after elderly
relatives as well as looking after their own children, so I’d say they’re probably, you know how they describe that whole sandwich generation.

11: Seniors who arrive here because they are being brought to take care of grandchildren so the parents can work. And then as the grandchildren grow older the grandparents are no longer needed and then therefore the grandparent is held in fairly low regard because they are no longer economically contributing to the family, quote-unquote. I think that it’s a real collision course of how traditional structures and places of origin are eroding because immigrant families find themselves in incredibly stressed economic situations where the social structures of this society are such that people are working two jobs around the clock are still poor, you know have all the traditional structures whereas a community people being able to come together um is no longer viable because people are just working their heads off.

It was not uncommon to have immigrant families described as being highly stressed and overworked resulting in strained family relationships. Some key informants discussed the situation of role-reversal that occurs within the family structure, which is described as the role as a caregiver once vital to the family is no longer a necessary once the grandchildren have grown. Newer immigrant seniors are often highly dependent on their adult children and therefore become viewed as a burden:

14: So you know before they might be, you know in Chinese culture senior would be more, have more respect and authority in the family but now when they move to a new place and they don’t have the language, transportation, finance, so now there role would be more like filial. I don’t know the word but more like a subordinate—a subordinate role. Before they might you know, they would go to the market they would go to the bank by themselves but now they have to depend very much on their you know, their grandchildren, their adult children, so it seems the role has changed. So the role adjustment for the seniors is quite, you know caused a lot of tense relationship with the family.

Key informants also discussed that for those immigrants who arrived in Canada at mid-age or younger who might have never had the opportunities to learn English, such as some Chinese or Italian immigrants, they become more dependent on their adult children as they age. Immigrant families as a whole then experience shifting family structures or conflicting family dynamics, especially families that live in a multi-generational household. Or some families were described as “transnational families” where one adult child in Canada has brought their aging parent to be cared for in Canada but other family members may be in other parts of the world.
These examples signify changes in perceptions about the role of the aging individual and their particular roles or a lack of role within the family.

Another related issue brought up by key informants with regards to roles within the family are the situations that arise involving sponsorship (n=6). Most key informants often did not comment on the nature of sponsorship or the motivations behind family reunification but recognized the benefits for families as well as for seniors. One key informant referred to sponsorship as an exchange of “mutual aid” and further explains that:

02: …(O)ften people are coming with a family reunification kind of thing. They are often but not always living with families which is a different dynamic. We do a lot of caregiver support. It’s never easy to live as a multi-generational family when someone has become ill. It’s not always easy anyway but it’s often harder as someone often requires more care. On the other hand, often times, the person themselves, the older adult is very helpful within a family they end up doing things like childcare or cooking or whatever.

However, more frequently key informants discussed the difficulties that surface as immigrant families struggle economically and cultural expectations that family members have with respect to the roles of senior members of the family begin to shift:

04: If it’s at the beginning of their immigration it’s like honeymoon period where everyone is happy but a few months later they start arguing and there are a lot of tensions in the family. And there is no real way out because they can’t afford to move out. So, in addition to that they have no income, so they fully depend on their children. And in the Russian culture its usually parents who help the children, even if children are older, even if they’re adult children, still their parents are helping their children…parents are completely dependent on their children which makes it very, very difficult for them to comprehend.

While the focus of the interviews was on the roles of immigrant seniors, the experiences as described by key informants were not limited to just seniors themselves. Many of the key informants’ accounts were greatly informed by the immigrant seniors’ families as well. In some cases, the family was viewed as a significant barrier to immigrant seniors’ participation and integration with the broader community mainly because they are often reliant on other family members in numerous ways, such as financial dependence or in the management of their own health and health care needs.
4.3.2 Describing the Role of Immigrant Seniors in the Community

In discussing the various roles of older immigrants, most key informants spoke in terms of their contribution to the broader society, whether or not it was valued or recognized (n=14). More specifically, key informants commented that aging immigrants had important roles within the local community, both within the broader Toronto/GTA community and within their own ethnocultural communities. The various roles in the community that key informants identified were: volunteering, offering peer support to other immigrants or to fellow seniors, providing multigenerational support by acting as mentors for younger generations building community and finally maintaining cultural values through sharing and building awareness. Many key informants emphasized that an important aim in seniors programming and/or immigrant settlement programs was to enhance older immigrants’ engagement in a variety of roles with their peers and the local community. To key informants, especially those in social and recreational programming for immigrant seniors, encouraging seniors to connect with other seniors in sharing knowledge about one’s own cultural background was seen as very important and relevant in a multicultural city like Toronto and in the surrounding areas of the GTA. They also identified older immigrants, those having lived in Canada longer, as being an invaluable source and guide for newer immigrants, who may be less familiar with services and programs available in Canada.

Volunteering (n=11) was identified by key informants as an important role that immigrant seniors have within the community, which allows many of them to utilize many of the skills and knowledge they have accrued over their lifetime. Volunteering, as the voluntary spending of one’s own time in the participation and involvement with organizations and groups often in unpaid activities for the benefit of others, is seen as one component of integration in later life as older adults retire and move away from work-oriented lives towards more community-oriented ones (Ravanera and Fernando, 2001). Key informants shared the important ways that their immigrant seniors have played a role within their own organizations as well as within the local community:
13: They have a lot to share from both their cultural knowledge as well as you know their experience here in Canada so their integrated life stories are very interesting. You'll see that people are helping each other out. So if somebody’s got a little bit more time here and knows a little more they’re going to help to navigate a system for someone else.

14: Another role that the seniors play, I think is ‘the volunteer’. Yeah, because for some of the seniors they do have their own knowledge, expertise and also they have the time to participate in many community organizations. So they can contribute back to the community – the seniors also playing a volunteer role; a very important role in the community.

19: Another role that the seniors play, I think is ‘the volunteer’. Yeah, because for some of the seniors they do have their own knowledge, expertise and also they have the time to participate in many community organizations. So they can contribute back to the community – the seniors also playing a volunteer role; a very important role in the community.

A major goal of many of the programs that key informants discussed during interviews was to improve social relations and social networks for immigrant seniors within the larger community. Often issues around health and poor access to health and social services are the result of social and physical isolation. A number of key informants also noted that even if the services are readily available for seniors, it does not necessarily mean that they will access them. Even when speaking generally about older immigrants, some key informants discussed the value of social and recreational programs which help to expand older immigrants’ social networks outside of the family or domestic sphere. For example, one key informant spoke about the differences she sees among older Filipinos within the community:

01: I find that there (are) older Filipinos that get involved in social kind of organizations so that’s good, social religious organizations. But there are also the other Filipinos who are very much home-bodies, because they are expected to take care of the homes, they’re kind of left to do the house chores or take care of the grandchildren. And because of maybe, language barrier or not used the kind of life that we have are pretty much isolated and so there are those who are I think severely isolated.

Often agencies and other service organizations implement a number of outreach strategies to connect with those seniors who are socially, culturally and physically isolated. However, it remains a real challenge for key informants to reach immigrant seniors that are highly dependent on family members whether it is for language translation or for transportation.

13: And then you have people who come here because their family has sponsored them to come and care for grandchildren and they, you know, in some cases once their utility in that role has
ended the kids are grown older they are sometimes neglected and the Toronto community housing buildings where we work, you'll find people who are very isolated because their families have less and less contact with them and they’re more and more on their own.

Another important aspect of community involvement also discussed by key informants was the role of peer support (n=6) among older immigrants as well as in supporting the newer immigrants arriving in Canada. Peer support was identified as an important way to promote integration of seniors overall. Many key informants discussed the valuable role that long-term immigrant seniors have in supporting newer immigrant seniors to the country. Socializing, participating in leisure activities and helping out fellow seniors are activities that encourage seniors to become more socially engaged with other members in their local communities and would help to ease social isolation and loneliness.

08: I see people for example, they immigrated before because they are more knowledgeable about the mainstream country, they may advise others, “Okay, you can do this”, “Here is this program…”, “There is this resource from the government…” So they are teachers for the new immigrants, right? And I think that it gets duplicated as time goes on.

Even among key informants who mostly service the most disadvantaged and struggling immigrant seniors, see the potential in them to share their knowledge and experiences with others like them. For one key informant, she acknowledged the diversity of settlement experiences, and how this diversity, in terms of those who more integrated with and engaged in the broader community, can be used to build peer support groups and networks to help other immigrant seniors as well as struggling immigrant families in the community:

16: You know I’m thinking that my perspective is probably a little skewed too, just because we really only see newcomers who are of the older population who are having a really bad time, you know for one reason or another. So you know I just want to put that out there that it might not be for all newcomer seniors having this experience, so in terms of seniors who are, you know, respected for their wisdom and for the information that they have and for their way of thinking, that’s what we want to use in order to do some peer support.

Another aspect of senior peer support is the fostering of intergenerational relationships outside of the family and within the community. While most key informants spoke about the role of caring for children and grandchildren within the family and other domestic spaces, some key
informants also referred to the role that immigrant seniors could play in mentoring youth within the community (n=3).

06: I know there’s lots and lots of senior programs where there’s opportunities to share with younger people within a community, I know that we have these sort of pen pal type programs as well, where kids in primary school are matched with a senior and you know the senior sort of, is able to talk to them about their life experiences and open the eyes of, you know, someone who wouldn’t have had that opportunity if they didn’t have a grandparent or that sort of thing.

18: Yeah I think the role should be more, and I guess I’m coming from it again because my culture informs everything from a Caribbean perspective, I think that older immigrants need to be utilized when we’re looking at even dealing with younger generations, right? So there needs to be more opportunities for that kind of knowledge transfer I guess to happen where you have like, I don’t know, like a grandparent program for example, where a 13 year-old, who doesn’t have a grandparent here, could actually have one.

One key informant who develops social programming for seniors in a settlement agency discussed a number of social programs for immigrants within the community. One such program was setting up a community garden program that utilized the knowledge and skills of many senior immigrants in the area but also involved other members of the community. She spoke proudly about one program in particular that she was able to recently secure funding for, which engaged multiple generations of immigrants in the community, supporting both older immigrants and teenage mothers:

07: Give them access to schools to speak to these young people who have no room for these older people. Like as a class where they will be tested on because they will not listen for fun. I started this program called _program name withheld_...The idea is to get teen moms, young mothers (that) find themselves with a baby when they’re like 16 or 17. They don’t even know what to do with their baby. They don’t want it even when it’s born. They don’t know how to babysit; they don’t know how to bathe; they don’t know how to come back to life. They are depressed. They should get back to school. They should move on and they should learn from their own mistake, but who would tell them? So I think, let me get this idea, we get seniors to volunteer. Strong. Active. Because all the seniors are also are, some of them are good professionals. Come and talk to them and pass knowledge.

The importance of fostering integration and community engagement among immigrant seniors was emphasized equally by key informants working with multi-ethnic immigrant populations or if they were focused on one particular ethnic group. Community building (n=11) was widely seen as an important and also mutually beneficial role for older immigrants to be
involved in, particularly in the role as leaders and mentors within their own communities. Because many of the agencies and organizations that key informants worked in provided services for multiethnic and multicultural communities, they spoke about the sharing of cultural values (n=6) as a role that immigrant seniors held with respect to their community peers. In terms of social and recreation programming, the sharing of one’s culture enhanced the community of seniors being served overall, as well as allowing a senior to be able to safely observe their own cultural or religious practices.

For one key informant who worked exclusively with South Asian populations she discussed how immigrant seniors’ participation in the South Asian community help to foster a safe environment and allowed them to improve their connections to the local community as well as the broader Toronto/GTA community:

19: Yes, I mean the South Asian seniors have taken on the lead role of definitely in places of worship and community centers. They, in a lot of instances, they become volunteers because that’s a place that feels safe. Okay so, in the safe environment, which is their places of worship and community centers, they take a lead role in organizing the prayer sessions and that’s where they’re taking a lead role. I also see a lead role when it comes to helping the families and all that.

Another key informant within the Filipino community noted the multiple roles that Filipino seniors have in building up the community by actively including other cultural groups and leaders in the community to be involved in their social and civic activities. She also discussed the importance of Filipino seniors in home spaces as caregivers as well as their role in teaching cultural values to Filipino youth:

03: Well, we do help in the social and the economic life of the community by participating in public affairs. We do help in the development of the community. And as to family life, we act as babysitters or housekeepers for our children, while they go to work and in so doing we also somehow have the grandchildren imbibe our values as a Filipino. Filipinos’ values we impart to them, because most of our mothers are educated and they help even in the preparation of their lessons. So we are—we do believe that we are not just immigrants living on the state.

Results from key informant interviews demonstrate that immigrant seniors represent a potentially valuable population with regards to community. Highly regarded for their knowledge and skills, seniors were seen by key informants as leaders, mentors and peers in the community.
Another important community role that key informants identified was the sharing of cultural values (n=6). As one key informant noted, many immigrant seniors she works with only need to be given the space, support and opportunities to engage with the broader community. An important aspect of this is the importance of not only allowing seniors to share their culture with others but to do so in a safe space that allows them to celebrate and participate their own cultural practices:

22: We hope that their role is mentoring their own community and building bridges to other communities, and really sort of, identifying themselves, and identifying their culture, and identifying their group, their peers, (and) their family. And we try and assist with that. We have culturally specific programming within our sites and within our elderly person centre downstairs. And we really try and help people not lose their individuality and not lose who they are, but be able to share who they are.

Social and recreation programs were designed to integrate seniors with the whole of society and immigrant seniors in particular were viewed as having an important role in contributing to the multicultural landscape of the city.

4.3.3 Describing the Role of Immigrant Seniors: Contrasting Key Informant Views

When key informants were asked to describe aging immigrants generally or what role they see older immigrants having most spoke about immigrant seniors in positive terms, discussing the various roles they currently serve in society as well as the potential roles they may have in connection to the larger Toronto and GTA community, to their own ethno-cultural community and within their own families in Canada and abroad (n=19). Key informants acknowledged the transnational practices of many immigrant families and the roles that distance and time had in shaping the geographies of many immigrant families. They also highlighted the relevance of their societal contributions earlier in their life and on a more global scale:

06: I think seniors always have a role in every sort of society. I think it’s important from a family perspective in terms of people that are here already...you know, I think family in general is important so from that perspective for sure, I think, they’re a fountain of information that’s for sure. I think that, you know they add a lot to community in general.
Although key informants spoke positively about immigrant seniors within the community and broader society, a few addressed the anti-immigrant viewpoint that believes that older immigrants are not entitled to social supports because they are not perceived to have participated and contributed to the social life and social structures of society. One key informant reasoned that better care and support should be extended to immigrant seniors because of their past contributions, as well as the potential contributions they may bring to the local community:

18: Their quality of life totally improves when you’re able to support them, and all people deserve to be supported. They deserve it! They’ve worked! They’ve contributed – if not to this society directly but to the world in general. So much knowledge they have that they could still offer to us. So when we medicate them and leave them in a corner, then really were not doing anything. We’re actually taking away from society, is what we’re doing.

She noted further that often when discussing the challenges of population aging and immigration in Canada ageist attitudes often arise which tends to undervalue immigrant seniors’ local and global contributions, as well as disregard the knowledge and experience they have accumulated across the life course.

In contrast to most of the key informants view of immigrant seniors, those who specified a role for older immigrants, whether it be within the community or in the family, there were some who did not discuss their position in society in terms of roles but rather they discussed generally what being an aging immigrant means in Toronto/GTA (n=3). Most notably, all three key informants shared the same degree of involvement with older immigrants, which was either at the policy or advocacy level. Unlike service providers or front-line managers they were not directly involved in the lives of seniors and their families and their responses were more aligned with approaches in population health or public health policy. They often discussed immigrant seniors from health equity or social justice lenses. For instance one key informant, a public health policy-maker, when asked about what role they thought aging immigrants have in society said she felt that answering that question would not provide a fair representation of aging immigrants in the city. She wanted to avoid casting them into a role because societal perceptions already views the
aged and aging negatively and emphasized that structurally, society had already deemed seniors as not valuable because being out of the workforce meant that they were not contributing to the economy. From an equity and access perspective, she reasoned that it was not an issue of having or not having a role that was important but that having access to health and social services should be available regardless of roles or contributions, whether society deems them to be deserving or not:

11: I don’t view them positively or negatively because that’s a way of stereotyping groups of people. There’s nothing inherently positive or negative about any group of people, right? So I don’t frame it that way. About whether there’s something inherently positive about immigrant seniors – No! They’re a part of society just like any other group. So I think for me that’s the wrong question. It’s not about how—what their role or you know, what should be their role, or what’s their positive or negative role –that’s not the question. They’re human beings. They’re worthy of good care and respect and dignity like everyone else in society. That’s the way I regard them. They are members of society and they’re human beings. And they should be upheld and protected and cared for the same as everyone else but they’re not, I would think.

In speaking from an advocacy background, one key informant felt that older immigrant groups needed to advocate for themselves and within their own ethno-cultural group in order to improve their access to health and social services. Rather than identifying a role, she spoke more broadly about their social positioning within the community, in which she envisions immigrant seniors to be more proactive and self-aware in overall community building efforts, rather than speaking about specific roles and connections to their ethno-cultural community.

05: Older immigrant groups... they need to do (things) for themselves and they need to find out, to be educated in what services are available and be able to pass that to their cultural group and it...has to be done. You know, you walk down the street and ask the first ten people you meet, “What’s the CCAC?” [Laughs] They won’t know! And that’s a common service. That’s not something unusual and people don’t know!

Additionally, she made specific reference to certain ethnocultural groups she considered more successful and organized communities in Toronto, such as the Jewish and Chinese populations, describing seniors in those respective communities as being better off than other groups because of the strength within their own communities.
Similarly, another key informant, a health care policy-maker chose to speak more broadly about the vulnerabilities of the aging immigrant population rather discuss their specific roles. Also approaching the question from an equity and equality perspective, she discussed that improving access to health care for vulnerable populations such as aging immigrants means acknowledging the differences across the older immigrant populations and within each group:

17: When we talk about aging we tend to talk about it as one but when you’re doing care and delivery a 95 year old is a distinctly different aging person then a 65 year old. And it’s how do you truncate that and the look at the immigration and the culture (factors)… The other thing about when we talk about aging and immigration is, you know as I say I still think it goes back to plotting it against the immigration wave. Because if you look at who the immigrants were that came in the various waves. So you know for the European, depending on what was happening and they came from poverty or class – that wave of immigrants is very different.

Speaking from a systems approach in reference to the delivery of health care and a health equity lens with regards to access, her view on aging immigrant populations was framed in terms of the intersecting factors of influence of the aging experience, arguing that the term “senior” is misleading as it identifies one kind of aging experience. As an example of this, she emphasized the local and regional needs of the population as well as looking at the evolution of immigration in Canada and broader immigration trends to discuss aging and immigration as intersecting experiences that affect the lives of aging immigrants as well as the aging population overall.

Because all three key informants operated from a wide population health lens either in health advocacy or policy, they naturally interpreted and approached the question differently than the service-providers. They were more focused on explaining the diverse complexities of immigrant seniors from a health equity, access or social justice framework, often viewing immigrant seniors as cohorts of individuals. Service-providers in contrast identified the varied and diverse circumstances of aging immigrants with respect to roles they held throughout the community and within the family as they tended to be more directly involved with immigrant seniors as individuals and in many cases involved with their families as well.
4.4 Challenges of Working with the Older Immigrant Populations

In discussing how key informants viewed immigrant seniors within the overall population, they also revealed the many specific challenges they faced in their work with this vulnerable population. The results presented below are in response to the question: “What are some of the problems or issues you or your agency faces with regards to aging immigrant communities?” In exploring the expert views and opinions of key informants and stakeholder groups who have specific knowledge of the diverse and often marginalized aging immigrant groups in Toronto and surrounding GTA, I wanted to know what challenges or issues they experienced when dealing with aging immigrants within the broader community and within their organization. Among the many challenges they faced, they ranged from client-based or senior-related issues to more broad systemic issues within the community and society at large. Originally this question was posed in order to determine what resources are required to aid in the planning and provision of services to support all later-life adults including immigrants, but as the interviews revealed many of the challenges discussed were not necessarily resource oriented. Many of the issues brought forth by key informants were related to perceptions and attitudes towards immigrant seniors as well as the diverse and complex issues within the aging immigrant populations themselves and their immediate and extended families.

Five major themes related to challenges and issues working with older immigrant groups are described as followed:

1. Funding challenges and lack of financial resources;
2. Establishing partnerships and working with community partners;
3. Service-provider and client relationships;
4. Senior/Client issues;
5. Mainstream society views.

Table 4-4 below summarizes these themes and related sub-topics as described by key informants.
### Table 4-4: Summary of Themes on the Challenges of Working with Older Immigrant Population

<table>
<thead>
<tr>
<th>Theme 1: Funding and financial resource challenges</th>
<th>Sub-topics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Limited resources for programming (n=6)</td>
<td>1b. Increased program demand and need (n=2)</td>
</tr>
<tr>
<td>1c. Limited resources for outreach activities and initiatives (n=6)</td>
<td>1d. Shifting funding priorities (n=7)</td>
</tr>
<tr>
<td>1e. Decreased funding for ethnocultural-specific agencies (n=2)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 2: Establishing and working with community partnerships</th>
<th>Sub-topics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2a. Community partnerships and networks (n=5)</td>
<td>2b. Coordinating services within the community (n=3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 3: Service provider-client relationships</th>
<th>Sub-topics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a. Establishing trust (n=7)</td>
<td>3b. Staffing issues (n=6)</td>
</tr>
<tr>
<td>3c. Working with families (n=9)</td>
<td>3d. Role of service provider (n=3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 4: Seniors client issues</th>
<th>Sub-topics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>4a. Complicated health issues (n=5)</td>
<td>4b. Mental health issues (n=5)</td>
</tr>
<tr>
<td>4c. Physical isolation(n=6)/transportation barriers (n=7)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 5: Mainstream societal views</th>
<th>Sub-topics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5a. Ageist attitudes (n=4)</td>
<td>5b. Discrimination (n=4)</td>
</tr>
<tr>
<td>5c. Immigration policy and anti-immigration attitudes (n=4)</td>
<td></td>
</tr>
</tbody>
</table>
4.4.1 Theme 1: Funding Challenges and Lack of Financial Resources

Many of the key informants working in agencies that offer services directly to aging immigrant populations were now operating with scaled budgets and or a general lack of funding opportunities. A number of key informants expressed that they felt that they had limited prospects for future funding opportunities as priorities for funding bodies, including the local and provincial governments shifted and evolved and often at the expense of excluding the specific needs of immigrant groups within the community. Not surprisingly one of the major themes that emerged about the challenges faced by many key informants was that of lack of funding opportunities or lack of financial resources to operate at capacity and to meet the increasing needs of the aging immigrant population. Key informants made reference to a number of issues relating to funding and resource challenges including:

- Limited resources for programming,
- Increased program demand and need,
- Limited resources for outreach activities and initiatives,
- Shifting funding priorities,
- Decreased funding for ethno-culturally specific agencies.

1a. Limited funding resources programming (n=6)

One of the most commonly cited consequences for decreased or lost funding was the inability to adequately run social and recreation programs to meet the needs of the community being served. In some cases, lack of funds resulted in the termination of employees or programs altogether. As the quote below indicates, operating social and recreational programs encompasses more than simple planning but involved a number of incidental costs such as offering lunch or other refreshments or providing tickets for public transportation in order for immigrant seniors to access the programs. For this key informant, the lack of funding hampers their ability to provide
services to seniors and often it is social and recreation programs which are the first to be suspended or cancelled altogether:

07: Every day I come in and say “Oh God! How much money do I have? Do I have any new cheques? Do I have...like today, even when we want to diverse funds [to other programs], we don’t have any funds even to change, to steal [from]. I say guess what, let’s leave the food less, give them the tickets. Then the food runs out. When it cuts off, we just suspend the programs. So it’s funding. Terrible.

Many key informants who were involved in the planning and running of community-based social and recreation programs explained that many of the seniors that used their services had limited incomes. Without the lure of refreshments or tickets for public transportation, especially among more impoverished populations, many immigrant seniors would choose not to attend programs. Because they believed that the programs were essential in maintaining the overall health and wellbeing of all seniors in general, not just immigrant seniors, it was also important to reduce as many barriers as possible, such as transportation issues or language and communication issues:

07: One program a week is not enough, because we give one program a week for different groups, we cannot have a program for everybody, every day.

22: I think that if you don’t have the proper avenues or the proper funding to hire the necessary people, then that’s a population that’s either going to be under served or not served at all.

It was particularly challenging for those key informants who served diverse populations. Making sure that no senior was isolated by language or culture the programming of certain activities had to be designed to be as inclusive as possible while ensuring that there was proper language translation of instructions, available staff with appropriate language skills or making sure that discussion topics, groups activities and even foods/snacks were sensitive to the diverse cultures of the broader group.

1b. Increased program demand and need (n=2)
There was a consensus among most key informants that as funding was decreased many of the services they offered were affected and would impact immigrant seniors the most. This included indirect influences such as province-wide hospital funding cuts for example or more direct influences such decreased funding for community based health and social programs. Many key informants observed that increased cutbacks in program funding, as well as in the funding for health and social services programs, was often related to increased demand for community services. A number of key informants noted that poor access to health care and multiple system barriers would result in increased demands and needs for more community-based services:

07: Finances is the worst. Funding is the worse. It’s very hard and if, for example we have finances for meals and also tickets. TTC\(^8\) to access the program. The ones who don’t have to access the program by TTC who stay in the building we say, we give them one ticket a month, two to go and see the doctor. And they like it, it’s so good. It helps them. Now when the budget shrinks because these programs grow, you start a program today you should know you’re going to get the money in six months. Because they grow—the people get to hear of it and they like it.

15: ...(S)ince we started the program just for one group—then all the sudden it’s like growing like a mushroom, so for us already, like for (the) Jane and Finch seniors program we’re already fully. It’s really full! So what I do is I do some referrals to other existing organizations. So like, within our seniors program there, of course it’s so hard to say no to you know if they really want to come to the group.

Some key informants noted that the burden of meeting seniors’ needs are often downloaded to the community and as the aging population continues to grow, so too will there be an increased demand for health and social programming seen within the community. For key informants who worked in community-based supportive services organizations, many anticipated a number of challenges with an increasingly aging population. One key informant described some of the existing problems seen with her organization, which provides a number of community supports to the elderly and argued that the aging population will only worsen the situation:

06: …(T)hat’s what I find with a lot of seniors here, immigrant and non-immigrant, there are a lot slipping through the cracks. Where CCAC is not able to fund services for them because they are not sick enough unfortunately and yet they are not able to pay for their own services, and they need services, and even a small amount of service could prevent people from going to hospital.

---

\(^8\) TTC: Toronto Transit Commission. Public transportation system for the City of Toronto. [http://www.ttc.ca/index.jsp](http://www.ttc.ca/index.jsp)
And so that’s sort of the struggle, where we’re at sort of now, with the ever-increasing senior population, cause it’s only going to get bigger, it’s not going to get smaller that’s for sure.

For many immigrant seniors who already experience significant access and economic barriers to health and social care, they will most likely experience these barriers accessing community-based services.

1c. Limited funding resources for outreach activities and initiatives (n=6)

One of the many commonly stated issues that key informants felt aging immigrants faced was not knowing or being aware about the services that are available to them. Some key informants also stated that simply not being able to navigate complicated health and social care systems was a barrier in itself. For key informants, it made the prospects for future funding insecure and unpredictable. Additionally, the social and physical isolation of many seniors also made it difficult for agencies to properly serve the wider immigrant communities. Many key informants explained that a significant proportion of immigrant seniors are hidden or socially isolated within the community.

16: This becomes an issue of isolation because they don’t really have an opportunity to learn the language, they don’t have an opportunity to go out and find out more about the country, the city, their neighborhoods as much. And so we have found that they are very often very isolated. We actually did a radio show with a Spanish speaking radio show on issue related to aging and it was quite remarkable. It was a call-in and quite a few seniors were calling in asking questions and it was good because it was a way to actually connect with seniors.

For key informants, the challenges of doing outreach to access and engage with isolated immigrant senior within their own communities or convincing them to travel out to various seniors programs was a resource draining task. The more common methods of outreach, such as information dissemination including pamphlet distribution and posters did not always translate into the greatest reach of immigrant seniors.

13: In the apartment buildings where we work, we have—it’s kind of a manageable space in which we can do outreach, so one thing, just by being present in the building and having programs there weekly. It’s amazing how we could be there for three years and someone didn’t know we were there and one day they walked by, and by being welcomed they can come in and connect to the programs that we have. But we don’t have a lot of resources to do outreach to the community at large.
The outreach activities that many key informants engaged in took on a number of forms and they often described how their services had evolved to meet the needs of the communities they served. Among the strategies employed for outreach activities, the initiatives considered immigrant settlement patterns and the level of social and physical isolation of certain immigrant groups within the community. These issues were also compounded with overlapping housing issues and inadequate public infrastructure, such as poor public transportation.

19: We go to various places of worship, like mosques, community centers, temples, and that’s where we raise awareness of our programs. That’s our outreach and that’s where we provide our programs and services too. So we outreach and we take mainstream service providers to places of worship.

21: And the other part is engaging newcomers in our process. In terms of engaging newcomers, we look at engaging really a range of newcomers from young to old. It is more difficult to get seniors engaged because there are mobility issues, language issues and yeah, so those would be in terms of challenges, in terms of engaging newcomer seniors.

Relating to the physical isolation that some immigrant seniors experience, social and cultural isolation from the mainstream culture is also a critical factor that key informants felt prevented seniors from accessing services and programs. An important aspect of outreach included having programs and services that are of specific interest to immigrant groups within the community. For organizations who receive funding based on outreach initiatives find cultural isolation a difficult barrier to overcome, and it becomes a challenging task to build outreach activities to specific communities, which can also become resource draining as well.

21: So [the] topics that newcomers find are important and have an impact on their life in Canada, we do outreach with community ambassadors who go around the community to raise awareness to what we do and to invite people to participate in our sessions. We also have interpretation available to a certain extent and with seniors, it is often that feeling comfortable to go out and also being able to go out. So, around being mobile and seeing the relevance of, you know, of what we do to their lives. So for seniors, they really look at, “Okay, is that really something that will assist me?”, “Is it something that is of importance to me?”

Recognizing that outreach programs were most effective in bringing awareness to resources and programs available to often isolated aging immigrants a number of key informants explained that these efforts became more difficult as constrained budgets hindered the outreach
programs. Poor knowledge and illiteracy of Canada’s health and social care systems, as well as available community program, combined with a number of structural barriers resulted in a number of implicit issues for community-based organizations. As key informants noted, many of these program issues were interpreted as poor program planning and execution or even, construed as irrelevant and redundant services.

1d. Shifting funding priorities (n=7)

Some key informants also discussed how they needed to adjust their strategies for securing funding in large part due to shift in funding priorities from different levels of government whether from the City of Toronto or the Ontario Ministry of Health and Long-term Care. As well key informants noted that concerns for the rapidly aging population expected to occur in the next twenty years and worries of an overburdened health care system are playing themselves out, as evidenced by shifting funding priorities with community-based services programs being low priority. One area that is most affected are preventative programming and the poor understanding of what prevention methods for aging communities means at the program, policy and funding levels.

08: You know just looking at where the funding dollars are spent right now, they’re talking about prevention and keeping them out of the hospital rooms and that. Which is what facilities like ours do, however we’re not recognized as a preventative measure.

13: Right now the government funds kind of prevention community development because you can hit a lot of people with a little bit of resource, that’s kind of why we exist right? Because you’ve got impressive numbers, because some people need very intensive care and then you can say, you know I can say you know I had a party with—I reached 300 people in one day. You know whereas people needing more support, so right now were okay but I think that as the shift to being really scared about the trend of aging they’re going to move things over to I think to concentrating all the efforts on dealing with the most acute situations. So that’s a fear, that’s a fear. Um but I think that they need to recognize that this prevention is not gravy, its essential right? And it means better outcomes for people. And less cost to the health care system.

Often funding requirements differ than what true needs or aims of the agency/organization are. Where this is most evident is around the language and translation needs
of the agency and their abilities to overcome language barriers and provide interpretation services with ease and efficiency.

12: We have (programs) so the Russian one overlaps and the English ones go like this and the Russian ones cover the whole (population served). And we do have workers who speak Italian, Hebrew, different languages, so obviously if a case comes in that’s not in someone’s area, if it’s language-specific they get that case but again we don’t—it is not a requirement, we don’t have one FTE\(^9\) Italian speaking social worker, one Hebrew. We have two Russians that way but not the other languages. So it’s a challenge I have someone going off on mat leave and she’s our Hebrew speaking social worker, but it’s not funded to be a Hebrew speaking position. So, the challenge is, it would be nice to have someone that speaks Hebrew because we have a Hebrew speaking clients but were not funded specifically that way so I can’t just go hire—you know of all the resumes I can’t just pick the ones who speak Hebrew.

Differences in funding priorities are most obvious when you compare the priority issues between key informants who provide direct service to immigrant seniors, such as community support agencies, to key informants who are indirectly involved in the welfare of seniors such as policy makers. Key informants noted that often what is proposed at the strategic level is not always feasible at the community level. A good example of this is language translation services, which is considered the cornerstone of culturally competent care but within the community and social service agencies the ability to provide a range of translation services is limited to the number of staff or resources available.

1e. Decreased funding for ethnocultural-specific agencies (n=2)

Many key informants discussed the specific challenges with reduced funding in running certain programs, but some key informants made reference to the notion that funding sources often do not find their way to serve specific ethnocultural communities within the broader senior population. Most key informants worked in agencies that were open to all ethnocultural or racialized groups. Three key informants who worked in agencies focused on one particular ethnocultural group and two key informants who, although working in multiethnic and multicultural agencies, worked with a specific sub-group of immigrants. While they all shared various disadvantages experienced by each of their respective ethnocultural groups there were

\(^9\) FTE=full time employee
suggests that broader community goals and interests were more likely to be funded than the interests specific to certain ethno-cultural groups. Again, funding for language-based needs was commonly referenced as an area that received very little attention despite it being a widely accepted barrier to health and social services.

19: Funding should go into ethnic organizations to assist the ethnic groups, to assist the culture groups that are coming too, so that seniors can assimilate into the mainstream...and they’re not left behind. If funding goes to mainstream, the newcomer immigrants who—you know they have culture and language barriers, they do not have access to the services. Because they do not feel safe—the environment is not safe. That’s what they’ve said to us.

As the key informant argued above, mainstream funding often does not reach ethnic groups, which has consequences for immigrant seniors’ ability to access services as well their perceptions of the post-migratory environments. This was especially true for those seniors who are socially and culturally isolated from the mainstream and dominant culture, which often made it difficult to reach certain members of the community or hampers their efforts to provide services to the broader community.

4.4.2 Theme 2: Establishing and Working with Community Partnerships

Most key informants worked within the community to provide services and support to immigrant seniors and their families. With decreased operating budgets and the scaling back of community and social program funding, many key informants discussed the necessity of building community partnerships and networks in order to fill service gaps or provide a more comprehensive set of services. In particular, key informants discussed:

- Community partnerships and networks,
- Coordinating services within the community.

As many key informants explained, establishing community partnerships and building networks to increase the reach of community support became increasingly important as funding challenges increased.

2a. Community partnerships and networks (n=5)
The lack of partnerships with agencies, outside communities and other organizations was identified as a challenge in trying to connect immigrant seniors with the resources they needed. Many of the key informants were involved in referral of services and had to be attentive to the limited resources of immigrants in the community. Key informants discussed this challenge in combination with the issues surrounding city-wide funding shortages and how many agencies and non-profit organizations in the city were vulnerable to service cutbacks or even closures. One example given was the closure of a neighbourhood settlement service centre within the same building that housed a home support service agency:

13: We used to have in this building a community action resource centre which was running settlement services and they were one of the agencies that lost all of their funding. So they had to shut their office down completely so, you know where we could have worked in partnership where we build a relationship with people based on them finding out about exercise or coming for something like that and we could have referred and connected them. Now that they’re not here we don’t have that same connection.

The closure of the settlement services centre because of lost funding was seen as a significant loss and missed opportunity to create service partnerships that would better serve the older immigrant community within the building. Similarly, other key informants also discussed the closures of other agencies in the city, narrowing the networks of partnering agencies which were seen as key in helping to fill the service gaps.

2b. Coordinating services within the community (n=3)

In a sub-theme related to lack of service partnerships in the community are issues that arise in coordinating services across different agencies and organizations in order to increase the availability of services to seniors. Among key informants who are able to make important partnerships in the community to better serve the aging immigrant populations, they discuss challenges of working with diverse groups and service agencies, which often meant not only knowing the services that exist in the community but also knowing the particular needs of the community that is being served:

06: The social work will link with them and then try to connect them to other services, try and connect them with potentially their own (culture)—because often people often feel more
comfortable within their own culture, so they’ll look into these types of groups. We’re actively involved, like there’s a new hub opening at Bathurst and Finch and again that is to assist immigrants, so we’re on those committees and really trying to look at resources in the community to help support people.

Whether speaking to the challenges of connecting immigrant seniors to relevant and culturally-sensitive services or building networks of organizations in a community or for a specific ethnocultural group, key informants emphasized the importance of building up resources and filling the gaps in service, often in the wake of decreased funding or the scaling back of certain services. An important systems-level challenge noted by one key informant was coordinating and synchronizing very different mandates and goals of various agencies and organizations:

21: Because we work with a range of agencies, some of them are settlement service providers but many of them are ‘other’ providers or other organizations, like health care, like community based organizations, faith groups. So, organizations with a range of mandates who, not specifically, but also provide services to newcomers, right? For example, hospital would provide services to everyone including newcomers. So it can be challenging to engage a lot of different agencies around the newcomer issue especially if there are capacity issues and if it’s not specifically part of the mandate of the agencies—and resources issues!

Key informants discussed the complexities of community building through the coordination of multiple organizations and services. The goal of increasing the capacity of organizations to better address not only the wider concerns of the community but to also meet the needs of a certain sub-population in that community can also be a challenge as described by the key informant above.

4.4.3 Theme 3: Service Provider-Client Relationships

Another important theme that was more consistent among those key informants directly involved in providing services to seniors was the nature of service provider-client (or senior) relationships. Many key informants discussed the nature of service provider-client relationships that either strengthen or hinder the ability of service providers to assist and support immigrant seniors and their families. Among the various issues they noted were:

- Establishing trust,
• Staffing issues,
• Working with families,
• Role of service provider/agency.

An underlying issue of this particular theme was the challenge of community diversity and having to provide services in cross-cultural contexts, especially with newcomer immigrant seniors.

3a. Establishing Trust (n=7)

Key informants made specific references to their own programs and services when speaking about the various ways they sought to create trusting relationships with immigrant seniors and their families. However, many key informants also described more broadly the issues that immigrant seniors face when navigating health care, social and settlement services. Many of the issues that key informants touched upon included, public perceptions about immigrants, particularly racialized immigrants groups, discriminatory attitudes of providers in mainstream services and language barriers. Among key informants who were directly involved in providing community-based health and social services for immigrant seniors, establishing trust was often viewed as a timely process but often an important and necessary step in ensuring that immigrant seniors receive the care and services they need:

01: They are so isolated and so there is that tendency for them to distrust or not immediately trust you. It could be because of many experiences that they have, that it takes a while for them to warm up to you.

08: I also find (the) barrier of trust, like can I trust you to help me, because I’ve been let down before. And how are you any different? So it’s building the trust in a relationship with somebody (to) say I will walk you through the process and make sure you get what you need to get. It’s just that relationship building that takes time. Like you know we can’t do it in one sitting or anything. But sometimes I feel that’s a barrier, because there a little bit “I don’t know you”, “I don’t know if you can do it for me?”

In particular, some key informants explained that it can be especially challenging for immigrant seniors if a service provider did not share the same cultural background or language as them, which is why many community-based organizations try to hire staff that reflect the cultural backgrounds of their clientele. Not only are cross-cultural relationships between service-
providers and immigrant seniors seen as a barrier to trust, but many immigrants coming from vast political and social circumstances may have different perceptions of government and understandings social and health services. As described by one key informant, seniors are often fearful about discussing their personal and family situations with non-family members:

13: It really shows how important needing to connect with a common language, and that’s one of the – the other I think I think is maybe a barrier is that people are coming from all sorts of political situations, and so they have different views of services, like social services and community supports some of them can’t believe that someone would come and give them support for free. Some of them fear talking to a social worker about their family situations because it’s not safe in the context that they knew, so I think that’s another barrier. Just peoples histories and their understanding of government or social services can do or if there safe.

In addition to acknowledging language barriers and providing services that are culturally sensitive key informants also identified the importance of imparting genuine empathy and understanding of the hardships that many newcomers experience. This was especially integral to building trusting relationships between immigrant seniors and service providers.

3b. Staffing issues (n=6)

The problems that key informants associated with staffing issues were mostly related to the lack of culturally similar staff at any given time, although overall shortages were also cited. As noted above, key informants felt that the process of establishing trust with immigrant seniors or newcomer immigrants could be fostered sooner if service providers shared the same background with their clients. From a managerial perspective, not being able to provide staff that match the background of the clientele, whether it was language or cultural sensitivity, was a common issue. In one instance, one key informant used the example of counseling services and the incidence of elder abuse among immigrant families. She noted that most of the newcomer immigrant seniors that she sees come to the agency at the point where they are in near crisis situations and this prolonging of such situations may have to do, in large part, with their perceptions of the less diverse staff that are available:

16: Seniors who come from more of a newcomer community are probably more likely to be seen in the VAW (Violence against Women) program rather than the senior program, which sounds
weird but that’s just the way it is. And I think probably a lot of it has to do with the senior (program), the counselors in the senior program are white, we have two who are Spanish speaking, I mean we only have five, six (overall).

Lack of awareness of the program, as well as counseling services being a novel concept were also identified for the poorly accessed seniors program by newcomer immigrants. However, she speculated that the low use of counseling services among minority language (non-English) seniors is due to fact that most of the counselors employed were from the white, English-speaking dominant culture. The need to have culturally similar staff was a recurring theme, as was providing services in the appropriate language:

12: Well we see here language barriers are huge. We have people here that don’t speak English, clients. So that’s a huge barrier. We try and we’ve looked at the languages that we’ve needed, we hire staff who speak different languages but people get sick, people go on vacation, people go to the bathroom, they take lunch breaks, and then you have clients who are needing care and obviously staff are trained, we can have staff speaking every language, so they are trained in non-verbal communication, crisis intervention, all those sorts of things, and just being creative.

22: I can’t speak to the community as a whole because I don’t supervise the community programs but within the buildings it took us the three years to get our client numbers up to where we had expected them to be. It was very slow going in the beginning because you start off with a certain number of staff, and those staff have a certain number of languages, and they’re not reaching the people within the building who don’t speak that language. You just, you don’t see these people out in the hallways, they don’t come to programming because they feel there is no point, because they won’t be able to understand what’s going on. So it has taken a while to find out exactly who are in the buildings and to try to hire and staff according to the need.

Additionally, key informants spoke about managerial challenges of ensuring that frontline service providers or social workers were adequately trained to deal with the complexities of immigrant seniors and the issues that are unique to the immigrant population.

3c. Working with families (n=9)

Another issue described as a key challenge in the service-provider and client relationship was that role of families and how service providers had to also be especially sensitive to the diverse family situations of immigrant seniors. Building trust with a senior’s family was viewed as equally important in establishing trust with seniors themselves, as most newcomer immigrant seniors are dependent on their adult children:
18: Here, we do provide interpretation services at no cost to the clients and families when they come in, but it's language, and it's also trying to build trust with the extended family, so they can know were willing to work with them and not against them.

However, key informants were also quick to note that while family members often are the most convenient and appropriate sources of information regarding a senior’s need for care, they were not always the best advocates of care for immigrant seniors and were even thought to be an obstacle to care:

10: A lot of them don’t understand that mom is our client, although I do expect to call them if I need anything like information. I cannot freely talk to them about what’s going on between our client and our services. So, that’s one of the issues.

She continued with numerous examples, many of which she identified as difficult situations that forced her to make “judgement calls” with regards to putting the needs of the senior over the expectations of the family, particularly in cases where a senior required hospitalization. She noted sadly that there is often a power struggle between the service provider and family members with regards to a seniors’ care and it becomes a situation of tenuously balancing other family members’ involvement but ensuring that the senior’s needs and wellbeing are the priority.

Similarly, another key informant spoke about having to explain the limits of care and the capacity of an agency to provide care to an immigrant senior:

12: …(T)he family just kept saying, “It’s my mother, I don’t want to talk about long term care, I don’t want to talk about it, I don’t want to talk about it.” But (his mother) was way beyond the care needs of this program. He wanted her to come here every day. Our limits of care state that the care has to be manageable for staff. I know that it’s vague but it’s vague on purpose because that can mean so many different things. And that case was just hours of social work and nursing time working with this family, but if they had been willing to consider other options it wouldn’t have been such a burden on them or on us.

Frustrated, she described that in some cases family members were not willing to listen to service providers about the care needs of a senior, which became a real obstacle for the agency in terms of balancing the work loads of staff and providing services within their mandate of care.

There were also some discussions about elder abuse within the family and the challenges of how to handle these situations when abuse is suspected. Instances of elder abuse remain a
taboo topic within various circles of the immigrant community and remains poorly addressed in
the community at large. Often seniors are hesitant to discuss their home situations with
“outsiders” or they may not even recognize that they are in an abusive situation:

04: They struggle and they suffer in silence because they are not able to talk about it to anyone. Because again it’s a language barrier and seniors are unable to talk so this is a lot of tension, so a lot of abuse situations. But again it’s Russian culture where you don’t bring your dirty laundry to the outside world so sometimes it takes a very serious episode for a senior to bring the abuse to the social workers, those who can help them.

14: I would say this is an issue that is in terms of the number is not very significant, but in fact it’s just like an iceberg, it is just hiding in that community. It’s like it’s disguised, but in fact there would be different degree or different levels of different kinds of abusive situation in the immigrant community. It might be in terms of psychological or financial. In the Chinese community I would say physical abuse is not that imminent but psychological, emotional, and financial abuse would be more common. It may not be identified by the seniors but (w)hat they might know is kind of abuse, like a taboo that they don’t want to talk about with other people, they just bear with it.

The example of the controlling family member was brought up a number of times, not only in terms of abusive situations between the senior and their caregivers, but key informants also disclosed that there were difficult situations between senior couples that service providers had to navigate. As one key informant discussed, while some family members may prevent seniors from participating in a particular program or information session, there are also situations where some women do not participate in a program because of a controlling husband:

15: They don’t want them to be exposed, because you know sometimes, it’s (the information) we share, right? Sometimes they—before their parents stay at home just to help them but like something with a minimum chance (to) explore and also for other immigrants whose tendencies to their culture in here, like for instance husband and wife seniors. And then back home, maybe like India, let’s say India or any other country, some men are so controlling. They try to control their wives even though they want to join some activities or join our organizations or group they are being controlled because of their culture, sometimes the culture, you know.

Navigating spousal or family expectations about social and recreational programs or organized information sessions for seniors also add to the challenges in providing services for seniors. Some key informants described these situations as more common among newcomer families, but even immigrant seniors who have been here for many years, particularly those who are socially and physically isolated were also vulnerable to stressful and difficult family situations.
Many key informants also discussed their own specific roles within their agency or organization and how they viewed their role in connection to the lives of immigrant seniors. For most, working with senior and immigrant populations was not just an occupation but was also a form of emotional work. Many service providers and managers described working with frustrated and stressed staff, particularly in those agencies that were financially strapped, working with limited budgets and resources. For instance, when discussing the challenges of decreased funding and increased need for services one key informant spoke about the specific role she has making decisions about how to allocate the limited funds, especially under the pressure from staff:

07: Every day I have three staff, three or four every day for different groups. When we sit here, they’re saying, “Please! You know they can’t come, they (immigrant seniors) need this”. It’s like, you know, you’re transferring your parental responsibility to the office.

As well, key informants described being very strong advocates for immigrant seniors, whether it involved lobbying for increased health care access and equity at the provincial level, advocating for a marginalized groups, to making decisions on behalf of the senior:

04: I’m just a real strong advocate. I’m working from a critical social work perspective. I’m just seeing this immigrant population as oppressed, the most oppressed population in the Jewish community and community at large. And that their needs have not been addressed, so this is basically the first program that’s addressing their needs of those isolated seniors.

In the case of client services for home support a number of key informants provided numerous examples of the kinds of struggles they experienced when supporting and advocating for seniors in order to provide appropriate care, including acting as a mediator when having to discuss plans with adult children or even health care service providers. One key informant who oversees a supportive housing service in a designated seniors’ building in Toronto discussed how she would have to communicate directly with pharmacists and physicians not only to ensure that the senior received proper care but also for her and support workers to do their job effectively:

10: There are some doctors that have no problem because I’ve been dealing them for a while. Some new doctors they use the confidentiality, the privacy thing. They don’t want to talk to you but there’s a lot more issues than the privacy thing. I have a particular client that I sent his
prescription off to another pharmacy because he’s on blister pack. But every time he goes to his doctor, the doctor would just hand over the prescription to the pharmacy that’s in his building. And I would say, “No! It has to be in blister pack.” What ended up happening is that he would have blister packs and then vials. Then we’re like, my staff, our support workers, we can look at blister packs and help them, assist them based on a blister pack but they’re not allowed to open vials and hand in the medication.

Despite the challenges that many key informants discussed ranging from administrative matters to client issues, most described their work as fulfilling and important not only for immigrant seniors but for the whole of the community they worked in.

4.4.4 Theme 4: Senior/Client Issues

While most of the challenges that key informants discussed when working with older immigrant populations reflected mostly resource-related issues, interactions with seniors and their families or issues with other agencies and organizations within the community, they also referred to issues among the seniors themselves. When speaking about aging immigrant populations, key informants made reference to the diverse cultural and ethnic backgrounds of immigrant seniors with respect to language, religious practices, dietary preferences and the social and cultural contexts of their homeland:

06: By the time you get staff within that culture trained, you’re almost behind the boat. Do you know what I mean? There’s already a number of people who have immigrated who need service and yet, you don’t necessarily have enough staff.

21: I think that’s the next step that in retirement homes or homes for the aging, right? How do these then deal with the cultural diversity? I think that’s also is coming up and it’s not at the level where it will be needed. Because yeah, there will be a diversity of seniors with really many different cultural backgrounds, many different language backgrounds who will move into retirement homes who won’t stay with their family.

Being culturally sensitive and understanding of this diversity was a significant challenge for key informants, which was unique to large cities like Toronto, where many newcomer immigrant families and seniors tend to settle. Additionally, key informants noted that the ethnocultural make-up of the immigrant population in Toronto is ever changing and the circumstances of international migration shift in many ways reflecting global political, economic and social movements. The inability for social and health service-providers to be able to
effectively respond to the constantly evolving ethnic and cultural diversity of the immigrant population often results in gaps of service for older immigrant seniors. More specifically, key informants discussed the following issues regarding seniors:

- Complicated health issues,
- Mental health issues,
- Physical isolation and transportation-related barriers.

Key informants described the numerous ways that the lives of immigrant seniors were diverse and complex often resulting in situations that greatly hindered key informants abilities to provide the services.

4a. Complicated health issues (n=5)

Most key informants referred to the health needs of immigrant seniors as complex, varied and difficult to characterize in simple terms. The aging and health experiences of older immigrants, as described by key informants, were very much influenced by their social and family situations ranging from the more common health issues, such as diabetes management to acute situations such as the unexpected need for long-term care. With respect to complicated health issues of immigrant seniors the challenge was not in the health issues themselves but with the situations and circumstances that led to or resulted from the onset of illness or an adverse health event.

For instance, one key informant described the challenges of working with seniors who experience inadequate physician care and have poor medication literacy. Many issues that follow from these situations inevitably spilled over into her realm of responsibilities:

10: A lot of our doctors don’t understand the problems of seniors. There’s not that many gerontologists around and there should be. And even family doctors, sometimes they’re very impatient with seniors, you can’t just spend 15 minutes with them, you have to spend a lot more time with them. I have seniors that are called “poly-pharmacy”. They don’t like to get rid of the old medication because, “Hey! We paid money for that!” So if the doctor decides to change the medication they have to take the time to say, “You have to throw away the other pills that I’ve given you and you have to start on this.”… And so that’s a challenge for us. It’s fortunate that I think pharmacists are getting into the picture that they’re realizing that. If my client deals with the pharmacy that is not on the ball, I call them and I would say “Did you give a new prescription?
This lady she’s not quite into like her meds so if you have any concerns can you put me down as your call person and we can talk about this.”

Many key informants acknowledged that most recent immigrants have few economic resources upon first arriving, and for seniors, they were especially vulnerable financially, often relying on family. More commonly, key informants spoke specifically about challenges being a new immigrant and a senior. Among these issues included: having to navigate a different health system, finding newcomer settlement agencies for support and information or ensuring they had a health care provider and health care coverage. Some described the multi-generational families as supportive, but often key informants described more stressed family situations and even instances of broken sponsorship:

06: If they’re new immigrants to the country they don’t have access to the same resources that other seniors would have. They’re often looking for less expensive housing that they’re often facing issues with sponsorship, children may bring them here, but once they’re here they’re virtually abandoned and really don’t have a lot of resources and so, I know our social workers will be working with clients in those situations, as long as a client has an OHIP number they can get CCAC services, but again even now with, unless they are quite acutely ill, or really in pretty dire straits from a health perspective, you don’t get a lot of service.

These particular challenges are especially important for seniors since it may affect their ability to access care or may even delay much needed care. For many immigrant seniors, having access to health care provided a sense of security and peace of mind during the early stages of migration and settlement. Some key informants described examples of immigrant seniors who expressed fear of getting sick while waiting for their health card to arrive and the risk of incurring costs of emergency hospital services. Key informants also described challenges with extended families, who may act as barriers to appropriate and timely care further complicating the health situations of immigrant seniors:

12: I would say that I have seen more crisis situations here over the last year and a half with people who are new immigrants as opposed to those who aren’t and that’s not to say that those who aren’t haven’t had crises, but in terms of the advancement of the illness, when the family reached out for help, accessing services, getting into long term care, not having health coverage, those kinds of real crises, as opposed to someone who might fall and break a hip, you know that kind of thing. We see more of those very extreme situations with the families who have sponsored a parent to come over.
Depending on the programs and services offered by the agencies and organizations, key informants had to work within their own defined mandates and limits of care, but the complicated situations of immigrant seniors often pushed the boundaries of care for some. A significant challenge was working within the capacity of their agency given the disadvantages experienced by many immigrant seniors.

4d. Mental health issues (n=5)

Also discussed among key informants was the rise of mental health issues among immigrant seniors. Among those who spoke specifically about mental health among immigrant seniors they brought attention to the stigma associated to mental health in other cultures:

04: A lot of mental health issues. Most of them would have either have signs of depression or over-diagnosed with depression and were prescribed the medication and but never use it. Russian seniors, Russians don’t use the mental health medication...It’s the taboo of illness and because of psychiatry in former Soviet Union. And in former Soviet Union, in psychiatry it was rampant, of those who spoke bad about the government, so those who dissidents let’s say, those who go against the government, they, they would be put in psychiatric facilities and they would give them a stigma of let’s say schizophrenia, they would give them a lot of medicine to help them...to keep them quiet. And that’s why, and it’s been for over 70 years in former Soviet Union, so that’s why.

10: But back home, and I’m pretty sure in a lot of other countries as well, mental health is a big stigma. So, you know, mom is an eccentric, that’s how, you know (she is). But as Mom ages, it becomes more and more pronounced and it becomes more apparent. This is not just being eccentric, there’s something wrong. But families are just not open to, you know, to accepting that or to even say, you know maybe mom needs to see this doctor.

A common concern among key informants is how mental health care is poorly addressed broadly, but most especially among older and immigrant populations. Many key informants discussed the hardships of migrating to a new country and the risks of poor mental health outcomes for new immigrants. With sponsorship, many key informants noted, it is emphasized that the responsibility lies with the sponsoring family member so often times, mental health issues are often not acknowledged or understood from a cross-cultural perspective.

One key informant, in particular, discussed that with regards to seniors’ health often the preoccupation is with the illness itself and the physical symptoms, but little attention is paid to more psycho-social or psychological issues. She mostly described her experiences of working
with the elderly Chinese population and having migrated from mainland China herself and the lack of understanding about how mental illness manifests and as a result is not appropriately addressed:

14: They are more concerned about physical health. Yeah, I’d say physical that is like the illness that is associated with aging, like diabetes, high blood pressure, heart disease and osteoporosis. Yeah so that kind of disease more associated with aging, and more physically related. But now there will be a growing concern of psychological and mental health as well, and usually the way we perceive whether it’s healthy or not is more whether, in terms of the sickness, not in terms of the behavior. I don’t know if you understand what I mean, in terms of sickness like pain, you feel pain—like symptoms, yes! Instead of the behavior like, “I can’t speak well” or “I feel very unhappy”.

Generally, key informants had a more heightened awareness and growing concern of mental health issues among immigrant seniors. The consensus among key informants was that it is problem that is not addressed as well as other age-related physical health issues or cognitive degenerative illnesses such as dementia or Alzheimer’s disease. A sizeable number of urban-dwelling immigrant seniors often find themselves in stressed and difficult situations which only contribute to poor mental health and wellbeing among this population.

4b. Physical isolation (n=6)/transportation-related barriers (n=7)

Another commonly cited challenge for key informants was how to reach physically and socially isolated immigrant seniors in their communities to make them aware of the services and programs available to them. Many immigrant seniors are also very dependent on their adult children, so physically trying to get from one place to another for whatever reason was a real difficult challenge for key informants to work around. Even when a senior is aware of or in need of services, being able to convince them to travel to these activities was also a difficult task.

08: I would say, in my case, maybe the limitation in some cases they – because many of them are coming here with a role already which is (caregiver). And then, if they have time they can do other things. But sometimes that doesn’t happen, because you know, life is hard, so their children are working, maybe one, two jobs and then who’s taking care of their children. So then, they don’t have time to do other things. They would like but they can’t. And if they live far and have no access to transportation—sometimes, they live in the suburbs, in the house, so they’re just dependent on others.

11: They are completely dependent on their adult children in order to get out and go anywhere. They live in physical places where there’s poor transportation, so it’s hard for them to get around,
especially in the winter time, so they’re incredibly isolated. We also, in a consultation study, we did—hearing a lot about elder abuse and how seniors have no avenue for which to seek help because they don’t know how to navigate the health and social service system, they physically don’t know how to get about and so they’re incredible vulnerable and that’s a huge need.

Key informants worked with different populations of seniors and transportation issues was a common concern whether seniors lived in more suburban areas and having to rely on their children to take them places or whether they lived within the city with relatively accessible public transportation. Still many key informants needed to subsidize the cost of transportation for seniors or they simply would not access the programs and services.

04: So they have to ask their children for money and they never do because they’re too proud to do that. So they’d rather not to eat or they’d rather not to come for English classes, let’s say, if it’s not subsidized like if the bus tickets are not subsidized.

07: They are poor. They’re hungry and they don’t even afford their medicine. I think they have some subsidies from the government and some housing is subsidized, but it’s not enough. And even if they were to go to see their doctor or to go get their drugs, they need tickets. They actually don’t have enough money.

In addition to the challenge of working with a very poor population of immigrant seniors as indicated above, this key informant also described how seniors in the program have approached her to request the food often made available for some programs be reduced in order to subsidized more tickets for public transportation.

4.4.5 Theme 5: Mainstream Societal Views

The last major theme highlighting the more common challenges that key informants face when working with older immigrant populations relate to public perceptions and attitudes about immigrant seniors. Among these challenges were:

- Ageist attitudes,
- Experiences of discrimination,
- Immigration policy and anti-immigration attitudes.

Whether addressing systemic discrimination embedded within the health care system or cultural shifts in attitudes towards the elderly, many key informants referred to the negative
discourses about aging and migration, with immigrant seniors often occupying the most disadvantaged of positions in society. Although this particular challenge is not material in nature or directly related to client-senior interactions, it does create a social and political environment that makes it difficult for both immigrant seniors and key informants alike to navigate. According to a number of key informants, the negative experiences of migration and settlement often lead to immigrant seniors’ perception of the wider community as an unsafe environment affecting their ability to integrate and make connections to the community.

5a. Ageist attitudes (n=4)

Seniors were viewed by key informants as highly valuable both to the community and within the family. Overwhelmingly most key informants felt that immigrant seniors had a lot to share with their peers, youth and the community as caregivers, mentors, leaders and volunteers. However, as results revealed many of these views are not shared within the community and in the broader society. In particular, a number of key informants spoke about how ageist attitudes had harmful consequences in how older immigrants were perceived:

01: They bring in a lot of wisdom, knowledge, also skills, but because of the ageist nature of society they don’t they seem to be not very much brought in to the table. So kind of what happens is that they are left alone, they are left on their own and also their dignity is kind of you know, I think they’re broken down because if they are coming in with maybe skilled people and then to come here and then doing nothing, no exposure to other people because they are so isolated.

Many key informants identified that our current understanding of aging is very limiting for many seniors. They argued that they all seniors, immigrant or not, have very different experiences of aging and by extension, health that it was very difficult to categorized seniors in a single category. One key informant reasoned that structurally older people who are no longer working, and therefore contributing economically to society, are undervalued, regardless of what their contributions were before retiring. For immigrant seniors, they are even less valued because even if they were working prior to migrating, their contributions are not recognized in Canada.

