The Chinese Elderly and Family Structure: Implications for Health Care

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THE CHINESE FAMILY traditionally has been viewed as a close-knit social unit from which its members derived support, security, and a means for meeting their needs. The Chinese elderly were cared for by their families; moreover, respect for the aged was considered a virtue in the Chinese tradition—exemplified by the concept of filial piety. The aged represented life experience, knowledge, authority, and status. China has been described as a "gerontocracy" because of the position of the elderly in the family and in the general veneration of the aged.

In today's world, however, the emphasis on individualism, nuclear family autonomy in an urban-industrial milieu, and economic discrimination against minorities often create pressures on the children of Chinese immigrants that lead to disregard for their elderly parents. In recent years, as the number of elderly has increased and the influence of cultural norms and traditional structures has diminished, the problems of older Asians have multiplied. Inadequate income, reduced physical capabilities, and social isolation often make old age a period of degeneration and suffering.

Of particular importance is the health care of the poor and minority elderly. The Chinese elderly especially are confronted with poverty, isolation, racial discrimination, poor housing, and poor health. Research data are notably lacking on the health care patterns of the Chinese elderly, particularly in terms of the family support system.

Health Needs

Among the many problems confronting elderly Asian-Americans, the Special Concerns Session on Elderly Asian Americans at the 1971 White House Conference on Aging identified exclusion from

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public, social, and health services that, presumably, are available to all older persons (*1*). Persons of Asian ancestry who appeared before the Sub-Committee on Long-Term Care of the U.S. Senate Special Committee on Aging attested to the absence of elderly Asians in nursing homes, extended care facilities, hospitals, and community mental health programs (*2*).

Carp and Kataoka (*3*) reported, based on a sample of 138 Chinese elderly in San Francisco's Chinatown, that twice as many Chinese (30 percent) as caucasian (15 percent) elderly considered health to be their most serious problem. More than three-fourths (78 percent) of this sample stated that poor health was the major reason for older people's inability to function. Their particular health problems concerned serious immobility, such as trouble with walking and climbing stairs, as well as slowness and stiffness in moving. Dizziness and vision and foot problems were also prevalent in this sample.

Hurly reported that in 1970 the tuberculosis rate in San Francisco's Chinatown was three to four times that of San Francisco as a whole (*4*). A few years later, Yuen (*5*) reported further that pulmonary and related illnesses were rampant among the elderly of Chinatown. He observed that the reduction in Medi-Cal coverage of physicians' office visits had inhibited sufficient medical attention and had resulted in otherwise preventable deaths from influenza in the Chinese elderly population.

The aforementioned health problems are compounded by immigration, urban residence, and language, education, and income factors. The 1970 U.S. Census reported a Chinese elderly population (age 65 and over) of 26,856, which constituted 6.2 percent of the total Chinese population of 413,583 (*6*). From 1971 through 1975, Chinese elderly (60 and over) comprised 7 percent of the total number of immigrants from Hong Kong, Taiwan, and China; the total immigration rose from 5.2 percent in 1971 to 7.6 percent in 1975. Because of the 1965 repeal of quotas, increasing numbers of young Chinese professionals have been migrating and bringing their elderly parents and relatives with them. The overwhelming majority of the Chinese elderly (92 percent) live in urban areas, particularly in San Francisco, Boston, Los Angeles, New York, Seattle, and Portland (*7*).

According to the 1970 census, only 1.4 percent of the Chinese foreign-born elderly spoke English as their primary language. The median number of school years completed for elderly men was 6.7 and for elderly women it was only 4.4, in contrast to 8.6 years for the total U.S. population. Thus, the illiteracy rate is high among elderly Chinese, especially among the foreign born who had only elementary school or less education. Furthermore, this lack of education affects their ability to seek services outside their ethnic community. The 1970 census also reported that the median income for Chinese elderly males was $805 less than that for all U.S. elderly males, and for Chinese elderly females, it was $322 less than that of all their U.S. counterparts (*6*).

Changing Family Structure

As a rule, few Chinese elderly live with their children. The American-born Chinese have left the central cities, while the Chinese elderly have elected to remain inside "Chinatowns," where their sociocultural needs can be met. However, they are confronted with loneliness and lack of family contact. Wu (*8*) reported that recently emigrated Mandarin elderly in Los Angeles generally elected to live alone rather than suffer the differences in lifestyle and role reversal associated with living with their children. The exception was those who had severe financial and health needs.

The Chinese pattern of immigration to the United States has contributed to the breakdown of their native patterns of community and familial conrol. This change often occurs long before they immigrate. The family structure in Hong Kong, for example, has been fluctuating throughout this century. As a result of rapid industrialization and stronger Western influence, the Chinese family's structure and function have changed in the Hong Kong socioeconomic environment; the emerging families in Hong Kong have become the nuclear units composed of parents and their own as well as adopted children (*9*). Although the elderly often settle in Chinatowns in this country, second and third generations often leave these areas for the suburbs. These offspring feel less obligated to take care of their aged parents.

