**Issues of Cultural Diversity in Long-Term Care[[1]](#footnote-1)**

**Future Immigration Policies**

**Challenges and Opportunities for Canada**



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**Abstract**

There is probably no other seniors’ issue that generates more fear and misunderstandings than the topic of long-term care. Unfortunately, the perceptions are often negative. This presentation examines long-term care in relation to immigrant and ethnic minorities. The health care field is a “culture unto its own” and this presentation will introduce the lay-person to the language and processes of accessing quality and culturally appropriate services for their aging family member. The presentation will also inform those assisting immigrants/refugees and minority persons about the aging process and the need for increasing assistance in living. It is also hoped that those in the health care field and especially those in gerontology will find it helpful in seeking ways to interface the access and integration of ethnic and minority persons in the mainstream social and health systems.

There is probably no other seniors’ issue that generates more fear and misunderstandings than the topic of long-term care. Unfortunately, the perceptions are often negative. The act of placing one’s aging parent into the ‘old folks’ home is viewed as the ultimate abandonment. Others view the adult child as callous and uncaring. After sacrificing a life time of love and care-giving, the adult child is viewed as shuffling the elder parent into a cold and depressing institution for reasons of personal convenience. Such views are grossly unfair to both the adult child and the health care service delivered by the competent and dedicated professionals of long-term facilities.

This chapter examines long-term care in relation to immigrant and ethnic minorities. It is meant to inform the lay-person and ameliorate the guilt and misconceptions associated with long-term care. The health care field is a “culture unto its own” and this chapter will introduce the lay-person to the language and process of accessing quality and culturally appropriate services for their aging family member. The chapter will also inform those assisting immigrants/refugees and minority persons about the aging process and the need for increasing assistance in living. It is also hoped that those in the health care field and especially those in gerontology will find the chapter helpful in seeking ways to interface the access and integration of ethnic and minority persons in the mainstream social and health systems.

This chapter begins with an overview of the model of continuum of care; describing the breadth and scope of health and social care for seniors. It describes long-term care, the process of admission into the system and the levels of care. Adult children with frail parents would find this information helpful in seeking appropriate care for their parents. The next section provides a summary of the current situation in Canada and the significance of the “industry” of long-term care. There is considerable provincial variance and some description of the resident population is provided along with a discussion of the cultural issues and tensions of long-term care for some ethnic groups. The chapter concludes with a short discussion of integrated services and culturally specific homes.

**Continuum of Care**

Aging is about loss: loss of physical abilities and can also include loss of emotional and intellectual abilities. As one ages, it means the need for increased support and care that represents a subtle “slope” rather than “steps” of care. The model of continuum of care can be quite confusing to the lay Canadian born person and overwhelming to newcomers. Yet, all of these services offer the immigrant family, with an aging member, possible options to sustain or improve the quality of life for the entire family. As to how the service can be delivered or accessed in a culturally appropriate context is open to consultation. The continuum of care model includes over 60 types of services that can be categorized into seven groups (Evashwick, 1987 in Dunkle, Kart & Luong, 2001). Below is a list and short summary of options that offer individuals and families with strategies:

* to delay illness and disease in healthy seniors,
* to maintain and maximize independence in culturally appropriate ways; and
* to improve the quality of life in the senior’s later life.

1. ***Extended inpatient care*** is what is commonly referred to as *nursing homes* and derogatorily as *old folk’s homes.* These formal institutions are for individuals who require constant nursing and support services because of limitations due to illness or disability. Most of this chapter focuses on this level of service.
2. ***Acute inpatient care*** includes hospitals and rehabilitation centres that provide health services on a short-term basis for serious but acute problems. Mental health services, physical rehabilitation and addiction services are also included. Normally, a treatment plan is established with goals leading to a discharge date.
3. ***Ambulatory care*** simply means “walking” care and includes all those health and social services where the client travels to the service. Examples include visiting the physician, outpatient services, counselling services, dialysis, and physiotherapy. These services can be preventive, maintenance, diagnostic and rehabilitative.
4. ***Home care***encompasses a broad spectrum of services provided in the home of the client who is limited in his/her ability to travel. It may include health-focused services such as nursing care or therapy or support services for independent living such as respite care, “meals-on-wheels” and domestic cleaning.
5. ***Outreach programs*** are designed to link clients to available programs and services improving access. These may include transportation services such as para-transport for persons with disabilities, information services and referrals. Outreach programs can be highly effective in improving accessibility when offered by ethnic groups through volunteer associations.
6. ***Wellness programs*** are very popular in various ethnic communities. They are for those individuals who are healthy and wish to remain so, through health promotion, preventive and educational services. The programs are very suited to being provided by ethnic organizations and can include exercise, and be recreational, social and educational in nature.
7. ***Housing services*** lend themselves to the ethnic community and are normally privately funded. They provide health and support services through the creation of a “home setting”. They appear as independent senior apartments, retirement communities, assisted living homes with supervision and adult family homes.