5b. Discrimination (n=4)
In addition to ageist attitudes, key informants noted that immigrant seniors also experienced discrimination in many forms, whether it was based on class, race, gender or sexual orientation. Experiences of discrimination coupled with ageism, key informants argue, create environments unsafe contributing to their social and cultural isolation, which further disadvantages older immigrants. Even among key informants who felt that they were skilled in connecting with immigrant seniors, providing culturally sensitive care that was both empathetic and understanding of their needs, said that newer immigrant seniors were still very hesitant to accept help from service providers in health and social care programs, settlement agencies or other community-based organizations:

11: If you stop to think of how incredibly disadvantaged on so many levels—culturally, linguistically, in terms of age, economically, politically disenfranchised, no family supports. You know it’s incredible, these are the people that are most marginalized in society. Amongst the most marginalized.

While issues of discrimination, ageism and/or racism, can be more thought of as directly affecting immigrant seniors themselves, key informants discussed this problem in terms of how this challenge affected their ability to gain trust with immigrant seniors or deal with these biases in the health, social and political systems.

5c. Immigration policy and anti-immigration attitudes (n=4)

A number of key informants spoke specifically on the role of the government with regards to the immigration policy and system in Canada. During the time key informant interviews were conducted, from May 2011 to September 2011, former Immigration and Citizenship Minister Jason Kenney had begun the process of immigration reform in Canada in response to the backlog of applications. In the February 2012 report of the Standing Committee of Citizenship and Immigration, entitled *Cutting the Queue: Reducing Canada’s Immigration Backlogs and Wait Times*, it stated that in July 2011 there was over 165,000 family class applications in the parent and grandparent category alone and it was expected to grow to levels that would be considered “unsustainable and in need of attention” (Tilson, 2012: 4). Phase 1 of
the recent reforms taking place with Canada’s immigration policy involved putting new applications, from 2011 and onward, on hold in order to deal with the current backlog. In May 2013, Kenney put forth new criteria to the family reunification immigrant class category as Phase 2 of the government’s efforts to revamp the current immigration system. Media news outlets reporting the announcement of the new criteria that would affect family reunification applications highlighted Kenney’s sentiments towards newcomer immigrant seniors and their families as a burden to the health and social care systems (Fitzpatrick, 2013). A number of key informants made specific reference to these anti-immigration sentiments, particularly about immigrant seniors brought over through family reunification:

07: There’s people here in this country, if they want they cannot stop (immigrant) seniors from coming here because then they’ll not get the other young ones who come with them to come and work for them. [Laughs.] So if they want this thing to work they should focus on this system, the senior people, especially those who come out in need.

While not making direct references to recent immigration reforms affecting family reunification and sponsorship, key informants noted that the current system needs to shift towards supporting immigrant families as a whole, not just seniors, since more often than not, seniors are very dependent on their family members who brought them to Canada:

14: I think there will be some kind of issue(s) that will be in the aging immigrant community that need to be paid more, you know, attention from the government. In fact there will not be enough funding. I would say not enough funding for those agencies serving the immigrant community, not just the aging but immigrant community. So if that issue is not dealt with it’s still causing the whole community a problem, not just the immigrant community but the country as a whole. I think the funding for those aging immigrant—I mean the organization serving the aging community is not enough.

19: I want to emphasize that it is very important and imperative that the government looks at the whole system, as they look at the immigrants. If they’re allowed into the country to begin with then there (has) to be some sort of programs specifically for them and funding should be poured into ethnic groups that can help them.

Among key informants involved with specific ethnic populations (Chinese and South Asian immigrants) they emphasized that the lack of funding or governmental support for these

---

often racialized and marginalized groups are not only bad for the communities but for the broader Canadian population including immigrant and non-immigrant populations.

4.5 Chapter Summary

The goal of this chapter was to present the findings from key informant interviews from various individuals with diverse backgrounds and working with a variety of older newcomer and immigrant communities. Seven health and age-related domains were identified among key informants based on the services and programs they offered to older immigrants. Most key informants were involved in outreach and community supports and/or social and recreation programming for immigrant seniors. Among this sample, there were two broad types of key informants, service providers and policy planners that offered their views about the health and aging experiences of immigrants. One specific aim of the chapter was to examine key informant perspectives on what the various roles older immigrants had at two distinct geographic scales – at the community and family level. While most key informants stated clearly defined and important roles of older immigrants, some key informants felt that framing immigrant seniors in terms of roles or utility contributes to negative perceptions about aging immigrants and seniors in general.

Another aim of this chapter was to explore the challenges that key informants experience while working with older immigrants and their families, during a time of economic upheaval, changes to immigration policy and health care administration and delivery restructuring. Key informants provided numerous examples describing how community, family and individual-level factors greatly challenged them to develop adequate and appropriate health and social services. There were five specific themes identified from the many challenges that key informants discussed.

11 Parts of this chapter were presented at the Association of American Geographers Annual Meeting in Los Angeles, U.S.A on April 12, 2013. Results were presented in an oral presentation in a session entitled, Health and Health Care in a Period of Economic Decline I.
The first theme was related to funding challenges or lack of financial resources. Key informants not only discussed the lack of funding for programming, outreach activities and initiatives, but many also described an increase in program demand and urgent need for community support and services. Many key informants discussed seeing a general decrease in funding and budget scale-back despite increasing demand, often as the result of shifting priorities. A number of key informants admitted that agencies and organizations that catered to specific ethnocultural groups were among the hardest hit by decreased funding.

The second major theme was on the challenges with community building and creating community partnerships. While funding challenges increased alongside the scaling back of programming funding, many key informants discussed the importance of establishing community partnerships and networks in order to fill in the gaps of service. Key informants discussed strengthening community supports and continuity of care through greater efficiency and coordination of services among different agencies and organizations within the community.

The third theme was on service provider and client relationships and the challenges that arose from these dynamics. More specifically, key informants discussed how the nuances of the service provider-client relationships either enabled or hindered their abilities to assist immigrant seniors and their families. They discussed challenges with trying to establish trust and working with widely diverse immigrant families, as well as dealing with issues around staffing and providing culturally appropriate service to older immigrants.

The fourth theme was related to senior client issues and the challenges in trying to meet the diverse cultural, social and economic needs of older immigrants. Among the more important issues that key informants identified were complicated health issues often stemming from diverse cultural views of health, the increasing incidence of mental health illness and issues and the physical isolation of vulnerable immigrant seniors.
Finally, the fifth theme was the challenge of mainstream societal views, whether it was systemic discrimination or attitudes in the health care system or with society at large. Many key informants discussed the fear and distrust of many older immigrants which influences their ability to become integrated with the wider community. Ageist attitudes, racial and ethnic discrimination as well as anti-immigrant policy and attitudes create hostile environments for many immigrant seniors and their families.

In general, key informants discussed challenges with the wide diversity of older immigrants in terms of ethnicity, language, socio-economic background and immigrant status. Although not explicitly stated, many key informants appeared to operate from a multicultural or culturally competent approach, which is underscored by an equity approach towards health and social services. Many of the descriptions that key informants shared about the older immigrant communities were broad in scope. Adopting a social determinants of health framework, key informants described the varied social, cultural, economic, and political situations of immigrant seniors and how these invariably influenced their health and wellbeing, as well as their access to health and social services.
Chapter 5

Ethnic and Cultural Diversity of Aging Immigrant Populations: A Key Informant’s Perspective

5.1 Introduction

The health and social disadvantages experienced by international migrants living in foreign countries has been well documented, with much of this research using large-scale population surveys for quantitative analyses. Research examining the health and social disadvantages of older immigrant populations often focus on a sub-group of immigrants, such as immigrant women or a specific ethnocultural group. From the research it is clear that immigrants, regardless of gender, race, ethnicity, age or immigrant invariably experience poorer health outcomes and access to health care than the native-born population. While the ethnic and cultural diversity of Canada’s overall population have been widely discussed, often focusing on the economic and political processes, there is little research that analyzes more in-depth intersections of race, ethnicity and immigrant status in later-life. There are some notable exceptions such as a scoping review on the health and health care of ethnocultural minority adults, where Koehn et al. (2012) review studies that specifically addresses health inequities from a intersectional and social determinants approach, including the “specificities of immigration” (Koehn, Neysmith, Kobayashi and Khamisa, 2012: 1). Other exceptions include intersectional analyses of gender, ethnicity and age, using Canadian Community Health Survey data, in examining the healthy immigrant effect (Kobayashi and Prus, 2012).

Koehn (2009) applied the candidacy model to examine health care access barriers among vulnerable groups including racial and ethnic minority immigrant seniors. Using focus groups, Koehn applies the candidacy model to frame the patient-provider relationship as a dynamic and contingent process of interaction in order to reveal the vulnerabilities that affect access to health care. Rather than focusing on utilization measures of equitable access, Dixon-Woods et al. (2006)
describe candidacy as a more useful measure of access based on eligibility of care that is constructed between the social contexts of people and the macro-level factors of health services and the allocation of resources. While identifying barriers to access is important, whether they be at the individual-level or system-level, it is also important to understand how these barriers may be the product of the patient-provider relationship.

This research is important and timely for two reasons, the first being that current research, political and public health discourse has been fixated on the spectre of the aging population and the challenges it potentially poses to health and social care systems, which is not only happening in Canada but worldwide. Secondly, as Canada’s immigration policy adapts and evolves to primarily meet the ever changing needs of Canada’s economy, whether it sets out to improve the economic standing of incoming immigrants, respond to regional labour demands with commodity booms, or to redistribute immigrant labour pools to less densely populated regions of Canada, the social composition of immigrants is also evolving (Ferrer, Picot and Riddell, 2012). These two powerful and intersecting forces result in a number of poorly addressed and difficult predicaments for the aged and aging immigrants across the country.

This study qualitatively analyses the perspectives and accounts of key informants on the central issues of aging immigrants’ health status and health care needs as well as the challenges faced. The previous chapter focused on how key informants viewed and described aging immigrants in various settings, outlining the important roles they saw older immigrants as having in the community and within the family. Key informants were also asked to discuss some of the difficulties they encountered when working with these vulnerable populations. Extending the discussion on the challenges that they face in dealing with aging immigrant populations, key informants made specific reference to issues of ethnic and cultural diversity, transnational practices, multiculturalism and culturally competent care and a focus on the older immigrant populations being served by the key informants.
As such, the aims of this chapter will be to examine more closely the role of ethnicity and culture in the migratory experiences of immigrant seniors as described by key informants. In addition to describing the various roles of older immigrants and the challenges that key informants faced, they were also asked to describe the most common issues unique to older immigrants. The results in this chapter aim to answer the following research questions:

- **What role does ethnic or racial background play in the health and wellbeing of aging immigrants? And how does this influence how key informants approach aging immigrants?**

- **What are the implications of an ethnic and cultural background with respect to issues of access and availability of health and social services, particularly in a multicultural city like Toronto? How does this influence the health and social service seeking behaviours and decisions for older immigrants?**

In answering these questions, this chapter addresses the overall research goal for this project, which was to:

- Describe the factors that influence health care seeking behaviours and decisions around issues of aging among later-life immigrants in Canada (Research Goal 2)

- Describe the social determinants, migration and the role of place influence the health and aging experiences of later-life immigrants (Research Goal 3)

The various descriptions given by key informants on the ethnic and cultural backgrounds of aging immigrants generated much discussion that was focused on the migratory experiences of health and aging, as well as the complicated geographies of immigrant families and seniors. Results from key informant interviews also revealed what community-based multicultural practices and culturally competent care looks like at the service level.
5.2 Migratory Experiences: Different Trajectories in Life

There has been growing interest in the relationship between the migratory experience and health or access to health care. A number of researchers have argued that migration should be conceptualized as an important social determinant of health since migration and resettlement is not a single event but has lasting effects that play out for the rest of an immigrant’s life (Vissandjee, Desmeules, Cao, Abdool and Kanzanjian, 2004). International migration is not as simple and straightforward as uprooting and resettling when an individual decides to relocate from one area to another as there are often many factors at play (Castles and Miller, 2009; Torres, 2004). Equally important is recognizing that an individual does not begin life as an immigrant but that often they have strong connections to their birth country, which are often sustained and in many cases integrated into their newer and continued life experiences (Kelly & Lusis, 2006). Within the limited literature in ethnogerontology there is also a growing interest in recognizing international migration as an important factor in the aging process (Torres, 2004). Despite numerous studies having examined the health outcomes and experiences of immigrant seniors living in Canada, a majority of this research is largely focused on Chinese and South Asian elderly populations (Gee, 2000; Chow, 2010; Lai and Surood, 2010; Surood and Lai, 2010), and few have explored how the complexities of migration influence health and aging.

One methodological challenge with immigrant health research is that many of these studies are limited to the use of large-scale cross-sectional data, which often cannot account for earlier (pre-migration) experiences as equally important. Cross-sectional studies of this type reveal a significant limitation in our conceptual understanding of immigrant status as a population category. There is no variable that can accurately measure the migratory experience, except to categorize individuals as immigrant or non-immigrant, or sub-categories of immigrants such as family class or economic immigrant. Life course theory is a useful framework for understanding the health and aging of immigrants in later-life and the associated health disadvantages that they may have accumulated in earlier stages of life. For many immigrants, the processes of
immigration and resettlement, the creation and reproduction of transnational spaces, as well as other globalization processes have important implications for health. Often the decision to move is not just the sole act of an individual but in some cases a social act, often including other family members in the decision making process (Castles and Miller, 2009; Kobayashi and Preston, 2007).

In this study, key informants offered numerous examples of how different migratory experiences played out in immigrant seniors’ lives with respect to health and aging. Beyond categorizing these seniors as immigrants, key informants portrayed immigrant seniors’ lives as highly complex, for instance when speaking about class differences among seniors:

17: Class is still alive and well even though I’m aging, right? But, when we think of white folks aging, we don’t think that the white folks from Rosedale age the same as the white folks from Regent Park. We instinctively know that those are two different white folks but when you think of immigrants, we don’t make that distinction any further we think of them all as just immigrants.

Not only was class a factor for the differences observed among different immigrant groups but also educational attainment or access to certain forms of knowledge. For instance, another key informant discussed the migration and integration experiences of long-term immigrants who, presumably, have had greater opportunities. Over time long-term immigrants are likely to have had more opportunities to participate and integrate into the social and economic life of Canada, accruing invaluable skills and wealth. Whether it was obtaining an education, furthering their own education or being active in the labour force, these activities and opportunities are invaluable to an immigrant’s ability to become integrated and exposed to mainstream systems that many native-born individuals tend to take for granted:

18: I think the difference for the ones who came when they were younger is they’ve had the opportunity or the privilege or whatever you want to call it to go through the educational system sometimes and then so they have been more aware of some of the things that they need to do. Like for example, planning for retirement, looking at getting an RSP or not. You know that kind of thing. Then they would have had the opportunity to learn those things through school. So they probably would have been able to retire a little more comfortably than someone whose come over at 65 and hasn’t contributed to the system. Cause then they’re going to absolutely get less.
As well, key informants also discussed the various motivations for immigrants choosing to migrate to Canada, which not only influence their decisions and behaviours about health but also have important consequences for expectations of aging. According to many key informants, immigrant seniors came from a wide variety of social, political and economic contexts and in a majority of cases migration disrupted their lives in a myriad of ways:

21: I think it—there are different aspects. If we talk about people who’ve come here as seniors or towards, yeah at later stages in their life, (their) ethnic and cultural background – what people are used to has a very big impact on their lives. It has an impact on their living, healthy living – what people are used to in terms of food, in terms of environment, in terms of lifestyle and what they can have once they are here. It has an impact on health practices and on how people access the health system and what they do to cope with health issues and it has a huge health impact in terms of accessing services – language, cultural understanding and navigating the services…

Again, as many key informants discussed, there were important differences between immigrant seniors who are newcomers versus those immigrants who have aged in Canada. When asked to explain the differences between these two generalized groups of immigrant seniors, most key informants described two vastly different portraits of the immigrant senior in Canada. The typical characterization by key informants follows below:

07: Those who worked here, those who grew up here – they’re professional(s) who’ve worked here. They worked, they know the system, they can demand their rights. They know what’s right for them – they know a lot. And they have money! They even have taste and they know where they are going. They have a goal. And they know why they came here. The other group happened to come by circumstances – different circumstances, family mostly, refugees sometimes. But refugees (or) through their children, they’re really misplaced.

For most key informants, they broadly viewed long-term immigrants as having accumulated the wealth necessary for retirement to enjoy a typical senior retirement. As the same key informant above noted later on in the interview, many newcomer seniors do not understand the concept of retirement and leisure. Their expectations of aging are disrupted by moving to a foreign land in later-life, whereas the long-term immigrant has had the exposure to more mainstream ideas of retirement in Canada.

In another portrayal of immigrant seniors, one key informant made reference to the self-selection of younger immigrants who tend to be healthier, resourceful and more ambitious than
those who choose not to emigrate. For some of these individuals, she notes that they may be more
at an advantage than the native-born population in coping with aging. She implies that there are
differences of abilities to adapt to the aging process among immigrant populations versus the
native-born, explaining that that immigrants have experienced the process of having to adjust to a
new way of life and thusly, are used to having to adapt to new circumstances. Whereas Canadian-
born populations may struggle with the associated age-related changes such as declines in health
or in mobility:

13: I always theorize that the people who have immigrated are the more ambitious and
adventurous people, right? Because you would look at those that choose to stay in their home
country, or might tend to be the people who are more used to routine and keeping things within
their knowledge of things...Whereas I think if you come to Canada you are looking at it—you are
expecting something new, right? And you have adapted to something different that is not like it is
back home and I think people who mourn what happened back home generally tend to, if they
can, go back if they’re not happy with what happened here...And as I’ve said they’ve had an
experience with change and adapting, which for someone who’s lived their whole life here, aging
and changes in mobility may be the first adaptation that they have to make.

Another important aspect of international migration that key informants discussed was
the diversity seen among sub-groups of immigrants. This was mostly emphasized by key
informants who worked with specific ethnic groups. For example, one key informant who worked
specifically with the Chinese community discussed the class differences among Chinese
immigrants in Canada explaining the various waves and geographies of Chinese immigration. She
noted important differences not only in the social contexts of migration but made reference to
changing immigration policy in Canada that results in different groups of Chinese immigrant
seniors:

14: One group of seniors, they have been here for a long period of time like over 30-40 years that
they just come here when they are young and in fact among this group some of them may be, you
know they are not very educated. I mean very, you know very – they don’t have the language but
they just come here for life, for living so they work here and what have you in the Chinatown,
and this is one group of seniors. But soon there will be another group of seniors that they are
more educated, like they come here for studying and then when they finish the school they get a
chance to stay here. So they will be a small group of seniors of very educated but they have been
here for a long period of time. Yeah and also the third group of seniors will be for those that
immigrated to Toronto because of the economic recession in 1970 and there will be a group of
quite the middle class seniors or more well-off seniors, so you know they just come here and you
know for business or for something. So, there will be sort of three group of senior(s) that has been staying here for a long period of time. And then there will be another group of seniors that they come here after like 1987 because of the changing of the immigration policy in Canada.

She continued to describe the wide-ranging sub-groups of Chinese immigrant seniors and the challenges of trying to meet the diverse needs of this group across the continuum of care. Although the agency she works in provides a broad set of services that cater to the Chinese-speaking population, she describes the Chinese community as highly diverse and complex. Not only do these seniors vary in their social circumstances or have different migrant experiences in Canada, she notes that they also have very different cultural practices and relationships within their own families.

There were also important differences among various sub-groups of immigrant seniors beyond race and ethnicity. In particular, there are very important differences that were noted between newcomer immigrants versus long-term immigrants, where one group of immigrants arrived at a younger age, and presumably under very different economic and political circumstances in Canada and countries of origin, and are now aging in place and the other group being those who arrived already as seniors, having lived a majority of their lives in another country:

11: Seniors that are arriving now and they are already seniors, their trajectory is very confined to their families, right? Their ability to have a bigger world versus a smaller world is very hinged on what’s happening with your family. Whereas I would think that with people that arrive at a younger age and age here in the society, they have a broader network…and there’s perhaps greater self-determination and their ability to choose one path over another. A lot more things can happen over that path, right? Whereas I would think that seniors who are arriving here today, you know they are already old and their ability to acquire language skills, to become employed, to tap into networks, you know is inherently sort of a condensed period. And the world is bit smaller.

More broadly, many key informants discussed long-term immigrants as being better equipped to access the many resources needed to integrate successfully, such as language skills, employment, Canadian citizenship, wider social networks, knowledge of the health and social care systems, etc. As the key informant above noted, many newcomer immigrant seniors are often bound to families, whether through sponsorship or because they depend on other family members
to help them navigate a foreign country, which limits their abilities to access the same resources as more long-term immigrants who have aged in Canada and are now seniors.

The same theme on the vulnerability of newcomer immigrant seniors is also echoed below. As discussed by one key informant, even though these seniors are protected by family, by not widening their social circles beyond family it has the effect of perpetuating their continued vulnerability and increasing dependence on family:

13: I think that those that have immigrated in later life are more vulnerable because they may come with less language skills and might be isolated because many of them are sponsored by their families. So they are—they would be having to negotiate their new country through the eyes of old, and are kind of vulnerable to the, you know the extent to which their children are interested in integrating them. But I think there are people that don’t get out of the house, don’t—at least in a work place people meet each other, get a better sense of their environment, culture. Whereas if you came to Canada, came directly to your daughter’s home, spend your time taking care of kids and know only to walk to the park and back or the one store and back, their lives could be very insular and have not had the real experience of what it is to live in this city. So I think that there’s a lot more vulnerability for those who moved in later life.

What is considered a “long-term immigrant” varies within the literature. For a majority of Canadian research this often refers to those immigrants who have lived in Canada for ten years or more, particularly among research that explores the healthy immigrant effect (Dunn and Dyck, 2000; Gee, Kobayashi and Prus, 2004; Kobayashi and Prus, 2012). Other research has used three categories of length of residency: recent (three years or less), mid-term (three to ten years) and long-term (ten years or more), to assess health trajectories over time (Vissandjee, Desmeules, Cao, Abdool and Kanzanjian, 2004; Asanin-Dean and Wilson, 2010). Other ways that researchers have measured the different stages of migration include duration of residence and cohort arrival year (Newbold 2005a; Newbold2005b). Rather than relying on a time threshold utilized by other studies, Newbold used the National Population Health Survey to track “aging” and assess the health of immigrant cohorts over time.

However defined the premise behind this measurement of migration is that there exist important differences in health over time, which has been most popularly denoted by the healthy immigrant effect describing recent or newcomer immigrants as having a significant health
advantage over long-term immigrants (Deri, 2004; Gushulak, 2007). The differences in the migratory experiences of immigrants who are either now beginning to age or who had arrived already aging have important implications for their health and wellbeing. Among the many differences noted by key informants, having established social networks and finding one’s community were seen as the most important. However, even between these two broad groups of newcomer and long-term immigrant seniors there still exists many differences among them.

Among long-term seniors, immigrants that arrived before the introduction of the formal point system in 1967 tended towards unskilled labourers (Ferrer, Picot and Riddell, 2012). With the point system, immigrants were admitted based on age, education, and language proficiency. This system was based on a number of economic goals including regional labour demands in certain occupations. While the emphasis for admission was the economic class category of immigrants, other immigrant classes including refugee status and family reunification were also widely permitted. Though the expectations of the broader Canadian society or the majority culture for newer immigrants include having to learn either the English or French language, and to politically, socially and economically integrate, this is not always the reality (Midiema and Tastsoglou, 2000). A number of key informants identified that participation in economic life does not always result in expected social integration and what would be considered the “successful” migration experience:

08: As I said, maybe they immigrated not young but their 30’s maybe 40’s and they come directly to work because they need to live and go to start jobs, maybe in the factory, things like that where, the minimum—like maybe they’re not focusing language, or similar language it’s just, you know, (a) sign language kind of thing and the (years pass) and they never really speak, learn the English language, right?

14: Although those who have been here for long time, but they might not have very good English, they might just have some conversational English, other than those who are you know visa student or businessman, but those in general, they come here for a long time, they don’t have the language here. And maybe for the 30 years they just stay in Chinatown, so they’re not integrated. Although they have been here for many years, but still they are not integrated in the community. For the reason may be they are busy you know making living, they don’t have the language and they you know (they are) just in certain area.
So while many key informants generalized long-term immigrants as having greater opportunities to access the social, economic and cultural resources required to become fully integrated with the broader society, there were also immigrants who, now at an older age, are not integrated and remain highly vulnerable and disadvantaged:

11: When seniors arrive and they arrive with low levels of education it’s very difficult for them to ever climb out of being in a very marginalized place in society. A concrete example, my mother came, she had grade three education she was not literate in English, neither was she literate in Chinese. She had a lot of children, we were poor. Someone like that really never stood a chance in hell that they would ever acquire fluency in English or make friends who, no she didn’t make any friends right? She was just busy, busy, working, working, working at home. She was quite isolated that way.

Compared to previous waves of immigration, more recent immigrants arriving in Canada are often much younger and highly educated. Looking towards the future aging of these younger immigrants, one key informant felt that the advantage of education is nullified by occupational barriers set within the hierarchy of social institutions, which perpetuates immigrants’ lower social standing:

11: Today’s immigrants—so that’s kind of like the younger people who come and then begin to age. As people like my parents age, I think for all intents and purposes they remain marginalized their entire lives, nothing really changed. Okay, right. I think today we have a different category of immigrants because of the—our immigration system has changed, you know the whole point system. People that are coming tend to be more educated and what’s at play today is quite different. So the sort of credential barriers, the different employment barriers are put in place that cause immigrants today to not be able to leverage their training and education, impoverishes them. Right?

She further argues that these early and prolonged migratory experiences stemming from the occupational and economic struggles of newcomer immigrants have a significant impact on their overall health and aging. She sees little difference between immigrants from the earlier waves of immigration, such as those arriving in the 1970s, compared to those arriving today precisely because the systematic barriers and hierarchical power relations rooted in the political and social institutions in society remain largely ignored or unacknowledged when describing the post-migration experiences of immigrants.
Another important issue regarding the diversity of the aging immigrant population is the
circumstances or reasons for why people choose to migrate. According to key informants, these
reasons or motivations vary widely among different sub-groups of immigrants and influence their
post-migratory experiences and expectations about health and aging. For instance, one key
informant stressed that just as the senior population itself is not a homogenous groups, one should
be cautious about describing one immigrant aging experience. She explained below that different
aging and health trajectories of immigrants can be mapped along immigration trends and patterns:

17: So, the aging immigrant population – there’s not one aging immigrant population in Toronto
– that’s the thing that’s really—what’s interesting! So for me, there’s a direct correlation between
the immigration pattern and aging. And so, depending on what year of immigrants you’re looking
at is where they are on the continuum (of aging).

She continued to describe the differences in the health and aging experiences of different sub-
groups of immigrants, including refugees, in terms of interactions with the healthcare system
revealing how complex immigrant seniors lived experiences of health and aging were. As she
further explained:

17: The aging are the ones that came—and it makes a difference because if they came in the ‘40s,
‘50s, ‘60s the seniors may not speak English themselves but their children and grandchildren do
so that is a whole different relationship with healthcare. It’s much more, more of a challenge say
for the Tamil (refugee population), who have just arrived, have children, have to interact with the
health care system, they themselves don’t speak English and their children are too young.

When discussing the challenges of working with diverse and vulnerable immigrant
populations, another key informant discussed the various social circumstances of immigrant
seniors, specifically Jewish-Russian immigrant seniors. She describes this particular immigrant
group as extremely oppressed and marginalized even among other sub-groups of immigrants,
explaining that they are often living in poverty having very little personal and economic resources
in addition to a lack of community resources that address their specific needs:

04: Even the small salaries, the pensions they were getting they still would manage (to) help their
children and grandchildren, give little gifts - a little something. They were able to give to them
and now they cannot do anything…(a)nd they struggle and they suffer in silence because they are
not able to talk about it to anyone. Because again it’s a language barrier and seniors are unable to
talk so this is a lot of tension, so a lot of abuse situation. But again it’s Russian culture where you
don’t bring your dirty laundry to the outside world so sometimes it takes a very serious episode for a senior to bring the abuse to the social workers, those who can help them.

As key informants discussed the experiences of migration and aging and the challenges they faced with regards to the immigrant senior population, many concluded that there was no one way to typify the aging immigrant experience. The consensus among key informants was that until the diversity of such groups, immigrant and older populations, is acknowledged and specifically acknowledged, there will always be an incomplete understanding about aging and migration for Canada’s immigrant seniors.

5.3 Processes of Immigration

There were a number of ways in which key informants discussed the migrant settlement experience of various immigrant populations across the city. The link between the migratory experience to ideas about culture, place and health were broad and widely diverse, many of which were tied to issues of social and physical isolation. In describing migration and settlement experiences, key informants used various terms, including integration, assimilation and acculturation. Though each of these terms have different and very important political, economic and social associations each tied to their meanings, many of the key informants did not define what they specifically meant in using these terms.

The process of assimilation, as described by some key informants, is explained as the complete adoption of the social and cultural patterns, customs and values of a host country so as to be indistinguishable from the native-born population (Henry and Tator, 2006; Walters, Phythian and Anisef, 2007). The process of integration in contrast is where an immigrant or immigrant group becomes an active part of the host society but also maintains their own distinct ethnic and cultural identity (Berry and Kalin, 1997; Walters, Phythian and Anisef, 2007). Early research on immigration and ethnic relations of immigrants primarily referred to assimilation processes to describe their settlement experiences. However, many scholars have since acknowledged that immigrants may undergo numerous and different processes over migration
experience – some immigrants may assimilate while others may exhibit more integrative strategies (Walters, Phythian and Anisef, 2007). As well, the focus has often solely been on minority migrant groups but it has become more apparent that the dominant culture group also experiences adaptations to demographic and cultural changes brought about by immigration.

With Canada’s Multicultural Act, which legitimizes cultural and ethnic diversity, assimilation is not a goal of multiculturalism since it assumes that only the minority group adapts to the culture and values of the dominant group. An alternate process of cultural adaptation and integration to a pluralist society is acculturation, a process where the minority and the majority cultural groups both adapt to each other. Several scholars have written on a number of acculturation strategies adopted by immigrants. For instance, Berry has written extensively on the interrelated processes of ethnic relations and acculturation (Berry and Kalin, 1979; Berry, 2001; Berry, 2006). He argues that often these two phenomena are written as parallel processes of multicultural practice in pluralist countries like Canada but that they actually work conjointly framing both ethnic attitudes of tolerance and acculturation expectations (Berry, 2006). Among the various acculturation strategies described from the point of view of immigrants these included assimilation, separation, integration and marginalization. Previously conceptualized as attitudes, these strategies incorporate both attitudes and behaviours and relate to different immigrant and settlement practices.

In describing the migrant experiences, results from key informant interviews confirm that different sub-groups of immigrants have wide-ranging experiences of multi-ethnic relations, both among themselves and with dominant culture groups. Acculturative experiences, such as racial segregation, the development of ethnic enclaves or the mixed integration of ethnocultural groups in health or social programming was also referenced by key informants. Many key informants emphasized the importance of enabling immigrants to maintain their own cultural identities and customs, but also described how it was necessary to provide them with the ability to make
informed decisions about their health and aging, especially with respect to understanding how the health and social care systems work. The related discussions around these different processes of settlement speak to the complex and intricate ways in which the discourse on multicultural practices, immigration and ethnic or cultural identity shape the realities of aging immigrants:

02: ...(T)he ways in which people become acculturated, so your knowledge base about the culture, the dominant culture that you’re living in so understanding the culture, understanding the health care system, understanding things like Alzheimer’s disease because there’s been a lot of I mean I’ve been in this line of work for a long time and I will tell you that people’s understanding of Alzheimer’s, just the general population is much better now than it was thirty years ago.

In response to the overall lack of culturally sensitive care for aging immigrants in Toronto, some key informants discussed the ability of some ethnocultural groups to branch out and develop their own culturally appropriate patient-centred care. For instance, both the Yee Hong Centre for Geriatric Care (http://www.yeehong.com/centre/) that was originally founded to address the elderly Chinese communities and the Baycrest Centre for Geriatric Care (http://www.baycrest.org/) which was first established to support older Jewish populations in north Toronto were notable and well-known examples of ethnocultural-specific care in Toronto. Although both centres have expanded to care for a multi-ethnic population they still maintain the founding principles of meeting the care needs that are specific to the cultural and religious values of diverse elderly populations. In particular, key informants explained that serving the culturally specific needs of an ethnically diverse population requires active participation and investment from the community:

04: The Jewish community, the Chinese community are, you know, well organized communities and the Yee Hong and Baycrest—are the jewels in the crown as far as care is concerned in Toronto. They all have the support of their own community besides what they get from the government. And that’s why they’re better.

17: …(P)articularly when you get over to the nursing home side where that the homes – unless you get into the culturally specific homes, and it’s only the immigrants that came early that made money that can afford to do that. The immigrants who came later and didn’t acquire the same wealth cannot have a Filipino home, a “this home”, a “that home”. But the homes themselves aren’t organized to provide cohorts of care to cohorts of people and therefore create culturally sensitive environments. You have a few exceptions, like in Toronto you have Ismaili community who have worked with one home to create, some floors for the Ismaili community and that
community provides culturally appropriate care… So that still is missing. You know the Italians have an Italian home, you know the Chinese have a Chinese home and the newer Chinese because they were the wealthy from Hong Kong have the money but all the other immigrants, the Tamil, the Filipino, the Caribbean, you know they came after a time that they couldn’t accumulate that much wealth.

In contrast to the above quotes, another key informant who worked exclusively with Chinese-speaking seniors discussed the poor integration of the Chinese community in various parts of Toronto with the broader Canadian community. She explained that while initially it would be beneficial for newcomer immigrants to be able to connect to other members of the community and have access to a full range of services in their own language there are some disadvantages with having an insular and racially segregated community:

14: …(I)ntegration is still another thing that, like before they don’t have the English so it’s difficult for them to integrate. But now for now, for those seniors that come here is because you know in Toronto or in Scarborough or somewhere in York region, there's lots of things that is Chinese. So, on the other hand it’s too difficult for them to integrate because it’s no different than to not integrate. You know what I mean? Because it seems that they are more—that now (things) are more convenient like when they go to the supermarket; it’s Chinese. The bank; Chinese. So in a way it’s good for them because it’s more easy to settle down, to adjust. But on the other hand it’s difficult for them to integrate because it’s no different than to not integrate.

So while from a health care and a newcomer settlement standpoint, living in a culturally specific community can be a positive environment overall, she cautions that social isolation can become a risk within these types of communities that are culturally or racially segregated. Many Chinese seniors she noted experience situations of elder abuse within the family. These communities are unequipped and lack the knowledge to address issues of abuse, as well there is a lack of data and statistics on the prevalence of these situations. Immigrant seniors in these communities, she recounted may be fearful of seeking help outside of their own community as these issues are considered taboo. Fear and lack of trust of the outside community are potential problems because they are unable to communicate or are simply unaware of the services available to help them. As many key informants described, ensuring that immigrant seniors receive the help they need, whether it is a health or social service, requires help from the community as well as the
family. And as another key informant described, one of the greatest barriers to receiving care or knowledge about one’s rights is not knowing where to find the information. For immigrant seniors whose lives are very much limited to the family, they may have difficulties getting the help they need unless they have connections in the community as well:

16: I mean if they had a job that means the likelihood is that they’ve learned some English. And if they’ve learned some English, the likelihood is that they’ll know more - they’ll know of resources more. Information; the law; their rights. You know if they’ve been around and outside of the family home they probably have picked up that information. Whereas for newcomer families or newcomer seniors that have arrived as an older person, they don’t have that. And if they are in a family that is likely to use and abuse them they’re probably very unlikely to ever receive it. Cause there’s no way they can get the information except if they go to a day program or the radio we could get things out through the media. I would think that is one of the biggest things is how to inform newcomer seniors. If they have a health problem that’s you know they’re taken to the doctor and they’re set up in a day program or some kind of health program that helps them with their diabetes, Alzheimer’s, whatever it is but until – that’s probably really one of the few things that they have an opportunity to learn things, is actually through their health.

Key informants working in community-based agencies also spoke about the immigrant experience as being a unifying trait among culturally diverse communities. Many of the key informants who participated in this study worked with diverse populations and emphasized multicultural practices that were centred on socialization through cultural sharing or modified communication, such as sign language, where language barriers exist:

13: But what always surprises me is that you always think, "Well seniors are so set in their ways" and that they'll have trouble adapting to no cultures and it’s not true. Here in the way people interact with one another it’s like they’ve lived all their lives integrated you know there’s a lot more desire to connect than to separate I find. And maybe it’s because everyone has something that they share in common and that is an immigration experience, being new, of not fitting in, so they don’t want to do that to each other maybe I don’t know.

As many of the key informants noted, immigrant seniors also had very diverse migration and settlement experiences that not only influenced their level of integration in Canada but also their strategies for adjustment and information seeking. For those who were tied to family, which may be good for some seniors, many key informants worried that these seniors will remain socially and culturally isolated and have negative consequences for their overall health and wellbeing.
5.4 The Structure of Immigrant Families

International migration, as described by Castles and Miller (2009) is a collective act driven by economic and political incentives where both receiving and sending nations undergo important social changes at the macro-level. Also important are processes of change that occur at the micro-level, such as family or the household unit. Transnational families, as assemblages of separation and reunification, often across distant international borders have important implications for the health and well-being of the family unit. Research on transnational families and the complicated geographies of migration systems and family networks has been growing steadily. The ascent of the “family” as an important unit of analysis of transnationalism has become an interesting study on citizenship, transnational identities, state policy and various forms of discrimination (Walton-Roberts, 2003; Waters, 2003; Kobayashi and Preston, 2007).

Social reproduction has been described as the social patterns, attitudes, practices, and behaviours that constitute the maintenance of everyday life (Laslette and Brenner, 1989). Researchers using the concept of social reproduction have outlined three attributes which include the biological aspect of reproduction and social constructions of motherhood, labour force reproduction including education and employment training and finally the production of private and informal care work at the micro-level of the family (Bakker, 2007). In the 1970s and 1980s the concept of social reproduction was strengthened by feminist writings and gender analyses of the social organization around work in the household and the political economy of the home (Laslette and Brenner, 1989; Bakker, 2007).

The family constitutes an important site of social reproduction and transnationalism, as migrant families are transformed and shaped in many ways that challenge the current norms and traditional structures of families. This is especially true for multigenerational immigrant families where seniors occupy a number of roles within the family. In recent years, immigrant seniors have found their way into Canada through family reunification in order to help care for their extended family and home. For many immigrant seniors, particularly newcomer seniors, family is
often at the heart of many immigrant seniors’ decision to move from one country to another, as well as the reason why they opt not to return to their home country in their retirement years. Key informants spoke about how commonplace multigenerational households were among immigrant families. For many immigrant seniors, families are an important source of social support, particularly in later-life as they transition to a new life in a foreign country. Key informants described family as a buffer to the migratory stress that accompanies immigrant and settlement:

01: …(S)upport is a big factor in terms of making people healthy or function well. So they are here because they want to be together, reunified with the family and or they might not have anyone anymore back home. Or (because) they are left in their home (back home) so they are brought in by their children here.

09: I think that if you, for immigrants, for instance people who’ve been living here. Some they have their own families here, so maybe they only came here with two children and their two children are gone, so they have nobody else here. But going back to their country is not easier because they won’t have the healthcare that they have here, or the pensions or I don’t know, many things. But then, they don’t have anything else, right. Whereas any person who has all their family here. Something happens and they know they have a brother, or whatever their family is.

Despite broad differences across sub-groups of immigrant seniors many key informants described immigrant seniors’ experiences with health and social care as being contingent upon their interactions with family members. For many newcomer immigrant seniors, family was integral to their social wellbeing and health as they settle in a new country. One key informant explained that having access to economic resources was an important factor in the aging process but added that for some immigrant seniors, particularly the poor, family was a substitute for money:

17: I would say the difference – the significant difference in your aging experience I would think is money. People may often think it’s family and family support but it’s because family is a substitution for money, right?

On the surface she explains that under this scenario a senior who may not have money but lives with their family has access to some type of care and financial support. She compares this situation to a senior who lives alone and does not have the income or economic resources to
move into a long-term care facility or to financially access home support services. What she implies is that the role of family is an important source of social capital.

The concept of social capital relates to various aspects of social relations, including interpersonal trust, reciprocity and mutual aid, often with intentions of mutual aid (Kawachi, 1999). Numerous studies have found associations of social capital and health at the community-, neighbourhood- and individual-level (Luginaah et al., 2001; Veenstra et al., 2005; Veenstra, 2005; Poortinga, 2006). Researchers have also suggested that social capital has a significant role in advancing the achievements of communities and individuals. For instance, Sanders and Nee (1996) refer to the social capital of family to enable immigrants to secure business ownership and self-employment during migration. For many immigrant families that are struggling financially, elder members are not only recipients of social support but also play a supportive role in providing informal care either to their grandchildren, their adult children or a spouse. As another key informant explained:

21: Many times too, (they) also help their family, take care of the children, take care of the household, also support their family – what they often face that at a stage in life where it is harder to learn new things and to get accustomed to new ways of living, they are transported into a completely, or often an environment that’s very different from the one they’re used too; food, cultural, lifestyle. And of course they lose a lot of their social contacts, so they have to rely on their family a lot.

Within immigrant families, intergenerational relations, personal ties and shared family interests help to facilitate economic resources and labour reproduction. The role of the senior caregiver is common in many immigrant families, particularly for those families that are struggling financially. However, key informants also discussed the many negative situations that can arise from multigenerational immigrant households. Many of them emphasized that multigenerational families that exist in immigrant communities were incredibly stressed financially, struggling to find childcare or juggling multiple jobs. Not only did seniors serve to provide unpaid and invisible labour in the way of childcare for their own grandchildren and in some cases also caring for an elderly spouse but they also tend to household duties such as
cleaning and cooking. Most notably, key informants described situations where the position of the senior as a respected elder shifted once they rejoined family and suddenly are cast in the role of a dependent:

01: There are some great stories but there are also some sad stories, where their children have changed, they are not as supportive to them, they are left on their own and sometimes there are even really abusive kind of situations where they are just kept in their room, and you know the expectations that they are like maids or something like that. Not given any financial support for them or not even facilitate them going to the church, so you hear all those kind of stories, so I think it’s a bit different for those who come in as seniors.

11: They have no language skills. They’re not employable. There’s no alignment with who they are with any opportunity for employment in this society...So that’s for me a manifestation of how stressed newcomer families have become that you see a whole phenomenon of seniors behaving in ways that (are not) within their own cultural context...you actually have immigrant families where the primary applicants are educated and skilled but they’re living in poverty and the family structure is completely broken and the culture’s broken.

14: Because back in the home country you know they have more independence they are more economic—or you know transportation wise, language wise, (are) more independent, but now when the seniors move to, you know a new place, and they have to depend very much on the adult children or the grandchildren as well. So you know before they might be, you know in Chinese culture senior would be more, have more respect and authority in the family but now when they move to a new place and they don’t have the language, transportation, finance, so now there role would be more like a filial. I don’t know the word but more like a subordinate—a subordinate role.

Key informants gave numerous examples illustrating how financially strapped immigrant families were. Among the accounts told by key informants, they shared stories about how some seniors would devise ways of supplementing the household income by collecting glass bottles and cans from the garbage for deposit return. Other cases included the removal of elderly patients from much needed services from long-term care facilities or day programs by their adult children because the family could not afford to keep them there only to have them end up alone all day in their homes vulnerable to a number potential hazards including falls or for those seniors with cognitive issues taking to wandering the streets in their neighbourhood.

In the most extreme cases of senior neglect within immigrant families were incidences of broken sponsorship (n=4) and the devastating impact on older immigrants. In Canada, family sponsorship is a common way for immigrant families to be reunited and requires that the
sponsoring individual be a Canadian citizen or a permanent resident\textsuperscript{12}. Ideally, family sponsorship requires that the sponsoring family member commit to ten years of unconditional support, which is the longest term of any other family class category of immigration (Koehn, Spencer and Hwang, 2010). Sponsorship breakdown can occur at various stages of the application process and most often when the sponsored individual lands in Canada. Many instances of senior sponsorship breakdown, which includes financial support from the sponsoring individual, result in great hardships for seniors, often leaving them financially and socially vulnerable (Koehn, Spencer and Hwang, 2010).

While there are a number of reasons for why families choose to sponsor older family members, the reasons for broken sponsorships among immigrant seniors are not well known. One key informant spoke about the more common challenges of meeting the basic needs of seniors, as well as the social isolation that comes from busy households where older immigrants may not see their family on a regular basis:

\textit{06:} The more assistance you can provide them, and then you know ideally if there were, you know some funds or anything like that available to assist them, I think that would be beneficial. I recognize that when you sponsor someone technically you are taking on that responsibility but I don’t think that people fully understand that.

For one key informant she noted that the most common concerns that service-providers like herself would hear from seniors would be that they lack stable housing, that they do not have access to food, that they are unable to retire or that they never see their family. These were often the most common issues voiced by seniors but she argued that there needs to be a more nuanced reading of seniors’ complaints:

\textsuperscript{12} Although a temporary freeze was been enacted for family class sponsorship applications received after 2013, the Citizenship and Immigration Canada (CIC) reported that a total of over 50,000 admissions for 2012 and 2013 for older parents and grandparents would still be processed. Most recently, newly appointed Immigration Minister Chris Alexander, reversed this freeze pledging to continue processing family reunification applications, in limited numbers, beginning January 2\textsuperscript{nd}, 2014.

I think that’s what we would hear from a senior but when you think about what seniors’ needs are I think another way of framing it is that seniors may also say, “I need the government to put in place more protection for someone like me when the sponsorship breaks down”; “I need a safety net”; “I need governments to not make my own welfare and rights dependent on another person so i.e. my child sponsoring me”, “That my rights are not my own rights, I’m not self-determined that way.” From the eyes of government law, we’ve created a situation where these human beings are dependent the mercy of someone else, and that someone else may not be kind to them.

For some immigrant seniors the more difficult challenges that they face may result from instances of broken sponsorship and the problems that seem to unravel as a result of that. Immigrant seniors are especially vulnerable not only financially and socially but also in terms of their being disconnected from family and even a loss of family. Key informants explained that changes in family dynamics or unforeseen family circumstances, such as marriage, are most often the reasons for broken sponsorship that they see but that there is little support from the government to ensure that these instances do not occur or that when they do occur seniors are not left abandoned with little recourse and support.

5.5 Migration, Place and Aging

The impact of human movements involving a change in residential location, both across short distances and internationally, has been studied widely. Increased movement of populations through enhanced modes of travel and the resultant shrinking of distances, hallmarks of a globalized world, pose significant implications for global public health. The link between international migration and health has often focused on the risks of disease exposure and spread, giving rise to a number of global public health initiatives such as the United Nations Millennium Development Goals (MDGs). The eight Millennium Development Goals, uniting 193 United Nations member states, promotes global policy development initiatives, which among them include eliminating worldwide poverty, improve access to primary education, implement vaccination programs and halt the spread of HIV/AIDS. However, despite the numerous successes of the MDGs lauded in annual progress reports, a number of scholars have noted that
they fail to address the impact of global population aging on health or raise the issue on the health of aging populations (Esser and Ward, 2013).

Globalization has important implications for the social-cultural and political contexts in which people live which in turn influence their differential exposures and vulnerabilities to certain health risks, health disparities and inequitable experiences with health care systems. Equally important are the micro-level factors of globalization and international migration for health and health care families or household units. As the previous section discussed, there is a rich diversity among aging immigrant populations, stemming from various migratory experiences that will invariably affect their health and health care access.

As such, another related theme is the process of immigrant settlement and the associated attributes of place and how these may influence their health and aging. In the context of this study, the attributes of place discussed have more to do with the affective perceptions about community or sense of place inherent in the lived experiences of aging immigrants, rather than the physical or spatial attributes of place. Through key informant interviews, I explored the second-hand experiences of immigrant seniors with place and their access and experiences with various programs and services in the health, community and social sector. Also discussed within these narratives about the experiences of immigrant seniors are issues of migration, settlement and transnational patterns.

Results from key informant interviews revealed that there are distinct settlement patterns throughout the city that can result in physical isolation, ethnic segregation and poor community and social connections. Furthermore, language barriers, immigration status or ethnic minority status also result in social and cultural isolation. Thus, fostering a sense of community, establishing strong social and community supports, bridging community networks within and among the different ethno-cultural groups are important in maintaining positive health experiences for aging immigrants. Among the many issues that key informants discussed there
were five key issues relating to migration, place and aging that emerged, which are summarized in Table 5-1 below.

**Table 5-1: Themes of Migration, Place and Aging**

<table>
<thead>
<tr>
<th>Place-based themes of aging and migration</th>
<th>Risks of Social Isolation (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Finding Community (n=8)</td>
</tr>
<tr>
<td></td>
<td>Sense of Belonging (n=4)</td>
</tr>
<tr>
<td></td>
<td>Fear (n=4); Lack of Trust (n=8)</td>
</tr>
<tr>
<td></td>
<td>Social and Community Support (n=10)</td>
</tr>
</tbody>
</table>

The results outlining these five issues continue the discussion of the diversity within various sub-groups of immigrant seniors, especially key differences between newcomer and long-term immigrant seniors. As well there are also important differences highlighted within different ethnocultural groups as well as differences in socioeconomic status and immigrant status. Where relevant, these differences will be explained within the results.

### 5.5.1 Risks of Social Isolation (n=11)

Social isolation is a common issue among immigrant seniors, for long-term immigrants and especially newcomer immigrant seniors. Social isolation greatly influences how immigrant seniors connect with their communities, neighbourhoods and to life in Canada. Key informants associated the risk of social isolation to loneliness, depression, unfamiliarity of public transportation systems, poor access to health care or social services, and not participating in community and social life. As a result, many immigrant seniors experience poor integration with the broader society whether they arrive as seniors or risk withdrawal from society as they retire and grow older (Ravanera and Fernando, 2001).

Key informants linked immigration and settlement experiences with issues of social isolation. They discussed the importance of providing social and recreational programming
allowing immigrant seniors to connect not only with community and social service agencies but with their cultural or community peers:

04: We’re still unable to address the socioeconomic needs because we can’t help them financially but we’re still at least helping to help them with social and recreation component. And we’ve done an evaluation recently, I think it was last week, with one community health centre, because they wanted to help us. They run programs with us and one of the comments I had was something like: “I just wanted to thank you for this program. It’s the first time when I felt welcomed in Canada. It’s the first time when I actually think I shouldn’t go back to...I’ve been so depressed, I’ve been so isolated. I was thinking that coming here was a mistake.” That’s what many seniors tell me it was a mistake coming here.

14: Because of language, transportation, for whatever reason the seniors are more isolated and also the (lack of) friends as well. Because in their country they might have their own group of seniors that go just, you know, in Hong Kong, in China, it’s very crowded – you know just go to the street and then they can know lots of people or they can have lots of friends but now in Toronto you know they’re just confined in their own house. Where they go out, they might not know each other.

Other key informants discussed the ways social isolation, as well as physical isolation by extension, limited immigrant seniors’ ability to obtain the information and knowledge of the social services and community supports available to them or in some cases to integrate fully with broader society. In the examples below, key informants imply that social isolation manifest from a multitude of factors not just in language and transportation barriers, but also in settlement experiences:

05: With immigrant groups, there are two kinds. There are the kinds that move into a place where most of the family is the same background as theirs and create a sort of ghetto of their own, do you know what I mean? And there are those that just move to a place that just looks good. If you’re in a community where everybody talks your language, you’re less likely to adapt to Canadian ways. You’ve got people you can talk to and you don’t worry about the rest of the world. You know that can happen. But if you move just to a place that’s convenience and affordable and just what you want, everybody around you is talking English, you’ll make more progress.

21: There’s a range of, there’s really a range of settlement (experiences). It’s about information access, accessing services and finding out you know, what services they can access and where. It’s about getting involved or getting to know their community and their neighbourhood and their neighbours. Isolation is a very, very big topic. Especially for seniors, it’s very big.

As discussed in the previous chapter, a challenge noted by key informants was how to access and reach out to isolated seniors, especially those hidden and relatively unknown immigrant populations in the community. It was only through outreach activities, which are often
underfunded, or through referrals from family, friends or other acquaintances of isolated seniors, could a senior potentially be helped.

Among the key informants who discussed issues of social isolation, two of them commented about the availability of multicultural television programming explaining that it was not uncommon to find seniors isolated within their homes where television becomes a substitution for social interaction. This was especially true for seniors who were identified as the most vulnerable of immigrant groups such as Jewish-Russian seniors and Tamil seniors:

01: I find that when I was talking with some Tamil seniors they tend to, because of some of these difficulties they have in terms of going to places and not being familiar with the transportation, they tend to use their TV for their 24 hours, because there is for example 24 hour TV for Tamil. And so they tend to be glued to that.

04: And it’s kind of – it’s sad, those who live in subsidized apartment buildings, they’re happy to live on their own. However, they miss their children, they miss their grandchildren: who are working, who are busy and unable to spend a lot of time with them. So, these seniors who live in subsidized housing they don’t have anyone except the TV.

It became an important goal for many key informants to identify those seniors who are isolated and connect with them either through peers or through other creative and non-conventional means such as radio or television programming.

### 5.5.2 The Need to Find Community (n=8)

Key informants referred broadly to community and place when describing the social and political contexts of older immigrants, the ethnic and racial composition of Toronto neighbourhoods and the residential settlements of immigrant seniors. They also spoke about the specific role of community in enhancing immigrant seniors’ connections to place, community and other people. Community was not seen as just a social structure comprised of a network of people, neighbourhoods and organizations but as also having affective dimensions in providing a sense of belonging, fostering new and greater social interactions and reducing social isolation. Finding community was seen as important to creating a sense of belonging and to building social networks and social supports:
11: There are also no common places to meet (in Toronto). So you know we heard a lot about seniors who said, “In my place at home”, “In my village”. You know there would be the central square, the central meeting place where community comes to celebrate weddings, to mourn, to bury their dead, you know where elders came to speak. And so physically in Toronto, especially with poor newcomers who live in high rises in the inner suburbs, there are no such physical spaces, so community no longer exists. You know they live in vertical towers where it’s heterogeneous and there’s no sense of community anymore.

One key informant who provides community support to older immigrant populations discussed the experiences of immigrants, coming from different ethnic and cultural backgrounds and who are in different stages of their immigration. She explained that it was necessary that they are able to easily find organizations, such as the one she works in, that provides them with resources and opportunities for social interaction with peers and to rediscover community:

13: From my experience here people are coming—there are people whose experiences are very different depending on when they immigrated. So many of the Caribbean seniors who come have been here for thirty-five years or so and have had time to build community and to find their place within the community, within the city. But we also have people coming who have been here for three or four months. A lot are generally from Latin American countries and they are just finding their way. And you can see how grateful they are that early on their experience of finding a place like this, where they can come and practice their English and learn how to navigate systems and create community.

Community was also referenced when describing certain ethnic groups or immigrant group settlement, such as the Chinese community or the Ukrainian community, so as to emphasize that community is also a unit of cultural commonality for some as well as a supportive network of peers. Ethnic affirmation or the ability to connect to one’s own cultural community is considered as equally important as connecting to the broader and multicultural social community, particularly for newcomer immigrant groups to enhance a sense of belonging and greater integration (Phinney et al., 2001).

5.5.3 Sense of Belonging (n=4)

Sense of belonging is identified as an important socio-cultural dimension of social integration and has been defined as an individual’s experience of being personally involved in a particular environment whereby they feel themselves to be an integral part of it (Hagerty et al.,
Among later-life populations, an increased sense of belonging has been linked to experiences of productive aging and increased civic engagement where an older person remains politically active and participates in economic life (Ravanera and Fernando, 2001). Sense of belonging has been attributed to health and psychosocial outcomes of various populations and has been negatively associated with depressive symptoms, feelings of isolation, loneliness as well as immigration and resettlement stress (Hagerty et al., 1996). For immigrant populations, finding a sense of belonging was identified by key informants as an important process of migration and settlement.

Key informants discussed the various ways that immigrant seniors struggled with negotiations of their cultural self and being perceived as the “other” in a foreign land. Immigrant seniors often maintain strong connections to their home land and keep up transnational ties to family and friends “back home”:

01: I think the other piece to this is that (for) Filipino seniors and other communities where their heart is always “back home” and so they continuously worry about “back home”, especially if they have families that are there. Or if there are things happening there in their own country. So my association with the Tamil and Afghan they worry so much about the war that is happening – the civil war and even when there are some calamities that happen. And so it’s like they are here physically but their life is back there. There’s little connection with the life here.

13: I think that there’s a lot more vulnerability for those who moved in later life. I think that it takes a long time to feel a sense of comfort and a sense of being a Canadian citizen and all of that takes years. So you see that you’ve had maybe more—those that have been here for longer have more of a sense of belonging and connection perhaps.

Key informants discussed the risks of feeling out of place and not having a sense of belonging while in Canada, such as social isolation, loneliness and symptoms of depression. Feelings of dislocation, of being emotionally “back home” but physically in a different place, transform into real barriers in accessing health and social services. For many immigrant seniors the decision to come to Canada was driven by the desire to be close to their own children and grandchildren:
08: Their sense of belonging, they come here and they are not from here and just—“I am here because of my children, I love them but I’m not happy here”. So they could get depression, because you’re here not because you want it – all those issues.

19: From my perspective and from the programs that we run, and I’m talking about the South Asian aging population, these are seniors who’ve come into the country – a lot of them are sponsored by their children. They live with their children either in the basement or the home, and many of them come here and provide babysitting for their children or for their grandchildren. However, when they come here they lose their sense of belonging. And they don’t feel as included as they felt in their homelands, so some of them feel very isolated and lonely. Many of them do not speak English, so they can’t easily integrate with mainstream society, unless—unless they have programs to go to, which are very few and far between.

Immigrant seniors may find their way to Canada in many different ways, ranging from migration in later-life to arriving at a young age and aging in place. They will also have different experiences of migration, and so their connection to Canada and ties to their home country will be greatly influenced by their particular migratory experience. Key informants described the choice of being closer to family as a selfless act, where the immigrant senior would rather forgo their own happiness or expectations of retirement in order to be among their loved ones. Often immigrant seniors’ plans for retirement changed depending on family circumstances or they adapted to the situation of the family. One key informant discussed how in some cases the wellbeing of the senior is based solely on the adult children’s situation. She recalls some of the stories that are shared with her from the seniors that she works with:

07: They feel really insecure, they (feel) very unsafe. They don’t know their rights and they don’t want to know. They’re thinking back, “What brought me here?” Winter comes and they don’t know what the hell they’re doing in Canada. They get sick they only know how to treat themselves if it was back home…and they’re afraid even to venture (out), yeah. Also, they’ve been brought for reasons like babysitting or because they were a problem back home. We have to keep going there so (adult children) say, “Let me bring all my problems here with me and I can deal with it”.

Situations such as the one described above, make it difficult for immigrant seniors to ever gain as sense of belonging, which has a number of implications for their overall sense of health and wellbeing. This particular view that caring for senior is seen as a problem was noted by a few key informants working with immigrant seniors, especially those key informants who worked with low-income immigrant seniors and their families. The self-perception of immigrant seniors
viewing themselves as a problem or a burden shape their own sense of belonging within the family and broader society and will greatly influence their access to health and social care as well as their experiences with the health and social care systems. For seniors who experience language or communication barriers this creates even more difficult situations for immigrant families.

5.5.4 Fear (n=4) and Lack of Trust (n=8)

In the previous chapter, establishing trust with immigrant seniors was reported to be a major challenge for many key informants working with immigrant populations whose cultural or racial backgrounds were not similar to their own. Trust was especially difficult for immigrants coming from social and political environments which were vastly different than that of Canada. One key informant discussed the fear of authorities in an unfamiliar country, such as the police, also made it difficult for immigrant seniors to access the public and social services available to them:

02: One of the other things is being afraid of authority. And, which is why abuse, you know, as a Canadian at least people that have lived in Canada for a long period of time they may be very embarrassed, but they trust tend to trust the systems, the police system, the authorities coming in. They may still hide but there is a trust factor so that if things get really bad, you can figure out someone that you trust to go to, whereas people coming from some other countries you did not, you could not trust police officers or politicians or people in position of power.

She also noted the differences between newcomer and long-term immigrant seniors in the level of trust with people outside of their communities. Immigrants who had more experience and exposure to the authority figures in a newer society are more likely to trust service-providers and access the help they need. Later in the discussion, she noted that trust can be established but often it takes time and for those seniors who remain socially isolated, highly dependent on their families and lacking the social networks within the community might always remain in fear.

Key informants discussed how immigrant seniors are often skeptical of the services being offered to them, such as counseling, social work or other services that are government funded.
This was particularly difficult in situations of elder abuse and resulted in incidences of a number of mental health issues:

13: People are coming from all sorts of political situations, and so they have different views of services, like social services and community supports some of them can’t believe that someone would come and give them support for free. Some of them fear talking to a social worker about their family situations because it’s not safe in the context that they knew, so I think that’s another barrier. Just peoples histories and their understanding of government or social services.

