The Journal of Sociology & Social Welfare

Volume 26
Issue 1 *March - Special Issue on Population Aging: Social Problems and Solutions*

Article 1

March 1999

Journal of Sociology & Social Welfare Vol. 26, No. 1 (March 1999)

Journal of Sociology & Social Welfare

VOLUME XXVI
NUMBER 1
March, 1999

The JOURNAL OF SOCIOLOGY AND SOCIAL WELFARE is edited and published by the SCHOOL OF SOCIAL WORK, WESTERN MICHIGAN UNIVERSITY, 1201 Oliver Street, Kalamazoo, MI 49008.

JSSW is sponsored jointly by Western Michigan University, the College of Health and Human Services, and School of Social Work.
The substantial support of Louisiana State University in the publication of the journal is gratefully acknowledged.

The *Journal of Sociology and Social Welfare* is published quarterly. Prior to photocopying items for educational classroom use, please contact the Copyright Clearance Center, Inc. 222 Rosewood Drive, Danvers, MA. 01923, or Current Contents/Social & Behavioral Sciences (CC/S&BS), Institute for Scientific Information, 3501 Market Street, Philadelphia, PA. 19104. The *Journal* is abstracted and indexed in: Applied Social Sciences Index and Abstracts, Psychological Abstracts, Social Work Research & Abstracts, Sociological Abstracts.

JOURNAL OF SOCIOLOGY AND SOCIAL WELFARE
Volume XXVI March, 1999 Number 1

TABLE OF CONTENTS

SPECIAL ISSUE ON POPULATION AGING: SOCIAL PROBLEMS AND SOLUTIONS

Guest Editors
Jordan I. Kosberg & Nelson W.S. Chow

BOOK NOTES

INTRODUCTION

The countries of the world, both developing and developed, are aging. Some already have sizeable populations of elderly persons and others are beginning to experience an aging of their populations for the first time. The causes of population aging in countries of the world are many and include improved medical technology, use of birth control, and emigration of younger members of a society. The demographic "explosion" of the elderly comes at a time of rapid Westernization with changes in the tradition of family caregiving responsibility for elderly members of the family. Simultaneously, even in advanced societies, economic recessions and competing demands jeopardize continuing public responsibility for the elderly.

This special issue of the *Journal of Sociology and Social Welfare* on "Population Aging: Social Problems and Solutions" is devoted to the sharing of information on aging and old age of different populations within and between countries in the Pacific Rim and North America (including the Caribbean). The overall goal of this special issue is to, at once, provide new information to readers as well as to generate interest in learning more about the multidimensional needs of the elderly so to ensure that informal and formal support services are available and are effective for meeting such needs.

Authors represent social scientists and applied professionals from different countries whose areas of expertise focus upon various substantive areas of inquiry and various service delivery systems. The contributors to this special issue address not only challenges with regard to aging and old age in their own countries, but also the unique and common problems of immigrant populations who arrive in their adopted country in their old age or become elderly many years after their arrival.

It is hoped that the special issue will be of interest to readers and lead to further inquiry (and scholarship) in topics related to population aging. The co-editors thank the Journal's Board of

Directors for believing in the importance of this special issue and Managing Editor, Dr. Frederick MacDonald, for his assistance.

Jordan I. Kosberg, Ph.D.,
Co-Editor
Professor
School of Social Work
Florida International
University
North Miami, Florida

Nelson W.S. Chow, Ph.D.,
Co-Editor
Professor
Dept. of Social Work and Social
Administration
University of Hong Kong
Hong Kong

Opportunities for Social Workers in an Aging World

JORDAN I. KOSBERG

Florida International University
School of Social Work

It is believed that there are professional opportunities for gerontological social workers in an aging world. To be discussed are potential social work roles within international organizations, multi-national businesses, foreign social service and academic institutions, with newly-arrived elderly immigrants, and in social work education, research, and training. It is concluded that—given global aging—if gerontological social workers do not respond to career opportunities, they will lose out to those from other professions.

In a call for "global mindedness" on the part of social work educators, Asamoah, Healy, and Mayadas (1997) allude to world-wide demographic changes. A major component of such changes is "world aging." In fact, the countries in the world are growing older at an unprecedented pace. The United Nations (1992a) has estimated that those 65 years of age and older in the world will be increasing from 6% of the total population in 1985 to 9.7% of the population by the year 2025.

In the past, the number and proportion of the elderly were the highest in the more developed nations of the world, resulting from higher standards of living; better preventive, acute, and chronic health care; and the greater economic ability to care for the needs of the elderly by the aged themselves, their families, and society (Cowgill, 1986). Currently, this growth in the aging of world's population is not a phenomenon characteristic only of developed countries. The increasing number and proportion of elderly persons in developing nations exceed those in developed nations (United Nations, 1991). Hernandez (1992) has indicated

Journal of Sociology and Social Welfare, March, 1999, Volume XXVI, Number 1

that the projected increase in the elderly population in developed nations—between 1990 and 2025—will be 67%, whereas the increase will be 205% in developing nations.

"The [old-old are] the fastest growing population group in the world, projected to grow by a factor of 10 between 1950 and 2025, compared with a factor of six for those 60-and-above, and a factor of little more than three for the total population" (United Nations, 1992b, p.3). Inasmuch as advanced age is associated with social, psychological, physical, and economic problems, the growing need for resources (personnel and programs) can be anticipated for meeting the growing needs of the increasingly elderly populations in the countries of the world. Changing demographics are coupled with contemporary changes in decreasing family size; increasing rates of mobility and emigration of younger members of society, divorce and remarriage, and the in-migration of older populations; and—most importantly—the changing role of women (Kosberg & Garcia, 1991).

Professional Consequences

"Social Workers' ethical obligations to improve social conditions, choice, and opportunity; eliminate discrimination; and promote social justice demand a look not just beyond one's own agency but also beyond national borders" (Herrmann, 1991, p. 102). Over the years, social workers in the U.S. have focused upon developing and developed countries (Rosenthal, 1990, 1991; Healy, 1987; Hokenstad, Khinduka, and Midgley, 1992). As Mary (1997) has recently stated: "Placing social work in the context of global problems . . . is the overarching theme of [the] exploration into social work in the 21st century" (p. 587).

The aging of populations in different countries has prodigious ramifications for the potential involvement of social work practitioners, researchers, and educators (Kammerman, 1976; Teicher, Thurz, and Vigilante, 1986; Hokenstad, 1988; Kosberg, 1995). In an article on an international imperative for gerontological education, Kosberg, Sohn, and Sheppard (1991) argue that in addition to the intellectual search for universals, a focus upon international gerontology permits (1) the study of commonalities and differences in aging within diverse societies, (2) the determination of

effectiveness of different methods by which to meet the needs of aging and aged persons, and (3) the identification of relationships between variations in attitudes toward the aged and opportunities for them. Thus, the study of international gerontology has both heuristic implications with regard to the interests of theoreticians and researchers as well as applied implications with regard to better meeting the needs of elderly populations.

In this latter regard, an international orientation to aging and old age also has great importance for social work practice and social work education by focusing upon how knowledge and experience gained in the U.S. might be beneficial to those in and from other countries (and vice versa). This is to suggest that there are several themes for social work education from world aging: (1) Expert Consultants To Foreign Social Workers. Those from developed and developing nations turn to professionals from the U.S. for guidance in planning, program and policy development, and intervention models for elderly populations. (2) Academic Interests in an Aging World. Social workers in the U.S. are interested in describing and analyzing aging and old age in other countries and carrying out cross-national research. (3) Social Work Employment in Other Countries. There are social work opportunities for those willing to relocate to developing and developed nations. (4) Social Work with Older Immigrant and Refugee Populations in the U.S. There are special needs for working with and for elderly groups newly-arrived in the U.S.

The "technical transfer," of sorts, between policies, programs, and models of care for the elderly in one country and applied to another is possible only with extreme care borne out of knowledge of the values, traditions, governments, economies, etc., in different cultures and different societies. Successful examples of such cross-national borrowing in the field of applied gerontology can be seen in hospice care, granny flats, retirement communities, day care, ombudsman programs, and respite services. Again, it is important that such possible cross-national "borrowing" should fit within cultural values, for fear that either the idea will be rejected or that it will be ineffectively altered to fit the adopting country (see Billups & Julia, 1996). The attention to culturally sensitive practice in the U.S. reflects concern with regard to the

appropriate application of social work in a manner consistent with cultural values brought to the U.S. from other lands.

Given the aging of the world, with more pronounced interdependence between nations; and social worker skills, commitments, and values; might there not be increasing roles and opportunities for social workers within the international scene in the future? Such involvement, in the above-mentioned areas, is perceived to be possible for practitioners, researchers, consultants, and educators alike. Indeed, it is suspected that greater attention is needed by social work education for the preparation of social workers functioning within the international scene, in general, and with regard to aging populations, in particular. A decade ago, Healy (1988) highlighted a growing imperative for social work education; more recently, Asamoah, Healy, and Mayadas (1997) have suggested a "Global Curriculum for the Millennium."

Thus, it is suggested that there will be increasing need for social workers with gerontological knowledge and skills in the international arena. Not only are such opportunities congruent with social work values and history, but may well provide rewarding career paths for social workers in a variety of settings using a variety of skills. What follows is an overview of the interface between international and gerontological emphases in social work education, and the identification of personal and professional benefits from a deliberate plan to pursue social work career paths in international gerontology.

International Organizations and Associations

There are an increasing number of international organizations and associations which focus upon the social welfare of those in different countries. Starting with the United Nations, and continuing with regional organizations (i.e., the PanAmerican Health Organization), there are many international associations which focus upon social welfare and social work, and such cross-national groups exist for different populations (i.e., children, women, families) and those with particular problems (i.e., mentally-retarded, the abused, AIDS victims). These organizations can be sectarian or non-sectarian, private or public, and organized by a country or a coalition of countries.

The United Nations Centre for Social Development and Humanitarian Affairs (in Vienna) is among the many international organizations devoted to aging and old age. Among others are Help Age International, the International Congress on Gerontology, the International Federation on Ageing, and the American Association for International Aging. The United Nations International Institute on Ageing, located in Malta, brings together those from both developing and developed nations for education and exchange of ideas on improving the lives of the elderly in different countries of the world. There are also regional organizations for the elderly located in every part of the world (i.e., European Association of Aging, Asia and Pacific Rim Association for Aging). Recently, the American Association for Retired Persons (AARP) emphasized its international commitment by establishing an International Activities Section and the publication of *Global Aging Report*.

A consequence of the growing number of international organizations and associations is that social workers may secure employment within such entities, as they may be excellent candidates for staff positions as administrators, planners, or organizers. Rosenthal (1990) has argued that social workers are especially well-prepared for, although under-represented in, overseas positions in international social welfare organizations for which people with social work training are eligible and desirable. Her explanation for the desire to pursue such professional opportunities includes the freedom to relocate, expectation of a rewarding overseas experience, possession of requisite skills, interest in the foreign intercultural arena, and global-mindedness (Rosenthal, 1991). While personal goals and family responsibilities will influence the desire and ability to pursue international employment opportunities (outside the U.S.), social work education can play an important role by creating interests and developing skills for students (in the classroom) and professionals (through continuing education).

Multi-National Businesses for the Elderly

As American social work educator Msgr. Charles Fahey has stated (1997): "Business and industry have discovered aging, and

are responding to it in a variety of ways" (p. 40). Although he was referring to the U.S., it is suspected that world aging is gaining the attention of those in the business sector who are aggressively marketing efforts to meet the needs of aging populations. While lacking in empirical proof, it seems likely that the increasing size, affluence, and organization of elderly populations in foreign countries (as well as in the U.S.) are resulting in the development of new industries focusing upon long-term care, housing for the elderly, retirement communities, and leisure time activities, among other areas. And while it may be that American businesses are reaching out to meet the needs of elderly consumers in other countries, so too are businesses from other countries seeking to meet present and growing needs of the elderly in their own countries as well in other ones.

It is further suspected that these business ventures may benefit from the contributions of social work employees who help identify needs, create effective resources to meet these needs, and "package" these resources to attract elderly consumers. As businesses can "market" their goods and services, so too can social workers seek to "market" their skills for the benefit of business, on one hand, and the needs of the foreign elderly, on the other. These are not mutually-exclusive goals and profit is not inconsistent with social work values.

Relatedly, social workers can "market" their professional skills for use by those in foreign countries (as clinicians, program planners, consultants, trainers and educators, or administrators). Jean Coyle (1985) has written about entrepreneurial gerontology, and stated:

> In order to operate successfully in today's work force, gerontologists need to learn, and to utilize, marketing skills for their gerontological expertise. Both professionals experienced in the field of aging and gerontology students seeking entry into the field should find it beneficial, indeed increasingly essential, to employ creative approaches to assessing skills need[ed] in the field, and, then, to identify and even create new types of positions, including roles in industries and in fields previously not employing full-time gerontologists (p. 161).

Coyle was not specifically referring to the profession of social work; yet, her words do have significance for the social work

educator and practitioner interested in aging and old age. An entrepreneurial orientation is not inconsistent with social work values or principles—consider the growth of private practice in the U.S. In addition, Mor-Barak, Poverny, Finch, et al. (1993) have suggested the aggressive development of occupational social work in business and industry. Thus, it may be that the future will see social workers reaching out for employment opportunities with social welfare agencies, public institutions or private businesses, or municipal and national governments in foreign countries, or seeking to develop their own private practice outside their native lands.

Foreign Employment Opportunities

Social workers from the U.S. have long been employed overseas in the military and as civilians working with military personnel and their dependents. Additionally, on a permanent or temporary basis, others have sought employment outside of the military in foreign countries. While such work possibilities include those with international associations or corporations, other employment possibilities might be found in social service agencies or in academic institutions. Of course, knowledge of the foreign language is generally (but not always) a prerequisite for such employment, along with an ability and a desire to leave the U.S. and live in another country. Additional incentives, especially for academics, are the possibilities of higher income, greater prestige, better qualify of life (i.e., less crime), attractive benefits, and travel opportunities. Employment in foreign countries can have potential disadvantages resulting from political instability, subtle or overt discrimination (toward foreign employees), distance from family and friends in the U.S., and a high tax structure (i.e., Canada, Great Britain, Sweden).

American social workers who relocate to developing nations face special challenges and rewards. As witnessed by those who enlisted in the Peace Corps, working in developing nations provides personal and professional satisfaction in community development activities, meeting the needs of vulnerable populations, and aiding in the empowerment of citizens. Given the rapid growth of elderly populations in developing nations, and given

the concomitant challenges to traditional informal caregiving mechanisms by changing values (Kosberg & Garcia, 1991), social workers can play important roles in developing nations. Working in such countries, of course, often comes with a lower standard of living and quality of life, and potential political pressures resulting from advocacy efforts for empowerment on behalf of indigenous populations.

Working with Newly-Arrived Elderly Populations

As mentioned, an international orientation for social work focuses within as well as outside of a national border. The U.S. is a nation of immigrants, perhaps less so than in the past; but, nonetheless, still with immigrant populations who have unique problems and are in need of social work assistance. Asamoah (1997) refers to the search for a better life in the U.S. by those in poverty coming from a foreign country and states: "This glaring contradiction is what has driven many immigrants to this country, and they form a significant portion of caseloads in agencies in our inner cities" (p. 2).

Social work involvement might be especially needed for recently-arrived groups of refugees who not only have problems of adjustment with which to contend, but also the "scars" from the past (Potocky, 1996). For example, Petzold (1991) has discussed the physical and emotional problems resulting from the rapid and radical cultural changes affecting Southeast Asian refugees, Jacob (1994) has discussed the problems of Salvadoran refugees and their need for social services, and Mui (1996) has written about the depression among elderly Chinese immigrants. The history of abuse suffered by migrant groups in the U.S. (often coming from foreign countries) also requires social work concern and action. The needs of the elderly immigrants groups can be neglected by those in the helping professions who focus more often on younger individuals.

Working with in-migrating populations necessitates special training, sensitivity, and knowledge. This knowledge not only pertains to individual immigrant groups, but to immigration policies as well. Castex (1994) has indicated that many social workers are confused by the influence of national origin, language,

racial ascriptions, religion, and citizens status when dealing with Hispanic or Latino clients. Drachman (1995) has described the importance of being aware of the statutes which influence immigrant status and the provision, access, and use of social services by immigrant groups.

American communities with significant immigrant populations may not be able to develop a social service system with sufficient numbers of professionals having similar backgrounds as the foreign born target population. For example, Miami has undergone the most dramatic ethnic transformation of any major American city and has the largest proportion of foreign born residents of any city in the U.S. There are, thus, educational ramifications for Miami-area schools of social work. Although the need to be conversant in a foreign language may be highly desirable, the need for social workers to have special preparation (and screening) for working with or planning for such in-migrating populations should be mandatory.

Social Work Research

Whether or not driven by funding opportunities, research efforts have often included cross-national studies of groups in need and services which attempt to meet such needs. Taking the lead from cultural anthropologists, social work researchers who engage in cross-national comparative analyses with regard to aging and old age must be prepared to understand and appreciate the dynamics which exist in the foreign countries they study and about which they make inferences. There is a danger in being too casual an observer, or as Kosberg, Sohn, and Sheppard (1991) have stated: it is wrong to engage in "the classic attraction of amateur anthropological-touristic curiosity about what is different" in foreign countries (p. 477).

Not only is there a challenge in the conceptualization of cross-national studies, but important tasks to be undertaken with regard to the creation of a methodology which permits the valid comparison of findings (i.e, data collection techniques). The need to ensure the comparable terminology or phraseology on questionnaires (resulting from translation) is a vital requirement for such research. Obviously, social work researchers need special

awareness and training for such subtle, but important, components of the research process in cross-national studies. For example, Kosberg, Garcia, and Lowenstein (1997) have written about conceptual and methodological challenges in carrying out cross-national studies of elder abuse.

Given the rich array of resources for American senior citizens, gerontological social work researchers in the U.S. who engage in cross-national studies may well be in a special danger of measuring differences between the roles and status of the elderly and/or the resources available to them through ethnocentric lenses. Thus, there is a special need for social work researchers to be anti-ethnocentric. In fact, they should take a leadership role in challenging commonly-held stereotypes and empirically verifying the differences and similarities popularly thought to exist in the treatment of the elderly from different cultures, in different countries, during different periods of time.

Practice Exchanges for Common Problems

Many of the issues and problems which are faced by social workers in the U.S. are similar to those which are faced by professionals in many different countries. Accordingly, an international perspective can be beneficial for professionals from different countries with regard to treatment models, planning efforts, and policy formulations. It is imperative that the attitudes of practitioners transcend parochial ethnocentrism to view—with an open mind—efforts made in other countries. Indeed, professionals representing different nations or different cultural groups can learn from one another—however similar or dissimilar the experience.

As one example of the fact that those in one country have as much to learn as to share with those from other countries, Dr. Nelson Chow (1995), Professor from the University of Hong Kong Department of Social Work and Social Administration, made the following observation in his presentation to the Annual Meeting of the Japanese Association of School of Social Work:

> . . . social work education nowadays requires us to take a global view and to introduce to our students, other than what is happening in our countries, also the policies and practices that are prevalent in

> other societies with different cultural traditions. This will not only enrich our curriculum but also give our students a greater sense of tolerance. Second, that in adopting the social welfare and social work theories from the West [or from the East], we should also be aware of the developments and changes which are occurring there.

Pearson and Phillips (1994) have discussed psychiatric social work in China and Mokuau and Matsuoka (1995) have written about social work practice with Hawaiians. The sharing of such information is believed to have importance not only for meeting the needs of a specific group, but also has wider general ramifications for other populations as well.

In the field of aging, elder abuse is one example of a common problem faced by professionals in all nations (although not always labeled as such). The problem was first thought to be an American problem, then believed to be a problem only in developed nations, but currently it is known that elder abuse exists in developing as well as developed countries (Kosberg & Garcia, 1995). International meetings, along with international publications, permit the exchange of ideas and experiences with regard to common problems faced by social work practitioners working with and for the elderly in different countries.

Additionally, an international perspective by social work publications—directly or indirectly—related to the elderly will provide (1) a heuristic description of the state of knowledge and practice in different countries for students, practitioners, and academics alike, and (2) practice examples to be considered by professionals in different countries. As an illustration of this, among articles in a special issue on home care services appearing in the *Journal of Gerontological Social Work* is one by Monk and Cox (1995) on such services in foreign countries. Both authors and editors need international orientations (and comparative analyses) for providing discussions of current social work practice and programs in a more global context.

Educational/Training Opportunities

As a reflection of social work's increasing attention to the interdependence of the countries in the world, the 1994 Council on Social Work Education *Handbook on Accreditation Standards and*

Procedures contains specific reference to the importance of global interdependence as a premise underlying social work education in the Curriculum Policy Statement (Asamoah, 1997). Additionally, the "shrinking" and aging of the world, given the history of American social work's experiences with aging and elderly populations, will increasingly result in opportunities for social work professionals to provide education and training to professionals, and others, in foreign countries. There are formalized efforts—both proactive and reactive—which will necessitate a commitment from universities and agencies. Three will be briefly mentioned: distance learning, visits to foreign countries and by foreign professionals, and program exchanges.

Distance Learning. Modern technology facilitates the cross-national exchange of information. Whether it is simultaneously-transmitted telecommunications or videotapes for later use, social workers with gerontological backgrounds may be asked to provide professional guidance to those from foreign countries. For example, one social work program in Florida is in the process of developing training modules to be broadcast to educational institutions within Latin American countries. While in this instance, competence in speaking Spanish becomes an important prerequisite for participation, so too is an interest in foreign countries and a desire for reaching out to those in other countries.

While it is true that such distance learning efforts have not frequently focused upon aging populations; given the increasing need for such models in the future (resulting from global aging), it is suspected that social work educators will be increasingly participating in such international activities. At one university (within which is located a school of social work), a Latin American Center on Aging and Old Age is being considered and will include distance learning as well as the exchange of students and faculty. Social work faculty are involved in planning efforts and will hold significant roles in such a center.

The increased sophistication of distance education (such as by satellite) opens up a plethora of possibilities for alternatives to on-site learning. Social workers with such skills will be attractive to educational facilities in the U.S. and helpful to those from other countries in the world.

Visits to Foreign Countries and by Foreign Professionals. Educational and employment opportunities for American social workers with gerontological backgrounds may result in invitations to visit foreign countries to meet with social worker practitioners, students, and educators. Such activities can be associated with the presentation of papers at professional conferences, consultations, or staff development and in-service training. It is also possible to meet with those from foreign countries either in the U.S. or in foreign venues with the purpose of providing education and training to others.

It is not uncommon for American social workers to host visits by those from outside the U.S., especially visitors seeking to learn more about how the needs of the elderly in the U.S. are being met. Such educational visits by foreign social work practitioners, educators, and students can vary in length from a few days to a semester or year. Some U.S. programs in social work education have established ongoing efforts for students and faculty to visit foreign countries as well as host visits by social workers from other countries.

Program Exchanges. Schools and departments of social work have established both formal and informal relationships with foreign universities. Some ventures are related to foreign students securing their master's or doctoral degrees in American social work programs. Other activities involve the exchange of faculty and/or exchange of students.

While there are, no doubt, many such arrangements at the university level (i.e., the University of South Florida and Nankai University in Tianjin, China), there are probably similar efforts involving schools and departments of social work. The University of South Carolina College of Social Work has established a program in South Korea. The Ph.D. Program in Social Work at the University of Texas at Arlington and the Universidad Autonoma De Nuevo Leon, in Monterrey, Mexico, have formalized a "collaboration between the two universities that will result in the first Ph.D. program in social work ever to be offered in Mexico and, indeed, in the whole of Spanish-speaking Central and South America" (University of Texas at Arlington *Social Work News*, 1996, p. 4).

No doubt, many social work programs throughout the U.S. have made efforts to establish similar relationships with foreign universities. It is suspected that, where they exist, little attention is being given to gerontological social work education and training. Yet, given a demographic imperative, such attention on aging and old age will become increasingly important.

Implications for Social Work Education

As Asamoah (1997) states: "Some schools of social work have established mechanisms to promote knowledge building and professional competence in international social work. . . . The foci includes curriculum development, faculty research on international issues, faculty and student exchange, sponsorship of internationally related regional and national seminars and conferences" (p. 4). This article calls attention to the potential opportunities for social workers with gerontological backgrounds and interests in the international arena, in response to the aging of countries in the world and elderly populations coming to the U.S. from other countries.

There is much to be done by social work education for preparing those wishing to meet the needs of such populations and seeking foreign career opportunities. Clearly, the creation of a cadre of well-prepared professionals necessitates two pre-conditions which can occur separately or together: (1) a social work educational emphasis on the international field of practice and (2) such an emphasis on aging and old age. While gerontological social work educators have their own national organization, the Association for Gerontological Education in Social Work, and journal, the *Journal of Gerontological Social Work*, the educational opportunities for such emphases in U.S. social work programs have been modest, at best. Despite the aging of America, in particular, and the aging of the world, in general, there is little reason to be optimistic regarding the present and future efforts for preparing social workers for careers in the field of international gerontology.

Healy (1988) has asked "How can social work students be better prepared for practice and professional action in an increasingly interdependent world? How might educators change curricula and educational objectives to assure that future social workers

have a better understanding of global issues and their impact on practice?" (p. 221). Her words are directed toward general efforts to train and educate social work students for careers in the international field, not toward the international study of aging and old age. There is a need for discussions regarding the minimum curriculum offerings in international social work, specializations in international gerontological social work, and the possibility of specific social work programs focusing upon particular areas of the world or cultural groups.

While some social work programs do offer a course or two in international social work or social welfare in developing or developed nations, it is suspected that there are few, if any, programs having a rich array of courses which focus upon international gerontological social work (or even on working with and for older immigrant populations). Clearly, then (if this suspicion is accurate), the field of social work education needs to actively work toward meeting the growing need for courses in international gerontological social work. Yet, Healy (1989) notes the realities faced by advocates of international curriculum: "Resource limitations, especially scheduling limitations with an already crowded curriculum, shortages of faculty time and expertise, and competition from other interests, all will make implementation of international curriculum difficult" (p. 228). In the U.S., weak interest by social work students for gerontological courses further limits the optimism that such curriculum offerings combining attention to international and gerontological social work will be wide-spread.

Given global aging, social work professionals will be competing for international gerontological opportunities with those from other disciplines (i.e., sociology, psychology, anthropology) and professions (i.e., urban planning, public administration, gerontology) in the coming years. Clearly, inattention to international gerontology by social work education, in a competitive world-market, will result in lost opportunities, will for social work students, graduates, researchers, consultants, educators, and practitioners alike.

Conclusion

As CSWE Executive Director, Donald Beless (1996) has stated: "The internationalization of social work education is not a utopian

ideology, but a useful approach to widening and sharing knowledge toward improving the course and experiential offerings of teachings and programs. The concentration of the world into reachable and comparable units makes the sharing more urgent [even] while [we must continue] recognizing and acknowledging the individual, regional, and cultural differences that remain" (p. 2). Such efforts and knowledge are related to not only the preparation of professionals for the international arena, but for the preparation of all social workers to be sensitive and knowledgeable citizens of the world.

It has been argued that there are many advantages for the internationalization of American social work education and practice which focuses upon aging and elderly populations. Aside from the important scientific and professional benefits with regard to education, training, and research, such an international orientation can provide career opportunities for social work students, graduates, practitioners, and academics. Moreover, with world aging, social workers are presented with real opportunities to assist elderly populations in other countries and elderly populations in the U.S. (from native and foreign subcultures).

There are many reasons for action in pursuing a path toward greater attention to career opportunities in international gerontological social work. But while there are many opportunities, so too are there dangers from inaction which will result in social workers losing out to those from other disciplines and professions. Thus, there are both personal and professional reasons for greater attention being given to aging populations in countries of the world. It is hoped that these opportunities resulting from demographic changes in the world will produce increased discussion, planning, and action by individual schools and departments of social work in the U.S. and elsewhere.

References

Asamoah, Y. (1997). A global outlook for the social work profession: The need for a paradigm shift. In Hunter College of the City University of New York, *Update*, Spring, 1997.

Asamoah, Y., Healy, L. M., & Mayadas, N. (1997). Ending the international-domestic dichotomy: New approaches to a global curriculum for the millennium. *Journal of Social Work Education, 33*, 389–401.

Beless, D. (1996). Learning from our international colleagues. *Social Work Education Reporter, 44*, 2.

Billups, J. O. & Julia, M. (1996). Technology transfer and integrated social development: International issues and possibilities for social work. *Journal of Sociology and Social Welfare, XXIII*: 175–188.

Castex, G. M. (1994). Providing services to Hispanic/Latino populations: Profiles in diversity. *Social Work, 39*, 288–296.

Chow, N. W. S. (1995). Social work education: From an international perspective. Unpublished presentation given at the Annual Meeting of the Japanese Association of Schools of Social Work, Tokyo, Japan.

Cowgill, D. (1986). *Aging Around the World*. Belmont, CA: Wadsworth.

Coyle, J. M. (1985). Entrepreneurial gerontology: Creative marketing of gerontological skills. *Educational Gerontology, 11*, 161–167.

Drachman, D. (1995). Immigration statuses and their influence on service provision, access, and use. *Social Work, 40*, 188–197.

Fahey, Msgr., C. J. (1997). Social work education and the field of aging. *The Gerontologist, 36*, 36–41.

Healy, L. M. (1988). Curriculum building in international social work: Toward preparing professionals for the global age. *Journal of Social Work Education, 24*, 221–228.

Healy, L. M. (1987). International agencies as social work settings: Opportunity, capability, and commitment. *Social Work, 32*, 405–409.

Herrmann, K. J. Jr. (1991). Social workers and the United Nations convention on the rights of children. *Social Work, 36*, 102–103.

Hernandez, R. (1992). Demographics of aging. *Bold* (International Institute on Ageing—Malta), 2 (4), 8–12.

Hokenstad, M. C. (1988). Cross-national trends and issues in social service provision and social work practice for the elderly. *Journal of Gerontological Social Work, 12*, 1–15.

Hokenstad, M. C., Khinduka, S.K., & Midgley, J. (Eds.). (1992). *Profiles in International Social Work*. New York: National Association of Social Work Press.

Jacob, A. G. (1994). Social integration of Salvadoran refugees. *Social Work, 39*, 307–312.

Kammerman, S. B. (1976). Community services for the aged: The view from eight countries. *The Gerontologist, 16*: 529–537.

Kosberg, J. I. (Ed.). (1994). *International Handbook on Services for the Elderly*. Westport, CT: Greenwood Press.

Kosberg, J. I., Sohn K., & Sheppard, H. (1991). International imperatives for gerontological education. *Educational Gerontology, 17*, 477–486.

Kosberg, J. I. & Garcia, J. L. (1991). Social changes affecting family care of the elderly. *Bold* (Journal of the International Institute on Ageing—Malta), 1 (2), 2–5.

Kosberg, J. I. & Garcia, J. L., (Eds.) (1995). *Elder Abuse: International and Cross-Cultural Perspectives*. New York: The Haworth Press.

Kosberg, J. I., Garcia, J. L., & Lowenstein, A. (1997). Multisystemic approach for the comparative analysis of elder abuse in the U.S. and Israel: Implications

for cross-national research. Paper presented at the 50th Annual Scientific Meetings of the Gerontological Society of America.

Mary, N. L. (1997). Linking social welfare policy and global problems: Lessons learned from an advanced seminar. *Journal of Social Work Education, 33*, 587–597.

Mokuau, N. & Matsuoka, J. (1995). Turbulence among a native people: Social work practice with Hawaiians. *Social Work, 40*, 465–472.

Monk, A. & Cox, C. (1995). Trends and developments in home care services: An international perspective. *Journal of Gerontological Social Work, 24*, 251–270.

Mor-Barak, M. E., Poverny, L. M., Finch, W. A., Jr., McCroskey, J., Nedelman, H. L., Seck, E. T., & Sullivan, R. (1993). A model curriculum for occupational social work. *Journal of Social Work Education, 29*: 63–77.

Mui, A. C. (1996). Depression among elderly Chinese immigrants: An exploratory study. *Social Work, 41*, 633–645.

Pearson, V. & Phillips, M. (1994). Psychiatric social work and socialism: Problems and potential in China. *Social Work, 39*, 280–287.

Petzold, J. E. (1991). Southeast Asian refugees and sudden death syndrome. *Social Work, 36*, 387.

Potocky, M. (1996). Refugee resettlement in the United States: Implications for international social welfare. *Journal of Sociology and Social Welfare, XXIII*: 163–174.

Rosenthal, B. S. (1991). Social workers' interest in international practice in the developing world: A multivariate analysis. *Social Work, 36*, 248–252.

Rosenthal, B. S. (1990). U.S. social workers' interest in working in the developing world. *International Social Work, 33*, 225–232.