We conducted a feasibility study in 1978 to identify changing patterns in family structure that have implications for the health care of the Chinese elderly.

Study Design

The specific research question for this study was: "What are the characteristics of the intrafamily health care structure of low-income Chinese elderly?" The sample population consisted of 60 Chinese persons aged 60 or older who lived in 3 low-income housing projects (Ping Yuen Center, New Helvetia, and River Oaks) in Sacramento, Calif. The interviewers had attempted a random sampling of every third household, but they soon discovered

that not all were willing or available to participate in a 2-hour interview. Thus, the sample was limited to 60 persons who expressed an interest in the study and were available.

We used a three-part questionnaire, printed in English and Chinese, for the study. The first part focused on demographic information—age, sex, birthplace, marital status, education, occupation, religion, length of time since immigration, and fluency in English. The second part related to family support in terms of geographic proximity to children, actual living arrangement, preferred living arrangement, contact barriers with children, transportation for medical care, purchase of medicines, preparation of special diets, and care for the bedridden. The third part dealt with health care resources, particularly referral information, type of physician preferred, race of physician preferred, visits to physician, availability of bilingual staff in medical facilities, and length of time waited for medical appointments.

Since our sample was confined to Chinese elderly in public housing projects, the data obtained from this population cannot be generalized to the total population of low-income Chinese elderly. Moreover, our sample was limited to a specific subpopulation in an inner-city area. However, the following findings tend to confirm much of the preceding discussion of the health needs and family structure trends among the Chinese elderly.

Table 1. Demographic profile of 60 Chinese elderly living in low-income housing projects

Characteristics	Number	Percent
Age:		
67–73	24	40
74–80	23	38
81 and over	13	22
Sex:		
Male	24	40
Female	36	60
Birthplace:		
Mainland China	59	99
Taiwan	1	1
Marital status:		
Married	21	36
Spouse dead	38	63
Never married	1	1
Formal education:		
6 years or less	33	55
7 years or more	27	45
Occupation:		
Retired	37	62
Unemployed	18	30
Cannery worker, seasonal	5	8
Religion:		
Christian	20	33
Buddhist	30	50
Nonaffiliated	10	17
Length of time in United States:		
15 years or less	36	60
16 years or more	24	40
English fluency:		
Non-English speaking	42	70
Marginal English speaking	14	23
English speaking	4	7

Findings

Demographic information. As shown in table 1, the 24 men and 36 women were aged 67 and older. All but one were born in mainland China. More than half were widows or widowers. At least half had received only an elementary level of education in China. The majority were retired or unemployed. One-third were Protestant or Catholic, and the remainder were Buddhist or had no religious affiliation. Most (60 percent) had immigrated to the United States less than 15 years ago. No English was spoken by 70 percent, and 23 percent spoke very little English. Thus, the demographic profile of the 60 persons was mainland China-born elderly with little formal education and language communication problems who had emigrated within the past two decades.

Family support. The sample was almost equally divided between those who had children living in the same neighborhood or city and those whose children lived in another town (table 2). Slightly more than half lived alone, 25 percent with a spouse, and only 12 percent with their children. These Chinese elderly recognized interpersonal conflicts with their children, but one-third wanted to live with their children because of physical or social health problems. At the same time, there were contact barriers with children—children were living far away, busy with their own families, or there were conflicts with daughters-in-law.

The preceding obstacles tended to interfere with family support for the Chinese elderly. Responsibility for transportation and care for the bedridden fell on the elderly themselves, spouses, relatives, friends, or neighbors. Children of the elderly tended somewhat to assist with the purchase of drugs and with the

preparation of special diets. On the whole, the provision of support from children was marginal with respect to contacts and care assistance (table 2).

Health care resources. Our sample population received information about health facilities and physicians from relatives, friends, neighbors, or their children (table 3). These elderly persons tended to seek a Chinese physician who spoke Chinese. They also tended to go to a Chinese herbalist for minor illness and to a medical doctor for major serious illness. All persons in the sample had visited a physician within the past 6 months. The majority tended to use the Asian Health Clinic, a free clinic in a nearby public housing project; when necessary, they were referred to the University of California-Davis Medical Center, which employs bilingual staff as patient advocates and translators for physicians. Most of the Chinese elderly were able to obtain medical appointments within 1 to 2 weeks. Thus, public medical services for our sample seemed to be appropriate and accessible.