As another key informant noted, negative perceptions of government as an authority figure and tenuous immigrant status also made for difficult situations for immigrant seniors to participate and integrate within the community. She also made reference to situations of elder abuse where family members who use seniors’ immigrant status or fear of authority to keep them isolated from the broader community:

07: When they say baby boomers, I think they mean the people who are born here. They understand because they’re not worried. The baby boomers are very knowledgeable. They know their rights. They know what they’re going for – the government had better not fool around with them. (Immigrants) have been hiding, the government has been having it easy (with them) or whoever is going by and this having it easy with ignorant people and people who are afraid even to access these things because maybe their papers are not right, maybe they are still hanging out there or their documents are not through with immigration, they don’t know. Some are hiding.

There was a consensus among key informants that the biggest challenge was working with immigrant seniors with different perceptions about the role of government or social services in general. The issues of fear of authorities and lack of trust were widely acknowledged as a barrier to services. For those organizations that fund outreach activities, the key informants also raised concerns about the number of immigrant seniors that they were not aware of and were therefore not receiving the care they needed because they remain so isolated in the community.

5.5.5 The Importance of Social and Community Supports (n=10)

While trust was seen as an important factor for building social networks, it was seen as equally important to provide the opportunities to access social and community support resources that encourage and enhance social support. Lack of community supports for immigrant seniors,
particularly newcomer immigrant seniors, was a significant barrier for creating the social networks and sense of community that could potentially buffer them against the stresses of adjusting to a new country. Studies that have explored social support among immigrant groups have often been based on the assumption that the length of residence is positively associated with social support as a result of spending more time building up social networks and assimilation-type behaviours (Wu and Hart, 2002). Other studies have also demonstrated that older adults with higher socioeconomic status (Krause and Borawski-Clark, 1995) or higher educational attainment (Wu and Pollard, 1998), which is associated with having more contact with friends and family, will experience greater social support. In some cases, chronic disease incidence or mental health issues were negatively related to social support with emotional health being the most common predictor for poor social support outcomes (Wu and Hart, 2002).

Although this study did not directly include and investigate measures of social support, such as perceived support, actual support or examine support-seeking behaviours, a number of key informants referred to social and community support resources indirectly in their descriptions of the services and goals of their programs. Other research on social support and immigrant groups have found that during initial migration and settlement, immigrants heavily rely on family and friends as their old social networks are disrupted and dislocated (Simich et al., 2005).

Formal support services, such as those services offered by social and community agencies, were described by key informants as an important resource. This was especially important among those immigrant seniors whose informal support networks, such as family and friends were perceived to be inadequate. Many key informants argued that their programs were integral to building and fostering a sense of community and social networks. As well, some key informants described their support programs as having started out based on a simple concept of gathering people together but have since evolved to become an important avenue for seniors to meet up with their ethnic peers or with other cultural groups:
09: (Having a) lack of networks, because maybe they have nobody to ask (for help). Maybe the people they know, they are, maybe they’re in the same situation, they don’t know either. So that’s be part of our role here, to somehow (say) okay, you are part of our network and we can help you.

10: I think the peer group – the support group is very important. So, we nurture that. As I’ve said that in the healthy living (program) we didn’t emphasize mental health because we didn’t want the stigma either. So when we formed the program, we didn’t even know what our goal was, you know what I mean? Because, like what are we supposed to say? Like when we’re putting it down on paper, what’s our goal? So we all decided, you know what – socializing. Even if the only result is that they would talk to each other after the program, that’s it, you know. Then it would grow from there. So, once we did that and we kind of just had it open for the first little while, it’s like whatever they want to talk about. At that time we had the tsunami in Sri Lanka (happening), so we became the support group for them. And they’ve actually mobilized each other, to say well if we send this money, this medication, that kind of thing.

One key informant spoke about the importance of informal social support among group members and commented that socialization can act as a stress outlet and is a factor in maintaining health. In the quote below she links increased socialization to decreased hospitalization and doctor visits:

15: Well, for us it’s that—since when we started the program because we do evaluation every quarter and sometimes most of the (seniors) will be in the hospital. Most of them are there for a month, they’ve been hospitalized for two, three weeks but since they try to socialize themselves, it’s been better for them. Since they have an outlet they have like—so it’s like their daily activities to come with the group. And it helps them like you know, keep away from the doctor.

She also discussed how she has seen an increase in demand for seniors’ recreation and social programs provided by her organization, which encourages both formal and informal social support. However, limited funding for these types of programs severely hindered the ability to keep up with the demand.

### 5.6 Exploring the Social Determinants of Health among Aging Immigrants

There has been an increasing body of literature on immigrant health issues that adopt a population health approach to examine the various social determinants that influence health (Dunn and Dyck, 2000; McDonald and Kennedy, 2004). The growing consensus in immigrant health research is that health cannot be explained solely by examining health care inputs and that it has become increasingly important to examine those factors that facilitate or impede health care access. Much of the discussion of immigrant health has focused on the social circumstances of
immigrants’ lives that influence their decisions and behaviours around health. Only in doing so can we fully understand the causes of health and illness among these vulnerable groups.

The more common approach has been to examine the social conditions of immigrant populations to understand how factors influence the ways in which they experience health and health care. This person-centred approach differs from a more systems-centred approach, where research on health care access is more concerned with the ways in which the health care or social service systems impose barriers to racialized and ethnically diverse older populations. From this approach, the systemic barriers embedded within systems reveal the intricate ways immigrants lives are structured around these dominant health and social institutions. The result of such research has been increasing concern towards the development of cultural competency skills and sensitivity training in the health and social services sector, most often at the level of provider-client communication and relationship (Brotman, 2003). However, many of these studies often do not focus on the racialized and discriminatory practices embedded within institutionalized power relations and structures inherent in health and social systems. The tendency in these studies is to identify what barriers or issues immigrants face when accessing health care and to recommend cultural competency and sensitivity as a set of skills or protocols rather than to examining the attitudes and beliefs.

Perhaps most critical to both these approaches in immigrant health, which can be applied to older immigrants is the emphasis on the “ethnicized” and “racialized” experiences of aging immigrants. As health research on immigrant seniors continues to grow, albeit slowly, there has been a marked shift from examining the influence of health care inputs on health to one that examines the social determinants of health (Dunn & Dyck, 2000; Gee, Kobayashi, & Prus, 2004; Newbold & Danforth, 2003; Choi, 2012).

Many key informants discussed the health and wellbeing of aging immigrants within a social determinants framework, identifying the links between positive aging and health outcomes
to their social circumstances. In particular, key informants discussed the role of staff and other service providers in ensuring that they are sensitive to all the factors that may negatively influence a senior’s experience with health and health care:

12: A lot of the social workers are new to the team, so making sure that things are just consistent. So our procedures are consistent, people know what they’re doing, and a lot of time meeting with the staff, helping them with cases, difficult cases. Cases are very complex because it’s not just housing, it’s housing and finance and the relationship with the son, you know all kinds of complexities, and I find that as clients get older it gets more complex because of mental health issues, depression, all kinds of things factoring in – lack of food, lack of shelter, it goes on and on.

Some key informants suggested the importance of the migration experience as being an important factor in how immigrant seniors experience health and aging in a foreign-land. Just as their health is informed by a myriad of social determinants, so too can the migration and settlement experience influence health. Most notably, as one key informant discussed, the shifting of traditional family structures, particularly role reversal where seniors once revered as a respected elder, are now viewed as dependents. As a result, many immigrant seniors new to Canada become increasingly reliant on family:

14: Back in the home country you know they have more independence, they are more economic, both economic or you know transportation-wise, language wise, is more independent, but now when the seniors move to a new place, and they have to depend very much on the adult children or the grandchildren as well. So you know before they might be, you know in Chinese culture senior would be more, have more respect and authority in the family but now when they move to a new place and they don’t have the language, transportation, finance, so now there role would be more like a filial. I don’t know the word but more like a subordinate—a subordinate role. Before they might you know, they would go to the market they would go to the bank by themselves but now they have to depend very much on their you know, their grandchildren, their adult children, so it seems the role has changed. So the role, adjustment for the seniors is quite, you know caused a lot of tense relationship with the family.

For the most part, key informants described the challenges faced by many immigrant seniors in terms of their health and aging, as very much informed by their settlement and adaptation experiences, racial or ethnic identity, their housing situations, food security, mental health issues or financial stress. Key informants explained that these challenges are most often eased with the aid of family and friends but for some groups, family may worsen a senior’s
situation. Table 5-2 summarizes the more common determinants that were discussed among key informants, and viewed as affecting immigrant seniors living in Toronto and the GTA the most.

Table 5-2: Exploring Social Determinants of Health among Aging Immigrants

<table>
<thead>
<tr>
<th>Social determinants of health (n=12)</th>
<th>Economic Barriers (n=10)</th>
<th>Housing Issues (n=7)</th>
<th>Transportation Issues (n=9)</th>
<th>Language Barriers (n=20)</th>
</tr>
</thead>
</table>

5.6.1 Economic Barriers (n=11)

Economic and financial barriers have a significant impact on many immigrant seniors, whether they were living with their families or apart from them. Key informants discussed the many varied material and structural ways that economic barriers were produced, which inhibit many immigrant seniors’ ability to access health care but also to integrate and participate in social and political life. As well, key informants identified the persistence of economic hardships and poverty among many of the immigrant seniors they worked with and often times they see these financial issues extended to the level of the family, creating situations that were often strained and tenuous. Accordingly, the impact of economic and financial barriers on immigrant seniors’ included the most commonly cited issue of being unable afford the basic necessities, such as paying for rent, buying groceries or obtaining much-needed medication.

One key informant who regularly works with some of the poorest immigrants in the city often characterized the immigrant seniors she worked with as disenfranchised and highly vulnerable and in dire circumstances. She shared many personal accounts and examples of the difficult situations that immigrant seniors have to deal with once they migrate to Canada:

07: The most glaring one is poverty. They are poor, they’re hungry and they can’t even afford their medicine. I think they have some subsidies from the government and some housing is subsidized, but it’s not enough. And even if they were to go to see their doctor or to go get their drugs, they need tickets. They actually don’t have enough money. And what I see, the senior population whatever they have, they seem to be having some dependents back home. Yes! One
sister or one brother comes with the mother or the father, those who are left at home, look up to see their parents and siblings for help.

In terms of family obligations, key informants discussed immigrant seniors as feeling pressured to provide financial support to other family members left behind in their home country as well as for family in Canada. Some described the sense of guilt or shame that some seniors felt when they were unable to afford the simple gesture of being able to buy small gifts for their grandchildren. For key informants, the challenge of working with financially disadvantaged populations was that seniors were less likely to use the services and programs that were being offered to them:

02: The other thing is that one of the reasons the number of immigrants, recent immigrants in this population, is that we do have a portion of our people subsidized. But it’s a small portion and what tends to happen is more recent immigrants just don’t have the financial sources to move into a retirement level of housing. So that has been a problem of a different order. I would say that within health care, which is why that group of people tend to be in the community more often.

Key informants described numerous examples from the lives of immigrant seniors ranging from having a lack of financial independence to situations of extreme poverty. The situations for immigrant seniors in Toronto were varied and diverse, with many key informants often feeling powerless to help seniors who are struggling to meet their basic needs. Key informants regretted that though they were unable to help immigrant seniors with their economic circumstance but their programs were aimed at providing immigrant seniors with the support and opportunities to become social and active in the community. In doing so, immigrant seniors would make the connections with other peers and services within the community to enable them to get the help and information they need. As a consequence, many key informants related poverty to increased instances of elder abuse and the rise in mental health issues, particularly in multigenerational households.

5.6.2 Housing Issues (n=7)

Often when key informants discussed financial barriers, they also made reference to housing issues among immigrant seniors, the most common issue being the inability to afford
rent, particularly in downtown Toronto and the more suburban parts near the outskirts of the city.

As one of the key informants in the previous section noted, the poorest seniors tended to remain within the community, often in inadequate housing situations, unable to afford retirement housing or home support services. Many also noted that there was little being done to improve the conditions for seniors living in inadequate housing or precarious housing situations, such as unregulated rooming houses:

05: I think you’ll find out that supportive housing is at the top of the list for keeping people at home, which is where everybody wants to be. Nobody wants to be at an institution. Although, some people with a lot of money could go into one of these really fancy places, they don’t have to worry about the house anymore. They got the luxuries and everything they want. They sometimes go in voluntarily. And of course, people who have any money at all hardly, what are they going to do? They go into these boarding house kinds of homes, where people are empty nesters, they have a few extra bedrooms, they don’t have enough money, so they take in a few seniors. Do they care that these people are getting the care they need or not? Are they sure that fire safety is there if you’re in a bedroom? Are there two staircases to go down or are there only one? All kinds of things like that. And, that’s what you’re stuck with if you’re really broke, if you don’t have family or friends to take care of you that’s what you’re stuck with.

As noted by this key informant, many poor seniors have very little choice when it comes to choosing suitable housing and often these seniors are hidden within the community. The lack of affordable and quality housing in Toronto perpetuates a system where people are compelled to earn money through the renting out of seniors-inappropriate rooms or units and because many seniors are poor themselves they often resort to these types of accommodations.

Housing issues in Toronto, particularly for immigrant seniors was very much a financial issue in terms of rent affordability. Key informants described how many immigrant seniors find themselves in precarious housing situations, often having to live further away from family and friends because they simply cannot afford rent:

14: I think the housing issue is also another issue that’s related to the aging population because the rent and also the housing cost is very expensive, especially in Toronto and in York region area. And I don’t think in fact the seniors would be able and afford to you know purchase a house or rent, you know the apartment. So to build the affordable housing for the seniors is quite a concern especially for the immigrant community. Yeah, they don’t have many CPP and you know they don’t have much money.
Some key informants whose agencies operated out of seniors designated buildings discussed a number of issues associated with poor quality housing and few subsidized housing opportunities in Toronto. In particular, one key informant discussed bed bug and cockroach infestations in a number of apartment buildings and how challenging it was for many immigrant seniors to cope:

22: For my department we'll only be dealing with a pretty finite number of people cause were only dealing within those buildings. I mean as they are aging, requiring more services, more complex health issues, and they’re doing it within Toronto housing. And well something I haven’t even touched on within Toronto housing is there’s a lot of bed bugs, there’s a lot of cockroach infestations, and for somebody whose already dealing with medically complex situation, having the added stress and upheaval of dealing with bed bugs is you know often creates that downward spiral. So for lower income seniors, which often tend to be the immigrant population, there’s not really enough support to assist them through that.

Another key informant discussed that even when measures are taken to control the outbreak of bed bugs and cockroaches, many immigrant seniors have no other place to go to temporarily while buildings are being treated. She also explained that for those who are living with very little income, they were also unlikely to purchase a new mattress, bedding and other linens once a building has been treated for bed bugs or other pests, and therefore risk infestation again.

Housing issues in Toronto and the GTA were not exclusive to immigrant seniors as many seniors, immigrants and families also faced the same difficulties with high rents, inadequate housing or the lack of available housing near certain amenities and/or family members. However, many key informants emphasized that immigrant seniors are very much at risk or more at risk of living in poor housing situations, especially newcomer seniors. The risk of living in poor and inadequate housing is often compounded by other factors, such as language barriers and discrimination and as a result they remain invisible within the community as a highly vulnerable population.

5.6.3 Poor Access to Transportation (n=9)
Key informants also made reference to immigrants’ poor access to transportation or lack
of transportation in some areas of the city, especially in poor weather conditions. The issue of
access and availability, coupled with fear and safety concerns of the neighbourhood, or even
within the buildings where some seniors live, led many immigrant seniors to remain socially
isolated. It was consistently mentioned that many immigrant seniors were not only physically
isolated but socially isolated and that their social isolation was often based on many fears that
later-life immigrants had about living in a foreign country and immersed in a different culture.
While this was a common experience among more recent immigrants, some key informants
commented that even long-term immigrant seniors were at risk of social and physical isolation if
they remain disengaged from the community.

One key informant discussed that many immigrant seniors were very dependent on their
family for transportation, but often they were limited by the willingness and availability of family
members to take them to places in the city, whether it was to go to a medical appointment or to
attend a place of worship. Many seniors have a tendency to remain at home, choosing not to leave
the house, if they are not able to access some form of transportation, either through family or with
a publicly reliable and accessible transportation system. As she describes below, transportation
barriers can prevent seniors from participating in even the most commonplace activities such as
meeting friends for coffee or going to church, which can have adverse effects on their
psychosocial or spiritual wellbeing:

01: Even people who are religious who like to go to church that is like if they are not are not able
to access appropriate transportation then they are not able. So, that’s a big thing for them, in terms
of really you know spiritual kind of this very much a part of peoples live and if you don’t even
get to meet that need that really can bring you down.

Key informants also discussed that among the most vulnerable immigrant seniors having
no way to physically navigate the city prevented them from seeking out information sources and
getting the help that they needed, such as health care or social services. In particular, one key
informant noted that for immigrant seniors who are in potentially abusive situations, not having the ability to understand and access the transportation system is a significant barrier:

11: They are completely dependent on their adult children in order to get out and go anywhere. They live in physical places where there’s poor transportation, so it’s hard for them to get around, especially in the winter time, so they’re incredibly isolated. We also, in a consultation study, we did—hearing a lot about elder abuse and how seniors have no avenue for which to seek help because they don’t know how to navigate the health and social service system, they physically don’t know how to get about and so they’re incredibly vulnerable and that’s a huge need.

14: Another thing is the transportation need for the seniors as well, although there will be the public transport, but still, it’s not that user friendly for the seniors. In a way like, all the public transport is on a main road but the seniors have to walk a long way to the main street in order to take a bus. And also in the winter time in fact the seniors cannot just walk so long for to take the public transport. So I think transportation is one of the concerns for the seniors, and it’s really important that it would reduce the seniors to come out, so they just you know stay at home with nothing to do. It’s good for them.

Even when transportation access is made available, for example, providing transit fare tickets to seniors who attended their programs, many key informants were very critical about how the public transportation system was structured within Toronto. In particular, many felt that transportation in the city was not friendly to seniors or people with mobility issues. As well, depending on where seniors were located in the city, many key informants felt that most seniors lived in areas where public transportation was not easily accessible which required them to walk a certain distance to get to the nearest bus stop or subway station. Many thought that this was a significant deterrent for seniors to get out of their homes and into the community, especially for immigrant seniors who are unfamiliar with the city and might not feel safe in certain neighbourhoods.

5.6.4 Language Barriers (n=20)

Language-related issues were regarded as one the most difficult challenges for immigrant seniors to overcome and for key informants to work with and adequately address. Among the issues relating to language, the chief concern for key informants was the inability for seniors to effectively communicate their health needs or to find out certain information:

22: I mean for somebody for whom English is their first language it’s extremely hard to navigate the health care system, if you find yourself ending up in the hospital. I mean, if you find yourself
needing to call 911, the person who’s responding to you often doesn’t speak the language that you speak and then it’s, “How do I communicate what’s wrong with me?” You know “How do I know where I’m going so I can pass that information on to family or friends?” “When I end up in the hospital how do I communicate my needs?” “If I have culturally specific needs who am I speaking to about those needs when I’m in the hospital, are those needs going to be met?”

Key informants described how many immigrant seniors often had to rely on family members to help with translation, which was not always in the best interest of the seniors. Key informants deemed it a challenge establishing a relationship with immigrant seniors and overcoming language barriers. They also noted that often the needs of immigrant seniors are not well understood and effectively communicated through family members. Family members often were considered gate-keepers of immigrant seniors’ health experiences and knowledge of their own health reinforcing seniors’ dependence on their family:

02: And family members can translate, but family members sometimes selectively translate. So it’s better to have some ability to have a translation service on site.

She went on to describe the overall lack of information that occurs with language and communication barriers, such as the scarcity of written materials in other languages or translation services personnel. Many factors contributed to communication and language barriers, not just being able to speak the main language and these greatly affect immigrant seniors’ ability to seek out the health care services that are available to them:

02: …navigating the health care system is a real challenge. It’s a challenge for all of us, even people who work in it it’s a challenge and so for an immigrant, who isn’t particularly savvy about the health care system or doesn’t speak the language even if they come with their family it’s not an easy system to navigate. So finding some support to do that getting the information you need to help to make decision that are respectful of your background and your belief system.

Language was grouped along with other markers of difference such as religion and race, which many key informants said went hand-in-hand with experiences of discrimination. Whether it was the inability to speak English “properly” or not wanting to speak at all because of the belief that their status as an immigrant would be revealed and they would be discriminated against was also discussed by key informants:
01: Language could also be an issue. Even if they could speak English there still is that hesitation that maybe they’re are not speaking the right language.

02: (T)he other thing (what) not speaking the language does is that it tends to isolate a community. So even within our community, the Hungarian group was somewhat isolated, and so we started a Hungarian social and we had Hungarian volunteers who come in and do particular programs but it did mean that they were isolated as a subgroup of the main resident population. And that caused some other issues. It could cause some friction sometimes, when you’re running some programs or floor meetings. Some people would be impatient to wait for translation but it did tend to marginalization some people to some extent.

Another related aspect of language and communication barriers is that lack of language skills is seen as solely an obstacle for care: language is something that needs to be overcome whether an immigrant learns to communicate in the language of the service provider or the service provider is able to communicate in the language of the immigrant. However, as discussed by one key informant, minority language as it makes up one component of a person’s cultural identity becomes the feature that perpetuates negative stereotypes and discourses about immigrants:

11: The other half of that is society’s reaction to our culture, our religion, our language, so i.e. the discrimination or the social exclusion. So there’s nothing inherently problematic about a person’s culture that would cause them to have poor health outcomes. It’s not that that is the link. The link to health and equities and poor health outcomes is not someone’s culture, it is the way people are treated because of their culture. Right?

5.7 Health and Aging among Immigrants in Toronto and the GTA

In the previous section, key informants identified the social determinants that greatly influenced immigrant seniors’ health and aging experiences in Canada. They also described the complex ways that those determinants of health interacted and transformed aging and migratory experiences to influence quality of life for older immigrants. The results presented here describe how key informants view barriers to health care for aging immigrants in Toronto and the GTA, beyond the social determinants of health. The results of these issues are summarized below in Table 5-3. They discussed cultural and socially produced meanings of health and aging and how these ideas influence not only immigrants’ views about their health but their patterns of behaviours and decisions regarding health care. Key informants also shared their opinions about
system-level barriers and what the implications are not only for the health of immigrant seniors but how the seniors perceive themselves and post-migration aging experiences.

Table 5-3: Issues of Health and Aging among Immigrants

<table>
<thead>
<tr>
<th>Immigrant Health Issues</th>
<th>System-Level Issues</th>
<th>Cultural Competent Care</th>
<th>Future of Population Aging: How will the older immigrant population fare?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic disease management and medical knowledge (n=9)</td>
<td>Health care issues</td>
<td></td>
<td>Worse (n=11)</td>
</tr>
<tr>
<td>Mental health issues and the migrant experience (n=11)</td>
<td>Health care reform and restructuring</td>
<td></td>
<td>Depending (n=8)</td>
</tr>
<tr>
<td>Healthy immigrant effect (n=5)</td>
<td></td>
<td></td>
<td>Unsure (n=3)</td>
</tr>
</tbody>
</table>

5.7.1 Immigrant Health Issues

During interviews key informants were asked to describe the most common health issues relating to immigrant seniors. Initial responses from key informants revealed that aging immigrants’ health needs were no different than most aging individuals. For instance, with respect to chronic diseases and illness, one key informant said:

06: The biggest thing we see is people with chronic disease processes. So, things like you know congestive heart failure, renal failure, cancers, I mean, we’ve seen a lot of sort of palliative type clients…I mean those types of diseases don’t necessarily discriminate.

However, as key informants continued to discuss age-related health issues for immigrant seniors it became more apparent that it was not necessarily the chronic disease or illness that was the primary factor influencing the overall health and quality of life for immigrant seniors. Instead key informants brought up chronic disease management and access to care and medical information. They believed that these factors greatly negatively affected older immigrants’ health
and aging experiences, which were also made more difficult by factors in the migratory experience further limiting their access to health care and knowledge about how to cope with and manage illness and chronic diseases. Additionally, barriers to health care access, key informants argued will be even more apparent as the demand for services increases and as the overall population ages.

With respect to immigrant health and aging, there were three main issues that were discussed by key informants:

1. Issues around chronic disease management and poor of medical knowledge of immigrants or the transfer of medical knowledge in a culturally appropriate way;
2. The rising incidence of mental health issues connected to migrant experiences;
3. Evidence of the healthy immigrant effect.

**Chronic Disease Management and Medical Knowledge (n=9)**

For many key informants, how immigrant seniors manage chronic disease and illness is very much connected to their ideas about health and aging. As results presented in the previous section illustrated, immigrant seniors often have different views about their health and health care needs from that of health care providers. The processes of acknowledging and seeking care to address the medical and behavioural signs of disease and illness invariably shape social experiences of health. The complex relationship between managing health with how one perceives their health based on their cultural beliefs or understanding of health is encapsulated in the quote below:

14: I would say it would have some sort of implication (on) the way that they perceive health varies, right? Like for some cultures or some ethnic group they would perceive health as more just physical health for example Chinese is more of physical health. Maybe for some culture they would have…health is a more holistic, mental, social, health. So the way of how to perceive health, would have some kind of implication on how they manage their own health, yeah.

Other key informants described the challenges for both immigrant seniors and health care providers to be in concordance with what is effective care and what is appropriate in terms of
managing chronic diseases such as diabetes or hypertension. Understanding the cultural and ethnic background of a client is equally important to understand how to not only provide care but to educate them with regards to medication or disease management:

02: And determinants of health are different, so I think that’s really an important thing to know about your client. It doesn’t mean that you won’t have a whole discussion or counseling around it but you need to know what people come with in terms of what people…will do. Things like sharing medication; not taking medications because they perceive that medicine is not a good thing to have (and that) you should be able to manage this on your own or with your diet or with you know other kinds of herbal this and that and other things. Because people do come, and I would say in the Chinese community, where Chinese medicine and traditional Chinese medicine dates back to centuries and has some pretty good proof behind it actually. If that’s where you’re coming from or if you’re a physician or a health care professional in that community, you need to be able to work and value both. It may not be the only thing you recommend but you need to be able to understand it and work with it with a client.

07: When they arrive here, they’re quiet. And then, one guy told me, he’s very sick now, he couldn’t even travel. He wants to go back home but he couldn’t go, he’s sick and old. He can’t go, the doctor has been telling him to wait. So he says to me, “You know what, this medicine in Canada, it cannot treat my diabetes and all this or my heart problem. I need to go back home and the get treated with herbs and traditional way”.

As many key informants above discussed, the challenge was the same in terms of the provision of health or social care services, which was how to balance cultural and spiritual beliefs and medical knowledge in order to be sensitive to cultural practices and religious traditions but to also ensure that health care needs are adequately taken care of. Key informants described how many health care providers do not take the time to understand the immigrant patient and generally assume that immigrants arriving in Canada understand, and immediately adopt, mainstream ideas of an allopathic medical care system and biomedical understandings of health and illness:

21: If we talk about people who’ve come here as seniors or towards, yeah at later stages in their life, the ethnic and cultural background – what people are used to has a very big impact on their lives. It has an impact on the living – healthy living, what people are used to in terms of food, in terms of environment, in terms of lifestyle and what they can have once they are here. It has an impact on health practices and on how people access the health system and what they do to cope with health issues and it has a huge health impact in terms of accessing services – language, cultural understanding and navigating the services that.

Key informants who worked either in multicultural settings or with specific ethnocultural groups were very much attuned to the importance of respecting culture as a determinant of health
to the degree that it enabled and empowered immigrant seniors to approach their health proactively. They also tailored many of their programs to suit the specific needs of an ethnocultural group or immigrant population.

**Mental Health Issues and Migrant Experiences (n=11)**

A number of key informants discussed their rising concerns about mental health issues increasing among immigrant populations. Newcomer immigrant seniors are especially vulnerable as they not only had to cope with the stresses of adapting to and settlement in a foreign land but also to the shifting family dynamics as seniors become increasingly dependent on their adult children and grandchildren.

There is a growing concern and interest in the social aetiology of mental health issues both in terms of research and care and in particular, this growing awareness is important in order to provide cross-cultural understandings about mental health problems and issues around care. A qualitative study on the underutilization of mental health care services among Asian Canadians revealed that there were a number of factors related to migration and the rise of mental health problems such as, lack of purpose, loneliness, difficulties adjusting to a new environment, heightened anxiety, and poor language and communication (Li and Browne, 2000).

Research on immigrant women in Canada have also found that immigrants are extremely vulnerable to developing mental health problems following migration (O’Mahony and Donnelly, 2007a; 2007b). In their research on poor access to mental health services, O’Mahony and Donnelly (2007b) used an intersectional approach to examine poor utilization of mental health services. They note that among the many challenges that immigrant women face some important barriers include cultural differences, social stigmatization, being unfamiliar with a biomedical approach to health, spiritual or religious practices and beliefs and provider-client relationship (O’Mahony and Donnelly, 2007b).
While this study did not specifically examine mental health problems or psychiatric services access, a number of key informants identified improving the mental health and wellbeing of immigrant seniors as an important strategy in ensuring positive health and aging experiences. As well, they noted that it also enhanced immigrants’ abilities to adapt and integrate with the broader community. Most key informants agreed that mental health issues were a common experience among immigrant seniors at all stages of migration. One key informant spoke specifically about the Russian-speaking population and the problems with identifying and addressing mental health issues and how connected these issues were to the migrant experience:

04: Russian speaking seniors have severe adjustment problems and difficulties overcoming their painful immigration experience. As well, high rates of depression, demoralization and somatisation when compared to native born population. And yes, the…depression is never, mental health illness is a taboo in Russia, in a Russian culture, in Russian society. And as a result it’s been never addressed, so what seniors do is they somatise their problems. So they come to the doctor when they have, let’s say, chest pains, or they have stomach issues, but it’s actually psychosomatic problems that haven’t been addressed by either by their physician, or psychologist or social workers because there are no Russian speaking specialists actually here in Ontario.

She mirrors many concerns by key informants about the perception of mental health issues among immigrant seniors as highly stigmatized both within the health care field and among different ethnic communities. Often mental health distress is dismissed as somatic symptoms of a physical ailment or treated as an eccentric personality trait:

10: But back home mental health is a big stigma. So, you know, mom is an eccentric. But as Mom ages it becomes more and more pronounced and it becomes more apparent. This is not just being eccentric, there’s something wrong. But families are just not open to, you know, to accepting that. You know maybe mom sees this doctor and says, “Oh, no, no, no, mom is just like that” That kind of thing.

Among those that discussed mental health problems occurring within older immigrant populations, key informants described how poorly understood mental health issues were, both in the awareness and treatment of mental health problems ranging from mild depression to degenerative cognitive disorders. Most key informants shared their views about psychosocial mental health issues experienced by immigrant seniors while few discussed age-related mental health conditions such as Alzheimer’s, dementia and other degenerative cognitive disorders. In
terms of caring for individuals, many immigrant families experience significant financial barriers to access the services that specialize in severe and age-related cognitive disorders, such as day programs or long-term care facilities.

02: Accepting help, being able to afford help, allowing help into your home. That is another whole issue. And I guess understanding illness too because so many of the people we see, the incidence of Alzheimer’s goes up after people are over 85 and there’s an awful lot of folks here in long term care with dementia and there are a lot of prejudices about that. In some immigrant communities people don’t talk about it. They don’t want other people to know and it’s a huge strain trying to hide an illness from someone especially an illness like that. I’ve worked as a social worker and my other job’s here as a social worker often worked with the families where part of our work was just understanding that it’s not a mental health issue because there’s a stigma against mental illness. That it is a cognitive problem and how to overcome that and how to tell people how to help people in your circle of friends and your family understand what’s going on. And often times be much more supportive as a result but just getting over that stigma about cognitive problems is tough and it’s tougher in some immigrant communities for some people.

Research focusing specifically on mental health issues among older immigrants is limited. One Toronto-based study explored the views of Chinese and Tamil communities to identify and examine barriers to mental health services (Sadavoy, Meier and Ong, 2004). Among the many barriers noted by the authors, most consisted of barriers at the service-level, such as lack of services that merge geriatric, ethnocultural and psychiatric care, to individual-level barriers such as low levels of self-worth. Many of the barriers identified by key informants regarding the mental health problems of older immigrants were similar to those noted in the study by Sadavoy, Meier and Ong (2004).

Healthy Immigrant Effect (n=5)

The healthy immigrant effect has been widely accepted as a hypothesis for why immigrants’ health tends to decline over time. Given the scope and parameters of this study it was not possible to test this hypothesis by comparing the immigrant population with non-immigrant populations; however, a number of key informants made specific reference to the healthy immigrant effect to describe the migration and health experiences of immigrant seniors. Even among the immigrants that arrived in later-life, key informants speculated that their rapid health declines are the result of the migratory experience in Canada:
19: And then they come here, they’re healthy. They come here and in a couple of years their health has fallen down. So that’s another barrier problem we see. That they come here healthy and in a couple of years their health deteriorates, they start having mental health issues, depression because they’ve lost a sense of identity, they’ve sense of belonging, there isolated – so all these things come into play then.

21: I mean there’s the healthy immigrant effect, and what we also know is that chronic disease is a topic that comes up a lot. And is something that many immigrant populations experience to a larger degree than even the Canadian population, like diabetes, like that’s now it’s all over there’s a lot of attention on that topic right now...what has been found is that diabetes the percentage of South Asian people who get diabetes is very high and chronic disease around coronary diseases, pain, chronic pain and pain management – these are topics that affect immigrant populations and what it is there, and there’s some work that’s being done on assisting immigrants with that but I think a lot more work needs to be done…

One of the most commonly cited health problem among immigrant populations was the prevalence of diabetes. In describing the various activities and educational programs for seniors, many key informants discussed the success and high demand for diabetes prevention and management programs. One key informant implied the environment-lifestyle interaction mechanism and improved diagnostic technology in Canada explained the healthy immigrant effect with regards to diabetes among aging immigrants. In her example, she speculated that Filipino immigrants come with pre-diabetes which becomes full blown diabetes once arriving and living in Canada:

15: Oh actually most of their, most of the probably—diabetes is the most (common) thing. Yeah, which is true—because most immigrants like especially when they came from their country, like for us maybe, like for instance the Filipinos – they’d have diabetes and whatever and when they come here it triggers.

22: We have a large diabetic population. Yeah, a large diabetic population and again just sort of not dealing with it, not properly navigating it. There’s a lot of fear in regards to poking yourself and giving yourself insulin because people won’t do that. In terms of diet, diet often goes downhill especially if there’s no body there to—you know we have a lot of immigrant population who want those specific meals the way they used to cook them when they were cooking for themselves, and instead of sort of trying to modify and find something else, they tend to not eat properly, which is not good if your somebody living with diabetes. It fast tracks the whole process and creates a lot of issues. That’s the worse one that we deal with.

These two examples of the healthy immigrant effect are revealing for a number of reasons. Firstly, it is telling that key informants characterize immigrant seniors’ health experiences in terms of the healthy immigrant effect as a key mechanism for poorer health
outcomes, which demonstrates how pervasive this argument has become. This is in spite of a number of studies illustrating inconclusive evidence for this hypothesis in later-life. By subscribing to the healthy immigrant effect as an explanation for declining health among immigrant seniors, key informant discussions point to various factors relating to lifestyle assimilation, health care access issues, and other social or system-level barriers leading to poor health. However, this disregards the possibility that the migrant experience or immigrant status may also be an important factor in poor health outcomes, since the label of immigrant is applied as a population category. Secondly, as the above narratives imply, the healthy immigrant effect may not be an adequate explanation for poorer health status overall since the assumption is that immigrants arrive with better health than the native born population. It is equally plausible that immigrants may have undetected or undiagnosed chronic conditions prior to migration. A recent study in the United States supports this suspicion indicating that disease unawareness was an important factor for undiagnosed illnesses such as diabetes (Barcellos et al., 2012).

5.7.2 System-level Issues

While previous sections discussed issues specific to more provider-level and individual-level barriers, this section focuses on the wider system-level issues that lead to poor access and underuse by immigrant seniors. There were two categories of issues that key informants referenced when discussing system-level issues and the barriers that many immigrant seniors faced when accessing health care or why access varies across different immigrant populations. The first category comprises issues related to inadequacies of health and social service systems, including language barriers and lack of interpreter services, gaps in health insurance coverage or the absence of culturally competent geriatric services. The second category include those issues that relate to healthcare restructuring and broader economic and political systems that affect the health, social and community care sectors. While most of the issues discussed here refer to
barriers at the service-level more than broader systems of care, many of these are interrelated and influenced by barriers at other levels.

Health Care Service Issues

Key informants were asked to described their views, in terms of their own experience with immigrant seniors, whether or not they thought Canada’s health care system addressed the needs and concerns of older immigrants. Fourteen (64%) of the twenty-two key informants responded “no” and felt that Canada’s health care system was inadequate in addressing seniors broadly and most especially immigrant seniors. Only seven (32%) responded that the health care system adequately addressed the needs of older immigrants, while one stated that they were unsure. Among those that responded yes, most of them that agreed that Canada’s health care system was sufficient in attending to the health needs of immigrant seniors but also invariably noted that there were a number of obstacles that made it difficult for immigrant seniors to access information and care with ease:

15: Actually yes, for me yes because like, they’re trying their best to give (as much) services as possible for the seniors but the thing is there are services there (that) of course some seniors are not aware of it. Some cultures are not aware of this and (are not) speaking for those immigrants.

While language and transportation issues represented the most significant barriers for immigrant seniors, many key informants argued about the complexity of Canada’s social and health care systems and the difficulty that immigrants experience when trying to navigate these systems. Not only are they are navigating a cultural and social environment that is unfamiliar to them, they are also contending with health and social care systems that are vastly different than the ones from their home country:

04: They are isolated in terms of language, they have many barriers facing, well they face many barriers when they trying to access social services, language of course, there’s an inability to get the transportation. Health care needs are tremendous because the health care system in Canada is different and because it’s really difficult to get to find a good doctor.

21: I think there are a few gaps, I think in terms of, especially around culturally appropriate and language supports. This is especially if we’re talking about immigrant and newcomer senior immigrants. This is a big gap because it’s very hard to find your way around the Canadian health
care system if you come from a background where the health care system is very different. And then too, there’s very little language support that’s offered and you know that it’s a resource issue in many (clinics) but it really impacts how newcomers can access the health care system. And for seniors, because seniors of course as per nature have a lot more health concerns than, or tend to have more health concerns that younger people right? So for then, coupled with that language is a big issue and many of them don’t speak English or French and probably won’t learn it to a degree that would be necessary to successfully find your way around – that’s a big, big gap.

In addition to issues of communication or difficulty finding a doctor, as described in the quotes above, key informants noted other gaps in service such as not having health care coverage in Ontario through the Ontario Health Insurance Plan (OHIP) that would allow immigrant seniors access to basic medical services. For many newcomer immigrant seniors to Ontario, there is a general three-month waiting period for OHIP coverage whether they have come from another province or another country. Many service providers discussed the challenges of working with immigrant senior populations that lack an OHIP health card which allow them to receive basic health care benefits. Key informants shared cases where family members who have sponsored their senior parents or grandparents have had to pay out of pocket to fill in the health care coverage gap, resulting in financial strain. Other stories described by key informants included the stress experienced by many seniors of heightened anxiety, worry and the fear that they might get sick before their OHIP coverage became active and the inability to pay for medical services:

02: The other thing is, depends on how recent the immigrant, because some people don’t even have OHIP and that’s a problem! That’s a huge problem. Now most people are able to get that within a time-frame but even our people that move here from another country or province we have to – it’s complex to make sure that their province covers them until the OHIP kicks in.

12: We’ve also seen finance, we have people who are on sponsorship, there being sponsored by their families and they are not eligible for long term care and the family can’t afford to pay for it. So, we have to work with the families on that—that was a huge challenge. We see people who don’t file taxes here in Canada, or they have pensions overseas, or they don’t have OHIP and all of those things, so those are challenges as well, the whole sponsorship. And then you have people who’ve brought family members over for a ten year period and they don’t necessarily, or are not able to, or don’t want to, or something, things change over ten years. And you see a lot of issues around that as well.

In terms of accessing long-term care, not having economic resources was a significant barrier. For seniors that require subsidized care often eligibility is based on financial need or in
some cases a needs-based level of illness, which often does not coincide with a senior’s or their family’s perception of need. One key informant described how they are often placed in a position where they felt unable to help their senior clients because the senior was ineligible for subsidies either for financial reasons or because they were not deemed “sick” enough.

Increasingly, many families find themselves in situations where family members make difficult decisions about how to care for a sick senior. There are many factors that play into the decisions that families may make including cost of care, long-wait lists, bed availability, not being in close proximity to the rest of the family, or even because long-term care is perceived to be inappropriate or inadequate:

02: And it’s really difficult for family members to cope with that. And then too, you know, making decisions about what to do with a loved one, like if they can’t be managed at home there are two choices. Either they’re placed in long term care, but again it’s not often that you have choices around where they go because it’s wherever a bed becomes available, I mean ultimately I think if you wait long enough you can maybe get where you want to go but it doesn’t happen sort of at the time when you need it. And that’s really distressing for families to deal with that, and families often feel, it’s almost like they haven’t done a good job in terms of managing when their parents have to go into long term care and people have not a great feeling about long term care because there’s been a lot of negativity around the care or the level of care, how much care they received when they’re in long term care.

Another service-level barrier mentioned by key informants is the shortage of geriatric doctors in the city who can better understand the complexities of older populations. One of the common complaints from key informants is the lack of attention paid to senior care, in addition to culturally appropriate care. Immigrant seniors are highly vulnerable to inadequate care which can result in mismanaged chronic illness, misinformation about medications or even undiagnosed conditions. Based on their interactions with immigrant seniors, key informants felt that doctors did not take the time necessary to ensure that seniors were well informed about their health or even addressed their issues sufficiently. With the lack of geriatric doctors who are well aware of the multiple ailments and health issues associated with aging, it made for poorer quality of care for many immigrant seniors in the eyes of key informants:
01: I think even seeing health providers, so say a doctor, and I think doctors who are also from these communities tend to still practice how they practice back home, so as a result there’s lack of information they are seen for five minutes, go home and then come back a next month it’s like five minutes, five minutes, there’s no explanation, adequate information about the medication they are taking, what is that for, so it’s both ways, the doctors that are explaining they are also not asking...you know that kind of culture, where we see the doctor and the doctor knows it all. That kind of, so that could be also practiced here and so in terms of from the point of view of how do you then take care of yourself, it’s almost like okay my health is, it’s the doctor that takes care of my health as opposed to that’s how I take care of myself. So, there is lack of education maybe of both way, on both sides.

10: A lot of our doctors don’t understand the problems of seniors. There’s not that many gerontologists around and there should be. And even family doctors, sometimes they’re very impatient with seniors, you know you have, you can’t just spend fifteen minutes with them, you have to spend a lot more time with them.

Another important concern for immigrant seniors according to key informants was that despite having access to universal health care insurance that cover basic needs, many immigrant seniors lacked private health insurance that covers other services such as dental care, eye care and certain medications. Many immigrant seniors, particularly if they arrived in later-life, are unable to afford private health insurance at a time when they would need it the most:

02: So not having and certainly, not having in most cases there many, many cases, not having additional private health insurance, so being able to afford the drugs, that’s not easy. You know, now if you’re a landed immigrant and you’re under ODB, the Ontario Drug Benefit plan then that, at least you get the basic ones. And actually that’s an interesting thing too because some of the other things we don’t think of all the time, dental health, dental health can have a big impact on an older person because maybe you’re starting to lose your teeth and it has an effect on pain and on infection rates and on diet.

10: So, I think our seniors should have a little bit more benefits. And medication-wise, when the government decided to cut off a lot of the funding for medication, a lot of you know, some of them who really needs the medication have to you know kind of just make do with a lot, make do or make without other things, to make sure that they have or just don’t buy those medications.

Key informants who worked in supportive home care service agencies described situations where immigrant seniors would hoard unusable medications due to changes in prescriptions or expired medications. They explained that immigrant seniors, or seniors in general, who experience significant financial barriers are reluctant to get rid of old medications throw away prescriptions that had been paid for. In many cases, key informants explained that many doctors or pharmacists did not take the time to explain the dangers of using inappropriate or expired prescriptions. For many seniors in general and immigrant seniors in particular who are
struggling financially, as well who are not well informed about the use of medications, these practices can lead to potentially hazardous situations.

**Health Care Reform and Restructuring**

Discussions with key informants represent one perspective of the complex relationship between policy, health and health care for aging immigrant populations. Results are especially informative in terms of demonstrating how more vulnerable populations, such as immigrant seniors, are sensitive to the transitions in the economy. Reductions in funding as well as hospital and health care restructuring have severe consequences for newcomer immigrant populations in Canada. When these system- and service-level issues, such as a declining economy and health care reform and restructuring, are compounded with individual-level issues, such as language and communication barriers, immigrant seniors are especially at risk.

With cost-containment measures implemented with Canada’s health care system since the 1990s, an increasing proportion of care is non-insured. The resulting impact of health care restructuring has not been equal across the populations. Low-income groups and the poorly educated are less able to deal with system restructuring even within Canada’s publicly financed system. Those experiencing language barriers or perceptions of culturally insensitive care, such as immigrant populations, especially newcomers feel the impact of health care restructuring more.

Key informants explained that health and social care restructuring was a given in the current economic climate and many organizations attribute many of the challenges they face to broad systems-level and structural issues. Health care reform and restructuring invariably affects the most vulnerable populations, so for some key informants, they felt it was especially important to support and strengthen families caring for elderly members:

18: We try to make it like a space where when families come into our routine they feel like they are also an active part. And an important part of how healthcare is delivered to their family members. So it’s language would be the biggest issue, finances is a big issue, because the pension doesn’t cover cost of living, it really does not. And so then trying to help them to navigate other resources if it’s a food bank for example, if it’s foot care at no cost to the person, if it’s dental care at no cost to them, just looking at services they’ll need and trying to provide it for them
where it’s minimal to no-cost. And when we do it for that person, not making them feel that they are obligated to us, but making them feel like this is something that they actually deserve to get, and that were not doing them any huge favour when we get these services for them because they've contributed.

As part of current health care reform and the impending population aging, a health policy initiative to have emerge in recent years was the the Aging at Home Strategy. Launched in 2007 the Ontario Ministry of Health and Long Term Care dedicated over $700 million over a four-year period in order to meet the needs of seniors through a locally driven community-based approach. With this policy initiative a significant investment was made in the community care sector to help provide seniors the home care and community support services needed in order to continue living independently in their home for as long as they are able to should they choose to do so. An additional aim of the Aging at Home Strategy is to alleviate hospital pressure by reducing unnecessary hospitalizations, inpatient bed use and increased wait times in emergency rooms.

Most of the key informants who work directly with immigrant populations were located within the community, offering community care and support services, who at the time of the interviews were directly or indirectly affected by this policy initiative. While most key informants spoke generally about the importance of community supports for seniors and especially for aging immigrants, only two key informants made specific reference to the Aging at Home Strategy when asked about meeting the health care needs of immigrant seniors:

07: With the long-term thing, Ministry of Long Term Care with LHIN – this Aging at Home thing, I think it’s a very good beginning. But they need a lot of resources because (when) it came everyone has a reason to get—general reason to be financed by Aging at Home. I don’t know how much pressure they have, for finances. They are not increasing the funding, the finances. They have lifted the funding levels this year but I think if there’s anything to focus, it’s there.

12: Well I think the Aging at Home Strategy overall you know is geared toward helping people stay at home and if you look at the Russian community that we work with here who want to try and keep people at home, to be able to access for services for program name withdrawn, day centres, all those things. I mean I think, I think there are efforts being made.

They felt that this policy initiative was a good start in addressing the needs of immigrant seniors, especially since many of them are located deep within the community. However, the
Aging at Home Strategy goal of broadening the community supports to allow seniors to age at home has been difficult to achieve for some agencies, partially due to limited funding and increasing demands. Other key informants expressed concerns that seniors have varied levels of need within the community and that it is a challenge to meet the diversity of needs across the community:

14: Another thing is the service that can support the seniors to stay at home is another issue that like I just mentioned, the home care service for nursing service, that can you know, go to the seniors home, but it’s not enough. If you want the seniors to be healthy and stay in the community there should be some kind of – enough support, adequate support, for them to stay, otherwise their physical health would deteriorate very easily and very quickly.

The results of health care restructuring often meant staff shortages, increased workloads of staff and general decrease in the amount of care or the nature of the provider-patient relationship. Additionally, lack of funding for social and recreation programs that allow seniors to remain active participants in social life can have negative implications on their social networks.

5.7.3 Cultural Competent Care

The concept of culturally competent care has been promoted in primary health care settings on that basis that it reduces health services disparities while addressing persistent health care access inequities. Additionally, it increases awareness of culturally-specific diseases and illnesses and influences the health status for culturally and ethnically diverse communities across Canada (Nova Scotia Department of Health and Wellness, 2005). Culturally competent care is one that promotes an awareness of culture and its prime importance in influencing health behaviours. Engaging in culturally competent health care requires consistent evaluation of intercultural patient-provider relations and the practice of care through dynamic and adaptive services, which meet the cultural needs of the patient. In no way does cultural competent care supersede the dominant framework of health care, evaluations of disease incidence and prevalence, and treatment and intervention outcomes, but rather acknowledges that the cultural
beliefs and health practices of different populations result in different health and illness experiences (Betancourt et al., 2003).

Interview results from key informants involved with diverse multiethnic and multicultural aging immigrant communities in Toronto demonstrate the importance of culturally competent care at all levels and within all sectors of care. Understanding cultural barriers to health care involves acknowledging the diverse cultural meanings given to health and illness. Additionally spiritual or religious obligations and practices may also interfere with more dominant ideas about health and illness. While it is important to understand how older immigrants experience health and illness in a post-migration context it is also important to know how they define the concepts of health, illness and aging in their own social and cultural contexts. Different groups of people will experience health and aging differently and by extension will experience the health care system in vastly different ways. Acknowledging the socially produced concepts of health requires challenging dominant definitions of health.

A number of key informants explained the challenges of providing care for ethnocultural seniors in a multicultural setting. One key informant argued below that at the service-level, Canada’s health system overlooks the different cultural or spiritual practices of diverse ethnocultural groups resulting in a number of shortcomings of the health care system with regards to aging immigrant populations. Many cultural or spiritual practices are often kept up by immigrant seniors in an effort to feel a sense of comfort and cultural connection to back home. In describing her definition of appropriate care which acknowledges old practices or pre-migration practices, she also emphasized diet:

01: I think appropriate care – first of all you really have to know what are their strengths, what kind of practices are they used to and really give credence to some of those practices which they might have used before but that’s not obviously acknowledged in the health system. So that would be one, looking at their old practices. What have been effective for them? …So diet for example, are those foods that are available to them here, are they really appropriate for them? For example, when they go to nursing home, even if they are not fed with the right diet they end up dehydrated or they end (with) their health deteriorating because of the diet that they have. If you lack the understanding of their diet then you’re missing quite a bit.
Diet was a common example used by key informants to explain how a very Westernized model of health care misses an important cultural component of how immigrant seniors go about their daily lives. Food as a basic component of health from the view of the health care system is stripped of its cultural significance and importance to a sense of wellbeing in the family. One key informant explained that despite changes to the Canadian food guide to address some of the more ethnic diets, there still are information gaps at the service-level:

10: I’m so glad that a couple years ago the Canadian food guide has changed, revised the Canadian food guide because a lot of them don’t address some of the food that our ethnic communities are using, like a lot of the beans and a lot of the grains and that kind of thing. Cause if I send somebody to a diabetic teaching nurse or whatever, they’d come out and they still go...[making a confused face]...cause you know, right? They eat plantain for breakfast! It’s not like they’re gonna (change). And some Filipinos they still like to have rice and some of my Jamaican (clients) like to have rice for breakfast, so how do you address that, those are the differences.

Key informants also explained that while it is important to acknowledge ethnic and cultural minority groups’ own practices and traditions, it is also important recognize that these patterns of behaviours shape health and aging experiences and how seniors view their own health. As one key informant emphasized diverse cultural practices and beliefs should also inform the approach and type of care and health interventions that immigrant seniors receive:

02: It’s important to understand, different cultures, people from different cultures come with different ideas about health and what health is, and one of the things we do at organization name withdrawn. But we also have a department that actually – it's a big department that actually trains anyone who comes and they also come too – who have very specific needs. And so that’s something that we do at organization name withdrawn and, I would say that health care facility that has a large number of immigrants, from any ethnicity really needs to have an ability to understand that background so that they are talking about the same things, valuing the same things. For example, end-of-life decision making is very different in different cultures.

It was also noted that if a doctor or other service provider did not take the time to explain treatments or medications in a way that an immigrant senior understands and viewed as relevant to their own views and definitions of health then it is likely that they will not adhere to medical advice. She described how the long-term care facility she works in often refers to a religious authority to help frame health, for example diabetes management, in a way that does not conflict with their spiritual beliefs:
02: One of the things our rabbi does every Yom Kippur is, we have the rabbi and come a meet with the residents and encourage them to know that they do not have to fast if they have a health problem for example diabetes, because people who have fasted all their lives, for them it’s a religious obligation and they need to know in Judaism there is an exemption for people who have a health problem.

One key informant discussed the dominance of the biomedical model in health care and how this approach tends to isolate many immigrant seniors, often depriving them of their cultural identity and their health beliefs, to the detriment of their health. In the quote below, one key informant described mental health care as one particular area in health that needs to be re-evaluated for its lack of cultural sensitivity and inclusive practices:

01: In terms of for us, for example in mental health care, what are some of the practices, so for Asians for example they use maybe acupuncture and all kinds of preventative kind of remedies. But are they validated or are they used because once again of the dominance of the biomedical model or Western approach it does not seem to jive with the needs that they have.

She further explains that many immigrants to Canada bring with them their own traditions of health care, whether it is maintaining an Ayurvedic diet or using Traditional Chinese Medicine (TCM) methods, either solely or in conjunction with Westernized medicine. She argues that the efficacy and reliability of these methods are slowly being researched and awareness is growing of them in the mainstream health care system but there still is resistance from a number of providers who dismiss these practices or do not try to understand how important these have been and are to the patients they see.

Many key informants stressed that despite efforts to incorporate multicultural and culturally sensitive practices within systems of health and social care what is missing is a multicultural approach to geriatric care. Strategies of care that are culturally sensitive and inclusive are not only important to broader minority ethnic and racialized seniors but immigrant seniors as well. With respect to concepts of health and illness, the consensus among key informants was recognition of pre-migration patterns of behaviour that influence health, many of which are still upheld following migration. Immigrant seniors’ health behaviours are not only
influenced by family and the community forces but a large part of their cultural identity and informed by historical forces as well.

As argued by one key informant a more accurate cultural competence approach would encompass broader dimensions of social determinants beyond culture, language and religion. Other social circumstances that influence a person’s health and well-being, their health behaviours and decisions, she pressed, should include other lived experiences:

11: Right so, we can improve health more by addressing social determinants than we do by medical interventions. Right? So a truly cultural competent approach would consider culture, language, religion, culture in the widest sense. So whether your homeless senior, whether you’re a gay, LGBT senior, whether you’re a mentally ill senior, whether you’re a disabled senior, whether you’re a poor senior, right whether you’re a homeless senior. Like all those things will be part of cultural competence is considering the broad context in which you experience illness.

The challenge of addressing a diverse population in health care and other social care service was noted consistently among key informants. Multicultural diversity was seen as both a strength and challenge when it came to working with older immigrant populations, or older racialized groups in general. Incorporating an intersectional culturally competent health care approach was not only important but necessary in multicultural urban settings such as Toronto:

13: So I think some of those, that’s just one example so when you have a multicultural setting you have everyone coming with a different history and story and view and for the most part it really works but you know it takes time to figure out why someone’s reacting in a way you didn’t expect. So there is tends to be some cliquing, when you have a big group of Caribbean ladies who know each other, their all Christians, they all share a common culture, so they feel good coming together but we worked really hard on making all the spaces all the programs inclusive so that you know that the Caribbean group doesn’t own the room.

15: I try to plan an activity for the group where they can come together and share their own culture and you know, their cultural food, or traditions. And they try to make their own tables, and then they try to explain their own (culture). "This is my background", “This is my culture”, “This is what we do.” We say what can we do this week? This is why we do something’s different you know like share their own culture.

However, in the case of ethnoculturally specific agencies, one key informant discussed the challenges of multicultural care and despite efforts for cultural sensitivity many immigrant seniors’ needs are still not addressed necessitating culturally specific services. She also noted that within multicultural settings and even within the community some immigrant seniors do not feel
safe or a sense of belonging creating many fearful perceptions about the broader community or to life in Canada. One key informant attributed the lack of appropriate and culturally competent senior care to many interrelated factors, such as structural racism in health care as well as ageist attitudes generally to language issues at the individual level:

01: I think racism is the big one. I think this is a society for the young and so there is a tendency to not pay attention to the old. Language barriers is a big one. Again, the lack of appropriate services, so those I think are all interconnected. So lack of appropriate services could be because of racism. You know, all those kinds of thing and I think the use of one approach to health is, I think, really not appropriate.

In addressing racial discrimination and ageist attitudes within society, another key informant described the success and inclusiveness of a seniors program that was specific to the South Asian community in Toronto and the GTA. The program was established as a result of the South Asian community not feeling safe in the broader community and has, according to this key informant, made a difference in the lives of older South Asians who felt discriminated against:

19: Now this program is provided in their language. It’s in Hindi – we do in all those languages. We have to be sensitive that the seniors do not understand English, okay? And this gives them the opportunity to mingle with other seniors who speak their language – who look like them…It was identified in the community. The community kept on asking that they want to go to programs where—in a safe environment. They want to go to programs where they are understood. The culture is understood and they are respected for who they are. The food is Halal food. They are able to eat the food – their cultural food, not just given any mainstream food because they can’t eat that food. So it was an outcome of what the community themselves wanted. And we got the communities input when we designed this program.

Many key informants reported that experiences about feeling unsafe or not feeling a sense of belonging among older immigrants often stemmed from experiences of discrimination. While not all immigrants are necessarily part of a racialized group, some key informants noted that many newcomer immigrant groups often report feeling discriminated against. Whether it is racialized identity, language or immigrant status or a combination of these identities, cultural difference or being the cultural other is reinforced within the broader community, often with interactions and experiences in health and social care systems:

01: I think culture and discrimination of all sorts would play a big part – systemic kind of discrimination play a big part in not providing them with the appropriate care when they are so
isolated. I don’t think agencies are able to really address those issues, these are social issues. There are severe social issues and they are left at home, either they are expected to take care of the home, take care of their grandchildren or to just really be left there and not know how to go to different places.

13: Well it’s like—there’s compounding factors right as an older adult you may experience some losses in your mobility, in your vision in your hearing, all those things may make negotiating the world more difficult but then you add a language barrier or a lack of knowledge of systems. Or you know even systems are hard for native-born Canadians to navigate. So you know in later-life without language—there’s all sorts of things that make life pretty complicated I think. I don’t know if older adults are also doubly stigmatized because there’s ageism and there’s racism—so you have this compounding of a being part of several groups that can experience prejudice.

Many key informants felt that while culturally competent care and multicultural practices are being widely adopted to help overcome some of the language and cultural barriers that immigrant seniors may experience, they do little to eliminate the discrimination and racism that also occurs. In the case of some immigrants, key informants felt that language also marginalized and stigmatized many seniors, particularly when accessing care. Although language was commonly seen as a barrier to care, many key informants also described how it emphasized cultural difference:

11: The way people are excluded, or discriminated against, or the way in which the health care system does not provide the adequate means in which people can understand health information or the health system that results in people having poor health, right? So we have to tease that apart, because often people say diversity is the problem, it’s not the problem, discrimination is the problem, right? Social exclusion is the problem. That’s what causes poor health.

A number of key informants also spoke about specific neighbourhoods in Toronto and the relationships between health, aging and place among immigrant seniors. One such neighbourhood, the area known as Jane-Finch, is recognized as a high priority neighbourhood by the City of Toronto and is an area associated with a higher than average number of low-income families, racialized groups and immigrants. Two key informants who worked specifically with low-income immigrant seniors in the Jane-Finch area shared their views on the challenges that aging immigrants face while living in a neighbourhood that has the reputation for poor social

13 In the Neighbourhood Action Plan, the City of Toronto proposed to improve areas known for high social risks, such as Jane-Finch, through continued monitoring and investment measures to improve social conditions over time (http://www.toronto.ca/demographics/pdf/priority2006/area_janefinch_full.pdf).
conditions. One key informant noted that many newly arrived immigrants have limited incomes and often settle in neighbourhoods characterized by low rent, poor amenities and infrastructure, and which are also racially stereotyped. Another described the migration and settlement processes that aging immigrants undergo when they arrive in Canada, discussing the risks of social isolation, stresses of adjustment and role change:

07: Once you come here you’re – once you leave your home you become a nomad. You’re neither here nor there. If they were to retire at home it would be easier, somebody gonna look after something. Even if you’re a teacher you can start a kindergarten, you can be an administrator or you can be something in the village. You can be an elder; you can be a sage; you can be an advisor. You can be anything – people will come to you because they knew you. Here people don’t know you, people don’t know (that) you know anything. They just say, “That’s Black – Jane and Finch”. They put them in this stereotype…

She further explained many of the clients she sees in her social and recreational program struggle to gain a sense of belonging while in Canada, especially when living in an area that is branded with negative connotations. Another key informant also working with immigrant seniors in the Jane-Finch area discussed how there are little differences between immigrants and non-immigrants even within the neighbourhood:

15: It’s the same thing, you know they live in the same (type of) apartment, unlike, maybe for Richmond Hill or you know, rich areas, you can actually see the difference(s). But like when you’re in this area, where everybody’s like in a similar situation, you cannot really give any comparison. It’s almost the same, though the thing here is, I believe like, most of the low income immigrants are in this area. One day I read in this paper that Jane and Finch area is sucking down you know, it’s sucking the government’s money because of the welfare and everything…I think it was last year. Most of the low income immigrants are in this area so definitely economically and financially it’s lower.