The continuum of care model provides an overview of the breadth and scope of services and supports available to maintain independence and maximize physical, emotional and intellectual well-being (Hollander, 2002). These services can be provided on a short-term, intermittent or long term basis. There are vast opportunities for both inclusion and exclusion of culturally sensitive or culturally focused services. Who and how services are formulated and delivered can influence the success or failure of their ability to provide satisfying and welcomed programs for ethnically diverse communities. Critics of the model argue that it has been developed from the perspective of administrative and professional services of the care providers rather than the needs of the elder (Gubrium, 1991).

Under the Canada Constitution (1982), health and health related services are mandated under the provincial/territorial governments. Policies and programs will differ slightly but the federal Canada Health Act ensures that services have uniformity under the principles of comprehensiveness, universality, portability and accessibility. However, long-term care is not included in the Canada Health Act and is not fully funded in any province or territory (Dignity Denied, 2007). While in the hospital, a senior may receive full medical services but in long-term care, he/she would be responsible as if in his or her own home. The study by Dignity Denied (2007) describes the system of continuing care as a “patchwork quilt” of complex and confusing services.

**Long-term Care Homes**

Long-term care homes are frequently referred to as “nursing homes” where 24 hour nursing care and supervision are provided in a secure environment. In Canada, there is no consistent nomenclature used to describe these homes (Neysmith, 1994; Havens, 2002). In Saskatchewan, the term “Special Care Homes” is used for “nursing homes” and “Personal Care Homes” is used for smaller private facilities without nursing care (Saskatchewan, 2008). Interestingly, in Quebec, the term “Centres d’ Accueil” (meeting places) is used. In a continuum of care, long-term homes offer higher levels of personal care and support than retirement homes or personal care homes (supportive housing). The provision of long-term care is broader than only the provision of nursing homes. It includes a complicated matrix of health and related support services for individuals who have limiting abilities in order to maintain or maximize independent living. The health, social and personal care services include both informal and formal sectors. In recent years, the meaning of *long-term care* has broadened to include all those services to maximize the physical, psychological, emotional and social well-being of persons with compromised functioning (Barresi & Stull, 1993 in Dunkle, Kart & Luong, 2001). With this definition, family members provide the majority of health, social and personal care services in personal homes and it is estimated that 80-90% is provided and financed by relatives, mostly adult children (Dunkle, Kart & Luong, 2001). With differences in the language and terms, it can be equally confusing to both professionals and lay persons. When communicating with newcomers, it is important for professionals to carefully explain the terms and avoid “industry jargon.”

Long-term care homes are mainly owned and operated by three types of organizations:

* Nursing homes that are owned and operated as for-profit private organizations that have their operating budget support through public funds;
* Municipal councils or regional health districts may be required to construct and operate a home in their area, sometimes in partnership with a local municipality
* Non-government homes operated by non-profit charitable corporations that may be community-based, faith-based or by ethnic/cultural groups.

It is these non-government homes that provide an opportunity to partner with government to own and operate ethnic specific homes. The Chinese-Canadian community has been one of the first visible minority groups to build and operate long-term homes for their aging population in communities where sufficient numbers of Chinese live. The Canadian Jewish community is another early provider of homes for their religious members.

There are mainly two types of accommodation. “Preferred Accommodation” is used to describe private or semi-private rooms with special features. “Basic or Standard Accommodation” is normally shared with 3 other residents. The term *resident* is the norm to describe the clients and avoids the connotation of illness/sickness in the term *patient.* The facility is meant to be a home and not a hospital. The category features varies from home to home depending upon when and how the home was built.

Each home has its own food services providing dining rooms and daily meals. Common rooms, lounges, and recreation services are also available and some larger homes may have beauty salons, gift shops, chapels and outdoor gardens. They are, in fact, a small community where the residents live, eat, socialize and sleep. At most homes, the staff work hard to create a *home-like* atmosphere, minimizing the institutional feel. In Regina, a visitor from the United States was shocked and complained that there was no security officer and *sign-in book* at the front entrance. Staff explained that such *security* would diminish the home environment. They asked the visitor, “Do you have security officers and sign-in books at your home?”