Social Work News (Fall, 1996). Ph.D. with Mexico to receive official sanction. The Newsletter for Friends of the U.T.A. (University of Texas at Arlington) School of Social Work, 4–5.

Teicher, M., Thursz, D., & Vigilante, J. (Ed.). (1986). *Reaching the Aged: Social Services in Forty-Four Countries*. Beverly Hills, CA: Sage.

United Nations (1991). *The World Ageing Situation 1991*. New York: Centre for Social Development and Humanitarian Affairs.

United Nations (1992a). *Global Targets on Ageing for the Year 2001: A Practical Strategy*. General Assembly (A/47/339).

United Nations (1992b). *Implementation of the International Plan of Action on Ageing*. General Assembly (A/47/369).

Aging in China

NELSON W. S. CHOW
University of Hong Kong
Department of Social Work and Social Administration

This article reports on a description of aging in China, in general, and Shanghai, in particular, with contrasts to the aging taking place in Hong Kong. Focused upon are the consequences of population aging on informal and formal support systems in the present and for the future. The efforts in the two cities of Shanghai and Hong Kong reflect differences in systems but are both influenced by traditional practices of a Chinese society.

Introduction

As a country with more than 1.25 billion people, the aging of the population in China has shown several features that are unparalleled in other countries (Minichiello, Chappell, Kendig, & Walker, 1996). Counting those aged 65 years and above, the number of elderly people now stands at around 6 percent of the total population, or 75 million, which already exceeds the population of most European countries. Not only is the number of elderly people in China enormous, it is also expected to increase at a rapid rate. It is commonly held by most Chinese demographers that it will take only 30 years for the elderly population in China to grow from 7 to 14 percent, while it had taken the populations in the United States 70 years and Germany 45 years to undergo the same change. China has therefore little time to prepare for the aging of its population (Kwong & Cai, 1992).

Since about three-quarters of the population in China are still living in the villages, the aging of the Chinese population is also characterized by its uneven distribution. While some of the big cities, like Shanghai, may have more than 10 percent of its population aged 65 years and above, villages in some remote

Journal of Sociology and Social Welfare, March, 1999, Volume XXVI, Number 1

areas may only have 5 percent or even less. The uneven rate of population aging in different parts of China is not only the result of rural and urban diversity but also caused by the "one child per couple" policy that the Chinese Government has enforced since 1979. On the whole, the policy has been much more vigorously carried out in the cities, resulting in a particularly speedy aging of the urban population (China Research Center on Aging, 1990).

Notwithstanding the fact that China still proclaims itself as a socialist country, its family system remains until today the most important provider of care for the elderly people. Whether or not the Chinese family system can continue its caring role is, therefore, a question that anyone interested in informal support for the elderly would like to ask (Olson, 1993).

As mentioned above, China as a vast country with a huge population is not ready to be treated as a uniform whole. Situations in fact vary so widely between different regions and cities that it will probably be much more fruitful to confine oneself to the examination of a few typical examples to see how population aging has affected elderly care. In this chapter, Shanghai and Hong Kong have been identified as the two cities that would offer the greatest interest to readers who want to know about the impact of population aging in China. Shanghai is chosen because it is the most populous city in China and it has also the highest percentage of elderly people among all the cities. The policies and practices that the Shanghai Government has adopted in regard to its elderly population would therefore serve as examples for other cities to follow. Hong Kong has just ceased to be a British colony and been returned to China on July 1, 1997. Under the "one country, two systems" arrangement, Hong Kong is promised the retention of its capitalist system and style of life for 50 years and is not required to adopt the socialist system practiced in the Mainland. Hong Kong has long developed its strategies to take care of its senior members and one can be sure that its experiences will be invaluable to policy makers responsible for the welfare of the elderly in other Chinese cities (Chow, 1995). On the other hand, while Hong Kong is not compelled to follow the examples in the Mainland, the fact that it is now a part of China opens up a new range of opportunities for the Hong Kong Special Administrative Region (SAR) Government to re-think its policies regarding the elderly.

In taking Shanghai and Hong Kong as examples, there is no intention here to make a comparison of the two. In many ways, these two Chinese cities are different from one another, because of their divergent paths of development. But increasingly, both Shanghai and Hong Kong are serving as examples for other Chinese cities to consider, with Shanghai exerting a greater influence in the north and Hong Kong making a stronger impact in the south. It is the aim of the Chinese leaders to build up a socialist system in China with Chinese characteristics. In the last assembly of the People's Congress (like the Congress in the United States) held in March 1998, the Chinese leaders openly accepted the necessity of learning from the best of the capitalist system, especially the importance of using the market mechanism. Hence, what ways and means Shanghai and Hong Kong have developed to promote the welfare of their seniors will be treasured, as no distinction will be made between the socialist and capitalist systems. The only shortcoming that will result from choosing two of the largest cities in China for examination is the omission of the rural areas where the majority of the Chinese still live (Wong, 1996). Such an omission is a serious one, but the situation of the villages is so different from the cities that it will not do the former justice if they are only covered briefly.

What is intended in the following is, first, to lay the scene of population aging in Shanghai and Hong Kong. It will then be followed by an examination of the impact it has made on the two societies, with special attention given to the caring functions of the family system and the changing role and status of the elderly people themselves. Mention will then be made of the measures that the two municipal governments have taken in protecting the interests of the elderly and the extent to which they are effective in response to the aging of their population. It is not expected that the above examination will result in any recommendation on the best strategy for China to take in securing for its elderly members the most satisfying life. However, it will certainly help the Chinese Government to understand better its own strengths and weaknesses in devising such policies.

Aging in Shanghai

The permanent population of Shanghai in mid-1996 was 13,044,300 people. It is not only the biggest city in China but also

one of the few most populous places in the world. Despite the high population density, the majority of the 4,574,858 households in Shanghai in mid-1996 had only a few members, averaging 2.9 persons per household. As mentioned, it is the city in China with the highest percentage of elderly people. In mid-1996, Shanghai had 1,620,550 elderly people aged 65 and above, or 12.5 percent of the total population. The number of elderly people in Shanghai is expected to increase to over 2.5 million in the year 2030, then level off and later decline gradually (Shanghai Aged Population Atlas Editorial Committee, 1997). Hence, in the next 30 years, Shanghai will be faced with a rapidly increasing number of elderly people in its population.

Similar to other big cities with a growing elderly population, those in the upper brackets of 75 years old and above will increase faster in number than those in the lower brackets. In mid-1996, over half, or 1.3 million out of the 2.3 million aged 60 and above, in Shanghai were aged between 60 and 69, while those aged 80 and above numbered around 240,000, or 10.0 percent of the total. However, it is expected that the "old-old" will greatly increase in number. On the whole, the sex ratio among those aged between 60 and 69 was about balanced, but female dominated, about 2 to 1, among those aged 80 and above. In terms of marital status, a much higher percentage of elderly men were reported in 1990 to be married than elderly women, 79.4 percent as against 42.4 percent. The reverse is true for those who were widowed, 55.6 percent of elderly women as against 18.75 percent of elderly men (Gui, 1996).

Traditionally, elderly people are expected to reside with their children, especially the eldest son. However, the "one child per couple" policy alone has made it almost impossible for children to follow this traditional practice, not to mention the increasing internal mobility that often results from rapid economic development (Economic and Social Commission for Asia and the Pacific, United Nations, 1996). It is therefore not surprising to find from the last Census conducted in 1992 that more than 13.0 percent of the elderly people in Shanghai were living alone and another one-third were elderly couples living by themselves. Those who lived with children and grandchildren represented about a half, with 16.0 percent living with unmarried children, 7.0 percent

with married children, 20.0 percent with three generations in the household, and 7.0 percent with their grandchildren (Gui, 1996). According to the findings of a survey conducted in the late 1980s in Shanghai on the elderly people's choice of residential preference, over 42.0 percent of those interviewed indicated that the most preferred living arrangement was for an elderly couple to live by themselves, with their married children living in the neighborhood. It should be noted that among the elderly in Shanghai, 78.0 percent of them owned the housing units they were occupying; hence it would only be natural for them to retain their present residence while encouraging their married children to live in another apartment nearby (Gui, 1996).

Since state-run enterprises employed nearly all urban workers in China in the past, the majority of the elderly people living in the cities who had retired from their work were entitled to the support of retirement pensions. The pension certainly formed the most important source of income for a great number of elderly people in Shanghai. According to a survey conducted in 1992, it was found that the major source of income for 36.3 percent of the respondents, who were all aged 60 and above, was retirement pensions. This was followed by assistance provided by the State for 33.1 percent, remunerated income for 14.2 percent, and support from children, relatives or friends for 12.8 percent (Gui, 1996). It should be mentioned at this juncture that a retirement protection system exists in China only in the urban areas and peasants are generally deprived of a similar coverage. Even peasants living in counties at the fringe of Shanghai seldom have retirement pensions and the majority of them have either to work to support themselves or to rely on community support (Wang, 1998). It should be noted, as found in the 1992 survey, that in both the urban and rural parts of Shanghai, very few elderly people (only 12.8 percent in the former and 18.3 percent in the latter) relied on the financial support of their children as their major source of income (Gui, 1996). It appears that on the whole, elderly people in Shanghai are financially quite independent, and unlike the traditional image, they hardly look to their children to provide for them in old age.

Compared to Shanghai, the population in Hong Kong is a bit younger as only about 10.0 percent, or 631,700 out of a total of

6,311,000 people in March 1996, were aged 65 and above (Census and Statistics Department, 1996). However, the extremely low fertility rate, about 12 per 1,000, that Hong Kong has experienced since the early 1990s implies that the rate of population aging will probably be faster in Hong Kong than in Shanghai. A note of caution has, however, to be made in that since January 1995, Hong Kong has been accepting 150 persons per day, or 55,000 persons a year, from the Mainland to settle in Hong Kong as permanent citizens. About half of these new arrivals, as they are called, are children born to Hong Kong permanent residents and since the majority of them are young in age, they will produce the effect of delaying the process of population aging. In fact, migration, both in and out of Hong Kong, has always made population projection a difficult task in the city, as the number is not entirely under the control of the government, both before and after 1997.

Aging in Hong Kong

In Hong Kong, there are more "old-old" in the elderly population than in Shanghai. Those 75 years old and above account for 36.3 percent of the elderly population, with 63.7 percent aged between 65 and 75. In other words, despite the fact that the percentage of the elderly people in the population of Hong Kong is lower than in Shanghai, Hong Kong has more elderly people in the upper brackets. In terms of the sex distribution of the elderly people, Hong Kong is not much different from Shanghai, with 45 percent of those aged 65 and above being male and 55 percent being female. Again, the ratio is more imbalanced toward the female in the upper age brackets. As to the marital status of the elderly, the two cities are surprisingly rather close to one another. Taking the Census data collected in 1991 in Hong Kong, so that they are comparable to those collected at more or less the same time in Shanghai, elderly men who were married accounted for 79.0 percent, with 15.0 percent widowed and 5.0 percent never married. The corresponding figures for elderly women were 41.0 percent, 52.0 percent and 5.0 percent (Bartlett & Phillips, 1995).

One is probably intrigued by the relatively low percentage of widowed men in both Shanghai and Hong Kong, being 18.8 percent and 15.0 percent in the two places, respectively. The explanations that one can give is that in Chinese societies, especially

among the older generations, men tended to marry women who are younger, and more women outlive their husband than vice versa as women generally live longer.

In terms of household compositions, 22.0 percent of the elderly people in Hong Kong, in March 1996, either lived alone or as an elderly couple. Nearly half of the elderly people, 44.1 percent, lived with their children, married or not married. Another 16.7 percent lived in households with three generations and only 9.8 percent were in households with two or more nuclear families. Nearly all studies on living arrangements of the elderly found that the trend was for more and more children to move away from their parents and start their own families, if they can afford to do so. On the other hand, though most of the elderly would still prefer to live with one of the children, especially the eldest son, even after the latter has married, they would not find it too objectionable if they have to live by themselves. In fact, studies have found that an increasing number of the elderly would choose to live away from their children (even when the latter have no objection to live with them), in order to avoid conflicts (Chi & Chow, 1997). However, the above changing trend has to be put in the context that housing units are generally very small in Hong Kong, mainly because of the lack of space, and it would almost be impossible for more than two generations to live in the same household. On the other hand, as property prices are extremely high in Hong Kong, the fact that some children still continue to stay with their parents, even after their marriage, does not necessarily imply that this is their choice. Rather, it may result from their financial inability to start a new home of their own.

Lastly, in terms of financial support, elderly people in Hong Kong are less fortunate than their counterparts in Shanghai. While a labor insurance program, covering old age, had been instituted in China for the majority of urban workers since 1951, legislation regarding the introduction of a retirement protection scheme for all employees was not enacted in Hong Kong until the year of its return to China. Except those working in government service or fortunate enough to be covered by private retirement protection schemes, the majority of the workers who retire now have either to depend on their own savings or the support of other family members. A study of the elderly people conducted in 1997 found

that about two-thirds of them had savings but the amount was generally insufficient for them to maintain a basic living standard (Chow, 1998). In other words, family support still remains a very important source of income for most of the elderly people in Hong Kong. Furthermore, while nearly all elderly people in Shanghai owned their own housing units, about half of the elderly in Hong Kong lived in housing subsidized by the government, with the other half in the private sector, mostly rental.

Impact of Population Aging

In both Shanghai and Hong Kong, population aging has not been recognized as an area to which the government should pay attention until the 1970s. This is so because in a Chinese society, the leaders would often hold that the support of the elderly should always remain a responsibility of the family, until they are confronted with the stark fact that an increasing number of old people are left unattended to (Zhu & Xu, 1992). In the 1960s, the stand of the Hong Kong Government was that the responsibility of caring for the elderly must fall on the natural family unit (Hong Kong Government, 1965). The Chinese Government has also been very insistent on the notion of family support for the elderly as stated in Article 49 of the 1982 Constitution of the People's Republic of China (PRC) that, "parents have the duty to rear and educate their minor children and children who have come of age have the duty to support and assist their parents." Although the insistence on the notion of family support does not necessarily imply a negation of government responsibility, it often result in a delay of the introduction of formal care measures that might give the impression of taking over informal family support.

Population aging was only recognized, both in Shanghai and Hong Kong, as an area that requires government action when its impact was too glaring to ignore. The first obvious sign of population aging was of course the increasing presence of the elderly people. The number itself does not necessarily cause concern but when more and more elderly people turn to the government for help and support, it becomes obvious that the problems associated with population aging can no longer be easily brushed aside (Leung, 1997). As mentioned, a retirement protection system was

absent in Hong Kong until recently, but the Hong Kong Government has set up since 1971 a Public Assistance scheme for those who are unable to maintain a basic living. Since its introduction in 1971, the majority of those applying for assistance were elderly persons, accounting for about two-thirds, and much higher than the sick and the disabled. At the end of 1997, it was reported that about 110,000 elderly people, or 15 percent of those aged 65 and above, were beneficiaries of the scheme, costing the government an annual expenditure of HK$ 4,000 million (US$1 = HK$7.8). The above sum does not include other residential care and community support services required by the elderly.

More or less the same concern about financial outlay has brought a heightened awareness of population aging to the Shanghai Government. As one of the cities in China with the longest history of industrial and commercial development, Shanghai has probably the highest percentage of workers who are retiring from work, as against those still working. As mentioned, a labor insurance program has been introduced in China since the early 1950s and in 1996, 1.89 million retired workers in Shanghai were receiving their pensions, causing an outlay of 10.3 billion Yuan (US$1 = 8.3 Yuan). This is no doubt a very heavy burden on the enterprises which are now contributing a sum equivalent to around 30 percent of the wage bill towards the labor insurance program, mostly to be spent on retirement protection. The growing burden of financing retirement pensions had largely been ignored when enterprises were heavily subsided by the state. However, with the economic reform introduced since 1984 in the cities, requiring enterprises to make their books meet, outlays on retirement pensions has become not only an unbearable burden but also an impediment to the enterprises' efforts to save up as much capital as possible for re-investment purposes (Li, 1997). This has resulted in the introduction of a series of measures since the early 1990s to lessen the financial burden of the enterprises by spreading the contributions to a broader basis.

The impact of population aging is also felt in a weakening of the caring role of the families. Contrary to popular belief, the size of the average Chinese family has never been very large since only the rich families can afford to have a large house spacious enough for several generations to live together. For the ordinary

people, the traditional practice has been for the elderly parents to live with one of their children, mostly the eldest son. However, the idea of filial piety also obliges other children, although they are not living with their elderly parents, to provide the latter with support and care (Chow, 1994). In other words, the concept of family support among the Chinese is not restricted to those living with one's elderly parents, although co-residence would make the performance of the caring roles easier. In fact, studies on family support in Shanghai found that married daughters are often the most important carers, although they are usually living away from their elderly parents (Gui, 1996).

As population aging in both Shanghai and Hong Kong is not simply the result of longer life expectancies but also due to a drastic drop in the fertility rate, it means that fewer children will be around in future to provide care. This change is particularly significant in Shanghai where the "one child per couple" policy has been most vigorously enforced. Indeed, government officials in Shanghai have repeatedly emphasized the importance of providing the elderly with adequate care and support so that young couples would not feel insecure about their own old age for having only one child. One can even venture to say that in supporting the elderly, the government officials in Shanghai have been motivated more by the mandate to enforce the "one child per couple" policy than an interest to promote the welfare of the elderly. Compared with their counterparts in Shanghai, government officials in Hong Kong have never been bothered by such kind of mandate. However, the drop in the fertility rate in Hong Kong, which is the result of a host of social and economic factors, produces the same result in that the elderly can no longer depend on other family members as their major source of support.

The decreasing importance of family support in both Shanghai and Hong Kong does not imply that family members, especially the children, are not prepared to help when the elderly are in need of assistance and care. The actual fact is that there are simply not so many family members to give help. Other sources of support, coming either from the community or the state, are therefore necessary to supplement where the family system is lacking.

So far, population aging has been perceived rather negatively in that the elderly are mainly regarded as objects requiring care and support. However, studies in both Shanghai and Hong Kong revealed that over 90 percent of their elderly remain healthy and are capable of self-care (Lam, 1997). In other words, apart from a small number of elderly people who are in need of assistance, the rest are not only able to look after themselves but also capable of rendering their service to other people. A vast pool of potential volunteers is thus found available in both cities. They are particularly invaluable because more and more women, who used to be the main source of volunteers, are now coming out to work and make their own careers. Furthermore, since formal health and welfare services for the elderly, as discussed later, have only been developed in both Shanghai and Hong Kong in recent years and are usually inadequate in supply, it is imperative for "elderly people to assist the elderly." The contributions that elderly people might make as volunteers should also be considered in the context of the society in the Mainland where neighbors are grouped into support networks. Elderly people as members of the community could therefore easily offer their service to those in the same neighborhood who require assistance. The situation in Hong Kong is substantially different as neighbors are often unknown to each other and families also move houses frequently. However, since social centers for the elderly have been established in almost every neighborhood in Hong Kong, elderly people who are able and prepared to render volunteer service could now be easily mobilized to do so.

To summarize, the impact of population aging in Shanghai and Hong Kong have produced similar effects in that more public resources are now allocated for the care and support of the elderly. With fewer members to provide care within the household, the role of the family as carers of the elderly has become less significant. However, the increasing number of healthy elderly means that more volunteer service can now come from this group and their contributions are too important to be ignored.

Policies Regarding the Aged in Hong Kong and Shanghai

In caring for elderly people, both the family and the community have long been perceived to be of primary importance.

Their importance lies in the fact that within these two institutions the elderly are most ready to establish their social relationships. In both Shanghai and Hong Kong, where social relationships are perceived as having fundamental significance under the influence of the Chinese culture, elderly people always feel more comfortable to receive help from the family and the community when they are in need (Ikels, 1992). Hence, it is not surprising to find that policies developed in Shanghai and Hong Kong on care of the elderly have put both the family and the community in the forefront as the most important care agents.

Since a policy on care of the elderly has been developed earlier in Hong Kong than in Shanghai, it will be examined here first. The principle that has guided the care of the elderly in Hong Kong since the early 1970s is known as "the care in the community" approach. The approach was first proposed in a report, published in 1973, of a governmental Working Party and was stated to mean that "services should be aimed at enabling the elderly to remain as long as possible as members of the community at large, either living by themselves or with members of their family, rather than at providing the elderly with care in residential institutions outside the community to which they are accustomed" (Working Party on the Future Needs of the Elderly, 1973, p. 15). The "care in the community" approach proposed in 1973 has since been reaffirmed in subsequent policy papers issued by the Hong Kong Government on care of the elderly. In the most recent report on care for the elderly, the "care in the community" approach was slightly changed to "aging in place," to mean that "appropriate support should be provided for older persons and their families to allow old people to grow old in their home environment with minimal disruption" (Working Party on Care for the Elderly, 1994, p. 48). Whether it is "care in the community" or "aging in place," the question that needs to be asked is: to what extent is the approach successful in enabling the elderly to live a satisfactory life? Is the approach most fitted to the situation of the Hong Kong society where, as mentioned above, the population is aging fast and the structure of the family is changing rapidly?

Conceptually, few objections can be raised against the "care in the community" approach, especially in Hong Kong where the family system is actually shouldering most of the burden in

taking care of the elderly in need of attention. However, evidence increasingly shows that the various assumptions made by the Working Party in 1973 are not necessarily correct. First, a policy paper published by the Government in 1977 on the development of social services for the elderly clearly stated that the "care in the community" approach could only succeed when the community was a caring one. Recent research has found that the roles and functions of the elderly, both within the family and in the community, have been so much weakened that the self respect of the elderly is now called into question (Chow, 1997). Secondly, the "care" that can be provided in and by the community has only been assumed but never clearly defined. Some take it to refer to the services provided in the community in support of the elderly, while others have in mind the assistance offered by relatives, friends and neighbors. The past development of services for the elderly has indicated that services are usually in short supply and they can only meet the needs of those in desperate need. The assistance offered by relatives, friends and neighbors is also known to be limited (Ngan, 1990). In other words, the unclear definition of care means that elderly people living in the community have often to do without the support they require, whether from the family, relatives, neighbors, or services provided by public welfare organizations. Thirdly, the "community" is also an ill-defined term. While it refers, in most cases, to communities where elderly people live, a geographical location does not necessarily entitle one to the membership of a set of social networks from which the elderly people could obtain help and assistance.

What one can conclude from the above discussion about the situation in Hong Kong is that while the "care in the community" approach has been a laudable one, it is far from being an effective policy in safeguarding the interests of the elderly. The major shortcoming of the approach is that it has assumed too much, especially regarding the obligations of the Chinese in taking care of their elderly members. The changes that the Hong Kong society has undergone, especially in terms of the continuous and substantial migration, both into and out of Hong Kong, indicate that the community can no longer be assumed to be a caring one. The care that can be provided by the family, relatives and neighbors, even if it still exists, is also dwindling both in scale and scope.

And the "community" in Hong Kong, taken here to mean a set of social relationships offering help and mutual-support, has also been found to be almost non-existent. In other words, if the "care in the community" approach is to actually perform what it intends to achieve, that is, to enable the elderly to live in the community for as long as possible, then a re-thinking of the policy objective is a must and the only way to stop it from being empty words.

It has been mentioned that services provided to support the elderly have always been in short supply. The health and welfare services provided for the elderly can roughly be divided into two types: residential care and community support services. Residential care services range from those that offer only minimal personal care to others that are fully integrated with the general hospital service. In fact, of the total number of patients requiring hospitalization in Hong Kong, around 40 percent are elderly persons. It must be noted that the residential care services for the elderly in Hong Kong are heavily subsidized by the government, with the recipients paying only a nominal fee, and they are usually provided at a very high standard. Their relatively high costs imply that they are usually insufficient to meet the demand, compelling those who could not wait to seek admission into the private nursing homes that are not only inferior in standard but also often charging exorbitant fees. The major shortcoming of the residential care services for the elderly in Hong Kong is thus a matter of uneven distribution, with a limited pool of quality services not necessarily serving those with the least means or the greatest need.

Compared to the residential care services, community support services are generally more sufficient in supply and ranging widely from general day center services, like meals and laundry, to the more sophisticated geriatric outreach support. Studies have, however, shown that although elderly people living in the community can obtain some kind of assistance from the community support services provided by the public welfare and health organizations, family members still form the most important source of help (Chow, 1994). Support to carers is thus important to ensure that they would not cease to play their caring roles but continue their contributions. To summarize, what one can say about the residential care and community support services for

the elderly in Hong Kong is that they are usually provided at a very high standard, albeit generally scarce in supply, with the large part of the costs covered by public revenue.

Compared to Hong Kong, the Chinese Government has been less consistent in its population policies. In the first twenty years after the establishment of the new government in 1949, China had stressed the benefits to be reaped from a large population; but the policy has been reverted since the end of the 1970s to restrict each couple to one child. This has made population aging in China very erratic. Despite the uneven pace of population aging, it has to be acknowledged that all along the Chinese Government has shown a keen interest in the well-being of its elderly population and it has always been a mandate written in the Constitution, except in the hey-day of the Cultural Revolution when all traditions were regarded as counter-revolutionary, that grown-up children should provide their elderly parents with the necessary assistance.

China's interest in population aging has only begun in the early 1980s. In 1982, China participated for the first time in an international conference on aging by sending a delegation to attend the World Assembly on Aging held in Vienna. Subsequently a National Committee on Aging was set up in Beijing to be responsible for the promotion and coordination of educational, health and welfare activities for the elderly. Similar committees were also set up at the municipal level in most of the big cities in China, such as the Committee on Issues of the Elderly established in 1984 in Shanghai (renamed the Shanghai Committee on the Elderly in 1995). The National Committee on Aging is a quasi-governmental organization working closely and in a way under the auspices of the Ministry of Civil Affairs, which is the ministry in China in charge of social welfare. The local committees on aging also work under the guidance of the Civil Affairs Bureaus in the cities to promote the welfare of the elderly.

During the 1980s, the National Committee on Aging, together with the municipal committees, focussed their work on organizing various projects and programs to encourage the elderly to be active members of the community. The vice-chairman of the National Committee on Aging once spelt out in a speech made in 1986 in a seminar held in Beijing that in response to population

aging, the policy measures of the Chinese Government were: to make everyone realize the importance and urgency of the issue of population aging, to put into effect laws and regulations to protect the interests of the elderly, to develop various types of programs for the elderly, to recognize the contributions of the elderly in society, and to establish organizational networks to serve the elderly (Wei, 1987). In a way, the Chinese policy on the elderly, as spelt out above, is broader than the "care in the community" approach adopted in Hong Kong because while China can make it a legal and primary responsibility of the children to support their elderly parents, supplemented by services provided by the government, Hong Kong can only resort to moral persuasion, and take up whatever is left undone by the children by providing the elderly with the necessary public support and care.

Other than enforcing the relevant laws and regulations to protect the interests of the elderly, the Chinese policy on the elderly has, on the whole, laid a greater emphasis on the active participation of the elderly in community activities or, as described in Shanghai, "the release of the remaining heat and light" of the elderly. The active participation of elderly people in community activities in China has been made possible by the special kind of local administration that exists there. In China, residents' committees are organized at the street level in the cities to promote mutual help among the residents. It is also at this level that the government provides its people with the most essential services. Elderly people requiring support, especially those with no families to give them help, can thus get the appropriate assistance from the residents' committees (Leung & Nann, 1995). On the other hand, as mentioned before, since elderly people are themselves members of the local communities, with some holding offices in the residents' committees, they can also render their service to other people living in the district through the work of the committees, such as helping in controlling traffic, assisting frail and disabled members in the community, and offering advice and help to mothers with new born babies.

Mention should also be made of the community service centers that have since 1987 been established in nearly all cities in China at the street level to render services to the residents (Chan, 1993). Almost without exception, community service centers are

run by the residents' committees, with guidance from the appropriate Civil Affairs Bureaus. The services provided by these centers vary greatly, depending on the resources available in each district, but usually include such as nursery, canteen, interest classes for different age groups, reading room, meals delivery, health education programs, clinics and accompanying service. It is obvious that most of these services are of special relevance to the elderly people and form an important source of help to enable them to live in the community. The former director of the China Research Center on Aging once reported in 1995 that so far as the promotion of the welfare of the elderly people is concerned, services provided at the street level for the elderly people could be grouped as follows: to provide care for the lonely elderly, such as homes for the elderly set up in the districts; to protect the health of the elderly, such as the organization of district health centers; to increase the employment opportunities of the elderly, such as the existence of local employment exchange centers; to enhance their cultural life, such as the setting up of schools for the elderly; to enrich their social life, such as the establishment of recreational centers for the elderly; and to protect the legal rights of the elderly, such as the setting up of legal advice counters at the street level (Hong, 1996). It was reported that with the rapid development of services for the elderly at the street level, enterprises that have in the past provided services for their own retired workers are now finding it more convenient to entrust this responsibility to the residents' committees by paying the appropriate fees.

With the provision of services at the district level to meet the needs of the elderly, the central government has found it possible to concentrate its efforts on issuing general directives, culminating in the passing of the Law on Protecting the Rights of the Elderly in 1995, and in ensuring the provision of a basic living for the retired workers through the enactment of appropriate social security measures (Palmer, 1995). The development of the retirement protection system will not be a subject of discussion here but it suffices to point out that most retired workers in the cities in China, including of course Shanghai, are provided with retirement pensions, equivalent to about 60 to 80 percent of their salaries before retirement. It has to be pointed out that up to now, only workers in the cities are protected by social security

measures and contributory insurance schemes for old age have only been introduced for peasants in the villages since the early 1990s. Elderly people in the cities can thus be regarded as a privileged group, who usually do not have to worry about their basic living.

Despite the fact that a Committee on Issues of Aging, as mentioned above, has been set up in Shanghai as early as in 1984, it appears that little has been done in the 1980s to anticipate the impact of population aging. All the important committees on aging were established in the 1990s, such as the Shanghai Joint Conference of Workers on Aging set up in 1991, the Shanghai Fund on Aging in 1992, the Shanghai Research Center on Aging and the Shanghai Social Insurance Bureau, both in 1993. It is obvious that the issues arising from population aging have only caught the attention of the Shanghai Government when Shanghai, as the biggest city in China, was given the green light to develop into a modern city in the early 1990s. Before that, in protecting the interests of the elderly living in the city, the Shanghai Government had done no more than followed the central directives, such as revising the labor insurance regulations. With the establishment of the committees and organizations on aging in recent years, the Shanghai Government appeared to have adopted a much more dynamic approach in tackling the issues of population aging.

As mentioned, the provision of services in support of the elderly is usually at the street level and the Shanghai Government has relied heavily on the social networks existing among the residents committees to provide the necessary services (Cai, Song, Luo, & Jiang, 1994). It was reported that at the end of 1996, over 300 homes for the elderly were set up in Shanghai, usually run by the residents' committees themselves, with each home accommodating about 20 to 30 elderly persons. On top of that, 4,540 centers were organized to provide the elderly with the appropriate cultural and recreational activities. Other than these, it was known that about 4,600 elderly persons, living in the rural areas at the periphery of Shanghai, were assisted in their basic living (Shanghai Aged Population Atlas Editorial Committee, 1997). There is no doubt that the emphasis on mutual support among the residents themselves in Shanghai is partly due to the lack of governmental funding; local communities have therefore

to mobilize their own resources. This has produced the effect of making the communities more aware of not only the needs of the elderly members but also the importance of preserving, as far as possible, the existing social networks. However, it should not be taken to imply that all communities in Shanghai are "caring" ones. The Shanghai Government has also perceived the importance of providing more support for the needy, especially as Shanghai is fast developing into a modern city with the accompanying characteristics such as the dwindling functions of the family system. However, as long as the social networks among the residents still exist and are functioning well, it is only natural for the Shanghai Government to make use of them to play a major role in providing the necessary support for the needy ones, especially elderly people who are held in high regard in the Chinese society.

Strategies of Tackling the Impact of Population Aging

The demographic data of Shanghai and Hong Kong indicate that both societies are aging fast. While the gap in economic performance between the two cities is still very wide, with Shanghai lagging behind Hong Kong, there are many similarities in their social structure. It is noteworthy that about half to two-thirds of the elderly in both cities are still residing with their family members, usually their children, with the latter also forming one of their major sources of income support. The retired workers in Shanghai are probably more fortunate since a retirement pension has existed in China for urban workers since the early 1950s. In Hong Kong, except those who are working in governmental service or in well-established companies, retired workers have either to rely on their past savings or the support of their children, if the latter are willing and financially able. This explains why a greater percentage of the elderly in Hong Kong have to turn to public assistance for a basic living, whereas in Shanghai poor elderly people are fewer in number.