Many of the seniors that she sees in her agency are struggling financially whether they were born in Canada or came from another country and added that the residential segregation of poor, racialized and immigrant populations can lead to poor perceptions of self and cultural identity. Common narratives about neighbourhood composition, class and racial identity about struggling areas such as Jane-Finch, where immigration settlement is high as well as higher rates of poverty, are significant and cast these neighbourhoods with the stigma of a living in a racially segregated area.
5.7.4 The Future of Population Aging on Immigrant Seniors

With the concerns of population aging looming in the near future, some key informants expressed concern for older immigrants, particularly newcomer immigrant seniors. Although the circumstances of migration varies widely among the aging immigrant population, key informants noted that those that experience language and financial barriers and who are socially isolated will have the greatest difficulty as they age and try to access health and social care in the community. Immigrant seniors’ poor position in society will exacerbate the issues that they are already experiencing including higher rates of poverty, earlier onset of age-related health issues, increased dependence on, increased vulnerability and social isolation.

When asked to describe how they see aging immigrant populations faring within the overall trends of population aging, future health care restructuring and shifting state-level political and economic priorities, half of the key informants believed that immigrants would be worse off (n=11). Three key informants remained unsure about the role of aging immigrants and what their health and aging experiences will be. No one key informant definitively said that immigrant seniors would be better or even the same as the rest of the aging population, given the impending future of population aging in Canada and globally. Among the remaining key informants (n=8), they were very hopeful and remained optimistic, believing that if more attention and effort was directed towards more settlement and immigrant family issues, then immigrant seniors will certainly benefit. As they evaluated the future of aging immigrants, many believed that as long as efforts were diverted towards broad aging policies, without focusing on the immigrant factor or even the social determinants, many vulnerable aging groups, including immigrants will be overlooked.

Many key informants weighed heavily in their opinions about the impact that the aging population will have on immigrant groups, namely immigrant seniors:
04: It will get worse because the burden comes...falls on us, those who are working. And, (immigrant) seniors will be more stigmatized and they will be based on the ageism and the racism and everything they will be, again they will be more invisible.

07: They’ll just be forgotten, they’ll be pushed and they support they get? They’ll ease off. They’ll be eased off, not deliberately. So somebody has to take a conscious effort to either distinguish them and separate them and make them into different groups. Or make sure that you know they’re there even if you don’t see them. Know they’re there. Even if they’re not accessing the system, they’re there.

16: There probably going to be further down the line in terms of getting what they really need. Because everybody is getting older of course but you know the population is increasing, the senior population is increasing, and as that increases and the demands become greater, then there’s going to be some groups that are going to be left behind. And based on the way we've been doing things in the past, will kind of show what we are going to do in the future unfortunately. And it’s going to be the newcomers that are going to have the hardest time. And are going to have to somehow “fit in” in a way that they might find very difficult and challenging.

17: I would say the immigrant population is at the foot of the bell curve. You’ll see more of them in the poor side of that bell curve, with more chronic condition, etcetera because they tended to have been poor and have a harder life. And if you are poor and have a harder life, you tend to have more chronic disease or the chronic disease manifests itself earlier. So if you think of aging population I think of most of the aging immigrants would be at the foot of the bell curve with more issues.

Immigrants who may have arrived in Canada earlier and are now aging in place, including members of the baby boom generation, were viewed as the most advantaged among the immigrant seniors. However, key informants were divided about what role the baby boomer, long-term immigrant would have on the overall senior population and what their impact will be on health and social care systems. Some key informants felt that with their accumulated wealth, familiarity with health and social care systems, and likely, their English or French language fluency will give them an advantage to advocate for themselves to the benefit of all seniors:

02: Well all we can hope is that the baby boomers who have pushed systems and I’m the lead edge of the baby boomers...we’ve always pushed systems, we pushed the education system wave pushed the work system, we push pension, and we’re gonna be pushing the health system. So helpfully that push will benefit all elders. I think it will, actually, I think it will because nowadays when we’re planning programs for elders we’re planning for increase of elders and as I said, because education has improved and knowledge of immigrant groups has improved and the willingness and the desire to program for those immigrant groups too so I think that the baby boomers will push the system and the people and the planning system come with a willingness to be inclusive, so I think that’s a good thing.
In contrast, some key informants felt that generally the aging population will result in weakened systems with less economic resources to support all seniors:

06: The dollars will be less than they have been to date because the baby boomers aren’t pumping money into our tax system…so basically the number of people that will be supporting the number of elderly will be less than what it is now. Now we have a big baby boomer population that is supporting a smaller group of seniors but that will reverse and the amount of dollars will be less and less and less. And so we’re going to have to find more efficient and better ways to provide services, and whether that means focusing more on technology, I don’t know but we’re definitely going to have to look at how we can provide better service with less because there certainly won’t be the infrastructure there to be able to support them. Yeah, it’s gonna get worse.

Amidst the uncertainties of what population aging will bring to the future of immigrant seniors, some key informants felt that the resilience and adaptability that typically characterize most immigrants will be beneficial as they tend to have less expectations and a lowered sense of entitlement allowing them to cope better than Canadian-born seniors. Some also noted that there are strong traditional family structures that are brought over with newcomer immigrants, such that these seniors will be buffered by family:

13: I guess this thing I had thought about the adapting, the adaptability of immigrant seniors. I think that native born Canadians have a much greater sense of entitlement and they’re going to be disappointed because when they come and expect a certain level of service, we haven’t as a country planned for that and don’t have the resources available to make that available to them. And so I think that it might be a little less traumatic for an immigrant senior who’s not expecting that level of health from government, from you know they’ll find ways to negotiate, which they had to do when they first came to Canada, and have throughout, whereas again it’s going to be a shock I think for people who have always been independent who’ve been able to do everything for themselves when they come to a point where they can’t and they don’t have the resources to pay, they’re going to be in trouble I think.

A number of key informants also expressed the need to move from a victim-blaming attitude towards immigrants and focus on the structural and systemic barriers through a more inclusive social determinants approach to addressing health issues among immigrant seniors. Many key informants felt the greatest responsibility for this lies in the role of the government to make the changes necessary to ensure that all populations have equal access to health care and that the social inequities that hinder this access is minimized:

11: I think that as society ages it’s going to be interesting to see how government changes to meet the needs of the aging population but there’s going to be a segments of the aging population that
will not be heard as well, right? So not just immigrant seniors but many other groups of seniors who are marginalized, simply cause they don’t have the political connections and the experience of advocacy and you know they don’t have the infrastructure in which to deliver their demands. So all of these things are important tools to get advances made.

Overwhelmingly, key informants suggested increasing the capacity of community agencies and organizations to help immigrant seniors at all stages of health improve their quality of life through efficient and effective methods, such innovative outreach strategies, in order to access those seniors who remain hidden within the community. Most key informants expressed that it was important that all communities of seniors be empowered and galvanized to change society’s often ageist attitudes and to exert their civic rights. Key informants also felt that immigrant seniors in particular needed to be especially engaged with the community, serving as mentors and leaders, and that more long-term immigrant seniors will help bring greater awareness to the problems that many immigrant seniors face and they age.

5.8 Chapter Summary

In the previous chapter, key informants described the importance of both the community and family roles of immigrant seniors by identifying how these experiences connected to notions of Canada as a second home. An overarching theme was the challenge of ethnic and cultural diversity as key informants discussed the health and aging experiences of immigrant seniors. During interviews most key informants returned to the important theme of diversity, in terms of age, immigrant status, health, family situation, ethnocultural background or perceptions of aging. This diversity was seen as integral to the experiences of immigrant seniors who were among the most vulnerable and disadvantaged in living in Toronto and the GTA. Not being able to meet the diversity of the senior immigrant population was a real challenge for many key informants. In many ways, this was seen as one of the limitations of culturally competent care, as many key informants admitted that despite efforts to address the diverse health practices and behaviours that are informed by an immigrant senior’s cultural, religion or family situation, they were unable to address all seniors in this way. As a result, some immigrant seniors may not receive the same
level of care and culturally sensitive care that is afforded another immigrant senior. As well, the ability to provide culturally competent care, such as offering interpreter services or matching clients and providers of the same cultural and ethnic background, was dependent on the availability of resources and available staff.

The findings from this chapter highlighted the interrelated themes of migration, place and aging. Key informants identified the importance of the migrant experience in the health and aging trajectories of many older immigrants living in Toronto and the GTA, and in some instances, key informants advocated for migration or migrant status to be recognized as an important determinant of health. They also were critical of classifying all immigrants under the single definition and category of immigrant. Key informants argued that immigrants experienced processes of migration and settlement differently, with some immigrants being able to adapt more easily while other experienced greater struggles. In particular, key informants identified how central the family was to older immigrants and that the migration and settlement experience was also associated with changing structures of immigrant families, which could be both positive and negative experiences for immigrant seniors. Key informants discussed many issues ranging from obligations in the home and within the family, to more broader societal issues, such as contending with often negative views and attitudes towards elderly immigrant populations or migration through family reunification.

Additionally, key informants made reference to social determinants of health and how they incorporated this framework of health in their own approaches to service and care for older immigrants. Among the important issues that key informants discussed, they included addressing economic barriers, such as low income and issues of extreme poverty. Key informants also reported on various housing issues including lack of appropriate and affordable housing to issues

---

14 Parts of this chapter were presented at the Association of American Geographers Annual Meeting in Los Angeles, U.S.A on April 12, 2013. Results were presented in an oral presentation in a session entitled, Health and Health Care in a Period of Economic Decline I.
of fear and stigmatized neighbourhoods in the Toronto area. Other related issues were the lack of transportation or poor access to transportation and language issues as barriers to health care, as well as social and community supports.

Many of the issues discussed by key informants came from their own first-hand work experiences in addressing the needs of older immigrant populations. Accordingly, key informants discussed experiences of migration and place as they relate to the health and aging of immigrant seniors. More specifically they discussed how immigrant seniors were at a significant risk for cultural and social isolation and the need to find a sense of community and a sense of belonging. As well, they discussed how issues of fear and a lack of trust were difficult obstacles for many immigrants to overcome resulting in the need to increase social and community supports. Key informants also explained their own personal and occupational challenges, in terms of remaining culturally sensitive to the diverse backgrounds of their clients as well as ensuring cultural competency among their staff and services. They also struggled to maintain a sense of inclusion among the diverse immigrant populations being served or in the adoption of multicultural practices and policies. Regardless of what program or service-level barriers they were facing, amid budget constraints or reduced funding, all key informants emphasized that the issue of diversity across immigrant populations was often not acknowledged in meaningful ways at the policy or health service levels to ensure positive health and well-being for immigrant seniors.

Finally, key informants also discussed aging and health among older immigrants with specific reference to immigrant health issues and system-level issues, the status of culturally competent care in Toronto and the GTA and the future of population aging and what it means for immigrant seniors. Among the many challenges faced these included accessing immigrant populations, providing effective outreach to immigrant seniors, managing staffing relations and issues, operating with declining budgets and lost funding, and attempting to compensate for the increased social inequities experienced by immigrant populations, particularly newcomer
families. For many key informants, older immigrants experienced multiple layers of disadvantage at all levels throughout society that negatively influenced their health and aging experiences, their sense of belonging and connection to Canada, their social and support networks within community and even their relationships with their own families.
Chapter 6

Exploring Health, Place and Aging among Later-life Filipinos in Toronto and the GTA: A Cross-sectional Study Using Survey Data

6.1 Introduction

Immigration is often viewed as an important strategy to bolster local and national economies and most recently to deal with the pressures of an increasing aging population and supplement Canada’s already fragile health care and social welfare systems. Canada’s population has changed considerably due to the influx of diverse immigrant populations. Data from the 2011 National Household Survey (NHS) reported that one in five people living in Canada were foreign-born, up to 20.6 percent of Canada’s total population from 19.8 percent based on data from the 2006 Census (Statistics Canada, 2013). Settlement patterns within Canada are also changing as recent immigrants are choosing to live in smaller municipalities versus the three major gateway cities of Toronto, Montreal and Vancouver. For example, in the municipality of Mississauga just outside of Toronto over 53 percent of the total population was foreign-born with 16 percent of those who were reportedly newcomers (Statistics Canada, 2013). This is compared to Toronto’s overall foreign-born population at 46 percent, of which 15 percent were newcomers to Canada. While Toronto still receives a high number of recent immigrants, alongside Montreal and Vancouver, patterns of recent immigrant settlement points to increased ethnic diversity towards less popular newcomer destination points. As a result, these diverse and varied patterns of immigration have also influenced economic development and the workforce composition of a number of municipalities in Canada.

Immigration patterns of Filipinos into Canada are unique and since 1967 have mostly reflected Canada’s labour demands such as the recruitment of nurses and medical technicians and domestic workers through the Live-In Caregiver Program (Darden and Kamel, 2004/5). As
reported through the Profile of Ethnic Communities series of Statistics Canada, the Filipino population in Canada is mostly concentrated in the provinces of Ontario and British Columbia. According to the 2001 Census used in the report, it was estimated that just over 50 percent of the Filipino population resided in Ontario (Lindsay, 2007). There is a surprising lack of health research on Filipino immigrants to Canada. This gap in health research literature is especially astounding if one considers that since the 1981 Census, the Philippines has been among the top five source countries for immigrants to Canada, steadily remaining the third largest non-European ethnocultural immigrant group arriving in Canada since the 2001 Census (Statistics Canada, 2013). Prior to the 1970s they represented a very small proportion of immigrants entering Canada, mostly recruited to fulfill labour shortages in health care although they were also recruited as teachers and garment workers. Under the Marcos martial law declared in 1972, an important component of the Philippines’ economic policy was the export of labour namely as overseas contract workers with North America as a popular destination. In the 1980s and 1990s many Filipino women arrived in Canada as domestic workers under the Foreign Domestic Movement (FDM) Program, now currently the Live-In Caregiver (LIC) Program (Velasco, 2002). Anita Beltran Chen reasons that the changing socio-demographics of the Filipino population in Canada is the result of Canada’s immigration policies which evolved to the shifting labour and economic needs of the country and provisions for family reunification. As a result of the immigration policy of 1976, during the late 1970s and well into the late 1980s the country received large numbers of older Filipinos arriving to join their adult children who had already settled and established their lives in Canada (Chen, 1998).

In 2010 and 2011, a large proportion of Canada’s permanent residents were from the Philippines, which topped the list of all source countries for permanent residency. Temporary foreign workers, in comparison, were sixth among all source countries for the same years (Citizenship and Immigration Canada, 2012). Notwithstanding the lack of health research on
Filipinos in Canada much has been written about the social, economic, labour and spatial contexts of Filipino migration into Canada. The migration trends of skilled and unskilled migrant workers dominate much of the literature on Filipino immigrants. Filipino migration in Canada has often been characterized under the historical labour demands of Canada and has persisted as a case study for understanding class and the creation of transnational spaces (Kelly, 2012). Dubbed “national heroes” by the Philippine state, Filipino migrants have come to represent the epitome of flexible labour migration with foreign remittances supporting the Philippines economy – a product of globalization and transnationalism.

The underlying goal of this study was to provide insights on the health and wellbeing of aging immigrants living in culturally diverse communities throughout Toronto and the GTA. In the previous chapters (Chapter 4 and 5) key informant interviews provided a backdrop to the economic, cultural and social realities of aging in post-migration context. Key informants identified the many ways that cultural communities and the broader community engages the health, aging and health care experiences of older immigrants. In this chapter and the following chapter the focus will be on the specific experiences of older Filipino immigrants. Although Filipinos are a relatively new ethnocultural group in Canada’s varied immigration history compared to other ethnocultural groups, such as Japanese and Chinese populations, they make up a significant proportion of newer immigrants arriving in recent years. Despite their growing presence, very little is known about their health experiences and health care use.

This chapter summarizes data gathered from survey questionnaires distributed to Filipinos 55 years of age and older living in Toronto and the GTA to provide a portrait of Filipinos health and health care use. Through a variety of validated scales and questions based on previously administered surveys as well as investigator generated questions, older Filipino immigrants were asked to self-report on their current health and health care use in Canada and to recall their pre-migration and migration experiences as they relate to health and health care. This
chapter provides the context for the research presented in Chapter 7 that examines qualitatively how later-life Filipinos perceive their own health and aging.

Given the lack of research that explicitly examines the health and aging experiences of Filipino communities in Canada, the data gathered from this stage of the research is descriptive and exploratory in nature and provides an ethnocultural case study on the intersections of age, migration and place and how they influence health and cultural practices that shape health and aging experiences in a post-migration context. As such this chapter addresses the following research goal using later-life Filipinos as a case study:

- To understand how social determinants, migration and the role of place influence the health and aging experiences of later-life immigrants (Research Goal 3)

More specifically, the quantitative component of the overall study which utilizes survey data examines the specific research questions:

1. What is the general health of later-life Filipino immigrants?

2. Do later-life Filipinos experience any barriers in accessing and utilizing health care?

3. How do health and health care use vary among later-life Filipinos, based on the five dimensions of place experiences outlined in Chapter Three?

The results presented within this chapter are organized according to the research questions above.

6.2 Demographics of Filipino survey respondents: Data and Definitions

Recruitment for survey participants began in September 2011 with data collection finalized in August 2012. Follow-up interviews occurred concurrently with survey data collection as with data entry of questionnaires in SPSS. Data collection ended once the follow-up interviews were concluded with saturation of themes. The final sample of later-life Filipinos who completed and submitted questionnaires was 138 and was comprised of 92 (67%) females and 46 (33%)
males. The mean age for the total sample was 67 ±7 years (median= 66 years) with the youngest respondent 56 years of age and the oldest at 88 years old.

Respondents were categorized into age cohorts in order to distinguish between various groups of the aging population, as it is inappropriate to group all seniors or elderly as 65 years and older (McDaniel, 1986; Canadian Institute for Health Information, 2011). As such, four age cohorts were identified for this study. Those older adults aged 55-64 years are referred to as “pre-senior” based on the government of Canada’s definition of senior identified as adults aged 65 and older for Old Age Security pension eligibility (Turcotte and Schellenberg, 2007). Those who were 65-74 years old are named the “young-old” seniors. Seniors 75-84 years of age are considered the “old-old” and those 85 years and older are considered the “very old” cohort. Most respondents were in the young-old age cohort of seniors with approximately 48 percent (n=66) aged 65 to 74 years of age followed by 35 percent (48) of respondents in the pre-senior age cohort group. Only 17 percent (n=24) of the total sample were aged 75 years or more. The majority of the survey sample was married (75 %), graduated college or university (73 %), retired (54 %) and currently living only with their spouse (46 %). The demographics of the total sample aggregated by sex are further summarized in Table 6-1 below.

**Table 6-1: Later-life Filipinos Survey Respondents Demographics**

<table>
<thead>
<tr>
<th>Demographic Characteristics:</th>
<th>Female</th>
<th>%*</th>
<th>Male</th>
<th>%*</th>
<th>Total</th>
<th>%*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=92</td>
<td>67</td>
<td>n=46</td>
<td>33</td>
<td>N=138</td>
<td>100</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age Range</td>
<td>56 - 88</td>
<td>-</td>
<td>57 - 86</td>
<td>-</td>
<td>56 - 88</td>
<td>-</td>
</tr>
<tr>
<td>Mean Age</td>
<td>67.1 ± 7.7</td>
<td>-</td>
<td>67.8 ± 6.8</td>
<td>-</td>
<td>67.3 ± 7.3</td>
<td>-</td>
</tr>
<tr>
<td>Median</td>
<td>65</td>
<td>-</td>
<td>66</td>
<td>-</td>
<td>66</td>
<td>-</td>
</tr>
<tr>
<td>Age Cohort</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-senior (55 to 64 years)</td>
<td>35</td>
<td>38</td>
<td>13</td>
<td>28.3</td>
<td>48</td>
<td>34.8</td>
</tr>
<tr>
<td>Young-Old (65 to 74 years)</td>
<td>42</td>
<td>45.7</td>
<td>24</td>
<td>52.2</td>
<td>66</td>
<td>47.8</td>
</tr>
<tr>
<td>Old-old (75 to 84 years)</td>
<td>10</td>
<td>10.9</td>
<td>8</td>
<td>17.4</td>
<td>18</td>
<td>13.0</td>
</tr>
<tr>
<td>Very-old (85 years and older)</td>
<td>5</td>
<td>5.4</td>
<td>1</td>
<td>2.2</td>
<td>6</td>
<td>4.3</td>
</tr>
</tbody>
</table>
The age of first arrival in Canada varied among the sample, ranging from 17 to 81 years of age. Among the sample of later-life Filipinos, the years since migration varied widely from two years to fifty years, with only 10 percent (n=14) of respondents who reported migrating at an older age (55 years and older). Ten percent (n=9) of the total females and 11 percent (n=5) of total males within the sample migrated at an older age. Fifty-four percent of respondents self-reported that they came to Canada under the skilled worker class category, followed by 42 percent arriving
under the family class category. All respondents reported that they currently held Canadian
citizenship. Table 6-2 summarizes migration variables of the total sample aggregated by sex.

Table 6-2: Later-life Filipinos Survey Respondents Migration Characteristics

<table>
<thead>
<tr>
<th>Migration Characteristics:</th>
<th>Female</th>
<th>%*</th>
<th>Male</th>
<th>%*</th>
<th>Total</th>
<th>%*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=92</td>
<td></td>
<td>n=46</td>
<td></td>
<td>N=138</td>
<td></td>
</tr>
<tr>
<td>Sponsorship Family Class</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Worker</td>
<td>40</td>
<td>43.5</td>
<td>18</td>
<td>39.1</td>
<td>58</td>
<td>42.0</td>
</tr>
<tr>
<td>Canadian work/education experience</td>
<td>4</td>
<td>4.3</td>
<td>1</td>
<td>2.2</td>
<td>5</td>
<td>3.6</td>
</tr>
<tr>
<td>Age of Migration (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Age</td>
<td>31.8±12.9</td>
<td>-</td>
<td>35.0±12.1</td>
<td>-</td>
<td>32.9±12.7</td>
<td>-</td>
</tr>
<tr>
<td>Age Range</td>
<td>17 - 81</td>
<td>-</td>
<td>22 - 66</td>
<td>-</td>
<td>17 - 81</td>
<td>-</td>
</tr>
<tr>
<td>Years since Migration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>35.3±9.7</td>
<td>-</td>
<td>32.8±10.9</td>
<td>-</td>
<td>34.5±10.1</td>
<td>-</td>
</tr>
<tr>
<td>Range</td>
<td>2 - 50</td>
<td>-</td>
<td>7 - 44</td>
<td>-</td>
<td>2 - 50</td>
<td>-</td>
</tr>
</tbody>
</table>

*Percentages may not add up to 100 because of missing data.

The mean age of migration for females (n=91) was 31.8 years±13.0 years and the mean age of
migration for males (n=46) was 35.0±12.1 years. An independent samples t-test was performed to
determine if there was a difference in the age of migration between males and females. The test
revealed that there was no statistical difference in males and females (t=-1.40, df=135, p=0.163).

6.3 The Health of Older Filipino Immigrants: Question #1

This section reports the responses given by later-life Filipinos about their health and
health behaviours with the aim of providing a general health description of aging Filipino
immigrants living an urban centre. The results presented here answers the question: What is the
general health of later-life Filipino immigrants? In most sections to follow, results presented are
in the order of the questions that appear in the survey administered to later-life Filipinos.
6.3.1 General Health

In the first part of the survey respondents were asked to consider their current physical and mental health status. In particular, they were asked to rate their health in general based on a five-point Likert scale ranging from excellent to poor. Over 81 percent (n=112) of respondents reported that their health was good, very good or excellent. A greater proportion of male respondents rated their health as excellent or very good compared to female respondents. Figure 6-1 shows the distribution of self-rated health (SRH) ratings by sex.

![Figure 6-1: Self-rated health by sex (N=138)](image)

A chi-square test was performed to assess sex differences in self-rated health measures: comparing across all five ratings and also comparing the dichotomous category of SRH (excellent/very good/good versus fair/poor). There were no statistical significant differences between the sexes in terms of SRH. In addition to self-reporting their health status, respondents were asked to compare their health to one year ago on a five-point Likert scale, which is illustrated in Figure 6-2 below. Ninety-one percent (n=125) of respondents felt their health was the same as one year ago or better. Most felt that their health was about the same as one year ago (n=102, 73.9%).
When asked to score their health on a scale from 0 to 10 where 0 means very dissatisfied and 10 means very satisfied, all but one respondent answered. The overall mean score was 8.2 ± 1.6. (Median = 8.0 and Mode=8, Range: 2-10). When broken down by sex, the mean score for females was 8.2± 1.6 and the mean score for males was 8.0 ±1.3 (Median = 8.0, Mode=8, Range: 8 and Median=8.0, Mode=9.0, Range: 5, respectively). Of the total sample, only two respondents (1%) rated their health below five on the health scale.

The mean scores for the sample were also broken down by age cohort as represented in Table 6-3 below which included 137 individuals. Although the mean health score was higher among the old age cohort there were no significant differences between group scores, based on a one-way ANOVA test that was conducted (F=2.05, p<0.110).

**Table 6-3: Health Scale Ratings by Age Group Cohort**

<table>
<thead>
<tr>
<th>Age Cohort (N=137)</th>
<th>Mean score</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-senior (n=48)</td>
<td>7.9</td>
<td>1.3</td>
</tr>
<tr>
<td>Young-Old (n=66)</td>
<td>8.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Old-old (n=18)</td>
<td>7.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Very old (n=5)</td>
<td>7.8</td>
<td>1.9</td>
</tr>
</tbody>
</table>

SD=standard deviation
6.3.2 Mental Health

In terms of self-rated mental health (SRMH) a five-point Likert scale was also used for respondents to self-report how they evaluate their mental health in general. Respondents felt positively about their mental health with over 96 percent (n=133) rating their health good or better. From the total sample, five respondents (4%) felt that their mental health was fair and no respondents had rated their mental health as poor. Chi-square tests were also performed for both the five scale ratings of mental health and a dichotomous variable of SRMH (excellent/very good/good versus fair/poor) with no statistical significances found for sex differences or for age group cohort differences.

Relating to mental health respondents were also asked to describe the amount of stress in their life rating how stressed they felt “most days”. Based on a five-point Likert scale from not at all stressful to extremely stressful, most rated their lives as being not very stressful (n=51, 37%) or a bit stressful (n=52, 38%). Results, broken down by sex and by age group cohorts are described in Figures 6-3 and 6-4.

![Figure 6-3: Self-reported stress experienced most days, by sex (N=138)](image)
6.3.3 Chronic Health Conditions

With respect to chronic health conditions, as diagnosed by a health care professional, respondents were asked to report the number of chronic conditions that they were currently experiencing. A list of 12 concurrent chronic conditions included allergies, arthritis, asthma, back problems, high blood pressure, chronic bronchitis (or emphysema, COPD), diabetes, heart disease, intestinal/stomach ulcers, effects of stroke, bowel disorder, and blood problems. The mean number of chronic conditions for the total sample was 2.6±1.6 (Median=2.5, Range=7).

The distribution of self-reported multiple chronic conditions by sex is illustrated in Figure 6-5. The mean number of chronic conditions was higher among females at 2.8±1.6 (Median=3.0, Range=7) when compared to males with a mean number of 2.3±1.6 (Median=2.0, Range=6). However, an independent samples t-test was conducted and there was no statistically significant difference found between males and females.
Figure 6-5: Number of chronic conditions experienced by sex (N=138)

The mean number of chronic conditions did increase among older age group cohorts, as is supported in the literature (Moore, Rosenberg and Fitzgibbon, 1999; Fried, Bernstein and Bush, 2012) although there were no statistically significant differences between the group means for the overall sample.

6.3.4 Use of Mobility Assistive Devices

Respondents were asked to report if they use the following assistive devices outside or inside the home: wheelchair, cane, walker, crutches, other. Among the overall sample, use of mobility assistive devices was minimal, with only eleven respondents (8%) using some type of device either inside the home, outside the home or for both settings. Of this group who reported using a mobility assistive device, the mean age was 80.6 ± 8.1 years, the youngest 65 years of age and the oldest being 88 years old.

From the total sample nine respondents (7%), eight of them female, reported that they used some type of mobility assistive device outside the home. Of the devices used, two females reported using a wheelchair and six females and one male reported that they used a cane outside the home. Seven respondents (5%), six of them females, reported that they used at least one
device inside the home. One male reported that he used a cane, as did five females. Four females reported using a walker to get around inside the home.

**6.3.5 Health Behaviours**

Respondents were asked to answer a variety of questions that intended to capture their current health behaviours over the course of the year, as they relate to physical activity, food and diet, as well as smoking and alcoholic consumption. The following sections describe the results from survey.

**6.3.5.1 Physical Activity**

The Duke Activity Status Index (DASI) is a validated measure of physical activity status that asks a series of questions about an individual’s perceived ability to perform everyday tasks relating to functional activity, such as taking care of oneself (i.e. eating or dressing, to higher performing activities, such as running a short distance). Respondents were asked to answer twelve yes or no (Y/N) questions regarding their current activity status. Each yes response corresponds to one point. The sum total of points results in the non-weighted DASI score. The weighted DASI score is the combined total of MET units specific to each activity, where MET units represent the metabolic cost for each activity (George, Kasbekar, Bhagawati, Hall and Buscombe, 2011). High performing activities correspond to higher MET units. Scores for the non-weighted DASI can range from 0 to 12, where the weighted DASI can range from 0 to 58.2. Higher non-weighted and weighted DASI scores indicate greater functional capacity which is a marker of good cardiac health.

For the overall sample, the mean non-weighted DASI was 10.2±2.3 and the weighted DASI was 47.0±12.8, suggesting that the overall sample has a high functional capacity on a variety of daily living tasks. A different picture emerges when comparing the mean DASI scores across all four age group cohorts as illustrated in Table 6-4. Respondents in the older age cohorts (i.e., old-old and very-old cohorts) had lower non-weighted and weighted DASI scores suggesting
a decreased functional capacity as one ages. However, the groups were uneven across the age group cohorts as the overall sample tended towards younger seniors.

Table 6-4: Non-weighted and Weighted Duke Activity Status Index (DASI) Scores by Age Group Cohorts

<table>
<thead>
<tr>
<th>Age Group Cohort</th>
<th>Number of respondents (%)</th>
<th>Mean Non-weighted DASI</th>
<th>Mean Weighted DASI (METs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-senior</td>
<td>48 (35)</td>
<td>10.9±1.3</td>
<td>50.2±8.9</td>
</tr>
<tr>
<td>Young-old</td>
<td>66 (48)</td>
<td>10.7±1.8</td>
<td>49.6±11.1</td>
</tr>
<tr>
<td>Old-old</td>
<td>18 (13)</td>
<td>8.3±2.4</td>
<td>34.9±14.5</td>
</tr>
<tr>
<td>Very-old</td>
<td>6 (4)</td>
<td>4.3±3.4</td>
<td>21.5±11.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>138 (100)</strong></td>
<td><strong>10.2±2.3</strong></td>
<td><strong>47.0±12.8</strong></td>
</tr>
</tbody>
</table>

As a more descriptive measure on how physically active later-life Filipinos are, respondents were also asked to report on the frequency, intensity and type of physical activity that they were currently engaged in. Twenty-seven (20%) self-reported that they did not regularly engage in any physical activity. Among those that had reported having engaged in regular physical activity, they were asked to describe the frequency at which they participated in leisure-time activity over the last three months. One hundred and twenty-five (91%) later-life Filipinos responded. Sixty-five (52%) respondents self-reported that they engaged in activity more than two or three times a week, while 55 (44%) respondents self-report that they engaged in each occasion of activity for more than 30 minutes at a time. Figure 6-6 and 6-7 illustrate the frequency and duration later-life Filipinos participated in leisure-time activity.
Figure 6-6: Self-report frequency of engaged leisure-time activity reported over the last three months (n=125)

Figure 6-7: Self-reported time spent on each occasion of leisure-time activity over the last three months (n=126)

Asked whether or not they were physically active in moderate activity for at least 20 minutes most days of the week, 107 (80%) respondents reported that they maintained a physically active
lifestyle. From the total sample, twelve (9%) respondents who reported that they were not physically active had planned to do so in the future. See Figure 6-8 for a summary by sex.

Figure 6-8: Respondents who self-reported that they consider themselves physically active (n=133)

6.3.5.2 Dietary Behaviours:

When asked to self-report on attempts to improve diet, most respondents were actively engaged in improving their diet. One-hundred and sixteen (85%) made attempts to eat more fruits and vegetables. One-hundred and fourteen (84%) of respondents made attempts to consume less saturated fats in their diet, and 122 respondents (89%) of the total sample made attempts to lower their salt consumption. Figure 6-9 illustrates the proportion of respondents that since migrating have seen a shift in diet based on traditional Filipino foods, either consuming less traditional Filipino foods or mostly Filipino foods.
6.3.5.3 Food Security:

Respondents were also asked to self-report on measures of food security. Results revealed that they did not experience issues of food insecurity. Respondents were asked to think about having enough money to buy food over the last twelve months. Asked if they ever reduced the size of their meals or whether they skipped meals because there was not enough money for food, only five percent (n=7) of respondents stated yes. A mere one percent (n=2) stated that they had eaten less because there was not enough money to buy food and no respondents reported experience of being hungry but did not eat because they did not have money to buy food.

6.3.5.4 Smoking Behaviours:

Of the total sample, only seven percent (n=10), four females and six males, self-reported that they currently smoke cigarettes. Among those, six reported that they were daily smokers. Two reported that they smoke cigarettes only once a month, while the other two reported that they smoke less than once a month. Among those who responded negatively to currently smoking cigarettes they were asked to report on both their past cigarette smoking behaviours, of which 127 respondents answered. Ninety-seven (76%) respondents noted that they had never smoked...
cigarettes, while 30 (24%) reported that they were former smokers. Among those who considered themselves former smokers, 70 percent (n=21) reported that they quit smoking cigarettes after immigrating to Canada.

6.3.5.5 Alcohol Consumption:

Among the 137 that reported on alcoholic drinking behaviours, 64 percent (n=88) indicated that they had at least one drink of beer, wine, liquor or any other alcoholic beverage. More males reported that they had an alcoholic beverage (85%) compared to females (54%). Chi-square testing found that there was a significant difference in alcohol consumption and sex ($X^2=12.7$, df=1, $p<0.001$). Of those that reported having an alcoholic beverage, 85 indicated in general, how often they engaged in alcoholic drinking. Figure 6-10, below illustrates the distribution by sex.

![Figure 6-10: The frequency that respondents report drinking alcoholic beverages by sex (n=85)](image)

Respondents were also asked to report on binge drinking behaviour and asked to report how often they have had five or more drinks on a single occasion. Overall, 66 percent (n=63)
have never had more than five drinks on one occasion. Among those who have, 15 (18%) had
more than five alcoholic drinks less than once a month and two (2%) claimed to have done so
only once a month. Two (2%) drank more than five drinks at a single time two or three times a
month, while one reported that they have had engaged in excessive drinking more than once a
month.

When asked to report on their alcohol consumption since immigrating to Canada, 66
responded. As shown in Figure 6-11 results demonstrate that more females reported drinking
more alcohol since immigrating than males and more males reported that they drink less since
immigrating. However, this survey did not ask about drinking behaviours prior to migrating and
chi-square testing cannot be considered reliable as a cell counts for analysis were below expected
amounts.

![Figure 6-11: Number of respondents reporting alcoholic drinking behaviour since immigrating to
Canada (n=66)](Image)

**6.4 Health Care Use of Older Filipino Immigrants: Question #2**

This question seeks to answer research question #2 which asks: *do later-life Filipinos
experience any barriers in accessing and utilizing health care?* As discussed in the previous
chapters (Chapters Four and Five) that explore key informant perspectives on the health and
aging experiences of older immigrants, there are a number of barriers that immigrants face when accessing health care and elder care within the community. When considering the current state of Canada’s health care system where reductions in funding, as well as hospital and health care restructuring have major consequences on newcomer immigrant populations in Canada, when these issues are compounded with those of aging, immigrant seniors are especially at risk. As many key informants explained that while newcomer seniors certainly are at a disadvantage compared to the general population, long-term immigrants also have their own struggles. While more long-term immigrants may be more established and settled in Canada often their diverse cultural and ethnic backgrounds, which influences much of their social, political and economic experiences are overlooked when considering their health and aging. The following sections describe the results from the survey on health care use in Canada and are in the order as they appear in the survey.

6.4.1 Health Care System Satisfaction

The first series of questions about health care, ask about their overall satisfaction with the health care system. More specifically, when asked to report on their level of satisfaction about health care services they receive in Toronto and the GTA, respondents were asked to comment on the perceived availability and quality of health care they receive. Overall, most respondents rated their satisfaction with availability of health care services in positive terms with 32 percent (n=43) rating availability of services as excellent and 58 percent (n=78) as good. Less than two percent of respondents rated availability as poor. Figure 6-12 illustrates the overall results ranking availability of health care services by sex.
In terms of rating the quality of health care services, again most respondents answered positively. Sixty-three percent (n=84) rated the quality of health care services as good while 26 percent (n=35) felt the quality was excellent. Less than one percent of respondents rated the quality of health care services as poor. Figure 6.13 shows the result of later-life Filipinos who ranked the quality of health care services by sex.

**Figure 6.12:** Rating the perceived availability of health care services by sex (N=134)

**Figure 6.13:** Rating the perceived quality of health care services by sex (N=134)
6.4.2 Health Care Utilization

In the next series of questions, respondents were asked to answer questions about their health care use. Having a regular doctor, particularly for older persons, is especially important as one ages, in the monitoring of risk factors and chronic conditions. Ninety-eight percent (n=136) reported that they had a regular medical doctor. Between the two respondents who reported not having a regular doctor, one reported that their doctor had left or retired and the other stated that doctors in the area were not taking new patients. Overwhelmingly, 99 percent (n=137) reported having a place that they can go to if they were sick or needed advice about their health, with the doctor’s office being the main place they go (n=128). Other places that were noted included the walk-in clinic (n=5), community health centre (n=1) and the hospital emergency room (n=1). Ninety-six percent of respondents (n=133) reported that they speak mainly English when communicating with their doctor. Of the remaining respondents, four (3%) reported that they communicated mainly in Tagalog with their doctors, while one left the answer blank.

6.4.3 Contacts with Health Professionals

Respondents were also asked to report from a list of health professionals, which ones they have had contact with in the past twelve months. Among this sample, respondents reported on seeing a wide range of health professionals, which is summarized in Figure 6-14 below.
6.4.4 Home Care Services

In general, this sample of older Filipinos revealed that they did not use home care services, including services such as health care, home maker services or some other supportive services at home. Other supportive services included nursing care, personal care, such as bathing, housework, meal preparation and even respite care. When asked to report whether or not they received home care services, either entirely or partially covered by the government only four respondents (3%) had in the last twelve months. Among the home care services described in the survey, respondents identified using the following home care services in the past twelve months. One received nursing care, two received personal care, such as bathing or foot care, another reported receiving respite care and other services specified by one respondent was for Canadian National Institute for the Blind (CNIB) services.

Respondents were also asked about use of home care services that was not covered by the government which included private agencies, spouse or friends. Seven responded “yes” that they had received home care service in the past twelve months. The sources of home care service varied among respondents. While two reported receiving physiotherapy or some other therapy
services from a private agency, most reported receiving home care from family (n=4) including their spouse, and friends (n=2).

With respect to any barriers experienced with home care services, respondents were asked if over the past twelve months did they ever feel that they needed home care services but did not receive them. Only two responded and cited cost and wait time for services as reasons for not receiving home care services.

6.4.5 Community-based Care

Community-based health care was not a widely used service among this sample, which included any health care received outside of the hospital or doctor’s office, such as home nursing care or community walk-in clinics. Within the total sample only nine percent of respondents (n=12), nine females and three males reported using community based health care in the last twelve months. Based on a five-point Likert scale on the quality of care they received, the vast majority rated the quality of community-based care as excellent (n=4) or good (n=6). The lowest rating was offered by one respondent who rated the quality as fair. In terms of satisfaction of services, only three reported being very satisfied, with most (n=6) having reported being somewhat satisfied. One respondent reported being neither satisfied nor dissatisfied and only one negatively reported on their satisfaction as being somewhat dissatisfied.

6.4.6 Access to Health Services

Survey respondents were asked about their use of various health care services. In the series of questions related to access to health care services, respondents were asked yes/no questions on specific types of health service over the last twelve months. Additionally, respondents were asked to report on the various types of difficulties they may have faced while accessing health care, by selecting from a list of issues. For each question where there were more than three types of difficulties were identified by respondents figure present the various issues
that were identified by respondents. The results are listed in order of how they appear in the questionnaire.

6.4.6.1 Care from a medical specialist:

One of the first questions in this section asked if in the past twelve months they required a visit to a medical specialist for either a diagnosis or a consultation. Of the 135 that responded, 40 percent (n=54) of them responded “yes”. Among those that responded yes they were also asked to recount if they experienced any difficulties in accessing specialist care. Only 24 percent (n=13) of those indicated that they experienced difficulties. Respondents were also asked to note what type of difficulty they had experienced. These are summarized in the Figure 6-15 below:

![Difficulty Types Graph](Image)

**Figure 6-15:** Number of respondents (n=24) reporting on the types of difficulties experienced in receiving specialist care

6.4.6.2 Non-emergency surgery:

Another question asked respondents to report whether or not they required any non-emergency surgery in the last twelve months. Of the 136 that responded to the question only seven (5%) respondents reported that they received non-emergency surgery. Among those only

265
one respondent noted any difficulties experienced to which they only described having to wait too long for surgery.

6.4.6.3 **Tests (MRIs, CAT Scans and angiographies) required:**

In the next question, respondents were asked to report whether they required any medical tests, such as MRIs, CAT scans or angiographies in a non-emergency situation. One-hundred and thirty-six responded to this question and among this sample, 26 (19%) reported requiring these tests, 22 percent of all females (n=20) and 13 percent of males (n=6). Only six reported experiencing any difficulties in receiving the tests required which is summarized in the figure below.

![Figure 6-16: Number of respondents (n=6) reporting on the types of difficulties experienced in receiving tests such as MRIs, CAT scans or angiographies](image)

**6.4.6.4 Health information or advice:**

Respondents were also asked to report on whether they needed and received any health information or advice for themselves. Out of the 137 that answered, 49 percent (n=67) responded that they had required some health information and advice. Of the various places that respondents received health information and advice the top places (respondents may have identified multiple
places) included the doctor’s office (n=63), walk-in clinic (n=5) and the hospital emergency room (n=3). None of the respondents identified community health centres or a telephone health line as places where they sought and received health information or advice. In terms of difficulties with obtaining the health information and advice that they needed, only two respondents reported having experienced any issues. The issues identified were difficulty contacting a physician or nurse (n=1) and not receiving adequate information and advice (n=1).

### 6.4.6.5 On-going and routine care:

Another question asked about health care accessibility was related to respondents requiring any routine or on-going care over the last 12 months. Of the 137 respondents who answered this question, 75 (55%) reported that they received on-going or routine care, but only eight (6%) noted that they had experienced difficulties, which is noted in Figure 6-17 below:

![Type of difficulties experienced in getting routine or on-going care](image)

**Figure 6-17**: Number of respondents (n=8) reporting on the types of difficulties experienced in getting routine or on-going care

### 6.4.6.6 Immediate health care services:

The last question on access to health care services asks whether respondents required immediate health care services for a minor health problem such as fever, headache or sprained ankle. Thirty-seven (27%) out of 137 respondents who answered the question reported having
received immediate health care services in the last 12 months. Only six respondents noted experiencing difficulties in accessing immediate health care. As the results indicate below in Figure 6-18, respondents experienced very few difficulties when accessing health services and seeking health information or advice. The most commonly cited issues to health care across most of the services as identified by respondents were related to difficulty contacting a physician, getting an appointment and wait times, including waiting too long to get an appointment or test and in-office waiting to see the doctor or receive a test.

**Figure 6-18:** Number of respondents (n=6) reporting on the types of difficulties experienced in receiving immediate health care

### 6.4.7 Insurance Coverage

In the next series of question, respondents were asked about the type of health insurance they have, if applicable and whether it was government-sponsored, employer-sponsored or private health insurance. From the overall sample, 87 percent of respondents (n=119) reported that they had health insurance that includes coverage for prescription medications. Figure 6-19 summarizes the percentage of respondents within each age group cohort. In a follow-up question, 107 respondents also reported on the type of insurance plan they had. The majority of
respondents, 59 percent (n=66), had insurance through their employer. Thirty-two percent (n=34) had a government sponsored plan and only nine percent (n=10) had private insurance.

![Bar chart showing percentage of respondents with dental insurance coverage](image)

**Figure 6-19**: Percentage of respondents who reported having insurance that covers prescription medications (n=119)

Sixty-nine percent (n=94) of respondents reported having health insurance that covers all or partial dental expenses. Of the 85 respondents who answered the question about the type of insurance they had, 80 percent (n=68) had an employer-sponsored plan, 13 percent (n=11) had a private plan, while seven percent (n=6) reported that their insurance was government-sponsored. Figure 6-20 shows the percentage of respondents within each age group cohort that had insurance which covered all or part of their dental expenses.
Ninety-one (66%) of all respondents reported having health insurance that covers all or part of the cost of eye glasses or contact lenses. Figure 6-21 summarizes the distribution of health insurance holders among each of the age group cohorts. Of those, 83 respondents indicated the source of health insurance with 76 percent (n=62) having an employer sponsored plan, 13 percent (n=11) reported having a private plan and 11 percent (n=9) with a government sponsored plan.

Figure 6-21: Percentage of respondents who reported having insurance that covers all or part of the cost of eye glasses or contact lenses (n=91)
In a final question about health insurance, 103 respondents (75%) reported that they had insurance that covers hospital charges which is summarized in Figure 6-22 below. Ninety-six (93%) respondents reported on the type of health insurance. Similar to other results on health insurance, employer-sponsored insurance was the most common with 73 percent (n=70) of respondents indicating this type. Nineteen percent (n=18) had a government sponsored plan while only eight percent (n=8) had a private plan.

![Figure 6-22: Percentage of respondents who reported having insurance that covers all or part of the hospital charges for a private or semi-private room (n=103)](image)

As results indicate in the figures above, the greatest percentage of health insurance holders were pre-senior respondents (55 to 64 years of age) for all four health services. For all respondents the most common type of health insurance was employer sponsored, which is not surprising given that most insured respondents were pre-senior and likely to be employed. Not surprising is that older respondents, those in the old-old and very-old age groups tended to lack health insurance. Chi-square tests were performed to determine whether there were significant differences across the age group cohorts and being insured for health services; however, small cell counts, particularly for the old-old and very-old group categories resulted in large group
differences but cannot be relied on to suggest that age is related to being a health insurance policy holder.

6.5 The role of place in health and aging – dimensions of place experiences:
Question #3

Chapter three introduced the Dimensions of Place Experiences which was incorporated within the conceptual framework guiding the overall project. The first group of dimensions (Dimensions One, Two and Three) captures migration and aging-in-place experiences, such that Dimension One groups those individuals who arrived in Canada before 1980, Dimension Two are those individuals who arrived in Canada after 1980 but did not arrive in later-life (55 years and older), and Dimension Three includes those who arrived in Canada in later-life. The second group (Dimensions Four and Five) are based on health care systems use and place, particularly health care use in Canada and the Philippines. Dimension Four includes those individuals who use health care only in Canada and Dimension Five comprises those who use health care in Canada and also in the Philippines, based on the question that asks if they have ever intentionally sought health care in the Philippines. Based on survey data which asked later-life Filipinos to self-report the year of first arrival in Canada, those who arrived before 1980 are likely to arrive at a younger age and have aged-in-place. This section examines research question #3, which asks: How do health care status and health care use vary among later-life Filipinos, based on the five dimensions of place experiences?

Over 70 percent (n=96) of later-life Filipinos arrived before 1980. Among those that arrived after 1980 (n=41), 34 percent arrived in later-life (n=14). As described above, varying degrees of migration and aging-in-place experiences were identified as dimensions of place experiences. Ninety-six individuals (70%) were grouped under the category of Dimension One. There were 27 individuals (20%) who were grouped under the category of Dimension Two that includes those that arrived in Canada in 1981 and onward but did not arrive in later-life. Finally,
the third dimension identified those respondents who arrived in Canada in later-life (n=14). Only one person declined to note their year of arrival in Canada, thus the total sample for analysis was 137.

As well, place-experience dimensions were identified to distinguish the health care use of older Filipino immigrants. For Dimension Four where respondents reported receiving health care in Canada, 122 respondents (88%) said they only received health care in Canada compared to 16 individuals (12%) who received health care in Canada and the Philippines (Dimension Five).

### 6.5.1 Life after migrating to Canada

Dichotomous categories were created for the following sociodemographic characteristics: **gender** (male versus female), **marital status** (married versus unmarried/divorced/separated/widowed), **living status** (alone versus living with spouse/extended family), **education** (high school graduate and less versus some college to post-graduate), **work status** (retired/not working versus part- and full-time work), **household income** (less than $60K versus $60K or more) and **immigrant class category** (family class versus skilled worker/education). Table 6-1, presented earlier in the chapter, provides a summary of these characteristics for the overall sample. Prior to the survey fieldwork and data gathering stage, the following hypothesis was proposed, which states that migration, measured as the time of arrival in Canada (prior to 1980 before significant changes to Canada’s immigration policy) and arrival into Canada as a senior (aged 65 years) greatly influences the health and health care use.

As indicated by a number of key informants from Phase One in this research, health and social wellbeing is dependent on the time of migration or when an immigrant arrives in a foreign land. Various social factors as well as migration experience were considered to be important in influencing health and aging experiences. Thus, in Phase Two of the research the focus was on determining the role of place and the migration experience of aging Filipino immigrants on a number of health outcomes and health care use. Chi-square tests were performed to assess group
differences of older Filipinos belonging to one of Dimensions 1, 2 or 3 and the sociodemographic characteristics listed in Table 6-1. Chi-square tests were also performed to assess group differences using Dimensions 4 and 5 as two broad groups of older Filipinos with same dichotomous sociodemographic characteristics. For both sets of chi-square tests there were no significant differences observed between the groups across all characteristics.

6.5.1.1 Immigration to Canada

Respondents were asked to answer a number of questions about their immigration experiences, including certain transnational behaviours, such as visits to their homeland to their use of health care outside of Canada. Table 6-2 summarizes descriptive statistics on migration, including age of migration, immigrant class category and years since migration by sex. Additionally, respondents were also asked whether they intended to live in Canada for the rest of their life. Overwhelmingly, ninety-seven percent (n=134) of respondents indicated that they do plan on living in Canada for the remainder of their lives. Of those that responded “no” (n=3), they indicated that they plan to live in the Philippines.

To get a sense of their connection to the Philippines, respondents were also asked whether they have since returned to the Philippines since migrating to Canada and to state whether they owned property in the Philippines. From the overall sample, 95 percent (n=131) of respondents reported that they have since returned to the Philippines, although the reasons and frequencies of their return trips to the Philippines are unknown. Thirty-six percent (n=49) reported that they own property in the Philippines.

When asked whether they would consider themselves to be regular visitors to the Philippines (e.g. returns every year), only 29 percent (n=40) of all respondents agreed, which corresponds to the percentage of those who stated that they own property. Chi-square tests were conducted to determine whether being a regular visitor to the Philippines is related to owning property. The results indicate that 53 percent (n=21) of those who made a regular visits to the
Philippines were also likely to own property. Among those that did not visit the Philippines regularly, only 28 percent (n=27) were not property owners in the Philippines \([X^2=7.57, \text{df}=1, p<0.01]\). Although it cannot be concluded what the exact relationship of owning property and being a regular visitor to the Philippines is in the context of this study, these results suggest those with property back home in the Philippines are likely to have family and friends still in the Philippines and would have the resources to travel more regularly.

Figures 6-23 and 6-24 below show the relationships between how respondents describe their status as a regular visitor to the Philippines by the different categories of dimensions as outlined in Chapter Three, relating to migration and aging as well as health care use.

**Figure 6-23:** Respondents on whether they considered themselves to be regular visitors to the Philippines, by Migration and Aging Dimensions (N=136)
Figure 6-24: Respondents on whether they considered themselves to be regular visitors to the Philippines, by Health Care and Place Dimensions (N=137)

When comparing migration and aging dimensions (one, two and three) and whether they were regular visitors, a greater percentage of respondents who came to Canada before 1980 (Dimension One) considered themselves regular visitors to the Philippines, although chi-square testing showed that these results were statistically insignificant (X²=1.58, df=1, p=0.455). When comparing the overall sample according to health care dimensions (four and five), a greater percentage of respondents who used health care in both Canada and the Philippines considered themselves regular visitors compared to those who only used health care in Canada. Chi-square testing found insignificant results at the p<0.05 level but were significant at the p<0.10 level, (X²=3.79, df=1, p=0.051). This result is not surprising given that respondents would most likely seek health care in the Philippines out of necessity while regularly visiting. This study did not explore the nature of their use of Philippine health care, such as elective or non-elective surgery needs while in the Philippines or whether respondents had waited on seeing a health care professional in the Philippines until they returned to Canada.

6.5.1.2 Migration and beliefs about health

Respondents were also asked to report whether they thought their health would be different than it is now if they had not migrate from the Philippines to Canada. Sixty-seven
percent (n=92) of respondents believed their health would be different. Of those that responded that their health would be different, eight (11%) felt that their health would be better than it is now, while 28 (36%) believed their health would be worse. Forty-two (54%) felt that their health would be different but could not say if it would be better or worse. Figure 6-25, shows how differently males and females responded, with more females believing their health would be worse than it is now. More males than females reported that their health would be different but could not say if it would be better or worse.

![Figure 6-25: Respondents beliefs about their health if they had not moved to Canada and were still living in the Philippines (n=78)](image)

**6.5.2 Health Care Use in the Philippines**

Respondents were asked to report whether or not they have intentionally sought elective (non-emergency) health care elsewhere since immigrating to Canada. Sixteen respondents (11.5%) reported that they had sought health care services in the Philippines. Twelve were female and four were male. Respondents were also asked to report all types of health care services that they had received in the Philippines. Results for all 16 respondents are shown in Figure 6-26.
Most of the respondents who indicated that they had received health care in the Philippines noted that they received advice or medical attention from a medical specialist (n=7). Under the category of “other” the respondent had listed cosmetic services, more specifically skin whitening procedures as the service they received while in the Philippines. When asked to report whether they had intentionally sought traditional medical care services or treatment in the Philippines that are not found in Canada, only seven respondents (5%) claimed to do so. Among the five were females and two males, they listed dental care services, massage and other medical treatments as the services they sought.

**Figure 6-26:** Number of health care services received in the Philippines (N=16)

Later-life Filipinos were also asked to recall the quality of care that they received in the Philippines prior to migrating to Canada, with 132 responded to the question. Overall, eight (6%) felt that the health care in the Philippines was excellent, 65 (49%) recalled health care as good, 45 (34%) rated health care as fair and 14 (11%) felt that the quality of care in the Philippines was poor. Figure 6-27 illustrates how males and females compare in their rating the quality of care in the Philippines.
In recalling their satisfaction with health care services in the Philippines, 131 later-life Filipinos responded. Overall 14 (11%) were very satisfied, 64 (49%) were somewhat satisfied, 27 (21%) were neither satisfied nor dissatisfied, 19 (14%) were somewhat dissatisfied and 7 (5%) were very dissatisfied. Figure 6-28 compares male and females responses on the level of satisfaction they recall with health care in the Philippines.

**Figure 6-27**: Rating the quality of health care in the Philippines prior to migrating to Canada (n=132)

**Figure 6-28**: Level of satisfaction with health in the Philippines prior to migrating to Canada (n=131)
Upon reflecting on the quality and satisfaction of health care in the Philippines as they remembered, respondents were also asked whether they would consider going to the Philippines to receive services, if for some reason they were not unable to receive care in Canada. Seventeen (12%) respondents stated that they would seek health care in the Philippines.

6.5.3 Health Measures

The measures used to compare health status and the place-experiences of health dimensions of older Filipinos included self-rated health (SRH), self-rated mental health (SRMH), number of chronic conditions and the Duke Activity Status Index (DASI). Dependent variables for chi-square testing included dichotomous variables for SRH (excellent/very good/good versus fair/poor) and SRMH (excellent/very good/good versus fair/poor).

6.5.3.1 Self-rated-health and dimensions of place-experiences

The independent variables for analysis were the place-experience dimensions. Figure 6-29 illustrates how respondents rated their health according to the Dimensions One, Two, and Three. Across all dimension groups more respondents rated their health in positive terms (i.e., excellent, very good or good). However, a greater percentage at 43 percent of individuals in Dimension Three rated their health in negative terms (43%) compared to those individuals in Dimension One and Two at 16 percent and 18 percent, respectively. Chi-square tests were performed and found to be insignificant at the p<0.05 level but significant at the p<0.10 level [X²=5.897, df=2, p=0.052]. Chi-square testing were also performed for each group of pairs of Dimensions One, Two and Three. The only significant result was between Dimension One and Dimension Three, indicating that there are differences in how these two groups rate their own health [X²=5.866, df=1, p=0.015].
Figure 6-29: Self-rated health by Dimension One, Two and Three (n=137)

To assess differences in self-rated health by Dimensions Four and Five, which relate to health care use and place, eighty-two percent of those individuals in Dimension Four rated their health in positive terms compared to 75 percent of those in Dimension Five. Chi-square testing revealed no significant differences in how these two groups rated their health.

6.5.3.2 Self-rated mental health and dimensions of place-experiences

In terms of SRMH for the overall sample, most respondent rated their own mental health in positive terms. Only a small group rated their mental health negatively (n=5). Thus, chi-square testing comparing place-experience dimensions with SRMH is unreliable given the small cell counts for both analyses on the aging and migration dimensions as well as health and place dimensions. Figure 6-30, illustrates how an overwhelming majority of respondents rated their mental health in positive terms.
6.5.3.3 Chronic conditions and place-experience dimensions

One-way between subjects ANOVA was conducted in order to determine if there is a difference in the dimension of migration and aging and the mean number of chronic conditions reported, both for the overall sample and for males and females. The mean numbers of chronic conditions for both the total sample and by sex are illustrated in Figure 6-31. For all analyses, respondents in Dimensions Three reported a higher mean of concurrent chronic conditions for the total sample and for both males and females. However, results from the ANOVA tests were insignificant for the overall sample and for analyses on the sexes.
Figure 6-31: Mean number of chronic conditions for the total sample and by sex for Dimensions One, Two and Three

Independent samples t-tests were performed to determine if there were differences in health care use, Canada only or care in Canada and the Philippines, and the mean number of chronic conditions reported. Analyses were performed for the overall sample and by sex. Figure 6-32, below summarizes the mean number of chronic conditions as reported by the overall sample and by both sexes across Dimensions Four and Five. For the overall sample, the mean for those individuals who received health care in Canada and the Philippines (Dimension Five) was higher than for those individuals who received health care in Canada only (Dimension Four). Results from the t-test showed that these results were not statistically significant.

When the data were split and t-tests were performed for each sex group, males and females, the results were mixed. For females, the mean number of chronic conditions for Dimensions Five was 3.7±1.4 compared to females within the Dimension Four group at 2.7±1.6. For males, the means were of reversed magnitude than for females for Dimensions Four and Five, which were 2.3±1.6 and 2.0±0.8, respectively. Such that males who receive health care from Canada and Philippines reported a higher mean number of chronic conditions than for those who
only received health care in Canada. The results were found to be insignificant. For females, the reverse was found where those who received health care from both Canada and the Philippines had a higher mean than females who received health care from Canada only. Results from t-tests indicate that these results were significant \( t=-2.15, \text{df}=15.3, \text{p}=0.048 \).

![Figure 6-32: Mean number of chronic conditions for the total sample and by sex for Dimensions Four and Five](image)

6.5.3.4 Duke Activity Status Index

Earlier in the chapter functional capacity as measured by the DASI, was determined for the overall sample. The means for the non-weighted DASI and weighted DASI indicated a high functional capacity. A one-way ANOVA was performed to determine the effect of the dimensions of place-experiences on both DASI measures (non-weighted and weighted), split by sex. Figures 6-33 and 6-34, illustrate the results for the non-weighted DASI scores only. One-way ANOVA tests for the overall sample yielded significant results. Using the Levene’s test for the equality of variances among the levels of the migration and aging dimensions found the variances to be significantly different, thus the Games-Howell post hoc test was used and found that there were
significant differences between Dimensions Three (arrived in later-life) and both Dimension One (before 1980) \( [p=0.001] \) and Dimension Two (after 1980) \( (p=0.001) \). There were no differences between Dimensions One and Two.

**Figure 6-33:** Mean scores for non-weighted DASI for Dimensions One, Two and Three by sex \( (n=137) \)

**Figure 6-34:** Mean scores for non-weighted DASI for Dimensions Four and Five by sex \( (n=137) \)
A t-test was performed for the effect of health care and place dimensions on DASI. Results were non-significant which suggesting that transnational health care use does not affect functional capacity scores. The overall mean scores for both the non-weighted and weighted DASI for five dimensions of place experiences are summarized in Table 6-5 below.