Along with 24 hour nursing care, personal care and supervision, the homes provide room furnishings, meals, laundry, housekeeping, social and recreational programs. Medication, physical therapy, personal hygiene supplies, and medical supplies and aids such as walkers and wheel chairs may be provided with a fee depending upon the income of the resident. Other optional services are offered for a fee such as cable TV, hairdressing, telephone and transportation.

A plan of care is developed for each resident that describes the necessary care and levels of service offered. In Ontario, the plan must be reviewed at least every three months and altered as the resident’s needs change (Ontario, 2008b). Essentially, there are two kinds of “stay” – long stay and short stay. The terms for the stays may differ from province to province but they mainly fit under these two categories. Long stay is open-ended and for an indefinite period of time. In most cases, it means until end of life but could mean transfer to another type of care or transfer to another institution. For example, a home may transfer a resident with Alzheimer disease to another facility with a specialized unit that has closer supervision for persons with severe dementia. In Ontario, short stay is limited to a maximum of 90 days per year (Ontario, 2008b). In some cases, short stay is provided to give respite service to caregivers, freeing family members from daily care giving duties. The break may be for a variety of reasons such as to rest and refresh or because of health issues of the caregiver. Supportive care, transition care or assessment care gives the resident an opportunity to recover from a hospital stay, accident or assessment to determine the resident’s need. It can give the resident time to improve confidence and strength in order to return to his/her private home or some kind of assisted living. The service needs can be determined and implemented as the resident returns home or to another care level/facility. These transition and assessment services sometimes can prevent admission and enable the elder to return home to live independently for a little longer (Durst, 1998).

Since the homes need provincial funding to operate, each province has related legislation governing long-term homes. The provincial ministry responsible for carrying out the legislation sets standards for care and regularly inspects the homes. Homes have mission statements and service goals that recognize the rights of the residents to quality care, privacy and well-being. National standards are ensured through accreditation by the Canadian Council of Health Services Accreditation (CCHSA). Homes with this accreditation have completed a self-assessment and been thoroughly reviewed and evaluated by the Council (Young, 2002). In 1996, the Council implemented the Client-centred Accreditation Program (CCAP) with a emphasis on client-centred care and service (Young, 2002). Any resident, family member or prospective resident should ask for annual reports and evaluation reviews from the home supervisor or provincial authorities. Each home and province has a mechanism to handle complaints or requests for information such as toll-free telephone lines. Residents or family members from ethnic minorities may not be aware of helpful and constructive communication processes.

Years ago, family members faced the daunting task of their parent’s diminishing abilities alone. The decision to give up providing care in the home was a difficult one plagued with guilt and shame. As their parent required increasing levels of care, they sought admission to long-term care homes that were filled and holding long waiting lists. Today, the admission process is open and transparent with a single point of entry. Health districts or regions have strict policies and procedures regarding admissions and discharges. These are considered public documents and are available to all with most documents accessible on their respective webpage. In Regina, the System Wide Admission and Discharge Department (SWADD) accept all applications, determine need, and place the resident on a single waiting list for the first available home. The resident can refuse the first homes offered if he/she has a preference to wait for a specific home of his/her choice. There is no queue jumping and no direct opportunity for discrimination. In one case, a family member complained that it was taking too long to find a bed for her elderly mother. She was expressing frustration and implying discrimination until she was told that a resident would have to die before a bed would be available. She quietly realized that her “peace of mind” was dependent upon someone else’s grief.

Before admission, a qualified social or health professional will complete a thorough assessment that includes demographic information, current living conditions, hospital stay, physical and mental health conditions and a list of daily activities to determine level of functioning. Usually, a case conference is held with professionals and family members. From the assessment, degree of risk is determined from minimal to high risk. The assessment determines the necessary services and the level of care. It is important that family members participate and provide input into the assessment. For ethnic/minority residents, cultural issues or concerns can be addressed before admission; thereby, preventing potential communication problems and concerns.

Regions vary as to language and definitions, but it is helpful to consider five levels of care. The following description is adapted from Saskatchewan Health (2007). In ***Level 1, Supervisory Care***, clients may live at an assisted living apartment, their own home or with family members but require some moderate supervision and assistance with daily living.

***Level 2, Personal Care*** is for clients who are ambulatory with or without walkers and aids or are independent with a wheelchair. They need supervision or assistance with hygiene and grooming. Normally, they are continent and capable of self-feeding. They may have some behaviour problems.