The impact of population aging on the expenditures on care for the elderly in the two cities has also been found to be different. In Shanghai, since income protection for retired workers is basically a responsibility of the enterprises employing the workers, the concern has been one of ensuring adequate protection

while not scarifying the competitiveness of the enterprises. The discussion in Hong Kong is centered on how to concentrate public expenditure on the most needy elderly while introducing income protection schemes to ensure that elderly people in the long run would be more self-reliant. Notwithstanding the variations between Shanghai and Hong Kong in their methods of protecting the income security needs of the elderly, it should be noted that population aging in both cities has so far not resulted in too excessive a level of public expenditure on their care. In a way, it is fortunate that the family system has so far played an important role in providing the elderly in both cities with the necessary support and care (Davis & Harrell, 1993). It is difficult to predict at this point whether family support will continue in Shanghai and Hong Kong, and thus the containment of public expenditure on care for the elderly, but as long as respect for the elderly remains a dominant feature of the Chinese society, children should still feel obliged to take care of their elderly parents.

So far as strategies to take care of the elderly is concerned, it is interesting to find that notwithstanding the differences in the socio-economic structure between Shanghai and Hong Kong, one being socialist and the other capitalist, the two cities are in fact very similar in their ways of caring for the aged. The "care in the community" approach adopted in Hong Kong has resulted in the elderly people remaining in the community for as long as possible, to be taken care of by their families when they are in need, while the role of the government is confined to one of providing care for those who must depend on public support. The emphasis of the Shanghai Government is also on encouraging the elderly to live in the community, and as it is clearly written in the Chinese Constitution that children must support their aged parents, such strategy is closely in line with the country's spirit.

Although both Shanghai and Hong Kong have emphasized the importance of enabling the elderly to remain in the community, it should be pointed out that due to the differences in the social networks that exist at the district level, Shanghai is in a better position to accomplish this objective than Hong Kong (Hu, 1987). As residents' committees have long existed in Shanghai to assume the responsibility for local affairs at the district level,

they can easily organize cultural and recreational activities for the elderly and operate homes for those needing care. Such kind of social networking is generally absent in Hong Kong as the government is less reliant on the residents to run their own affairs. Hence, the development of public community support services becomes the only way to achieve the objective of the "care in the community" policy in Hong Kong, whereas in Shanghai greater initiative is left to the residents themselves, resulting in much more variations in the kinds of care provided for the elderly. The variations in care for the elderly is seen most clearly in the range of activities and services provided by the community service centers in each district of Shanghai. While some centers may provide the most sophisticated form of health and welfare support for the elderly, some may be satisfied with nothing but a meeting place where the elderly may assemble. In other words, though communities in both Shanghai and Hong Kong appear to be similar, at least on the surface, they in fact vary greatly in their functions in promoting the welfare of the elderly, depending most importantly on the kinds of social networks that actually exist.

The last point that needs to be discussed is the impact of population aging on the role played by the elderly themselves both within the family and in society. References have already been made to some research findings indicating that the role and status of the elderly in both Shanghai and Hong Kong are declining, to such an extent that one wonders whether the tradition of respecting the old among the Chinese is still maintained. The falling status of the elderly in Hong Kong is attributed to the rapid social and economic development that Hong Kong has undergone in recent years, making the experiences of the elderly less treasured than before. The respected position of the elderly in Shanghai has also been very much eroded during the days of the Cultural Revolution when all traditions were regarded as counter-revolutionary. However, the retirement pension to which most elderly people in Shanghai are entitled implies that financially they are less vulnerable than their counterparts in Hong Kong, and are thus better able to retain their independent status both within the family and in society. But it is no longer possible for the elderly in both Shanghai and Hong Kong to rely on the tradition of respecting the old to command the respect of others; they must

redefine their role and discover anew their position both within the family and in society.

In establishing their new role and status, elderly people in Shanghai are again offered more opportunities than their counterparts in Hong Kong. The heavy reliance on public support in Hong Kong means that the elderly there are often regarded as no more than recipients of formal services. On the other hand, the emphasis in Shanghai, partly because of the lack of resources, is to encourage the elderly to participate, as much as possible, in community activities. In this way, elderly people in Shanghai can also be said to have been empowered to promote their own welfare, whereas in Hong Kong, elderly people appear to be more passive. One cannot say for sure whether this empowerment of the elderly in Shanghai has anything to do with the socialist economy that exists in the Mainland, but it is obvious that before 1997, the Colonial Government in Hong Kong had perceived its role towards the elderly as no more than meeting the needs of the most needy.

Conclusion

In one article, one cannot do justice to the impact of population aging for such a big country as China, though discussions have already been confined to the situation in only two cities, namely Shanghai and Hong Kong. However, the above examination has revealed several interesting points. First, notwithstanding the differences in the socialist or capitalist system adopted, it appears that the two cities have both to tackle the problems arising from rapid population aging. Furthermore, the ways adopted by the two governments in Shanghai and Hong Kong to promote the welfare of the elderly in fact differ little from not only one another but also those implemented in other developing economies with fast aging populations.

Secondly, though both cities are very much influenced by the traditional practices of a Chinese society, they are not immune from the effects of urbanization and modernization; and in caring for the elderly, the governments must recognize the declining role played by the family system and devise their caring strategies accordingly. The above examination reveals that it is certainly

not an easy task for the governments in both Shanghai and Hong Kong to strike a balance between accepting, on the one hand, the need for increasing governmental intervention in providing care for the elderly and retaining, on the other, as far as possible the traditional roles of the family and community in supporting their elderly members.

Thirdly, despite the fact that elderly people are still held in high respect, at least as a value, among the Chinese, it appears that the pressure of a modern society has prevented the younger members, however willing they are, from fulfilling their filial duties, especially in providing the elderly with the personal care they require. In other words, the Chinese elderly in both socialist Shanghai and capitalist Hong Kong must strive to re-establish their new roles, not relying so much on the traditional concept of filial piety, but as independent members of the family and society, with their distinct rights and responsibilities. It does not imply that the elderly in China can no longer make use of the existing social networks in protecting their own welfare but, similar to the experiences of other countries with aging populations, the elderly would only be ensured a reasonable level of care when their interests, abilities and rights as members of society are fully recognized. The special characteristics of the Chinese society, especially its emphasis on respecting the old, can only be treated as an asset, but not a substitute, for the measures that the governments can employ in furthering the welfare of the elderly.

References

Bartlett, H. P. & Phillips, D. R. (1995). Aging trends—Hong Kong, *Journal of cross-cultural Gerontology*, **10**: 257–265.

Cai, W.M., Song, Y. H., Luo, X. Y., & Jiang, L. M. (1994). China. In J. Kosberg (Ed.), *International Handbook on Services for the Elderly*, pp. 80–94. Westport, CT: Greenwood Press.

Census & Statistics Department, Hong Kong Government. (1996). *1996 Population By-census: Summary Results*. Hong Kong: Government Printer.

Chan, C. (1993). *The Myth of Neighborhood Mutual Help: The Community-Based Welfare System in Guangzhou*. Hong Kong: Hong Kong University Press.

Chi, I. & Chow, N. (1997). Housing and family care for the elderly in Hong Kong, *Aging International*, Winter/Spring: 65–77.

China Research Center on Aging. (1990). *A Collection of Statistical Data on the Elderly Population*. Beijing: Hua Ling Publishing Company. (In Chinese)

Chow, N. (1991). Does filial piety exist under Chinese communism? *Journal of Aging & Social Policy*, **3**: 209–225.

Chow, N. (1994). Care of the elderly: Whose responsibility? *Hong Kong Journal of Gerontology*, **8** (1): 12–18.

Chow, N. (1995). Social security reform in China—an attempt to construct a socialist security system with Chinese characteristics. In L.Wong and S. MacPherson (Eds.), *Social Change and Social Policy in Contemporary China*, pp. 27–49. Aldershot, Hants: Avebury.

Chow, N. (1997). *A Study of the Role and Status of the Elderly in Hong Kong*. A research monograph. Hong Kong: Department of Social Work and Social Administration, The University of Hong Kong.

Chow, N. (1998). Social welfare and the Challenges in a new era. In S. L. Wong & T. Maruya (Eds.), *Hong Kong Economy and Society*, pp. 135–152. Hong Kong: Center of Asian Studies, The University of Hong Kong.

Economic and Social Commission for Asia and the Pacific, United Nations. (1996). *Population Aging and Development*. Asian Population Studies Series No. 140. New York: United Nations.

Gui, S. X. (1996). *A Comparison of Population Aging in Tokyo and Shanghai*. Shanghai: East China Normal University Press. (In Chinese).

Hong, G. T. (1996). The integration of services for the elderly at the neighborhood level. In *The Proceedings of the Third Conference on Social Welfare between the Mainland and Hong Kong*, pp. 271–278. Hong Kong: Hong Kong Council of Social Service.

Hong Kong Government. (1965). *Aims and Policy of Social Welfare in Hong Kong*. Hong Kong: Government Printer.

Hu, R. Q. (1987). The roles of Chinese urban elderly in social development: Direct and indirect participation. In J.H. Schulz and D. Davis-Friedmann (Eds.), *Aging China: Family, Economics and Government Policies in Transition*, pp. 271–280. Washington, D.C.: The Gerontological Society of America.

Ikels, C. (1992). Family caregiving and the elderly in China. In D. Biegel and A. Blum (Eds.), *Aging and Caregiving: Theory and Practice*, pp. 270–284. Newbury Park, CA: Sage Publications.

Kwong, P. & Cai, G. X. (1992). Aging in China: Trends, problems and strategies. In D. Phillips (Ed.)., *Aging in East and Southeast Asia*, pp. 105–127. London: Edward Arnold.

Lam, S. K. (Ed.) (1997). *The Health of the Elderly in Hong Kong*. Hong Kong: Hong Kong University Press.

Leung, J. (1997). Family support for the elderly in China: Issues and challenges, *Journal of Aging & Social Policy*, **9** (3): 87–101.

Leung, J. & Nann, R. (1995). *Authority and Benevolence: Social Welfare in China*. Hong Kong: The Chinese University Press and New York: St. Martin's Press.

Li, Z.Y. (1997). The effect of population aging on the selection of age pension insurance model in China. In *Developing Policy Planning and Research*

Capabilities in Asia and the Pacific, pp. 47–65. Manila: International Social Security Association.

Minichiello, , V., Chappell, N., Kendig, H., & Walker, A. (Eds.). (1996). *Sociology of Aging: International Perspectives*. Australia: Research Committee on Aging, International Sociological Association.

Ngan, R. (1990). The availability of informal support networks for the Chinese elderly in Hong Kong and implications for practice, *Hong Kong Journal of Gerontology*, 4 (2): 19–27.

Olson, P. (1993). Caregiving and long-term health care in the People's Republic of China. In S. A. Bass and R. Morris (Eds.), *International Perspectives on State and Family Support for the Elderly*, pp. 91–110. New York: The Haworth Press.

Shanghai Aged Population Atlas Editorial Committee. (1997). *Shanghai Aged Population Atlas*. Shanghai: Shanghai Science and Technology Press. (In Chinese with English titles).

Unger, J. (1993). Urban families in the eighties. In D. Davis and S. Harrell (Eds.), *Chinese Families in the Post-Mao Era*, pp. 25–49. Berkeley: University of California Press.

Wang, J. (1998). The national experience of the People's Republic of China, In *Social Security in Asia and the Pacific; The Road Ahead*, pp. 187–198. Manila: International Social Security Association.

Working Party on Care for the Elderly. (1994). *Report of the Working Party on Care for the Elderly*. Hong Kong: Government Printer.

Working Party on the Future Needs of the Elderly. (1973). *Services for the Elderly*. Hong Kong: Government Printer.

Wong, L. (1998). *Marginalization and Social Welfare in China*. London and New York: Routledge.

Wei, H. C. (1987). Growth of the aged population in China: Trends and Policy. In J. H. Schulz and D. Davis-Friedmann (Eds.), *Aging China: Family, Economics and Government Policies in Transition*, pp. 10–18. Washington, D.C.: The Gerontological Society of America.

Zhu, C. Y. and Xu, Q. (1992). Family care of the elderly in China. In J. Kosberg (Ed.), *Family Care of the Elderly: Social and Cultural Changes*, pp. 67–81. Newburg Park, CA: Sage Publications.

Getting Old in the U.S.: Dilemmas of Indo-Americans

PALLASSANA R. BALGOPAL
University of Illinois, Urbana
School of Social Work

Adapting to old age is an arduous task in every society. For Asian immigrants because of drastically different value systems getting old in the U.S. poses a number of dilemmas. For the Indo-American elderly and their families a major dilemma is whether to expect and abide by the value orientation of collectivism or follow the main stream American value of individualism. In this study the ethnographic approach operationalized through Interpretive Interactionism for an understanding of the interaction between the elderly and their families and their overall coping and adaptation process in the United States is presented.

Introduction

Since the liberalization of the immigration policies in the United States in 1965, the number of new immigrants from Asia, Africa, and Latin America has dramatically increased. At the present time, it is estimated that there are nearly 1.5 million Indo-Americans[1] in the U.S. Like their predecessors, these new immigrants come to the U.S. primarily to improve their economic status. A majority of these immigrants, at the time of their arrival in their new homeland, are between the ages of 25 and 35. This demographic pattern is contributing to a rapid increase in the elderly population of this group.

Adapting to old age is an arduous task in every society. Due to the decline in their health as well as in economic status, the elderly need supportive networks both at informal (social and kinship) and formal (human and health services) levels. For the Indo-American elderly and their family, a major dilemma is whether to

Journal of Sociology and Social Welfare, March, 1999, Volume XXVI, Number 1

expect and abide by the value orientation of collectivism, which implies dependence and nurturance from family and kinship networks, or to comply with the dominant value of their new environment, which is individualism (implying minimal dependence on others). This conflict or dilemma creates turmoil both in the elderly as well as in their family members. For example, placing a family member in a nursing home is not an easy decision, but for an Indo-American family, this option simply does not exist. In reality, even if these families believe in such options they have tremendous difficulty in implementing it. Such decisions are unacceptable on an emotional level, including the fear of alienation by the social and kinship networks.

The focus of this study is to examine the current status of Indo-American elderly in the U.S., including the role of their social and kinship networks. The specific aim of this study is to examine: The current profile of the Indo-American elderly in the U.S., differences and similarities of Indo-American elderly with other Asian American elderly, the structure and functions of their social and kinship networks, feelings about living in the U.S. at this stage of their life cycle, and their current dilemmas, conflicts and concerns.

Asian American Perspective of Getting Old

Percentage-wise, Asian Americans is the fastest growing ethnic group in the U.S. Between 1970 and 1980 the U.S. population increased by 11%, whereas the Asian American group increased by 141%, and between 1980 and 1990 the total American population increased only by 10% compared to the increase of the Asian American groups by 99%. Currently there are nearly eight million Asian Americans and it has been projected by the year 2030 that this population will cross the 20 million mark (Barringer, Gardner and Levin 1993).

The Asian American group is a collection of extremely diverse groups. These differences are clearly evident along racial, religious, and lingual dimensions. Adherence to their ethnic customs and values is often influenced by the historical context of their arrival in the U.S. The term Asian American connotes people who can trace their ancestry to all the countries of South Asia, South

East Asia and East Asia. The individuals from the Pacific Islands including Hawaii are included in this cluster known as Asian and Pacific Islanders. Because of their high numbers, racial commonality, and their early arrival in the U.S., often the Asian American group is perceived as people of Japanese, Chinese, Korean and Filipino ancestry. It needs to be recognized that people from the South Asian countries and new arrivals from the South East Asian countries must also be included in the Asian American cluster. The Asian American groups have both a great deal of similarity as well as unique features related to the role and status of their elderly members. However, often their features are very different from the mainstream American values. A brief examination of the role and expectations of the elderly in these groups is in order.

In her discussion of **Chinese** values of aging, Cheung (1989) identifies four categories. First, it is expected that elderly parents are supported by and live with their children. Filial piety and respect for the elderly are seen as essential values which promote close family relationships. Second, older people, because of their life experience, knowledge and authority, represent a link to the past. Third, aging is seen as a harmonious process, and fourth, the elderly are seen as being productive. Mui (1996) also postulates that the elderly Chinese immigrants, as well as their culture, place a strong emphasis on family togetherness and active interdependence. Thus, when children move out and establish their own homes, the parents are disappointed, hurt, find it difficult to accept, and experience shame. According to Cheung (1989), to overcome the pain of isolation and rejection coupled with economic hardship, the Chinese elderly lean on their peers for support and foster less dependency on governmental assistance.

Kitano (1990), in describing **Japanese** family values related to the elderly, identifies the following dimensions: obedience to rules, roles and controls, obligation to the family, sense of fatalism, strong dependency needs, family reciprocity and filial piety, indirect methods of communications, and modesty. Yamashiro and Matsuoka (1997), in their analysis of Japanese-Americans help-seeking behavior, indicate that such behavior is greatly influenced by the doctrines of the Buddhist religion, which teaches that all life is subject to suffering. Adherence to this doctrine is reflected in

a number of Japanese beliefs such as *gaman* (to endure) and *shikata ga nai* (whatever has happened cannot be helped). According to Kim and Kim (1992), unlike the Japanese elderly who maintain a close support network with their cohort group members, the **Korean** elderly are determined to maintain their independence and are reluctant to ask for help from sources outside their family. They are observed with traditional value of *Che-myun* (or face-saving). Even if they are living in abject poverty, the Korean elderly often pretend they are being well cared for by their children. Such behavior is to save their children's and their family's dignity and reputation.

The **Filipino** and **Hawaiian** cultures emphasize respect for their elderly, but strict adherence to such practice is not required. In the Filipino family hierarchy, age is important, but it does not imply authority. Grandparents are indulged and respected, but they are not perceived as authority figures and do not have the final say in family matters. The elderly are considered valuable and their opinion is sought on important matters (Agbayani-Siewart 1994). Based on their study of life experiences of native Hawaiian female elders known as *Kupuna*, Mokuau and Browne (1994) report three major life themes for this population. These themes/expectations are: (a) relationships with people, (2) relationships with nature, and (3) spiritual and religious beliefs. The Hawaiian elders have a special responsibility of tutoring the young and transmitting knowledge and values. In their view, one should not be greedy and take only as much as one needs. Regarding religious beliefs, the *Kapunas* have uniquely blended the Hawaiian indigenous spiritual beliefs with Christian ones.

The **Indo-Americans** share many of the above features, but they have a certain unique perspective on these issues. From ancient times the family has dominated the cultural values and belief systems of the Indian society. The Indian family has changed in recent years as the aging of family members has become problematic and continues to increase. Unfortunately, a majority of the elderly Indians have to rely on their families for support and have little or no means of independent support (Gulati, 1995). Ramanathan and Ramanathan (1994), in discussing the attitudes and expectations associated with the aging process, articulate that in the Indian cultural context this stage of life cycle is seen

as a period of rightful dependency with security assured by the extended family, especially the sons. Caregiving by the children is a product of cultural expectations, duty, love, and mainly an extraordinary sense of positive regard for their elderly family members. Every aspect of Indian life is integrally intertwined with religion. *Dharma* is the Ultimate Law of all things in Hinduism that governs "correct" individual conduct. Scrupulous role fulfillment is the *dharma* of every member of society. *Dharma* for a female is to be the devoted daughter, wife, and—the most vital—mother. It demands her submission to the hierarchical imbalances of a patriarchal culture within which she is nurturer, server and procreator but always subservient to the male. The *dharma* of a male is to be the provider, and protector, of the family, the guardian of the family's morals, and preserver of the status quo (Kishwar, 1984; Miles, 1980). As guardian, the male has the obligation to subjugate and channelize highly potent "Feminine Energy" which could be destructive to society if left uncurbed. Often such beliefs of women's power presents the recognition of violence against them in the Indo-American families (Das Dasgupta & Warriar, 1995).

Karma is the unending chain of conduct and its reward or punishment that is meted out through successive rebirths, and that constitutes fate or destiny. *Karma* ties all joys and sufferings in *this life* to good or evil deeds in *past births* (Venkataraman, 1996). Scrupulous compliance or non-compliance with *dharma* impacts all aspects of one's rebirth, including gender (male birth signals reward, female birth signals punishment), position in the power hierarchy, occupation, and the degree of pain to be suffered. There is a clear-cut reciprocity of *dharma* and *karma* especially as related to parents and children. The reciprocal responsibilities and obligations for both parents and children are explicitly delineated, implying each of them caring for one another in different stages of their life cycle.

Respect and honor given to the elderly in the Indian culture is structured through the socialization process. In the Indian homes, children are taught to treat their grandparents as if they are deities. As the father in the Indian household becomes older, the elder son assumes more family responsibilities (Pillai 1985). *Dharma* and *karma* are more culture-specific rather than religious concepts,

and non-Hindu Indian families equally adhere to these concepts as do most Hindus.

In the life cycle stages of Hinduism, the final stage before death is asceticism and renunciation expressed through denial of material and sensual pleasures (Pillai, 1985). In the Indian culture, this process is known as "*Vairagya*," translated as "detachment-from," referring to a disengagement from material possessions and ego-fulfilling desires, and engagement in spiritual pursuits through philosophical introspections. The latter is carried out both individually and through in-depth discussion amongst peers. Most Hindu elderly men and women in India spend much of their time in spiritual activities, such as singing (*"Bhajans"*) hymns, praying, and engaging in spiritual discussions.

Profile of Indo-America Elderly

The first group of Asian Indians arrived in the U.S. as early as the middle of the nineteenth century, and were primarily agricultural workers. Their numbers significantly increased in the later part of the nineteenth and beginning of the twentieth century. In July 1946, the U.S. Congress passed a bill allowing naturalization for Indians. While highly educated and technically, and professionally trained, Indians desired to enter the U.S., restrictive immigration policies and quotas ensured that only a small number (about 100) were allowed to immigrate per year. Overall, about 6,000 Asian Indians immigrated to the U.S. between 1947 and 1965. After the 1965 Immigration Act, which abolished the quota system, the Indo-American population is one of the fastest growing ethnic groups.

The 1990 U.S. Census (U.S. Bureau of Census, 1992) placed the Indo-American population at 815,447, the fourth largest Asian American group. Based on the data of new immigrants arriving every year, the current figure for Indo-Americans is easily estimated to be over 1.5 million (U.S. Statistical Yearbook of the Immigrating and Naturalization Service, 1995).

In the present context, Indo-American elderly are those who are above 60 years of age. They are classified in three groups: (1) Those who came prior to 1965. As mentioned above, because of the restrictive immigration policies of quota system, it was very

difficult for people from the South Asian countries to immigrate to the U.S. Most of them came as students and, after completing their education, many decided to become American citizens. These individuals, because of their educational achievements as well as good employment, are generally well-settled. Generally, they seem to have balanced their American and Indian identities. (2) The second group includes those who came after the 1965 Immigration Act. Individuals falling under this category are usually professionals and others with technical expertise who had been well-employed in India, married with children, and immigrated to the U.S. primarily to improve themselves professionally and economically. (3) The third group of Indian elderly include those who came to the U.S. as elderly immigrants because their adult children (often sons) had immigrated here and left little option for them to live in India.

As presented in Table 1, in the 1980 Census, it was reported that there were 23,966 Indians over the age of sixty. This number had increased to 37,347 in the 1990 Census. Interestingly, there is a dramatic increase amongst the male population over sixty compared to their female counterparts. In 1980 there was a total of 5,776 men and 17,990 female; this number increased to 17,744 men and 19,503 female in 1990. Although, there is a numerical increase in the female population over sixty, percentage-wise there is a significant decline. In the absence of hard data explaining such significant changes among the gender distribution, one can only speculate the reasons. In the first phase of Indian immigration there was a disproportionate number of single men entering the U.S. who are presently over the age of sixty. The likelihood of these men marrying non-Indians was greater than their marrying Indians. More recently, secondary immigrants (i.e., parents sponsored to immigrate by their children) include more men than women. However, these factors do not fully justify the dramatic drop in numbers of female Indians, especially those over the age of seventy.

After two decades of steady annual increases, the number of parents of U.S. citizens immigrating declined for the third consecutive year. In 1992, 64,764 parents were admitted whereas in 1995 this number dropped by 25% to 48,382. However, it needs to be noted that parents immigrating to the U.S. were

Table 1

Distribution of Indo-Americans in the U.S. Sixty Years and Above by Age and Gender for 1980 and 1990.

Age	*1980*			*1990*			*%*		
	All	*Male*	*Female*	*All*	*Male*	*Female*	*All*	*Male*	*Female*
Total	361,531	187,083	174,448	815,447	437,843	377,604	126	134	116
60 to 64	5,080	1,603	3,477	14,243	7,161	7,082	180	346	104
65 to 69	5,164	1,387	3,777	10,285	4,690	5,595	99	238	48
70 to 74	4,807	1,142	3,665	6,281	2,837	3,444	31	148	(19)
75 & over	8,915	1,844	7,071	6,438	3,056	3,382	(28)	60	(52)

Source: Adapted from U.S. Bureau of Census 1980 and 1990.

primarily born in Asian countries (57%). India being the third highest source to send the elderly immigrants, and numbered 4675 or almost 10% of the total number of parents coming to the U.S. This number constitutes almost 14% of all immigrants coming from India (Statistical Yearbook of the Immigrations and Naturalization Service, 1997).

Methodology

As the increase of the Indo-American population in the U.S. is a recent phenomena, there are minimal systematic data related to their elderly members. Thus, this exploratory study was undertaken not to test specific hypotheses, but rather to generate questions for further investigation. The ethnographic approach operationalized through Denzin's Interpretive Interactionism (1989) methodology helped in understanding the interaction between the elderly and their families and their overall coping and adaptation process in their new environment. This approach further enhanced understanding of the meaning of getting old for this ethnic group and the dilemmas of spending the final years of their lives in a drastically different cultural setting. This research strategy was sensitive to the Indian cultural norms and customs. Interpretive interactionism was operationalized through a series of steps from data collection to analysis based on "thick descriptions" which conveyed the meanings and feelings of the dilemmas experienced by the elderly and their family. "Thick descriptions" are the data which capture the meanings and feelings of the elderly as shared with the researcher and providing extraordinary experience of having "been there."

Most of the interviews were conducted in the respondents' homes or in other informal social settings. They were identified through a purposive and chain referral sampling method. Research sites included three cities of different sizes located in the Eastern and Midwestern U.S. Virtually all of the thirty respondents (seventeen men and thirteen women) interviewed were very receptive in sharing their experiences, and were willing to discuss their current dilemmas and struggles.

As all three aforementioned groups of elderly in this study have different life experiences, conscious efforts were made to

gather data from individuals representing all the categories. In-depth interviews were conducted, and the data were analyzed, using the interpretive interactionism perspective. The emphasis was on understanding how the Indo-American elderly were adapting to getting old in the U.S. Besides personal interviews, sensitive observation, careful listening, and interacting with the respondents, were other sources of data collection. In addition to finding out the reasons for their immigrating to the U.S., the respondents were asked to share information concerning their current living situations, and economic, employment and health status. They were encouraged to share their thoughts and feelings about getting old, especially in a place so geographically and culturally distant and different from their country of origin. They were also asked to share their cultural, religious, and social needs and how these were being met. Special care was taken to understand what and how the elderly were relating and sharing about their joys, happiness, sorrows, concerns and dilemmas. The analysis process involved linking and organizing data to highlight themes, patterns, struggles, compromises, and conflicts experienced by these elderly Indo-Americans. Besides English, other South Asian languages such as Hindi, Tamil, Marathi, Malyalam and Urdu were used to interact with these elderly persons.

Findings

The Indo-American elderly who came prior to 1965 and those professionals who came after the relaxation of the immigration policies are economically independent. Also, those immigrants who arrived prior to 1965 are financially stable and have sufficient retirement benefits ensuring economic independence. Those belonging to the third group which include parents sponsored by their children, lack any source of income. They are completely dependent on their children and feel very vulnerable.

The common health ailments reported by Indo-American men are hypertension, diabetes, high cholesterol and cardiovascular difficulties. Health ailments among Indo-American women include hypertension, arthritis and obesity. In a study of Coronary Artery Disease (CAD) among Indo-Americans, Jha and

colleagues (1993) report the following distressing facts: Indo-Americans have one of the highest rates of CAD, conventional risk factors, such as high blood pressure, high serum total cholesterol level, high fat diet, and obesity. Interestingly, though, more than fifty percent of all Indo-Americans are life-long passionate vegetarians, and the high prevalence of CAD is not fully explained.

A pervasive sense of depression was noticed among a number of men and women respondents. Depression was evident through their emotional sharing of a sense of social isolation, lack of meaningful existence, mechanical life, infrequent contact among peers, and limitation in mobility.

With regard to social and kinship networks, various themes were consistent among subjects. If living in the same town, children and parents live in the same households. Frequently, parents live with their married sons, and if several children are married, extensive visits are made to their homes. If parents are living by themselves, they have regular contacts with their children. Such established contacts are not limited to immediate family but also maintained through extended families. This pattern is similar to that prevailing in all the South Asian countries. In all the three research sites it was evident that this ethnic group had well established social networks, especially for the younger generations. The elderly reported that they interact with other Indo-Americans in both formal and informal gatherings. Yet, these meetings provide an outlet for socialization and support, but participation is less frequent due to their advanced age. Some shared that the only time they get together revolves around more formal events, such as weddings, birthdays, ethnic holidays, and cultural events. A degree of disappointment and even sadness was expressed that the formal setting of such gatherings prohibit meaningful personal interactions and avenues for mutual support.

Religious and cultural needs of Indo-Americans are met through many groups. Indian religious and cultural groups are ample in the large metropolitan communities where temples, mosques, and other places of worship are available to meet the needs of the diverse Indo-American population. Unfortunately, many of the elderly reported that because of their dependence on their family for transportation they are not able to go to

these places as often as they would like. Those living in smaller communities have virtually no opportunity to partake in such activities.

The responses of the elderly Indo-Americans who participated in this study can be classified into subcategories with regard to specific conflicts or dilemmas related to their coming to and staying in the U.S. This exploratory study generated the following themes related to the dilemmas and conflicts experienced by the Indo-Americans:

Pervasive ambivalence of having immigrated

Social isolation

If children have no identification with Indo-American culture, parents feel sense of failure and question immigrating to U.S.

Should have returned to India while the children were young

Spiritual needs are not met

Health deterioration and fear of dependency on children

Fear of being placed in nursing homes, but denial also that it will not happen to them

Fear of what will happen to their spouse after their death

Problem with severe winters

Visits to their native homes and concern about the continuation of such travels

Exploitation by children (seen to be glorified baby-sitters)

Discussion

Pervasive ambivalence of having immigrated to the U.S. was evident in the discussion with virtually all the subjects. However, those in the third group (that is, the parents who immigrated due to limited choice) were more vocal in their desire to spend their final years in their countries of origin. Also, women respondents readily expressed their preference to live in South Asia.

In situations where children are married (irrespective to Indo- or to non-Indo-Americans) and have no identification with South Asian cultural tradition and heritage, the respondents expressed a tremendous sense of failure, and questioned their decision to

immigrate to the U.S. Questioning the decision to immigrate to the United States is followed by conflict/guilt of having not returned home when the children were young. Helweg (1987), in his research in understanding migrant behaviors of Indians through case illustrations, suggests that these individuals came to the U.S. to seek experience and knowledge which would make them more marketable in India. A recurrent theme emerged that, unfortunately, the longer the immigrants stayed in the U.S. the harder it became for them to return to their homes in South Asia. Some believed that if they did not achieve in America what they had set out to do, they would be considered failures in their countries of origin. Others found that the money and employment opportunities here made it difficult to leave, thus postponing return to South Asia until it was no longer an option. In the present study, the respondents falling under the second category (that is, those who came after the 1965 Immigration Act) frequently shared this sentiment reported by Helweg (1987). It is also important to recognize that Indo-Americans do not make unilateral decisions. Family members are actively involved in the decision-making process. With grown children who categorically oppose returning to South Asia, the elderly feel "stuck" in an alien environment.

A number of respondents voiced that there was not an outlet for their spiritual needs. Although there is a growth of religious institutions, including temples and mosques, they are not always easily accessible. Women respondents especially shared the discontentment in not being able to go to a place of worship on a regular basis. Missing spiritual discourses and lack of peer group discussions around religious and philosophical issues emerged frequently.

Concerns for advancing age include health deterioration, fear of dependency on children or others, and uncertainty of whether children will care for them as they grow older. The utmost fear is whether they would be placed in a nursing home. The respondents were reluctant to speak on this topic. There was a pervasive sense of denial. They were quick to emphasize that their own children will never place them in a nursing home, but one could sense their apprehension. Also, it is interesting that this issue was brought up by virtually all the respondents, but they discussed it only in terms of how the elderly in the U.S. are "pushed" into

nursing homes. This fear of abandonment by children is similar to that being discussed about other Asian elderly. In the traditional Chinese culture, the children take care of their older parents who live with them. Children and societal values promote support and respect for the aged. In recent years it is evidenced that once respected elderly Chinese persons are increasingly neglected and forgotten by their families (Cheung, 1989). One of the myths discovered by Liu (1986) is "that elderly Asian Americans are adequately provided by their families and adult children, and that ethnic institutions exist for older immigrant communities" (p. 156). In discussing the Korean elderly, it has been suggested that to alleviate their adjustment problems, the elderly parents should discard their attachment to preimmigration belief systems, such as the traditional expectation of filial piety, and accept the modified expectations (Kim et al.,1991). As resources become scarce, often family members—even with the best intentions—are unable to access and locate culturally-sensitive services for their elderly, and increasing number of Indo-American families are finding themselves in this predicament. Because of religious differences and dietary restrictions, they are reluctant even to consider placing their elderly in general nursing homes.