Table 6-5: Descriptive Statistics for Non-weighted and Weighted Duke Activity Status Index (DASI) for Dimensions of Place Experiences

<table>
<thead>
<tr>
<th></th>
<th>Non-weighted DASI (unit)</th>
<th>Weighted DASI (METS)</th>
<th>Number of Respondents</th>
<th>Males (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Migration and Aging Dimensions (n=137)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimension One</td>
<td>10.6±1.6</td>
<td>48.5±10.3</td>
<td>96</td>
<td>32</td>
</tr>
<tr>
<td>Dimension Two</td>
<td>10.9±2.1</td>
<td>50.8±12.5</td>
<td>27</td>
<td>37</td>
</tr>
<tr>
<td>Dimension Three</td>
<td>6.3±3.5</td>
<td>28.5±15.7</td>
<td>12</td>
<td>42</td>
</tr>
<tr>
<td><strong>Health Care and Place Dimensions (n=138)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dimension Four</td>
<td>10.2±2.3</td>
<td>46.8±13.1</td>
<td>121</td>
<td>35</td>
</tr>
<tr>
<td>Dimension Five</td>
<td>9.9±2.8</td>
<td>48.5±10.1</td>
<td>15</td>
<td>27</td>
</tr>
</tbody>
</table>

6.5.4 Psychosocial Measures of Health, Place and Aging

The survey administered to aging Filipino immigrants included a number of mental health and psychosocial health measures including the Geriatric Depression Scale [Section N: Your Feelings], the Multidimensional Scale of Perceived Social Support [Section O: Your Social Supports] and the Unmitigated Communion Scale [Section P: Your Interpersonal Relations].

6.5.4.1 Geriatric Depression Scale

The Geriatric Depression Scale (GDS) asks respondents to answer yes or no to fifteen statements that ask them about their feelings. The long-form version of the GDS utilizes 30 questions to assess depressive symptoms among older adults. The project used the short-form version of the Geriatric Depression Scale (GDS-SF), which has 15 items used to measure depression among older populations (Yesavage, Brink and Rose, 1983). Among the 15 items, 1, 2 and 7, indicate depressive symptoms when answered negatively while items 2, 3, 4, 6, and 8-15, when answered positively did. Each item that indicated the presence of depression was given a
value of one. The sum of all items indicates a score on the GDS-SF, which corresponds to level of depressive symptoms. Scores ranging from zero to four are considered normal, scores in the five to nine range are indicative of mild depression, while scores from 10 to 15 indicate severe depression (Greenberg, 2012; Mui, 1996).

For the total sample, the mean score was 1.9±3.0 (Median=1; Range: 14). The mean scores for females and males were 1.9±3.0 and 1.7±3.1, respectively, which falls under the category of normal for the presence of depressive symptoms. Table 6-6 shows the distribution of categories of depressive symptoms based on GDS-SF scores the total sample by sex.

**Table 6-6: Descriptive Statistics for the Geriatric Depression Scale – Short Form (GDS-SF)**

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GDS-SF (mean±SD)</td>
<td>(%)</td>
<td>GDS-SF (mean±SD)</td>
</tr>
<tr>
<td>Normal (0-4)</td>
<td>1.0±1.3</td>
<td>80 (87)</td>
<td>0.6±1.0</td>
</tr>
<tr>
<td>Mild depression (5-9)</td>
<td>6.8±1.6</td>
<td>9 (10)</td>
<td>6.7±1.5</td>
</tr>
<tr>
<td>Severe depression (10-15)</td>
<td>12.7±2.3</td>
<td>3 (3)</td>
<td>11.0±1.0</td>
</tr>
<tr>
<td>Total</td>
<td>1.9±3.0</td>
<td>92 (100)</td>
<td>1.7±3.1</td>
</tr>
</tbody>
</table>

There is currently no research that measures prevalence of depression or the cultural appropriateness of using the GDS on older Filipinos. Results from this study found that only a small percentage (4%) of older Filipinos show signs of severe depression. This confirms earlier findings asking respondents to self-report their mental health, where only a small sample rated their mental health in negative terms. There was no correlation found in the relationships between depression with age or gender for this sample.

When comparing GDS-SF scores for Dimensions One, Two and Three, the mean scores varied but by a small degree with all means falling within the normal range of depressive symptoms. Figure 6-35 describes the result of comparing the mean scores for the total sample and for both males and females. The means scores for GDS-SF varied across all three dimensions, although t-test and ANOVA analyses yielded insignificant results.
The mean scores for the GDS-SF for the total sample and for both sexes were also compared for Dimensions Four and Five, which are summarized in Figure 6-36 above. Similar patterns in the means were observed for the total sample and for both sexes. As with analyses
among the migration and aging dimensions of place experiences, t-test analyses found insignificant results. Thus, there appears to be no relationship between reported mean scores of GDS-SF and the various dimensions of place-experiences.

6.5.4.2 Multidimensional Scale of Perceived Social Support (MSPSS)

The MSPSS is a validated measure of perceived social support and consists of 12 items based on a seven-point Likert scale asking respondents to comment about various sources of support from family, friends and significant others. The total score calculated can range from 12 to 84 with higher scores indicating the greater perceived social support. Sub-scales of the MPSS can also be calculated and include the domains of family, significant others and friends. Items 3, 4, 8 and 11 measure family subscales of the MSPSS. Items 1, 2, 5 and 10 measure social support from significant others. Items 6, 7, 9, and 12 measure the level of perceived social support from friend. The scores for each subscale can range from 4 to 28, with higher scores indicating greater perceived social support.

The overall mean score for the sample was 73.2±11.6, with the lowest score at 16 and the highest at 94. Table 6-7 shows the MSPSS scores, including the subscales that measure social support provided through family, significant others and friends, for the total sample and the males and females.

Table 6-7: Descriptive Statistics for the Multidimensional Scale of Perceived Social Support (MSPSS)

<table>
<thead>
<tr>
<th></th>
<th>Females (SD)</th>
<th>Males (SD)</th>
<th>Total (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSPSS – Family (#3, 4, 8, 11)</td>
<td>25.0 (4.2)</td>
<td>24.6 (3.9)</td>
<td>24.9 (4.1)</td>
</tr>
<tr>
<td>MSPSS – Significant Other (#1,2,5,10)</td>
<td>25.1 (4.1)</td>
<td>25.2 (4.2)</td>
<td>25.2 (4.1)</td>
</tr>
<tr>
<td>MSPSS – Friends (#6,7,9,12)</td>
<td>23.6 (4.8)</td>
<td>22.3 (4.8)</td>
<td>23.2 (4.8)</td>
</tr>
<tr>
<td>MSPSS Total</td>
<td>73.8 (11.6)</td>
<td>72.1 (11.5)</td>
<td>73.2 (11.6)</td>
</tr>
</tbody>
</table>

SD=standard deviation

Independent samples t-tests and a one-way ANOVAs were performed to determine the effect of the dimensions of place experiences and the MSPSS scores, for total scores and all three subscales for the overall sample. The results are illustrated below in Figures 6-37 and 6-38.
**Figure 6-37**: Mean scores for multidimensional scale of perceived social support (MSPSS) total and subscales by Dimensions One, Two and Three

**Figure 6-38**: Mean scores for multidimensional scale of perceived social support (MSPSS) total and subscales by Dimensions Four and Five

Across all dimensions of place experiences the total MSPSS scores and subscales were evenly distributed, although the mean scores for the MSPSS friends subscale is slightly less than the
family and significant other subscales which suggests that family and significant others, such as a spouse, are important sources of support for later-life Filipinos.

**6.5.4.3 Unmitigated Communion (UC)**

The construct of unmitigated communion (UC) describes the outward focus and concern for others often at the exclusion of oneself (Fritz and Helgeson, 1998). Two important characteristics of UC are communion and agency. Communion is representative of an individual’s concern for their interpersonal relations with a greater focus on others, while agency describes a concern for one’s own sense of achievement and a focus towards the self (Fritz and Helgeson, 1998). The UC scale (UCS) utilized in the survey portion of the project is a 9-item scale, in which respondents are asked to rate each of the nine statement about their interpersonal relations on a five-point Likert scale with one being “strongly disagree” to five being “strongly agree”. A mean summary score is calculated by scoring each item is based on the five point scale with items 2 and 5 reverse scored. High means scores on the UCS indicates a high level of UC, indicating that an individual puts the needs of others ahead of themselves. The act of helping others is associated with higher levels of mental health compared to not helping others. In a study by Schwartz and colleagues (2003) they noted that being older, female and a church-going elder signified a greater likelihood of helping others. However, the authors also found that when an individual gives beyond their own resources, at a cost to their own wellbeing, they more often reported lower levels of mental health.

Six respondents had missing data and therefore were not included in the analysis. For this sample the mean UCS was 3.2±0.6, which is considered a moderate level of UC. The UC scores were found to be evenly distributed among different group comparisons. For instance scores in this sample of 44 males was 3.14±0.6 compared to the 88 females whose mean scores was 3.3±0.5. Results were found to be insignificant based on t-tests. The mean scores were also compared among the dimensions of place experiences. Testing for the effect of Dimensions One,
Two and Three on the UC mean scores resulted in mean scores of 3.2±0.6, 3.2±0.5 and 3.1±0.5 respectively. One-way ANOVA testing found no significant results in this relationship as the scores were evenly distributed. Similarly, mean scores for Dimensions Four and Five, which categorize health care and place, were 3.2±0.6 and 3.1±0.5 respectively, which also was found to be statistically non-significant.

Studies often examine relationships between the presence of depression and high scores of unmitigated communion (Helgeson and Fitz, 1999; Jin, van Yperen, Sanderman and Hagedoorn, 2010). Among this particular sample, measures of UC and the presence of depressive symptoms based on GDS-SF scores were found to be unrelated as demonstrated with a bivariate correlation analysis. These results suggest that later-life Filipinos maintain a balance of communion and agency, whereby they are engaged in helping others but not at a cost to their own health and wellbeing.

6.6 Summary

The purpose of this chapter was to provide a context for the health and health care utilization patterns of aging Filipino immigrants, with the goal of examining how social determinants, migration and the role of place influences the health and aging experiences. In doing so, I sought to answer three questions about the later-life Filipino immigrants: What is the general health of later-life Filipino immigrants? Do they experience any barriers when accessing and utilizing health care? And, how does health status and health care use vary among later-life Filipinos, based on the five dimensions of place experiences?

Descriptive statistics on health status, health care use and various psychosocial scales revealed that most later-life Filipinos in the sample are relatively healthy on many of physical and psychosocial health measures. Later-life Filipinos in the survey tended to rate their own perceived health and mental health positively and on average, reported experiencing fewer chronic conditions. Most Filipinos described being engaged in healthy lifestyle behaviours as only a few
identified being a current smoker or engaged in excessive consumption of alcoholic beverages. Most Filipinos considered themselves to be physically active and were conscious about their eating behaviours including increasing their consumption of fruits and vegetables while lowering their intake of saturated fats and salt.

With regards to health care utilization, later-life Filipinos experience very few barriers with regards to health care access in Canada. In general they rated the overall quality and satisfaction with Canada’s health care positively. Among the most common difficulties identified by later-life Filipinos were the waiting times to see a doctor or to make an appointment. Common issues such as language and communication barriers or lack of information, as identified from key interviews were not described by later-life Filipinos. This is not surprising given that the survey was only available in English and was lengthy. Those who completed and returned the survey were likely proficient in English, which is reflected in the fact that this sample of older immigrants was a highly educated group.

The overall healthy immigrant bias may be due to the fact that the sample surveyed consisted of younger seniors. Less than 20 percent of the sample was older than 74 years of age resulting in a younger overall group of seniors. Other factors contributing to the healthy bias may be because most Filipinos surveyed were highly educated with over 70 percent of the sample having graduated with a college or university degree. All Filipinos were also living in Canada for at least 10 years and likely have been exposed to public health campaigns and public service messages on health issues. For this group of Filipinos, being highly educated and living in Canada for over 10 years may contribute to high levels of health literacy.

Health literacy refers to the ability to not only understand but to also act on medical advice and instructions about positive health outcomes including managing chronic diseases, early cancer detection screening, medical adherence and even patient compliance with health professional’s instructions (Shaw, Huebner, Arnin, Orzech and Vivian, 2009). Although a
number of researchers caution that education or socio-economic levels are not proxies for health literacy, it is likely that these factors contribute to this sample of Filipinos’ tendencies toward healthy behaviours. Other studies have noted that cultural discord or language issues between patients and health care providers may inhibit health literacy of immigrants, as they tend not to participate in health promotion activities due to a number to cultural and even, structural barriers (Zanchetta and Poureslami, 2006; Simich, 2009). Many of the Filipinos in this sample indicated that they communicated mainly in English with health care professionals, as well as English literacy and comprehension were important requirements in to completed the survey in its entirety. While health literacy was not directly measured in this study, results from the survey suggest that health literacy is high among this group. However, given the nature of this study as exploratory and the convenience and snowball sampling strategies used, this sample of Filipinos may not be generalizable to other groups of Filipinos across Canada.

A unique aspect of the analysis was to explore the interacting concepts of migration, aging and place, resulting in the dimensions of place experiences. Overall, there appeared to be some differences in the health, aging and health care experiences between Filipino immigrants who arrived in Canada at a younger age and are aging in place and those who arrived in Canada in their later-life stages (Dimensions One, Two and Three). Although there were little differences observed between older Filipinos who arrived in Canada before 1980 (Dimension One) and after 1980 (Dimension Two). The results support those from key informant interviews that suggested that newcomer seniors or seniors who arrive later in life experience greater difficulties than those who arrived earlier in life.

The analysis of the dimensions of place experiences revealed a number of important factors to consider with regards to examining health and aging experiences of immigrants. Firstly, it is important to consider the time, not just in terms of when during an immigrant’s life had they migrated but what were the circumstances politically and socially that an immigrant arrived into.
For instance, important issues to consider are current immigration policies and how this impacts the type and composition of immigrant populations arriving in Canada. For the migration and aging dimensions of place experiences, the year of 1980 was the chosen demarcated time to distinguish between two broad groups of older Filipinos. In the 1980s, changes to immigration policies saw a shift in the emphasis of family reunification towards economic immigrants (Moore and Rosenberg, 1997; Newbold and Filice, 2006). This resulted in the arrival of immigrants who were highly skilled and highly educated both in the early 1980s and 1990s. Many of these immigrants are now aging-in-place and have plans to live out the remainder of their years in Canada. As noted by a number of key informants in this study, the important advantage among these immigrants is their ability to familiarize themselves with health and social care systems as well as accrue the wealth and resources to support them as they age.

Existing research that examines health in later-life among other ethnocultural groups have found variable results, depending on the type of data used and whether analyses made group comparisons between different ethnocultural groupings. Much of the research in Canada has been on the Chinese ethnic population, which is not surprising given that they represent the largest visible minority ethnic group in Canada. In one particular study, Lai (2004) compared the health of older Chinese immigrants to all other seniors using data from the Health and Well Being of Older Chinese in Canada and the Medical Outcomes Study 36-Item Short Form. Based on a number of physical and psychological health domains and summary scores he found that Chinese immigrants rated their physical health better than older adults in the rest of the Canadian population but reported poor levels of mental health and wellbeing.

Lai’s study also found gender differences in physical and mental health, where females reported being less healthy overall than Chinese immigrant males. This finding is similar to a different study on South Asian immigrant seniors living in Edmonton, Alberta, where Ng and Northcott (2010) found that females were more likely than males to the skills required to live an
independent life as they had poorer English language skills, more dependent on family members for transportation, less likely to become more engaged in broader society and tended to live in three-generation households. In my study of later-life Filipinos, no gender differences were observed among the various physical and mental health measures, despite this sample having a fairly higher representation of females to males. There were no gender differences observed in terms of social support (MSPSS) and UC scores, which measure one aspect of interpersonal engagement or the act of helping others. Though my study did not compare the health of older Filipino immigrants to any other ethnocultural group or with Canadian-born seniors, the overwhelming majority of the Filipino sample rated and reported on their physical and mental health highly.

One study that was found was most similar to Phase Two of this project and explored the health and wellbeing of community-dwelling Chinese immigrant seniors in downtown Calgary. Chow (2010) used various measures of physical and psychosocial health and found that over two thirds of Chinese immigrants in the Calgary sample described their physical health as very good or good and most had regular communication with health care professionals, which is similar to this sample of later-life Filipinos. However, based on summary and composite scores for overall physical and psychological wellbeing, he also found gender differences but in this case, females who were married, had higher levels of education, reported higher levels of physical mobility and had been living in Canada for a longer time reported higher levels of psychosocial well-being (Chow, 2010).

Chow’s study sample had a higher percentage of females (79.3%) as did my study, however his sample differs in numerous ways. For example, Chow’s overall sample was over ten years older (78 versus 67 years of age), a majority of his sample reported having difficulties communicating in English, most respondents reported living alone and over three-quarters had high-school educational attainment or less. Other important differences between my study and
Chow’s sample came from three Chinese-exclusive residential complexes in Calgary. Descriptive statistics revealed that my sample consisted of a group that was younger, highly educated, was highly proficient in the English language, married and living with their spouse and/or extended family. In many respects, the overall sample of later-life Filipinos were on average much healthier, happier and well-adjusted to life in Canada. Although the range of years living in Canada ranged from two to 50 years, very few reported barriers or any difficulties experienced when accessing health care. Most notably, there were virtually no language barriers reported among this sample, which is different from numerous studies, including the ones mentioned above that noted that language and communication barriers were among one of the greatest issues that many older immigrants face when accessing health care (Lai, 2004; Chow, 2010; Lai and Surood, 2010; Ng and Northcott, 2010; Surood and Lai, 2010).

There a number of limitations in my study that are discussed below, including the fact that I relied on a combination of validated and investigator-generated scales and measures. Many of the measurement tools used differed from those used by researchers as described above and thus direct comparisons cannot be made as the results are not empirically similar. However, study limitations aside there are a number of possible explanations to account for the high levels of physical, mental and social health among my sample of later-life Filipinos. One explanation is that among this particular sample many Filipinos came to Canada through the skilled worker or Canadian work/education experience category. Most notably many female Filipinos, approximately 52 percent arrived in Canada under these categories and likely came during the early immigrant waves of the 1960s and 1970s where many skilled workers, particularly health care professionals, were among the first recorded Filipino immigrants. As many young Filipino immigrants took up meaningful jobs that utilized their skills and training, as indicated by the high levels of university graduates in my sample, they represent a very different immigrant group than
those discussed in the studies above, as well as the immigrant experiences discussed by key informants from Phase One of the overall study. Many of these immigrants, Chinese and South Asian, consist of more recent immigrants and likely came to Canada through family reunification. Secondly, many Filipino women have worked and are now retired (53%) and over 33 percent are still working either full-time or part-time. These Filipino women are likely to have a pension or accumulated some wealth having worked or are still working in Canada. They are at an advantage as they aged when compared to non-immigrant and other immigrant older women who were under-represented in the labour force and as a result were not able to secure pensions, had limited pensions or ended up losing their pension support upon the death of their spouse. And finally, my sample did not include later-life Filipinos who are socially isolated, those who are less active or inactive but are still living within the community.

While the final sample of the survey component of this research yielded a reasonable sample size given the limited scope and resources of the project, the overall results revealed a lack of statistical power in order to make more definitive conclusions about the health and health care use of older Filipinos in the Toronto and GTA. Other limitations of the pool of respondents were the sampling strategies utilized, which necessarily shifted throughout the fieldwork in order to improve recruitment of survey respondents. Every effort at the onset of data gathering was made in attempt to recruit a variety of older Filipinos from different settings. Numerous e-mails were sent out to various Filipino organizations and groups with an attached poster and contact information. However, efforts to contact Filipino leaders within the community were unproductive. At the start of the data collection, efforts to maintain careful documentation and tracking of surveys resulted in fewer returns of questionnaires. In order to spread the reach of the survey distribution, snowball sampling was employed and proved to be the most successful method in achieving a better return of questionnaires; however, it made the tracking of surveys and follow-up more difficult to manage.
Although key informants discussed the importance of the migrant factor when considering the health of senior immigrants there is high variability in how migration is defined within the literature. An important limitation is the lack of a conceptual definition of the migratory experience, despite the fact that it is widely acknowledged to have a significant effect on the overall health experiences and social lives of many immigrants, particularly when using more quantitative methods and survey data. The migrant experience is often categorically based on temporal definitions, such as time of arrival or years of nativity (Dunn and Dyck, 2000; McDonald and Kennedy, 2004; Newbold, 2005a), rather than on the cultural experience, cultural shifts in behaviours, processes of integration (Dyck and Dossa, 2007) or even the influence of ethnicity on immigration (Kobayashi, Prus and Lin, 2008). As well, there is no agreed upon definition or category for migration in research that seeks to quantitatively examine how important the migratory process and migration experience is in the health and aging of immigrants (Dyck, 2006; Koehn, Neysmith, Kobayashi and Khamisa, 2012).

The survey attempted to capture some of the migration experiences of older Filipinos, as well as some their transnational activities such as health care use in the Philippines, return visits and property ownership. Another limitation of the survey was the reliance on memory, particularly on questions about the quality and satisfaction levels of health care in the Philippines. With less than a third of Filipinos who admitted to regularly visiting the Philippines, many Filipinos likely based their opinions and beliefs about the Philippine health care system on their own, recent experiences with Canada’s health care system, which is a vastly different system in terms of having to pay out of pocket for many services in the Philippine system.

Perhaps the most important contribution of the chapter is that this is the first type of study that comprehensively explores the health and aging experiences of older Filipinos, with a focus on migration experiences in Toronto, Ontario. Within the body of literature on the state of aging immigrants in Canada, Filipinos are very much an underrepresented ethnocultural group. In the
book Diversity and Aging among Immigrant Seniors in Canada (2010) there is a glaring lack of discussion on the aging experience of immigrant Filipinos, which is incongruent with the fact that Filipinos are one of three largest immigrant groups arriving in Canada in recent years (Statistics Canada, 2013). Even with the recent release and of the ironically titled book, Filipinos in Canada Disturbing Invisibility (2013), which discusses the politics of gender, migration and the identity of Filipino migrancy in Canada, there is very little discussion of older Filipinos or the impact of migration and gender on their health and aging experiences.
Chapter 7

Health, Place and Aging in Multicultural Toronto: An
Ethnogerontological Case-study of Aging Filipinos

7.1 Introduction

This chapter examines more closely the ways that migration and transnationalism influences the health and aging experiences of older Filipinos living in the city of Toronto and the surrounding Greater Toronto Area (GTA). The overall aim of the chapter is to explore experiences of health as well as meanings of health and place attributed to aging among later-life Filipinos. In the previous chapter, the results gathered from survey data on the health and health care experiences of older Filipinos were described (see Chapter 6). This chapter expands upon those results using interview data collected from a sub-sample of survey respondents, by exploring individual and personal experiences of migration and aging and the meanings they give to health and place in a post-migration context.

Under the healthy immigrant paradigm a number of theories have been proposed in explaining the health trajectories of immigrants upon arrival in a host country (See Chapter 2 for description). As noted in the literature review, one of the more commonly utilized frameworks for understanding health among immigrants is the healthy immigrant effect, (HIE) where it is observed that newly arrived immigrants are healthier than their native-born counterparts. However, the health gap diminishes over time and immigrants’ health converges to the level of the native born population. A different picture of immigrant health emerges when considering the aging and older immigrant populations. Fewer studies have explored the assumptions of the healthy immigrant effect with later-life populations and among those that have tested this hypothesis, they have found mixed results. Health gaps between the foreign-born and native-born populations may vary widely among men and women, among different ethnic or racial groups.
and even among different age cohorts 60 years and over. Even within gerontology research there are few studies that have explored the implications of immigration or ethnicity. Research has been slower to address the role of race and ethnicity with experiences of aging in a post-migration context. Literature on the intersections of aging and migration remains a relatively specialized research interest within the broader discipline of social gerontology (Torres, 2004; McDonald, 2011; Zhou, 2012). Often migration is seen most commonly as movement across physical boundaries. However, migration can also mean movement into a different state of being, not just in terms of physical location but moving between social, cultural, political and economic boundaries (Castles and Miller, 2009).

Using Filipino senior immigrants currently living in Canada as a case study is both a unique and important endeavor mainly because of the dearth of literature exploring the aging experiences of Filipino-Canadians. It is important in that Philippine migration to Canada has been, and still remains, an important source of skilled and unskilled labour in the Canadian labour market. As such, this research on aging Filipinos’ health is largely exploratory given the lack of health research on older Filipino immigrants. The research is also important to me personally as my parents were new immigrants to Canada many decades ago and over the years I have learned of their own struggles and experiences of living in Toronto and aging in the neighbouring suburban city of Mississauga, located in the GTA, as they participate fully in the social, economic and political lives of the Canadian multicultural landscape. A unique aspect of this study is the focus on the place experience of later-life Filipinos, particularly the use of other health care systems outside of Canada, which has the potential to influence policy and the provision of health and social care for ethnoculturally specific groups.

The chapter draws from semi-structured interviews conducted with older Filipinos (n=15) living in Toronto and the GTA. The aim of the chapter is to present the views of older Filipinos and how they perceive and give meaning to their health and aging experiences and how these are
tied to their views of their Philippine homeland or “back home”, as many of the participants
called the Philippines, and their lives here in Canada. More specifically, I argue that age,
migration, place, ethnic identity, health and cultural practices all intersect to shape the health and
aging experiences of Canada’s immigrant population that cannot be explained by the HIE, which
has been substantiated mostly through large-scale quantitative studies. Similarly, the immigrant
experience as often described by researchers, policy-makers, health care providers and other
stakeholders (See Chapters 4 and 5) cannot be generalized to a single experience. Nor do all
immigrants experience health and aging in the same way. Immigrants at all stages of migration
vary widely and experience health and aging in profoundly different ways. I explored broad
issues of health, aging, place and migration using a mixed methodology. Essentially, I wanted to
know: How do older Filipinos view their lives as they age in the context of globalization? This
chapter addresses the following research goals using Filipinos as a case study.

- Examining how experiences of aging and immigration influence the health and
  health care use of later-life immigrants (Research Goal 1)
- Examining the relationships with aging, migration and re-settlement among
  later-life immigrants (Research Goal 2)
- To understand how social determinants and the role of place influence the health
  and health care use of later-life immigrants (Research Goal 3)

7.2 Later-Life Filipinos

The final sample of later-life Filipinos interviewed after completing the survey was 15
and consisted of four males and eleven females. See Table 7-1 (See Appendix 11) in provides a
summary description of later-life Filipinos in the order that they were interviewed, including
pseudonyms which are used throughout this chapter. Most interviews were conducted in-person
(n=12) but for the convenience of the respondent where preferred, telephone interviews were
arranged (n=3). The socio-demographics of the sample aggregated by sex are described in Table
The age of first arrival in Canada varied among the sample, ranging from 22 to 66 years of age. A majority of the sample arrived in their 20s (n=7), four arrived in their 30s and one Filipino male indicated that he first arrived in Canada at age 44. The remainder of the Filipinos (n=3) indicated that they first arrived in Canada over the age of 60, under the family class category sponsored by their children. Among them two were females arriving in Canada at ages 61 and 64 and one male who arrived at the age of 66 years. Seven Filipinos indicated that they arrived under the skilled worker class category and one Filipino female came under the contract worker immigration class category.

7.3 Health and Aging Trajectories in the Context of Migration

There is a growing concern that the migration experience itself should be conceptualized as a determinant of health (Vissandjee, Desmeules, Cao, Abdool and Kanzanjian, 2004; Torres, 2004). As noted previously, an individual does not simply begin life as an immigrant but often strong connections are maintained and sustained, which are very much integrated and incorporated in their post-migration lives and experiences and can greatly influence health experiences over the life course (Kelly and Lusis, 2006). Also associated with immigration comes the creation of transnational spaces and other globalization processes that have important implications on the health trajectories of immigrants. It has been noted by a number of researchers that current understandings of aging are being challenged by dynamic and global process of migration and transnationalism. Social gerontologists have argued that little attention is paid to international migration as determinant in health and a factor in the aging process (Torres, 2004; McDonald, 2012). Zhou (2012) in particular calls for a ‘rethinking’ of aging that understands the contexts of immigration and transnationalism that considers space, time and perceptions of self. She argues that complex and dynamic global processes, such as technological advances in communication, family restructuring and immigration itself, have far reaching implications for aging populations both locally and globally. The lack of empirical research that
incorporates broader concepts of immigration and transnationalism has prevented a greater understanding of the impact of globalization on aging populations.

7.4 Reasons for Migrating

The decision to migrate is a complicated one and determined by a number of factors. Decisions are influenced indirectly by broad global processes such as political and social economies and directly including local and micro-level factors such as family and personal reasons. In many instances, immigrants often maintain strong ties and connections with their birth country whether they are rooted emotionally, politically or economically. Thusly, the decision to migrate is not only a life-changing event but migration and resettlement continues to play itself out for the rest of their life even as they age.

When asked to think back to when first arriving Canada, older Filipinos were asked to recall some of the reasons or motivations for why they chose to migrate. One of the most common motivating factors for Filipinos was family. Even though a majority of participants came to Canada under the skilled worker class (n=7) which suggests that they may be more motivated by economic reasons, many older Filipinos discussed the important role of family as the main factor for leaving the Philippines (n=11) regardless of what immigrant class category they arrived under.

For many Filipinos in this study the decision to migrate was not based on a single factor but was influenced by multiple factors that on the surface seemed straightforward but were in fact complex and dynamic. So while family was a prime factor, the nature of family relations, family obligations or family structure varied widely and informed their decisions for migrating and settling in Canada. Older Filipinos described many transnational activities that were rooted in the care and responsibility for family members overseas. The most common activity was in the form of remittances to family. For instance, some older Filipinos recalled migrating from the Philippines to help family ‘back home’ seeking better economic opportunities overseas in order to
send remittances to the Philippines so that other family members could attend university or afford
the luxuries they would not otherwise be able to purchase, such as certain food items or toiletries.
Some Filipinos also recalled migrating and remaining in Canada to work and sending remittances
to the Philippines to help in the care of their own elderly parents or other aging family members,
such as paying for caregiver help, which was a common arrangement in many Philippine
households. While most Filipinos successfully brought their own elderly parents to Canada to be
with them, some Filipinos remarked that no amount of convincing could persuade their elderly
parents to join them in Canada. It then became even more important to maintain employment
while in Canada in order to be able to send money to the Philippines to assist their elderly
parents. Among the many reasons relating to family, a number of Filipinos discussed their own
children’s welfare as a motivating factor for why they decided to leave the Philippines (n=4).

As one Filipino male, Alex (84 years, migrated at age 44) recalled the reasons why he
and his siblings moved to Canada in the ‘70s were a complex of factors:

**Alex:** For a better life, you know economically back home is so difficult. That’s one of the
reasons why we came here because our—my siblings came here one by one. We are eleven
before so we left the Philippines one by one. They tell you nice stories about Canada or the U.S.
and you know, like I said (to) the people back home so they decided to come here.

For Alex, he and his siblings were at various stages of their lives and while they all decided to
leave in search of a better life in Canada, they each had their own personal reasons for migrating.
When asked to describe the types of hardships he and his family endured making life difficult
back home, Alex not only explained the broader social and political issues of the Philippines but
also disclosed that while as a larger unit he and his extended family decided to leave one-by-one,
he had his own personal reasons relating to his own immediate family:

**Alex:** Food is very expensive and politically, the Philippines was not very well. There’s
corruption, you know. And there was some successive bombings of buildings, like that. I don’t
know (but) I think it’s politically motivated or they attribute that to the rebels or something. Like,
it’s so unstable and I had family, growing children. So I—we decided to have a better life in
Canada.
Most Filipinos already had family that migrated either to Canada or the United States, mostly siblings or adult children, and often made the decision to move at the suggestion or urging of those who already migrated (n=6). For those who had young families, the decision to migrate greatly involved decisions between spouses and the desire to have a better life for their small children. In most cases, one spouse would be the first to move and settle in Canada before sponsoring the other spouse and small children. None of the Filipinos described the decision to remain separated for an extended period of time, as is the cases with some immigrant families referred to as satellite families. For the few Filipinos who sacrificed years of married life together in order to set up roots in Canada in the hopes of having a better life overall, all had the intention of being reunited.

Other Filipinos chose Canada because they had family that migrated to the United States and wanted to be nearer to them but preferred Canada because they believed it was more quiet and peaceful, while others defaulted to Canada because immigration applications to the United States took longer to process. For some, Canada represented a modernized society and the ‘easy life’ compared to the Philippines, where if you were not one of the privileged few to have the monetary wealth to live comfortably you experienced a life of hardship and poverty. Only one Filipino discussed having worked and lived in another country outside the Philippines prior to arriving and settling in Canada, the decision to stay made firm with the birth of her two children.

Migrating for a better life and to have more access to economic resources was the second most common reason for older Filipinos migration into Canada (n=7) and as noted above, this was often tied to family reasons. One Filipino woman, Erlina, who was the youngest participant in the sample of interviewees (57 years old, migrated at age 26) explained that migrating was the only option to escape the poverty of the Philippines. When asked to think about the reasons why she migrated she simply stated: “We’re very poor so that’s the only way.” When further pressed about what opportunities she was seeking when she migrated, Erlina admitted that she had no job.
prospects lined up and applied to work in Canada as a contract worker having worked as a nanny in other countries outside of the Philippines. For a small number of Filipinos, particularly those who migrated to Canada in their early twenties (n=5), when recalling the reason why they migrated to Canada they also stated that they had no immediate plans once they migrated and viewed both Canada and the United States as countries of opportunity. Often these Filipinos were unmarried and without children. Among their reasons for migrating some mentioned that they had just recently graduated from university in the Philippines and migrated in search for adventure (n=2) while others said they wanted to gain international work experience (n=2). For older Filipinos who arrived at a younger age and were most likely to be single, they more often cited economic reasons or opportunities for a better life in Canada. Older Filipinos who arrived later in life (aged 30 and older) also cited economic reasons and a better life, but often they tied these reasons to family or family obligations such as wanting to be closer to their children or to help in the caring of their grandchildren.

Only in one instance did an older Filipino report that they were brought over from the Philippines specifically to care for her grandchildren. Teresita (87 years, migrated at age 64) had described the sole reason for her migrating to Canada was explicitly to help care for her grandchildren, when her daughter first left for Canada first along with her small children:

**Teresita:** Because we brought the children here. But they were still small and my daughter is working so she cannot take care of her children, so she tried to sponsor us with—what do you call that, she sponsored us here to take care of her children.

That this experience, as described by Teresita, was the only one that had emerged among this sample of older Filipinos was surprising given that interview results with key informants revealed that many older immigrants in Toronto were often brought over to care for grandchildren (See chapter 4). Including Teresita, only a small number of Filipinos who participated in follow-up interviews migrated to Canada over the age of 60 years (n=3) under the family class category. And only Teresita specifically stated that she was brought her to care for her adult daughter’s own
children while she worked full-time. The other two seniors, Edgar (male, 79 years, migrated at age 66) and Zenaida (female, 88 years, migrated at age 61), arrived in Canada long after their children arrived in Canada and had very different experiences to share. For instance, Zenaida arrived with her late husband at the urging of her children, who all arrived in Canada at an earlier time, and who were concerned for their safety given the political turmoil of the Philippines:

**Zenaida:** It was because of the political upheaval in the Philippines during Marco’s time and my children were afraid that we’d be left there and lose everything so they called us here.

While Zenaida, enjoys the company of her children (four) and many grandchildren (nine), at 88 years of age she remains active and dedicated to the local Filipino community, as well as the broader senior community, working almost full-time hours. With Edgar, he too was sponsored and migrated to Canada having recently retired after a long career with the government and having lost his wife. Like Zenaida, he arrived in Canada a recent retiree only to take up full-time work in various jobs but now enjoys volunteering for a number of community organizations in both Filipino and seniors’ groups. While he would not specifically state his reasons for coming to Canada, even while three of his five children still remain in the Philippines, he alludes to wanting a better life despite having had to work when first arriving in Canada:

**Edgar:** There was a lot of adjustments – a lot of adjustments. Because being new and I’ve not been away from [the Philippines]. This country is not that familiar to us, right? Canada, it was actually my first time to come here to a foreign land. We have different culture in my country. And you know that living in a third world country we don’t have all this modern facilities that you have here in Canada or Toronto. So this city was so new to us, new to me. Like the street car, the subway, etcetera. Even in the work place, when I came here I work.

Both Zenaida and Edgar, maintain very independent and highly social lives, compared to Teresita who came to care not only for her daughter’s children but now is also having to care for her own ailing husband. For Teresita, family both her husband and the daughter who sponsored her and whom she currently lives with, is a central to her life in Canada. She often spoke about the needs of her daughter and her obligations to her family above her own needs in terms of her and her husband’s health. Even when prompted to discuss any difficulties or health issues that she
herself experiences in aging, she regrets that she cannot do more for her daughter who has her own health issues and works full-time:

**Teresita:** Good health? I don’t feel like this. I cannot walk anymore. I cannot stand. I have to sit down when working or anything. In taking the clothes, wrapping the clothes or fixing the clothes. I cannot stand too much, I cannot cook anymore. Like before I was the one cooking. Now my daughter was the one cooking before she goes to work, she prepares all our needs, our food for the lunch and before she came home. She has to cook again for our dinner.

**Janette (interviewer):** So it’s difficult for you to get around the house?

**Teresita:** It’s a difficult time for her, yeah. Because it’s very tired – tired in the office and very tired here in the house. There’s also cleaning, I cannot clean anymore, not like before. I cannot even go down in the basement to wash the clothes and everything… Yeah, about moving around, it’s very hard for me. I can use my walker in going to the washroom, going to the kitchen to get our food. But it’s very hard for me to take care of my husband. He’s also disabled and I cannot do it for him so sometimes my son was the one who was doing it for him and my daughter when she is out for work.

Unlike Edgar and Zenaida, Teresita was not as active in the community and was limited to being indoors by her own restricted mobility and her obligations to care for the home and her husband.

### 7.5 Perceptions of Health and Aging

The World Health Organization (WHO) defines health as “… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” (Tulloch, Davies and Fitzpatrick, 2005; World Health Organization, 2014). The prominence of research on social determinants, and by extension social inequalities, that give rise to good and poor health has given credence to this holistic definition of health. Ideas about health and wellness as it manifests in later-life stages have given rise to alternate understandings about health and aging or what it means to be healthy or living well in later-life. This approach to aging in later-life, which signaled a paradigm shift in social gerontological inquiry and the way we understand aging from a health and wellbeing perspective, grasps the idea that despite increased longevity one can delay the onset of morbidity and age-related functional declines and living healthy into older age (Fries, 2012). Amidst related ideas has been the development of a variety of “aging well” concepts including successful aging, active aging, healthy aging or positive aging.
Though each are derived from different empirical sources and/or theoretical underpinnings, all of them rely upon improving the opportunities, competencies and self-identity of aging persons and denotes an engaged and continued participation in a variety of activities that enhance health and wellbeing (Andrews and Philips, 2005). The crux of social gerontology research is to understand what it means to age well, with much of this research influencing aging policy and practice (Torres, 2004).

The idea behind aging well in longevity, also known as the “compression of morbidity” has driven much of the aging policies in most Westernized countries, including Canada, and permeates health policy of the WHO. Given the occurrence of global population aging at all scales in both the developed and developing parts of the world, the WHO has extended their multi-dimensional definition of health to incorporate the concept of active aging as integral to healthy aging, described as “… the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age” (WHO, 2002:12). In Canada, Ontario specifically, the Aging-at-Home strategy described previously in Chapter 5, endorses this view of productive and healthy aging through the strengthening and improvement of community supports and networks. A number of key informants interviewed in the first phase of this research felt strongly that the Aging at Home strategy was an important step in helping to improve the quality of life and continued independence of older adults. However, as many key informants noted generally, older immigrants experience health and aging in vastly different ways informed by race, culture, class and gender.

While the current ideas of aging and the promotion of policies and initiatives aligned with these positive aging concepts help enhance our understanding of how to improve health and wellbeing through the suppression of disease and age-related declines in older age, critics argue that these concepts promote a new type of ageism (Biggs, 2004). While these concepts of productive and successful aging are attractive, Biggs asserts that these ideas rely on a single
trajectory of aging, in particular of aging well and has important implications for perceptions of self, health and aging identities within the confines of the normative aging experience (2004). The emphasis on the concepts of positive aging contradict diverse experiences of aging and in doing so unnecessarily marginalizes those individuals that are not aging in accordance to these concepts and to aging and health policies based on these ideas. Other critiques of these positive aging concepts argue that conceptualized definitions of successful aging are lacking or vary widely and invariably do not include aging individuals’ own self-identified experiences and definitions of aging and health (Phelan, Anderson, LaCroix and Larsen, 2004).

In the following sections, how older Filipinos discussed their own perceptions of health and what it means to age in Canada is described. More specifically, older Filipinos shared their ideas and expectations of retirement and continued aging in Canada versus the Philippines.

7.5.1 Self-perceptions of Health and Aging: Retirement, Aging and Social Wellbeing

When asked to describe what “good health” means to older Filipinos, they offered various definitions of health based on their own experiences of aging and health care. They also referred to the health of their peers when discussing their own health and often described their health in holistic terms, which closely aligns with the WHO definition. For instance, Edgar described his health in the following way:

**Edgar:** First, as an old man, how do I define my good health—because at age 79 I feel that I’m still not exactly strong but I am still both mentally and physically active….I don’t want to be immobile, you know what I mean? Mobile is always moving! I don’t want to be immobile because if I am sedentary and I am reclusive—that’s what I keep on telling the other tenants here because most of them are very much younger than me but you look at them they look sickly. They look so weak and they look so unhappy!

For Edgar, he gauged and reflected upon his health as he sees his peers in relation to himself. Being very active with both the senior community and with Filipino groups, one of his first jobs shortly after arriving in Canada and having recently retired from a lengthy career with the Philippine government was as a maintenance worker. In the ten years following migration, Edgar
continued to work full-time and even after retiring, a second time but in Canada, he continues to remain active.

Similarly, Zenaida who also arrived in Canada in her sixties and who retired from a career in law while in the Philippines also continues to work full-time serving on various executive committees. At the time of the interview, Zenaida was in the process of finding a replacement for her own job as a high positioned board member but admitted that she was not happy with the potential candidates and will continue to work until a replacement was found. Being able to continue working was important to her and she believed that all seniors should continue to be active as they grow older, either as a volunteer or socially engaged within the community. She noted that her health was not what it once was when she first arrived in Canada (at age 61) and has since been experiencing more health difficulties as she continues to age, but felt that it should not stop her from working, at least she admits until the right candidate is found to replace her. In contemplating her second retirement like Edgar, she describes retirement and aging in Canada versus the Philippines:

Zenaida: Well aging in Canada is I think less difficult than it is in our country… there are only a few, those who are with the upper crust of society are the ones, that can still go out and attend social functions. But for a teacher in the barrio for example they stay home until they die. The joke when I was there is when you retire one foot is in the hospital, the other foot is in the cemetery. That was our joke.

For Zenaida, her aging experience in Canada is very different than the cultural joke she shares about retirement and aging in the Philippines. In particular, she believed that being socially active and engaged in social activities is what has helped her to stay healthy, despite experiencing some physical limitations in her health. As active and engaged with the local Filipino community and the broader senior community as she is, she explains that living in Canada allows for many opportunities to be socially active and credits being active to what has allowed her to live much longer than previous prognosis of doctors’ after having had two major surgeries in the 1990s. The Philippines in contrast have fewer opportunities for older adults to build and maintain social connections and networks once they retire and as Zenaida reveals in her quote, there is a distinct
class structure of aging in the Philippines, where only those with money are able to remain socially active after retirement.

Both Edgar and Zenaida were among the only seniors who lived alone in an apartment within a designated seniors’ building. As active members of their local communities they interacted regularly with seniors both within and outside their building, as neighbours and as volunteers in local seniors groups. For them, they believed that good health in older age was related to being active or “mobile” as Edgar emphasized in his earlier quote, which they saw as vital to their overall sense of wellbeing and happiness. Also, they both strongly felt that the seniors they perceived as being unhealthy were individuals who were socially isolated and withdrawn from the community. Seeing how poorly some older seniors were within the community only reaffirmed their belief that being active in older age is integral to healthy aging.

When describing what good health in older age entails, many Filipinos described the specific ways in which they maintained their own sense of good health. From their descriptions about their attitudes and behaviours towards health many Filipinos believed that good health is achieved through individual responsibility rather than social responsibility (n=9). Although they praised Canada’s universal health care system, most Filipinos felt it was their own individual responsibility to maintain their current health and wellbeing as they age and that health care was to be used for times of major health issues or health emergencies. This idea contradicts the myth that aging and immigrant populations will rely heavily on health and social systems to support their health and social needs. However, most Filipinos adopted a proactive sense of one’s own health as they age discussing the very specific health behaviours in which they engaged. Considering Edgar and Zenaida again, who are among the oldest and most socially engaged with their local communities in this group of Filipinos, they shared this sentiment of personal responsibility about health:

**Edgar:** Good health to me depends on how you manipulate your lifestyle. Yeah it all depends on the person, because how do you expect somebody to have the good health if he abuses himself?
**Zenaida:** …I think it’s a matter of knowing how to make yourself well. And I always tell my friends I think it’s in the mind, I say. And it’s will power. I am really very, very sick if I don’t get up. I always manage to get up if I can. Even if I—say, I don’t even have aches too often, it’s very rare. It’s a matter of attitude I think.

Most Filipinos agreed upon this self-directed notion of health and positive outlook on aging. Filipinos were very well aware of what health behaviours are important to achieving positive health outcomes and managing chronic disease symptoms. Among the many health behaviours that Filipinos actively engaged in and attributed to their health as they age they included observing a good diet (n=5), getting enough physical exercise (n=3) and taking supplements or monitoring the risk factors identified by their doctors (n=3). In addition to these specific health activities, Filipinos also cited other behaviours or attitudes that were important to their good health such as working or volunteering in their spare time (n=3), being able to cope well in stressful times (n=1) and having self-discipline and not ‘abusing oneself’ (n=2).

In addition to engaging in an active and healthy lifestyle, having opportunities for good health was also acknowledged by many Filipinos. Having access to quality health care was among the most cited factors among Filipinos. Alex for instance, also considered his health in relation to his peers and more specifically to his peers who are still in the Philippines and that he occasionally communicates with. He described having good health as very much related to the access and quality of health care, especially as one ages:

**Alex:** Good health? Canada has a good Medicare system. So, in spite of getting old and getting sick, still you are getting taken care of very well: free medication and modern science. Any time you get sick here you are taken care of very well. I cannot compare any other country you know that has a good medical system. I think it’s sort of the best that we have. And for that I’m very grateful because I have some relatives back home you know of my age that used to be my mates like that and about fifteen years ago most of them passed away. Because of lack of medication, maybe—

Many Filipinos also expressed that health and wellbeing was a state of mind as one grows older (n=6). In particular, Filipinos specifically commented that as they become older, health is not just a physical state of being but that it also includes, or may even be superseded, by other
dimensions of health including mental, emotional, intellectual and spiritual health and wellness. For example, Elizabeth (female, 75 years, migrated at age 38) noted that at the time of the interview that she was not well, having difficulty walking without pain. She emphasized that her experiences of not being healthy or feeling well was a natural part of aging and something that she has accepted as part of the aging process:

Elizabeth: Even if I’m sick, I don’t dwell about it. I don’t pity myself that I’m sick, no. You think I’m not sick? You know that I’m taking ten pills a day! Yeah! I have diabetic meds… I take five pills a day. Five, ano (what) six kinds of pills a day …Even our friends (say), “How do you do it?” Even my husband’s relatives they said, “I know that you have been sick a long time ago but how come you still look happy!” and I’m still the same. It’s in your [Points to head]. Maybe it’s the social worker in me too. [Laughs]. Maybe! Yeah! It’s how you do yourself! … We’ve done well for ourselves even if we are not rich but I’m happy. Happiness is not in the money. It’s in you. How you manage yourself. How you deal with other people. I hope everybody would be like me. [Laughs].

In describing health as a state of mind, many Filipinos shared the types of activities they engaged in and felt were strongly associated with their holistic sense of health and wellbeing: among them were prayer and meditation (n=3), attending church daily (n=2) and keeping up with intellectual pursuits and new hobbies after retirement (n=2). Many Filipinos felt that in order to do these types of activities it was important to “get out of the house” even if it meant coping with pains associated with chronic illness and often they would express fears of being home-bound (n=5). As described by Cecilia (female, 66 years, migrated at age 23) she recounts how most days she struggles with chronic pain but tries to not let it inhibit her activity and social life, especially now that she is retired:

Cecilia: (The pain) still on-going. But sometimes you don’t think about it all the time. Because if you do, you’re not gonna be…you’re gonna stay home. No! I don’t take that. Even if I’m in pain, I try to ignore it and go on because you try to do the things that you can do even you are at this stage of having pain or because you don’t really want to think about it all the time. Even when I’m in pain, as long as I can move I don’t stay at home. What we do is, we belong to a fitness club and Monday, Wednesday we belong to a Seniors Citizen (club). We walk, with my husband, yeah. And during the opposite days like Tuesday, Thursday, Friday any of the other days. My

---

15 I had observed Elizabeth walking about, socializing and conversing with a group of older Filipinos I had invited to a small house party to answer a survey questionnaire which would be followed by one-on-one interviews. Before conducting an interview with her I would not have imagined her to be as unhealthy as she described as she appeared enthusiastic, happy and sociable.
husband I walk. Make sure we’re out every day. This is when you’re old, you don’t stay home that’s when you get more problems. You go out, enjoy life, you walk, see what you can now, life is too short. We always do it, everyday I’m always with my husband. If after the day ends in the afternoon I play bingo, mah-jong...all these, yeah.

Janette: So you keep quite busy.

Cecilia: They said, my children said they can’t find me now that I’m retired than when I was working. So...make sure we got to church first. That’s my big line then go to church in the morning and then after that (we go) out the whole day.

Most Filipinos were part of some type of social group, whether it was a prayer group, seniors group, Filipino culture group or simply regular weekly meet-ups with friends. Being social and keeping up social ties with friends, both Filipino and non-Filipino, were common activities for many Filipinos. They acknowledged the importance of being social and were very much aware of the potentially negative implications of not being social. For instance, Helen (female, 66 years, migrated at 23) strongly believed that being social is important in warding off mental health issues:

Helen: That’s how you get healthy in aging. Because if you just get (into) yourself—so in yourself and get an introvert that’s how you get all those people so in despair and you know, they are lonely. They get so lonely. I notice it.

Alex also felt similarly and likened his regular social group gatherings as a type of therapy that allows him to socialize, learn and experience new things. He too discussed the importance of being active and keeping up social ties:

Alex: Gardening, I do gardening. Our Seniors’ Club keeps us busy, you know. Sometimes we go on a tour. Visit new places. We meet, you know the Seniors Club, meet once a week. Other clubs won’t meet once a week, they meet once a month. But the Seniors Club is very active. And you go there and you practice some dancing…It’s kind of a—sort of therapy.

In addition to being socially active, many Filipinos felt that an important aspect of health was maintaining independence and being free from physical limitations (n=10). In particular, many Filipinos referred to good health as being free from age-related aches and pains (n=7). Despite many older Filipinos having to manage concurrent chronic illness or the “typical aches and pains of aging” they consistently described social and mental wellbeing as paramount to their
overall health. Among those, three women made specific reference to their own experiences with pain but added that despite living with pain, it was important to cope as best as they could by maintaining a positive outlook and keeping up activity levels (n=3). Norma (female, 65 years, migrated at age 22), when speaking about her current health was very detailed about the chronic conditions she has and all the medications she is taking. She explained the extent to which the aches and pains that she deals with on a daily basis affect her everyday life. For instance, driving which she sees as an important part of her independence can be difficult at times when executing basic skills like checking mirrors and her blind spots. In the exchange below, she describes how she perceives the daily aches and pains she experiences and what she does to cope and manage the discomfort and inconvenience of her pain:

**Norma:** I don’t think you can avoid aches and pains but as long as you can work around it I would call that a healthy aging because that’s part of aging – aches and pains, as long as you’re not totally incapacitated, you should be healthy.

**Janette:** And what sorts of things would you have to do to work around the aches and pains?

**Norma:** Lifting which is hard to do. So I have to change being a left-handed or right-handed person. Bending. I have to use a baby chair so I can sit and do my work at a floor level.

Many Filipinos had different ideas of what it meant to be free from physical limitations. For some, it meant being able to do physical activities for a certain amount of time before becoming tired, such as dancing or gardening (n=4). Dancing was a popular past time for many Filipinos and they often referred to it as a measure of their physical fitness. During an interview with Reynaldo (male, 72 years, migrated at age 28) which took place at a seniors’ group gathering, he explained the importance of maintaining physical mobility for good health, as did many others:

**Reynaldo:** Well you should be able to walk, get up and down no problem. [Gestures to seniors dancing in the distance.] You should be able to dance like this.
Similarly, Norma measured her health according to her ability to dance continually and categorized her “good days” as ones where she can keep up her dancing (line dancing) for an extended period of time without suffering any pains, shortness of breath or heart palpitations.

**Norma:** No pains, and (to be) able to do like, run without panting or with short breath or dance and don’t stop for three hours. Yeah, if I can dance and not stop for three hours, I’m fine.

These symptoms that she experiences from time to time, she noted, also contributed to her feelings of anxiety, so not only was dancing and socializing important for her physical fitness but it also helped ease her occasional symptoms of anxiety or lessened their frequency.

Other activities that older Filipinos identified as examples of living with independence and free from physical limitations included being able to do house chores, including shopping or being able to keep up with personal care routines such as washing one’s own hair (n=3). Equally important was being able to continue participating in the workforce for as long as possible (n=2) or to keep busy in retirement (n=3).

### 7.5.2 Aging in Canada: In Sickness and In Health

When describing experiences of aging older Filipinos had different ideas and expectations of what it meant to grow older in Canada compared to growing old in the Philippines. In the previous section, older Filipinos described their perceptions about their own health. When asked to elaborate on their experiences of aging, many Filipinos re-evaluated their own pre-conceived notions of health and aging and in doing so offered deeper understandings of aging and a re-understanding of their own aging experience and future expectations of growing old in Canada. A number of Filipinos explained that their previous view of being a senior was very different to how they view themselves now as seniors:

**Norma:** Before I got sick I thought I would die by sixty. But now I’m sixty-five and I cannot complain, I think I’m pretty blessed. It’s good in spite of everything...It’s just – I thought I’d (be) done everything by sixty, I don’t want to go past sixty because I thought it would be very old. When you’re young I guess you look at it like it’s very old but now, like I’m sixty-five, I think I’m still young and I look at ninety as very old.
Zenaida: I don’t feel it. I don’t feel like, oh I know that I am eighty-eight, the day after tomorrow. ..[but like my daughter was asking me “How does it feel to be eighty-eight?” I don’t know! I don’t feel eighty-eight. I’m not excited, I’m not. But I am thankful to God I live. I live this long because when I was operated on for the first time the doctors said you’re good for seven years. And on the second operation they said, you’ll live for another five. But that was 1991 and it’s 2012 now.

Similarly, Violeta (female, 69 years, migrated at age 23) evaluated her own experience of the process of aging in comparison to her peers. In comparing herself to others she notes that she has managed to delay the need for certain medications, such as blood pressure medication, that many of her younger peers are taking but also accepts that she cannot escape aging entirely. Like Norma and Zenaida, despite the normal aging process, Violeta considers herself to be healthy:

Violeta: My current health, I consider myself one of the very fortunate people around because I left work at 62 and at that time all I was taking was vitamins and a lot of the people I work with who were even younger than I am, they’ve been taking blood pressure pills, diabetic pills. And even to this day my blood pressure is staying normal. The only thing is, again to me, this is a normal process, where I guess over the years you always get this, I mean you will have this what they call “wear and tear” just like clothes. So my knees I, you know, I could feel—I go out for my daily walks, I’m able to go for long walk but a lot of the times now I feel the tiredness in my knees. Yeah, so I consider that my normal wear and tear over the years. But other than that I consider myself very healthy.

In thinking about aging some Filipinos reflected upon their own retirement or plans for future retirement and the possibility of needing care when they are older and unable to continue living independently. In the case of Erlina, who is considered pre-senior at 57 years old, she has very different perceptions of what kind of care she may expect to receive when she becomes older. Her current perceptions about aging and elder care are influenced by how her own parents were cared for in their old age back home in the Philippines and her perceptions about what aging in Canada will be like for her once she retires, which she says she would prefer to hold off as long as she can. In particular, she describes her fear about being placed in a nursing home by her children:

Erlina: I don’t have parents anymore, they passed away. So that’s why I’m so scared to be—like you know, because back home maybe I will stay there too (there are) lots of relatives that can look after you but in here, of course if your kids is working they’re gonna put you to a home. So back home maybe if you had your money, your pension, then maybe somebody gonna look after you. Just like, what I did to my mom when I—I bring her home to the Philippines then I paid
someone to look after her, yeah. So maybe that’s what I’m gonna do when I’ll gonna get older. That’s what I am thinking—because I don’t have relatives here. I don’t have relatives here it’s just my two kids. So, maybe when they get married, it’s different already. It’s really different once they get married, you know, it’s hard.

Even Violeta, who considers herself to be healthy has considered her future now that her children are moved out and married. Among her future plans for her and her husband is whether or not to downsize her home to live in a condominium. For her and her husband, the house provides the kind of activities that she enjoys and maintains her independence, such as gardening, tending to regular house chores and having the space to do a variety of other leisure-time activities. At the time of the interview she had resolved to remain in her home rather than move into a condominium, which she believes would result in her just sitting at home and watching television. But when she reflects on a future where she will no longer be able to keep up with the upkeep of a house and her usual activities she discusses her options and her fear of ending up in a nursing home:

Violeta: And even that, God willing perhaps maybe down the road when I can no longer do much, perhaps maybe we’ll just you know if we can afford it, hire somebody to come and look after us here instead of us going to a nursing home. And I see it as probably being able to be looked after better than I would be in a nursing home considering the experience that I have, you know, gone through, like I see how other people look after the older people in the nursing homes or in the hospitals for example. So being in my own home where I’m just the only patient that the one I hired is looking after (me) I would feel I will be better cared for.

For Violeta, her desire to stay in her home rather than move into a condominium or in a nursing home makes her consider the possibility of hiring a live-in caregiver for when she is frail and unable to care for herself and her husband. For Violeta, and a few others, they believed that nursing home care was inadequate and held negative perceptions about nursing home or long-term care in Canada. To avoid being placed in a nursing home she hopes to save enough money to be able to hire someone to care for her and her husband within their own home.

Violeta was not the only one to have this expectation of paying out of pocket for private home care services or for a live-in caregiver. In the Philippines, hiring someone to provide care and support for elderly persons was discussed as a common activity and a number of Filipinos
admitted that they chose this option for their own elder parents. For those interviewees whose older parents refused to migrate to Canada so that their adult children could help care for them, they opted to send money to the Philippines to pay for private caregivers. Cecilia, who has negative perceptions of nursing homes based on her own experience having worked briefly in a nursing home setting, had opted to not to put her older parents in a nursing home and instead her and her siblings took turns in caring for them. Here she reflects on her options for when she and her husband are older and cannot live independently:

**Cecilia:** ...(W)hen my mom got sick we never took her to a nursing home or retirement home. We look after them, my dad and my mom. We take turns. We take turns.

**Janette:** So you’ve never considered a nursing home?

**Cecilia:** [Shaking head vigorously.] For me only, eh? Because I’ve seen. I’ve seen...I told my plans to my husband. When we get old, I said, maybe we’ll get a private—somebody because we’re going to paying the two of us. We’ll be paying say $2000 or $3000. We’ll just get somebody who’ll come stay with us and (over)see everything. $3000 a month that’s not bad. You know you’re cared for that way and hopefully my children will help, which I don’t expect really, because they have their own lives.

However, Alex, who at 84 is still living independently, did not share the same fear of being put in a nursing home but rather referred to it as a viable option. For him, the ability to have a variety of options of care when he is older and make the decision about where he would like to end up in his old age is important to his own sense of independence even, as he puts it, in a retirement home. Another aspect of Alex’s independence is the ability of not having to rely on his children to care for him in his older age. Independence, he argued, as integral to his health and his well-being, is something that he believed could not be achieved in the Philippines, as a result of an inadequate pension plan in place in the Philippines or an accessible health care system in contrast to the public pension plan and health care system in Canada:

**Alex:** ...(I)t’s different there. Once you get old, there’s no pension system there. So it’s very difficult to get old unless you have, nice children who will take care of you. Which is—what can I say? It’s not nice to be staying with your daughter in law, relations like that...So unless you have a lot of money when you retire you can stay by yourself (in the Philippines). But here you can always go to the nursing home or the retirement home.
He also noted that in the Philippines the option of retiring and aging in a retirement home or nursing home, is a less common situation than hiring someone who will care for you in your own home. Even among the Filipinos who had the experience of caring for their own older parents while in Canada, they did not consider a retirement or nursing home choosing instead to either provide the care themselves or to pay for help in the Philippines. However, for Alex, living in a retirement or nursing home is preferable to being dependent on family.