At ***Level 3, Intensive Person and/or Nursing Care***, the residents have advanced physical or mental illnesses that are stabilized and not likely to significantly deteriorate further in the near future. Most of the health care is provided by *special care aides* or nursing assistants under the supervision of a Registered Nurse and directed by the resident’s physician. The resident may be completely ambulant, ambulant with a walker or aid, wheelchair restricted, or bed-fast.

***Level 4, Extended Care*** includes residents who do not require acute hospital care and treatment but need constant advanced health/nursing care on a 24 hour basis. This care may include special medical procedures to achieve improvement or stabilize a condition. Almost all of these residents will be bed-fast, bed-chair-fast or severely limited in personal mobility. The exception will be residents with dementia who may be completely ambulant. Within Level 4 there are three subcategories. *Specialized Supervisory C*are focuses on the management of serious mental deterioration and the associated problems with care and safety. Along with the dementia, there may be physical health conditions that require medical attentions as well. *Supportive Care* is provided through nursing care to stop or slow health deterioration. *Restorative Care* is meant to improve the functional ability of the resident through gradual rehabilitation, physical therapy or medical treatment. The optimistic goal is to achieve a high level of functioning found in *Level 3 or 2.*

***Level 5, Intensive Rehabilitation*** is not normally provided in long-term care facilities but in specialized rehabilitation centres. These centres provide aggressive rehabilitation for persons with physical disabilities from injuries including strokes, illnesses and congenital conditions. Under a team of rehabilitation specialists, a treatment plan is developed to restore or improve the resident’s functioning. Results from intensive treatment are expected within approximately three months. Once the team has assessed that further improvements are unlikely, the resident will be assessed and discharged home, or to another facility. Depending upon the cause of the loss of functioning, the resident may move into a facility at *Level 3 or 4 Care*.

Because of the level of comprehensive care, long-term care homes need to be financially subsidized by provincial governments. The real costs would be prohibitive for all but the richest of residents. Residents are required to contribute to the partial costs and in Ontario; it is called a “co-payment” (Ontario, 2008b). In 2008, Ontario residents pay about $1500 for basic accommodation, $1800 for semi-private and $2100 for private rooms. Indigent residents have Old Age Security and Guaranteed Income Supplement that will cover the basic payment and in some cases, other welfare/support programs make up the difference. In Saskatchewan, the standard resident fee was $948 plus 50% of their income between $1,151 and $2,855.

At the time of admission, a social worker or health professional will meet with the client and his/her family to calculate the resident’s monthly fee. This income test normally only assesses income including all pensions, investments and interest from deposits. Personal assets such as private poverty and possessions are not considered in determining the monthly fee. There are considerations for married couples, separated couples and other circumstances. The process is open and transparent and potential residents are encouraged to ask questions. Unfortunately, the policies regarding the specifics of what services and products are covered depend upon provincial regulations. These services and benefits vary widely from province to province.

Usually a short time after the admission, the staff will arrange a care conference with the family, doctor, senior nurses and other professional staff. A professional staff member will discuss with the admitting senior and his/her family *Advance Directives*. This is an opportunity for the senior to inform the doctor, the facility staff and family of his/her wishes as to the level of care when no longer able to speak for him or herself. The decision rests with the senior’s wishes and takes considerable pressure off the family in times of emergency or end of life situations. In most provinces, there are four levels of care. Supportive or Comfort Care provides services to maximize comfort and normally does not include transferring to a hospital or cardiopulmonary resuscitation (CPR). For elderly persons with complicated health conditions or a terminal illness, CPR does little to save lives but only prolongs death. Limited Therapeutic Care may include hospital transfer for comfort reasons but not include CPR. Level Three involves emergency hospital transfer for treatment where an assessment is completed. The elder may be admitted for treatment or returned to the long term care home. Level Four includes CPR and full medical care, including admission to an intensive care unit.

In accordance with provincial legislation, a person must be identified to make substitute health care decision. Soon after admission, a conference is held to determine the decision maker. At this conference, the resident identifies a substitute decision maker who will make difficult decisions when the senior is no longer mentally or physically able. It is usually the person’s spouse, adult child or sibling but may include other relatives. *Advance Directives* are reviewed annually and can be changed at the will of the resident.