Most respondents reported a close relationship with their spouses and how they nurtured their mutual needs and created inter-dependency. With such positive symbiotic relationships, there is a growing concern of what will happen when the partner passes away. This fear was shared by male respondents, especially if their wives did not have formal education or professional training and had never held any employment in South Asia or in the U.S.

Even after living for a long period in America, with very different climatic conditions, most Indo-American elderly feel adversely towards the winters and they seem to be quite preoccupied with living in a warmer area. Although, this concern is shared by most elderly in general, the respondents in this study felt that by using the option of returning to their native countries they would not have to experience the agony of the severe winters.

Most respondents reported that they have been regularly visiting their native countries. They readily shared how pleasant these visits have been, and how their socio-cultural needs have

been met through such trips. But they were quick to express their concerns of how long they would be able to sustain the strains of such a long journey. Because of their advancing age they may not be able to undertake these frequent sojourns and a sense of sadness is evident. Of course, some respondents (especially from the third group) also referred to the high expenses involved in making these trips. Some of them are also worried about who they will stay with in their country of origin.

As pointed out by Pillai (1985), a significant point that enhances Indian women's familial position is the devotion and respect she receives from her children. Often in India this devotion reaches the point of worship as if towards a deity. Sons are expected to abide by their "Dharma" to take care of their mothers unconditionally until they die. Some of the women respondents expressed anguish over the disrespectful treatment they were receiving from their children, their spouses, and even grandchildren. A few of these women felt they were exploited by their children, and the only reason they were brought to the U.S. was to be a "maid" and "baby sitter" for the family. Interestingly, this sentiment was not shared either by the male respondents or by women from the first and second groups.

Summary

This exploratory study has generated significant data concerning the dilemmas and conflicts experienced by the Indo-Americans in the U.S. As these immigrants are getting older there seems to be an increasing sense of ambivalence over the issue of immigrating, especially over not returning back to India while their children were still young.

Respondents from group one seemed more assimilated and adapted to American culture and customs. Socially they interacted with both Indo-Americans and other Americans. They also reported feeling less socially isolated. Of course, most of these respondents, even those who were near 70, were still employed. In this group, both spouses are frequently professionals. In the second group, respondents reported more interaction with their fellow ethnics. They socialized with other Americans only during formal events. These immigrants seemed intensely involved in

socio-cultural and religious activities including establishing and participating in these institutions. Respondents from group three felt, by-and-large, out of place in the U.S.

Almost all of the respondents in this study came from middle or upper middle income families. Indo-American families with marginal incomes, whose numbers are rapidly increasing, are more likely to experience greater degree of social isolation. In discussing Indian immigrants in Canada, Murzello (1991) reported that migration increased social isolation and destroyed extended kinship networks for the elderly. Unfortunately, similar patterns is emerging among the Indo-American families.

Finally, the findings of this study confirm those related to other Asian American elderly groups (Cheung 1989; Kim & Kim, 1992, Mui, 1996; and Miah & Kahler, 1997). Most of these elderly are disturbed about the loss of tradition and family values, and feel they do not get the respect from their children and grandchildren. Having immigrated to the U.S., they do not have much of an option of returning home. To preserve their family's pride they are reluctant to expose the family conflicts in the open.

The existential dilemma of getting old is real and universal, and especially for the immigrants it does not matter whether they were forced out of their homelands or migrated voluntarily. The dilemma is compounded when they have to spend their final years in a society with drastically different values, customs, and norms (as presented in this study of Indo-American elderly in the United States). The themes which emerged in this study warrant further investigation, which should capture the stories of the elderly from different ethnic immigrants. It will be interesting to learn of the similarities and differences among the various ethnic groups in the Asian American cluster, as well as among other ethnic groups.

Note

1. The term 'Indo-Americans' is used here to refer to immigrants tracing their ancestry to the six countries of the Indian subcontinent, viz, India, Pakistan, Bangladesh, Sri Lanka, Nepal and Bhutan. While the countries are separate nations, they share a common cultural history dating back 5000 years. Sociologists and political scientists have more popularly used two additional classifiers to describe immigrants from the Indian subcontinent, viz, Asian

Indians and South Asians. The term 'Indo-Americans' is chosen because it is more in line with other more culturally distinctive classifiers for hyphenated categories of immigrants such as Chinese-American or Japanese-American; it reduces the element of confusion between natives of the Indian subcontinent and other Asian groups, such as Southeast Asians; it clearly distinguishes between residents of South Asia and American citizens or legal residents of America, and it eliminates opportunities for confusion between Asian Indian Americans and Native Americans.

References

Agbayani-Siewert, P. (1994). "Filipino American Culture and Family: Guidelines for Practitioners". *Families in Society: The Journal of Contemporary Human Services*. Vol. 75(7) 429–437.

Barringer, H. R., R. W. Gardner, and M. J. Levin, (1993). *Asian and Pacific Islanders in the United Sates:* The Population of the United States in the 1980s. New York: Russell Sage.

Cheung, M. (1989). Elderly Chinese Living in the United States: Assimilation or Adjustment. *Social Work*, 34(5), 457–461.

Das Dasgupta, S. and S. Warrier, (1995). *In Visible Terms: Domestic Violence in the Asian Indian Context*. N.J.: Manavi.

Denzin, N. K. (1988). *Interpretive Interactionism*. Beverley Hills, CA: Sage.

Gulati, L. (1995). Women and Family in India—Continuity and Change. *Indian Journal of Social Work*, LVI (2), 1333–154.

Helweg, A. (1987). Why leave India for America? A Case Study Approach to Understanding Migrant Behaviour. *International Migration*, 25(2), 165–176.

Jha, P., Enas, E. A., and Y. Salim, (1993). "Coronary Artery Disease in Asian Indians: Prevalence and Risk Factors" *Asian American and Pacific Islander Journal of Health*, Vol. 1(2), 161–175.

Kim, P. K. and J. S. Kim (1992). "Korean Elderly: Policy Program, and Practice Implications." S. M. Furoto, et al. (Eds). *Social Work Practice With Asian Americans*. Newbury Park: Sage Publications.

Kiswar, M. (1984). "Some Aspects of Bondage" in (Eds.) Kishwar, M. and R. Vanita, *In Search for Answers*. London: Zed Press.

Kitano, H. (1990). Values, beliefs, and Practice of the Asian-American Elderly: Implications for geriatric education. *Minority Aging*. Washington, DC: U.S. Department Health Human Services.

Liu, W. T. (1986). Health Services for Asian Elderly. *Research on Aging*, 8(1), 156–175.

Miah, M. R. and D. R. Kahler, (1997). "Asian American Elderly: A Review of the Quality of Life and Social Service needs." *Journal of Sociology and Social Welfare*. Vol. XXIV: 1, 79–89.

Miles, M. (1980). *Women and Patriarchy: Conflicts and Dilemmas of Students and Working Women*. (Translated from German by Sarkar, S.) New Delhi: Concept Publishing.

Mokuau, N. and C. Browne (1994). "Life themes of Native Hawaiian Female Elders: Resources For Cultural Preservation." *Social Work*, Vol. 39. No. 1, 43–49.

Mui, A. C. (1996). "Depression Among Elderly Chinese Immigrants: An Exploratory Study." *Social Work*. Vol. 41, No. 6, 633–645.

Murzello, F. (1991). *Quality of Life of Elderly East Indian Immigrants*. Unpublished Master of Social Work Thesis. University of Calgary, Canada.

Pillai, A. K. B. (1985). The Asian Indian Model of the Elderly: A Study in Anthropological Gerontology. *Journal of the Indian Anthropological Society*, 20(3), 210–225.

Ramanathan, C. S. and P. N. Ramanathan, (1994). Elder Care Among Asian Indian Families: Attitudes and Satisfactions. *Community Alternatives*, 6(1), 93–112.

U.S. Bureau of Census (1992).

U.S. Immigration and Naturalization Service, (1997). *Statistical Yearbook of the Immigration and Naturalization Service*, 1995. Washington, D.C.: U.S. Government Printing Office.

Venkataraman, J. (1996). "Indigenization Process of Alcoholism Treatment From the American to the Indian Context." Unpublished doctoral dissertation, University of Illinois at Urbana-Champaign, Illinois.

Yamashiro., G. and J.K. Matsuoka, (1997). "Help Seeking Among Asian and Pacific Americans: A Multiperspective Analysis" *Social Work*, Vol 42, No. 2, 176–186.

The Use of Senior Volunteers in the Care of Discharged Geriatric Patients

IRYNA M. DULKA

McGill University
The Centre for Applied Family Studies
School of Social Work
Montreal, Canada

MARK J. YAFFE

McGill University
Department of Family Medicine
Montreal, Canada

BENITA GOLDIN

Jewish Support Services for the Elderly
Montreal, Canada

WILLIAM S. ROWE

McGill University
School of Social Work
Montreal, Canada

This article reports on a project that utilized senior volunteers in the role of health advocates for geriatric patients discharged from a hospital. The project was evaluated to determine if healthy and active seniors could make a contribution to the health and social welfare of such discharged elderly persons. The study was conducted in Montreal, Canada and funded by a federal grant from Health Canada. The research collaborators came from a 414-bed secondary care university-affiliated community hospital, a community social service agency with a mandate to respond to the needs of its frail elderly constituents, and a university-based research centre

Journal of Sociology and Social Welfare, March, 1999, Volume XXVI, Number 1

that works with health professionals in various settings to develop and evaluate service programs addressing the needs of disadvantaged families and individuals.

The increase in elderly populations in most countries in the world presents significant challenges, particularly with respect to community-based health care. Additionally, specific apprehensions arise when traditional sources of support for the elderly may be lacking. For example, family members may be deceased or may not live in close proximity; they may have insufficient skills; their own health condition may preclude them from care giving functions; or they may be in the paid workforce. Patients of advanced age who are discharged from a hospital to their own homes may, thus present special concerns for health and social service professionals. At the same time, as concern mounts, there is growing recognition of the potential contribution that healthy older individuals can make in meeting the needs of other elderly who are frail.

Background

Hospital discharge planning includes an assessment of patients' social and health care needs, the co-ordination of comprehensive services and supports, and the identification of patients who may be at risk of deterioration following discharge (Berkman, Millar, Holmes & Bonander, 1990). Comprehensive discharge planning may contribute to decreased readmissions and/or a reduction in subsequent lengths of stay (LOS), as the patient, family, and community support personnel acquire an accurate understanding of the patient's limitations or health care needs following hospitalization (Berkman et al., 1990). Hospital administrators, and their counterparts in public health care and private non-profit community-based service agencies, are increasingly expressing the need to ensure effective utilization of services and continuity of care for this at-risk group. Most have recognized the difficulties that have existed in ensuring systematic post-discharge follow up to this segment of the patient population.

Barriers to Continuity of Post-discharge Care

Even meticulous plans for hospital discharge do not always

ensure timely access to community-based health and social service resources (Wertheimer & Kleinman, 1990). Discrepancies between hospital recommended community-based care, services and supports—and the care and services a discharged individual actually receives—can contribute to problems which, in turn, lead to hospital readmission. Furthermore, lack of adequate home supports, services, or monitoring can result in an inappropriate move to a sheltered setting or to an institutional placement.

The stress of hospitalization possibly combined with grief over a recent loss or with fear of permanent, partial or complete loss of independence, may render ineffective a person's usual coping mechanisms and consequent home recovery (Johnson & Fethke, 1985). Discharged patients are sometimes unaware of the community services available to them due to a failure of hospital personnel to inform them about available community services (Jones, Densen & Brown, 1989). Rowe, Dulka, Pepler & Yaffe (1997) found, in a study of outcomes for 651 discharged hospital patients aged 55 and over, that at least 70% of patients reported that they failed to receive adequate information that might have made easier and quicker their home recovery.

Socioeconomic influences

Economic status is an important determinant of hospitalization outcomes. Limitations experienced by patients who are economically disadvantaged have been associated with unsuccessful discharges (Wimberly & Blazyk, 1989). Poorer and older patients have more frequent readmissions, and are at greater risk of not benefitting from services provided in the community, including home-delivered meals or collective or communal outings. Such former patients are also more prone to hardship as a result of their inability to pay for private services while on waiting lists for government subsidized services. Despite the known links between economic status and health outcomes, patients may not routinely be asked about their financial situation (Wimberly & Blazyk, 1989). In contrast, a recent study surprisingly found that 100% (N=40) of community-based primary care physicians who treat older patients included socioeconomic background as part of their assessment of patients' medical problems (Kaufman, 1995).

Adult children have traditionally provided parents with emotional and instrumental support in their old age, including acquir-

ing necessary information and arranging for the service delivery (Choi, 1994). Next to help received from a spouse, older persons rely on their children for assistance in both acute and chronic illness situations, and to help fend off the social isolation that may accompany old age. Childless elderly persons may successfully substitute relatives by seeking close friends or hiring formal care providers (Choi, 1994).

Access to information alone does not guarantee utilization of services by the elderly, as those with higher levels of education and income, and correspondingly better (theoretical) access to facts on resources, do not necessarily use these services (Choi, 1994). A tendency to be self-sufficient and unreliant on others may also be a barrier to seeking needed health and social services.

Health and Functional Status

Differing findings emerge from studies on discharge planning. Jackson (1990) found that patients at greatest risk for readmission were those who received the most community-based homecare services (i.e. nursing care, assistance with personal hygiene, housework, meal preparation), lived alone, had the greatest number of medical and nursing diagnoses, and were the frailest—though not necessarily the oldest—patients. By contrast, Victor and Vetter (1985) found that readmissions were not related to patients' social or demographic characteristics, but rather were a result of relapses and breakdowns in the patients' original medical conditions.

Findings of gaps in continuity of community-based care following hospital discharge suggest a need for follow-up. Even patients whose health care needs, at first glance, appear to have been met may have unresolved issues that are physical, social, or environmental in nature, and place them at risk for decline in health and consequent hospital readmission (Blumenfield & Rosenberg, 1988; Wertheimer & Kleinman, 1990). Studies of different models of discharge planning have pointed to screening procedures which fail to accurately examine or record patient post-hospital needs (Iglehart, 1990).

The Senior Volunteer as Peer-Advocate

The use of community volunteers is frequently cited as one

solution to the needs of frail elderly discharged geriatric patients (Blumenfield & Rocklin, 1980; Cnaan & Cwikel, 1992; Cusack, 1994; Ehrlich, 1983; Turner, 1992). However, as growing numbers of men and women are employed on a full-time basis outside the home in order to meet personal desires or economic realities, their availability for volunteering in the community is limited. As well, the reality exists that caring for an ill elderly individual may not be as attractive an area as in other areas of voluntarism.

The basic principle underlying peer-advocacy (that is, assistance by an elderly volunteer given to a dependent elderly person) is that the skills learned by the advocate can be transmitted to those in need in order to promote their more independent and effective functioning (Bolton & Dignum-Scott, 1979). As one example, by virtue of their everyday experience, elderly volunteers can communicate about and advocate for elderly individuals through role modelling.

In a health care context, peer advocacy occurs when a private citizen enters into a relationship with, and represents the interests of, an elderly person who may need assistance to improve his or her quality of life and obtain full rights and access to needed resources (Cohen, 1994). Discharge planning, however, confronts two possibly conflicting ethical constructs facing the peer-advocate (Clemens, 1995). The first is the principle of self-determination which maintains that individuals have the right to make decisions that are voluntary and free from undue influence. The other is the principle of beneficence which promotes the rights and the good of clients.

Voluntarism for the Elderly

The Third Age, or retirement stage of life, has the potential to be a period of personal enrichment, self-actualization and fulfilment by virtue of active engagement in challenging and worthwhile activities, such as voluntarism (Cusack & Thompson, 1992). It can be argued that volunteer activities should be available for all those 65 and over because they provide for a greater sense of usefulness, engagement, and purpose (Cnaan & Cwikel, 1992). So, too, can voluntarism permit persons to maintain a structure to their lives, and to do so using familiar, successful behavioural strategies. Thus, voluntarism provides opportuni-

ties for older persons to maintain, develop, or increase levels of activity in accordance with their personal preferences and lifestyles.

Voluntarism has also been found to be associated with higher life satisfaction among members of older population groups, as an extension of the activities and values that preceded retirement. Further, it has been associated with volunteer activities and community work which took place in the life of older persons (Cnaan & Cwikel, 1992). Not surprisingly, those people who rate their health as good or excellent are more than twice as likely to volunteer than those who perceive their health as poor to fair (30% vs. 13%) (Cnaan & Cwikel, 1992).

Unique elements of senior leadership in voluntarism include (a) the richness and diversity of life experience, (b) genuine concern and empathy for others, c) the need to be involved, recognized, have fun, conserve energy, make time count, (d) the matter of choice (e.g., the time and the freedom to choose what to do and when to do it), and (e) the issue of power and control (e.g., respect for, and recognition of, seniors' strengths and rights (Cusack & Thompson, 1992). A suitable framework upon which to develop a senior volunteer program includes the notion of shared participatory cooperation (Cusack & Thompson, 1992).

Perry's (1983) study of the willingness of the elderly to volunteer concluded that the respondents more often wanted meaningful assignments that involved interpersonal communication rather than activities with mechanical or physical tasks. Similarly, Ozawa and Morrow-Howell (1988) found that elderly volunteers overwhelmingly preferred to provide services that were social in nature and that provided needy elderly with reassurance.

Senior volunteers seek rewards that, in fact, may be less evident when their efforts involve interactions with difficult patients or clients who are depressed, unresponsive, hostile, or feel hopeless (Blumenfield & Rocklin, 1980). Encouragement and support to volunteers is particularly necessary in these situations. Volunteers may also benefit from learning techniques that lead to effective outreach with those for whom interaction is particularly difficult. Valuable opportunities may allow volunteers to bring out into the open and diffuse feelings of anxiety, over-identification, and frustration. For example, regular

group meetings may provide opportunities to promote solidarity for disseminating new information and for discussing helpful principles.

There are potential particular drawbacks, however, to seniors acting as volunteers to other seniors (Blumenfield & Rocklin, 1980). The older volunteers may over-identify with clients or patients, causing the volunteers increased anxiety. They may also feel compelled to do something and, hence, take over, re-enforcing dependency rather than finding new ways of restoring autonomy (Cohen, 1994).

Project Rationale and Development

The present project results from the findings from other studies which have concluded that systematic follow-up, especially for at-risk older individuals, contribute to better patient care and post-hospitalization management, thus reducing the likelihood of readmissions. The project also arose from the desire to determine if there is a potentially beneficial role that seniors can play in the lives of geriatric patients discharged from hospitals (Edwards, Reiley, Moris, & Doody, 1991; Hauser, Robinson, Powers & Laubacher, 1991; Thliveris, 1990).

The research team was comprised of a family physician, a social worker, and a coordinator of senior volunteers (the latter was based in a social service agency). The project had an advisory committee comprised of "stakeholders" interested in care of the elderly, including representatives from the participating secondary care community hospital from which the patients were recruited, two local health and social service centres (CLSCs), and a community agency addressing the needs of frail elderly. The advisory committee took part in the review of the study protocol, in the project evaluation, and in the dissemination of findings. The study protocol received approval of the appropriate research ethics committees and was conducted between October 1996 and April 1997.

Objectives

The goal of the project was to determine whether it would be possible to recruit and train a cohort of senior citizens who could function in a time-limited capacity as volunteers. To be evaluated

was whether elderly persons discharged from a hospital could be assisted by elderly volunteers in order for them to receive the community services designated in a discharge plan, and also to advocate for their more recent service needs (as necessary). Beyond the potential benefit of positive outcomes for patients, the study also aimed to determine whether there were potential benefits for the senior volunteers themselves, and for the community at-large.

Recruitment of Patients

To be eligible to participate in the study, patients had to be aged 70 years of age or older, reside in the Metropolitan Montreal area, speak and read either English or French, be accessible at home by telephone, and have a primary hospital nurse indicate that the nature of their medical/social problems required a written discharge plan for community services. A research assistant liaised with these nurses from October, 1996 to February, 1997 to identify individuals who met participant patient criteria.

During hospitalization, a research assistant approached qualifying patients with a verbal and written description of the study. Explained to them was the extent of their involvement in the project and assurance that they could change their mind about participation without negative consequence to their health care. An informed consent document was subsequently signed if they agreed to participate. Discharge summaries, which included names of recruited patients and their age, address and phone number and recommended services, were supplied by a hospital-based research assistant to a coordinator of senior advocates who would then link patients with volunteer advocates.

Recruitment of Volunteer Senior Citizen Advocates

Outreach to potential seniors volunteers was made through the posting of notices in local community agencies that addressed the needs of frail elderly or that provided volunteer services in the community. Recruitment announcements were also placed in the newspapers most widely read by those in the Montreal area. The publicized responsibilities for the volunteers included the following activities: (1) Telephone contact with an elderly patient post discharge to arrange a home follow-up visit; (2) An

evaluation, according to a discharge plan and using standardized questionnaire, to determine if services identified in a hospital discharge plan were in place; and (3) The identification of other services that might be valuable, but not identified in the discharge plan; and (4) Taking initial first steps to try to get the assistance required.

The recruitment criteria for the volunteers were that they be aged 60 and over, have an interest in voluntarism and advocacy, agree to participate in an interview to assess their general ability to interact with their peers, and be available to participate in training sessions. Candidates completed an application form that included information about their age, gender, past volunteer experience, time availability for the project, and relevant past or present work experience. In consideration of their own needs, volunteers were asked whether they had any allergies to pets or cigarette smoke, since they would be making visits to patients' homes.

The coordinator of volunteers conducted personal interviews with interested volunteer advocates. In the interviews, the potential volunteers had to demonstrate reasonable interpersonal communication and interviewing skills, an ability to verbally administer a short questionnaire and to accurately record responses, give evidence of being able to be objective, non-judgmental, and flexible, and have an interest and ability to initiate—at minimum —a single follow-up to an identified problem in a persistent, but diplomatic, fashion.

Volunteer Training

Two different three-hour sessions were held with volunteers to review the project goals, volunteer roles, the nature of the patients needs as well as their own, basic interviewing skills (including active listening and empathy), observation strategies, and guidelines for dealing with unexpected eventualities during home visits. Volunteers were also sensitized to the types of elderly patients that they might encounter during the course of the project: living alone or lacking social supports; chronically ill or in pain; with hearing, vision, or mobility limitations; in palliative care; with limited financial resources; or with some

form of temporary mild cognitive impairment. Role playing of potential situations that might arise supplemented discussions.

The senior advocates were sensitized to matters related to health and social services as they affect the elderly and they received specific training to identify gaps in post-discharge continuity of care. This was facilitated through the use of a questionnaire developed for the project which focused on an inventory of items generally associated with community based services (medical, nursing, home assistance). The questionnaire also provided an opportunity to compare existing services to those identified in the discharge plan and to make a preliminary assessment of what additional assistance might be required (e.g., with activities of daily living such as help with housekeeping, meal preparation, or medication supervision). Dates of onset of services, or perceived reasons for absence of these services, were to be recorded.

Manuals supporting training sessions were given to each volunteer to consult on such topics as communication skills, observation of the patient's living environment, nature and range of normal homemaker services, tips regarding home safety, medication use/abuse by the elderly, and dietary suggestions.[1] At the end of the training session, volunteers and all those associated with the research project were required to sign an oath of confidentiality beyond the confines of the project.

Post-Discharge Patient Contact

The project required that the volunteers make contact minimally during the third post discharge week and maximally at the fourth week. This allowed for a reasonable time interval to elapse between the time of discharge and the potential onset of the utilization of home services. The volunteers observed what was actually taking place by using the previously-described short questionnaire. Discrepancies between the hospital discharge plan and what was actually observed by the volunteers initiated a process whereby the patient with identified needs was linked to appropriate community-based care providers. The questionnaire was initially administered during face-to-face interviews in the patients' homes; however, toward the end of the data collection period, some interviews were conducted over the telephone. This

permitted a determination of patients' understanding of their discharge plans, their perceived post-hospitalization needs, and a summary of the presence or absence of recommended and/or needed services and supports.

Project Results

The study took place during a Canadian winter when the negative impact of snow and ice is difficult to predict in advance. A particularly inclement weather pattern during the project period made home visits by the senior volunteers difficult to accomplish. Consequently, later in the project the study protocol was modified to permit, when weather necessitated, for volunteers to make contact with some patients not in their homes but by telephone.

Project Volunteers

A total of 13 senior citizens (ten of whom were women) volunteered and met the inclusion criteria to conduct the follow-up home visits. The volunteers ranged in age from 60 to mid-80s; four were between 60 and 65; five were between 66 and 75; and four over 75 years. Of the 13 volunteers, 11 were retired, one was a full-time geriatric nurse, and one was unemployed. Of those volunteers who had worked outside the home prior to their retirement, two were in social work, two in teaching, one in office work, and three in the field of commerce or business. Eight spoke both English and French and seven of the group spoke a third language.

Project Patients

A total of 121 patients were initially recruited and, as expected, some withdrew over the course of the study. Among those reasons for withdrawal from the project were the following: Refusal to participate in a post-discharge visit; could not be reached by phone; remained in the hospital; had been transferred to chronic care or rehabilitation institution; died; volunteer was unable to visit; patient was on vacation; and patient information was lost following discharge. While the program design called for the follow-up of 80 patients aged 70 and over during a three month period, 75 patients ultimately received volunteer follow-up.

The ages of patients ranged from 72 to 95 years, with an average of 83 years. Under 60% were living alone; the majority of this group were women. The range of hospital stay days was between one day and 113 days, with mean LOS of 10.6 days.

Patient-Volunteer Interaction

The number of patients contacted per volunteer ranged from one to 20, with an average of 5.8 contacts. Successful volunteer contact which took place during the specified three to four weeks post-discharge period represented 49.4% of the total. An additional 25.3% of the contacts took place one to ten days earlier than planned, and the remaining 25.3% of the contacts took place one to 21 days later than intended. Of all contacts, 41% of the interviews occurred, as intended, in the patients' homes; 57% took place, unintended, by telephone; and one person preferred a meeting outside the home in a neutral location.

Through the follow-up surveys, the volunteers were able to document which services were received following discharge. These services included meals-on-wheels, household assistance, physiotherapy, education, friendly hello calls, assisted transportation, bathing, and new follow-up medical assessments. In addition, volunteers were to make and record the distinction between new and resumed (and previously-used) services.

It was found that 14 patients (18.6%) needed—on average—1.4 services (e.g. assisted transportation, household chores, meals, mobility help, accompaniment, bathing) which had not been identified for them in the discharge plan. In all, the senior volunteers identified 13 patients in need of what amounted to an average of 2.4 new services; seven of these services were unavailable. The volunteers assessed needs independent of the patients' reports and through their own assessment of patients' situations. From a survey of 12 recently-hospitalized seniors, it was learned that they believed that needed services had not been recommended for them, with transportation assistance the most often reported missing service.

Focus Group Findings

Based on the recommendations from a study by Blumenfield and Rocklin (1980), a focus group was held to provide a forum

for the volunteers to discuss their involvement in the project. The senior volunteers were highly satisfied with their roles and involvement in the project to the degree that it was their desire and hope to motivate other seniors to participate in similar advocacy endeavours. They indicated an interest to learn how frail elderly persons are managing their post-hospitalization needs, so to offer them information and advocacy, as needed.

The senior volunteers participated as well-motivated contributors toward the development and meeting of project objectives. This project also provided the volunteers with unique insights into a vulnerable group of people: recently discharged geriatric patients who required continuity of community care. It also afforded them opportunities to deal with illness and to analyse their own reactions to the experience of others. They helped at-risk seniors find their way through the medical system and the advocate volunteers developed a greater understanding of the system, illness, and the impact illness has on individuals and their families. Other knowledge that senior volunteers obtained was a sense of reassurance that, at least within the context of the limits of the study, community services were generally available. Senior volunteers spoke of the need to better understand the role of advocacy and rules for how to get things done, and a desire to develop "maps" to use the health care system, to ensure personal consumer rights, and to make other seniors aware of the valuable role that they can play as potential volunteers in similar projects.

Discussion

This article illustrates the potential use of senior citizens as volunteer advocates for elderly discharged from the hospital back to the home setting. While there were a large number of patients who were enrolled but did not get follow-up (for the reasons cited), the study was not intended to test how many patients could be recruited and ultimately followed-up. Rather, the goal was to see what kind of outcome there might be in the interaction between elderly patient and senior volunteer where such contact occurred.

The volunteers were a relatively well-educated group, given prior or current occupations. Their involvement suggests that

under a well-structured recruitment process, it is possible to find older people interested in being volunteers for the sick elderly. Participants indicated that beyond the potential benefit for the ill person, there were other factors which contributed to their motivation and their satisfaction. Specifically, volunteers believed that what was learned in the orientation sessions, and dealing with even only one ill elderly person, provided a rewarding experience. They acknowledged, at a personal level, a desire to start thinking about how they themselves could better prepare for the eventuality of their own illness or for family members. Furthermore, they spoke of the desire to share their knowledge and experience with family and friends, and that they would encourage others to volunteer in similar programs. The volunteers further referred to a need to develop a better personal "mental set" of how health and social services work, and of the importance of advocacy and consumer rights in health care.

The volunteers were able to successfully identify patients who required services that had been proposed at discharge, but not initiated. As well, they were able to take the next step to contact a community resource to get advice on behalf of the patient. In some cases, they were able to do most of this on their own. Given that 36% of the home visits took place in the presence of another member of the patient's family, the senior volunteer was also able to impart important information to a relative regarding the accessing of health and social service systems.

The logistics underlying a successful volunteer program using seniors require certain special considerations. Just over 50% of the patients followed were contacted either earlier or later than indicated by the protocol. Beyond the challenge of finding a mutually-convenient time during which to meet, volunteers were most influenced by climatic conditions. The majority of follow-ups took place in unpredictable winter weather, prompting appointments to be scheduled earlier or later than intended. Heavy snow falls, uncleared streets, and slippery sidewalks caused a number of deferred home visits. The fact that a little over half of the interviews actually took place over the telephone instead of in the home was an adaptive measure taken by the senior advocates to minimize potential risks to themselves due to weather hazards. Knowledge of these particular issues suggests the need to have

a selection process for volunteers that recognizes the importance of scheduling visits according to physical abilities and personal limitations or concerns. One might imagine similar concerns in other geographical regions subject to such constraints as extreme heat, torrential rains, tornados, or other climatic extremes.

Conclusion

This paper describes an antecedent effort to follow-up a group of discharged geriatric patients who returned home following hospitalization and the use of older volunteers who helped to reduce situations or eliminate factors which place seniors at-risk. Findings contribute to a better understanding of barriers to health and social services for such at-risk elderly. Furthermore, the project promotes, and defines, inter-agency and interprofessional collaboration which will benefit seniors at-risk, while demonstrating the value of senior advocates. The project design, implementation and results may benefit organizations striving to improve the quality of life for at-risk elderly as well as those promoting the contributions that seniors can make in bringing about positive change for an at-risk group. Volunteer advocates, regardless of age, can work for the benefit of older, recently-hospitalized individuals by providing emotional and instrumental support through friendship, advocacy, and by making opportunities available for them to learn new skills necessary to obtain needed services.

The demonstration project addresses needs common to many older Canadians, both those recovering at home following a hospitalization who may be isolated and frail and those who are healthy, active, and wish to participate and contribute to their communities through voluntarism. The project demonstrated a way by which seniors, themselves, can advocate on behalf of their frail and disadvantaged age-peer counterparts to increase well-being and reduce and eliminate factors which place older seniors at-risk, and lead to rehospitalization or institutionalization.

This unique one-to-one relationship seems to be of mutual benefit to both patient and volunteer, and the senior volunteers bring dynamism, enthusiasm, and interest in both helping the patients and their own personal investment in further strengthening the health and social service network. The program is simple

enough that it can be adopted in communities in various countries in the world. It is a model which benefits older patients and older volunteers, alike, while ensuring a more effective formal health and social service system.

Note

1. Copy of the training program may be obtained from Jewish Support Services for the Elderly (JSSE) in Montreal.

References

Berkman, B., Millar, S., Holmes, W., & Bonander, E. (1990). Screening elder cardiac patients to identify need for social work services. *Health and Social Work*, 64–72.

Blumenfield, S. & Rocklin, C. (1980). Senior counsellor-assistants for a geriatric program in a community hospital. *Social Work in Health Care, 6* (1) Fall, 89–100.