Similar to the reflections of Erlina, Violeta, Cecilia and Alex about care in older age, the notion of having to depend on family was viewed negatively. While most of the older Filipinos in this sample lived alone or with their spouse, only a small number were living in extended families consisting of children and/or grandchildren (n=4). Family obligations and the dependence on family members greatly influenced older Filipinos’ self-perceptions and ideas about health and aging. For instance, Teresita, who is living with her adult daughter who is also in her 60s and her sick husband, describes some of the difficulties of growing older in Canada compared to the Philippines. While she receives some home care services once a week, she describes it as inadequate for her and her husband’s needs. She explained that being older in Canada means she has the health care that she needs, she does not have to worry about high cost of medications and hospitalizations or the stress of potentially not receiving necessary care because of a lack of money in the Philippines. To fill in the gaps of her inadequate home care services for her and her husband and her desire for independence, she occasionally looks toward her friends and neighbours for assistance but does so reluctantly. Below she describes her situation that while she has friends and neighbours here in Canada that she could reach out to, it is not the same kind of community of friends and relatives that she had when she was in the Philippines:

**Teresita:** So, we have friends but you see they cannot help us because they are also, like us, they are also old. My two neighbours are very old also. They don’t have —the other one, the Ukraine one have three daughters who are coming to visit them. But the other neighbour only had one child and married with children so maybe they visit them sometimes. We don’t have anybody, any children here but my daughter and my son but some friends also visit us.
Janette: … So it’s difficult to connect to people here unlike, if you were in the Philippines there would always be somebody there for you?

Teresita: Yeah, somebody! I had so many relatives there that can—they’re trying to convince me to live there so they can help me…It’s very hard for me because I have my daughter here and I don’t want to leave her…And my husband is also here. Not like in the Philippines you don’t have treatments there free like here. Living here is good also because if you are already old you have free medicines and sometimes free hospital.

Community and social support as described by Teresita was an important difference in aging between Canada and the Philippines. Teresita also described that having already retired and in her sixties before moving from the Philippines she had a network of relatives and neighbours available to help her if she needs it. Since moving to Canada she guiltily admits that she cannot help her daughter with the cooking, cleaning and the care of her husband like when she first moved to Canada and she does not like to ask for help. While there are some neighbours and friends that she will occasionally ask for help she seldom does so because of the shame she feels in asking, especially since she greatly values being able to reciprocate in kind and often is not able to give back to those who help her and her husband:

Teresita: Yeah. I have plans [to meet with friends] but they are all working so they cannot come. But sometimes their mother comes here to visit me. And sometimes, she still stronger than me, so she can help in giving me food or giving me something or doing something in the house. Some of my friends, yeah. But I ashamed, I cannot do that every time.

The practice of reciprocity or systems of exchange within social support networks underscored many of the narratives about expectations of care and support in older age. Whether elder care was provided in Canada or the Philippines, many Filipinos acknowledged the value of offering help in return, the giving of gifts in appreciation, or the ability to pay for services that provide care and support. For many Filipinos, the idea that they should not ask for help without being able to reciprocate in kind or in terms of monetary exchange was common although the circumstances around elder care and/or support differed.

In asking Filipinos to recall their early migration histories and their experiences of health and aging since migrating, they were also asked to reflect upon whether or not they thought their
health would be different if then had not come to Canada and stayed in the Philippines. Most Filipinos believed that their health would be different if they had remained in the Philippines (n=9), with most of them stating that their health would be worse than it is now (n=7). In contrast, only four Filipinos believed that their health would be the same whether or not they stayed in the Philippines and two were unsure about what state their health would be in if they had not moved to Canada.

There were many reasons given as to why they believed their health would be different if they had stayed in the Philippines. For those that felt their health would be worse if they stayed in the Philippines, they often referred to differences with the health care systems in Canada versus the Philippines, most notably in terms of availability and accessibility of services. Overwhelmingly, most Filipinos felt the greatest difference lies in the financial barriers in the Philippine health care system compared to Canada’s universal health care (n=6). Among those who cited better health in terms of having migrated to Canada, the high cost of medicine and hospitalization in the Philippines were identified as significant barriers to receiving the health care needed to support one’s health as they grow older:

**Alex:** It is very important to maintain your health. (That) you have the medication that you need, hospitals, and all that. You’re being attended to. My life has been extended. Maybe (if) I live in some other place I’d have passed away. At my age I am 83, so I consider myself healthy enough.

Other reasons that Filipinos gave as they attributed to better health since moving to Canada were framed in terms of the quality of life in Canada compared to living in the Philippines. For many Filipinos, they rated the quality of life in Canada as superior than in the Philippines, and often described life in the Philippines as fraught with many hardships and struggles:

**Erlina:** The weather and the work in the Philippines. If you work in the farm it really is different—it’s hot and it’s really physical too. Because I live on the farm, it’s physical.

**Violeta:** Because I come from you know a family who do not have much money and since I came to Canada, food-wise I’ve been able to eat all the kinds of food are available and I can afford it.
Food was a subject that was brought up in interviews as an important material experience and tangible symbol in migrating for a better life. Whether it was the lack of or poor quality food in the Philippines versus the availability and convenience of a variety of foods in Canada, food was a very relevant and important aspect of their health and quality of life. For some Filipinos they shared stories of the difficulties they first encountered when they arrived in Canada. As Violeta notes about the importance of food in her quote above, she explains earlier in the interview the type of difficulties she first experienced when arriving in Canada in the 1960s:

**Violeta:** …The one problem that I encountered mainly would be the food. Yeah, I’ve been looking for, you know, the Filipino foods that you’re used to eating which at the time they weren’t available. But other than that, again it’s not really all that much of a problem (migrating).

Filipinos discussed how food was very expensive in the Philippines but in Canada, especially in a multicultural city like Toronto, food was more accessible and affordable, even foods and food products that are native to the Philippines. Some Filipinos, who were part of a seniors’ group, discussed how they looked forward to the group trips and excursions where they were often given a food allowance to indulge in food buffets or ethnic restaurants. To be able to indulge in a variety of foods was highly valued and regarded as emblematic of a life lived well. Food was not only a comforting symbol of home or living the *good life* but was also an important means of participating in the practice of reciprocity towards guests and within social circles. For example, Edgar, who during the course of the interview gave a tour of his kitchen in his small apartment in the seniors’ building where he lived, discussed the theme of food multiple times. For him, he had a hearty and generous approach to food in terms of both his health and in showing his hospitality:

**Edgar:** Now I am preparing myself to cook the rice now because my friend, she just called and she’s coming tonight, yeah. So I have to cook something...because my friend is fond of – *[Laughs as he opens his freezer to show me some food]* – so I have to bring out the meat because she likes this. See? Look at that. Oh, see? See? *[Showing more of the food items in his freezer]*? Okay I have to show you...You like ice cream? I have ice cream too, you like? See? This is how I keep myself, I have to maintain it in my food. I do not observe austerity for my food. I buy anything that I want to eat. When will I eat? When I can no longer eat? I eat and I eat until I can
no longer, I have my limitations. Not because you want to eat, you have the craving you keep on eating but that is disastrous to your health. Is it not?

Although many Filipinos enjoyed food heartily, they also recognized that overindulging or poor food choices can lead to poor health outcomes. Alex acknowledged the gap in the knowledge about diet and nutrition in the Philippines. His own health experiences made him reflect on poor quality foods of the traditional Filipino diet and what it has meant for his health now in Canada:

Alex: Since I have some health problems I look for a better diet, look for a healthy diet. Before I used to eat lechon (roast pork) you know, those salty foods, but when you get sick you learn to take care of yourself...When I got sick I was hospitalized for angina they call that. The heart pain. So I was advised to take a good diet, I think our diet back home is not that healthy. We’re used to eating salty foods and fat; fatty foods. We don’t have a nutritionist who will advise you those are bad foods or you know there’s supper back home, you eat almost anything, you know. We don’t think of fatty foods or things like that.

For many Filipinos, the extent to which their quality of life and health would differ if they had not moved from the Philippines was dependent on the type of life they had before they moved to Canada. For example, Erlina and Violeta discussed some of the hardships they encountered in their lives in the Philippines but others recalled having a life that was not as difficult and who had more opportunities available to them than most Filipinos, such as being able to afford an education. So while Erlina spoke about the kind of life she had prior to moving to Canada as having had to survive in a rural setting working on a farm, other Filipinos shared very different circumstances. For example, Elaine (70 years, migrated at age 35) lived in Manila, the capital city of the Philippines before migrating to Canada. Growing up for her it was normal to have maids and other help living at home to attend to the care and running of the household. For Elaine, she remained unsure about whether or not her health would be any different had she stayed back home in the Philippines:

Elaine: I think—I don’t know, because if I’m in the Philippines, I have maids, I have everything also there. It’s the same.
Before immigrating to Canada, Elaine was already married and had small children and as most of her relatives and friends moved to various parts of North America, she and her husband decided to follow them as well. Emilita (65 years old, migrated at age 23) also was unsure about how her health would have progressed had she remained in the Philippines. Like a number of Filipino women, who arrived in Canada in their early twenties (n=4) recent university graduates in search of international work experience, Emilita commented that most of her life she has lived in Canada and could not envision what her health would be like if she stayed in the Philippines:

**Emilita:** I can’t say because you know I started here when I was 23 years old. Everything is just starting in life. And yeah I didn’t come from a family that was riddled with diseases. Like my mom and dad...my mom is still alive, she’s 95.

Among those that stated that their health would be different than it is now if they had stayed in the Philippines, two reported that their health would in fact be better. The reasons given by them were vastly different and were very much unique to their own experiences in the Philippines. For instance, Douglas (70 years old, migrated at age 30) explained that his health would be better partially because of the job he left before migrating which was teaching at a government university that had a hospital that employees had access too. However, he quickly added that if he were to have retired from his job in the Philippines he would not have the same access and the cost of medications would be a significant barrier. He admitted that he has not experienced any barriers with accessing health care in Canada and yet still he believed that his health would be better if he remained in the Philippines. For Douglas, being socially active and engaged was extremely important to him and his overall sense of wellbeing. He recounted the network of friends back home in the Philippines, many of whom were university and work colleagues and remained there. He describes his current health as poor, despite having ease of access to medicine and health care, and spoke sadly about how much his poor health and experience of aging overall has affected his ability to be as socially active:

**Janette:** Overall, what would say your experience of aging in Canada has been like?

328
Douglas: I would (say) relatively it’s okay because I have friends in the mall. I spend some time drinking coffee (with them) and, you know, I used to do that regular but now I do it once and a while.

Janette: Is it just because everybody is busy or are you busy?

Douglas: It’s my illness that prevents me. Sometimes I don’t feel like going out. Yeah, I tire easily… I realized earlier that I have to accept that I’m aging. There are things that I used to do that I cannot do anymore.

Teresita also believed that she would be healthier had she stayed in the Philippines, and as described previously, she explains that she would have a broader community to offer the help and support she needed as she ages. Additionally, she described the change in climate, having migrated at an older age, as a significant factor in her poor health, more specifically the rapidity of her declining health. Overall Filipinos referred to the weather as being an important factor in their migration experience and although a vast majority described the cold weather as a shock initially they have come to accept and adapt to the cold weather conditions of Canada. However, for Teresita who suffers from mobility issues, she describes the weather as being a major reason why her health has worsened:

Janette: Do you think that your health would be different if you didn’t come to Canada?

Teresita: Yeah! [Laughs] Maybe, because in the Philippines it’s hot. It’s not as cold as here. When I came here I’m still strong. But year after year I’m becoming lame because of the cold weather… in the Philippines [I] have so many relatives to help me to do all the things… but here in Canada the hardship is nobody can help you here except you to do the thing. I have to do it myself. If I can do it, I do it, but if not I just leave it alone.

Her reflections about her declining health provide one of the few subjective accounts of the healthy immigrant effect among older Filipinos. For some Filipinos, the severe climate change made for some difficult circumstances for older Filipinos as they continue to age. For example, Teresita who finds the cold weather at times aggravates her osteoporosis, which said had developed when she arrived in Canada.
In one other account of the healthy immigrant effect, Reynaldo refers to experiencing too much of the “good life” in Canada, describing some of the unhealthy habits he adopted that perhaps contributed to his cardiac issues:

Reynaldo: Good health? You don’t have no aches, no pains, nothing. Although, I had an angioplasty done. That’s because of bad eating habits. There’s nothing in my family about heart problems. Nothing. And I guess the good life, took care of me. Too good, yeah. I was eating steak left and right, hamburgers and sometimes cooked with butter. Then, in 2000, but I’ve gotten passed that now.

Despite his recent health issues which he says progressed while in Canada, he credits having a good doctor and access to medication for the proper management of his chronic health issues. When asked to consider what his health would be like if he were still in the Philippines, he hesitantly suggested that his health would be worse with the cost of care and medications, but also noted that much of his health issues were due to some of the poor habits he picked up while in Canada. Although Teresita and Reynaldo provide their own subjective experiences that suggest a healthy immigrant effect, in general most Filipinos believed they are better off in Canada in terms of their health and wellbeing.

7.5.3 Health Care and Aging: A Matter of Life and Death

When talking about their health, Filipinos’ discussion often made reference to health care access as well as their own perceptions and comparisons with the Philippine and Canadian health care systems. Many Filipinos had very strong feelings and opinions about the state of their health and health care while aging in Canada. In general, all Filipinos in this sample felt that Canada’s health care system addressed their health needs and concerns speaking more favourably about health care in Canada than in the Philippines. Describing the ways that Canada’s health care system met their own needs they cited a number of system-level health determinants they believed strongly contributed to their current health status and aging experiences. For instance, some Filipinos discussed having access to publically funded services as well as provincial and national aging programs in Canada, in terms of receiving a pension (n=6), having easy access to
health care whether it was fully or partially subsidized medical care, prescription medicines or home support services (n=9). They recognized Canada as a pro aging society with numerous benefits for seniors (n=3). Many Filipinos were fortunate to have some type of pension or retirement benefit or supplement having worked in Canada, which they identified as an important difference in the aging policies of Canada versus the Philippines. Reynaldo described his own comfort with aging knowing that he has a pension to support him as a senior:

Reynaldo: It’s okay. To me it’s okay but I don’t know about other people. I had a good pension that’s one of the things that’s helped a lot…Take for instance my mother in-law when before she died. She’s just got all this pensions, right, and she’s living alone she gets to travel to the Philippines once a year. Can you imagine how much that is?

Similarly, Helen who is looking forward to retiring in the next year was also very optimistic about her later years, choosing to focus on the present moment and cope with situations as they arise. Her optimism for a retirement of leisure is based on the knowledge that she and her husband have adequate pensions to supplement them in their later life:

Helen: So far it’s still good, right? I am very independent. I go out. I drive. And I find it good so far. I always go wherever I like and because I’m working too I am okay. And because I’ve worked full-time all along I’ll be having a good pension and I can see it. That is why I will still be travelling. My husband worked as well before so I’ll be okay. Yeah and my kids are all educated now so that’s fine, they can all look after themselves. I’ll be okay. Yeah and my kids are all educated now so that’s fine, they can all look after themselves. I’ll be okay. We will be okay, I mean – my husband and me. In terms of aging, I’ll take things as they come and keep myself healthy and keeping myself socially active and mentally up to date with all these current events that’s going on. Keep on reading, things like that. Keep your mind active. And eat a lot of food that’s good for you – the whole thing.

With regards to health care most Filipinos acknowledged that they have easy access to medical attention and to medications in Canada, which in the Philippines can be costly. A number of Filipinos emphasized the importance of having the financial resources to pay for medical care in the Philippines. As with most Filipinos in this study, Alex reported having access to a regular physician and could not recall any difficulties in trying to access care at any stage of his life in Canada. His only complaint was the long wait in the emergency services department but admitted that it was only a few times that he has used those services and to him, this was minor compared to the barriers one would have to face if they were seeking care in the Philippines:
Alex: If you were in the Philippines (it) is even worse, you got to have a doctor and if you don’t have money you’re out of luck…But you gotta have your money. You don’t have your money, you’re out of luck. So if you just imagine how many percent (are) not able to get healthcare.

Despite the general consensus that individuals can expect greater accessibility and availability of health care services in Canada than in the Philippines there were some doubts expressed by some Filipinos about the nature of care or type of care in older age. Yvette (73 years old, migrated at 30 years of age), described herself as being healthy and having access to doctors and hospitals, but once her workplace comprehensive health insurance ended she observed that many of the health care services that were no longer covered are the ones that were more vital in later life. She and her husband now have to pay for private health insurance which reduces their income:

Yvette: With our situation now because, as you know, we’re healthy and hope, you know God willing we will stay healthy, you know when it is time our health insurance you know the supplement was discontinued at age of 65 so when it comes to vision, dental and what else is the other one that was not included... We have to pay that from our own pocket. I wish, you know, where we worked before in the hospital that should be a lifetime because we need for our dental, our eyesight. When you are growing older your eyesight is deteriorating too so...Yeah, we don’t have any private insurance, and we have to take our private insurance with our small pension from the government and our workforce. It’s just enough but you know we should have had, you know, a free, not a free but some help from the government. We don’t have any except for the OHIP. We hope to stay healthy [Laughs].

Similarly for Zenaida who compared the financial burden of surgery in the Philippines to Canada was grateful for Canada’s health care system during her times of poor health, although being sick also meant having to pay out of pocket for maintenance medication:

Zenaida: In the Philippines for the first operation, I spent almost including the dress on my back. But in here when I had the second operation I spent only for my telephone bill and a $100 worth of gifts to the nurses as a thank you gesture. I did not have to pay anything. That made a big, big difference. And my medicines are—there are only a few that I have to buy and they are very expensive. Something for my eyes; something for my heart; something for my gums—oh many things! But I managed to be up and about, that is what makes me thankful to our maker…Well I have many ailments but thank god I am able to go about most of the time. I am happy to be here, speaking of health, because I am looked after very well. The government gives me—has given me a homemaker since 1991. Although the range of, the extent of the help is limited, more limited now, I still welcome it because well I think even putting up my head and washing my hair is tiring. I would have to stop and somebody does it for me twice a week and uh, I think that has lengthened my life—somebody helping me with things.
Zenaida explains that despite the costs of prescription medicine in Canada, she agreed with many other Filipinos in this study who believed that growing older in Canada is better than growing older in the Philippines. Zenaida praised the Canadian government in their approach to seniors in society and in particular is grateful to have a subsidized personal support worker visit her once a week to tend to her personal care and hygiene.

Overwhelmingly, most of the seniors viewed Canada’s health care favourably and were very satisfied with the accessibility and quality of health care in Canada. Among those that reflected on medical care some commented about the lack of quality of doctors in the Philippines compared to Canada. As well, they praised modern facilities and state-of-the-art technologies of care found in Canadian hospitals. Expanding on her own experience with navigating health care in the Philippines and having to contend with the high cost of life saving surgery, Zenaida again emphasized the enormous financial obstacles to care and the poor quality of care in the Philippines which she attributed to the loss of quality personnel due to the brain drain of medical health professionals:

Zenaida: Well with the scarcity of—no not the scarcity—the cost. The cost is exorbitant! Imagine with my operation I spent more than three hundred thousand. And more because of the recuperation period! And this, also the scarcity of doctors because they all want to come here abroad. Yes, the quality doctors would rather come here and you find difficulty finding affordable and really good doctors.

While many Filipinos were generally satisfied with health care in Canada, there were some criticisms offered, particularly among those who worked in the health care industry themselves who felt that with budget constraints and the restructuring of health care has affected the quality of care. Cecilia, who worked many years as a nurse described her own experiences of overnight hospital stays and the level of care that has declined since her early years in the nursing profession. When asked to describe any difficulties that she encountered as a patient she recalled that despite the modern facilities and technologies of Canada’s health care, she would prefer the patient-centred approach of care in the Philippines:
Cecilia: Not (in) earlier times, you know like in the 70s and 80s. But when I was in the hospital the last time this was in 2000, you know what because probably a shortage of nurses or health care personnel, I noticed. You know that in my career, I always liked my profession – I enjoy it. Even how hard it is! I told them that the only the time that I could say that I don’t want to see what is going on (in health care) then I will retire, which I did.

What is noteworthy about her description of the quality of care in Canada is that she felt deeply conflicted about her own experiences and perceptions of health care and her expectations about how she will be cared for as a senior while living in Canada. She regretted that the financial cost of health care in the Philippines was the greatest obstacle to receiving the type of care that, in her perspective, is empathetic and puts the patient first:

Cecilia: Worse financially because if you can’t afford it. If you can’t afford it, it will be worse. But people who are rendering the care, if they only have the facilities that we have in here (in Canada) you’re better off there. Because people there are not only doing for the money you could see the empathy, you could see the feeling of helping you could see it there. I’m sure here too, eh. Here, you are better off here because you have everything – you have all the facilities, all the drugs, all the things. But if I will bring (what) this country has to the Philippines maybe the difference is the people, who is rendering the care. But if you, if this is the Philippines and this is Canada and both of them have the same facilities and all the things that they need, between the two, even I’m Canadian I’ll go Philippines.

One of the most salient themes to have emerged from the health and aging narratives of older Filipinos, as they reflected on their migrant experiences in the context of their own health and aging, was that of life and death. Amid their own perceptions, self-reflections and understandings about their health and aging in Canada they often framed these experiences in life and death terms. This was most evident when Filipinos shared their ideas and beliefs about their access to health care and their ability to afford much needed care.

When asked to consider what their health would be like had they stayed in the Philippines many made reference to shorter life expectancy or early death. So certain were they in their convictions about their health that often they spoke with a deepened sense of gratitude for migrating from the Philippines and for socialized medicine in Canada. The theme of life and death weaved its way throughout many of their accounts about what it meant to age and live as a senior immigrant in Canada versus the Philippines citing their own health and aging experiences.
and those of their friends and relatives. While expressing a sense of appreciation for living in Canada there also was a sense of sadness conveyed in their narratives. Many came to the realization that if they ever wanted to return to the Philippines to live out the rest of their senior years there was the understanding that they would do so at an extreme risk to their health and their hard-earned financial wealth. In some ways, seniors very simply stated that life as a senior is very different in the Philippines than it is in Canada. For Alex, he viewed Canada as very much an age-friendly country, crediting his own longevity to having migrated from the Philippines:

**Alex:** …I feel grateful for being here and getting older. I’m still–I still am healthy enough at my age and I am grateful for the government that takes care of older people. You get benefits and the government recognizes the older people. They recognize their former contribution to society. We get discounts from the stores.

But when he thought about living in the Philippines as a senior he solemnly added that, “(i)t is wrong sometimes in back home. You can get sick very easily there.”

Many Filipinos described similar situations when seeking medical care in the Philippines. Even before being admitted into a hospital, they needed to provide a down payment for care to be received without first being assessed for diagnosis for their health problem. Emilita discussed her most recent visit to the Philippines along with her mother and the experience of seeking health care services there:

**Emilita:** Recently with my mom, yeah because my mom is a Canadian citizen, she’s been living here for almost thirty years. So she got sick last time (in the Philippines) with the high blood pressure and we were flying back here. So I had to bring her to the hospital and they said I need a down payment of so much, so much, you know? In the Philippines, yeah! Because when you going there you have to have the cash money just to hospitalize her to lower the blood pressure because I don’t want to take her in the plane with the high blood pressure. So it’s really not good.

A number of Filipinos who considered what their life as a senior would be like if they were living in the Philippines believed they would have long been dead if they had not migrated to Canada. Even those who migrated later in life also believed that their life has been extended precisely because they left the Philippines. Often they made references to the high cost of living, natural disasters, unstable politics and widespread poverty in many regions of the Philippines as
reasons why life in the Philippines was difficult. With the lack of aging policies supportive of seniors and a glaring class divide in aging experiences in the Philippines, many Filipinos strongly believed, that in comparison, Canada was a better place to live if you were a senior. This assertion was based on their ability to afford and pay for health care in the Philippines, as such, one of the most commonly cited reasons for why Filipinos believed they would not survive in the Philippines in older age was the financial barriers to health care.

Many Filipinos discussed the challenges of living and surviving as a senior in the Philippines, sharing their own experiences or the stories about relatives who remain back home. Alex discussed his views about his health if he were still living in the Philippines and summarized many of the financial hardships that Filipinos face:

Alex: Maybe I’d been long dead. Back home there’s no medication and looking for a doctor it will cost you thousands of pesos. Yeah, if you have an operation or something, major operation, you will be spending thousands! But if you don’t have the money what do you do? Nobody can help you there. But here, there’s a health care system that you can use and you don’t spend money because you pay health insurance, right?

Similar views were shared among Filipinos where they identified having the wealth and financial resources made the difference between life and death as a senior in the Philippines:

Elizabeth: They would die without money. If you don’t have money in the Philippines you’ll die. They will not cure you. Before they start curing you they want to know if you have money to pay.

Edgar: Probably If I waited in my country, probably by this time probably I would already be in the grass, six feet below the ground…Yes. That’s the way I size it up. Premonition. Because, the weather is very hot. And then high cost of medicines, high costs of medical fees, so unlike here if you get sick. Here you can easily go to your family doctor and get some prescription, or you go to a specialist, like (with) my cataract.

Although the intention of this study was not explicitly about older immigrants’ perceptions of death and dying many of their discussions returned to this theme when relating to their health in Canada versus the Philippines.

For many Filipinos they could not imagine living in the Philippines with their current health issues. Only one Filipino mentioned the most recent change in aging policies and senior
positive social programming in the Philippines with the Expanded Senior Citizens Act of 2010\(^\text{16}\).

Under this act, seniors receive a 20 percent reduction, including exemption from the value-added tax, with most goods and services including medical care services and prescription medications.

**Yvette:** … in the Philippines they have a medical insurance too for seniors and when we went home we even applied for a senior’s card, that if you will be hospitalized in the hospital, there you have 20 percent. It is a good improvement since we left.

Yvette was one of the few Filipinos in the sample that made regular visits to the Philippines (at least once a year). She and her husband both have Canadian and Philippine citizenships and co-own a house in the Philippines that she shares with other family members. However, despite recent improvements in the Philippines with aging policies and social programming, Yvette has no plans to live out her senior years in the Philippines stating:

**Yvette:** I don’t have any worry at all, because we are settled here we are comfortable this is where I grow up. [*laughs.*] Half of my life (was) in Canada so I don’t think (I’ll go back home). It’s a big adjustment if I go home. I’m settled here with my children. I have all sisters all around the United States and they’re all coming here every Christmas and New Year and summers. My in-laws are coming here for visit.

As with many Filipinos in this study, being close to family remains a very strong influence on decisions in later life, and in particular, the decision to remain in Canada as one grows older. Though some Filipinos admitted that aging in the Philippines meant having a larger community of friends, neighbours and family that they could turn to for help, they were reluctant to leave their families in Canada.

---

\(^\text{16}\) On February 15, 2010, the Philippine government enacted the Republic Act No.9994, known as the *Expanded Senior Citizens Act of 2010*. Under this new policy the Philippine State outlines several important amendments to previous aging and social policies that is meant to directly improve the lives of senior citizens (adults aged 60 years and older). In particular, Section 2 of the Act endorses a senior positive approach with a social justice clause, with regards to how the elderly are treated and perceived by the State and the public, stating: "In accordance with these objectives, this Act shall: (1) establish mechanisms whereby the contributions of the senior citizens are maximized; (2) adopt measures whereby our senior citizens are assisted and appreciated by the community as a whole; (3) establish a program beneficial to the senior citizens, their families and the rest of the community they serve; and (4) establish community-based health and rehabilitation programs for senior citizens in every political unit of society."

**Source:** "RA 9994 - The Expanded Senior Citizens Act” URL: [http://www1.umn.edu/humanrts/research/Philippines/RA%209994%20-%20The%20Expanded%20Senior%20Citizens%20Act.pdf](http://www1.umn.edu/humanrts/research/Philippines/RA%209994%20-%20The%20Expanded%20Senior%20Citizens%20Act.pdf)
7.6 Aging and Attachment to Place

7.6.1 Adjusting to Life in Canada

Very few Filipinos expressed having difficulties adjusting to life in Canada, regardless of whether they migrated at a younger age or in later life. Surprisingly, most could not recall any major difficulties in their early migration and settlement experiences. Many Filipinos arrived at a time when finding employment was relatively easy, regardless of their level of educational attainment, although some expressed frustration that they were not initially hired because they lacked Canadian experience. Depending on the kind of work they were seeking, most Filipinos stated that they were able to find employment within months (some within weeks) of arriving in Canada. There were more stories describing the numerous opportunities available to them, which allowed them to accumulate wealth, make the social connections and networks, bring other family members to Canada and live a relatively better life than they would have lived if they remained in the Philippines.

With respect to language and communication barriers that are often cited by newcomer immigrants and confirmed by key informant results in this study, most Filipinos in the sample experienced little difficulty. Many arrived in Canada with English language skills and the only difficulties they described were adjusting to local customs and colloquialisms. Cecilia and Yvette discussed in detail some of the challenges they experienced when first arriving and working in Canada:

**Cecilia:** You know, you have to adjust to the English (here), although you understand but it’s the intonation, you know it’s really different cultural-wise, eh, because our culture’s different but you really have to adjust to them, even at work. I don’t even wanna answer the phone at that time, you know because their accent is different, like you really have to (listen)...and they (talk)...fast! You really have to react when you’re on the phone and they say “Hello...dadadada-da.” You can’t hardly understand them...You know when they speak in the Philippines slowly, it’s not really fast, (even) if it’s in English. No that was the thing that I had difficulties with when I first came here.

**Yvette:** In the first time, because we don’t have any relatives and the adjustment and the culture...As you know, when you work in the hospital you have some issue with the language barrier. Our second language is English but they have accents and so it’s difficult for us to (communicate), otherwise we are comfortable? ...We adjust. We adjust.
Periods of adjustment for many Filipinos were relatively problem free and short, often described in terms of months. It would seem that many Filipinos, regardless of their age of migration, had few struggles in adapting and adjusting to life in Canada. By most accounts, Filipinos could not explain specifically why they found it relatively easy to adapt to or integrate into broader Canadian society. With the exception of one Filipino (Teresita), all described being immediately immersed in the cultural, social and economic life, having family and friends already in Canada and being able to secure employment. Many of them spoke matter-of-factly about migration adjustment as a necessary and inevitable process. Despite some of the workplace challenges that she experienced as well as coping with vastly different cultural and class values within the Philippine and Canadian health care systems, Cecilia offered her explanation of why she has fared relatively well. She discussed her beliefs and attitudes on immigration and settlement with both the broader Canadian culture and in the workplace as a nurse for a busy, urban hospital where she admitted that she was one of two women of colour in her department:

**Cecilia:** You know here, when you be able to adjust, first of all, to be happy in one place you really have...if you are here in Canada, do what the Canadians will do. You don’t insist your culture. You, only if they ask you or you want to show them. It’s not like I have to do this because I’m Filipino. If you are intending to be happy and stay here you have to live with them. You have to adjust to their culture and you know you don’t...we are only a small fish in the ocean. This is their county. Now it’s our country because this is us now. I’m very proud to be Canadian, really. It’s not that I don’t like Filipinos, no. There are other cultures, other things that I can’t leave behind. But to improve your life you really have to see what’s in here that you could embrace and be happy. I like it here very much.

Even for those Filipinos that arrived in Canada in later life, such as Zenaida, there were very few difficulties that they experienced when first arriving to Canada. As she described her and her husband’s experiences with adjusting to life in Canada, she noted that she connected with the Filipino community almost immediately, many of whom were familiar to her as they all had come to Canada as well:

**Zenaida:** It’s like throwing a turtle into the water. As soon as we came I saw that the members of the seniors’ association were all my friends, they were my friends in the Philippines! Some of them worked under my husband, so we already adapted.
Many Filipinos recalled being drawn to idealized imaginings of Canada, many of which were described by relatives who migrated before them. Among these ideas about Canada, Filipinos envisioned a country that was spacious, clean, peaceful and grandiose in nature. Naturally, many Filipino seniors commented about having to make adjustments to the cold climate and weather conditions of Canada when first migrating. The weather was a common complaint, particularly in the early stages of post migration when many of them began job searching. Emilita recounts her earliest experience with job hunting in a foreign land before online job searching became commonplace:

**Emilita:** The climate. It was the most difficult thing. You know when you are you know you have to look for work without all this mode of, like looking for work now. You don’t have the internet you just have to go personally to every…go from hospital to hospital. And that’s kinda hard because you are commuting in the winter.

While many Filipinos missed the warmer tropical climate of the Philippines they also discussed that coping with the cold weather was a minor issue compared to the rainy seasons that afflict many parts of the Philippines, which often results in flooding, landslides and many other natural disasters

**Alex:** It’s nice…Canada is I think the best place to stay. Weather-wise or we don’t experience all these calamities that you experience in other countries. You only experience the cold but you can manage yourself. You don’t experience these floods, earthquakes, tsunami…

As well, some Filipinos felt that living in Canada during the winter season was especially difficult in older age. For instance, Teresita explained that although she is now used to the cold, it still affects her physically and she strongly attributes the cold weather to her increasingly weakened state and mobility issues:

---

17 Annual rainstorms, flooding and other natural disasters, which have increased in intensity over recent years, are a real fear among many Filipinos. During interviews, a number of Filipinos referred to the eight-day rain and thunderstorms in August of 2012. Many were glad to no longer be under the threat of the devastating floods and typhoons, but were also very fearful for family members left behind. Most recently, Typhoon Haiyan (or locally known as Typhoon Yolanda) deemed one of the strongest storms on record hit central Philippines in November of 2013.
Teresita: It’s so cold here and that’s why maybe I got this sickness of mine. [Laughs]…Yeah, even if you wear so much clothes. It’s always so cold. Not like in the Philippines. It’s not cold. It’s a little bit hot. And only in Christmas time, December, that it’s becoming cold but not the whole year. But now, oh my God, in the Philippines is always raining…You really don’t want the rain in the Philippines like because of the flooding. Too much rain, it would be flood.

Teresita admitted that her life might be easier if she were living in the Philippines but remains in Canada because of her family. However, as she noted above, having to contend with the climate of the Philippines is a risk she also wants to avoid. She admitted that when it is snowing outside she stays indoors, content to watch television as long as she can view her daily locally, televised Catholic mass. In describing the emotional conflict she experiences with her desire to be “back home” in the Philippines versus “home” in Canada with her family, as most Filipinos in this study did, it revealed the difficult decisions that many older immigrants must grapple with having to age in a foreign country.

7.6.2 At “Home” in Canada but Longing for “Back Home”

Among this sample of Filipinos, most gave generalized reasons for why they chose to migrate to Canada and many of which involved family. However, as they reflected on their lives in Canada and contemplated their future, they discussed the ways in which their original plans for migration had changed and shifted over time. A number of Filipinos admitted that they were not sure how long they intended to stay in Canada, often stating that their original plan was to work just enough to gain international experience or to earn enough money to live comfortably in the Philippines with no thought of considering Canada home. But when asked whether or not they felt that Canada was home to them, overwhelmingly, all Filipinos agreed.

Often describing and connecting to Canada as “home” and the Philippines as “back home”, Filipinos’ attachment to place, formed through memories and experiences both to Canada and the Philippines were most frequently related to their networks of family and social relations. In recalling some of their initial reasons for migrating, often with the original intent to return back
to their home country, many recalled that over the years their lives shifted and became more complicated:

**Norma:** Well, it was my first taste of freedom and it was a—like exhilarating and I kept doing that for quite (awhile), like maybe six years? Ten years? And then, settled down to have (a) family and it’s still fun because (I) still party, (I) still meet the same group of people, so it’s just like, just my home.

Like Norma, Filipinos who arrived at a much younger age, in their 20s or 30s, were satisfied with their current lives in Canada. Norma, who has spent more of her years in Canada than in the Philippines, describes feeling a stronger connection to Canada as her home than the Philippines. Over the course of their lives, many Filipinos who came to Canada in their younger years have since had other family members from the Philippines make their way to Toronto, other parts of Canada or the U.S. such that the location of family and social relations has become more proximal and they often explained that the desire to go “back home” had diminished.

Even among those that make yearly visits to the Philippines, their perceptions of “back home” have been informed by their knowledge and experience of health care in both Canada and the Philippines. As Edgar reflected on the experience of his Filipino-Canadian friend who, on an extended trip to the Philippines, ended up sick, he talks about his own fear of getting sick while visiting the Philippines:

**Edgar:** I know a lot of seniors (who) just stay in the Philippines for two months, three months – they get sick. Because this is a tropical country, it’s really very hot in my country. That’s why I – actually I was contemplating to go to the Philippines for six months for a change of my whole denture. Yeah, but then I got scared because I was talking to one senior Filipino who said “Oh Edgar, if you go to the Philippines just spend your vacation there for one month, I stayed there for six months and I got sick”. Medicine is very expensive, medical fees very expensive. So everything is very expensive. Look at that, I was scheduled to go, last time I was there was in 2008 when I had my diamond here. So – but I only stayed there for one month.

Throughout the interview, Edgar demonstrated the numerous ways he saves his money, keeping emptied juice cans for dollar and two-dollar coins, his collection of public transit ticket fares and explaining his frugal shopping strategies. All of which were meant to help him budget for his regular trips back home. However, there was a sense of sadness that underscored many of
the experiences he described, including his intentions and future plans as he grows older. As he reminiscenced about the loss of his wife, his long career with the government and the many friends he left back home in the Philippines, he longingly wished for the same life he once had, despite having many friends and being well connected to the community in Canada. He compared the sense of community and family ties in the Philippines to that of Canada, describing how the social networks of family and community in the Philippines are closer. In describing these differences he discussed his relationships with his adult children who are currently living in Canada but had recently moved to a suburban city outside of the Toronto. He sadly commented that he rarely sees them and his grandchildren and has little communication with his children back home in the Philippines:

Edgar: (I communicate) through the computer but because they are also busy sometimes I give some tongue lashing because they do not even bother to write me. Because they have their family, they are really busy, yeah, especially my eldest son is a very busy lawyer and every now and then—he goes to the courtroom, he goes everywhere, that's why he is really busy, has no more time to write me. My youngest son, the same with my daughter, yeah. You know if you (are) a family person you will experience that, that once you get older you don’t expect your children to be always at your side. Yeah, that is true to everybody – that’s why most of the parents that are old, they're being dumped in the home for the aged, especially in Toronto.

When asked if he would consider living in the Philippines now that he is retired, for a second time, he explained that because of the high cost of living in the Philippines that he would be better off in Canada, having earned a pension and access to health care and medications that he needs, even though there is the possibility of ending up in a nursing home. This may partly explain the remarkable measures he takes to ensure that he is physically, mentally and socially healthy.

Similarly, Elizabeth also shared her views of family ties and obligations as she ages in Canada. When she first arrived in Canada in her late 30s she explained that her and her husband’s decision to migrate from the Philippines was specifically for her son, in order to provide him with as many opportunities that he would not have had if they continued living in the Philippines. Her son who at the time of the interview was living in the United States, as well many of her own
close relatives live either in the Philippines or in parts of the United States and Australia. However, despite the distance between her and much of her family, she describes her intention to remain in Canada because of the health and social care available to seniors. In the long excerpt below she describes how she feels she is in a very good position to be aging both in terms of accessibility of health and medical care as well as in her state of mind:

Elizabeth: Are you kidding me? Here – health insurance is good! Health care is good. I don’t want to go home to the Philippines… I like to go to the Philippines every now and then, having holiday (but) I wouldn’t want to live there. I don’t want to get sick because all your money will go to the doctors and the hospital there… We can take care of ourselves. (My son) worries a lot about us because we are getting old but I say, “No don’t worry because we have great care in Canada.” We have home care too, I say to my son, because he worries a lot, maybe because he’s an only son maybe he’s thinking of us. So, I just say, no don’t worry. He wants to take us (to California), he will pay $500 a month for our health insurance there and I say, “No we better stay here in Canada.” I don’t worry. I have very much faith in God. I don’t worry. If I lay down and sleep, I don’t think about the future or anything because it will make me sick, like I cannot sleep then you will have headache. When I was younger I worry maybe because I have to think about all that. Now, no! I don’t worry, no more stress!

While the theme of death was mostly discussed in the context of health care access in terms of the affordability and availability of health care in Canada versus the Philippines, underlying these very deliberate discussions about death and dying was the notion of dying away from home. Even when discussions skirted around issues of death and dying in a foreign land, many Filipinos did not raise concerns about not being buried back home as a few mentioned having already bought burial plots in Canada. Such as Yvette, who shared her own funeral and burial plans for herself and her husband, when asked to explain whether she viewed Canada as home she said:

Yvette: I believe so because our families are here. As a matter of fact, we’ve already got in the memorial garden – our plot for our (burial) in the years to come. Yeah because I don’t think we are going home as I said all my children are here, so I believe we will settle here. I have my sisters at home but they’re also getting elder you know also.

Like Elizabeth, Yvette also initially came to Canada for her young family but remaining in Canada was not part of her original plan. While Edgar and Elizabeth described staying in
Canada because of health care, Yvette explained the importance of family in her decision to remain in Canada even though her family is now grown:

**Yvette:** We (had) a comfortable life in the Philippines and because, as I said because of the kids, with a good future for them we decided to come. So that’s the main reason but we—at home now it’s so difficult to have five children and to send them to university – it’s too difficult, I think, if we were in the Philippines...Oh, the first two years, we were thinking of you know going back because of the adjustment even. The housework, when you (can) have a maid at home, [laughs] we do everything here we have no help and it’s too expensive for me too. During the time there is no such, you know, caregiver that could help you out. And besides, I don’t have any, as I said, I have no relative around, but we survived.

Yvette also compared the differences in lifestyles in the Philippines to that in Canada and her early experiences coping with the hardships of adjustment and different culture and customs of keeping a family and household, such as having no help with household chores (in the Philippines she had maids and other help around the house) which made it difficult for her to imagine remaining in Canada for the long-term. Now that she has settled in Canada, her family and the high cost of living in the Philippines are reasons why she has planned to live the rest of her years in Canada.

For some Filipinos, when considering Canada as home, many reflected on the lives they left behind “back home” in the Philippines. For instance, Violeta admitted that during the period following migration and settlement, numerous times she experienced feelings of homesickness and loneliness and in actuality she came to Canada by default as she originally applied for immigrant status in the United States. However, because of the backlog of applications, she decided to apply to Canada instead which, at the time turned out to be a faster process. As she describes below, she came to learn of the opportunities for skills training and improved economic outcomes and her original plan of temporary migration shifted:

**Violeta:** When I first came here because I had, you know my family back home and I had a lot of friends and I was busy helping at the church back home and I miss those things. I miss what I was doing. So again, homesickness. So I said to myself I’m just going to be here for a couple of years, hopefully in that couple of years I will have made what I spent, okay. But as I found what is available here, education-wise for example, hey, I could pursue nursing with the help of the government and I could obtain that for very little. Practically free I would say, because we had a free board and lodging at the residence; tuition fees paid. So that was really a good opportunity
which I did not see in the Philippines. So, because of all this I became more of a dreamer and became more ambition to pursue these things and so then the thought of going back home after a couple of years had become no more.

While some Filipinos discussed feelings of loneliness initially in their migration experiences, there were a number of Filipinos who also described strong feelings of longing for the Philippines and the desire to be back home. These feelings were more intensely described by those who migrated at an older age, such as Zenaida, Teresita and Edgar. Often they were concerned about their own health and the fear of what would happen if they got sick while in the Philippines. For some Filipinos, the ability to travel, even to visit relatives for a short visit was viewed as extremely risky in terms of their health and in some cases was not advisable according to their physician in Canada. Zenaida described feeling trapped in Canada and missing not only the life she left behind in the Philippines but also her many relatives and friends there:

Zenaida: (O)nce in a while that longing to be with the relatives is there. I went home in 2002 for a reunion and I realized I was the oldest living relative left and right now they are clamoring for me to go back for another reunion but the doctors would not permit it. I feel like I want to escape.

Similarly, Teresita in her numerous descriptions about the pain and struggles of her mobility issues as she ages, feeling trapped in the limitations of her body, she not only regrets not being able to help around the house more, for the sake of her daughter who has health issues of her own but she also woefully described being unable to travel to the Philippines. As she concludes that she is no longer able to vacation in the Philippines she is hopeful that her relatives will visit her and her family here in Canada:

Teresita: Maybe we visited the Philippines once in a while, this year ano, the last year this September but maybe we cannot go anymore because I’m too—it’s very hard to walk and I’m already disabled and I cannot walk so. My daughter too is around sixty. Sixty-plus and she told me she cannot walk too that something is wrong with the bones too. Maybe we cannot take a vacation anymore. Maybe those children of mine in the Philippines and grandchildren maybe will come here to visit us.

However, not only were feelings of longing experienced by Filipinos who came to Canada in later life, having lived much of their life in the Philippines, Erlina, who arrived in Canada in her 20s, considered her plans for when she retires and grows older. A regular visitor to
the Philippines, she described being pulled in two directions. In one sense she wants to remain in
Canada because of her children who were born here but she also felt a strong desire to move back
to the Philippines where most of her relatives are located:

**Erlina:** Sometimes no, sometimes yes. Because I had already kids here. It’s hard to leave them. I
had my two kids. It’s hard to leave them because they were born here. So it’s really different.
You know, you want to go back to your roots but you’re thinking of the family here too, so—
Maybe fifty-fifty for me *[Laughs]*. I don’t really have relatives here. So, once I get home maybe,
especially I have two boys, maybe nobody— Like you know, it’s really different in here. Once
I’m in a nursing home, maybe nobody will visit me already once I’m in.

As she struggled to describe how she felt being in-between feeling at home in Canada with her
sons but the sense of longing and wanting to be connected to her birth country and her family
roots, she expresses fears of being abandoned and alone in a nursing home, which she views as
the consequence of being a senior Canada.

### 7.7 Chapter Summary

The results presented represent one of the first studies to explicitly explore the health and
place experiences of aging Filipino immigrants living in Canada. Current research on the cultural
specificity of aging experiences of various immigrant groups reflects the ethnic and cultural
diversity of Canada’s growing population, both immigrant and non-immigrant. The overall goal
of my study was to contribute to a broader understanding of the challenges, perceptions and
experiences of aging for immigrants in Canada. As a case study, this chapter specifically explored
Filipino immigrants’ perceptions about aging in Canada and the Philippines, as well as their
impressions about the health care system and their various health behaviours. One of the aims of
the chapter was to explore experiences of place and health among later life Filipinos, including
their various musings and meanings they gave to their aging and migration experiences as it
influenced their health. The results examined the role of place, in terms of Filipinos’ sense of
belonging and community in a post-migration context as well as their attachments to place as they
reflect upon their aging and their health\textsuperscript{18}. As the results illustrate, the ways that older Filipinos evaluated their own health and aging experiences varied in terms of family relations, retirement decisions, community connections and reflections about growing older in Canada.

For many of the senior participants in this study, they spoke in general terms about their satisfaction with health care in Canada when compared to the Philippines. As well, their views on health and aging in Canada were often made in reference to their perceptions of what it might be like to age in the Philippines, many who believed they would be worse off had they not moved to Canada. Results from the chapter demonstrate the importance of recognizing the cultural specificity of aging and health experiences of immigrants, as well as aging expectations with regards to care, social and community engagement, shifting family structures and retirement plans. As well the results also illustrate the importance of time of migration (i.e. migrating as a recent university graduate versus migrating as a senior) as experiences of aging, ideas about managing chronic disease and illness or decisions around retirement, family and even death depends greatly on when a senior immigrated and the circumstances of their migration.

\textsuperscript{18} Parts of this chapter were presented at the International Medical Geography Symposium in East Lansing, Michigan U.S.A on July 9, 2013. Results were presented in an oral presentation in a session entitled, Aging Spaces.
Chapter 8

Discussion and Future Directions

“An awareness of the age dimension of migration sensitises us to movement over time as well as over space.”

8.1 Introduction

In the Age of Migration: International Population Movements in the Modern World Castles and Miller (2009) first refer to human migration in the simplest of terms; defining migration as movement across physical and locational boundaries. However, no sooner do they point out that human migration is not just physical movement but is an important global force. As they describe, “(m)igration is a collective action, arising out of social change and affecting the whole society in both sending and receiving areas” (Castles and Miller, 2009: 20). With human migration comes the movement of cultural, social and economic artifacts and as such, the consequences of migration encompass more than a change in location and often the implications are far-reaching, permanent and enduring. The results from this mixed methods study reveal that the experience of migration is neither stereotypical nor singular as immigrants’ lives are inevitably changed and continually change.

Migration is most often understood and explained from an economic perspective, for example, the development of push-pull theories that originated from Ravenstein’s observations in 1885, who noted that migration flows were influenced by a number of economic factors, such as employment and proximity to commerce and industry centres (Velasques, 2000). Other ideas about immigration premised on the economy include understanding migration flows as a result of wage and income differentials in sending and receiving countries. This theory proposes that

19 (Biggs and Daatland, 2004: 4).
20 See Ravenstein’s (1885) Laws of Migration thesis for a detailed account on migration flows in relation to town and population growth.
greater levels of migration occur between mid-range income differentials between sending and receiving countries, such that the migration tends not to occur among the poorest countries but rather from middle-income nations (Velasques, 2000).

Even public perception and attitudes towards migration have economic underpinnings. For instance, a study by Harrell and colleagues, explained that the general perception about immigrants or support for immigration in general, are influenced by economic characteristics of the both the migrants themselves and the economic situation of receiving country. In the case of Canada and the U.S. they had noted that negative perceptions about immigrants and conflict about immigration often arise during times when the economy is poor (Harell et al., 2012). Similarly, Chavez (2001) noted that during times of economic downturns, media coverage on immigration policy was likely to increase, which was confirmed by Wilkes et al. (2008) who also observed that attitudes towards immigration are sensitive to the state of the economy.

Although migration studies have certainly demonstrated how important it is to study the economic factors involved in migration flows and their influence on both the receiving and sending countries, a number of migration researchers argue that the economic perspective cannot be the only way to understanding the process of migration (Castles and Miller, 2009). A quick perusal of Citizenship and Immigration Canadian (CIC) research and current report listings illustrate the importance not only of economic outcomes but also cultural implications of immigration. Among these issues include religious and cultural identities, visible minority groups and English/French language, and though these factors play less of a role in the public perception of immigrants than economic characteristics, namely because of the language and framing of diversity and tolerance embedded in multiculturalism policy, they are important in their contributions to our greater understanding of the how migration affects both social and cultural ideas. Even so the majority of CIC reports on immigration discuss employment outcomes relating to education, migrant labour supplies, wages and labour market progression, which suggests that
improving the economic outcomes of immigrants remains the single most important priority for immigration policy in Canada.

Politically, immigration has been the response in helping to solve some of the problems that stem from a flagging economy, dealing with the perceived and real social and fiscal pressures of an aging population and to ease fragile health care and social welfare systems. Underscoring this economic basis for evaluating the merits of migrants in Canada at all stages of migration – pre-migration, migration and settlement – is the notion that the state decides not only who can and cannot migrate to Canada but also defines who can be considered successful as an immigrant living in Canada. As such, this creates the notion of a model immigrant or ideal immigrant, on state terms and may include references to the relative ease of settlement or integration with the whole of society that deems an immigrant as successful. Resilience, resourcefulness and adaptability as traits are highly valued and promoted within the discourse of the ideal immigrant (Gardiner-Barber, 2009) that both receiving and sending states highly value. For example, Philippine migration has become so ubiquitous that Filipino migrants are often viewed as “national heroes” by the Philippine state fulfilling a role that transcends economy and embodied in the persona of the Filipino migrant and likewise encourages receiving countries, such as Canada to recruit certain individuals (Kelly and Lusis, 2006). It is not surprising then that the healthier and wealthier immigrants are likely to self-selectively migrate, with the implicit understanding that their success is contingent on their economic achievement for Canada as well as for their own families. However, critiques on this economically based understanding of immigration to Canada argue that improved economic outcomes do not necessarily translate into

---

21 See Kelly and Lusis’ paper entitled, “Migration and the transnational habitus: evidence from Canada and the Philippines”, for a detailed analysis on economic subjectivities of Filipino immigrants in Canada. More specifically, using the work of Pierre Bourdieu, they discuss the Filipino-Canadian habitus and the transnationalism of Filipinos, which in turn construct the notion of an ideal immigrant. They discuss how different forms of capital – economic, social and cultural – are implicit within transnational spaces. Gardiner-Barber, in her paper “The Ideal Immigrant? Gendered class subjects in Philippine–Canada migration” discusses the Filipino as a flexible migrant and though she does not use Bourdieu’s theory of the habitus she also examines close the gendered and economic subjectivity of the Filipino migrant.
better integration experiences within Canadian society (Walters, Phythian and Anisef, 2007). As well, improved health outcomes are not necessarily a product of better economic outcomes, as noted by the healthy immigrant effect.

These types of human movements that stretch beyond the physical have an important impact, not only in terms of what it represents politically but its profound effect on an individual’s own understanding and experiences of health and aging. In conducting this research my intention was to emphasize how the experience of migration can also mean movement into different states of being, health or otherwise, and more importantly, how migration persists to influence expectations and experiences of aging. Underlying my study is the question: What does it mean to be an immigrant who is aging in a foreign land?

8.2 Successful Aging versus Active Aging among Older Immigrants: Exploring Key Informant Perspectives and Filipinos’ Understanding of Aging in Canada

Although the conceptual framework guiding my project encompassed multiple theories and concepts, the one prevailing theme in the narratives of key informants was the idea of improving the health and aging experiences of immigrant seniors, or rather encourage and support successful and active aging for older immigrants. In attempting to include a wide variety of key informants, as noted in Chapter Four, most of the key informants’ activities and roles were focused on building communities, providing community support, improving the health and social wellbeing of immigrant seniors through social and recreational activities, or the promotion of improved social support and social networks within local communities. Improving adaptation skills for immigrants both as newcomers and as older adults was an important goal that many key informants strived for in their programs. Coincidently during interviews, the Aging at Home Strategy, a health care reform and policy initiative described in Chapter Five was currently being launched. This policy was highly supported through a number of community based programs, in the sectors of both health and social services, to help seniors to maintain their independence and
promote healthy aging at home that many key informants referred to and discussed. Key informants stressed the importance of encouraging independence, self-determination and self-reliance among immigrant seniors. A majority of key informants also pointed out that long-term immigrant seniors were significantly better off than newcomer seniors because they were more likely to be independent and self-determined compared to newcomer seniors, who often were very reliant on family for their needs.

The consensus among key informants with regards to aging immigrants living in Toronto and the GTA was that social and cultural isolation were significant barriers to improved health and wellness outcomes, but also in terms of their integration and positive aging and settlement experiences. As a result, many key informants adopted the active aging framework to designing and implementing programs and strategies to improve the health and aging experiences of older immigrants. They identified a number of issues that they felt needed to be addressed in order to improve the social lives of aging immigrants and to address issues of health inequity and inequality. The results from key informants are summarized in the following key points, which support strategies that encourage active aging among immigrant seniors, especially newcomer seniors who were among the most disadvantaged and vulnerable:

- Acknowledge distinct settlement patterns among immigrant groups that may result in physical isolation, increased transportation barriers, lack of social supports and poor community engagement;
- Recognize and respond to the language barriers that older immigrants may experience resulting in social and cultural isolation, not only in their ability to communicate but also in accessing information in the appropriate language;
- Foster a sense of community by increasing social cohesion, strengthening social supports and bridging community networks both within and among different ethnocultural groups and communities;
Include more culturally informed ways of understanding and addressing health in later-life, and experiences of aging, rather than focusing on a biomedical view of aging, illness and disease;

- Avoid treating immigrants as a monolithic group, more specifically distinguish between the health needs of recent and long-term immigrants;

- Acknowledge that different groups of immigrants may have different experiences of migration and settlement in Canada and may have different motivations, reasons and situations for entry to Canada, for example, certain waves of immigration to Canada based on immigration policy reform or the introduction of temporary foreign workers programs such as the Live-In Caregiver Program.

Key informants shared their ideas about what constituted active aging within the communities of immigrant seniors they regularly worked with. Many believed that being active and engaged within the community was an important part of actively aging and often shared many program successes whose goals were specifically to improve the engagement and involvement of immigrant seniors to their peers and their local communities. As described in Chapters Four and Five, it was important not only to improve immigrant seniors’ engagement in the community and avoid social and physical isolation but to also improve their integration with the broader community and build community capacity to work with culturally and linguistically diverse groups, to prevent cultural isolation of immigrant seniors. For many key informants, it was important to not only empower older immigrants to adopt the lifestyle of successful aging but to be able to provide the opportunities and resources in line with the active aging approach to positive aging and health.

Phases Two and Three set out to examine the ways that Filipino immigrants are aging or have aged in Canada. In linking the concept of active aging among immigrants that most, if not
all, key informants endorsed to results from later-life Filipino, one question that emerged was: *How do Filipinos define active aging?* Through individual in-depth interviews older Filipinos shared their own ideas about what aging in Canada means to them. In particular, later-life Filipinos were asked: *What does active aging or healthy aging mean to you?* A majority of Filipinos understood the term “active aging” as a literal definition and often made reference to the levels and types of activities that they engaged in or discussed the degree at which they were “active” outside the home. However, Filipinos also made the distinction between being healthy and being active while they age, so despite admitting that may not be considered healthy by biomedical standards as being disease-free, they felt they were healthy in other respects.

As well, Filipinos did not have a singular and common understanding of what it meant to be aging well. Results from Chapter Seven revealed that Filipinos had diverse views and understandings about aging in general and what growing older in Canada meant to both them and their families. Many Filipinos revealed an overall acceptance about physical and biological aging, as many believed themselves to not be aging well. In fact, quantitative results presented in Chapter Six revealed that a majority of Filipinos rated their health good or greater. They defined aging in more traditional and common place understandings, where they understood that aging comes with increased incidence of disease and age-related disabilities but they also discussed the ways in which they coped with these facts and the inevitability of aging.

In the following sections, I revisit the main objectives of my project as well as discuss and answer the research goals and questions stated in Chapter One. In particular, I explore the connections and interrelatedness of migration and aging experiences to understand the health and

---

22 This point of the interview with older Filipinos was a constant reminder of my own assumptions and bias about Filipino immigrants’ experience of aging in Canada. By not providing a working definition of what “active aging” was or by assuming that respondents would understand the term, many Filipinos struggled on how to respond to this question. I was often asked to explain what I meant and no matter how inert I believed my definition was or my encouragement to interpret the term to their own understanding, there was the sense that respondents wanted to answer the question to my (as the researcher’s) satisfaction, as though there was a right and wrong way of aging. I had only come to this realization halfway through interviews and in order to maintain the consistency across all interviews I decided to keep this question.
wellbeing of older immigrants from the perspective of key informants. In describing, through second hand experiences, the challenges and issues faced by aging immigrants, this sets the context for a deeper understanding of aging and migration among older Filipino immigrants living in Toronto and the GTA.

8.3 Re-visiting the Research Goals and Questions

One of the main objectives of my project was to describe migration and settlement experiences in older age as they relate to health. To restate, the original intent was to determine the effects of migration, including settlement experiences and family, as they influence health and aging trajectories of older immigrants. In order to gain as much knowledge and understanding on the health and aging experiences of immigrants I included multiple perspectives. In one perspective, I chose to describe the experiences of aging immigrants from the view of key informants. This was important, in part to gain a contextual understanding of the broader challenges that immigrants face and likewise to understand the challenges that service providers, health and social policy planners and settlement workers face in their experiences working with a diverse and by many accounts, a disadvantaged population. The other perspective was that of aging immigrants themselves, more specifically through a case study of older Filipinos living in Toronto and the GTA. Through the collection of survey and interview data, I gathered older Filipinos’ insights, perspectives and narratives about their own health and aging experiences while in Canada. This was conducted in two phases, with the first phase utilizing a questionnaire to ask various questions about Filipinos’ health and health care use. In the second phase, I gathered interview data on a sub-sample of older Filipinos to explore more in-depth understandings and ideas about aging and place-making in a foreign land.

Key informants were aware that one of the goals of my research was to explore the ethnoculturally specific experiences of Filipinos and sometimes would offer their own experiences with Filipino seniors, many of which were overgeneralizations as few Filipinos used
a number of services offered by key informants, especially settlement services. From key informant interviews the results illustrated the diversity and variety of the senior immigrant population and that many ethnocultural immigrant groups experience important disadvantages, but some advantages too, with both the broader society and within their own local communities.

The case study on aging Filipino immigrants was based in the general observation and hypothesis that they too experience significant barriers to health care and poor health outcomes. More specifically I hypothesized that data gathered from older Filipinos would corroborate and align closely with the general experiences that key informants shared about aging immigrants. The impetus for conducting a case study on the health and aging experiences of Filipino immigrant seniors was partially due to the fact that there has been little health research conducted on this particular ethnic group. The results from my study on aging Filipino immigrants is to my knowledge the first exploratory study on health and aging specific to Filipinos living in Toronto and the Greater Toronto Area in Ontario, Canada. The results from older Filipinos illustrate that while the common consensus is that many immigrants at all stages of migration experience barriers in health care or feelings of exclusion not all immigrants share this reality.

There were six specific research questions that were guiding my research, as described in Chapter One. My project was a large undertaking as three sets of data were collected to answer these questions, involving three phases of fieldwork and a mixed methodology. In-depth interview results revealed important insights about the health and aging experiences of older immigrant communities living in Toronto and GTA. This provided the context from which a sample of older Filipino immigrants living in Toronto and the surrounding GTA were surveyed. To follow-up a sub-sample of Filipino immigrants were recruited to participate in an interview to explore experiences of health and aging for this specific and understudied ethnocultural group. The following section highlights the more important findings from the study.
**Question 1:** What role does ethnic or racial background play in the health and wellbeing of aging immigrants?