**Current Situation: Long-Term Care Homes in Canada**

Long-term care for the aged is a significant health care industry and it has some unique features that separate it from most health care services. In Canada (outside of the Province of Quebec), there are 2,086 facilities with four or more beds that are funded, licensed or approved by provincial/territorial authorities, normally the Departments of Health and/or Social Services. Since Quebec has a different method of data collection, their statistics are not included in this chapter; however, similar patterns can be expected.

In 2005/2006, these facilities provide 206,170 approved beds with 196,242 residents (95% occupancy rate). There are over 82,000 full time employees and 76,000 part-time employees working 335 million hours and earning close to seven billion dollars in salaries and wages (Canada, 2007). When comparing total expenses over total revenues ($11 billion), they operate with a profit margin of less than one percent.

It is an industry that is divided into three substantive sectors of the social and health service field based upon ownership: private (proprietary), government (federal, provincial, municipal) and non-profit (lay, cultural and religious operated). Although provincial standards establish quality and uniformity among the sectors, differing owners have different objectives based upon the purpose of their existence. In 2005/2006, there were 1006 private facilities (81,085 beds); 420 government (42,448 beds) and 447 non-profit with 42,645 beds. Approximately 54% are for profit private facilities and almost half of the beds at 48.8%. On average, private facilities have 76.4 beds per facility; government have 89.1 beds per facility and non-profit have 95.1 beds per facility (Canada, 2007).

Although privately-owned facilities provide approximately half of the number of facilities and beds, they have only 43.4% of the full time employees, 37.2% of the part-time employees, 38.7% of the hours and only 36.2% of the wages. Private homes operate with lower employee-per-bed, hours-per-bed, and wages-per-bed than government and non-profit homes. Private homes provide less hours per bed and spend fewer dollars per bed than other owners. Private homes provided 1,154 hours per bed compared to government (1,598 hours) and non-profit (1,892 hours) and spent $39,001 per bed compared to government ($59,421) and non-profit ($52,845) facilities (Canada, 2006). Part of the explanation for the differing hours and expenses can be found in the type of care. Private facilities provide services to proportionately more residents at lower levels of care (higher functioning residents) than government facilities with higher levels of care requiring more employees, more hours, and higher skilled health workers. Therefore, government facilities have higher hours and operating expenses.

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| **Table 1** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Characteristics of Long-term Care in Canada- Except Quebec** | | | | |  |  |
|  |  |  |  |  |  |  |
|  |  |  | **Private** | **Non Profit** | **Government** | **Total** |
|  |  |  |  |  |  |  |
| **Facilities** |  |  | 1,006 | 447 | 420 | 1,873 |
| **Approved Beds** | |  | 81,085 | 42,645 | 42,448 | 166,178 |
| **Residents** | |  | 75,837 | 40,910 | 40,751 | 157,498 |
| **Average Beds per Facility** | |  | 76 | 95.1 | 89.1 | 83.7 |
| **Full-time Employees** | | | 35,844 | 21,297 | 25,501 | 82,642 |
| **Part-time Employees** | | | 28,287 | 23,704 | 24,099 | 76,090 |
| **Paid Hours (X $1,000)** | | | 93,581 | 68,149 | 80,327 | 242,057 |
| **Wages & Salaries (X $1,000)** | | | $1,841,283 | $1,432,998 | $1,806,979 | $5,081,260 |
| **Total Expenditures (X $1,000)** | | | $3,162,377 | $2,253,585 | $2,522,321 | $7,938,283 |
| **Total Revenues (X $1,000)** | | | $3,347,388 | $2,248,755 | $2,484,689 | $8,080,832 |

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(Canada, 2007)

In 2005/2006, long-term homes spent $2,571 per person per month aged 65 or older but there is considerable variance among the provinces. For example, British Columbia spent a low of $1,874 per senior, Prince Edward Island spent $3,494 and a high of $6,530 per month in the Territories (Canada, 2007).

**Resident Population**

In Canada, the senior population in residential care has seen a steady growth in recent years. The population grew 5.5% in 2005 and another 3.6% in 2006. Within this growth, there are significant gender differences in resident populations. Reflective of women’s longevity, women were more than twice as likely as men to live in long-term care for the aged. Of the total reporting population, 110,555 were women (70.2%) and only 46,943 were men (29.8%) (Canada, 2004, 2005, 2006).

Over 90% of residents lived in large facilities with at least 50 beds and about 70% lived in homes with 100 beds or more (Canada, 2006). The resident population is elderly with 71% over 80 years of age (59.3% of the men are over 80 and 75.9% of the women). It is not surprising that the chances of living in long-term care increase with age. In Canada, only 4.3 % of seniors 65 or older live in a home but increases dramatically to 12.5% for seniors aged 80 years and over. Women over the age of 85 years are much more likely to live in long-term care than men. About 18% of these women live in care compared to 12% of men. Since older men are close to twice as likely to be married or living common law, they have the benefits of supportive care that prevent or delay the need for residential services.