Blumenfield, S., & Rosenberg, G. (1988). Towards a network of social health services: Redefining discharge planning and expanding the social work domain. *Social Work in Health Care, 13* (4), 31–48.

Bolton C. R. & Dignum-Scott, J. E. (1979). Peer-group advocacy counselling for the elderly: A conceptual model. *Journal of Gerontological Social Work, 4*, (Summer), 321–331.

Choi, N. G. (1994). Patterns and determinants of social service utilization: Comparison of the childless elderly and elderly parents living with or apart from their children. *The Gerontologist, 34* (3), 353–362.

Clemens, E. L. (1995). Multiple perceptions of discharge planning in one urban hospital. *Health & Social Work, 20* (4), 254–261.

Cnaan, R. A. & Cwikel, J. G. (1992). Elderly volunteers: Assessing their potential as an untapped resource. *Journal of Aging & Social Policy, 4* (½), 125–147.

Cohen, P. (1994). Ageing Matters. *Nursing Times, 90* (9), 66–69.

Cusack, S.A. (1994). Developing leadership in the third age: An ethnographic study of leadership in a seniors' center. *The Journal of Applied Gerontology, 13* (2), 127–142.

Cusack, S. A. & Thompson, W. J. A. (1992). Leadership training in the third age: The research and evaluation of a leadership and personal development program for the retired. *The Journal of Applied Gerontology, 11*, (3), 343–360.

Edwards, J., Reiley, P., Moris, A. M., & Doody, J. (1991). An analysis of the quality and effectiveness of the discharge planning process. *Journal of Nursing Quality Assurance, 5* (2), 17–27.

Ehrlich, P. (1983). Elderly health advocacy group: an integrative planning model of elderly consumers and service deliverers. *The Gerontologist, 23* (6), 569–572.

Hauser, B., Robinson, J., Powers, J., & Laubacher, M. A. (1991). The evaluation of an intermediate care-geriatric evaluation unit in a veterans administration hospital. *Southern Medical Journal, 84* (5), 597–602.

Iglehart, A. P. (1990). Discharge planning: professional perspectives versus organizational effects. *Health and Social Work, 15* (4), 301–308.

Jackson, M. F. (1990). Use of community support services by elderly patients discharged from general medical and geriatric medical wards. *Journal of Advanced Nursing, 15*, 167–175.

Jones, E. W., Densen, P. M., & Brown, S. D. (1989). Posthospital needs of elderly people at home: Findings from an eight-month follow-up study. *Health Services Research, 24* (5), 643–664.

Johnson, N., & Fethke, C. C. (1985). Postdischarge outcomes and care planning for the hospitalized elderly. In *Continuity of care: Advancing the concept of discharge planning* (pp. 231–240). Orlando: Grune & Stratton Inc./ Harcourt Brace Jovanovich.

Kaufman, S. F. (1995). Decision making, responsibility, and advocacy in geriatric medicine: Physician dilemmas with elderly in the community. *The Gerontologist, 35* (4), 481–488.

Ozawa, M. N. & Morrow-Howell, N. (1988). Services provided be elderly volunteers: An empirical study. *Journal of Gerontological Social Work, 13* (1–2), 65–80.

Perry, W.H. (1983). The willingness of persons 60 and over to volunteer: Implications for social service. *Journal of Gerontological Social Work, 5*, 107–118.

Rowe, W. S., Dulka, I.M., Pepler, C., & Yaffe, M. J. (1997). *Discharge planning and organization for short stay and same day surgery patients aged 55 and over: A descriptive exploratory study: Final report.* Montreal, QC: The Centre for Applied Family Studies, McGill University.

Thliveris, M. (1990). A hospitalwide discharge planning program. *Dimensions*, 38–39.

Turner, Howard B. (1992). Older volunteers: An assessment of two theories. *Educational Gerontology, 18*, 41–55.

Wertheimer, D. S., & Kleinman, L. S. (1990). A model for interdisciplinary discharge planning in a university hospital. *The Gerontologist, 30* (6), 837–840.

Wimberly, E. T., & Blazyk, S. (1989). Monitoring patient outcome following discharge: A computerized geriatric case-management system. *Health and Social Work*, 269–276.

Victor, C. R., & Vetter, N. J. (1985). The early readmission of the elderly to hospital. *Age and Ageing, 14*, 37–42.

Policy Implications of Australian Ageing: The Greying of a Young Society

JOHN MCCALLUM

University of Western Sydney
Faculty of Health

Australian population ageing is moderate by Western country standards but there are major issues emerging in national policy debates. The proportions 65+ will double and the proportions 85+ will more than quadruple by 2050. The first concern is the long-term trend to earlier retirement from work along with a nearly universal dependency on publicly funded age pensions rather than on private savings and superannuation. New mandatory superannuation guarantee scheme will ease some of the financial pressure from income dependency. Secondly heart, musculoskeletal, cancers, mental illness and digestive diseases are high cost conditions but musculoskeletal and mental conditions are a higher cost for women than for men. About two thirds of health expenditures are spent on the tenth of the population 65+ which indicates an issue of control of health costs through appropriate servicing. Third severe handicap rates reported in national surveys have stabilised over time to cover the last 3 or 4 years of life. Over two thirds of the remaining years of life at age 65 are currently spent free of handicap. Aged care services have shifted in focus from intensive options like nursing homes to less intensive options like hostel care and home and community care. There is about a two thirds risk of ever entering a nursing home or hostel at age 65. Consequently long-term care financing is one of the most urgent issues in Australian aged care policy.

Introduction

Population ageing first became popular in public debates in the mid-1970s when it was discovered that older Australians were living longer than expected. Because of increased concerns on July 2, 1998, the Australian Government announced a decision

to hold consultations to develop a National Strategy for an Ageing Australia. Australians have generally viewed themselves as members of a youthful society and have high expectations of government support. This presents some unique challenges of ageing. Over time the role of government has increased both as a direct provider of services and as a funder of non-government agencies providing aged care services. Government is, as well, a regulator in all these areas. For various reasons, future governments are likely to find it less easy to increase social spending in the same way as they have in the past. This report explores three policy issues arising from demography: retirement and pensions, disability and health, and aged care services.

Demographic Ageing

While aged activists regard much of the discussion of demography of ageing as overly negative, it is a topic of perennial interest to the general public. There are several important points from the most recent projections for people 65 and older (ABS, 1996). First, the number of Australians 65 and older will increase by 8% from 1996 to year 2001, 35% to 2011, 82% to year 2021, 227% to 2031, 259% to 2041 and 274% to 2051. Second, the proportion of the total population 65 and older doubles, between 1996 and 2051, from 12 percent to 23 percent. Third, the proportion of population 65 and older increases rapidly between 2006 and 2011, when the "front end" of the babyboom cohort reaches age 65 years. Fourth, the rate of growth of the population 65 and older will be at its maximum around 2016.

These rates of population ageing are of most interest if the working years continue to end at around ages 60 to 65 years. Should this assumption hold, then around 2006–2010 there will be great demands on retirement income support, for housing, leisure, and other activities suitable for older adults.

Although the absolute numbers are relatively small, the rate of increase of the population 85 and older—the "old old"—is exceptional. The main points of the most recent projections for people 85 and older are that the number of Australians 85 and older will increase by 29% from 1996 to year 2001, 94% to 2011, 233% to 2021, 325% to 2031, 485% to 2041 and 603% to 2051. As a proportion of the total population, people 85 and older move

from 1.1 percent to 4.6 percent between 1996 and 2051 and, as a proportion of the population 65 and older, from 9 percent in 1996 to 20 percent in 2051. The proportions of population 85 and older increase rapidly to 2001 when the front end of the post World War I babyboom—supplemented by adult migrants arriving in the 1940s and 1950s—reaches age 85 years and again from 2031 when the Initial World War II babyboom cohort reaches age 85 years. The rate of growth of the population 85 and older is double-peaked at its maximum at 2001 then declining and peaking again around 2036 (ABS, 1996).

If rates of "old old" age health and dependency continue to follow the same patterns, then around 2001 (and more so in 2030) there will be greater demands on health care and long-term care for very old people. The demands will be even more substantial if, as in countries like Sweden, there is the growing tendency for very old people, predominantly women, to live apart from their families. This is to suggest that people living alone are likely to need more, and earlier, services than people co-residing with their social supporters.

Retirement

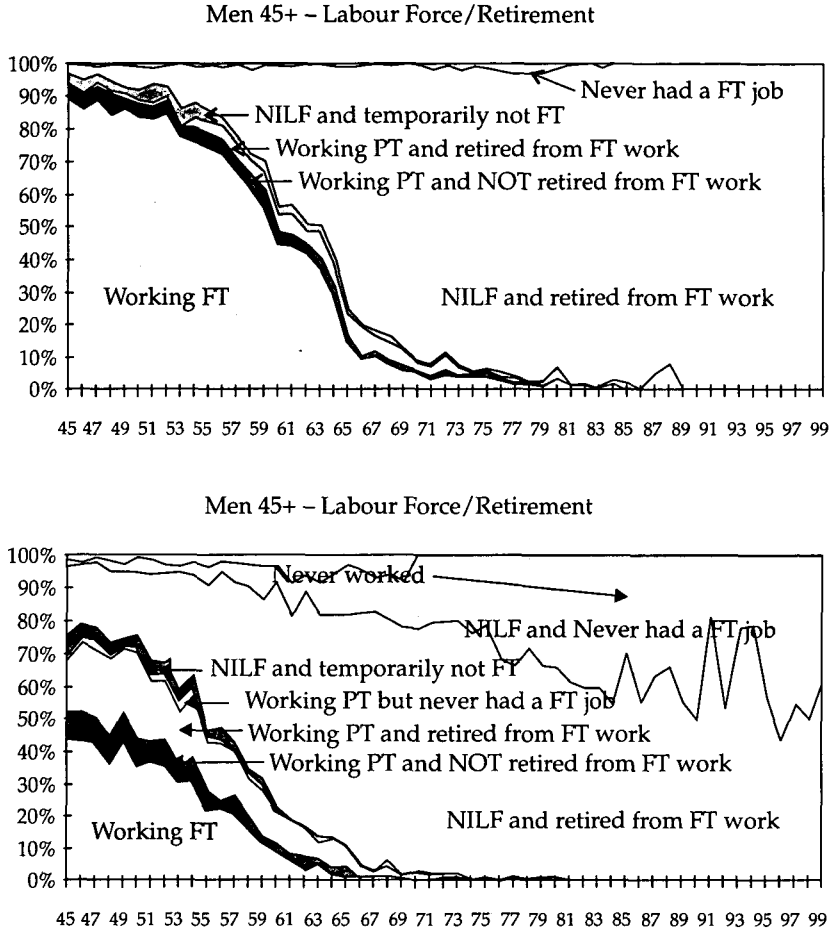
The existing patterns of work and retirement of an industrial society are evident in the differing patterns of labour force status for men and women (Figures 1 & 2).

Current retirement behaviour is problematic in an ageing society. At ages 60–4 years, the participation rate for men drops below 50 percent and for women below 20 percent. There are 'retirement' rate peaks at ages 55, 60 and the highest at age 65 years for men and the largest at 60 years for women, with smaller peaks at ages 55 and 65 years (Figure 2). Given the absence of compulsory retirement, these single year peaks reveal strong effects of eligibility for age pensions and superannuation preservation rules, along with persistent cultural patterns, set by historical mandatory retirement ages. This early retirement is a concern for the future viability of retirement income support.

Retirement Age

As Australia moves away from an industrial society to being one with more flexible work patterns, there has been a slow

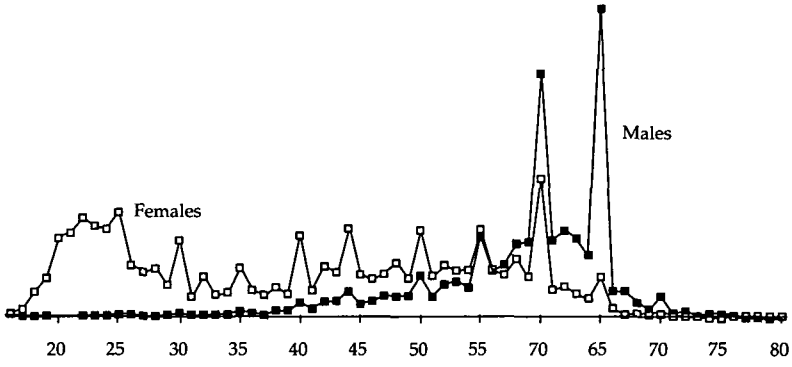
Figure 1
Labour Force Status Men and Women 45+.



Source: Bacon 1996.

convergence between the labour market experiences of women and men (Bacon, 1996). This indicates that there has been a gender shift, with relatively more women employed and fewer men. Further, there is an increase in part-time and casual employment,

Figure 2
Age of Retirement from Full-time Work, Persons Over 45, November 1994



Source: Bacon 1996.

as well as new cohorts retiring before pension eligibility of age 65. A final trend is that more women are re-entering the work force after having children. Yet, unless government produces more incentives to longer working lives, early retirement trends will not slow down.

Pensions

There are two main parts to the Australian pension system: government means-tested age pension and mandatory superannuation for employed persons. There are about 1.7 million aged and wives pension recipients and estimated outlays of $13.6 billion in 1997–8. This accounts for 32 percent of total social security pension outlays. About half of men and women 65 and older receive the full pension, while about 20 percent of men and 30 percent of women receive part pensions due to means-testing. Pensions make up two-thirds of the income of people 60 and older compared to about one-fifth for interest earnings, and 8.5 percent for superannuation. There is, then, no evidence that the current generations of older people retired to live on the benefits of superannuation or private savings. Three quarters of pensioners own

their own homes which are estimated to account for two-thirds of the total assets of people of pension age. Older Australians hold most of their wealth as equity in their own homes and live on publicly funded age pensions.

The major policy development in anticipation of population ageing in the last 10 years has been the introduction of compulsory contributions to the Superannuation Guarantee (SG) scheme by employers and employees. The expected impact of the SG can be seen in Retirement Income Modelling Unit estimates for years 1996/7 to 2015/6 (Table 1).

Some key issues can be seen in these numbers. Superannuation payouts, as a consequence of increased contributions from the late 1980s, begin to outweigh the value of other assets excluding housing around the year 2000. The interaction of the superannuation payouts with the age pension means test causes gains in superannuation to be reduced by means testing on the age pension. The combination of both means testing and tax almost halves the extra income to the older person by the year 2015/6.

Table 1

Average Impacts of SG on Individual Retirees

Year	*Average Super Payout A$*	*Payout to Average Financial Assets**	*Estimated Extra Annual Income A$*	*Extra Income after Pension Reductions A$*	*Extra Income after Pension and Tax Reductions A$*
1997/8	52,241	0.9	2,012	2,012	2,012
2000/1	69,484	1.2	2,874	2,737	2,737
2005/6	93,083	1.3	4,054	3,327	3,191
2010/1	115,051	1.3	5,153	3,876	3,662
2015/6	216,281	1.9	10,214	6,407	5,504

* Financial assets exclude the value of homes.

Source: Retirement Income Modelling Unit (unpublished data)

* A$1= US 60c approx in Sept. 1998

Retirement and pensions are a major policy issue for an ageing Australia. The Organization for Economic Cooperation and Development (OECD), in 1995, considered a number of pension scenarios in 20 countries between 1995 and 2030, using World Bank data. A "later retirement" scenario modelled the gradual lifting of retirement ages to age 70 years whereupon people were working and paying tax and other contributions. This change allowed upward pressures on pension costs to be offset by longer participation and periods of contribution. A 'targeted pensions' scenario held the ratio of pension benefits to wages constant from 2010 and gradually reduced the proportion of older people qualifying for the pension to 30 percent. This dramatically reduced pension costs. For Australia, the pension expenditure as a percent of Gross Domestic Product (GDP) in 2030 was simulated to be 2.4 percent under the 'later retirement' scenario, 1.7 percent under the 'targeted' scenario, and 3.8 percent if policies did not change. In 1995 the actual ratio was 2.6 percent.

Disability

Being able to function independently is the desired state for older people but this is threatened by increasing risk with age of accidents and illnesses. The most prevalent cause of disability among people 65 years of age and older is arthritis and other musculoskeletal disorders which have a prevalence rate of 17.3 percent for all people over 65, but 19.6 percent among women 65+. The next most prevalent are diseases of the ear (8.1 percent) and circulatory diseases (8.0 percent). Diseases of the ear are much higher among older men (11.5 percent) than women (5.5 percent) and circulatory disease is slightly higher among men. By comparison to these prevalent causes of disability, only 1.7 percent of older Australians had psychiatric conditions. Whilst organic disorders like Alzheimers disease are low in prevalence they are high in impact, accounting for around 8 out of 10 persons in nursing homes.

Using the most recent disability survey evidence, the expected years that a person aged 65 has in different disability states can be calculated (Table 2). Handicap is more severe than disability since it is defined by costs associated with loss of function.

Table 2

Health Expectancies (HE) and proportions of Life Expectancy (LE) for men and women at age 65 in 1993

Expectations at age 65 with—	*HE in years*		*HE/LE percent*	
	men	*women*	*men*	*women*
Profound handicap	1.72	3.72	12.7	19.1
Severe handicap	0.64	0.94	4.1	4.8
Moderate handicap	1.62	1.64	10.3	8.4
Mild handicap	3.34	2.90	21.2	14.9
Disability only	1.90	1.19	12.1	6.1
Disability free	6.51	9.09	41.4	46.7
Life expectancy at age 65	15.73	19.48	100	100

Note: Disability is less than full function and handicap is disability with a social, economic or cultural cost.

Source: Mathers (forthcoming)

Thus, we expect men and women to spend more than half of their years remaining after age 65 years free of handicap. On the negative side, of the 16 years men have remaining at age 65 they will have almost 2 years, or an eighth, with profound handicap and women will have almost 4, or a fifth, of their remaining 19.5 years with profound handicap. Without wanting to emphasize the negatives, it is these more severe conditions that will be explored because of their personal and policy importance.

The Australian Bureau of Statistics (ABS) measure of disability is complex and relatively "soft" or inclusive, so it is better to concentrate on severe (and profound) handicap as indicator measures for morbidity. The ABS disability surveys indicate that rates of severe handicap increased between 1981 and 1988 but returned to 1981 levels in 1993 (Table 3). Womens' rates were almost double those for men. This is due to the fact that there are many more older women at advanced ages than men and they have greater risk of severe handicap than men, due to a less active lifestyle and possibly a greater underlying vulnerability than men to disabling disease.

Table 3

Trends in Rates of Severe Handicap (percent) 65+.

	Severe Handicap		
	Men	*Women*	*Persons*
1981	12.3	20.4	17.0
1988	13.1	22.6	18.6
1993	12.4	20.3	16.9

Source: Wen, Madden & Black (1995) and various ABS Disability Surveys.

On average, 20 percent of women and 12 percent of men 65+ suffer severe handicap but there are higher rates of severe handicap at older ages, growing to half of men and almost two thirds of women aged 85 years and over (Table 3). A fourth in the series of national disability surveys will be released early in 1999. Analysis by Wen, Madden and Black (1995) shows only a few percent are due to increased age-specific rates (ie sicker people at older ages), with most being simply due to increases in numbers of older people. Evidence is even more positive from recent U.S. work (Crimmins, Saito, & Ingegneri, 1997) where disability-free life expectancy increased from 1980 to 1990 for people 65 and older. The improvements in the 1980s were evident in declines in levels of disability in people living in the community. In the previous decade, 1970 to 1980, the trend was in the opposite direction; namely, disability-free life expectancy decreased. The authors point to improved experiences in education, the labour market and socio-economic circumstances, as well as health advances to explain the change. These factors could operate in Australia in the future to produce improvements in disability-free life expectation.

Health

In Australia, national health insurance began life in 1976 as Medibank, then it was weakened under a changed government only to be given new life by a new Labor government in 1984 as Medicare. The Medicare system exists alongside voluntary

private health insurance—the latter covers about a third of the population and slightly less of older people. Medicare is a social insurance system with a levy on pre-tax salary of 1.5% for those with incomes above the specified minimum. For this, all Australians were provided with 85% of the scheduled fee for GP consultations, 85% rebate of the scheduled fee for specialist consultations out of hospital; a bulk billing option from private providers if they did not require consumer copayments and make no charges to the consumer: 100% of specialist services scheduled fees for in-hospital services; and 100% of public hospital and other medical services provided in hospital.

Most older people have incomes that fall below the level at which they are required to pay contributions, but all are provided with high quality services when they need them. Rationing occurs only according to health need and, *de facto*, through waiting lists. No funds are accumulated and the government pays its share of costs on a pay-as-you-go basis. That cost is increasing. Total expenditure on health care services in Australia amounted to $41.7 billion in 1995–6. 8.5% of gross domestic product. Total health expenditure rose by 5.3% in real terms between 1994/5 and 1995/6 while population grew by only 1.3%. Government health expenditure increased by 6.4% over the same period, double the rate for non-government expenditure. Approximately 37% is spent on public hospitals, 25% on medical services and 9% on pharmaceuticals. Government expenditures on the last two areas are uncapped.

Health costs of an ageing society are hotly debated in Australia (EPAC 1994; National Commission of Audit 1996). A key issue is whether to project *pro rata* on historic evidence of use and costs on years from birth versus years from death. The later method is preferred on the historical evidence that a low percent of health cost increase is attributable to population ageing. While even under appropriate projections costs increase, the traditional methodology over-estimates health expenditure per aged person by 4–8 percent by 2030 (Eckerman, 1992). The OECD (1996) modelled health costs for ageing in 20 countries. A first scenario assumed that as people grew older they consumed more health care so current per person health care expenditure was multiplied by the total number of older people. Under this model, public

health care costs in Australia grew from 5.8 percent of GDP in 1995 to 7.6 percent in 2030, assuming health expenditure grew at the same rate as GDP. The second scenario modelled consumption of health care in the period immediately before death so current per person expenditure was multiplied by the number of deaths in the elderly population. Under this scenario, health care costs rose to 6.2 percent of GDP, again assuming health costs grew at the same rate as GDP. For most countries, as for Australia, the first assumption yielded higher health costs than the second.

People 65 and older constitute 11.8 percent of the Australian population, 10.3 percent of men and 13.3 percent of women, but they account for 33.6 percent of health costs for men and 35.5 percent for women. People 65 and over receive three times the expenditure in health costs compared to their population representation, slightly more for men and slightly less for women (Mathers, Penm, Carter, & Stevenson, forthcoming). The breakdown by type of disease shows, however, that older people have less than their average costs on some of the most costly diseases (Table 4).

Digestive and respiratory disease costs for older men and women, in the range of 20 to 25 percent of all age costs, are lower than the proportion of costs for all diseases. By constrast the costs for circulatory disease are much higher, at 60 percent for men and 71 percent for women—almost double for all diseases. To complicate the picture, musculoskeletal and mental diseases are higher only for women, at about 50 percent, whereas cancers are higher only for men, at 55 percent. Injury costs are lower for men but about on par for all diseases for women. The composition of these costs in terms of the sectors also varies by type of disease. It is important, then, to look at high cost diseases for older people to identify just where costs arise for the population 65+ and, further, to look at the contributions of different sectors.

On the basis of this evidence, a major area of interest will be changes in circulatory disease rates, and other high cost, high prevalence conditions, among older people. For example, if all age trends continue, then circulatory disease might be expected to become a low prevalence condition by 2020. If this were achieved it would require massive reallocations of the medical and community workforce and reorientation of resources in the health system.

Table 4

Total Health System Costs Persons 65+ by sex for Diseases by Health Sector and ICD-9 Chapter 1993–4 ($ million)

ICD-9 Chapter	*All Hospital*	*Nursing Homes*	*Medical Services*	*Pharmaceuticals*	*Dental & Allied*	*Total Costs**	*65+% of All Ages*
All Diseases							
men 65+	2351.6	646.1	598.8	486.4	178.8	4595.2	33.6%
women 65+	2532.4	1620.7	757.4	766.1	274.1	6340.8	35.5%
Digestive							
men	165.0	13.6	38.3	41.0	80.3	357.8	22.6%
women	175.4	17.7	40.2	53.8	119.7	430.3	20.2%
Circulatory							
men	553.8	189.1	123.8	158.4	12.0	1102.0	60.0%
women	481.7	318.0	147.5	155.9	13.1	1292.4	70.5%
Musculoskeletal							
men	170.6	78.7	59.9	6.0	28.8	394.3	31.3%
women	273.3	316.8	93.3	73.5	50.2	850.7	50.0%
Mental							
men	102.6	149.7	23.2	23.0	1.4	318.2	28.3%
women	147.5	453.3	47.2	50.5	2.7	743.4	49.3%
Injury							
men	185.5	33.2	18.4	6.9	9.7	268.8	18.8%
women	297.6	59.0	37.0	12.5	13.8	445.0	37.8%

continued

Table 4

Continued

ICD-9 Chapter	*All Hospital*	*Nursing Homes*	*Medical Services*	*Pharmaceuticals*	*Dental & Allied*	*Total Costs**	*65+% of All Ages*
Respiratory							
men	162.9	31.1	50.5	61.9	2.5	326.4	26.3%
women	134.6	58.8	50.0	65.8	4.3	331.4	26.1%
Neoplasms							
men	368.8	11.2	47.4	15.2	4.6	487.9	54.5%
women	265.0	18.1	34.1	17.9	3.4	376.9	37.3%

* Total costs include research and other categories not listed above.

Source: Mathers. (Forthcoming)

Around 80 percent of coronary artery disease deaths are now among older people. There has been a decreasing reduction in chronic heart disease (CHD) mortality with age between 1950 and 1994 with decreases of nearly 65 percent in the 45 to 54 age group and 40 percent in the 75 and older age group. So CHD deaths are down in all age groups but less among older people. There is also increasing prevalence of coronary artery disease with age from 9.4 percent at age 55 to 64 years to 18.1 percent at ages 75 and above. As a consequence there is a projected doubling of numbers of patients who need treatment for hypertension between 1996 and 2026. It is this issue that is being highlighted by writers who resist the claim that there are too many physicians and cardiologists in the community, and who put a note of caution on the good news about heart disease declines (Kelly, 1997).

Achieving continuing reductions in CHD, especially at older ages, is uncertain but possible. Trends are down in smoking and hypertension, but trends in other major risk factors are either flat or. in the case of obesity, getting worse. These factors operate in different ways at very old ages compared to younger ages. There may be greater expenditures on pharmaceuticals, such as antihypertensives and cholesterol-lowering drugs. There will also be investments in public programs to help people become more active and fit. On the other hand, continuation of current downward trends would reduce costs for that illness. The problem for older people is competing risks (i.e., saving someone from heart attack will keep them alive a little longer to die from a pre-existing cancer or to develop dementia). We can actually see this in the declining rates of death attributed to cardiovascular disease compared to increase rates due to cancers.

Australia has developed a Draft National Healthy Ageing Strategy which was approved by the Health and Community Services Ministerial Council in 1997. While having a broad focus, it seeks to "improve health and well-being for all older Australians." A broad set of strategies are provided to prevent illness and disability, and to promote well-being and participation. However, the potential impacts of shifting epidemiology also need to be explored.

Aged Care Services

Most care of older people is delivered on an informal basis by family members, neighbours and charities—crude estimates suggest about two thirds of care service events. Thus, putting residential care in its proper place, government or formal services are really supplementary to services provided informally in the community. As well, the bulk of formal services for older people are provided by generic service providers such as GPs, hospitals, and community health services. The effectiveness of the connections between generic services and specific aged care services, such as residential aged care, home and community care, respite and assessment services, is currently being investigated in a series of coordinated care trials. There has been as well a major attempt to shift the balance of care from more intensive to less intensive residential care and from residential to community-based care.

Nursing homes were the dominant form of residential care in the late 1970s, but since the mid-1980s the less intensive hostel accommodation has grown at the expense of nursing homes. While expenditure on nursing homes has grown most because of high unit costs, the number of places in hostels and the availability of community-based care services such as community aged care packages (CACPs) (which provide hostel level care in the community) and home and community care programs (HACCs) (which cover the full range of community services received by older people) have grown at a greater rate than nursing homes. Between 1985 to 1997, residential care places per 1000 persons 70 years of age and older decreased from 67.2 to 47.8, while for hostels there was an increase from 32.3 to 41.7 (Steering Committee for the Review of Commonweath/State Service Provision, 1988).

In June, 1997, there were about 132,500 residents (permanent and respite) in residential care facilities, 72,500 in nursing homes and 60,000 in nursing homes. The growth in persons in residential care between 1992 and 1997 was 12.7 percent. Places in nursing homes increased by 0.1 percent and hostels by 31.7 percent while, overall, the proportion of the older population in residential care declined over the period. Less than 10 percent of the population 65 to 69 are profoundly or severely handicapped and less than

1 percent are in nursing homes or hostels. Of those 85 and older over half are severely or profoundly handicapped and 31 percent are in nursing homes or hostels.

Commonwealth funding for long-term residential care was around $2.7 billion in 1996–7, $2.2 billion for nursing homes and $0.5 billion for hostels. (Note, as of September, 1998, the Australian $1.00 equaled $0.60 U.S.) Client contributions to nursing home costs was $685 million in 1996–7. On the more complex issue of contributions to hostels, data is not available. Nursing home costs were around $24000 per place a year which is about four times the cost of hostels. Among OECD countries, Australia has made exceptional progress towards informal and community based care. The critical decision is when the shift to home based care reaches a natural limit. The OECD (1996) argued that the development of home based care in member countries had failed to keep pace with growth in numbers of people 80 years of age and older.

Between 1 and 4 percent of the aged population are assessed by multi-disciplinary aged care assessment teams (ACATs) in standardised procedures which is mandatory for admission to aged care residential facilities. Among people 80 and over, around 12 percent were assessed and women were more likely to be assessed than men. Of the assessed men, 26 percent were recommended for nursing home and 19 percent hostel care. For women the comparable figures were 23 and 24 percent, respectively. ACATs are one of the effective rationing mechanisms for expensive residential care services which allow them to be received by those who need them most. There is some concern that the current practice of setting provision levels as proportions of persons 70 and older will be unworkable with the rapid increases in numbers at very old ages. This has provided a rational basis for setting supply, but the increasing number of very old at risk people suggest that 70 and over ratios may create under-supply in the future. Levels are also dependent on the health status, levels of independence, and care support technologies that may be available in the future.

About 6 percent of people 65 years and over are in residential care facilities. The rates increase rapidly with age, from 1 percent at ages 65 to 69, to 31 percent at ages 85 and older This first raises

the question of the focus for a national aged care strategy: What about the other 90 percent? From a public sector cost point of view the focus is nursing homes, but from the general public point of view the focus is on the majority of non-institutionalised elderly. What is not well understood by the public is that the probability of ever using a nursing home is considerably higher than the proportion of older people currently in residential care (Table 5) This can be explained by analogy to hospitalisation. Most people will not be in hospital in any one year but the lifetime expectation of hospitalisation will be nearly 100 percent.

On the current evidence, women have a 35 percent chance of ever entering a nursing home and a 28 percent chance of entering a hostel. Men have a 21 percent chance of entering a nursing home and a 13 percent chance of entering a hostel. These probabilities, with respect to nursing homes, increase with age to half of all persons at age 80 and two-thirds at age 85.

Roughly a third of people 65 and older are living in family settings at home, but 4 percent of these are sole parents even at this advanced age. About a quarter live alone and another 10 percent are in some form of care, for example in residential care or acute care facilities.

Prior to age 60, women predominate as carers and those cared for are predominantly children and parents. At ages 60 and above,

Table 5

Probability of Future Residential Care Use at Various Ages 1994–5

At Age	*0*	*65*	*70*	*75*	*80*	*85*	*90*	*95*
Nursing Homes								
Men	0.21	0.27	0.30	0.34	0.40	0.49	0.57	0.61
Women	0.35	0.41	0.44	0.50	0.61	0.78	0.97	0.95
Persons	0.28	0.34	0.37	0.43	0.53	0.67	0.85	0.86
Hostels								
Men	0.13	0.17	0.19	0.22	0.27	0.36	0.44	0.41
Women	0.28	0.33	0.35	0.41	0.51	0.63	0.65	0.45
Persons	0.21	0.25	0.28	0.33	0.42	0.53	0.58	0.44

Source: Steering Committee for the Review of Commonwealth/State Service Provision (1998)

partners become the major recipients of care and men become the majority of care providers. Spouses are 90 percent of carers 60–69 and 72 percent of carers of those 70 and older. Many older women do not have spouses to care for them. Daughters are about a third of carers and sons are about 5 percent. On the other hand, a third of Australian children under 12 years are cared for by grandparents or other older relatives. Over half of older people living alone have adult children living within half an hour travelling time.

The OECD (1992) had indicated a number of policy initiatives aimed at informal care: day and longer term respite care providing relief for carers; home monitoring and security systems with 24 hour triage, for which installation and monitoring costs may be subsidised; home and community care services delivered to the home; partnerships with non-profit and voluntary organisations providing contracted out and complementary services; and financial support for informal carers.