The term ethnocultural group (sometimes ethnoracial) was used throughout to emphasize the ethnic, cultural and racial diversity in Canada’s population. The key informants in my study had diverse backgrounds and perspectives on various ethnocultural communities and immigrant populations. Key informants were selected based on their experiences working with various ethnic and racialized immigrant groups, which were referred to as multi-ethnic communities in order to include both people of white ethnic origin as well as people of colour.

There were numerous ways in which key informants discussed ethnicity and racial background to explain the health and wellbeing of aging immigrants living in Toronto and the GTA. For instance, key informants described how aging immigrants’ unique ethnic/racial backgrounds, as well as their experiences relating to their migrant status, influenced much of their ideas and decisions about their own health and aging. They acknowledged that older immigrants’ ideas about health and aging, as well as how older immigrants made decisions around their health, were influenced by their own cultural beliefs and norms. Key informants also noted that many times their ideas were in conflict with mainstream and/or biomedical approaches to health and wellbeing, which presented numerous barriers to health care as well as issues around health. For example, many immigrant communities did not acknowledge mental health issues of seniors, which coincidentally were common issues, especially among newcomer and isolated immigrant seniors. Another issue that many key informants discussed was that ethnicity/race could not be treated as an individual feature or characteristic among immigrant groups, that often immigrant seniors experienced the intersectionality of multiple social determinants, including race and migrant status, all which combined to influence health in varied ways. This was an important observation among service providers who acknowledged that no single factor could be identified for why immigrant seniors are most at risk within the community for poorer health outcomes and
difficult aging experiences. As well, their experiences are also very specific to their ethnocultural background including their religious or spiritual beliefs, their cultural understanding and ideas about health and aging, their own expectations of family obligations and the role of an elder, their struggles with migration and their own lack of knowledge about Canada. Many key informants emphasized that older immigrant populations in general tend to be categorized or subsumed under the single category of immigrant or the aged, which generalizes and marginalizes their own experiences.

**Question 2:** What are the implications of an ethnic and cultural background with respect to issues of access and availability of health and social services, particularly in a multicultural city like Toronto?

In addition to understanding how ethnicity and race impact older immigrants’ health and aging, from the perspective of key informants my study also examined how these factors influence the way health, community and social services are delivered at the service provider and policy levels and to what degree does ethnicity and race influence the way service providers and policy-makers address service barriers among older immigrants. While most key informants agreed that ethnic and racial background are important they felt that these factors were less influential in determining how immigrant groups access and utilize health care, community and social services. For instance, class or the socio-economic position of many newcomer seniors was cited as a more fundamental and poorly addressed factor in determining the social and health status of many immigrants, especially seniors. These findings reflect other research that finds that health inequalities and issues of class, such as education and employment (Asanin Dean and Wilson, 2009) are indeed important in determining the overall health and wellbeing of immigrants, especially when compared to non-immigrants (Chen, Ng and Wilkins, 1996; Chen, Wilkins and Ng. 1996; Dunn and Dyck, 2001; Perez, 2002; Newbold and Danforth, 2003; McDonald and Kennedy, 2004; Halli and Anchan, 2005; Kennedy, McDonald and Biddle, 2006).
Key informants felt ethnicity and race among older immigrants also manifested as barriers to care and social disadvantages that many of them faced in their daily lives. Some were very specific to immigrant populations or ethnocultural group such as finding appropriate health information in a specific language or receiving health care that is respectful cultural ways of living. Other barriers identified by key informants were issues in accessing health and community services and coping with discrimination and anti-immigrant attitudes that result in social and cultural isolation. In doing so, key informants reported on the challenges in working with older immigrants’ diverse understandings about health and aging, particularly in a foreign country. Without addressing the economic disadvantage that many immigrant families faced it was likely that issues such as poverty, lower income and other economic resources would remain persistent challenges for immigrant to overcome and in many cases become worse over time, especially in older age. Key informants also noted that many of these barriers were difficult to overcome at the service-level and many key informants acknowledged that health care and social policy, as well as mandates for care needed to incorporate anti-racist, anti-classism and feminist principles to neutralize the systemic barriers that many older immigrants faced.

Most key informants who were interviewed specialized in immigrant, multiethnic or ethnocultural communities and many admitted having strong connections with the communities they served. These connections were reflected in their views and policies that not only adopted culturally competent or cultural sensitivity approaches, but many admitted to investing a lot of their own emotional labour and empathy with many of the groups. Additionally, key informants discussed the importance of recognizing immigrant status and migratory experience as an important determinant in health. They argued that immigration adds another layer of disadvantage to older often times poorer seniors, many who have come to Canada through family reunification and remain dependent on their adult children and other family members. As well, they argued that by not addressing these fundamental concerns, of poverty and increased dependence in older age,
many immigrant seniors will continue to be marginalized as the ethnicized and racialized other and continue to fuel anti-immigrant, ageist and discriminatory attitudes towards the older immigrant population.

**Question 3: What is the general health of later-life Filipino immigrants?**

The apparent gap in research that specifically examines the health status of aging Filipino immigrants in Canada is both perplexing and unusual (Koehn, Neysmith, Kobayashi and Khamisa, 2012). This is despite Canadian census and migration data reporting that significant numbers of Filipino immigrants arrive and settle in Canada every year (Citizenship and Immigration Canada, 2012; Statistics Canada, 2013). Existing research on the health of specific groups of immigrant and ethnocultural populations have shown that there are culturally-specific health inequities that stem from cultural health beliefs and other cultural factors (Lai, Tsang, Chappell, Lai and Chau, 2007; Lai and Surrood, 2009) to the role of ethnic identity in health status (Gee, 1999).

My project surveyed a small sample of Canada’s Filipino immigrant population living in Toronto and the GTA to capture a snapshot of their health status and experiences of aging. In general, results from the survey data (Chapter Six) revealed that most Filipinos rated their health in mostly positive terms, based on self-rated health and mental health measures, self-reported chronic disease and use of mobility assistive devices. Only a small percentage of the total sample reported having very poor health status. Similarly, the survey asked Filipinos to describe their health behaviours in a series of Likert-scale type questions that included diet, physical activity, smoking and drinking behaviours. Most Filipinos reported being engaged in healthy behaviours or were currently making attempts to be healthier. On some items, such as smoking, alcohol beverage consumption and dietary behaviours, Filipinos were also asked to report whether their health behaviours have changed since migrating to Canada. Most Filipinos spoke in favour of improved health behaviours after migration or reported maintaining their habits even after
arriving in Canada. As well, many Filipinos in my sample reported increased levels of life satisfaction, happiness and enjoyed high levels of social supportive networks.

There are a number of explanations that could account for why my sample of later-life Filipinos reporting better health outcomes and health care access than what has been reported in the research. For instance, this particular sample of later-life Filipinos has high levels of educational attainment. As indicated in the survey data, over 80 percent of the sample of Filipinos graduated from college or university. As well, my sample has high English language proficiency. That many Filipinos regularly visited a medical doctor, reported few access barriers to other health services and were engaged in healthy behaviours suggests that later-life Filipinos surveyed have high level of health literacy and are quite knowledgeable about the benefits and importance of engaging in a healthy lifestyle. In-depth interviews with a small sample of later-life Filipinos also demonstrated that most Filipinos valued the importance of remaining both physically, emotionally and socially active. Later-life Filipinos described the many ways they engaged in a healthy lifestyle and the ways they try to maintain their health as they have aged and are aging. Grateful for universal health care in Canada, many Filipinos reported in interviews that they highly valued and respected the health care they received in Canada, attributing their current health status to the high quality, availability and ease of access of Canada’s health system.

Another explanation that was also suggested in Chapter Six was the role of occupation or other related social explanations for health, particularly in reference to Filipino women in my sample of survey respondents. Certain social conditions and resources have been associated with health inequalities observed between various groups, such as men versus women, immigrant versus non-immigrant groups, etc. Existing research has found that having high income levels, working full-time in a meaningful occupation, having social support and caring for family members are better predictors of positive health outcomes for women compared to men (Denton and Walters, 1999; Laroche, 2000; Prus and Gee, 2003). In my study, over half of later-life
women were retired while over one third was currently engaged in full-time or part-time work, similar to the Filipino men in the sample. Most later-life Filipinos in the sample were active in the labour force or currently retired and thus, are likely to have earned a pension, have higher educational attainment, be more civically engage and have higher income levels compared to their non-immigrant peers. Less than 20 percent of Filipino women in the sample reported a household income of less than $30,000 and just under two-thirds of women were currently married. In the sample, there were little gender differences among later-life Filipinos with regards to health, despite research suggesting that there are significant gendered inequalities in health.

Denton et al. (2004) refer to the social structures of inequality to explain the health inequalities between men and women. Drawing from literature that show the relationship between health inequalities and socio-economic inequalities, they use data from the Canadian National Population Health Survey to examine gender differences in many measures of physical and psychological health (Denton, Prus and Walters, 2004). They found that there were observable differences between men and women, in which women reported lower levels of self-rated health, functional health, more chronic conditions higher levels of distress compared to men (Denton, Prus and Walters, 2004). They argue that in general, poor access to the same social and material resources as men, as well as increased exposures to more stressful living conditions and events relating to gender roles may contribute to lowered health status among women. In this particular sample of later-life Filipinos, the success of Filipino women in terms of employment, impact of occupation, social support, high levels of education and income, likely positively skewed the results for the overall sample.

The migratory experience has often been labelled a stressful life event as many immigrants experience the stress of adapting to a new country, having to find work, being separated from families and experiencing and coping with discrimination, all of which have been
reported as predictors for poor physical and especially mental health (Noh and Avison, 1996; Noh and Kaspar, 2002; Wu and Hart, 2004; Beiser, 2005). My sample of later-life Filipinos reported few mental health issues, both in self-rated mental health status, depression (GDS-DF) and social support scales (MSPSS). It may be that there is a stigma in discussing mental health among Filipinos, although there is currently no research to date that has assessed the mental health or cultural perceptions of mental illness among later-life Filipinos. Canadian studies on the mental health outcomes of immigrants have found that immigrant women are often at risk for experiencing depression, post-migration stress disorders, and even incidences of schizophrenia (O'Mahony and Donnelly, 2007a; O'Mahony and Donnelly, 2007b). Similarly, a study assessing the “decline” associated with the HIE examines mental health outcomes and various characteristics of migration, such as length of residency (Lou and Beaujot, 2005). They found that immigrant women living in Canada the longest reported the poorer mental health and experienced the worst mental health outcomes than immigrant men and even non-immigrant men and women.

Results from in-depth interviews, and specifically, responses to the interview question: *What kinds of difficulties did you experience when you first immigrated to Canada?* revealed that the sub-sample of later-life Filipinos experienced few difficulties when first migrating to Canada. While recall bias may influence their retrospective descriptions about their first migration experiences, most recalled a sense of excitement and the satisfaction of starting a new chapter in their lives that would mean improved social and economic conditions for themselves and their families, both those back home and those that eventually made their way to join them in Canada. Nine out of the 15 interviewees were in the health care profession and described experiencing few difficulties finding jobs in the hospital setting. More men reported having difficulties finding work when they first arrived in Canada, stating that they were often turned away from employment because they lacked Canadian experience.
Question 4: Do later-life Filipinos experience any barriers in accessing and utilizing health care?

Research on the health of immigrant populations has identified a number of barriers that may limit access to health care or result in poor utilization of health services (Zanchetta and Poureslami, 2006). The more commonly cited issues for poor access to health care are those around language and communication (Steele, Lemieux-Charles, Clark, and Glazier, 2002; Wu, Penning and Schimmele, 2005) and as well as a lack of culturally sensitive or culturally competent care in many clinical settings (Vissandjée, Weinfeld, Dupéré and Abdool, 2001). Other issues noted by researchers are widespread systematic barriers faced by many vulnerable populations including immigrant populations, which often result in the persistent health inequalities. For instance, Singh-Manoux, Ferrie, Chandola, and Marmot (2004), refer to accumulation theory to explain health inequalities experienced over the life course, where lower education levels or occupational attainment in early life results in the reproduction of these poorer outcomes in later life which contributes to health and social inequalities. These issues may present other limitations such as increased costs, poor access to transportation or caregiving responsibilities, which in further add to social disadvantage leading to poor health. Results from key informant interviews discussed many of the same issues and barriers of older immigrants that are reflected in much of the literature. Key informants were very well aware of the issues faced by older immigrants, particularly those that arrive in Canada through family reunification.

In the existing research however, there is little understanding or an awareness on the barriers or limitations that may be experienced by older Filipino immigrants specifically. Interestingly, many of the key informants included in my sample had little experience with older Filipino immigrant populations. Among the few that did have interactions with Filipinos in a service provider-client context did not describe health care access issues as a problem among them. The questionnaire distributed to Filipinos also included a series of questions about their
health care use. In general, many Filipinos reported high levels of satisfaction with the quality and availability of health care services in Canada, and only a few reported experiencing any barriers to health services. With regards to barriers to health care, survey results as reported in Chapter Six were compared to key informants results described in Chapters Four and Five. Among the many barriers that key informants cited, these included language barriers, transportation or lack of culturally appropriate care. However, results from later-life Filipinos revealed that many of the common barriers as described by key informants were not observed among this particular group. Instead Filipinos described long wait times for appointments to see the doctor as the most common issues they had. As many in the sample were able to read and communicate in English, language barriers were unlikely to be a limitation to health care – a barrier noted by key informants. Also noted in Chapter Six, the sample of Filipinos consisted of many Filipino women who arrived in the 1960s and 1970s and were able to find jobs as health care professionals, such as nurses, mid-wives, or clinical technicians. Having worked for a number of years they are likely to have a pension, compared to other women in Canada who may not have been in the labour force during this time. As a result, their economic advantage as well as their knowledge and working experiences in the health care system in Canada may have skewed the results.

Likewise with my interview sub-sample, most of the later-life Filipinos who were interviewed could not describe any major barriers when trying to access health care in Canada. In actuality, many Filipinos in general spoke highly about health care in Canada and often made comparisons with the Philippine health care system with regards to access issues. They described high costs of the Philippine health care system, scarcity of private health insurance, poor old age pension systems and the lack nursing homes for the elderly as reasons why many Filipinos would not consider returning to the Philippines in later-life. There were very few Filipinos in sub-sample who did not draw comparisons between the two health systems when discussing access to
Canada’s health care system. Many Filipinos also believed that had they lived in the Philippines, they would not have lived as long as they currently are, as a direct result of being unable to afford care and prescription medication.

**Question 5**: How do health and health care use vary among later-life Filipinos, based on the five dimensions of place experiences outlined in Chapter Three?

As introduced in Chapter Three and reported in Chapter Six, a unique analysis of the survey data was to explore the five Dimensions of Place Experiences. The first set of dimensions examines the migration and aging-in-place experiences based on waves of migration for Filipinos (before and after 1980) and migration as a senior, and the second set of dimensions explores health care use and place, namely whether or not Filipino immigrants use health care in the Philippines. The idea for my analysis was based on the widely accepted healthy immigrant effect (HIE) and the commonplace assumption that once an immigrant migrates from their birth country and arrive in their new host country, they adopt the health behaviours and patterns of the native-born population which results in the tendency to leave behind their more familiar and traditional ways (Chen, Ng, Wilkins, 1996; Torres, 2004). In this sense, often research in immigrant health focuses on an immigrant’s health from the time of arrival in a host country and the HIE presupposes that all immigrants experience the same trajectory, whereby their health is negatively associated with the increased length of time that they live in a foreign country. As a result immigrant health status is then conceptualized as a composite of current health outcomes, health care use (access issues), comparisons to Canadian-born populations, level of integration with the mainstream society and the diversity they bring to the multicultural landscape. Boyle and Norman (2010) argue that with international migration culture is not the only import but rather, as immigrants arrive in a foreign land they often bring with them their own health characteristics, understandings about health and their own cultural practices.
One of the most recognized explanations for the better health status of new immigrants compared to non-immigrant populations with the HIE hypothesis is the self-selection of healthier and wealthier immigrants. However, as a number of researchers have pointed out, this hypothesis does not appear to apply to older immigrants, and particularly in the case of older immigrants arriving under family reunification and at an older age they are likely to be less healthy than those who arrive under economic class categories and at a younger age as premised by the HIE (Gee, Kobayashi and Prus, 2004; Newbold and Filice, 2006; Kobayashi and Prus, 2008; Zhau, Xue and Gilkinson, 2010). As well key informants also noted that many newcomer immigrant seniors already arrive at a significant disadvantage and argued that that in addition to their age-related health issues, their social, economic and filial circumstances upon arriving in Canada, creates increased vulnerability to more physical and mental health issues. Key informants also pointed out that the lack of health care experienced in the first few months of migration before being able to apply for and receive a health card, as well as the stress of migrating can have a detrimental effect on their physical and mental health in a short amount of time, which may be difficult to overcome.

Given the importance of the migratory experience on health and aging, as research has demonstrated that age of migration, particularly mid- to later-life results in reports of poorer health status compared to non-immigrant population, it is important to provide a context of migration when considering the relationship between migration, health and aging. The results from Chapter Six and Seven attempted to quantitatively and qualitative examine the interrelatedness of the migratory experience and migrant characteristics to experiences of health and aging. Results from the quantitative chapter more explicitly analysed the Dimensions of Place Experiences, while the qualitative results with later-life Filipinos explored the dimensions more experientially.
In terms of health, the measures used for analyses in Chapter Six were self-rated health, self-rated mental health, prevalence of chronic conditions, the Duke Activity Status Index (DASI), and the psychosocial measures of the Geriatric Depression Scale Short Form (GDS-SF), the Multidimensional Scale of Perceived Social Support (MSPSS) and the Unmitigated Communion (UC) scale. Detailed results are reported in Chapter Six, however overall results illustrate that there are some differences in terms of when Filipinos arrived in Canada and how they perceived their own health. This was more clearly demonstrated when comparing Dimensions One and Two, consisting of later-life Filipinos who either arrived before 1980 and those who arrived after 1980 to Dimension Three, which is comprised of Filipinos who arrived in later-life. For instance, a greater percentage of later-life Filipinos who immigrated in later life rated their physical health as fair or poor compared to those who arrived at a younger age. This compares to the results found by Zhao and colleagues (2010) who found that older immigrants were more likely to rate their health as poor or fair compared to younger immigrants. They also found that immigrants who came to Canada as a skilled workers rated their health better than family class applicants. Interestingly, across all three dimensions, later-life Filipinos rated their mental health highly, there appeared to be no differences. In fact all later-life Filipinos in Dimension Three rated their mental health as good or higher.

In terms of health care use in Canada or the Philippines, few later-life Filipinos described using the Philippine health care out of necessity, that is, using the Philippine health care system is likely the result of having required care while visiting. The second set of dimensions of place experiences (Dimensions Four and Five) captures the health care and place behaviours of later-life Filipinos. Dimensions Four and Five comprise those individuals who use health care in Canada and those who use both health systems in Canada and the Philippines, respectively. There is little evidence in the data collected that supports medical tourism or transnational health care seeking behaviours of Filipinos in the Philippines. The two health systems differ greatly in terms
of cost, as Canada has a socialized health care system which is predominantly publicly financed. Canada’s 13 single-payer universal systems cover most hospital and primary physician care, as well as a number of insurable services that are governed by Canada’s Health Act (Marchildon, 2005). In comparison, the Philippines has a fee-for-service system and loosely restricted governance over service providers, and as a result the quality of health care varies considerably throughout and poor access for the vulnerable, including the elderly, has remained a low priority issue (World Health Organization, 2011). As a result, there are few differences observed in overall health and health care use across Dimensions Four and Five. While key informants described the difficulties that older immigrants face when accessing health care, Filipinos experience very few barriers and tended to use Canada’s health system exclusively.

**Question 6: How do older Filipinos view their lives as they age in the context of globalization?**

Results from in-depth interviews (Chapter Seven) revealed how later-life Filipinos described their current health and aging experiences in Canada. The purpose of in-depth interviews was to expand on results from the questionnaire and explore changes, if any, in later-life Filipino immigrants’ values and expectations of aging in a foreign land. As they recalled their pre-migration and post-migration experiences they were asked to discuss the varied ways that their cultural, economic and familial situations shifted and evolved and how these experiences may have influenced their current health as well as their own self-perceptions of health and aging while living in Canada.

Results from interviews with later-life Filipinos revealed that ideas about health and aging are very subjective and diverse. Through discussions about aging in Canada and the interrelatedness of health and migration, later-life Filipinos shared views that were both unique to the Filipino population and similar to results found in other studies on the health of older immigrants. For instance, later-life Filipinos shared their ideas about what constitutes good health and described what measures they took to remain healthy as they aged. Most Filipinos
defined health in holistic terms. In a study by Meadows and colleagues (2001) they described how a multiethnic group of immigrant women living in an urban Alberta city described health in holistic terms. However, they were more inclined to discuss the specifics health and aging in a physical sense, rather than within the multidimensional definition they first offered. In describing their personal health they shared their views around issues of functionality or being able to perform and fulfill roles as mother, wife, grandmother, or employee (Meadows, Thurston and Melton, 2001). Later-life Filipinos in my study also spoke about health as being made up of physical, mental, social and spiritual dimensions of health and wellness, and also evaluated their own health around this concept of functionality, as discussed by Meadows et al. (2001).

In many ways, being able to continue to live an active life was important, not only for Filipino women but for men as well. For example, many later-life Filipinos felt that it was important to regularly attend Catholic mass or church service and was viewed not only as an aspect of their spiritual wellbeing but was also a way to “get out of the house” and be social. Being well enough to go and attend church was important, as was being able to go out and “do things”, especially in retirement. A number of later-life Filipinos also boasted that they are busier now than when they were working. Many later-life Filipinos also recognized being socially and physically isolated could lead to mental health issues, and many were engaged in some a social group, whether it was a church group, a seniors’ group, volunteer group or even regular meet-ups at the mall. Being socially engaged and connecting with people was highly valued, often identifying social wellbeing to various roles they fulfilled, either in the family as a caregiver and to the broader community, as an active volunteer. Even among those who were currently working, they felt that working was a way of being physically active and mentally engaged.

A study by Shemerani and O’Connor (2006) also used in-depth interviews to explore what aging meant to Iranian immigrant women living in Canada and found that their experiences of aging were interconnected with their experiences of immigration. For the Iranian women in
Shemerani and O’Connor’s study, their immigration story was so important to how they understood and shared their experiences of aging in Canada. Given the history of Filipino migration to Canada from the recruitment of nurses and other health care professionals from the early 1960s into the 1990s (Ronquillo, 2011; Damasco, 2013) to foreign domestic workers through the Live-In Caregiver program (Stasiulis and Bakan, 1997; Pratt, 1999; Kelly and Lusis, 2006) it would be expected that for many of the Filipinos, particularly the women in my sample would connect their ideas about health and aging to their migration stories. In the context of globalization, the pressures of increased social inequalities globally and the economic competitiveness of global powers, particularly with the role of the Philippine state in strongly encouraging the transnational labour migration of Filipinos, I was interested in their reasons for migrating. Additionally, given the fluidity and flexibility of Philippine migration, I also wanted to know, what their reasons were for choosing to stay in Canada in later-life.

For Filipinos, their ideas on living, aging and remaining in Canada in older age, were more focused on comparisons of what it would be like to be a senior in the Philippines compared to what they are experiencing now. Many later-life Filipinos also discussed their reasons for emigrating from the Philippines which either was in search for a better life for themselves or their family, while others indicated that they left to escape the poverty or a hard life of rural living. From a critical stance, globalization has been the catalyst and important force behind Philippine migration, but not only did many Filipinos in my study build careers, accumulate wealth and economic resources in Canada they generated much social and cultural capital in the building of vibrant and growing Filipino communities across Canada. Kelly and Lusis (2006) critique transnationalism in the context of Philippine migration and what it means to be Filipinos in Canada. Using Bourdieu’s habitus they argue that within the processes of migration and transnationalism Filipinos accumulate economic, social and cultural capital, which in turn are valued and devalued, exchanged and converted in varied and complex ways that are connected to
space and place (Kelly and Lusis, 2006). In my study, Filipinos connected their aging and health experiences to place at various scales, often drawing on their own knowledge about what it would be like to age in the Philippines versus Canada. Many Filipinos in my study also discussed being part of a some type of Filipino group, whether it was an alumni group, a fraternal group (e.g., Knights of Rizal), senior group or Filipino community organization. It was within these spaces that Filipinos connected with each other and the community, but also, as many explained, to keep up Philippine heritage often in intergenerational settings, in order to instill Philippine values in Canada’s Filipino youth.

With regards to aging, later-life Filipinos discussed their expectations of retirement and aging in Canada, including their plans for eldercare and their reasons for choosing Canada as the place to live out the rest of their years. Later-life Filipinos discussed their satisfaction with their lives in Canada and often linked these discussions to their own understandings and views about health and aging. It was not uncommon for Filipinos to speak about aging in Canada versus aging in the Philippines as a matter of life and death, drawing comparisons between Canada and the Philippines in terms of the cost of living (and dying) as well as the importance of affordable and accessible health care. Especially for those who immigrated in later-life, they felt that aging in the Philippines was more difficult. Even though they had to leave behind many friends, family and a way of life to which they were accustomed, there was little struggle to adjust to life in Canada, as they tended to arrive through family reunification. Some older Filipinos even enjoyed a second retirement having found work shortly after immigrating that likely helped them to adjust to life and culture in Canada. Later-life Filipinos who arrived at a younger age explained that their home was now in Canada and most expressed no desire to move back to the Philippines to live out their later years, especially now that they raised children and grandchildren in Canada. However, many Filipinos still arranged for regular visits to the Philippines. For most Filipinos, family was the locus upon which many made decisions about what they expected in older age, but not in the way
that other immigrant groups perceived elder care and the role of the family. The notion of *filial piety* enactment or the obligation of sons and daughters to provide care and support to respected elders (Chappell and Kusch, 2007; Kobayashi and Funk, 2010) was not as evident within the Filipino community based on my sample. While later-life Filipinos’ made decisions about remaining in Canada in order to remain in proximity to their own adult children and grandchildren the burden of elder care was not one that was expected of their children. In many cases, later-life Filipinos discussed other options of elder care, should the time come, and involved hiring out of private home care services or a live-in caregiver, or to settle in a long-term care facility. When later-life Filipinos shared their ideas about death and dying in Canada, narratives from older Filipinos revealed strong attachments to family, rather than place, such that the importance of dying and being buried in Philippine soil was not as important as being close to family. These discussions around themes of eldercare and dying, and the self-determination of Filipinos to make decisions around their own care as they grow older both supported and challenged the concept of aging-in-place, which is often promoted as the ideal aging experience for the older populations, particularly in public and aging policy.

### 8.4 Immigration and Aging in Canada: Experiences and meanings of place in later life

One central theme that emerged from my project that had originally started out as a guiding principle was the connection between place and aging in the context of migration. In revisiting my project’s overall goals and research questions, there was a common narrative where older immigrants, whether arriving in Canada in later-life or having arrived in Canada at a younger age and are now aging in place\(^{23}\), grapple with health issues and experiences of aging.

\(^{23}\) For this study I used the concept of “aging in place” which encompasses the multiple and interactive ways in which older adults connect with their environments. Rowles (1993) discusses attachment of place over time and the components of environment that define aging in place beyond the process of simply “inhabiting a place”. He notes that older people develop both
through place-making as they also struggle to make connections to Canada while maintaining ties with their native country. Dyck (2005) valorized and emphasized the importance of everyday spaces of the routine, often occurring in the home space as hidden spaces of place-making. Using the lens of feminist geography to trace commonplace and routine activities in both the home and community through the act of caregiving or household activities, she demonstrates that immigrants often are engaged in the processes of place-making and emotional work in their search to recreate “home” or a sense of belonging (Dyck, 2005).

The interest in place and space in gerontology had first appeared in the 1980s with a number of important and seminal works on the role of place and the lives of elderly persons such as residential location and spatial behaviours of older adults, concepts of place and identity in old age to the elderly and their geographic environments (see Andrews et al., 2007; Golant 1972, 1981, 1982, Rowles, 1978). While geographic approaches to aging and place have often focused on two sites of aging: the home space and the residential care facilities (Andrews and Philips, 2005), many of the key informants discussed the health and aging experience of older immigrants in the context of the home or their connections to family. Key informants discussed the role of family and the home space as central sources of support for many immigrant seniors living in Toronto and the GTA. For many immigrants, particularly newcomer seniors, their lives and social circles shrink considerably upon migrating to Canada. As such, their post-migration existence within the social fabric of Canadian society often occurs at the family scale, a site of social

physical attachment and social affinity for the community and neighbourhoods through interactions with friends and neighbours. Cutchin (2003) explains aging in place as the development of familiarity and the “experiential context of space and place” in both the attachment of place and the process of place integration. While aging in place has been regarded in policy and research, as concept that has focuses those factors that are central to the experience of aging and the home setting, Wiles et al. (2011) explored the meaning of aging of place from the perspectives of older persons and found that the aging in place experience was not solely rooted in the home space but at the social and community levels that influenced not only their attachment to place but their sense of security and identity through autonomy and independence. For a more in-depth discussion on aging in place please see Rowles, Cutchin and Wiles.
reproduction. Filial obligations, the changing structure of families, as well as cultural pluralism within intergenerational families consisting of foreign-born parents and Canadian-born children and grandchildren, change the way immigrant seniors experience and seek out a sense of place and belonging. As well, older immigrants’ connections to their birth country and other transnational activities of immigrant families, redefine meanings of place and displacement in later life.

One of the more dominant anti-immigrant themes that key informants reflected on was the notion that immigrants should not cost the state more money and through family reunification, by bringing family members here the financial responsibility lies with the sponsoring family members alone. However, many key informants challenged this pervasive attitude, arguing that many immigrant families are faced with financial hardships and unpredictable and precarious economic circumstances. The lack of supportive systems and resources for sponsoring immigrant families have grave consequences for immigrant seniors, no matter how good their family’s intentions were. Rather than looking at the later-life immigrant as a passive agent that is influenced solely by the social and physical environment I incorporated the important component of individual agency in health-related behaviours, decisions around migration and especially decisions around aging and retirement (Forde and Raine, 2008). This is reflected in discussion with later-life Filipinos, which formed the basis of the case study of health and aging among Filipinos.

Another important finding of my research is the importance of incorporating alternative and more ethnocultural-specific ways of understanding aging, as well as understanding aging from the perspective of an immigrant. This point of view is not well represented in the literature and there are few theories that explore other concepts of aging that acknowledge not only the diversity of aging itself, as a 60-year old is very different than a 90-year old, but also acknowledging the increasing cultural and racial diversity of Canada’s aging population. While
aging in my project was described and understood as an experience, Biggs (2004) has argued that
aging is not just an experience but can be considered another aspect of identity. In particular, he
discusses the identity of aging as a site of power dynamics (Biggs, 2004:96). As he and other
researchers have argued, there are problems with the concepts of normative aging which are too
often applied to all groups of seniors without acknowledging that the aging experience is very
subjective and individualistic. When discussing issues of immigrant health in later-life, very few
theories in ethnogerontology or social gerontology engage in the expectations and experiences of
migration. A number of gerontology researchers have proposed the inclusion of the migratory
experience with aging theory may help explain the immigration process more and the impact of
immigration on aging for older immigrants (Torres, 2006).

Torres in particular, uses a critical constructionist approach to describe older immigrants
in Sweden, rejecting the social term of *elderly immigrant*, which she argues mislabels the older
immigrant population often with negative connotations (2006). In particular she asserts that the
problematic category, this was especially noted during key informant interviews, particularly
when asked to describe older immigrants’ role in society. Policy-makers/planners defined
immigrant seniors differently than service providers, some key informants who took issue with
the term “role” and its implied meaning of being *useful*. They argued that immigrant seniors, as
all seniors, were a part of collective society. By using the word “role” I had inadvertently implied
that immigrant seniors needed a role in order to be deserving of services, rights and other
privileges afforded to non-immigrant groups. In contrast, front-line service providers, whether
they were settlement workers, health care providers or program directors, those who had direct
contact with older immigrants had felt that they needed to justify immigrants’ varied roles in the
immigrant family and within the broader community. This is likely because they are used to providing rationales for funding grants for various programs and initiatives.

There are also diverse pre-migration experiences, many immigrants from various social and political contexts which can enable easy integration into the mainstream society. For instance, many Filipino immigrants recalled having no persistent difficulties when first arriving, because most were fluent in English and able to communicate and find the information they needed to find jobs, navigate health and social care systems. Structures of families are also important in terms of diversity in filial obligation which impacts elder care and the dynamics of intergenerational families. Key informants discussed diversity in terms of cultural family roles and expectations, spousal relationships and traditional gender roles, changing family structures, the complicated geographies of families as well as the economies of families, all of which have an important impact on healthy living in later life. They also described the different ways that immigrants’ themselves envision and experience aging in a foreign land. As well, key informants identified that they were aware of the changes in the recent changes with immigration policies, most specifically designed to restrict migration. As they noted that addressing issues with immigration is not just an issue of controlling who is permitted to migrate and who is not. A more honest analysis of immigration policy in Canada would also consider the amount of support that is available to newcomers. The current lack of support or the decreased funding for newcomer and settlement services that many key informants discussed highlighted the deficiencies in the way that immigration policies inadequately addresses the difficulties and challenges of the immigrant population. As many key informants noted, a focus on economic output and outcomes of immigrant families ignores the reality of the immigrants’ lives in coping with child care, elder care, low wage and unskilled work, etc.

In the case of older Filipino immigrants, and as discussed in Question Six, family reasons factored greatly in Filipinos’ desires to migrate to Canada from the Philippines, but are motivated
by complex transnational processes. Philippine migration to Canada has an interesting and diverse history. To understand Filipino migration, it is important to consider the context of migration in terms of globalized and transnational labour practices in Canada and the economic relationships between Canada and the Philippines, as well as the Philippine’s practice of promoting the Philippine people as a labour export. In particular, the history of Filipino migration has received little attention and is largely misunderstood in the context of Canada’s broader immigration history. Damasco argues that the liberalization of Canada’s immigration policies since the early 1960s accounts for little understanding of Philippine migration to Canada (Damasco, 2012).

It is largely assumed that immigrants’ reasons to migrate include the search of better living conditions or labour prospects or to improve the lives of family members remaining back home in various patterns of transnational activities. However, the history of Filipino migration into Canada is difficult to trace. Early documentation of Filipino migration in Canada or the First Wave of Filipino immigrants have been noted to occur in the 1960s where a significant proportion of immigrants, most notably healthcare professionals, were actively recruited to work in Canada, particularly nurses (Damasco, 2012). However, the cohort of Filipino immigrants who arrived in Canada in the 1980s and onward present a different type of professional with vastly different challenges and experiences. The focus of current literature on Filipino migration in Canada has emphasized Filipino migration through the Live-In Caregiver program, and as important as these descriptions of Filipino immigration are, they represent only a snapshot in the limited history of Filipino migration. Politically, economically and socially, the older Filipino immigrant population in Canada is highly diverse in terms of their transnational activities, occupational histories, family relationships, social supportive networks and their connections to place.
8.5 Key Challenges and Limitations

There were a number of key challenges and limitations that arose from my research, and while my study answers some very important questions about immigrant health and aging, it also raises a number of issues too. One question that emerged was whether or not the relationship between migration and health is an issue of ethnicity or an issue of class, as key informants struggled to identify the most important social determinants of immigrants’ health experiences. In many cases, key informants described their own definitions and working knowledge of culturally competent and culturally sensitive care to discuss the challenges of immigrant populations. This generated even more questions about the appropriate use of the categories of culture, ethnicity or immigrant status when assessing health and health care. For instance, what does cultural competence entail at the service-level versus what is acknowledged within a multicultural community? What are the multicultural practices in place in health care and social care systems and how to effectively merge dominant health and social systems with minority health and cultural systems?

Critiques of cultural competence and the misuse of “culture” in health care approaches have identified the primacy and dominance of the biomedical model which may frame certain cultural aspects as being pathological, whether it is diet, tradition, religious practice, etc. In an effort to shed light on the diverse cultural customs and practices of Canada’s older immigrant population a number of studies have focused exclusively on the role of culture in determining health. However, an important critique of many of these studies, particularly in the realm of health promotion and culturally competent care, has been on the essentializing of culture (Kao, Hsu and Clark, 2004). Often, the extent of culturally competent care is addressing language and communication barriers. As such, for reasons of practically, as confirmed by a number of key informants in my study, cultural competence is often framed as an issue of language where they address communication first, then follow-up about culture and tradition after. This sheds some light onto other ways that language can also act as markers of difference and further identify
immigrants as the cultural other. As explained by Dyck (2001), the culturally marked bodies of patients and the unmarked bodies of health care practitioners reinforce power dynamics and discursive constructions of the other. Language is one form of marking the bodies of older immigrant seniors, where communication about health and health care needs between the provider and patient or caregiver and recipient of care, is of the utmost importance.

Unfortunately, my study did not look closely at the types of culturally competent programs that were available to Toronto and the GTA’s immigrant community. Nor is it clear whether cultural competency skills and training occurs as a standard of care in various settings of care for older persons or how effective they are in improving settlement and integration experiences for newcomer immigrant seniors. Yet these issues raise concerns about the way immigrant seniors are treated within the health care system and reveal some of the complex ways in which migrant status, language, ethnicity and race intersect to create complicated health and health care access issues. With funding cut-backs and program closures to badly needed immigrant and settlement services, that many key informants explained were part of the life history of social and community services in Toronto and the GTA, it is would seem that culturally competent care is falling short in meeting the needs of this vulnerable population.

It has also been reported that the diversity seen in the aging experiences from one individual to another may be the result of predisposed conditions or the interaction of heredity and the environment (Smith and Gerstof, 2004). A major critique of current immigrant health studies has been the near lack of pre-migration data to compare the impact of the migratory event. This is often an issue of time and cost as it would require significant resources to conduct a transmigrant longitudinal study to capture the health and aging experiences accurately from pre-migration to post-migration. Instead, my project, as a cross-sectional analysis on the health of later-life Filipinos relied on retrospective data through recall in order to gain some contextual understanding of the conditions that led to migration and decisions around eldercare. This
represents a serious limitation as much of their discussions about their early migration histories may be subject to recall bias. A significant percentage of Filipino immigrants had already been living in Canada for a long time, that it is likely that recall of their earlier experiences of migration are very much informed by their current context of their lives. For instance, some Filipinos reported not having a family history of diabetes or cardiovascular issues, despite having their own issues with these chronic diseases. They would in turn attribute this to diet or some other lifestyle factor of living in Canada. However, it really is unclear whether the change in environment may have actually resulted in manifestation of congenital chronic diseases that remained latent while living in the Philippines. As diligently pointed out by immigrant health researchers, it is impractical and logistically difficult to incorporate past birth country experiences in the assessment of post-migration health.

Another challenge that came up was in terms of whether migration even factors in as an important element in the aging process. As a consequence of my inquiry, I believed that it was hugely important to understand health and aging as they concern relational concepts of mobility, time and sense of place. The popular assumption, and an important limitation, of health research on immigrant groups, is the view that the effects of migration and settlement occurs the moment when an immigrant first arrives in a foreign land. The healthy immigrant effect which argues that immigrants have better health at the outset of migration compared to the non-immigrant population but whose health rapidly deteriorates over time is premised on this very assumption. To complicate the situation, immigrant groups are often lumped within a single category, or multiple categories such as recent immigrant versus long-term immigrant, without acknowledging that the pooling of all immigrant individuals into a single category ignores the fact that they have all come from different countries, cultures, social and economic systems. This logic, of assuming all immigrants are the same on the hand, is flawed as there is a rich diversity of aging and health experiences in addition to cultural, ethnic and racial diversity of the population itself. In large-
scale studies, the disaggregation of multiple ethnic groups within the immigrant category decreases the statistical power of measuring intergroup differences. This makes it difficult to properly address cultural pluralism and diversity in a meaningful way and to aid our understanding about how immigrants experience aging in a foreign country. This study did not assess the validity of the healthy immigrant effect within older Filipino immigrants, as there were no comparisons made to either non-immigrant born populations or Canadian-born Filipinos. As well, there were no comparisons of Filipino immigrants to non-visible minority immigrants, to examine the role of race and ethnicity and how these factors influence the health and aging experience of Filipinos immigrants. These analyses would certainly enrich our understanding about why my sample of Filipinos are, by most measures healthier, happier and well-adjusted than what is reported in the literature on immigrant populations. Given that very little research on the health of aging Filipino immigrants exist in the Canadian context this study serves as a starting point for more inquiry into Filipino immigrants, or other ethnocultural immigrant groups in Canada.

Lastly, though this study offers a first assessment on the health of aging Filipinos in Canada, using both qualitative and quantitative analyses, my sample is not generalizeable to the broader Filipino population in Canada. This is limitation is especially important to emphasize. While my results have yielded positive results generally about the health status and service utilization of Filipino immigrants in the GTA, readers are cautioned against misconstruing my sample to be representative of all later-life Filipinos residing across the GTA. More specifically, absence from my sample are those Filipino immigrants who lack English-speaking skills, are gravely infirm, reside in long-term care homes, and have newcomers who arrived in the last two years. These specific individuals aside, among my sample the experiences of later life Filipinos were diverse, but not representative of all older Filipino immigrants and thusly these results cannot be generalizeable to the rest of later-life Filipino population living in Canada. Changing
immigration policies from the early 1970s and 1980s onward (and even throughout the fieldwork stage of my research and even after data were analyzed), as well as the changing demographic of newly landed Filipinos are important issues and have significant implications on policy in Canada. This research only captured a specific time, not only in the cross-sectional analyses of older immigrant views and experiences of health but is reflective of a specific time in Filipino migration to Canada, which is vastly different from the contemporary migration experiences of present-day Filipinos.

As there are numerous thriving Filipino communities throughout Canada, it is impossible to extrapolate the findings in this Toronto/GTA sample to other Filipino communities. The Philippines is also made up of thousands of islands and in my study I did not explicitly ask respondents or interviewees to specify what province they came from. While every effort was made to recruit Filipino immigrants from diverse settings in the Toronto and surrounding GTA, it is likely that only a small segment of the Philippine diaspora is captured in this study. As well, where in the Philippines, such as urban versus rural settings, affluent areas versus the barrios or the North versus the South, is likely important information on the migrant background of the Filipinos in my sample but was not sought. Finally, though my study focused on community-dwelling Filipinos, it is missing important information about older Filipinos who are residing in long-term care facilities or supportive senior housing complexes. Likewise, those Filipinos who have remained in the community but are physically isolated, either as a result of being socially and culturally isolated or who are inactive and remain in their homes due to poor access to transportation or supportive networks, they too remain voiceless in my study. Future studies on the aging experiences of later life Filipinos are warranted that take into account the diverse social, economic and gendered circumstances of migration for Filipino immigrants, as well as the specific regions, social, occupational and economic situations of emigrating Filipinos.
8.6 Future Directions

One of the key contributions of my study is that it offers important insights into the health and aging experiences of older immigrants living in an urban area. It adds to the growing field of ethnogerontological research and knowledge taking place in Canada where immigration and aging are two driving forces in demographic change and increasing diversity. More specifically, my study actively recruited key informants who worked in a variety of settings, but with a focus on newcomer settlement services and senior programming. Interviews took place a couple of years after the 2008 Global Financial Crisis, and at a time when a number of controversies plagued immigration policy and political agendas in Canada (See Chapter Four). As a result the key informants shared not only their expert knowledge about the older immigrant population and the many problems they face, but they also expressed their opinions and experiences of how these forces directly influenced their ability and capacity to meet the needs of immigrant seniors and maintain important services to vulnerable immigrant populations.

Another important aim of my project was to explore the intersections of place, migration and aging on a specific group of ethnocultural seniors. More specifically, my project focused on the health and aging of later-life Filipinos, who are an underrepresented and understudied group within Canada-based ethnogerontology. The results from later-life Filipinos were two-fold. Firstly, utilizing mixed methods my study offered a cross-sectional and in-depth view on how health, migration and aging are interrelated, which provided insights into how older Filipinos in Canada connect meanings of place and health to expectations and decisions around aging in a foreign-land. Survey results involved unique analyses on dimensions of place experiences that incorporated transnational and migratory experiences involving waves of Filipino migration, age of migration and health care systems use. Secondly, my study also proposes an alternate way of understanding how race, ethnicity and aging are interrelated and influence health as well as health care and eldercare services, which can be applied or adapted to other understudied ethnocultural and/or immigrant groups in Canada. Often the health inequalities faced by immigrants are the
result of marginalization and marginalizing practices, rather than inherent biology and innate predisposition to disease and illness (Lynam and Cowley, 2007; Hankivsky and Christoffersen, 2008). This research contributes to broader understandings about the role of ethnicity and migration as important social determinants of health. In doing so, this research validates the need for more life-course analyses and perspectives on aging immigrant health as common hypotheses as the healthy immigrant effect offer few explanations about the health trajectories of older immigrants.

There are a number of issues specific to seniors that are important that warrant attention and future study. While demographic predictions about increased diversity, population aging and demographic change are starting to raise concerns about their political and economic implications, they should also raise concerns about seniors policy and pension programs in Canada as well as the quality and availability of eldercare and home support services across all settings (e.g. day programs, long-term care facilities, supportive-housing, community-dwellers, etc.). Additionally, increased diversity in labour and senior populations will mean increased trans-cultural or cross-cultural relationships between health care providers and seniors, which will have important implications on the quality of care being delivered and received. This will not only impact the care for ethnocultural seniors but could potentially influence the workplace conditions and workloads of health care providers. Berry (2010) explores diversity and representation in the nursing profession as a way to address the inequalities and inequities of care overall. In her dissertation she discusses the ways in which the curriculum of nursing needs to change in order to improve care for diverse and multicultural populations of Canada. For instance, she argues for addressing the westernized and Eurocentricism of the nursing education curriculum, increasing the number of minority faculty and to examine commonplace and taken-for-granted assumptions in nursing (Berry, 2010).
Rather than discuss issues of inclusion and exclusion in health care contexts, particularly among immigrant and visible-minority populations, the emphasis of transforming and reforming care should be on the notion of centering of care and the nature of care itself rather than on the recipient of care. That is, how is care delivered and what common assumptions and taken-for-granted practices inform the quality of care that is being delivered. A common critique of studies that research ethnoculturally-specific health issues is the claim that as a descriptive of health, such as Filipino seniors, there a tendency towards essentializing the cultural other or racializing the other (Johnson, Bottorff, Browne, Grewal, Hilton and Clarke, 2004). However, integral to this research is understanding how important social determinants, such as gender and race, interact with other factors to influence how immigrant or visible minority seniors are perceived and therefore treated in health care settings.

Drawn to the notion that immigrant seniors face unique barriers to health care resulting from a lack of culturally competent care models as well as health care systems addressing the cultural contexts in which immigrants seek out health information and care, Koehn (2009) explores the concept of candidacy. In addition to examining the changing circumstances and inter-generational tensions among immigrant seniors with their families, Koehn uses the candidacy framework to identify the intricate ways that access itself influences and is influenced by the vulnerabilities of a senior immigrant group (Koehn, 2009: 588). Dixon-Woods et al. (2006), define candidacy as: “the ways in which people's eligibility for medical attention and intervention is jointly negotiated between individuals and health services…(I)t is a dynamic and contingent process, constantly being defined and redefined through interactions between individuals and professionals, including how "cases" are constructed” (p.7). New ways of thinking about elder care among vulnerable immigrant and visible-minority groups are useful in ensuring that they do not remain disadvantaged and disenfranchised as they struggle to find a sense of belonging and home as they continue to age.

387
An important application of these findings could be to aid in the evaluations of current policy and programs designed to promote active aging and positive health experiences for seniors, such as Ontario’s Aging at Home strategy, which was a plan to reform home and community care programs in Ontario, with the main strategy of integrating community-based care for seniors (Sharkey, 2008). For instance, how have these policies and programs addressed health and social inequalities among vulnerable immigrant and visible-minority group seniors? Given the increasing diversity and cultural pluralism of Ontario’s senior population, how have anti-racist policies been incorporated and anti-immigrant attitudes been addressed both at the policy-level and service delivery-level, particularly in the conduct of health administrators and care professionals. And finally, the information and evidence collected from these informed evaluations can be used to direct policy-making.

As noted above, there are a number of issues open for further inquiry on the health of older immigrants, which are not only timely but relevant in Canada’s growing demography and increasingly multicultural diversity. In the near future, there will be significant challenges and inevitable debate about Canada’s changing demography and many of these changes will require immediate attention and consideration. In 2011, population growth in three of Canada’s largest census metropolitan areas (CMAs) including Toronto was attributed to international migration and it is likely that this upward trend will continue (Statistics Canada, 2012). As well, most recent projections of population growth in Canada predict that international migration may be the only source of growth, outpacing natural growth in decades to come (Statistics Canada, 2012). Much of this increased diversity and changes to Canada’s multicultural landscape will not only impart demographic changes but will also fuel significant social changes as the number of visible minorities will continue to grow (Cardozo and Pendakur, 2008). Cultural and racialized identities, notions of Canadian-ness, negotiations of citizenship, sense of belonging, transnationalism and the processes of place-making are issues that will be at the forefront of the Canadian multicultural
and demographic debate (Dyck, 2001; Dib, Donaldson, Turcotte, 2008), while the worsened conditions for newcomer immigrant populations such as poor economic outcomes, deskilling of the migrant labour force, restrictions on family reunification and poverty will be among some of the most crucial issues for Canada’s current immigration policy and temporary foreign worker programs (Li, 2005). It is important that seniors do not end up being overlooked and their voices are not absent during these important discussions and debates.
Bibliography


Dean, J. A. & Wilson, K. (2009). ‘Education? It is irrelevant to my job now. It makes me very depressed…’: exploring the health impacts of under/unemployment among highly skilled recent immigrants in Canada. *Ethnicity & Health, 14*(2), 185-204.

Dean, J. A. & Wilson, K. (2010). “My health has improved because I always have everything I need here…”: A qualitative exploration of health improvement and decline among immigrants. *Social Science & Medicine, 70*(8), 1219-1228.


IBM Corporation. (2013) *IBM SPSS Statistics 22* [Software]


Lusis, T. (2005a). Filipino immigrants in Canada: A literature review and directions for further research on second-tier cities and rural areas. Immigrant Labour Project, University of Guelph.


Microsoft Ltd. (2010) *Microsoft Excel* [Software]


Appendix 1: Key Informants In-depth Interview Guide

Key Informant: Basic Information

1. Gender:  Male _____  Female _____
2. Title in the organization: __________________________________________
3. Number of years with organization: ______ years
4. Number of years working with elderly population: ______
5. Number of years working with immigrant populations: ______

Organization: Basic Information

1. Type of organization:  (e.g. Newcomer services, Seniors’ community centre, Health clinic, Specialized agencies, etc.) __________________
2. How many years has the organization been active? ______ years
3. Geographic Area Served: _________________________________________
4. Ethno-cultural group served: (e.g. Poly-cultural, mono-cultural, etc.)
   __________________________________________
5. Approximately, what percentage of the clientele are later-life (aged 65 years and over) immigrants? _____ %
6. What services are offered? _______________________________________

General

1. Describe your role in your organization.
2. Describe your involvement with the immigrant community.
3. Describe the role that later-life immigrants have in the GTA. In Canada?
4. Describe to me the later-life Filipino community in the GTA. In Canada?

Later-Life Immigrants

1. What are some of the challenges faced by later-life immigrants in Canada, i.e. immigrants over the age of 65?
2. Can you describe to me the most common health concerns and issues for later-life immigrants are?
3. There are two general groups of later-life immigrants, whose health and health care use, I’m interested in. The first group are those immigrants who arrived in Canada at a younger age, lived a number of years in Canada and are now over 65 years of age. The
second group are immigrants who are sponsored immigrants and are 65 years of age and older when they first arrive in Canada. Can you describe some ways in which these groups may differ? Probes may include:

- Culturally and socially
- Changes in economic situations
- Certain health issues such as chronic illness, medical treatment, etc.
- Changing family roles, social support networks
- Retirement plans

4. What are the some of the challenges faced by later-life Filipinos in Canada?
5. Can you describe to me the most common health (physical or mental) concerns and issues for later-life Filipinos?

### Health Status and Health Care Use

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Generally, do you think Canada’s health care system addresses the needs and concerns of later-life immigrants?</td>
</tr>
<tr>
<td>2. Describe some of the strengths and weaknesses Canada’s health care system with regards to the health of later-life immigrants?</td>
</tr>
<tr>
<td>3. Describe some of the barriers that later-life immigrants may face when accessing health care in Canada?</td>
</tr>
<tr>
<td>4. To your knowledge, do later-life immigrants seek out and receive health care outside of Canada, for example, from their home country? If yes, what types of health care do later-life immigrants receive outside of Canada’s health care system?</td>
</tr>
<tr>
<td>5. To your knowledge, do later-life Filipinos ever return to the Philippines for medical and health care? If yes, what are their reasons for doing so?</td>
</tr>
</tbody>
</table>
Appendix 2: Survey Questionnaire for Later-life Filipinos

Health and Later-life Filipino Immigrants:
Your Attitudes and Health Care Use

Participant # __________

Department of Geography, Queen’s University, Mackintosh-Corry Hall,
Kingston, Ontario K7L 3N6
Contact: Janette Brual, Ph.D. Candidate
Phone#: (613) 533-2000 (ext. 75940), email: 7jb45@queensu.ca
SECTION A: GENERAL HEALTH

1. To start, in general, would you say your health is:

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Compared to one year ago, how would you say your health is now? Is it:

<table>
<thead>
<tr>
<th>Much better than 1 year ago</th>
<th>Somewhat better now (than 1 year ago)</th>
<th>About the same as 1 year ago</th>
<th>Somewhat worse now (than 1 year ago)</th>
<th>Much worse now (than 1 year ago)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Indicate on the scale below of 0 to 10, where 0 means "Very dissatisfied" and 10 means "Very satisfied", how you feel about your life as a whole right now?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>Very satisfied</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. In general, would you say your mental health is:

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Thinking about the amount of stress in your life, would you say that most days are:

<table>
<thead>
<tr>
<th>Not at all stressful</th>
<th>Not very stressful</th>
<th>A bit stressful</th>
<th>Quite a bit stressful</th>
<th>Extremely stressful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION B: CHRONIC HEALTH CONDITIONS

Now I’d like to ask about certain chronic health conditions which you may have. We are interested in "long-term conditions" which are expected to last or have already lasted 6 months or more and that have been diagnosed by a health professional.

<table>
<thead>
<tr>
<th>Chronic Health Conditions</th>
<th>Have it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Do you have asthma?</td>
<td></td>
</tr>
<tr>
<td>b. Do you have allergies? (Hay fever, dermatitis, eczema, allergies to medication, food allergy, others)</td>
<td></td>
</tr>
<tr>
<td>c. Do you have arthritis, excluding fibromyalgia?</td>
<td></td>
</tr>
<tr>
<td>d. Do you have back problems, excluding fibromyalgia and arthritis?</td>
<td></td>
</tr>
<tr>
<td>e. Do you have high blood pressure? (Hypertension)</td>
<td></td>
</tr>
<tr>
<td>f. Have you ever been diagnosed with high blood pressure?</td>
<td></td>
</tr>
<tr>
<td>g. In the past month, have you taken any medicine for high blood pressure?</td>
<td></td>
</tr>
<tr>
<td>h. Do you have migraine headaches?</td>
<td></td>
</tr>
<tr>
<td>i. Do you have chronic bronchitis, emphysema or chronic obstructive pulmonary disease or COPD?</td>
<td></td>
</tr>
<tr>
<td>j. Do you have diabetes?</td>
<td></td>
</tr>
<tr>
<td>k. Do you currently take insulin for your diabetes?</td>
<td></td>
</tr>
<tr>
<td>l. In the past month, did you take pills to control blood sugar?</td>
<td></td>
</tr>
<tr>
<td>m. Do you have heart disease?</td>
<td></td>
</tr>
</tbody>
</table>
n. **Do you have cancer?** (breast, lung, prostate, cervix, stomach, colon, kidney, bone, metastasis or spread, lymphoma, leukemia, others)  
   - YES ☐
   - NO ☐

o. **Have you ever been diagnosed with cancer?**  
   - YES ☐
   - NO ☐

p. **Do you have intestinal or stomach ulcers?**  
   - YES ☐
   - NO ☐

q. **Do you suffer from the effects of a stroke?**  
   - YES ☐
   - NO ☐

r. **Do you suffer from urinary incontinence?**  
   - YES ☐
   - NO ☐

s. **Do you suffer from a bowel disorder?** (Crohn’s Disease, ulcerative colitis, Irritable Bowel Syndrome or bowel incontinence)  
   - YES ☐
   - NO ☐

t. **Do you have Alzheimer’s Disease or any other dementia?**  
   - YES ☐
   - NO ☐

u. **Do you have a mood disorder?** (Depression, bipolar disorder, mania or dysthymia)  
   - YES ☐
   - NO ☐

v. **Do you have an anxiety disorder?** (Phobia, obsessive compulsive disorder or a panic disorder)  
   - YES ☐
   - NO ☐

w. **Do you have any blood problems?** (AIDS or HIV+, anemia or low blood count, hemophilia or other bleeding problems, others)  
   - YES ☐
   - NO ☐

x. **Other problems**  
   - Please list: ______________________________  
   - YES ☐
   - NO ☐

---

**SECTION C: USE OF MOBILITY ASSISTIVE DEVICES**

1. **Do you use any of the following devices outside of the home?**
   - ☐ Yes
   - ☐ No
   (If Yes) Please indicate which device(s) you use **outside of your home:**
   - ☐ Wheelchair
   - ☐ Cane
   - ☐ Walker
   - ☐ Crutches
   - ☐ Other - Please specify: ________________________

2. **Do you use any of the following devices to get around inside your home?**
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Can you take care of yourself, that is, eating, dressing, bathing or using the toilet?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2. Can you walk indoors, such as around your house?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3. Can you walk a block or two on level ground?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4. Can you climb a flight of stairs or walk up a hill?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5. Can you run a short distance?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6. Can you do light work around the house like dusting or washing dishes?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7. Can you do moderate work around the house like vacuuming, sweeping floors, or carrying in the groceries?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8. Can you do heavy work around the house like scrubbing floors, or lifting or moving heavy furniture?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>9. Can you do yard work like raking leaves, weeding or pushing a power mower?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

(If Yes) Please indicate which device(s) you use inside of your home:
- Wheelchair
- Cane
- Walker
- Crutches
- Other - Please specify: ______________________

SECTION D: ACTIVITY STATUS

The following questions have to do with your current activity status.
10. Can you have sexual relations?

   Yes   No

11. Can you participate in moderate recreational activities like golf, bowling, dancing, doubles tennis, or throwing a baseball or football?

   Yes   No

12. Can you participate in strenuous sports like swimming, singles tennis, football, basketball or skiing?

   Yes   No

SECTION E: HEALTH BEHAVIOURS

1. At the present time, do you smoke cigarettes?

   Yes
   (If Yes) How often do you smoke cigarettes?
   - Daily
   - 4 to 6 times a week
   - 2 to 3 times a week
   - Once a week
   - 2 to 3 times a month
   - Once a month
   - Less than once a month

   Did you smoke cigarettes prior to immigrating to Canada?
   - Yes
   - No

   Please choose the category that best describes your smoking behaviour since immigrating to Canada:
   - I smoke less cigarettes since immigrating.
   - I smoke the same since immigrating.
   - I smoke more cigarettes since immigrating.

   No
   (If No) Please choose the category that best describes you:
   - Never smoked cigarettes
   - Former smoker

   (If “former smoker”) Thinking about the last time you quit smoking, how long ago did you quit? _________________

   Did you quit smoking after immigrating to Canada?
   - Yes
   - No
2. **During the past 12 months, that is, from one year ago, have you had a drink of beer, wine, liquor or any other alcoholic beverage?**

- No
- Yes

   (If Yes) During the past 12 months, how often did you drink alcoholic beverages?

   - Less than once a month
   - Once a month
   - 2 to 3 times a month
   - Once a week
   - 2 to 3 times a week
   - 4 to 6 times a week
   - Every day

How often in the past 12 months have you had 5 or more drinks on one occasion?

   - Never
   - Less than once a month
   - Once a month
   - 2 to 3 times a month
   - Once a week
   - More than once a week

Please choose the category that best describes your alcohol consumption since immigrating to Canada:

- I drink more alcoholic beverages since immigrating.
- I drink the same alcoholic beverages since immigrating.
- I drink less alcoholic beverages since immigrating

3. **Have you done any of the following in the past 3 months, that is, from [date three months ago] to yesterday? (Choose all that apply.)**

   - Walking for exercise
   - Bicycling
   - Ice hockey
   - Jogging or running
   - Downhill skiing or Snowboarding
   - Tennis
   - Volleyball
   - Gardening or yard work
   - Popular or social dance
   - Ice skating
   - Golfing
   - Bowling
   - Weight-training
   - Basketball
   - Swimming
   - Home exercises
   - In-line skating or rollerblading
   - Exercise class or aerobics
   - Baseball or softball
   - Fishing

Any other, please specify: ____________________________

   - No physical activity

4. **Thinking about your leisure time activity over the past 3 months, how often did you participate in any physical activity?**
5. Thinking about your leisure time activity over the past 3 months, how much time did you spend on each occasion of physical activity?