Table 2 provides the total number and percentage of residents over 65 years in long-term Care facilities in Canada and by provinces. Because the numbers are low, the three territories are totaled to protect the privacy of the individuals. It is clear that there is considerable variance among the provinces which demonstrate the “cultural” nature of long-term care. Of all adults 65 years or older, 4.3% of seniors are in long-term care with a high of 7.2% in Prince Edward Island and a low of 3.3% in British Columbia. Generally, the provinces of Atlantic Canada have higher rates of institutionalization. The progressive social programs of Quebec have broken the traditional pattern of institutions resulting in a low percentage of seniors in care (3.4%).

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Table 2** |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **Totals and Percentage of Residents Over 65 in Long-term Care** | | | | | |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **Province** |  | **Population of 65+** | | **Total** | **Pop in LT 65+** | | **Percentage** | |
|  |  |  |  |  |  |  |  |  |
| CANADA |  | 4,335,255 |  | 196,242 | 186,790 |  | 4.3% |  |
|  |  |  |  |  |  |  |  |  |
| NF |  | 70,265 |  | 4,246 | 3,974 |  | 5.7% |  |
| PEI |  | 20,185 |  | 1,555 | 1,463 |  | 7.2% |  |
| NS |  | 138,210 |  | 6,585 | 6,144 |  | 4.4% |  |
| NB |  | 107,635 |  | 6,333 | 5,561 |  | 5.2% |  |
| PQ |  | 1,080,285 |  | 38,744 | 36,658 | est. | 3.4% |  |
| ON |  | 1,649,180 |  | 84,365 | 79,823 |  | 4.8% |  |
| MB |  | 161,890 |  | 9,541 | 9,032 |  | 5.6% |  |
| SK |  | 149,305 |  | 7,873 | 7,353 |  | 4.9% |  |
| AB |  | 353,410 |  | 15,676 | 14,461 |  | 4.1% |  |
| BC |  | 599,810 |  | 21,015 | 19,968 |  | 3.3% |  |
| TER |  | 5,075 |  | 309 | 267 |  | 5.3% |  |

(Canada, 2007).

There are no reliable statistics on ethnic diversity in long term care but it is understood that seniors of ethnic backgrounds have many barriers to accessing long-term care (MacLean & Klein, 2002). In a study of six special care homes including long-term homes in Regina, it was found that few residents were members of visible minorities (Wasylenka, 2004). However, one large home listed over seven percent as visible minorities which over represents the general population of senior visible minorities (2.4%). At the time, the city of Regina had a population of only 5.2% as visible minority but staff in the homes regularly exceeded the general population of minorities (Wasylenka, 2004). Among the six homes, 35.6% of staff members were visible minorities and the largest home with 390 residents had 47% visible minority staff (Wasylenka, 2004). In Regina, these staff members were located in all positions throughout the homes, from cleaning, kitchen, care giver aids, nursing assistants, nurses and other professionals. Admittedly, the few higher level positions in the administration were not visible minorities. The professional care givers are multicultural and it is generalized that this pattern exists in many homes across Canada and the United States (Morris, Caro & Hansen, 1998). Sadly, it is more common than admitted but many visible minority staff are subjected to racist slurs and comments from residents (MacLean & Klein, 2002).

**Cultural Issues, Tensions and Conflicts**

Historically and globally, the final years of the life cycle occurred in the home under the care of the extended family. People grew old and died at home surrounded by the extended family and multiple generations. Adult children automatically assumed filial piety – the care of their aging parents until death and everyone helped. In western societies, the responsibility of elder care has become shared with the family and the state with each taking on different roles. Among many ethnic groups, filial piety is the ideal and the expectation of family members from countries such as China, South Asia, the Philippines, and Latin America. However, life in Canada creates different pressures and many families need dual income earners in order to maintain the North American lifestyle. In addition, as the parent ages and demands for both physical and mental care increase, families do not have capacity to provide the level of care required. The realistic roles of the adult children may conflict with their wishes. Even though they want to provide care, the demands are just too great. These nuclear families may not have the larger extended family and its supports. There is no respite for them in their continuing care which can become 24 hours/seven days per week. In a study by Wong, Yoo and Stewart (2005), in situations where Chinese seniors were living independently, their preference was to utilize community and public services rather than family. Many foreign born seniors are caught between two value systems – their traditional kinship oriented system versus the western value of independence and individuality. Clearly there is a role for formal assistance in maintaining and enhancing a sense of empowerment that strengthens family and community resources (Yang, Kim & Chiriboga, 2006).