Australia has programs in all these policy areas. HACC expenditure increased at 8.3% annually in real terms over the last 10 years to reach $763 million in 1997. The future issue is how to fund the growing needs.

Conclusion

Recent Australian policy initiatives dealing with ageing issues (see Budget Papers 1996 a,b) have been (a) to require workers to save for their own income needs in retirement during working life; (b) to make older people pay towards the costs of their care (user pays) in residential aged care and home and community care; (c) encouraging people of retirement age to continue working by allowing people 65–70 to continue contributing to improving a superannuation fund if they are in the paid workforce at least 10 hours a week or more; (d) improving the coordination of the range of care services by innovations, such as community options, community aged care packages, and coordinated care trials; (e) increasing support for carers in the carers package amounting to A$36.7 million over 4 years; and (f) targeting health promotion programs on the elderly.

More policy development is needed and new options will need to cross sectoral and Commonwealth/State boundaries.

There is international interest in various forms of long-term care insurance as a way of ensuring adequate coverage of care needs and of limiting public outlays. The U.S. has some experience in private long-term care insurance and has reviewed performance of the product. On the demand side there has been a disappointing 3 percent take-up of insurance by older people. Public long-term care insurance has just been introduced in Japan and already exists in Israel, Holland and Germany. A variety of options exist for examination in Australia. We could have schemes that operate like Medicare, the Superannuation Guarantee or private health insurance. Equally as important is the need for public acceptance and understanding of any new financing system.

A number of countries allow older people to access their housing equity to finance long-term care. Housing finance initiatives have been taken up by few people and has had little impact on public expenditure (OECD 1996). France has experimented with partial recovery from inheritances of its dependency allowances. On the basis of this evidence, the OECD (1996) concluded that public sources are likely to continue to bear the major part of the risk of long-term care.

While examining the range of experiences with policies in other countries, Australians must avoid learning lessons that come from situations that existed in the past rather than the present. Discussion is needed to deal with this gap since most policy demands from the public will typically come from models that already exist in other countries. Some changes have been that older peoples expectations of quality of life and social participation have dramatically improved; fewer men work in full-time career based jobs and most retire before age 65; more women are well educated, work until retirement and others prefer flexible but permanent working arrangements; and family ties and living arrangements are changing. Informed but guided debate around a national strategy is as likely to reveal options for dealing with Australian ageing as is review of international options. However, both processes will be important.

By any standards Australia has created a world class aged care service system across all areas. It is a system that has been built on strong public funding which is unlikely to be maintained at the same rate and which will be put at risk by demographically

driven cost growth. The future challenge will be to contain public expenditure without affecting the quality of care.

References

Bacon, B. R. (1996). "An Ageing Society: A Working Life / Retirement Perspective." Paper presented at the 8th National Conference of the Australian Population Association 3–6 December.

Budget Paper (1996a). *Budget Overview and Economic Outlook 1997–7*. Commonwealth of Australia, Canberra, 20 August.

Budget Paper (1996b). *Recognising Older Australians*. Statement by the Treasurer and Ministers for Social Security, Family Services and Veterans Affairs. Commonwealth of Australia, Canberra. 20 August.

Source: ABS 1996 *Projections of the Populations of Australia, States and Territories 1995–2051*

Crimmins E. M., Saito, Y., and Ingegneri, D. (1997). Trends in disability-free life expectancy in the United States, 1970–1990, *Population and Development Review* 23(3): 555–572.

Eckerman, S. (1992). "Projected health expenditure and ageing: revised methodologies." Paper presented at the Public Health Association conference, Canberra, September.

Economic Planning and Advisory Council. (1994). *Australia 's Ageing Society*. Canberra: Office of EPAC.

Kelly, D. T. (1997). Our Future Society: A Global Challenge, *Circulation* 95(11): 2459–2464.

Mathers, C., (forthcoming). Gains in health expectancy from the elimination of diseases among older people, *Disability and Rehabilitation*, due in June issue.

Mathers, C., Penm, R., Carter, R., and Stevenson, C. (forthcoming). *Health System Costs of Diseases and Injury in Australia 1993–94*. Canberra: AIHW.

National Commission of Audit (1996). *National Commission of Audit Report to the Commonwealth Government*. Canberra: AGPS.

OECD (1992). *Urban Policies for Ageing Populations*. Paris: OECD.

OECD (1996). *Ageing in OECD Countries. A Critical Policy Challenge*. Paris: OECD.

Steering Committee for the Review of Commonwealth/State Service Provision (1998). *Report on Government Services Volume 2 Community Services, Housing*. Melbourne: Commonwealth of Australia.

Wen, X., Madden, R., and Black, K. (1995). *Population Indicators of Needs for Disability Services: An Exploration*. Welfare Division Working Paper No. 9, Canberra: Australian Institute of Health and Welfare.

Population Aging in Korea: Social Problems and Solutions

IK KI KIM

Dongguk University
Department of Sociology
Seoul, Korea

Aging in Korea is discussed in light of the rapid growth in numbers and proportion of the Korean population and has a great impact upon planning and policy development. The demographic transition has implications on the traditional family caregiving system. Living arrangements and employment status of the elderly will be described, and the economic implications on society will be addressed. There are many roles for the Korean Government to provide for the welfare of the country's growing elderly population.

Introduction

Korea experienced a major demographic transition, from a rapidly growing population to a moderately growing one, after the beginning of the 1960s. Population aging is a natural outcome of the demographic transition from high fertility and mortality to low fertility and mortality. Since the 1960s, while population growth became moderate, Korean society has been undergoing vast demographic changes including the rapid increase in both the proportion and the absolute number of the elderly. The interaction of rapid socioeconomic development and full-scale adoption of family planning programs facilitated the rapid process of demographic transition in Korea (Kim, I.K., 1987). During the period of the first five-year economic plan, 1962–67, the Gross National Product (GNP) grew at an annual rate of 7.0 percent. The GNP growth for the next five-year economic plan

Journal of Sociology and Social Welfare, March, 1999, Volume XXVI, Number 1

was even higher, 11.4 percent. Since then, the Korean economy has consistently grown over time.

Sociological theorists of structural functionalism and modernization argue that with industrialization, urbanization, and overall economic development, household structure will shift generally from an extended to a nuclear form (Cowgill & Homes, 1978; Martin, 1989). It is argued that industrialization requires a flexible, mobile, and nuclear family because it is functionally more adapted to the new mode of production (Kim, I.Y., 1993). Modernization theorists have also argued that the status and well-being of the elderly are closely linked to their living arrangements, implying that modernization means the transformation of living arrangements from the type of living with children to that of living alone or living with spouse only (Cowgill, 1986; Cowgill & Holmes, 1978).

The rapidly changing socioeconomic and demographic characteristics, in conjunction with population aging in Korea, have created greater awareness and commitment among policy-makers and planners to concerns regarding the elderly (Kim, I.K. et al., 1997). A better understanding of the process of population aging will facilitate the development of policies and plans to ensure meeting the needs of the Korean elderly.

This article examines the process of population aging in Korea within the context of demographic transition. More specifically, it will deal with the changes in the characteristics of population and family structure, process of population aging, and changes in the demographic status and living arrangements of the elderly. In a conclusion, the socioeconomic implications of the aging population will be discussed.

Demographic Transition and Features of Population Aging

Demographic transition is defined as changes in the fertility and mortality of a specific society in the process of transition from an agrarian state to an industrialized and urbanized state (Coale 1973). According to this definition, modernization brings about demographic transition; that is, the reduction of both fertility and mortality.

In Korea, mortality continued to decline after 1960, but the reduction rate has been lowered. On the other hand, the level of

fertility for the period of 1955–60 was record high in the recent demographic history of Korea because of the baby boom that followed immediately after the Korean War (Kim, I.K, 1987). The fertility level slowly declined after the peak year (1959) up until 1965. Until this time, effective methods of fertility control were not widely practiced. The Korean government launched a five-year economic plan and adopted family planning as a national policy in 1962. In this sense, the demographic transition in Korea started in the mid-1960s (Kim, I.K. 1987).

The year 1960 marks a decisive turning point in the mortality trend. The Korean War during 1950–53 had great impact on the Korean population, especially on mortality. War casualties were estimated to be 1.6 million and the crude death rate rose sharply during this period (Lee 1980). The crude death rate in 1955 was record high at the level of 33 per thousand. Since then, the mortality level of Korean population has slowly but consistently declined (Korea National Statistical Office, 1997). The crude death rate in 1960 indicates 16 per thousand, which is decreased by 17 per thousand, compared to 5 years ago. The crude death rate continuously declined and reached 5.3 per thousand in 1996.

In accordance with the continuous decline of the crude death rate, life expectancy at birth has consistently increased over time (Korea National Statistical Office, 1997). Life expectancy at birth in 1960 was 51.1 years for males and 57.3 years for females. Life expectancy for males increased from 51.1 years in 1960 to 57.2 years in 1970, 62.7 years in 1980, 68.2 years in 1990, then to 69.5 years in 1996. Life expectancy for females increased at the same speed from 57.3 years in 1960 to 64.1 years in 1970, 69.1 years in 1980, 75.0 years in 1990, then to 77.4 years in 1996. Continual increase of life expectancy has brought about a consistent increase in the proportion of the elderly; that is, population aging.

Decrease of the fertility level has also affected population aging. The crude birth rate in 1960 was as high as 45 per thousand. Since then, however, the rate has continuously declined over time (Kim, I.K., 1997). While the crude birth rate declined only by 3 per thousand during the period of 1960–65, it declined sharply from 42 per thousand to 32 during the period of 1965–70. The reduction of the crude birth rate by 10 per thousand for the five-year period is record high. Since then, the fertility level has steadily declined

without interruption. The crude birth rate declined to 23.4 in 1980, 15.6 in 1990, then to 15.2 per thousand in 1996.

During the period of demographic transition, Korea experienced a rapid urbanization process, as well (ESCAP, 1980). In 1960, only 28 percent of the population lived in cities. The urbanization rate increased to 41 percent in 1970, 57 percent in 1980, then to 74 percent in 1990 (Korea National Statistical Office, 1997). In contrast to the rapid increase of urban population, the rural population growth rate has continuously declined over time. The loss of rural population is totally due to the heavy out-migration. Such a heavy out-migration, especially of working age population, has resulted in a severe imbalance of the age distribution between urban and rural populations. The imbalance of the age distribution again results in different proportions of the elderly population.

Migration to cities, in conjunction with the process of industrialization, has broken down the traditional family system of agricultural society and thus expanded the nuclear family system (Bae 1987). The proportion of nuclear family has consistently increased, with the exception in 1970, whereas that of stem family has continuously decreased over time (Kim, T.H. et al, 1993). The proportion of nuclear family increased from 66.6 percent in 1966, to 72.9 percent in 1980, to 76.0 percent in 1990, then to 81.3 percent in 1995.

The rapid process of demographic transition has brought about the increase of both the absolute number and proportion of the elderly in Korea. Those aged 60 and over increased from 1.5 million in 1960 to 3.3 million in 1990, and are projected to increase to 9.9 million by the year 2020. This shows that the number of elderly population aged 60 and over doubled within the past three decades and is expected to increase by almost three times of the 1990 figure and more than six times of the 1960 figure. Table 1 shows the proportions of the elderly since 1966. The proportion of those aged 60 and over was 5.2 percent in 1966, then it consistently increased. However, it does not show notable changes until the 1980s. The proportion of those aged 60 and over was still 7.6 percent in 1990 but it is projected to reach almost 26.5 percent in 2030.

Increase of the proportion of the elderly has affected both dependency ratio and aging index in Korea since 1966. The dependency ratio of those aged 60 and over was 10.2 in 1966 and

Table 1

Proportions of the Elderly in Korea, 1966–2020

Year	*1966*	*1970*	*1975*	*1980*	*1985*	*1990*	*1995*	*2000*	*2005*	*2010*	*2015*	*2020*	*2030*
Age													
10–14	43.5	42.1	38.1	33.8	29.9	25.7	23.4	21.6	21.2	19.5	18.4	17.2	16.0
15–59	53.2	52.5	56.3	60.1	63.3	66.7	67.5	67.4	66.3	66.5	65.1	62.8	57.5
60–64	1.9	2.1	2.1	2.2	2.5	2.7	3.3	3.9	3.9	4.2	5.2	6.9	7.2
65–69	1.5	1.4	1.6	1.7	1.8	2.1	2.3	2.9	3.4	3.4	3.9	4.7	6.7
70–74	1.8	1.9	1.9	2.2	2.5	2.9	1.7	1.9	2.4	2.9	3.0	3.4	5.7
75–79	0.6	0.6	0.6	0.6	0.8	0.9	1.0	1.3	1.5	1.9	2.4	2.5	3.5
80+	0.3	0.4	0.4	0.5	0.5	0.7	0.8	1.0	1.3	1.6	2.0	2.5	3.4
60+	5.2	5.4	5.6	6.1	6.8	7.6	9.1	11.0	12.5	14.0	16.5	20.0	26.5
65+	3.3	3.3	3.5	3.9	4.3	5.0	5.8	7.1	8.6	9.8	11.3	13.1	19.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Korea Statistical Yearbook, 1997.

13.5 in 1995 but it is projected to triple in the future, increasing to 46.1 in 2030 (Korea Statistical Yearbook, 1997). The aging index of those aged 60 and over also shows a drastic increase. The index was 12.0 in 1966, increased to 38.9 in 1995, and is projected to reach 165.6 in 2030. The aging index indicates that in 2030 the population aged 60 and older will be larger by 66 percent than the population aged 0–14.

The dramatic demographic transition within a short period of time has accelerated the population aging in Korea. Korea, which has already experienced large declines in fertility and mortality, has a tremendous momentum for further population aging. The projected declines in fertility and mortality will add to the momentum for even further population aging in Korea (Kim et al., 1998).

According to Chung (1998), the aging speed of the Korean population is apparently faster than that of developed countries. The year when the proportion of those aged 65 and over reached 7 percent of the total population was 1865, in France 1890, in Sweden, and 1970 in Japan. In Korea, the proportion is expected to reach 7 percent in 2000. The time required to double this proportion was 115 years for France, 85 years for Sweden, and 25 years for Japan. It is projected to take 22 years in Korea.

Changes in the Demographic Status of the Elderly

This section examines the changes in the demographic status of the elderly in conjunction with the aging process. Table 2 illustrates the proportions of currently married among the elderly during the period of 1966–95. For both sexes, the proportions have slightly but consistently increased over time. The proportion of currently married for the population aged 60 and over was 48.0 percent in 1966, but increased to 57.2 percent in 1995. Also, the proportions are higher in the categories of younger cohorts. One notable thing in this table is that there have been big differences in the proportions of married between male elderly and female elderly. The proportions have been much lower for females than for males all through the age groups.

While the population in Korea has experienced rapid urbanization, the urbanization rate for the older population has been

Table 2

Proportions of the Currently Married Elderly in Korea, 1966–1995

Year	*1966*	*1970*	*1975*	*1980*	*1985*	*1990*	*1995*
Age							
Both Sexes							
60+	48.0	50.3	52.0	53.0	55.9	54.9	57.2
65+	41.3	41.6	44.6	45.0	47.0	47.2	47.6
Male							
60+	77.5	80.3	83.3	84.7	86.5	86.3	87.9
65+	71.0	73.5	77.6	79.9	82.2	82.6	83.6
Female							
60+	28.7	29.4	31.0	31.6	35.2	34.5	36.8
65+	22.0	21.7	24.3	24.3	27.4	26.0	26.5

Source: Economic Planning Bureau, Population and Housing Census Report, each year.

lower than that for the total population (Kim, I.K., 1997). Among the total population, the proportion of urban residence was 33.5 percent in 1966. This proportion continued to increase during the following three decades and reached 78.7 percent in 1995. For those aged 60 and over, however, the proportion of urban residence increased from 23.3 percent in 1966 to 58.5 percent in 1995. A closer examination of the differences in the share of old population in rural and urban areas reveals that, throughout the past three decades, the proportion of old people in rural areas constantly outnumbered the corresponding proportion in urban areas.

Socioeconomic Situation of the Elderly

Table 3 indicates the living arrangements of the elderly by region in 1994. One of the most notable features in this table is the sharp increase in the proportion of the elderly living alone. The proportion of the elderly living alone in 1994 is 11.9 percent, which is increased by 8.6 percent compared to 1981 (Kim, I.K. et al., 1992). The proportion of the elderly living alone or with their spouse is only 41.0 percent, which is greater by 21.3 percent

Table 3

Living Arrangements of the Elderly by Region, 1994 (%)

	Region		
Living arrangements	*Total*	*Urban areas*	*Rural areas*
Living alone	11.9	9.6	15.0
Living with spouse only	29.1	21.6	39.0
Living with children	53.8	64.1	40.1
Living with others	5.2	4.7	5.0
Total	100.0	100.0	100.0
	(2,056)	(1,170)	(886)

Source: Rhee, K.O. et al., 1994, p. 38.

than that in 1984 (Eu, 1991). The proportion of the elderly living with children is 53.8 percent, which is decreased by 24.0 percent compared to 1984 (Kim and Choe, 1992).

Another notable feature in Table 3 is the big differences in living arrangements between the urban and rural elderly. The proportion of the elderly living alone is 9.6 percent in urban areas but 15.0 percent in rural areas. The proportion of the elderly living with their spouse is only 21.6 percent in urban areas but 39.0 percent in rural areas. On the other hand, the proportion of the elderly living with children in rural areas (40.1 percent) is less by 24.0 percent than that in urban areas. This is due to the massive out-migration of children from rural areas.

The living arrangement is a very important mechanism to the elderly because it is closely related to the support for them. Co-residence with family members seems to be the best way of supporting the elderly because most types of support (financial support, emotional support, assistance in activities, etc.) are possible with co-residence. Of course, living alone does not necessarily mean a lack of support from family members. However, the elderly living alone or with their spouse normally only have a limited access to these types of support.

In Korea, there have been big gender and age differences in educational attainment (Kim, I.K., 1997). The proportion of the male elderly reporting "no school" is only 23.6 percent while the

proportion for the female elderly is 55.7 percent. Similarly, the proportion of high school graduates or over for male elderly is 25.0 percent but only 4.8 percent for the female elderly. Moreover, with increasing age, educational attainment for both sexes consistently decreases. The proportion of middle school graduates or over is 33.0 percent for the elderly aged 60–64 years, 21.2 percent for the elderly aged 65–69 years, 13.3 percent for those aged 70–74 years, 8.8 percent for those aged 75–79 years and 5.8 percent for those aged 80 years and over.

The employment status of the Korean elderly is not so favorable (Rhee et al., 1994). As of 1994, only 36.7 percent of the elderly are employed. The proportion of the employed among male elderly (53.9 percent) is much higher than that among female elderly (25.3%). The proportion of the employed elderly is consistently decreasing, in comparing older age groups. The proportion for the elderly aged 60–64 years is 53.1 percent, whereas that for the elderly aged 75 and over is 9.5 percent.

According to Rhee et al. (1994), the most important reason for working among the employed elderly is "need money" (72.2%), followed by "just want work" (8.2%), "to keep healthy" (7.0%), "to kill time" (4.8%) and "to feel ability to work" (4.0%). Among the currently employed elderly, 79.9 percent of the elderly want to continue to work mainly because they need money.

In terms of the support for the elderly, almost 20 percent of the respondents receive no financial support in 1997 (Kim, I.K., 1997). Most of the financial support comes from family members. The proportion of receiving financial support from family members is 77.6 percent. The proportion from formal support is only 2.6 percent and that from friends and neighbors is 0.8 percent. On the other hand, the proportion of receiving emotional support is greatest among those who receive it from friends and neighbors (57.7%), followed by from family members (36.5%). In the case of physical support, 58.0 percent of the respondents do not receive any support. The proportion of receiving physical support from family members is the greatest at 39.2 percent. The proportion receiving support from friends and neighbors is 2.7 percent and that from formal sources is almost zero (0.2%).

Then, who is responsible for the elderly support? According to a survey done in 1997 (Kim, I.K., 1997), the greatest portion (49.6%) of the elderly indicates that the eldest son should support

them. The proportion of the elderly who think that sons (including the eldest son) should support them is 63.7 percent. The proportion of the elderly who think that children should support them is totally 78.2 percent. Only 17.1 percent of the elderly think that they themselves are responsible for their lives.

Socioeconomic Implications of Population Aging

Analysis of changes in the characteristics of the Korean elderly over the past three decades reveals the following phenomena (Kim et al., 1996): an increase in the absolute size and proportion of the older population; an increase in the proportion of older people reflected in the dependency ratio; an increasingly imbalanced sex ratio; and substantial sex differences in the proportions of currently married elderly.

In addition, the educational attainment of the elderly has consistently increased over time. However, improvement in the educational attainment is projected to be greater for older women than for older men. The literacy rate for older women was in Korea 20 percent in 1980 but it will increase to over 95 percent by 2020 (Hermalin and Christenson, 1991). The proportion of males aged 60 and over who receive at least a secondary education will also steadily increase by the year 2020. These changes will significantly affect the role of the elderly both in the family and the society, and will also influence the pattern of the support for the elderly.

Support is crucial to the elderly, especially after their retirement. Living arrangements of the elderly are critical in the support for the elderly. Living together with the elderly is considered as the best way of providing support for the elderly because living together makes possible every kind of support. In recent years, however, the proportion of the Korean elderly living alone has increased while the proportion of those living with family members has decreased (Kim and Choe, 1992).

The elderly living alone suffer from serious economic problems. Thus, although the proportion of the Korean elderly receiving support is still relatively high, an increasing proportion of the elderly living alone might indicate that the tradition of strong family support is somewhat weakening owing to the rapid socioeconomic transformation.

Economic difficulties are not confined only to the elderly living alone. The majority of the elderly suffer from economic problems. The 1984 Korea Elderly Survey revealed that about half of the elderly people aged 60 and over had financial difficulties (Lim et al., 1985). According to the 1988 Korea Gallup Survey (Korea Gallup, 1990), the proportion of those who reported financial difficulties had increased to almost two-thirds of the elderly respondents.

As a consequence of the rapid changes both in socioeconomic development and population aging, the role of the government should be extended in providing welfare for the elderly. However, welfare services of the Korean government for the elderly are very limited. An Elderly Survey in Korea shows that the proportion of the elderly receiving public assistance is less than 2 percent and those receiving medical insurance and pension benefits account for only 3 percent and 2 percent, respectively (Rhee et al., 1994).

The limited services of the Korean government are well indicated in the national budget. Table 4 indicates composition of Korean national budget for the welfare services. The proportion of the budget for social security among Gross National Product (GNP) is 0.86 percent in 1995, which has slightly decreased compared to that in the early 1990s. The proportion of the budget for welfare services for the elderly among national budget is only 0.12 percent in 1995. This proportion is extremely lower than the proportion in Japan (17.3%) and even much lower than the proportion in China (2.9%) (Rhee et al., 1994). The proportion of the budget for the welfare services for the elderly among total social welfare in 1995 has been lowered compared to that in 1990. Despite the fact that the absolute number and proportion of the elderly have increased, the proportion of the welfare services for the elderly has decreased. This will bring about serious social problems to the elderly in the future.

To make the matters worse, the role of the government would be limited to some extent because it is impossible for the government to take full responsibility if the number of the elderly unlimitedly increase. In this situation, the family should continuously take part in the care of the elderly. Without increased filial piety, supporting the elderly in the family would be very difficult. Most Korean elderly take it for granted that they will

Table 4

Composition of Korean National Budget for the Welfare Services

	1988	*1989*	*1990*	*1991*	*1992*	*1993*	*1994*	*1995*
Social security/GNP	0.7	0.8	1.0	1.0	0.9	0.9	0.88	0.86
Social security/ national budget	4.5	5.2	6.6	7.0	6.4	6.4	6.1	5.8
Welfare for the elderly/national budget	0.02	0.03	0.14	0.13	0.17	0.22	0.11	0.12
Welfare for the elderly/total social welfare	8.8	10.5	33.3	28.2	30.2	37.7	22.3	22.9

Source: Kim, I. K. 1995.

receive financial help from their own children. Contrary to this expectation, however, there are many circumstances under which such support is not available from their children (due to recent socioeconomic transformations).

Mason (1992) argues that norms about the care of the elderly by their children were traditionally strong in most of Asia and appear to remain strong; but despite this, traditional patterns of co-residence are eroding in many countries. The further economic growth and urbanization are likely to erode the family's ability to care for the elderly. It is really a dilemma whether the elderly should be taken care of by the family or by the government.

Furthermore, massive out-migration of young people from rural areas due to industrialization and urbanization has brought about different patterns of living arrangements between urban and rural settings. Modernization theory hypothesizes that urban residence is negatively associated with living with children (Martin, 1989). In Korea, however, rural residence is negatively related to living with children because of the massive out-migration of young population (Kim, I. K. 1998).

Patterns of the living arrangements of the elderly are quite different in urban and rural areas (Kim, I.K. 1998). The most salient finding here is that more than half of the rural elderly live alone or only with a spouse. The proportion of the elderly

living alone or spouse only in rural areas is much higher than that in urban areas. Age differentials in the living arrangements of the elderly are more distinctive in rural areas than in urban areas. Sex differentials in the living arrangements are also more distinctive in rural areas, especially among the elderly who live alone or with spouse only. Marital status is another important variable which differentiates the living arrangements in urban and rural areas. It is especially notable that in rural areas the proportion of the elderly living alone or with spouse only is extraordinarily higher among the more educated elderly. Likewise, home ownership, employment status and income status are also important variables influencing the determinants of the urban-rural differentials in the living arrangement of the elderly. The urban-rural differentials in the living arrangements of the elderly would make the lives of the rural elderly more disastrous.

Conclusion

Far East Asian countries including Japan, China, Taiwan, and Korea have shared the ideas of filial piety (Hyo in Korean: Hsiao in Chinese; Ko in Japanese) for many generations (Sung 1990). Filial piety is composed of two concepts; one as a family-based concept which indicates that children should care for the elderly as a response to the love and benefit given by their parents, another one as a society-based concept which indicates that the society should pay back the contribution which the elderly gave to the society while they were young. In Korea, the family has, so far, taken the full responsibility of caring for the elderly. In accordance with the industrialization and urbanization, however, society should share the responsibility to a certain extent. Not only the family; but the government, social organization, and the company where the elderly had worked for a lifetime; should have the shared responsibility of taking care of the elderly.

Respect for the aged has strong roots in Korean culture; it is a value based on filial piety which has not yet been undermined by socioeconomic and demographic changes. Despite the forces of industrialization and urbanization, the family still retains its role as the backbone of old age support (Kim et al. 1992; Liang et al. 1992; Martin 1988; Sung 1990; Tu et al. 1989).

As mentioned earlier, however, the proportions of the elderly living alone have sharply increased while the proportions of those living with family members have consistently decreased. Several projections indicate that the elderly population will continue to grow and the share of old people in the dependency ratio will become greater than that of children by 2020. Thus, an increasing number of Korean elderly would suffer from financial difficulties because of their children's avoidance or inability to provide financial support (Choi 1992). The emergence of this problem is reflected in rising demand for social welfare for the elderly and increasing government's responsibility to support the elderly.

Nevertheless, the role of Korean government in the welfare services for the elderly has been limited to a great extent. The role of government in the welfare services for the elderly will be more limited as the number of the elderly continuously increase not only in Korea but in other Asian countries. A recent projection indicates that the contribution rate for Japan's largest public pension scheme will have to rise from 17 percent of wages in 1995 to 30 percent in 2025 for all anticipated benefits (Ogawa and Retherford, 1997). Population projections suggest that the much newer pension systems in Korea and Taiwan will also encounter operating deficits soon after they become fully functional, requiring an increase in contribution rates, government support from tax revenues, or both (Westley, 1998).

As a way of responding to population aging, the Japanese government is seeking to shift some of the burden of caring for the elderly back to families and to the elderly themselves (Westley, 1998). The Japanese government launched a 10-year project to expand nursing-home capacity and to improve social services for the elderly who live at home. The main focus of the plan is to improve both day-care services and short-term stays in nursing homes and to help families who are looking after elderly relatives at home. Home nursing services are also considered. However, Westley (1998) predicts that the Japanese government's efforts to shift some of the responsibility for elderly care back to families are not likely to be very successful because of the increase of elderly population and the shrinking availability of

family caregivers. Korea and Japan have shown similar patterns of demographic transition and socioeconomic development with some time lag (Kim, I.K. 1992), Japan's experience would thus be a good implication in applying the programs in Korea.

Another serious social problem in relation to the population aging in Korea is urban-rural differentials. As indicated, the proportion of the elderly living without children has continuously increased due to rapid socioeconomic transformation in recent decades, especially in rural areas. This is a critical sign that the tradition of strong family support in Korea has been changing and that the strong tradition of support for elderly family members could continuously weaken in the future. In Korea, the family ties have traditionally been much stronger in rural than urban areas. In this context, the elderly in rural areas are facing a crisis.

The trend of rural-to-urban migration of young populations has continued until recently mainly due to the relatively worsening socioeconomic conditions in rural areas. In addition to the rapid process of population aging, this tendency of continuous out-migration of young people would make the situation of the elderly in rural areas more serious. As a consequence of changes and rapid process of population aging, special measures for the welfare of the elderly would be necessary in both urban and rural areas (Choi, 1992; Rhee et al., 1993). Nonetheless, the measures for the welfare of the elderly should be more emphasized in the rural areas.

References

Bae, Hwa-Ock. (1987). "Changing Family Structure and Aging Issues." Journal of Population and Health Studies 7:203–23.

Choi, Sung Jae. (1992). "Ageing and Social Welfare in South Korea." in Phillips (ed.). Ageing in East and South-East Asia. London: Edward Arnold.

Coale, Ansley. (1973). "The Demographic Transition." International Population Conference. Vol. 1 Liege: IUSSP.

Chung, Kyunghee. (1998). "Aging and Social Welfare Policies: Health Care and Income Maintenance Programs." Paper Presented at UNFPA Conference in Seoul.

Cowgill, Donald O. (1986). Aging Around the World. Belmont: Wadsworth.

———, and L.D. Holmes. (1978). "Ageing and Modernization." in Carver, V. et al. (eds.). An Ageing Population: The Open University Press.

Economic Planning Bureau, Population and Housing Census. (in Korean) 1966, 1970, 1975, 1980, 1985, 1990.

Economic and Social Commission for Asia and the Pacific (ESCAP). (1980). Migration, Urbanization, and Development in the Republic of Korea. Bangkok: ESCAP.

Eu, Hongsook. (1991). "The Determinants of Living Arrangements among the Korean Elderly." Doctoral Dissertation. Brown University.

Hermalin, A.I. and B.A. Christenson. (1991). "Comparative Analysis of the Chnaging Educational Composition of the Elderly Population in Five Asian Countries: A Preliminary Report." PSC Research Report No. 91–11. AnnArbor: Population Studies Center.

Kim, Ik Ki. (1987). Socioeconomic Development and Fertility in Korea. Population and Development Studies Center. Seoul National University.

———. (1992). "A Comparative Study of Demographic Transition between Korea and Japan." (in Korean) Dongguk Journal of Sociology. Vol. 1:43–78.

———. (1995). Population Aging and Policy Implications in Korea." Paper presented at an International Conference on Korea in the Global Society. Seoul, Korea.

———. (1997). "The Aging Society and the Quality of Life of the Elderly in Korea." Korea National Statistical Office.

———. (1998). "Urban-rural Differentials of the Living Arrangements of the Elderly in Korea." D. I. Kim (ed.). Rural Korea in Flux. Seoul: Hoonum-Sa Publishing Company.

———, and E. Choe. (1992). "Support Exchange Patterns of the Elderly in Korea." Asia-Pacific Population Journal 7(3): 89–104.

Kim, Ik Ki et al. (1996). "Population Aging in Korea: Changes since the 1960s." Journal of Cross-Cultural Gerontology 11: 369–388.

Kim, Il-Young (Yoo). (1993). "A Comparative Study of Living Arrangements among Elderly Asian Immigrants in the United States." Doctoral Dissertation. Brown University.

Kim, T.H. et al. (1993). Size and Structure of Korean Population. Korea National Statistical Office.

Korea Gallup. (1990). Life Style and Value of the Aged in Korea, Korea Gallup.

Korea National Statistical Office. (1995). Population and Housing Census.

———. (1997). Korea Statistical Yearbook.

Lee, Hae Young. (1980). "Demographic Transition in Korea." Bulletin of the Population and Development Studies Center 8: 5–17.

Liang, Jersey et al. (1986). "Social Support among the Aged in Wuhan, China." Asia-Pacific Population Journal 7(3): 33–62.

Lim, Jong Kwon et al. (1985). A Study on the Aged Population in Korea. Seoul. Korean Institute for Population and Health.