Discussion

Our elderly sample exhibited major psychological problems with respect to linguistic, economic, familial, and health issues. They were confined to their homes and were lonely and isolated. Responsibility for care assistance fell on the elderly themselves, spouses, relatives, friends, or neighbors. Only limited assistance was provided by children because of separate living arrangements and geographic distance. Yet, children in Chinese families traditionally are taught that they are responsible for their parents, especially in health care crises and in dealing with problems of old age. As a consequence, the Chinese elderly have not relied traditionally on public social services (home health care) for assistance.

However, family support networks involving children are changing to the extent that persons other than the immediate family perform the usual support functions. In major metropolitan areas with Chinatowns, ethnic-oriented service centers—such as On Lok in San Francisco—offer home health care for shut-ins. Such care is an example of bridging the gap in the support system network between the family and the public agency in the absence of support from children. At the same time, the findings of our study underscore the need to identify the factors that may lead to a redefining of family support areas between the elderly and their children. Owing to geographic separation, daytime work schedules, and other lifestyle obstacles, second- or third-generation children may have to rely on ethnic-oriented public services on weekdays and fulfill their obligations to their parents on weekends or evenings. Teenage grandchildren also may be available to assist in the health maintenance

Table 2. Family support for 60 Chinese elderly living in low-income housing projects

Support factors	*Number*	*Percent*
Geographic proximity to children:		
Same neighborhood	9	15
Same city	22	36
Another city	29	49
Living arrangement, actual:		
Alone	31	52
With spouse	17	28
With children	7	12
No response	5	8
Living arrangement preferred:		
Alone, because of personality, values, lifestyle conflicts, privacy, and freedom	12	20
Alone and maintain periodic contacts with children	12	20
With children, because of loneliness and wish to be with grandchildren	18	30
With children, because of health problems	2	3
No response	16	27
Contact barriers with children:		
Children live too far	24	40
Children too busy with own families	16	27
Daughter-in-law conflicts	5	7
No response	15	26
Transportation to physician:		
Self	21	35
Children	16	27
Relatives, friends, neighbors	23	38
Purchase of drugs:		
Self	21	35
Children	27	45
Relatives, friends, neighbors	12	20
Preparation of special diets:		
Self	12	20
Spouse	17	28
Children	24	40
Relatives, friends, neighbors	7	12
Bedridden care:		
Self	7	12
Spouse	17	28
Children	16	27
Relatives, friends, neighbors	20	33

of their Chinese elderly grandparents.

Social workers, ministers, and other human service agents are needed to identify and to help clarify and encourage these alternative means for family support. Although such resource persons are available, their assistance must be solicited from professionals who have established relationships with the Chinese elderly and the immediate or extended family network system.

Beyond these alternative means is the issue of the most appropriate type of medical care delivery to meet the unique medical and social needs of the Chinese elderly. Apart from quality medical care (accessible medical facilities and medical manpower trained to meet the biopsychosocial needs of the Chinese elderly), the question of extended community outreach into the homes of the elderly comes to mind. Bilingual and bicultural public health nurses and clinical and community oriented social workers form the basis for an effort to follow through with medical and social treatment plans. In the role of physicians' social and health extenders, these nurses and social workers can make alternative care arrangements with family members, relatives, friends, and neighbors. With respect to formal support programs, the Chinese elderly may be referred to day care treatment programs, ethnic nutrition groups, or home health care services located in or near Chinatowns or in suburban areas where large clusters of the Chinese elderly congregate to attend, for example, ethnic churches or meetings of family associations.

Conclusions

The theme of the Chinese elderly and family structure underscores the changing kinship pattern within the Chinese family and its effects on the traditional mutual interdependency between generations. Extended health and social support systems are needed for the elderly, based on the significant inadequacies of the individual resources of the elderly and family networks.

Similar problems will continue as a result of the influx of Chinese-speaking elderly from Hong Kong and the ethnic Chinese "boat people" from Vietnam and Cambodia. A broadened scope of alternative health services that interface modified family care systems and bilingual-bicultural outreach may be an effective way to meet the health care needs of the Chinese elderly, as well as other elderly ethnic groups with similar needs. Certainly, health care administrators who have been sensitized to the unique problems of elderly ethnic minorities may be in a strategic policy and program position to design appropriate health and social welfare delivery systems to serve these people.

Table 3. Health care resources for 60 Chinese elderly living in low-income housing projects

Health care factors	*Number*	*Percent*
Source of referral for health care:		
Self	11	18
Children	16	27
Relatives, friends, neighbors	33	55
Type of physician preferred:		
Medical doctor for major illness	32	53
Chinese herbalist for minor illness	28	47
Race of physician preferred:		
Chinese	51	85
Caucasian	6	10
No preference	3	5
Time since last visit to physician:		
Within past 3 months	33	56
Within past 4 to 6 months	27	44
Bilingual staff in medical facilities:		
Chinese-speaking workers in physicians' offices	42	70
None	18	30
Medical appointment received:		
Within 1 week	22	37
Within 2 weeks	30	50
Within 3 weeks	8	13

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