Out of cultural guilt, these struggling families may delay accessing appropriate and timely care. Frequently, the elder enters care in very poor mental and physical health and has serious difficulty adjusting. In one case, a Lao grandmother came into care for about 2 weeks and returned home to die a week later. Had she entered the home in better mental and physical health she may have adjusted better and had an improved quality of life in her last months.

If the parent immigrated under the Family Class, the sponsoring adult children are responsible for all care and not able to access benefits afforded to seniors until ten years have passed. After ten years, the senior is eligible for Old Age Security, Guaranteed Income Supplement and related heath and social welfare benefits. The aging parent may have no choice but to stay with the family and be completely dependent for services like transportation, social and recreation activities, spending money, translation and information. Even though the family home may be quite luxurious, some seniors have described their lives as “living in a golden jail”.

There are also differing expectations regarding filial piety. The parents may have one expectation and the adult children another. It can be difficult for the entire family, as in Chinese custom where the eldest son is expected to care for his parents but the weight of care falls on his wife – the daughter-in-law. If there is a poor relationship between the women, the situation can have some significant tensions. With feelings of guilt and tensions, the family may be reluctant to seek help, increasing the sense of burden on the caregiver. The appropriateness and support of homecare is lost.

There may also be stigma regarding mental illness, dementia and even physical conditions. All of these prevent the family from seeking outside supports. When the situation deteriorates to the level that the family cannot cope any longer, they seek long-term care. The elder enters the system in very poor physical and mental health.

On a more positive note, the family may be relieved and now has time to recover from the demands of constant care. Once in the home, they can participate in more engaging and personal ways as the aspects of physical care are mainly handled by the home. Regular visits, social outings and celebrations with food can enrich the parent’s quality of life.

Staff of the home may encounter complicated family-based decision making. In many Asian cultures, there is heavy emphasis on preventing “losing face” so careful discussion and options are explored respecting the dignity of the parent and family. Some families will insist that all or important family members participate in the decision. It could complicate or delay the decision-making process when the eldest son is out of the city or lives in another city. Family decisions regarding important treatment may be delayed putting the elder at risk when all members are not available.

Cultural taboos about dying and death are not uncommon among many individuals and many cultural groups. Decisions around *Advance Directives*, including end of life care, may be avoided or complicated because of a reluctance to discuss or an inability to come to a family consensus. Among some cultures, the topic is taboo and very disturbing. This situation is common among mainstream families as well but the cultural context may further complicate the situation. Shortly after admission, the ethnic resident and his/her family will be confronted by professional staff openly talking and asking questions regarding the resident’s wishes. Although the staff are sincere in following the resident’s wishes, the family may find the experience deeply disturbing and shocking.

However, this is an excellent opportunity for the resident and family members to express their wishes regarding cultural and religious customs in care. Issues or concerns about recreation, social situations, diet, touching, modesty, and whatever is of concern should be raised at the earliest stage in the admission process. Confusion, disappointment and emotional hurt can be avoided through frank and open communication by both parties. However, it is recognized that there are structural barriers that can complicate the communication in this “foreign institution”. Language limitations can put family members at a disadvantage when they are not able to understand the options available to them and able to express their wishes. Also, there are power relationships at work. After a cultural lifetime of deferring to authority and authority figures, it may be overwhelming difficult for elders and family members to assert their wishes and insist on special services or programs. Then the fear of having their wishes denying and the “loss of face” prevent some from pushing too hard.

In a private meeting and later in the resident’s care, the family should discuss their specific wishes when the resident dies. If the family has cultural and religious customs regarding the deceased body and death rites, they should be clear. They should not assume that the staff will know their beliefs and customs. The family has a responsibility to inform staff and express their wishes at or near death. Good communication is essential at these times of stress and bereavement.

Finally, it is critical that professional staff at the home include and utilize the extensive support system many ethnic families have (Morris et al., 1998). The family members may be shy about their involvement, so staff should encourage and suggest their involvement, especially during special celebrations and religious holidays. Encourage the family to decorate the room and even common areas of the home with seasonal/cultural decorations and symbols. It will engage staff and other residents and make the elder feel comfortable and welcomed.