Martin, Linda. (1988). "The Aging of Asia." Journal of Gerontology: Social Sciences 43(4): 99–113.

———. (1989). "Living Arrangements of the Elderly in Fiji, Korea, Malaysia and the Philippines." Demography 26: 627–43.

Mason, O.K. (1992). "Family Change and Support of the Elderly in Asia: What Do We Know?" Asia-Pacific Population Journal 7:13–32.

Ogawa, Naohiro and R.D. Retherford. (1997). "Shifting Costs of Caring for the Elderly Back to Families in Japan: Will it Work?" Population and Development Review 23(1): 59–94.

Rhee, K.O. et al. (1993). Development of Welfare Policies for the Elderly. Seoul: Korean Institute of Health and Social Affairs.

Rhee, K.O. et al. (1994). Analysis of Life Conditions of the Elderly and Policy Questions. (in Korean). KIHASA.

Sung, Kyu-Tak. (1990). "A New Look at Filial Piety: Ideal and Practices of Family-Centered Parent Care in Korea." Gerontologist 30: 610–17.

Tu, Edward J. et al. (1989). "Mortality, Decline and Chinese Family Structure: Implications for Old Age Support." Journal of Gerontology: Social Sciences 44(4): s157–68.

Westley, Sidney B. (1998). "Asia's Next Challenge: Caring for the Elderly. "Asia-Pacific Population & Policy. #45.

Religion, Adversity and Age: Religious Experiences of Low-Income Elderly Women

AMANDA SMITH BARUSCH
University of Utah
Graduate School of Social Work

Elders throughout the world turn to religious organizations and rely on religious beliefs to cope with both the routine challenges of daily life and the hardships brought on by severe adversity. Hundreds of studies have documented a positive association between health or well-being and religious participation. Yet few have examined religious experiences of the elderly themselves. In-depth consideration of these experiences might shed light on the contribution of religion to individual lives. This study examines religious experiences of women living in poverty in the United States. Results underscore the deep-seated religious commitment of this group. The dominant theme, mentioned more often than any other, was gratitude. Respondents view the Lord as the source of all that is good, and are grateful for life, good fortune, help in times of hardship, and material goods. This view of an all-powerful God contrasts with some respondents' views of themselves as weak or irrelevant. Finally, one-third of respondents who mentioned church attendance reported that ill health or functional limitations restricted their ability to go to church regularly. So, while religion may be good for one's health, good health may facilitate participation in church-related activities.

Introduction[1]

"Eat right, exercise regularly, and go to church on Sunday." This advice, offered by the *Maranatha Christian Journal*, is based on a report by Dr. Jeffrey Levin, an epidemiologist at East Virginia Medical School. Dr. Levin is one of hundreds of researchers who have observed an association between favorable health status and religious observances. Like others, he has concluded that religious participation is literally good for one's health (Levin, 1994).

Journal of Sociology and Social Welfare, March, 1999, Volume XXVI, Number 1

Indeed, the prevailing ethos of the 1980s and 1990s has been very "pro-religion;" in a sharp contrast to Marx's pointed critique, published in the *DeutschFranzosische Jahrbucher*, in 1844: "*Man makes religion*, religion does not make man . . . Religion is the sigh of the oppressed creature, the heart of a heartless world, just as it is the spirit of spiritless conditions. It is the *opium* of the people. To abolish religion as the *illusory* happiness of the people is to demand their *real* happiness . . ." (Marx, 1844).

Although at face value, these viewpoints seem entirely incompatible, both may contain an element of truth. Religion may, for a multitude of reasons, enhance the physical and psychological well-being of individuals. It may also facilitate the oppression of the very individuals whose lives it has enhanced. This article examines the religious experiences of an oppressed group, elderly women living in poverty, in an effort to give voice to their perspective and shed light on the contribution of religion to their efforts to cope with adverse conditions.

Theoretical Perspectives on Religion

Sociological theories offer contrasting views of the role of religion in the lives of the elderly. The functionalist perspective, typified by the work of Emile Durkheim (1947) and Max Weber (1963), places religious organizations in the context of other major social institutions, suggesting that their continued existence argues for their value. In contrast, Conflict Theory, exemplified by the work of Karl Marx (1904), focuses on struggles for power, suggesting there will always be competing classes (the "haves" and the "have nots"); and that major social institutions are simply vehicles through which the "haves" maintain their position. Under this view, religion's promise of a better world to come serves to anesthetize the disadvantaged to their discomfort in the present one. Finally, what Brewer (1995) describes as "the one theory indigenous to American culture," (p. 535) symbolic-interactionism, focuses on the construction of identity through social interaction. George Herbert Mead (1934) is credited with founding this approach which views religious institutions as settings that contribute to the development of personal identity and the construction of meaning.

Religion and Aging

Most studies on religion and age reflect one of these three perspectives. The vast majority apply a functionalist approach, seeking to describe or explain the value of religion, both for individuals and for society. So, for example, numerous studies published in the past 20 years have examined the contribution of religion to the well-being of the elderly (see, for example, Broyles & Drenovsky, 1992; Courtenay, et. al., 1992; Holt & Dellmann-Jenkins, 1992; Idler & Kasl, 1992; Levin, 1994; Musick, 1996; McFadden, 1995; Morris, 1991; Oxman, Freeman, & Manheimer, 1995; Ruffing-Rahal & Anderson, 1994). A smaller set of studies employ the perspective of symbolic-interactionism, seeking to describe the role of religion on elder's search for identity and meaning. Conflict Theory is rarely reflected in the work of researchers in this field, although a few studies have examined the role of women in religious organizations whose leadership is dominated by (or restricted to) men (see Dodson, 1988).

Religion and Well-Being

Perhaps the most popular topic for research on religion and aging in recent decades has been the relationship between religious participation and health or well-being. Studies have examined associations between participation and several dimensions of well-being: physical health, mental health, life satisfaction, and functional ability. Most of these studies have been cross-sectional, and the vast majority have reported a positive association between religious participation and well-being.

The association between religious participation and physical health has been described in numerous studies. Typically these have been cross-sectional surveys employing multivariate statistics to identify factors correlating with health measures. Several studies have reported positive relationships between religious participation and mental health or life satisfaction. In one of the earlier studies of this topic, Blazer and Palmore (1976) reviewed data from the Duke Longitudinal Study of Aging and found a significant positive relationship between church attendance and personal adjustment. Similarly, Markides (1983) reported that religious participation was associated with emotional well-being. The growing number of studies on the relationship

between religion and adjustment or emotional well-being is summarized in a 1995 bibliography compiled by Koenig. Numerous studies have also documented a positive relationship between life satisfaction and religious participation (Edwards & Klemmack, 1973).

This has led most to suggest that Durkheim was right: religion *is* an antidote for anomie, a critical thread in a web of social relationships. Still others have concluded that religious thought offers cognitive and emotional tools for coping with adversity (Koenig, Cohen, Blazer, et.al., 1992; Saltz, Denham & Smith, 1991).

Religion, Identity and Meaning

The contribution of religion to the individual search for identity and meaning has seldom been empirically examined. Two studies in this area are worthy of note.[2] First, in 1985, Woodworth conducted content analysis on in-depth interviews with 40 elderly institutionalized women and reported that respondents varied in the certainty of their religious beliefs, and identified three categories (uncertainty, certainty and speculation) to describe observed differences in her sample. She also reported religious ideas regarding conduct, including acceptance, persistence, being and doing good, doubt and confidence. Ultimately, Woodworth argued that these categories represent distinct positions from which elders address issues related to meaning in life.

In a 1996 paper, Black and colleagues from the Philadelphia Geriatric Center examined the "spiritual narratives" of a sample of fifty low-income, elderly African-American women. These authors reported two key themes. First, women's spiritual beliefs contributed to positive self-esteem in part through their sense of the Lord as a companion on their life journeys. Second, religious beliefs lent meaning to suffering, treating it as a means to redemption. Black and colleagues also observed widespread belief in an afterlife and suggested this accounted for their respondents' lack of concern about death.

The present study looked to a group of older women whose incomes were below the U.S. federal poverty threshold for an understanding of the role of religion in their lives. Specifically, there was an interest in understanding 1) the contribution of religious activity to the women's psychological and physical well-being,

2) the role of religious beliefs in their coping with adversity, and 3) the contribution of religion to their personal identities.

Method

Sample

A selective sample of 62 low-income older women was recruited through contacts with agencies serving the elderly and through a snowball technique. Respondents were invited to participate in a study of the lives of older women with limited incomes, which would be used in a book (Barusch, 1994). They were informed that no information they provided would be released to referring agencies or individuals, and were asked to specify measures they would like used to disguise their identities.

Respondents were chosen to optimize diversity along several factors: ethnicity, age, income level, housing arrangement and family composition. They lived in California, Utah, Alabama, Illinois, New York, Virginia, Washington D.C., and the U.S. Territory of Guam. These sites were chosen to optimize cultural and ethnic diversity.

Women of color constituted 53% of the group. They were slightly over-represented, in that they make up 46% of the general U.S. population of older women in poverty (U.S. Bureau of Census, 1992). Respondents ranged in age from 49 to 100 years, with a mean of 73. Six of the seven women under 55 years old were living in homeless shelters, settings within which older women were difficult to locate.

Most of those interviewed (68%) had annual household incomes below the federal poverty threshold in the U.S. (This includes cash income only, not such in-kind support as food stamps.) Another 19% had incomes between the poverty threshold and 125% the poverty level. The remaining 13% had incomes up to 185% of the poverty level. These "higher income" women had either medical or housing expenses that absorbed much of their income.

The majority of the sample (81%) were not married, with roughly equal proportions being divorced (34%) and widowed (37%). About one-third (34%) of the women owned their homes. Another third (31%) had rent subsidies. Nine women (15%) rented

homes without subsidies. Three were in nursing homes. Nine homeless women were interviewed.

About one in five (22%) of the interviewed women experienced mental illness or cognitive impairment. Typically these women were either depressed, suffering memory loss, or unable to sustain thought. In most cases they self-identified. That is, they indicated that they had been diagnosed as having a psychiatric disorder. In three cases, interviewers noted that women who did not self-identify seemed to have difficulty sustaining thoughts.

Interviews

It was determined from the pilot interviews that low-income older women, especially those for whom English was a second language, found it difficult to respond to structured instruments. Accordingly, a semi-structured conversational format was used for life history reviews. Most interviews took place in respondents' homes and lasted from one to three hours. Four social scientists (including the author) conducted these interviews. Interviewers were Caucasian, and ranged in age from 23 to 50.

All but three of the interviews were conducted in English. Those three were done by an interviewer who was fluent in Spanish. Eight of the women were familiar with English, but used it as a second language. Three had spoken English since childhood. The other five immigrated and learned English over 15 years prior to the interview.

Although religious experiences were not an explicit focus of these interviews, several questions elicited references to the topic. These included:

- What do you like most about yourself?
- Do you consider yourself poor?
- What kinds of support, if any, did you have . . . [for coping with bereavement, stress, loss]; and a wide range of questions related to childhood experiences.

"Ethnograph" software was used to code and extract statements related to religion. These were reviewed, and themes identified. A coding scheme was then developed to reflect the

occurrence of themes. Two independent reviewers coded statements. To determine the clarity and distinctness of the subcategories, a reliability check was performed without prior discussion or training between reviewers. Inter-rater agreement for the thematic scheme reported here was 78%. After this coefficient was computed, instances of disagreement were examined and resolved.

All statements related to religion, church, or the Lord were compiled for this analysis. A statement is a phrase that expresses one idea, and usually consisted of one sentence, rarely including more than three. Statements were identified then reviewed using an iterative process that involved the development and refining of fourteen thematic categories related to either religious beliefs or religious participation.

Findings

Thirty-four respondents discussed their religious experiences in the course of the life history interview. Their references to religion ranged from brief sentences to extended discussion. This group was comparable to the overall sample with respect to ethnicity, age, income, marital status, housing, and mental health. Most (56%) were women of color. Fourteen (41%) were African-American, three (9%) were Hispanic, one (3%) was Native American, and one was Asian. The remaining 14 (41%) were non-Hispanic Caucasians. The group ranged in age from 49 to 100 years, with a mean of 72. Most respondents who discussed religion (73%) had incomes below the federal poverty threshold, and the remainder had incomes between 100% and 150% of poverty. The vast majority (91%) were either divorced/separated (41%), widowed (34%) or single/never married (9%). Just over a third (44%) of the group owned their homes, while 38% rented, and another 10% lived in an institutional setting. Seven of the nine homeless women in the sample discussed religion. Finally, seven of the respondents who mentioned religion had identified mental health problems.

Table 1 indicates the number of respondents who made remarks in each of the thematic categories. These categories are divided into two broad areas: religious beliefs and religious participation.

Table 1

Frequency of Thematic Responses

Religious Participation			*Religious Beliefs*		
	*Respondents**			*Respondents*	
Topic	#	%	*Topic*	#	%
Public Participation					
Participation in church Activities	24	71%	Gratitude to God	32	94%
Parents' role in religious involvement	9	26%	Faith/Trust in God	20	59%
Desire to Give or Serve	6	18%	Identity and Beliefs	13	38%
Reaction to church	6	18%	Beliefs Regarding Death	8	24%
			Religious Coping	7	21%
Private Participation			The Bible	6	18%
Prayer	14	41%	Companionship	3	9%
			Sins & Forgiveness	2	6%
			Wealth & Religion	2	6%

* Number and percent of respondents do not add to 100% because most mentioned more than one of the thematic topics.

Religious Beliefs

The most common theme, mentioned by 94% of respondents, was gratitude. Respondents thanked the Lord for several things, including: **life**, "We have a lot to thank God for . . . But honey, I thanks God every day of my life for the blessings that He has given me. Because I could have been dead and gone you know." (75-year-old African-American); **good fortune**, "I thank the Lord because He has given me a life that is so good. I couldn't ask for more." (84-year-old Hispanic); **help in times of hardship**, "The Lord has been : . . wonderful to me . . . through a long time with the hardship . . . He's providin' a way." (86-year-old Caucasian); and finally, **material goods**, "But I thank God for everything anyway. I'm able to manage and able to keep some bread to eat." (69-year-old African-American).

More than half (59%) of the respondents expressed their faith in the Lord and their confidence that He will provide for them. For example, one 71-year-old Caucasian said, "I just, I just . . . trust in God; He makes a way somehow or another, He makes a way. He just makes a way." Another 79-year-old African-American said,

> "I don't care how tight it's gonna be, there's a bright light comin. It's gonna get better. And if I ain't got food, honey if I don't have food . . . I'm goin' in that kitchen anyway and I'm gonna fix a place. I'm gonna get a plate. I'm gonna get a spoon. I'm gonna sit down. I'm gonna say, 'Now, Jesus you know . . . I done did what I do (you should make the first step). I done put the plate here and here the spoon be. Now you provide the food.' And I believe somebody is gonna knock on that door and bring me a loaf of bread. Praise the Lord."

This faith was sometimes instilled by parents. One 67-year-old Caucasian woman was raised in severe poverty. Her family subsisted on corn meal for weeks at a time and she vividly remembers a time when even that was almost gone. When she told her mother there was not enough for the next day her mother said, " . . . you have to trust in the Lord. She said, 'You love Him don't you?' and I said, 'Yes.' I didn't know who He was at the time, but she said, 'yes.' so I said 'yes.' She said, 'Just have faith. He's not gonna let you kids get hungry.' " And as it turned out, a family member arrived the next day with food for the family. Throughout

her life review this respondent cited numerous occasions when she placed herself in the Lord's hands. Once, for example, she had been evicted and was in search of shelter from a Chicago winter. "Oh boy, I says, 'Lord here I go.' I says, 'You've got to send me in the right direction . . . I've got faith to move this whole building.' " Another 60-year-old Caucasian woman reported that after her sister died she was afraid of the dark. Her mother said, "You say these prayers every day . . . you tell Him what you want is to get over the fear . . . And she said, 'In seven days it will be gone.' and she said, 'That's what I do; that's why I was able to take what happened to Marilyn [sister].' " The respondent's prayers were answered. "I did those prayers every night . . . before I went to sleep. And the week later, I shut off that light . . . I was alright."

Just over a third (38%) of these respondents discussed a connection between religion and their views of themselves. Most reported that they did not consider themselves poor because of their religious convictions. One 71-year-old Caucasian said, "I am rich in spiritual things. I'm rich in that kind of life." Another said, "They say I'm poor, but as for being in a church, that's helped me and it makes me feel rich. The Lord just keeps my thinking that way . . . because I'm still blessed."(63-year-old African-American). Half of the women who mentioned identity issues discussed their personal insignificance. One, a 75-year-old African-American said, "I lean and depend on Him . . . because without Him I couldn't do nothing." Another, 87-year-old Caucasian said, "If I hadn't a had the Lord in my life, what would I have done?" A 94-year-old African-American said, " . . . with Him, we can do all things. And without Him, we can't do nothing. Can't even lift our little finger up." Finally, a 75-year-old African American said, "Well there's one thing you have to do. You've got to put your trust in God, because one thing about it, we can't do nothin' about what happens."

Nearly a quarter (24%) of these respondents mentioned that religion governed their beliefs regarding death. Consistently, they reported that the idea of death neither frightened nor worried them. The response of one 97-year-old Caucasian was typical, "We got a certain amount to do here and we got to do it before we go. And when He sees cause to take me, I'm ready. I'm ready if He calls today. If He calls tomorrow, I've right on prepared myself."

Confidence in a better life after death was also widespread. One 87-year-old Caucasian said, "Listen, this little old place I've got right here is my mansion on earth . . . you know, in fact I am havin' a home in heaven when I die . . . forever." Another 76-year-old Asian woman explained that she didn't worry about dying, "I don't worry because I have . . . because I know we are all resurrected. Why should I be worried?"

Seven respondents mentioned religious beliefs that helped them cope with bereavement. The martyrdom of Jesus helped some put their own suffering in perspective. For example, one 62-year-old African-American said, "I don't mind sufferin'. I don't mind sufferin' because I'd never add up with His suffering for me and for you and for the whole entire world because He died for all of us . . ." A 94-year-old African-American reported that she attempted suicide when her spouse left her. "But the Lord wasn't ready for me. I'm very glad He wasn't." The idea that their loss is part of a larger plan was helpful to some. For example, a 76-year-old Caucasian said, "I wonder sometimes now why I'm left, but it may be because God's got more work for me to do."

Six respondents mentioned the Bible, explaining that they use it in prayer. Only two specific passages were mentioned. One was the story of Job. A 56-year-old Caucasian woman who has homeless and diagnosed with schizophrenia explained that " . . . prophets have to go through it, and so I call it a black time. It's a time where everybody's against you. You can't get no place no matter what you do. And I think this is it [for me]." Another biblical reference related to forgiveness. As related by a 94-year-old African-American, "the 37th Psalm says, fret not yourself because of evil or be envious. If somebody mistreats you or treats you wrong, you treat them good. You see, you can't do that by yourself. You have to ask the Lord to help you . . . and then you can do good for that person who has mistreated you with a clean heart."

Other less common themes included the notion that the Lord provides comfort through companionship. Three women were comforted by His constant presence. Two women mentioned the importance of forgiveness. One told an especially poignant story regarding her efforts to forgive a husband who had left her, "I was fuming and blowing smoke out of my ears one day when a priest

came in and he said, 'Jan [substituted name], what is the matter?' I said, ' . . . It makes me very angry.'He said, 'You should pray for Him . . . Just do it.' Well I found there's one way to diffuse anger, because you cannot stay furious at somebody when you try to pray for them . . . Well it worked out alright I guess."

Finally, two women mentioned their beliefs abut material wealth. One 87-year-old Caucasian was asked why she thought some people were rich. She replied, "Some of them, it's handed to them on a platter I guess. And some of them work hard for it, but not all of them I don't think. I guess the Lord's blessed 'em and maybe they don't know it or don't think about it . . . You know what? If you have money and you don't trust in your heart, it could be just taken from you." Another explained that people who are rich fail to contribute money to religious causes, "That's how people get a lot of money, because they don't have knowledge enough to use it. If they use it wisely . . . you're supposed to give . . . you're supposed to give Jesus, I mean God the Father, his portion first . . ."

Religious Participation

Formal Participation

Religious participation was discussed by fewer respondents than religious beliefs. The most common theme in this area, mentioned by 71% of respondents, was their participation in church activities. In some cases this participation was extensive. For example, one 75-year-old African-American said, "I belong to the Strawberry Cove Baptist Church [substitute name] and I've been the president of the choir, the senior choir down there for 32 years. I'm also one of the . . . well I am the lead cook in the kitchen. When it come time to cook, I do that. And I'm president of the Pastor's Aid Board, and I'm still the Vice-president of the Missionary Society. So I told them some of this [load] is gonna have to come off the old lady, cause I'm gettin' too old to carry it all."

One-third (eight) of the women who discussed their religious participation mentioned barriers to church attendance. These barriers consistently related to poor health or functional limitations associated with advanced age. For example, one 86-year-old African-American woman said, "I didn't get to church Sunday

because I didn't feel well..I just had to stay here at home." One 100 year old African-American described the measures she used to overcome her mobility problems and attend church: "I walk to church every Sunday. I walk back . . . It's right up there. I've got a little grand-boy. He's 12, and another little friend of mine . . . her little boy, he is 10; so I hold both of those little boys' shoulders and I walk in between them and they pull. We walk right up the hill there. That big, old big church right on up the hill there . . ."

Just over one quarter of the women who discussed religion mentioned that their parents influenced their own religious participation. In most cases parents served as models of active church participation. As one 52-year-old Native American put it, "I enjoy goin' to church because I was raised in a Christian home and my daddy and mother carried us to church . . . they was raised in the church." One 60-year-old Caucasian remembered her father's dismay when she came home on Ash Wednesday having wiped her ashes off of her forehead, "He yelled at me and he scared me . . . he thought that I didn't get my ashes . . . he shook me. He said, 'You've got to go and get your ashes and do all of the things that you're supposed to do.' Because he thought that if I didn't, you know, that I would go to Hell . . ." But this type of recollection was not the norm. Most respondents who discussed their parents' involvement had fond or at least positive memories to recount.

Two less common topics were the desire to contribute and reactions to church attendance. Six respondents mentioned their desire to give to or to serve the church. Two found it difficult to contribute as much money as they would have liked, but the remainder described the enjoyment they derived from service. Six women also described the support they received from their churches. One 67-year-old Caucasian woman reported that her church had supported her education. Others mentioned counseling they had received from pastoral leaders. Still others simply enjoyed being there, like one 63-year-old African-American, "I have a good time at church. I have a really good friend [there]. I love people . . ."

Prayer

Fourteen (41%) of the women who discussed religion mentioned prayer. The vast majority reported that they pray for

assistance or guidance. In one typical statement, a 69-year-old African American said, "I pray and pray. I said, 'Lord, you know. Give me strength in my leg and give me strength all over my body." Others pray to be free of pain, "I ask the Lord not to let me suffer. Every night when I go to bed, 'If you're gonna take me take me in my sleep; in my own bed.' " (69-year-old African American). Others used prayer to help them make decisions or to thank the Lord. Finally, one respondent (mentioned above) used prayer to forgive a husband she felt had wronged her, and another 59-year-old Caucasian woman said, "Well I pray unto the Lord and He does let me know certain things; but it's not a communication like I used to do."

Discussion

The results of this study should be taken as suggestive rather than definitive. They offer themes and ideas that illuminate the experiences of respondents and may provide direction for future research in the area.

Religion and Well-Being

This study suggests an alternative interpretation of the well-documented association between well-being and religious participation. One third of the respondents who discussed church attendance reported that ill health or functional limitations interfered with their regular participation. This finding is consistent with that of Ainley and colleagues (1992), who suggested that the functional limitations brought on by age significantly limit church participation. So, while church attendance may be good for one's health, it is equally likely that the causal relationship goes the other way. That is, good health may facilitate regular attendance.

Religion and Adversity

Particularly striking in this group of disadvantaged women is their gratitude. Respondents appreciated life, good fortune, help in times of trouble, and material goods and saw the Lord as the source of all benefits. This sense of themselves as fortunate may assist these respondents to maintain a positive sense of themselves in the context of severe adversity (Barusch, 1997).

As Black and colleagues (1996) suggested, religion may help individuals cope with adversity by giving meaning to suffering. These respondents did not refer to the concept of redemptive suffering. But they did draw tremendous comfort from their faith that the Lord would provide for them in times of need. In some cases parents reinforced this faith by directing these women to turn to the Lord for relief. Notably, while respondents easily recalled the times the Lord did provide for them, prayers that went unanswered seem to have been forgotten.

Religion and Identity

Most women reported seeing themselves as tremendously enriched by their faith in an the all-powerful Lord. This view is in sharp contrast to some respondents' assessment of their own abilities. Religious references to identity often mentioned a sense of personal weakness or irrelevance. Is that because society (including religious institutions) has consistently and repeatedly reinforced a sense of personal powerlessness?

Marx felt that the persistence of "religion as the *illusory* happiness of the people" denied them their *"real* happiness." Yet, religious institutions offer tremendous comfort and support to their disadvantaged congregants. Within this paradox, human service professionals can work to optimize the contribution of religious organizations to the well-being of the disadvantaged, even as they reject conditions and beliefs that foster oppression. Congregations and denominations vary in their commitment to human service and social justice (Delgado, 1996; Huber, 1987). Some emphasize service, employing social workers to assist elderly congregants (i.e., Brashears & Roberts, 1996). Others, like Glide Memorial in San Francisco, offer both service and advocacy, helping disadvantaged members to overcome the sense of hopeless irrelevance.

Worldwide religious participation varies considerably, but in most settings the elderly are the mainstay of organized religion, with the highest levels of participation of any age group (McFadden, 1995). Through service and advocacy, churches around the globe can tremendously enhance the quality of life for all elders, including victims of economic and social oppression.

Notes

1. "Religion" is a muti-faceted construct, including the several factors: "religious participation" has traditionally referred to involvement in organized church activities, but participation may also include a *private* dimension with activities ranging from prayer to watching religious programs on television; "religiosity" means the intensity and nature of personal religious beliefs; finally, "religious orientation" indicates the extent to which beliefs are in accordance with a congregation. This article does not deal with the many complex issues involved in measurement of these dimensions. The interested reader should consider Neil Krause's 1993 article on the subject.
2. A third, intriguing study was reported by Edward Quinnan in 1994. He conducted life history interviews with eleven elderly men who were members of a monastic order. These illuminated several major themes of relevance to profoundly religious individuals.

References

Ainley, S. C., Singleton, R. & Swigert, V. L. (1992). Aging and religious participation: Reconsidering the effects of health. *Journal for the Scientific Study of Religion, 31(2),* 175–188.

Barusch, A. (1997). Not old or poor, but fortunate and blessed: Self concepts of low-income elderly women. *International Journal of Aging and Human Development,* in press.

Black, H. K., Rubinstein, R. L., Goodman, M., & Bower, A. R. (1996). Life as gift: Spiritual narratives of elderly African-American women. Paper presented at the Annual Meeting of The Gerontological Society of America, Washington, D.C.

Blazer, D. & Palmore, E. (1976). Religion and aging in a longitudinal panel. *The Gerontologist, 16,* 82–85.

Brashears, F. & Roberts, M. (1996). The black church as a resource for change. In Logan, S. L. (Ed.) *The Black Family: Strengths, Self-help and Positive change.* Boulder, CO: Westview, pp. 181–192.

Brewer, E. D. C. (1995). Sociological Theories. In Kimble, M. A., McFadden, S. H., Ellor, J., & Seebers, J. J. (Eds.) *Aging, Spirituality, and Religion: A Handbook.* Minneapolis: Fortress Press. 533–540.

Broyles, P. A. & Drenovsky. C. (1992). Religious attendance and the subjective health of the elderly. *Review of Religious Research, 34(2),* 152–160.

Courtenay, B. C., Poon, L. W., Martin, P., Clayton, G. M., & Johnson, M. (1992). Religiosity and adaptation in the oldest-old. *International Journal of Aging and Human Development, 34(1),* 47–56.

Dodson, J. E. (1988). Power and surrogate leadership: Black women and organized religion. *SAGE, 5(2),* 37–42.

Delgado, M. (1996). Religion as a caregiving system for Puerto Rican elders with functional disabilities. *Journal of Gerontological Social Work, 26(3–4),* 129–144.

Durkheim, E. (1947). *The Elementary Forms of Religious Life.* Glencoe, Ill: Free Press.

Edwards, J. N. & Klemmack, D. L. (1973). Correlates of life satisfaction: A re-examination. *Journal of Gerontology, 28,* 497–502.

Holt, M. K. & Dellmann-Jenkins, M. (1992). Research and implications for practice: Religion, well-being/morale, and coping behavior in later life. *Journal of Applied Gerontology, 11(1),* 101–110.

Huber, L. W. (1987). Connections: Congregational differences in the place of the church in the personal networks of elderly members. *Journal of Religion and Aging, 4(2),* 59–73.

Idler, E. L. & Kasl, S. V. (1992). Religion, disability, depression and the timing of death. *American Journal of Sociology, 97(4),* 1052–1079.

Koenig, H. B. (1995). *Research on Religion and Aging: An annotated bibliography.* Westport, CT: Greenwood Press.

Koenig, H. G., Cohen, H. J., Blazer, D. G., Pieper, C., Meador, K. G., Shelp, F., Goli, V., & DiPasquale, B. (1992). Religious coping and depression among elderly, hospitalized medically ill men. *American Journal of Psychiatry, 149(12),* 1693–1700.

Krause, N. (1993). Measuring religiosity in later life. *Research on Aging, 15(2),* 170–197.

Levin, J. S. (1994). Introduction: Religion in Aging and Health. In J. S. Levin (Ed.) *Religion in Aging and Health: Theoretical Foundations and Methodological Frontiers.* pp. xv–xxiv.

Marx, K. (1904). *A Contribution to the Critique of Political Economy.* New York: International Library.

Marx, K. (1844) Contribution to the Critique of Hegel's Philosophy of Law, Introduction. *DeutchFranzosische Jahrbucher.* Transcribed Feb. 7, 1996 for the Internet by director@marx.org.

Markides, K. S. (1983). Aging, Religiosity, and adjustment: A longitudinal analysis. *Journal of Gerontology, 38,* 621–625.

Markides, K. S. & Martin, H. W. with E. Gomez (1983). Older Mexican Americans: A study in an urban barrio. Austin: University of Texas Press.

McFadden, S. H. (1995). Religion and well-being in aging persons in an aging society. *Journal of Social Issues, 51(2),* 161–175.

Mead, G. H. (1934). *Mind, Self and Society.* Chicago: University of Chicago Press.

Morris, D. C. (1991). Church attendance, religious activities, and the life satisfaction of older adults in Middletown, U.S.A. *Journal of Religious Gerontology, 8(1),* 83–96.

Musick, M. A. (1996). Religion and subjective health among black and white elders. *Journal of Health and Social behavior, 37(3),* 221–237.

Oxman, T. E., Freeman, D. H., & Manheimer, E. D. (1995). Lack of social participation or religious strength and comfort as risk factors for death after cardiac surgery in the elderly. *Psychosomatic Medicine, 57(1),* 5–15.

Quinnan, E. J. (1994). Life narrative and spiritual journey of elderly male religious. In L. E. Thomas and S. A. Eisenhandler (Eds.) *Aging and the Religious Dimension.* Westport, CT: Augurn House.

Ruffing-Rahal, M. & Anderson, J. (1994) Factors associated with qualitative well-being in older women. *Journal of Women and Aging, 6(3)*, 3–18.

Saltz, C., Denham, T. E., & Smith, T. A. (1991). Relationship patterns and the role of religion in elderly couples with chronic illness. *Journal of Religious Gerongology, 7(3)*, 41–54.

Weber, M. (1963). *The Sociology of Religion.* Boston: Beacon Press.

Woodworth, D. L. (1985). Patterned religious meanings; Orientations expressed by a sample of elderly women. *Journal for the Scientific Study of Religion, 24(4)*, 367–383.

Confronting Ageing as a Caribbean Reality

JOAN M. RAWLINS

University of the West Indies
Medical Sciences
Trinidad, West Indies

This article acknowledges the increased life expectancy which Caribbean populations presently experience. It draws upon data collected throughout the region and identifies some of the main concerns which families, communities and governments need to address, in order to ensure that the elderly will not be severely disadvantaged as a consequence of their increased life expectancy. The article recommends closer cooperation between governmental agencies and non-government organizations (NGOs) in determining the needs of the elderly, as well as the provision of services for them.

Throughout the Caribbean, families, communities and governments are having to confront, on a daily basis, the challenges which arise as a consequence of the larger number of aged persons within their populations. By "aged" here is meant persons age 60 years and over, and the term will be used synonymously with "elderly." This article recognises that age 60 years represents a chronological figure and does not fully address social, psychological and biological aspects of ageing. For example, one might be 70 or more and be acknowledged by society as elderly, whilst displaying physical and intellectual alertness which might only have been expected in a significantly younger person.