- Once a month
- Two or three times a month
- Once a week
- Two to three times a week
- Four to six times a week
- Daily

6. At the present time are you physically active, i.e. participate in any moderate activity for at least 20 minutes most days of the week?

- Yes
- No
- No, but I plan to be.

7. Since immigrating to Canada, has your diet changed?

- Yes
- No

   (If Yes) In general, which statement best describes your current diet:
   - I mainly eat traditional Filipino foods.
   - I eat more traditional Filipino foods.
   - I eat less traditional Filipino foods.
   - I do not eat any traditional Filipino foods.

8. Thinking about your current diet, do you eat more fruits and vegetables:

- Yes
- No

   (If Yes) In general, which statement best describes your diet in a typical week (7 days):
   - I eat the recommended 7-8 servings of fruits and vegetables everyday
   - I eat the recommended 7-8 servings of fruits and vegetables most days of the week
   - I eat 3 to 6 servings of fruits and vegetables everyday
   - I eat less than 3 servings of fruits and vegetables most days
   - I rarely eat fruits and vegetables

9. Do you make attempts to eat less saturated fats (e.g. red meat, chicken, pork, cheese, eggs, milk, butter, fried foods, baked goods, etc.)?

- Yes
- No

10. Do you make attempts to lower your salt intake?

- Yes
- No
11. In the past 12 months, did you ever cut the size of your meals or skip meals because there was not enough money for food?
   ☐ Yes ☐ No

12. In the past 12 months, did you ever eat less because there was not enough money to buy food?
   ☐ Yes ☐ No

13. In the past 12 months, were you ever hungry but did not eat because you could not afford enough food?
   ☐ Yes ☐ No

SECTION F: HEALTH CARE SYSTEM SATISFACTION

Now, a few questions about health care services in Toronto and the surrounding GTA.

1. Overall, how would you rate the availability of health care services in Toronto and the surrounding GTA?
   
   Excellent  ☐  Good  ☐  Fair  ☐  Poor  ☐

2. Overall, how would you rate the quality of the health care services that are available in Toronto and the surrounding GTA?
   
   Excellent  ☐  Good  ☐  Fair  ☐  Poor  ☐

SECTION G: HEALTH CARE UTILIZATION

1. Do you have a regular medical doctor?
   
   ☐ Yes ☐ No

   (If No) Why do you not have a regular medical doctor? (Choose all that apply)
   
   ☐ No medical doctors available in the area
   ☐ Medical doctors in the area are not taking new patients
   ☐ Have not tried to contact one Walk-in clinic
   ☐ Had a medical doctor who left or retired
   ☐ Other (specify) ________________________________
2. **Is there a place that you usually go to when you are sick or need advice about your health?**

   [ ] Yes  
   [ ] No

   **(If Yes) What kind of place is it?**

   [ ] Doctor’s office  
   [ ] Community health centre / CLSC  
   [ ] Walk-in clinic  
   [ ] Appointment clinic  
   [ ] Telephone health line (e.g. HealthLinks, Telehealth Ontario, Health-Line TeleCare, InfoSanté)  
   [ ] Hospital emergency room  
   [ ] Hospital outpatient clinic  
   [ ] Other (specify) ____________________________________________________________

   If more than one usual place, what kind of place do you go to most often?

   ________________________________________________________________

3. **Do you and this doctor usually speak in English, in French, or in another language?**

   Please specify ________________________________________________

**SECTION H: CONTACTS WITH HEALTH PROFESSIONALS**

Now I’d like to ask about your contacts with various health professionals during the past 12 months, that is, from [date one year ago] to yesterday.

1. **In the past 12 months, have you been a patient overnight in a hospital, nursing home or convalescent home?**

   [ ] Yes  
   [ ] No

2. **In the past 12 months, have you seen or talked to any of the following health care professionals about your physical, emotional or mental health?**

   A **family doctor** or a **general practitioner**?

   [ ] Yes  
   [ ] No

   Any other **medical doctor** or specialist such as a **surgeon**, **allergist**, **orthopaedist**, or **psychiatrist** (urologist or gynaecologist)?

   [ ] Yes  
   [ ] No

   A **nurse** for care or advice?

   [ ] Yes  
   [ ] No

   An **ophthalmologist** or **optometrist**?

   [ ] Yes  
   [ ] No

   A **dentist**, **dental hygienist** or **orthodontist**?

   [ ] Yes  
   [ ] No

   A **chiropractor**?

   [ ] Yes  
   [ ] No
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A physiotherapist?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A psychologist?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A social worker or counsellor?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>An audiologist, a speech or occupational therapist?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A dermatologist?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A naturapathic doctor?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A massage therapist?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>An acupuncturist?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, please specify: _____________________________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION I: HOME CARE SERVICES

Now some questions on home care services. These are health care, home maker or other support services received at home. People may receive home care due to a health problem or condition that affects their daily activities. Examples include: nursing care, personal care or help with bathing, housework, meal preparation, meal delivery and respite care.

1. Have you received any home care services in the past 12 months, with the cost being entirely or partially covered by government?

   □ Yes
   □ No

   (If Yes) What type of services did you receive?
   □ Nursing care (e.g., dressing changes, preparing medications, V.O.N. visits)
   □ Other health care services (e.g., physiotherapy, occupational or speech therapy, nutrition counselling)
   □ Medical equipment or supplies
   □ Personal care (e.g., bathing, foot care)
   □ Housework (e.g., cleaning, laundry)
   □ Meal preparation or delivery
   □ Shopping
   □ Respite care (i.e., caregiver relief)
   □ Other
   (specify) ___________________________________________

2. Have you received any other home care services in the past 12 months, with the cost not covered by government (for example: care provided by a private agency or by a spouse or friends)?

   □ Yes
   □ No

   (If Yes) Who provided these other home care services?
   □ Nurse from a private agency
   □ Homemaker or other support services from a private agency
   □ Physiotherapist or other therapist from a private agency
   □ Neighbour or friend
   □ Family member or spouse
   □ Volunteer
   □ Other
   (specify) ___________________________________________

   What type of services have you received?
   □ Nursing care (e.g., dressing changes, preparing medications, V.O.N. visits)
   □ Other health care services (e.g., physiotherapy, occupational or speech therapy, nutrition counselling)
   □ Medical equipment or supplies
   □ Personal care (e.g., bathing, foot care)
   □ Housework (e.g., cleaning, laundry)
   □ Meal preparation or delivery
   □ Shopping
   □ Respite care (i.e., caregiver relief)
   □ Other
   (specify) ___________________________________________
3. During the past 12 months, was there ever a time when you felt that you needed home care services but you didn’t receive them?

☐ Yes  
☐ No  

(If Yes) Thinking about the most recent time, why didn’t you get these services?

☐ Not available - in the area  
☐ Not available - at time required (e.g., inconvenient hours)  
☐ Waiting time too long  
☐ Felt would be inadequate  
☐ Cost  
☐ Too busy  
☐ Didn’t get around to it / didn’t bother  
☐ Didn’t know where to go / call  
☐ Language problems  
☐ Personal or family responsibilities  
☐ Decided not to seek services  
☐ Doctor - did not think it was necessary  
☐ Did not qualify / not eligible for home care  
☐ Still waiting for home care  
☐ Other (specify)_______________________________________

Where did you try to get this home care service?

☐ A government sponsored program  
☐ A private agency  
☐ A family member, friend or neighbour  
☐ A volunteer organization  
☐ Other (specify)_______________________________________

SECTION J: SATISFACTION – HEALTH CARE SERVICES

Earlier, I asked about your use of health care services in the past 12 months. Now I’d like to get your opinion on the quality of the care you received.

1. In the past 12 months, have you received any health care services?

☐ Yes  
☐ No  

2. Overall, how would you rate the quality of the health care you received? Would you say it was:

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

3. Overall, how satisfied were you with the way health care services were provided? Were you:

<table>
<thead>
<tr>
<th>Very satisfied</th>
<th>Somewhat satisfied</th>
<th>Neither satisfied nor dissatisfied</th>
<th>Somewhat dissatisfied</th>
<th>Very dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
4. In the past 12 months, have you received any health care services at a hospital, for any diagnostic or day surgery service, overnight stay, or as an emergency room patient?

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(If Yes) 4a. Thinking of your most recent hospital visit, were you:

- ☐ admitted overnight or longer (an inpatient)?
- ☐ a patient at a diagnostic or day surgery clinic (an outpatient)?
- ☐ an emergency room patient?

4b. Thinking of this most recent hospital visit, how would you rate the quality of the care you received? Would you say it was:

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>Good</td>
<td>Fair</td>
<td>Poor</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

4c. Thinking of this most recent hospital visit, how satisfied were you with the way the hospital services were provided?

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>Somewhat satisfied</td>
<td>Neither satisfied or dissatisfied</td>
<td>Somewhat dissatisfied</td>
<td>Very dissatisfied</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

5. In the past 12 months, not counting hospital visits, have you received any health care services from a family doctor or other physician?

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(If Yes) 5a. Thinking of your most recent time, was care provided by:

- ☐ A family doctor (general practitioner)?
- ☐ A medical specialist?

5b. Thinking of this most recent care from a physician, how would you rate the quality of the care you received? Would you say it was:

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>Good</td>
<td>Fair</td>
<td>Poor</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

5c. Thinking of this most care from a physician, how satisfied were you with the way physician care was provided?

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied</td>
<td>Somewhat satisfied</td>
<td>Neither satisfied or dissatisfied</td>
<td>Somewhat dissatisfied</td>
<td>Very dissatisfied</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
SECTION K: SATISFACTION – COMMUNITY-BASED CARE

The next questions are about community-based health care which includes any health care received outside of a hospital or doctor’s office. Examples are: home nursing care, home-based counselling or therapy, personal care and community walk-in clinics.

1. In the past 12 months, have you received any community-based care?

[ ] Yes

[ ] No

(If Yes) Overall, how would you rate the quality of the community-based care you received? Would you say it was:

- Excellent
- Good
- Fair
- Poor

Overall, how satisfied were you with the way community-based care was provided? Were you:

- Very satisfied
- Somewhat satisfied
- Neither satisfied or dissatisfied
- Somewhat dissatisfied
- Very dissatisfied

SECTION L: ACCESS TO HEALTH SERVICES

The next questions are about the use of various health care services. I will start by asking about your experiences getting health care from a medical specialist such as a cardiologist, allergist, urologist or gynaecologist or psychiatrist (excluding an optometrist).

1. In the past 12 months, did you require a visit to a medical specialist for a diagnosis or a consultation?

[ ] Yes

[ ] No

2. In the past 12 months, did you ever experience any difficulties getting the specialist care you needed for a diagnosis or consultation?

[ ] Yes

[ ] No

(If Yes) What type of difficulties did you experience?

- Difficulty getting a referral
- Difficulty getting an appointment
- No specialists in the area
- Waited too long - between booking appointment and visit
- Waited too long - to see the doctor (i.e. in-office waiting)
- Transportation – problems
- Language – problem
- Cost
- Personal or family responsibilities
- General deterioration of health
- Appointment cancelled or deferred by specialist
- Still waiting for visit
- Unable to leave the house because of a health problem
- Other (specify) ____________________
The following questions are about any surgery not provided in an emergency that you may have required, such as cardiac surgery, joint surgery, caesarean sections and cataract surgery, excluding laser eye surgery.

3. In the past 12 months, did you require any non-emergency surgery?
   - [ ] Yes
   - [ ] No

4. In the past 12 months, did you ever experience any difficulties getting the surgery you needed?
   - [ ] Yes
   - [ ] No
   
   *(If Yes) What type of difficulties did you experience?*
   
   - Difficulty getting an appointment with a surgeon
   - Difficulty getting a diagnosis
   - Waited too long – for a diagnosis
   - Waited too long – for a hospital bed to become available
   - Waited too long – for surgery
   - Service not available - in the area
   - Transportation – problems
   - Language – problem
   - Cost
   - Personal or family responsibilities
   - General deterioration of health
   - Appointment cancelled or deferred by surgeon or hospital
   - Still waiting for surgery
   - Unable to leave the house because of a health problem
   - Other (specify) ____________________________

5. Now some questions about MRIs, CAT Scans and angiographies provided in a nonemergency situation. In the past 12 months, did you require one of these tests?
   - [ ] Yes
   - [ ] No

6. In the past 12 months, did you ever experience any difficulties getting the tests you needed?
   - [ ] Yes
   - [ ] No
   
   *(If Yes) What type of difficulties did you experience?*
   
   - Difficulty getting a referral
   - Difficulty getting an appointment
   - Waited too long – to get an appointment
   - Waited too long – to get a test (i.e. in-office waiting)
   - Service not available – at time required
   - Service not available – in the area
   - Transportation – problems
   - Language – problem
   - Cost
   - General deterioration of health
   - Did not know where to go (i.e. information problems)
   - Still waiting for test
   - Unable to leave the house because of a health problem
   - Other (specify) ____________________________
7. In the past 12 months, have you required health information or advice for yourself?

☐ Yes

(If Yes) Who did you contact when you needed health information?

☐ Doctor's office
☐ Community health centre/CLSC
☐ Walk-in clinic
☐ Telephone health line (for example, HealthLinks, Telehealth Ontario, Health-Line, TeleCare, Info-Santé)
☐ Hospital emergency room
☐ Other hospital service
☐ Other

(specify)______________________________________

☐ No

8. In the past 12 months, did you ever experience any difficulties getting the health information or advice you needed?

☐ Yes

(If Yes) What type of difficulties did you experience?

☐ Difficulty contacting a physician or nurse
☐ Did not have a phone number
☐ Could not get through (i.e. no answer)
☐ Waited too long to speak to someone
☐ Did not get adequate info or advice
☐ Language - problem
☐ Did not know where to go / call / uninformed
☐ Unable to leave the house because of a health problem
☐ Other

(specify)______________________________________

☐ No

9. Do you have a regular family doctor?

☐ Yes ☐ No

10. In the past 12 months, did you require any routine or on-going care for yourself?

☐ Yes ☐ No
11. In the past 12 months, did you ever experience any difficulties getting the routine or ongoing care you needed?

☐ Yes

☐ No

(If Yes) What type of difficulties did you experience?

☐ Difficulty contacting a physician

☐ Difficulty getting an appointment

☐ Do not have personal / family physician

☐ Waited too long - to get an appointment

☐ Waited too long - to see the doctor (i.e. in-office waiting)

☐ Service not available - at time required

☐ Service not available - in the area

☐ Transportation - problems

☐ Language - problem

☐ Cost

☐ Did not know where to go (i.e. information problems)

☐ Unable to leave the house because of a health problem

☐ Other

(specify)_________________________

12. In the past 12 months, have you or required immediate health care services for a minor health problem?

☐ Yes ☐ No

13. In the past 12 months, did you ever experience any difficulties getting the immediate care needed for a minor health problem for yourself or a family member?

☐ Yes ☐ No

SECTION M: INSURANCE COVERAGE

Now, turning to your insurance coverage, please include any private, government or employer-paid plans.

1. Do you have insurance that covers all or part of the cost of your prescription medications?

☐ Yes

☐ No

(If Yes) Is it:

☐ A government-sponsored plan?

☐ An employer-sponsored plan?

☐ A private plan?

2. Do you have insurance that covers all or part of your dental expenses?

☐ Yes

☐ No

(If Yes) Is it:

☐ A government-sponsored plan?

☐ An employer-sponsored plan?

☐ A private plan?
3. Do you have insurance that covers all or part of the costs of eye glasses or contact lenses?

☐ Yes

☐ No

(If Yes) Is it:

☐ A government-sponsored plan?

☐ An employer-sponsored plan?

☐ A private plan?

4. Do you have insurance that covers all or part of hospital charges for a private or semi-private room?

☐ Yes

☐ No

(If Yes) Is it:

☐ A government-sponsored plan?

☐ An employer-sponsored plan?

☐ A private plan?

SECTION N: YOUR FEELINGS

Instructions: We are interested in how you feel about the following statements. Read each statement carefully and choose the best answer for how you felt over the past week. Circle “yes” or “no”.

1. Are you basically satisfied with your life?  Yes  No
2. Have you dropped many of your activities and interests?  Yes  No
3. Do you feel that your life is empty?  Yes  No
4. Do you often get bored?  Yes  No
5. Are you in good spirits most of the time?  Yes  No
6. Are you afraid that something bad is going to happen to you?  Yes  No
7. Do you feel happy most of the time?  Yes  No
8. Do you often feel restless and fidgety?  Yes  No
9. Do you frequently worry about the future?  Yes  No
10. Do you feel you have more problems with memory than most?  Yes  No
11. Do you feel downhearted and blue?  Yes  No
12. Do you feel pretty worthless the way you are now?  Yes  No
13. Do you think that most people are better off than you are now?  Yes  No
14. Do you frequently get upset over little things?  Yes  No
15. Do you frequently feel like crying?  Yes  No
SECTION O: YOUR SOCIAL SUPPORTS

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the “1” if you Very Strongly Disagree
Circle the “2” if you Strongly Disagree
Circle the “3” if you Mildly Disagree
Circle the “4” if you are Neutral
Circle the “5” if you Mildly Agree
Circle the “6” if you Strongly Agree
Circle the “7” if you Very Strongly Agree

☐ There is a special person who is around when I am in need.  
☐ There is a special person with whom I can share my joys and sorrows.  
☐ My family really tries to help me.  
☐ I get the emotional help and support I need from my family.  
☐ I have a special person who is a real source of comfort to me.  
☐ My friends really try to help me.  
☐ I can count on my friends when things go wrong.  
☐ I can talk about my problems with my family.  
☐ I have friends with whom I can share my joys and sorrows.  
☐ There is a special person in my life who cares about my feelings.  
☐ My family is willing to help me make decisions.  
☐ I can talk about my problems with my friends.
SECTION P: YOUR INTERPERSONAL RELATIONS

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Slightly Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Slightly Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I always place the needs of others above my own.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I never find myself getting overly involved in others’ problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. For me to be happy, I need others to be happy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I worry about how other people get along without me when I am not here.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I have no trouble getting to sleep at night when other people are upset.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. It is impossible for me to satisfy my own needs when they interfere with the needs of others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I can’t say no when someone asks me for help.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Even when exhausted, I will always help other people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I often worry about others’ problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION Q: IMMIGRATION TO CANADA

1. In what year did you first come to Canada to live? __________

2. Which category best describes how you first arrived in Canada as a permanent resident:
   1. Skilled worker or professional
   2. Canadian work or education experience
   3. Business (Investor, entrepreneur, investor)
   4. Provincial nominee
   5. Family class (sponsorship)
   6. Refugee
   7. Other (specify) _______________________

3. Are you currently a Canadian citizen/landed immigrant?
   □ Yes  □ No

4. Do you intend to live in Canada for the rest of your life?
   □ Yes  □ No  (If No) Where do you plan to live?

5. Do you intend to apply for Canadian citizenship?
   □ Yes  □ No
6. Since your first arrival in Canada, have you returned back to your birth country?

☐ Yes  ☐ No

7. Do you consider yourself to be a regular visitor to the Philippines (e.g., you return every year)

☐ Yes  ☐ No

8. Do you currently own property in your birth country?

☐ Yes  ☐ No

SECTION R: HEALTH CARE USE ELSEWHERE

1. Since immigrating to Canada, have you ever intentionally sought elective (non-emergency) health care outside of Canada?

☐ Yes  ☐ No

(If Yes) What health care services did you receive?

☐ Emergency care services
☐ General practitioner – consultation and diagnosis
☐ Medical specialist – consultation
☐ Medical test or treatment
☐ Prescription drugs
☐ Physical therapy
☐ Mental health care
☐ Elective (non-emergency) surgery
☐ Non-elective surgery
☐ Medical information or advice
☐ Dental services
☐ Optical
☐ Other (specify) ____________________________

2. Since immigrating to Canada, have you ever intentionally sought traditional medical care/treatment in the Philippines not found in Canada?

☐ Yes  ☐ No

(If Yes) Please describe the type of care/treatment: __________________________

________________________________________________________

3. Thinking back to before you immigrated to Canada, did you have a regular doctor?

☐ Yes  ☐ No
4. Do you think your health would be different than it is now if you didn’t come live in Canada?

☐ Yes (If Yes) What do you think your health would be like if you didn’t move to Canada and were still living in the Philippines?
☐ No ☐ Better than it is now
☐ My health would not be the same
☐ Worse than it is now

5. Thinking of the time before you immigrated to Canada, how would you rate the quality of the care you received? Would you say it was:

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

6. Thinking of the time before you immigrated to Canada, how satisfied were you with the way the services were provided?

<table>
<thead>
<tr>
<th>Very satisfied</th>
<th>Somewhat satisfied</th>
<th>Neither satisfied or dissatisfied</th>
<th>Somewhat dissatisfied</th>
<th>Very dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

7. If you were to experience any difficulties in accessing health care services in Canada (e.g. long waiting list for surgery or treatment or medication not available in Canada), would you consider going to the Philippines to receive these services?

☐ Yes ☐ No

SECTION S: SOCIODEMOGRAPHICS

1. What is your sex?

☐ Female ☐ Male

2. What is your date of birth? _____Day_______ Month_____ Year

3. What is your present marital status?

☐ Never Married
☐ Married
☐ Divorced
☐ Widowed
☐ Other (specify)____________________________________________________

4. Who do you live with?

☐ With spouse
☐ With children
☐ Alone
☐ Other (specify)____________________________________________________
5. What is the highest level of education you have completed?
   - Less than grade 9
   - Less than high school
   - Completed high school
   - Some college or university courses
   - Completed college or university degree
   - Graduate School/Professional Program

6. What best describes your current work status?
   - Full-time work
   - Part-time work
   - Full-time caregiver or homemaker (inside your home)
   - Unemployed
   - Receiving disability
   - Retired
   - Other (specify) _____________________________

7. What is your gross family income (before taxes from all sources)?
   - $19,999 or less
   - $20,000 - $29,999
   - $30,000 - $39,999
   - $40,000 - $49,999
   - $50,000 - $59,999
   - $60,000 - $69,999
   - $70,000 - $79,999
   - $80,000 - $89,999
   - $90,000 - $99,999
   - $100,000 - $149,999
   - $150,000 - $200,000
   - $200,000 or greater

8. What type of dwelling do you live in? Is it a:
   - Single or detached house
   - Double
   - Row or terrace
   - Duplex
   - Low-rise apartment of fewer than 5 stories or a flat
   - High-rise apartment of 5 or more stories
   - Institution
   - Hotel/rooming or lodge house
   - Mobile home
   - Other (specify) _____________________________

9. How many bedrooms are there? ___________

10. Is this dwelling owned by a member of the household?
    - Yes
    - No
Thank you for taking the time to answer this questionnaire. Your assistance in providing this information is very much appreciated.

We are also inviting a select number of participants to participate in a follow-up face-to-face interview to share further their immigration and health experiences. If you are interested in participating, please provide the following information:

Name: ______________________________________________________________________
Day time telephone number (mobile, home, or work) _________________________________
E-mail address __________________________________________________________________

We will contact you if you are eligible to participate.

If there is anything else you would like to tell us about this survey, or about your health experiences, please do so in the space provided below.
**Appendix 3: Later-Life Filipino In-depth Interview Guide**

<table>
<thead>
<tr>
<th>Later-Life Filipino Immigrant Socio-demographics:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender:</strong> Male _____ Female _____</td>
</tr>
<tr>
<td><strong>Date of Birth:</strong> ____________________________</td>
</tr>
<tr>
<td><strong>Marital Status:</strong> Never Married ______ Married ______ Divorced ______ Widowed ______ Other ______</td>
</tr>
<tr>
<td><strong>Number of Children:</strong> __________ Grandchildren: _______</td>
</tr>
<tr>
<td><strong>Current Work Status:</strong></td>
</tr>
<tr>
<td>Full-time __________ Part-time __________ Retired ______</td>
</tr>
<tr>
<td><strong>Living Status:</strong> Alone ______ Spouse ______ Other ______</td>
</tr>
<tr>
<td><strong>Current Residence:</strong> Own ______ Rent ______ Other ______</td>
</tr>
<tr>
<td><strong>How many people are currently living with you?</strong> _______</td>
</tr>
<tr>
<td><strong>Most Recent Work Experience:</strong> ______________</td>
</tr>
<tr>
<td><strong>Work Experience Before Immigrating to Canada:</strong> ______________</td>
</tr>
<tr>
<td><strong>Highest Level of Education Attained:</strong> ______________</td>
</tr>
<tr>
<td><strong>Languages Spoken:</strong> __________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immigration and Settlement:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immigrant Class Category:</strong></td>
</tr>
<tr>
<td>Skilled Worker ______ Economic ______ Family ______ Refugee ______ Other ______</td>
</tr>
<tr>
<td><strong>If through Family Reunification Category, who sponsored you:</strong> ______________</td>
</tr>
<tr>
<td><strong>Date of First Arrival in Canada:</strong> ______________</td>
</tr>
<tr>
<td><strong>Years in Canada:</strong> ______________</td>
</tr>
<tr>
<td><strong>Country of Birth:</strong> ______________</td>
</tr>
<tr>
<td><strong>Do you currently have Canadian citizenship?</strong> ______________</td>
</tr>
<tr>
<td><strong>If no, do you intend to apply for Canadian citizenship?</strong> ______________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-Migration Experience:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Thinking back to when you first arrived in Canada, what were your reasons for immigrating?</td>
</tr>
</tbody>
</table>
2. Did you face any difficulties or barriers when you first immigrated to Canada?
3. Do you maintain ties with friends or family in the Philippines?
4. Do you maintain a residence in the Philippines? If yes, do you own or rent your residence in the Philippines?
5. Do you own or rent a residence in Canada? If yes, how often do you return to the Philippines?
6. Have you ever returned to your home country since immigrating to Canada?
7. Describe your reasons for returning to your home country?
8. Do you intend to live in Canada for the rest of your life?

**Health Status:**

1. How would you define health? Wellbeing?
2. How would you rate your current health status?
3. Thinking back to before you immigrated to Canada, how would you describe your health status then?
4. Do you think your health would be different than it is now if you didn’t come to Canada?
5. In Canada, the retirement age is 65. Are you currently retired?
6. Did you expect to live your retirement years in another country like Canada?
7. OR (If not retired) Describe your plans for retirement?

**Social Support and Active Engagement:**

1. How many close friends do you have here in Canada?
2. Describe your current living arrangements. (i.e. Who do you live with?)
3. Are you active within your community? (e.g. church groups, seniors groups, Filipino-related community groups, etc.)
4. Do you belong to any social groups?
5. Do you vote in political elections?

**Health Care Use:**

1. Do you experience any difficulties getting the health care you need in Canada?
2. Describe any barriers to medical and health care in Canada, if any.
3. Have you ever received health care outside of Canada? If yes, where did you receive this health care? If applicable, describe the types of health care services you received.
4. How would you compare your health care use in Canada to your health care use when you were in the Philippines? (For example, did you have a regular doctor? Did you see a dentist regularly? Were you able to access health care?)
Appendix 4: Letter of Information – Key Informants

Department of Geography
Mackintosh Corry Hall
Queen’s University
Kingston ON
K7L 3N6

Title of Project: Exploring social determinants and the role of place among aging immigrants: challenging the health status and utilization of health services by later-life Filipino immigrants

Faculty Supervisor: Dr. Mark W. Rosenberg, Department of Geography
Phone: (613) 533-6046 E-mail: mark.rosenberg@queensu.ca

Student Investigator: Janette Brual, Department of Geography
Phone: (613)533-6000 ext.75940 E-mail: 7jb45@queensu.ca

Study Purpose: Changes in Canada’s immigration and citizenship programs and policies have had an important impact on immigrants arriving in Canada over recent years. As well, Canada is experiencing an aging population with the frontrunners of the baby-boom generation entering retirement. Both immigration and aging are two demographic forces which may have important consequences for many communities in Canada. I am a Doctoral student in the Department of Geography at Queen’s University conducting research under the supervision of Dr. Mark Rosenberg and I am interested in the health and health care issues for the aging immigrant population.

The purpose of this study is to understand how place and other core social determinants of health, such as race, gender, age and socio-economic status, affect health status and health care patterns. I am also interested in the migration and settlement experiences of aging immigrants and how this may also influence their health and well being. There has been little research that has addressed the health concerns of Canada’s immigrants in later-life (≥ 65 years) regardless of time since arriving in Canada. I am especially interested in Filipinos living in the Greater Toronto Area (GTA) who are 65 years and older.

Key informants were identified based on their affiliations with organizations/ agencies in the GTA that serve later-life immigrant and newcomer communities. You have been invited to participate in this study because I am interested in hearing about your experiences working with aging and/or immigrant communities in the GTA. I am also interested on your perspectives of what the current challenges are for the health care management of aging immigrants and what you believe the current public health and program policies mean for later-life immigrants. Key informants will include health care professionals (nurses, doctors, etc.), residential and long-term care directors/managers, social services workers, immigrant/newcomer services employees and church leaders. Key informants will be asked to discuss their perspectives on the general health and/or health care experiences of later-life Filipino immigrants in the GTA. Key informants will also be asked what the challenges are for both the aging immigrant community and the
community at large. By participating in this interview and completing a brief survey, you have the opportunity to share your experiences.

Your participation in this research is strictly voluntary. It will involve an interview of approximately 60 minutes in length and will take place at a mutually agreed upon time and location. You may choose not to answer any question and may withdraw from this research at any point during the interview. The information you provide during your participation in this research will remain strictly confidential and will remain known only to myself and. Your name will not appear in any written materials, publications or presentations that result from this project. With your consent, the interview will be audio taped to document the conversation and will be transcribed at a later date. If you choose not to be audio taped, then notes will be taken by the interviewer. You will have the right to review the transcription record from your interview.

The information gathered during this study will remain confidential and will not be used for any purposes other than the objectives of this research. The results of this research may be published as part my doctoral dissertation as well as in standard academic outlets such as journals, books, and papers for presentation at academic conferences. The information collected will be retained for seven years in a secure location. There are no known or anticipated risks to you as a participant.

This research project has been reviewed and received ethics approval by the General Research and Ethics Board at Queen’s University. Any questions about study participation may be directed to Janette Brual at 613-533-6000 ext.75940 or by e-mail at 7jb45@queensu.ca or to Dr. Rosenberg at 613-533-6046 or by e-mail at mark.rosenberg@queensu.ca. Any ethical concerns about the study may be directed to the Chair of the General Research Ethics Board at chair.GREB@queensu.ca or 613-533-6081.

Thank you.

Sincerely,

Janette Brual

PhD Candidate
Queen's University
Department of Geography
Mackintosh-Corry Hall, Room D314
Kingston, Ontario, Canada, K7L 3N6
Appendix 5: Letter of Information – Later-Life Filipinos: Survey

Title of Project: Exploring social determinants and the role of place among aging immigrants: challenging the health status and utilization of health services by later-life Filipino immigrants

Faculty Supervisor: Dr. Mark W. Rosenberg, Department of Geography
Phone: (613) 533-6046 E-mail: mark.rosenberg@queensu.ca

Student Investigator: Janette Brual, Department of Geography
Phone: (613)533-6000 ext.75940 E-mail: 7jb45@queensu.ca

Study Purpose: Changes in Canada’s immigration and citizenship programs and policies have had an important impact on immigrants arriving in Canada over recent years. As well, Canada is experiencing an aging population with the frontrunners of the baby-boom generation entering retirement. Both immigration and aging are two demographic forces which may have important consequences for many communities in Canada. I am a Doctoral student in the Department of Geography at Queen’s University conducting research under the supervision of Dr. Mark Rosenberg and I am interested in the health and health care issues for the aging immigrant population.

You have been invited to participate in this study on the health and aging immigrants in the GTA. The purpose of this study is to understand how place and other core social determinants of health, such as race, gender, age and socio-economic status, affect health status and health care patterns of aging immigrants. I am also interested in the migration and settlement experiences of aging immigrants and how this may also influence their health and well being. There has been little research that has addressed the health concerns of Canada’s immigrants in later-life (≥ 65 years) regardless of time since arriving in Canada. I am especially interested in Filipinos living in the Greater Toronto Area (GTA) who are 65 years and older.

By participating in this survey, you have the opportunity to share your health experiences. The questions on this survey will ask about your current health status, your health care use as well as some demographic questions. Your participation in this survey is strictly voluntary. You may choose not to answer any question(s) and may withdraw from this research at any point. Please do not put your name on the survey. An identification number will be assigned to the survey to ensure that there is no way to link your personal identity with the survey, and as a result, your responses will be both anonymous and confidential. The final question of the survey will ask if you are interested in participating in a separate one-on-one interview. You are under no obligation to participate in a follow-up interview. If you do wish to be contacted you will be asked to provide us with basic contact information. If contacted you will be free to withdraw your consent.
and discontinue your participation at any time. If you supply contact information for participation in a follow-up interview the page that has your information will be separated from the survey and kept in a separate electronic file then destroyed.

The information you provide during your participation in this research will remain strictly confidential and will remain known only to myself and my supervisor. The results of this research may be published in my doctoral dissertation as well as standard academic outlets such as journals, books, and papers for presentation at academic conferences. Your name will not appear in any written materials, publications or presentations that result from this project. The information collected will be retained for seven years in a secure location. Refusal or withdrawal from the study will in no way affect any treatment, care, or support that you are currently receiving. There are no known or anticipated risks to you as a participant.

This study has been granted clearance according to the recommended principles of Canadian ethics guidelines, and Queen's policies. If you have any questions regarding this study, or would like additional information, please contact Janette Brual at (613) 533-6000 ext.75940 or via email at 7jb45@queensu.ca. If you have any questions or concerns resulting from your participation in this study, you may also contact the Chair of the General Research and Ethics Board, Dr. Joan Stevenson, telephone (613) 533-6081 or email chair.GREB@queensu.ca.

Thank you.
Sincerely,

Janette Brual
PhD Candidate
Queen's University
Department of Geography
Mackintosh-Corry Hall, Room D314
Kingston, Ontario, Canada, K7L 3N6
Appendix 6: Letter of Information – Later-Life Filipinos: Interview

Title of Project: Exploring social determinants and the role of place among aging immigrants: challenging the health status and utilization of health services by later-life Filipino immigrants

Faculty Supervisor: Dr. Mark W. Rosenberg, Department of Geography
Phone: (613) 533-6046  E-mail: mark.rosenberg@queensu.ca

Student Investigator: Janette Brual, Department of Geography
Phone: (613)533-6000 ext.75940  E-mail: 7jb45@queensu.ca

Study Purpose: Changes in Canada’s immigration and citizenship programs and policies have had an important impact on immigrants arriving in Canada over recent years. As well, Canada is experiencing an aging population with the frontrunners of the baby-boom generation entering retirement. Both immigration and aging are two demographic forces which may have important consequences for many communities in Canada. I am a Doctoral student in the Department of Geography at Queen’s University conducting research under the supervision of Dr. Mark Rosenberg and I am interested in the health and health care issues for the aging immigrant population.

The purpose of this study is to understand how place and other core social determinants of health, such as race, gender, age and socio-economic status, affect health status and health care patterns of aging immigrants. I am also interested in the migration and settlement experiences of aging immigrants and how this may also influence their health and well being. There has been little research that has addressed the health concerns of Canada’s immigrants in later-life (≥ 65 years) regardless of time since arriving in Canada. I am especially interested in Filipinos living in the Greater Toronto Area (GTA) who are 65 years and older.

You have been invited to participate in this study because you expressed an interest in participating in a follow-up interview after completing the survey questionnaire earlier. I am interested in hearing about your experiences migrating to Canada and with the health care system as well as your personal perspectives on health and aging. I am conducting this study throughout the GTA. By participating in this interview and completing a brief survey, you have the opportunity to share your experiences.

Your participation in this research is strictly voluntary. It will involve an interview of approximately 60 minutes in length and will take place at a mutually agreed upon time and location. You may choose not to answer any question and may withdraw from this research at any point during the
interview. The information you provide during your participation in this research will remain strictly confidential and will remain known only to myself and my supervisor. Your name will not appear in any written materials, publications or presentations that result from this project. With your consent, the interview will be audio taped to document the conversation and will be transcribed at a later date. If you choose not to be audio taped, then notes will be taken by the interviewer. You will have the right to review the transcription record from your interview. Refusal or withdrawal from the study will in no way affect any treatment, care, or support that you are currently receiving.

The information gathered during this study will remain confidential and will not be used for any purposes other than the objectives of this research. The results of this research may be published in my doctoral dissertation as well as standard academic outlets such as journals, books, and papers for presentation at academic conferences. The information collected will be retained for seven years in a secure location. There are no known or anticipated risks to you as a participant. This research project has been reviewed and received ethics approval by the General Research and Ethics Board at Queen’s University.

This research project has been reviewed and received ethics approval by the General Research and Ethics Board at Queen’s University.

Any questions about study participation may be directed to Janette Brual at 613-533-6000 ext.75940 or by e-mail at 7jb45@queensu.ca or to Dr. Rosenberg at 613-533-6046 or by e-mail at mark.rosenberg@queensu.ca.

Any ethical concerns about the study may be directed to the Chair of the General Research Ethics Board at chair.GREB@queensu.ca or 613-533-6081.

Thank you.
Sincerely,

Janette Brual

PhD Candidate
Queen’s University
Department of Geography
Mackintosh-Corry Hall, Room D314
Kingston, Ontario, Canada, K7L 3N6
Appendix 7: Informed Consent Form for Key Informant Interviews

Department of Geography
Mackintosh Corry Hall, Room D314
Queen’s University
Kingston ON K7L 3N6

INFORMED CONSENT FORM FOR KEY INFORMANTS

Exploring social determinants and the role of place among aging immigrants: challenging the health status and utilization of health services by later-life Filipino immigrants

I have read the information presented in the information letter regarding the study being conducted by Janette Brual under the supervision of Dr. Mark Rosenberg of the Department of Geography at Queen’s University. I have had the opportunity to ask any questions related to this study and have received satisfactory answers to my questions and to any additional concerns. I am aware that my participation in this research is strictly voluntary and I was informed that I may withdraw my consent at any time without penalty. I am aware that I can choose not to answer any question and any information I provide will remain confidential. I understand that neither my name nor that of my organization will appear in any materials resulting from this study and that my comments reflect my personal views as an expert in the field but not as an official spokesperson of my organization.

This research project has been reviewed and received ethics approval by the General Research and Ethics Board at Queen’s University. I am aware that I can contact the researcher, Janette Brual at Queen’s University, Kingston, Ontario by telephone at 613-533-6000 ext.75940 or email at 7jb45@queensu.ca. I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact the Chair of the General Research Ethics Board, Dr. Joan Stevenson, by telephone at (613) 533-6081 and by email at chair.GREB@queensu.ca.

I agree to participate in this study:

☐ YES  ☐ NO

I agree to have my interview audio-recorded recorded:

☐ YES  ☐ NO

Key Informant Name: _______________________________ (Please print)

Key Informant Signature: ____________________________

Investigator Name: ________________________________ (Please print)

Investigator Signature: _____________________________

Date: ____________________________

451
Appendix 8: Informed Consent Form for Later-life Filipinos – Survey

Department of Geography
Mackintosh Corry Hall, Room D314
Queen’s University
Kingston ON K7L 3N6

INFORMED CONSENT FORM FOR LATER-LIFE FILIPINOS

Exploring social determinants and the role of place among aging immigrants: challenging the health status and utilization of health services by later-life Filipino immigrants

I have read the information presented in the information letter regarding the study being conducted by Janette Brual under the supervision of Dr. Mark Rosenberg of the Department of Geography at Queen’s University. I have had the opportunity to ask any questions related to this study and have received satisfactory answers to my questions and to any additional concerns. I am aware that my participation in this research is strictly voluntary and I was informed that I may withdraw my consent at any time without penalty. I am aware that I can choose not to answer any question and any information I provide will remain confidential. I understand that my name will appear in any materials resulting from this study and that my comments reflect my personal views and experiences.

This research project has been reviewed and received ethics approval by the General Research and Ethics Board at Queen’s University. I am aware that I can contact the researcher, Janette Brual at Queen's University, Kingston, Ontario by telephone at 613-533-6000 ext.75940 or email at 7jb45@queensu.ca. I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact the Chair of the General Research Ethics Board, Dr. Joan Stevenson, by telephone at (613) 533-6081 and by email at chair.GREB@queensu.ca.

I agree to participate in this study:

☐ YES  ☐ NO

Study Participant Name: _______________________________ (Please print)

Study Participant Signature: ____________________________

Investigator Name: _________________________________ (Please print)

Investigator Signature: _______________________________

Date: ____________________________
INFORMED CONSENT FORM FOR LATER-LIFE FILIPINOS

Exploring social determinants and the role of place among aging immigrants: challenging the health status and utilization of health services by later-life Filipino immigrants

I have read the information presented in the information letter regarding the study being conducted by Janette Brual under the supervision of Dr. Mark Rosenberg of the Department of Geography at Queen’s University. I have had the opportunity to ask any questions related to this study and have received satisfactory answers to my questions and to any additional concerns. I am aware that my participation in this research is strictly voluntary and I was informed that I may withdraw my consent at any time without penalty. I am aware that I can choose not to answer any question. I understand that any information I provide will remain confidential to the extent that is possible and within the requirements of agency regulations and the law. I understand that my name will appear in any materials resulting from this study and that my comments reflect my personal views and experiences.

This research project has been reviewed and received ethics approval by the General Research and Ethics Board at Queen’s University. I am aware that I can contact the researcher, Janette Brual at Queen's University, Kingston, Ontario by telephone at 613-533-6000 ext.75940 or email at 7jb45@queensu.ca. I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact the Chair of the General Research Ethics Board, Dr. Joan Stevenson, by telephone at (613) 533-6081 and by email at chair.GREB@queensu.ca.

I agree to participate in this study:

☐ YES  ☐ NO

I agree to have my interview audio-recorded recorded:

☐ YES  ☐ NO

Study Participant Name: _______________________________ (Please print)

Study Participant Signature: ____________________________

Investigator Name: _________________________________ (Please print)

Investigator Signature: ______________________________

Date: ____________________________
### Appendix 10: Table 4-1: Characteristics of Key Informants

<table>
<thead>
<tr>
<th>Key Informant (In order of interview)</th>
<th>Title in Organization (Related Experience)</th>
<th>Number of years working with older populations</th>
<th>Number of years working with immigrant populations</th>
<th>Provides Direct Services to Immigrant Seniors</th>
<th>Population(s) of Focus</th>
<th>Type of Organization</th>
<th>Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>#01</td>
<td>Director (Nursing)</td>
<td>&gt;20 years</td>
<td>&gt;20 years</td>
<td>Yes</td>
<td>Multi-ethnic immigrant and non-immigrant groups</td>
<td>Mental Health Agency and Community Centre</td>
<td>Social &amp; Recreational; Mental Health; Health &amp; Wellness</td>
</tr>
<tr>
<td>#02</td>
<td>Program Director (Social Work)</td>
<td>29 years</td>
<td>29 years</td>
<td>Yes</td>
<td>Multi-ethnic senior immigrant and non-immigrant groups</td>
<td>Geriatric Centre (hospital, long-term care, supportive housing, community centre, day program and outreach)</td>
<td>Health Care Services; Housing &amp; Home Supports; Health &amp; Wellness</td>
</tr>
<tr>
<td>#03</td>
<td>President</td>
<td>26 years</td>
<td>26 years</td>
<td>Yes</td>
<td>Filipino senior groups</td>
<td>Seniors Social Civic Group (Filipino Seniors)</td>
<td>Social &amp; Recreational</td>
</tr>
<tr>
<td>#04</td>
<td>Program Coordinator (Social Work)</td>
<td>3 years</td>
<td>10 years</td>
<td>Yes</td>
<td>Multi-ethnic senior immigrant and non-immigrant groups; specific work with Russian Jewish seniors</td>
<td>Senior Health and Wellness Program &amp; Community Centre</td>
<td>Social &amp; Recreation; Health &amp; Wellness</td>
</tr>
<tr>
<td>#05</td>
<td>Board Member</td>
<td>&gt;22 years</td>
<td>Not specific to role (various projects)</td>
<td>No</td>
<td>Multi-ethnic senior immigrant and non-immigrant groups</td>
<td>Advocacy; Seniors Organization (Provincial Coalition)</td>
<td>Health care services; Housing and Home Supports</td>
</tr>
<tr>
<td>#06</td>
<td>Manager of Client Services (Nursing)</td>
<td>30 years</td>
<td>22 years</td>
<td>Yes</td>
<td>Multi-ethnic senior immigrant and non-immigrant groups</td>
<td>Home Care and Community Support Agency</td>
<td>Housing &amp; Home Supports</td>
</tr>
<tr>
<td>#07</td>
<td>Seniors' Program Manager</td>
<td>2 years</td>
<td>2 years</td>
<td>Yes</td>
<td>Multi-ethnic immigrant newcomer groups</td>
<td>Settlement and Community Support Agency</td>
<td>Newcomer Settlement; Social &amp; Recreational; Community</td>
</tr>
<tr>
<td>#</td>
<td>Name of Interviewee</td>
<td>Years of Experience</td>
<td>Years in Current Position</td>
<td>Yes/No</td>
<td>Population Served</td>
<td>Organizational Unit</td>
<td>Support; Health &amp; Wellness</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------</td>
<td>---------------------</td>
<td>--------------------------</td>
<td>--------</td>
<td>-------------------</td>
<td>---------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>#08</td>
<td>Manager of Programs and Services</td>
<td>13 years</td>
<td>8 years</td>
<td>Yes</td>
<td>Multi-ethnic senior immigrant and non-immigrant groups</td>
<td>Social and Recreation Centre for Seniors</td>
<td>Social &amp; Recreational</td>
</tr>
<tr>
<td>#09</td>
<td>Coordinator for Spanish-speaking Program</td>
<td>3 years</td>
<td>3 years</td>
<td>Yes</td>
<td>Multi-ethnic senior immigrant and non-immigrant groups; Focus on Spanish-speaking communities</td>
<td>Social and Recreation Centre for Seniors</td>
<td>Social &amp; Recreational</td>
</tr>
<tr>
<td>#10</td>
<td>Manager of Supportive Housing (Nursing)</td>
<td>23 years</td>
<td>12 years</td>
<td>Yes</td>
<td>Multi-ethnic senior immigrant and non-immigrant groups</td>
<td>Supportive Housing in a seniors’ designated building</td>
<td>Housing &amp; Home Supports; Community Support</td>
</tr>
<tr>
<td>#11</td>
<td>Manager of Access and Equity. (Health equity consultant)</td>
<td>Not specific to role (various projects)</td>
<td>25 years</td>
<td>No</td>
<td>All populations</td>
<td>Public Health Agency</td>
<td>Health care services</td>
</tr>
<tr>
<td>#12</td>
<td>Manager of Day Centre for Seniors and Manager of Social Work (Social Work)</td>
<td>4 years</td>
<td>4 years</td>
<td>Yes</td>
<td>Multi-ethnic senior immigrant and non-immigrant groups with cognitive impairments, age-related dementia, Alzheimer’s disease</td>
<td>Day Centre for Seniors</td>
<td>Health Care Services; Mental Health Care</td>
</tr>
<tr>
<td>#13</td>
<td>Manager of Community Development and Engagement</td>
<td>6 years</td>
<td>3 years</td>
<td>Yes</td>
<td>Multi-ethnic senior immigrant and non-immigrant groups</td>
<td>Community Support Agency</td>
<td>Social &amp; Recreational, Community Support; Home &amp; Housing Supports</td>
</tr>
<tr>
<td>#14</td>
<td>Program Director</td>
<td>3 years</td>
<td>22 years</td>
<td>Yes</td>
<td>Chinese ethnic groups (both)</td>
<td>Multi-service Agency for Seniors</td>
<td>Health Care Services,</td>
</tr>
<tr>
<td>#</td>
<td>Job Title</td>
<td>Experience</td>
<td>Key Responsibilities</td>
<td>Organization</td>
<td>Community Support; Housing &amp; Home Supports; Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#15</td>
<td>Project Manager (Social Work)</td>
<td>6 years</td>
<td>Multi-ethnic senior immigrant and non-immigrant groups</td>
<td>Seniors’ Social and Recreation Program and Community Support Agency</td>
<td>Social &amp; Recreational; Community Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#16</td>
<td>Manager of Violence Against Women and the Senior Caregiver Team.</td>
<td>20 years</td>
<td>Multi-ethnic immigrant newcomer groups (with projects focused on specific groups)</td>
<td>Social Service Agency</td>
<td>Mental health and Counselling; Community support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#17</td>
<td>Executive in senior management</td>
<td>&gt;30 years</td>
<td>All populations</td>
<td>Local Government</td>
<td>Health care services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#18</td>
<td>Satellite Manager of Community (Nursing)</td>
<td>30 years</td>
<td>Multi-ethnic immigrant and non-immigrant groups</td>
<td>Community Health Centre</td>
<td>Health care services; Community Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#19</td>
<td>Program Manager</td>
<td>6.5 years</td>
<td>South Asian ethnic groups</td>
<td>Community and Social Service Agency</td>
<td>Social &amp; Recreational; Community Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#20</td>
<td>Community Development Worker</td>
<td>5 years</td>
<td>Multi-ethnic immigrant newcomer groups (with projects focused on specific groups)</td>
<td>Social Service Agency</td>
<td>Community Support; Social &amp; Recreational; Health &amp; Wellness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#21</td>
<td>Manger for Settlement Program</td>
<td>Not specific to role (through community partners)</td>
<td>8 years</td>
<td>Multi-ethnic immigrant newcomer groups</td>
<td>Settlement and Newcomer Agency</td>
<td>Newcomer Settlement; Community Support</td>
<td></td>
</tr>
<tr>
<td>#22</td>
<td>Manager of</td>
<td>11 years</td>
<td>Multi-ethnic senior</td>
<td>Community Support Agency</td>
<td>Housing &amp; Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supportive Housing</td>
<td></td>
<td></td>
<td>immigrant and non-immigrant groups</td>
<td>Supports; Health Care Services; Community Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>---</td>
<td>---</td>
<td>------------------------------------</td>
<td>-----------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 11: Table 7-1: Later-Life Filipino Interview Participants

<table>
<thead>
<tr>
<th>Names*</th>
<th>Sex</th>
<th>Interview Type</th>
<th>Age**</th>
<th>Age at Migration</th>
<th>Immigrant Class Category</th>
<th>Marital Status</th>
<th>Education</th>
<th>HH Income</th>
<th>Work Status</th>
<th>Philippine Work Experience</th>
<th>Canadian Work Experience</th>
<th>Living Status</th>
<th>Dwelling type</th>
<th>Home Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edgar</td>
<td>Male</td>
<td>In-person</td>
<td>79</td>
<td>66</td>
<td>Family class</td>
<td>Widowed</td>
<td>University graduate</td>
<td>&lt;$20,000</td>
<td>Retired</td>
<td>Government</td>
<td>Janitor/maintenance</td>
<td>Alone</td>
<td>Apartment</td>
<td>Rent</td>
</tr>
<tr>
<td>Reynaldo</td>
<td>Male</td>
<td>In-person</td>
<td>72</td>
<td>28</td>
<td>Skilled worker</td>
<td>Married</td>
<td>University graduate</td>
<td>&lt;$50,000</td>
<td>Retired</td>
<td>Construction/machinery</td>
<td>Operations manager</td>
<td>Spouse and son</td>
<td>House</td>
<td>Own</td>
</tr>
<tr>
<td>Zenaida</td>
<td>Female</td>
<td>In-person</td>
<td>88</td>
<td>61</td>
<td>Family class</td>
<td>Widowed</td>
<td>Post-graduate</td>
<td>&lt;$20,000</td>
<td>Retired</td>
<td>Court justice</td>
<td>Volunteer board member</td>
<td>Alone</td>
<td>Apartment</td>
<td>Rent</td>
</tr>
<tr>
<td>Norma</td>
<td>Female</td>
<td>In-person</td>
<td>65</td>
<td>22</td>
<td>Skilled worker</td>
<td>Re-married</td>
<td>University graduate</td>
<td>&lt;$50,000</td>
<td>Retired</td>
<td>Recent graduate</td>
<td>Nurse</td>
<td>Spouse</td>
<td>House</td>
<td>Own</td>
</tr>
<tr>
<td>Alex</td>
<td>Male</td>
<td>In-person</td>
<td>84</td>
<td>44</td>
<td>Family class</td>
<td>Married</td>
<td>Some university</td>
<td>&lt;$30,000</td>
<td>Retired</td>
<td>Military air force</td>
<td>Financial data centre</td>
<td>Spouse, son, grand-children</td>
<td>House</td>
<td>Own</td>
</tr>
<tr>
<td>Cecilia</td>
<td>Female</td>
<td>In-person</td>
<td>66</td>
<td>23</td>
<td>Skilled worker</td>
<td>Married</td>
<td>University graduate</td>
<td>&gt;$100,000</td>
<td>Retired</td>
<td>Recent graduate</td>
<td>Nurse</td>
<td>Spouse</td>
<td>House</td>
<td>Own</td>
</tr>
<tr>
<td>Emilita</td>
<td>Female</td>
<td>In-person</td>
<td>65</td>
<td>23</td>
<td>Skilled worker</td>
<td>Married</td>
<td>University graduate</td>
<td>&lt;$30,000</td>
<td>Retired</td>
<td>Recent graduate</td>
<td>Nurse</td>
<td>Spouse</td>
<td>Condo unit</td>
<td>Own</td>
</tr>
<tr>
<td>Violeta</td>
<td>Female</td>
<td>In-person</td>
<td>69</td>
<td>23</td>
<td>Family class</td>
<td>Married</td>
<td>College graduate</td>
<td>Refused</td>
<td>Retired</td>
<td>Midwife</td>
<td>Nurse</td>
<td>Spouse</td>
<td>House</td>
<td>Own</td>
</tr>
<tr>
<td>Teresita</td>
<td>Female</td>
<td>Telephone</td>
<td>87</td>
<td>64</td>
<td>Family class</td>
<td>Married</td>
<td>High school graduate</td>
<td>Refused</td>
<td>Retired</td>
<td>Buying/selling goods</td>
<td>None</td>
<td>Spouse and daughter</td>
<td>House</td>
<td>Rent</td>
</tr>
<tr>
<td>Douglas</td>
<td>Male</td>
<td>Telephone</td>
<td>70</td>
<td>30</td>
<td>Skilled worker</td>
<td>Married</td>
<td>Post-graduate</td>
<td>&lt;$40,000</td>
<td>Retired</td>
<td>Computer programmer</td>
<td>Services</td>
<td>Spouse</td>
<td>Condo unit</td>
<td>Own</td>
</tr>
<tr>
<td>Erlina</td>
<td>Female</td>
<td>In-person</td>
<td>57</td>
<td>26</td>
<td>Contract worker</td>
<td>Never married</td>
<td>Some college</td>
<td>&lt;$70,000</td>
<td>Part-time</td>
<td>Nanny</td>
<td>Hospital instrument technician</td>
<td>Children</td>
<td>House</td>
<td>Own</td>
</tr>
<tr>
<td>Helen</td>
<td>Female</td>
<td>Telephone</td>
<td>66</td>
<td>23</td>
<td>Skilled worker</td>
<td>Married</td>
<td>University graduate</td>
<td>&gt;$100,000</td>
<td>Full-time</td>
<td>Recent graduate</td>
<td>Nurse</td>
<td>Spouse</td>
<td>House</td>
<td>Own</td>
</tr>
<tr>
<td>Elaine</td>
<td>Female</td>
<td>In-person</td>
<td>70</td>
<td>35</td>
<td>Family class</td>
<td>Married</td>
<td>University graduate</td>
<td>Refused</td>
<td>Retired</td>
<td>Insurance</td>
<td>House-wife</td>
<td>Spouse</td>
<td>House</td>
<td>Own</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>Female</td>
<td>In-person</td>
<td>75</td>
<td>38</td>
<td>Family class</td>
<td>Married</td>
<td>University graduate</td>
<td>&lt;$30,000</td>
<td>Retired</td>
<td>Social work</td>
<td>None</td>
<td>Spouse</td>
<td>House</td>
<td>Own</td>
</tr>
<tr>
<td>Yvette</td>
<td>Female</td>
<td>In-person</td>
<td>73</td>
<td>30</td>
<td>Skilled worker</td>
<td>Married</td>
<td>University graduate</td>
<td>&lt;$70,000</td>
<td>Retired</td>
<td>Nurse</td>
<td>Nurse</td>
<td>Spouse</td>
<td>House</td>
<td>Own</td>
</tr>
</tbody>
</table>

*Pseudonyms have replaced actual names. **Age at time of the interview.
## Appendix 12: Table 7-2: Later-life Filipino Interview Participants Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Female n=11 (73%)</th>
<th>Male n=4 (27%)</th>
<th>Total N=15 (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age Range</td>
<td>57 – 88</td>
<td>67 – 84</td>
<td>57 – 88</td>
</tr>
<tr>
<td>Mean Age</td>
<td>71</td>
<td>76</td>
<td>72</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>9</td>
<td>3</td>
<td>12 (80)</td>
</tr>
<tr>
<td>Unmarried (widowed, never married)</td>
<td>2</td>
<td>1</td>
<td>3 (20)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed high school</td>
<td>1</td>
<td>0</td>
<td>1 (7)</td>
</tr>
<tr>
<td>Some college or university</td>
<td>1</td>
<td>1</td>
<td>2 (13)</td>
</tr>
<tr>
<td>Completed college or university</td>
<td>8</td>
<td>2</td>
<td>10 (67)</td>
</tr>
<tr>
<td>Graduate school or professional</td>
<td>1</td>
<td>1</td>
<td>2 (13)</td>
</tr>
<tr>
<td><strong>Work Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td>9</td>
<td>4</td>
<td>13 (87)</td>
</tr>
<tr>
<td>Currently working</td>
<td>2</td>
<td>0</td>
<td>2 (13)</td>
</tr>
<tr>
<td><strong>Immigrant Class Category</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sponsored – Family Class</td>
<td>5</td>
<td>2</td>
<td>7 (47)</td>
</tr>
<tr>
<td>Skilled Worker</td>
<td>5</td>
<td>2</td>
<td>7 (47)</td>
</tr>
<tr>
<td>Other (Contract Worker)</td>
<td>1</td>
<td>0</td>
<td>1 (6)</td>
</tr>
<tr>
<td><strong>Canadian Citizenship</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11</td>
<td>4</td>
<td>15 (100)</td>
</tr>
<tr>
<td><strong>Age of Migration (years)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Age</td>
<td>34</td>
<td>42</td>
<td>36</td>
</tr>
<tr>
<td>Age Range</td>
<td>22 – 64</td>
<td>28 – 66</td>
<td>22 – 66</td>
</tr>
<tr>
<td><strong>Years since Migration</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>38</td>
<td>34</td>
<td>37</td>
</tr>
<tr>
<td>Range</td>
<td>23 – 46</td>
<td>13 – 44</td>
<td>13 – 46</td>
</tr>
</tbody>
</table>
Appendix 13: Ethics Certificate

May 11, 2011

Ms. Janette Bual
Ph.D. Candidate
Department of Geography
Mackintosh-Corry Hall, Room D201
Queen’s University
Kingston, ON K7L 3N6

Dear Ms. Bual:

GREB Ref #: GGE1-121-11
Title: “Exploring Social Determinants and the Role of Place Among Aging Immigrants: Challenging the Health Status and Utilization of Health Services by Later-Life Filipino Immigrants”

The General Research Ethics Board (GREB), by means of a delegated board review, has cleared your proposal entitled “Exploring Social Determinants and the Role of Place Among Aging Immigrants: Challenging the Health Status and Utilization of Health Services by Later-Life Filipino Immigrants” for ethical compliance with the Tri-Council Guidelines (TCPS) and Queen’s ethics policies. In accordance with the Tri-Council Guidelines (article D.16) and Senate Terms of Reference (article C), your project has been cleared for one year. At the end of each year, the GREB will ask if your project has been completed and if not, what changes have occurred or will occur in the next year.

You are reminded of your obligation to advise the GREB, with a copy to your unit REB, if applicable, of any adverse event(s) that occur during this one year period (details available on webpage http://www.queensu.ca/ors/researchethics/GeneralREB/forms.html – Adverse Event Report Form). An adverse event includes, but is not limited to, a complaint, a change or unexpected event that alters the level of risk for the researcher or participant(s) or situation that requires a substantial change in approach to a participant(s). You are also advised that all adverse events must be reported to the GREB within 48 hours.

You are also reminded that all changes that might affect human participants must be cleared by the GREB. For example you must report changes in study procedures or implementations of new aspects into the study procedure or the Ethics Change Form that can be found at http://www.queensu.ca/ors/researchethics/GeneralREB/forms.html - Research Ethics Change Form. These changes must be sent to the Ethics Coordinator, Gail Irving, at the Office of Research Services or irvingg@queensu.ca prior to implementation. Mrs. Irving will forward your request for protocol changes to the appropriate GREB reviewers and / or the GREB Chair.

On behalf of the General Research Ethics Board, I wish you continued success in your research.

Yours sincerely,

Joan Stevenson, PhD
Professor and Chair
General Research Ethics Board

c.c.: Dr. Mark Rosenberg, Faculty Supervisor
      Dr. Anne Godlewski / Dr. Mark Rosenberg, Co-Chairs, Unit REB
      Joan Knox, Dept. Admin.

JS/gi