Staff members need to recognize each person’s unique life experience and be careful not to generalize. Upon admission, a thorough assessment is normally done and it is here that a social history is documented. It is also an opportunity to assess the resident’s degree of acculturation and note any special cultural considerations that should be undertaken. Some assessment of family involvement and degree of support should be documented and encourage their involvement in the resident’s future care. It is helpful for professional staff to review the file and keep informed of culturally-appropriate care. It is also helpful if professional staff members learn and document cultural practices and customs. There are important cultural differences regarding self-determination, trust, privacy and family care-giving responsibilities (Durst & Ram, 2003). An excellent and practical resource is the toolkit called *Diversity in Action: A Toolkit for Residential Settings for Seniors* (Ontario, 2008a). The report *Creating Welcoming Communities in Long-Term Care Homes* has numerous helpful tips for both professionals and members of ethno-cultural communities including a list of practical resources from across Canada (Christensen & Rajzman, 2007).

**Future Issues**

It is clear that our aging population is changing and changes are needed to address Canada’s ethnic diversity. Specific to long-term care, there are two basic approaches to address the needs of frail seniors. Existing homes that have been created to provide services to the mainstream population need to respond with greater cultural sensitivity and appropriateness. These homes already have culturally diverse staff and the transition to increasing culturally appropriate services and programs should not be as difficult as it first appears. However, it does require recognition and commitment from the administration down through the entire staff of the home. It starts with leadership and serious effort to respect and develop sensitive services and programs.

The other strategy is the creation of long-term homes that are faith or ethnicity specific. This is not a new model as homes for Jewish seniors have been in existence for decades. There needs to be a large enough group of acculturated members in order to succeed in creating a home. Presently there are successful homes for Ukrainian, South Asian/Indo, Slovenian, Italian and many others across Canada. Homes that are specific to Chinese seniors are the fastest growing group of long-term homes. Many of these homes started with informal recreation and social programs for their aging seniors. Some groups developed day-care like programs and evolved into higher levels of care. One of the first steps in this process is the creation of a membership and Board of Directors leading to provincial incorporation. Provincial incorporation is necessary as no government or organization will grant or loan money to a non-incorporated body. Incorporation requires the group to have a level of sophistication and competency to deal with government and legal administrations. Hence, the group must be acculturated and “integrated” sufficiently into mainstream culture to be successful. They must be able to raise money through fund raising and grant applications. This spirit of volunteerism and altruism may be foreign to some groups where, if services are provided, they are provided through established institutions such as the government or religious bodies. The self-help strategy may be new to some groups. Many Chinese Canadians are highly successfully and possess significant resources; hence the creation of new homes in cities with sizable Chinese Canadian populations. Vancouver is also seeing the creation of specialized services and homes for Indo-Canadians (Chaudhury & Mahmood, 2005).

Often, there is an assumption that most ethnic seniors desire to live-in with adult children. For many years, they have lived independently and held successful careers and/or businesses. They have been sponsored to Canada in order to provide child care for their grandchildren, leaving behind their homes, businesses and family/friends. Times change and as the grandchildren mature and no longer require close supervision, many seniors are seeking independent living in retirement apartments and assisted living. They want to be on their own but being close to family and friends remains important (Chou & Chi, 2002).

In conclusion, the wish of most ethnic seniors is to age in their own homes but due to changes in their family’s acculturation, it is anticipated that more of these aging seniors will seek long-term care. There are four needs to ensure the development and maintenance of quality care (Luh, 2003). First, there is a need for qualitative research to understand the meanings of quality of life, independence and values of older ethnic adults. Second, policy makers, service providers, and community workers need to be more informed about the importance and impact of ethnicity and culture. Third, there is a need for active recruitment of staff from diverse backgrounds for administrative and direct service provision. Fourth, there is a need for improved education and training both academically and in-service for staff on inter-cultural practice.

The solution to improving and maximizing the quality of life for frail ethnic seniors is communication and collaboration. If they work together, the resident, family members, staff of long-term care and members of the ethnic community can create warm and healthy environments for those in the last years of their life. Improved communication can go a long way in reducing confusion and healing the cultural tensions.

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1. See also: Durst, D. (2010). “Cultural Diversity in Long-Term Care: Confusion with Cultural Tensions”. In Durst, D. & MacLean, M. (Eds). Diversity and Aging among Immigrant Seniors in Canada: Changing Faces and Greying Temples. Calgary, AB: Detselig Enterprises Ltd. pp. 187-204. [↑](#footnote-ref-1)