The Caribbean, like anywhere else in the world, has always had elderly persons within its region, and—anecdotally—in any Caribbean country stories abound of persons who had lived to age 90 years and more. However, until more recent times (for example the 1950s), those older than 60 years of age would only have represented a small percentage, less than 4%, of the total population in any of the Caribbean countries (Lewis, 1997).

Journal of Sociology and Social Welfare, March, 1999, Volume XXVI, Number 1

Life expectancy only began to significantly increase in the region after the 1960s. In 1946, for example, life expectancy for men in Trinidad was 53 years, and for women was 56 years (Towards Wellness, 1994).This is not unlike the situation which has unfolded for other countries, such as Barbados and Jamaica.

The ageing of the Caribbean population has come about as a consequence of that gradual process which is commonly referred to as the demographic transition. Some of the features of the demographic transition are: (1) Significant decline in mortality, leading to an increase in population, (2) Fertility rate declines which lead to a decrease in the younger population and a trend towards an increased population of the older age group, and (3) Increased life expectancy.

Some of the changes in the Caribbean were a result of public health improvement, general upliftment in the standard of living, improved education for women, and successful family planning programmes. One of the significant end products of the interaction of these factors has been the expansion in the numbers of those counted as aged. The life expectancy data for a number of Caribbean countries are shown on Table 1.

Life expectancy, on average, is almost 70 for the men across the region and is more than 70 years in all the countries (cited in the table) for women, except for Guyana. Indeed the life expectancy for many of the countries of the Caribbean is not unlike that which exists in some of the more highly developed countries (for example, in 1997 it was 76.7 years for the U.S.,[1] and it was 77 years for the U.K.[2]).

The countries of the so called "first world," for example Holland, Sweden, and the U.K., have in large measure become reasonably comfortable with having populations over 60 years who represent as much as 12% of the total population. These countries are able to provide adequate social and health services, for the most part. Within the Caribbean, this is not as yet the case. At present, larger number of older people provide families, communities and governments with challenges for which many of the countries are not adequately prepared.

Table 1

Life Expectancy at Birth (1996–2000)

	Males	*Females*	*Total*
Anguilla	74.1	80.1	77.0
Antigua & Bahamas	71.8	76.1	73.9
Bahamas	70.5	77.1	76.4
Barbados	73.6	78.7	76.4
Belize	73.4	76.1	74.7
Dominica	74.7	80.6	77.1
Cayman Islands	75.4	78.8	77.1
Grenada	68.6	73.7	71.6
Guyana	61.1	67.9	64.4
Jamaica	72.4	76.8	74.6
Montserrat	73.9	77.4	75.6
St. Kitts & Nevis	64.2	70.4	67.2
St. Lucia	66.7	74.2	70.3
St. Vincent & the Grenadines	71.7	74.8	73.2

Source: Health Situation in the Americas Basic Indicators 1997. Pan American Health Organization. (Summarized)

Realities of the Ageing in the Caribbean

Although the realities may vary in small measure from country to country, depending on specific social, cultural and economic factors, basically most of the concerns which families and governments in the Caribbean have in relation to the elderly are similar. These concerns involve changes in family organization throughout the region including more women working outside of the home, more family members working a greater distance away from the home, and a higher incidence of divorce (which leaves elderly family members at risk, in a similar fashion to the ways in which such separation places children at risk).

Another concern in relation to specific groups of elderly in the Caribbean is the lack of planning for the re-integration of returned migrants. Retirement issues, pension-related matters, social security concerns, and—most importantly—health and health care

are all issues which must concern all who are elderly, and their families also.

Poverty among the elderly is an important issue which Caribbean societies need to confront. Some elderly persons have served their families and society all their adult working years. In their later years, they find themselves in dire straits towards the end of their lives, and some who are not home owners might become homeless.

Throughout the Caribbean, basic health care is provided by the state. However, even with the best intention, such services do not adequately meet the needs of all who require them. It is the elderly who represent a significant proportion of those seeking services.[3] Sometimes there is the need to turn to fee-for-service options, especially if there is some urgency. Unfortunately, only a small percentage of all the elderly seeking service would be able to take up this option. Ideally this should not be an option which elderly persons of lower and lower middle socio-economic situation should have to contemplate.

The survey of living conditions for Trinidad in 1997 shows that only 8.5% of the population has health insurance. Also, it has been found that 95% of the health insurance coverage was group health packages provided by employers. It is fair to surmise that the majority of the elderly, under such circumstances, would not have health insurance. Adequate health care for all, including the elderly, is an ideal which needs to be worked toward in all countries in the Caribbean region.

In relation to health, and also in relation to broader concerns, some questions need to be asked of families, communities and governments, and answers insisted upon. The questions would include the following: Are we, as a region, ready to cope with the current and future needs of our ageing population? What is being done to ensure that added life expectancy does not leave large numbers of people significantly more disadvantaged than they had been earlier? Have the various relevant sectors within the state been made aware of their responsibilities to this age group and the group's expectations of them? A closer look is needed at some of these concerns and the attempts made by family, community and government to address these concerns.

Family and the Elderly

With all of the aforementioned in mind, it should be instructive to examine the family situations in which the Caribbean elderly are most likely to find themselves. Rawlins (1996) notes that the elderly in Jamaica might find themselves in a variety of household situations. Older married couples might be living on their own, away from extended family members, after their children and grandchildren have grown. Older women who had previously lived in common-law relationships might be living alone or with grandchildren.

Eldermire (1997) notes that although most of the elderly in the region live with others, some live alone: Barbados 25.4%, Guyana 11.6%, Jamaica 16.5% and Trinidad 13.6%. Rawlins (1996) noted that elderly women, who outlive their men folk and who do not live alone, most frequently are found in the homes of their daughters. In a preliminary study in Trinidad, Rawlins (1998) locates elderly persons most frequently in the home of their daughters, when informal care is required.

However, the family situation in which the elderly spend their final days will invariably be influenced by social and cultural factors. A Trinidad study of caregivers of the elderly; which is currently in progress out of the Public Health and Primary Care, Faculty of Medical Sciences, at the University of the West Indies and in which race is a key variable; should provide interesting information on any differences found among the family situation of the older persons being studied. However, outside of the issues of class and race, the health status of the individual will influence the "care arrangements" which are made for the elderly.

The young-old (those 60–74) and those in reasonably good health are in some measure cushioned from some of the trials which beset the old-old (those 75 years and over), the sick, and the disabled. Not all elderly people are sickly, but inevitably older members of the population will experience some ill health and will require health care and/or hospitalization. For some older people, the prospect of ill health and hospitalization are the issues which haunt their lives, as they are aware of the inadequacies of the health services and the high cost of fee for health care service.

Throughout the Caribbean region, the main causes of morbidity and mortality for older people are heart disease, malignant neo-plasm, diabetes, stokes and accidents. When these conditions enter the lives of the elderly, there will be the need to access available health services. Health care, whether provided by the public or private health sector, is costly (Levitt, 1991). The governmental health sectors throughout the region tend to be overstretched in terms of human and material resources. The elderly are rarely treated as a special group and need to compete with all other age groups for necessary health services (Rawlins, 1996).

Private hospitals, private nursing homes, and private wings attached to government hospitals are available throughout the Caribbean. Elderly persons with savings, health insurance, or family members who can facilitate their use of these services, take advantage of private services where they exist. Anecdotally, some who can ill afford private care enter these facilities for limited periods, and for surgical procedures. Naturally, those without health insurance, savings or economically-enabled families will not be able to access what some perceive as "better facilities" within the private sector.

The private health sector as well as the State sector throughout the Caribbean provide institutional care for the sick elderly and the very old who need long-term care which cannot be provided by relatives. The expense of geriatric care varies from institution to institution, but most often is very costly. Where costs are less-expensive, questions are raised about standards. Less than adequate standards, in terms of natural and human resources, have been reported even in geriatric homes which are so expensive that their clientele are exclusively middle-class. A recent report in Trinidad provided confirmatory evidence.[4] Similar findings might be expected for other countries of the region. Geriatric homes throughout the region are usually supervised by the Ministry of Health, but critics comment on the low standard of care and service delivery in some of these homes which have received the Ministry's approval. The argument is that the Health Ministries throughout the region do not have the personnel to adequately supervise these geriatric facilities.

Home care by the family or by paid help within the family home remains the most common option for the care of the sick

and the very old. Rawlins (1998) notes that a daughter or spouse is the person most likely to be charged with the responsibility to care for the elderly. Similar findings have been confirmed by Eldermire (1997).

Financing the Elderly

Besides the issues of health and health care, financing for the elderly is perhaps the most serious challenge in relation to ageing in the Caribbean. Available data (Theodore, 1998) indicate that even those persons who have been most prudent in their 30s and 40s find that the previously made provisions will be inadequate. General societal inflation erodes savings, rendering sums—which in earlier decades might have been seen as adequate for the future—grossly inadequate. This is the reality even for those who had been employed from their youth right through to old age. Meantime, there are many others who make no meaningful plan for retirement and old age.[5] Rawlins (1996) showed that depending on children as a future investment was not a particularly good idea, at least in the Jamaica context, as many were unable (note, not unwilling) to live up to those expectations. Working class older women in Jamaica were more likely to see children as investments for the future, while among the middle class the following was a typical comment: "Children should never be seen as guarantee for the future as they have their own lives to live and their own responsibility" (Rawlins 1996:102). The data available for Trinidad and Jamaica show the elderly as financed by five main types of pensions: national insurance schemes, private retirement schemes, government retirement schemes, old age pension, and public welfare. Additionally, Rawlins (1996) has found relatives being mentioned as a source of income for the elderly.

Generally for the Caribbean, then, those elderly persons who had made no plans for old age will find themselves in economic difficulty. This is in spite of social security provisions which exist in all the countries of the Caribbean.

Social Security and the Elderly

The Social Security provisions throughout the region are of the type into which workers and their employers pay a contribution

during the individual's period of employment. Those beneficiaries then receive payments in the form of pensions and other financial benefits in their post-retirement or later years. What emerges from personal communications with elderly persons in Jamaica, Trinidad and St. Kitts is that although some of the benefits have been increased in recent years, recipients continue to complain about their inadequacy. But there are some elderly persons who do not benefit from major state organized programs, such as national insurance systems (NIS). These persons are, for example, mainly working class and the self employed, who had not paid into an NIS and, thus, do not benefit from such a scheme, which is contributory. However, in some Caribbean countries, public assistance (a meagre type of financial assistance) is available to persons who had not contributed to any scheme and who have no other form of income.

It has been argued by Theodore (1998) that what is required for Trinidad—and is true also for other Caribbean countries—"is not a privatized pension system with a 'devil-take-the hindmost principle' but a reform of the existing National Insurance System along the lines that several actuaries and advisors have been suggesting for years" (p. 10). Theodore is convinced that the National Insurance System has the greatest potential for equity for its contributors.

Before leaving the issue of financing the elderly, it should be noted that continued employment is desired by some of the elderly after retirement; some from choice and because they have specific skills, while others are employed out of economic necessity. Continued employment for the elderly, part-time or full-time, is an issue which Caribbean populations must confront, even while they seek to resolve unemployment problems among the younger population. This employment should not be reserved for men only. There are and will be more older women, and we are reminded by Kosberg (1998) that women are less likely to be economically viable.

Conclusion

The concerns which confront Caribbean societies in relation to ageing are numerous. The most important ones, or perhaps

the ones most frequently discussed, have been mentioned in this article. Among these are health and financial issues. These realities are influenced by reduced family size, internal and external migration, and changing societal attitudes toward the elderly resulting in prejudices against them.

The seeming lack of will for Caribbean governmental agencies to join more closely with families and communities has been noted. But despite this, there are valiant efforts by community groups and service organizations, such as Kiwanis, Soroptomists and Rotary Clubs, to rise to some part of this challenge throughout the region. A National Council on Ageing exists in Jamaica, Barbados and Dominica. In Trinidad, The Ministry of Social Development, Family Services Division, seeks to provide and coordinate special services for the elderly. Similar initiatives exist throughout the region, but the elderly population and their families complain about the inadequacies of social service-type provisions.

One particular area of special need is support to families with chronically ill elderly members, for example those suffering with Alzheimer's or other forms of dementia. This researcher has observed, in Jamaica and in Trinidad, the trials which families undergo in such cases. In this regard, there is the need for day care facilities which would cater to the needs of such elderly persons. Day care facilities, which are desperately needed in the region, could be of different types, and cater to both the fit elderly (who need to get together for recreational purposes) as well as to those who provide relief for relatives from the burdens of daily care-giving.

Another situation which is impacting upon the lives of older persons is that of HIV/AIDS. A recent report out of Barbados[6] found 8 persons between the ages of 55–60 years who were HIV positive in the first half of 1998. Similar findings are available for Trinidad.[7] Thus, HIV among the elderly in the Caribbean has become a reality. Meanwhile, AIDS deaths among younger groups is currently presenting elderly family members throughout the region with added "care" responsibilities for grandchildren, whose parents have died.

Larger number of returned migrants are now to be found throughout the region (having "come home" from countries such as the U.S. and the U.K. to which they had migrated in their

earlier years). Besides the efforts of family members, no special provisions have been made to integrate them properly into the society. Some have become disgruntled and have migrated again, taking their financial resources and human potential which could have benefitted the region. Those who remain, in illness, complain about the high cost of private health care and the inadequacies of state provisions. More thought needs to be given by family, community and state to the smooth integration of this group of people.

Governments throughout the region need to be constantly reminded that the elderly is an important sector of their constituency. Each country should have very specific policies on the elderly and have councils on ageing to provide planning and coordination of a wide range of programmes for the elderly.

Notes

1. Health Conditions of the Americas, 1997.
2. 1998 World Population Data Sheet. Population Reference Bureau. Washington D.C.
3. Eldermire 1997 reports substantial use of primary health care facilities by the elderly, being 38.2% for Guyana; 27.9% for Jamaica and 69.8% for Trinidad, of those elderly surveyed who reported visits to doctors in the 6 months prior to the interview.
4. Television Programme, entitled "Homes for the Elderly in Trinidad," reports presented after the 7:00 pm Evening News, during the March, 1997 on TV.
5. The majority of the students (Class of 1999) in a discussion (June, 1998), in the Faculty of Medical Sciences, Public Health and Primary Care Unit), argued that older people in Trinidad have very little saved for the future because of the high investments they make in their children's education. On retirement, they have little money saved and so expect the children to take care of them.
6. Newspaper report, Trinidad Express, 23 August, 1998, pg. 21.
7. Personal communications with Ms. Muriel Douglas (National AIDS Coordinator, Trinidad) on September 9, 1998 provided information about the increasing incidence of AIDS in elderly men.

References

Eldermire. (1993). An Epidemiological Survey of the Elderly in Jamaica; Ph.D. Thesis, University of the West Indies , Jamaica.

Eldermire, D. (1997). Health of the Elderly. *Health Conditions in the Caribbean*. New York: Pan American Health Organization Scientific Publication No.561, 251–263.

Kosberg, Jordan. (1998). "Changes in the Caribbean and the Impact Upon the Elderly: Implications for Social Work Education and Practice. Paper presented at the International Symposium on Social Work in the Caribbean: Variations in Practice and Education," Orlando, Florida, March 8, 1998.

Levitt, K. (1991). The Origins and Consequences of Jamaican's Debt Crisis 1970–1990. University of the West Indies, Mona, Jamaica. Consortium Graduate School of Social Sciences.

Lewis, Merle. (1998). The Caribbean Health Situation. (Set of Transparencies) CAREC, Trinidad.

Pan American Health Organization (PAHO). 1989. A Profile of the Elderly in Trinidad and Tobago. Technical paper 22, WHO.

Patrick, Angela. (1995). Spotlight on Health: Trinidad and Tobago, 1995–2004, Ministry of Health, Trinidad and Tobago, West Indies.

Rawlins, Joan. (1997). "Ageing: A Challenge for Family and Society." Paper presented at the 3rd. Conference of Caribbean and International Social Work Education, Hilton Hotel, Trinidad, July 6–10, 1997.

Rawlins, Joan. (1998). "Continuity of Care for the Chronically Ill Elderly: The Health and Social Implications for Older Care Givers." Paper presented at the Annual Caribbean Studies Association, Antigua, West Indies, May 25–29, 1998.

Theodore, Carl. (1998). "New pension arrangements for Trinidad and Tobago." *Trinidad Express*, Section 2, page 10; July 6, 1998.

Population Aging, Changes in Living Arrangement, and the New Long-term Care System in Japan

WATARU KOYANO

Health Sciences University of Hokkaido
School of Nursing and Social Services

During the last five decades, family life of the Japanese elderly and long-term care have drastically changed. As a response to the rapid population aging and the increasing difficulty of family care, a new universalistic system of long-term care services is going to be introduced in 2000. The new system, called the Insurance Against Care, acknowledges societal responsibility for long-term care, and guarantees a certain level of provision of care services. While the insurance is a response to the changes in family life of the elderly, symbolized by the decrease of co-residence with adult children, it may further stimulate and complete the changes to family life of the Japanese elderly which began in the 1960s.

Acknowledgment

The author is grateful to Prof. Nelson W. S. Chow, University of Hong Kong, and Prof. Mallory Fromm, Meiji University, for their professional advice.

Introduction

Rapid population aging is one of the most salient social changes in today's Japan. Mass media repeatedly report the seriousness of population aging and the burden of long-term care. Further, today's Japanese are rather knowledgeable about the problems of an aged society and life in old age, and thus are anxious about their own and/or their parents' old age. An opinion poll conducted by the Prime Minister's Office in 1993 revealed

that 89.3% of the Japanese, ranging in age from 30 to 59 years, felt some anxiety about their lives in old age; the most frequently mentioned anxiety being the deterioration of health and care in old age (Prime Minister's Office, 1993).

During the last 50 years, Japan has experienced drastic social changes. She rose up from the ruins of a world war and achieved remarkable economic growth. However, economic growth was not the only change that Japan experienced, though it made possible and facilitated other social changes covering almost all facets of life and thought. Due to these changes, the lives of today's Japanese are more Westernized than in the past. Family life of the elderly and long-term care of the disabled elderly have also changed, and are changing.

The traditional living arrangement of the Japanese elderly was the patri-lineal, patri-local stem family. Typically, co-resident family members provided every kind of support. Even if the elderly were completely dependent, their lives seemed secure because co-resident family members were to be "protective" (Hashimoto, 1996). However, long-term family care of the disabled elderly has become more and more difficult through, for example, the reduced number of children and household members, reduced percentages of the self-employed and farmers, higher geographical mobility, the increased labor force participation of women, the aging of caregivers, the extended duration of care, and the increased financial cost of caregiving. Reflecting the difficulty of family care, people's attitudes toward family care has been changing rapidly (see, for example, Elliott & Campbell, 1993).

As a response to the aging population and the increasing difficulty of family care, a completely new system of long-term care services is going to be introduced in the 2000 fiscal year (starting in April, 2000). In this article, the author briefly describes the population aging, changes in the living arrangement of the elderly, and the new system of long-term care and its possible further effects on changes to family.

Population Aging

Population aging started relatively late in Japan. In 1950, Japan was the least aged among today's developed nations: the

percentage of people aged 65 years and older in the total population was only 5.0% in Japan while it was more than 10 % in France, Sweden, and U.K. However, in Japan, the percentage has been more rapidly increasing: it reached 7.0% in 1970, 14.6% in 1995, and is projected to increase continuously. Because of her rapid population aging, Japan will be the most aged among developed nations in the early 21st century.

The rapid population aging has been brought about by the population transition which occurred in the latter half of this century. During the five decades after World War II, the death rate decreased from 1.46 in 1947 to 0.73 in 1997; total fertility rate has declined from 4.54 to 1.39; and the life expectancy at birth has risen 1.5 times, and marked the longest life expectancy in the world (in 1997, 77.19 years for men and 83.82 years for women). These statistics clearly indicate that Japan has completed the population transition within a very short period. Further, the baby boom after the war, which simultaneously occurred with the population transition, accelerates the population aging. When baby boomers enter the aged population, the aging of the Japanese population will reach its peak.

While population aging in Japan may possibly cause several social changes, long-term care of the disabled elderly is generally regarded as the most important issue of the aged society, and the core of societal preparation for the aging of the population is considered to be the expansion of provision of long-term care services. During the last five decades, the percentage of people aged 75 years and older has grown five times and is expected to increase rapidly both in actual number and proportion: for a 30-year period from 1995, the population aged 75 years and older is projected to increase from 5.7% to 15.2%, or 7.2 million to 18.5 million (National Institute of Population and Social Security Research, 1996). The projected increase of people aged 75 years and older implies an increase of the disabled elderly. The Ministry of Health and Welfare (1997) reported that the number of bed-ridden elderly (including those with dementia) would increase from 900 thousand to 2.3 million, and that of demented would rise from 100 thousand to 400 thousand, within the next 30 years.

"Weakening" of Family Support

During the five decades since the war, the family life of the Japanese elderly has drastically changed. Before the end of the war, life in old age was typically found for a retired household head who had already transferred the headship to his eldest son, wife, or widow of the household head. The elderly person lived with the successor's nuclear family within the same household, and was given every kind of support by the successor, his wife, and children. For the successor, co-residing and sharing all assets with elderly parents were legal, as well as moral, obligations. Gratitude and respect, rather than intimacy or affection, were to be attached to the instrumental support, because providing support to elderly parents was an actualization of filial piety.

Filial piety was regarded as an extremely important moral virtue corresponding to the infinite grace of parents including the grace of bearing, nurturing, and allowing marriage. The norm of filial piety was propagated by the Imperial Japanese Government in combination with loyalty to the Emperor. Ideally, only family and nation were regarded as "formal" organizations, and the nation was conceptualized as a big family, consisting of real families, headed by the Emperor. Thus, filial piety and loyalty to the Emperor were tightly interwoven in the Imperial Japanese ideology.

After the war, as a part of the democratization of Japanese society, the concept of family was completely changed: co-residence with elderly parents was no longer a legal obligation of children, and filial piety has never been taught in classrooms, at least in its original and extreme form of pre-war Japan. Nevertheless, the percentage of the elderly co-residing with adult children was very high (over 85%) for 20 years after the war. It was in the 1960s when the percentage started to decrease. During a 35-year period from 1960, the frequency of co-residence decreased from 86.8% to 55.9%, while that of living alone and living only with spouse increased from 3.8% to 12.0% and from 7.0% to 27.8%, respectively. The percentage of co-residence is generally lower in urban areas, among employees, and younger generations, and is expected to decrease further.

The decrease of co-residence is usually taken seriously as reflecting the weakening of family care. Generally, co-resident family members are the most dependable source of social support (Koyano, Fukawa, Shibata, & Gunji, 1994). Especially, for instrumental support, including long-term caregiving, co-resident family members are almost the only dependable source of support. For the elderly needing care, co-residence with children is still the only way to sustain their lives by obtaining necessary support from family members. A large-scale survey conducted by the Metropolitan Tokyo Government in 1995 found that 88.4% of the disabled elderly were cared for by co-resident family members, and the remaining 5.1% by children or relatives living apart; 31.5% of principal caregivers were wives, 23.0% were daughters, and 22.1% were daughters-in-law (Metropolitan Tokyo, 1996).

Introduction of a New System

Responding to the increase of the disabled elderly, the decrease of co-residence, and increasing difficulties of family care, the Ministry of Health and Welfare has proposed new long-term care policies almost every year (see, for example, Adachi, Lubben, & Tsukada, 1996), and finally proposed establishing a new compulsory social insurance named "Insurance Against Care" (IAC) in 1996. The bill was approved by the Diet in December, 1997, and the law will come into force in April, 2000.

IAC will create drastic changes to the long-term care of the disabled elderly in Japan, because care services under the IAC system are completely different from traditional services. The outlines of IAC are as follows:

The insurance covers 90% of the cost of long-term care services provided either in community (home-help, day care, visiting nursing, etc.) or institution (nursing home, long-term care hospital, etc.).

The insurer is the municipality. The insured are all residents aged 40 years or older (including those who are institutionalized) and are divided into two categories: those aged 65 years or older (Category 1) and those who are 40 to 64 years old (Category 2). For the Category 1 insured, long-term care services are covered by IAC irrespective of the cause of disability. However, for the Category 2 insured, services are covered only if his or her disability

is caused by "geriatric disorders" (such as cerebrovascular stroke or Alzheimer's disease).

The insured needing long-term care services should apply to the insurer (municipality) for assessment of eligibility. If the insured is judged eligible, based on the severity of disability, the person will be assigned to one of six ranks; for each rank, an upper limit of reimbursement is defined. After the assessment, the individual can purchase necessary services by paying 10% of the cost, up to the upper limit of reimbursement of his/her rank. The user can select the kind, amount, and provider(s) of services; the provider may be a private company, non-profit organization, municipality, or any combination. Care management services are available, without any fee, for all eligible persons. If the elderly wish to pay 100% of the cost, they can purchase additional services which exceed the upper limit of reimbursement.

While the insurance acknowledges the societal responsibility for long-term care of the disabled elderly, and guarantees a certain level of provision of care services, care services for the disabled elderly have long been provided mainly in the system of welfare services defined by the Law for the Welfare of the Elderly enacted in 1963. Although they have been gradually weakened during the past 35 years, welfare services for the elderly are selectivistic in nature; long-term care services are provided only for a limited number of the disabled elderly who are regarded as eligible by governmental agencies, while the vast majority of the disabled elderly are cared for informally by family members. Further, even for the users of care services, services provided in the community are far less than sufficient to sustain their lives without additional family care.

Almost all care services under the traditional welfare service system are publicly funded, and users do not need to pay any costs at all, or pay only a very small portion of the cost of services. Some people, especially those who are old and live in rural areas, may feel stigmatized by using care services under the welfare service system.

These characteristics of traditional long-term care services might be related to the historical background of the Law for the Welfare of the Elderly. Like other fields of welfare services, care services for the elderly under the law were developed from public

assistance. Considerable numbers of the disabled elderly and their families prefer to use institutional care provided as medical services (such as those provided by long-term care hospitals), because of the sense of stigmatization and/or the shortage of provision of welfare services. However, the long-term care services provided as medical services are generally much too costly for the funds of the national health insurance. Very few people use long-term care services provided by private companies because only a few people can afford such expensive services.

In order to introduce the IAC system smoothly, preparations are being vigorously carried out by each municipality. However, many difficulties are expected; most of them seem rooted in large discrepancies between the IAC system and the tradition of long-term care services as welfare services. For example:

Shortage of service provision: The introduction of IAC may cause a tremendous increase in demand for long-term care services because the use of services is a right of the insured corresponding to their insurance premiums. Major providers of services in the traditional welfare service system (i.e., municipalities and public organizations supported by municipalities) seem incapable of meeting the increased demands for care services. Further, in the IAC system, private companies are assumed to take major roles in the provision of services. However, they are still insufficiently developed because the demands for their services have been very few under the traditional welfare service system.

Regional differences in provision: The provision of services by private companies seems especially difficult in depopulated rural areas. In such areas, demands for services are fewer, residents are poorer, and the cost of service delivery is much higher than in over-populated urban areas. Naturally, companies may hesitate to extend their business into rural areas.

People's attitudes toward expense: Under the traditional welfare service system, users of long-term care services have not been expected to pay for the services. This "tradition" seems to carry with it the concept that care services for the disabled elderly are (or should be) free of expense. Also, this notion may obstruct service use, because each care service has a price, and the users must pay 10% of the cost of their services under the IAC system. Further, people are likely to estimate the costs of care services

as unrealistically low (Dia Foundation for Research on Aging Societies, 1998).

Differences in eligibility: Eligibility in the IAC system is exclusively defined by physical and mental functioning, while socioeconomic conditions have been largely taken into account under the traditional welfare service system. Thus, some of today's users of long-term care services might be regarded as ineligible under the IAC system. For such cases, municipalities should make special arrangements.

Amount of reimbursement: The upper limit of reimbursement seems too low to obtain sufficient care services for the disabled elderly without family care. However, if the upper limit of reimbursement is raised, the insurance premium would also rise, and the insufficiency of service provision would be still greater.

Pilot Study in a Depopulated Rural Area

Pilot studies of long-term care services were conducted, in the 1997 fiscal year, in three depopulated rural areas where transition into the IAC system seemed especially difficult. In the studies, as in the IAC system, services were provided by private companies, and users were asked to pay 10% of the cost of services. Among the three study areas, the most successful results were obtained in Kurihara region, Miyagi Prefecture, an inland rural area in the northeastern part of Honshu Island. The total number of residents in three towns and one village in the Kurihara region in 1996 was 30,255, and 26.4% of them were 65 years of age or older. As in other regions in Japan, long-term care services had been provided by municipalities and/or public organizations funded by municipalities to a limited number of the disabled elderly.

A complete survey of elderly community residents in the Kurihara region was carried out in November, 1997. The response rate was 97.4% for the screening and 95.0% for the detailed surveys. Among the respondents, 522 (6.7%) were regarded as disabled in bed-ridden or semi-bed-ridden conditions. Most of them (71.8%) co-resided with children and/or grandchildren, 96.2% of principal caregivers were co-resident family members or relatives, and 65.5% had not used any long-term care services. Most of the non-users of care services (79.7%) indicated that sufficiency of family care was the main reason of their non-use.

Service provision by a private company started in February, 1998. After extensive efforts of explanation and propagation by social workers of the company and public health nurses of the municipalities, 13 cases decided to use some services by the end of the 1997 fiscal year (May 31, 1998). Compared to the general population characteristics of the disabled elderly in this region as revealed by the complete survey, the users were relatively young but severely disabled (Table 1). A common, striking feature of the users was shown in their living arrangements: eight out of 13 users did not have a co-resident child, while the majority of the disabled elderly in the Kurihara region co-resided with their children.

Although the number of service users increased to 50 by the end of August, 1998, users have not yet reached 10% of the disabled elderly living in the Kurihara region. Users were likely to be limited to the disabled elderly without co-resident children, and most of them did not purchase as many services as care managers recommended and did not pay 20,000 yen or more per month. Nevertheless, researchers, practitioners, and municipal officers were strongly impressed by the fact that they could have *many* users paying *much* money for care services, because they had anticipated more difficulties. After reviewing the cost of service delivery, they concluded that the provision of long-term care services by private companies under the IAC system could be possible even in such a depopulated rural area (Miyagi Prefecture, 1998).

Effects on Family Life of the Elderly

The results of the pilot study conducted in the Kurihara region seem to clearly indicate that it is the disabled elderly without co-resident children who have the strongest need for long-term care services and for whom the IAC system is especially beneficial. The users of care services in the Kurihara region seem to have received insufficient care because they could not obtain informal family care from co-resident adult children, and could not utilize a sufficient amount of care services under the traditional welfare service system. Therefore, they decided to use the services under the pay for care system. Although they purchased fewer services

Table 1

Characteristics of Service Users and the Disabled Elderly Population in the Kurihara Region

		Users		*Disabled Elderly in General*[a)]
Gender	Men	38.5%	(5)	33.5%
	Women	61.5	(8)	66.5
Age	65–74	15.4	(2)	21.1
	75–84	69.2	(9)	40.0
	85+	15.4	(2)	38.9
Living Arrangement	Living Alone	15.4	(2)	1.0
	Only with Spouse	46.1	(6)	10.2
	With Child(ren)	38.5	(5)	71.8
	Other	0.0	(0)	17.0
Severity of Disability [b)]	Rank 1–2 (mild)	0.0	(0)	31.5
	Rank 3–4	38.5	(5)	40.5
	Rank 5–6 (sever)	61.5	(8)	28.0
Amount of Payment (per month)	−9,999 yen	23.1	(3)	–
	−19,999 yen	53.8	(7)	–
	20,000 yen +	23.1	(3)	–
Total		100.0	(13)	100.0

Note: Figures in parentheses are number of cases.

[a)]Bed-ridden or semi-bed-ridden respondents in the complete survey of the elderly aged 65 years and over (n = 522).

[b)]For users, severity of disability was assessed by a care manager and public health nurses according to the assessment procedure of IAC. For the disabled in general, the severity was estimated by their responses to the questionnaire items.

Source: Miyagi Prefecture, *Report of the Pilot Study on Community Services in Depopulated Area.*

than recommended, the amount of money they paid seems quite high relative to their income level. Ironically, the disabled elderly without co-resident children are still rare in such depopulated rural areas as Kurihara. However, for Japanese society in general, the elderly without co-resident children are rapidly increasing.

The need for long-term care services would arise firstly from such elderly. Thus, IAC is a good means to meet the increased demands for care services in the aged society in the near future, though several problems are still remaining to be solved.

The introduction of IAC is, in a sense, a response to the changes in the family life of the elderly symbolized by the decrease of co-residence with children. At the same time, the insurance may further stimulate changes to the family. In pre-war Japan, two types of instrumental support provided by adult children were greatly stressed as the actualization of filial piety. They were financial aid and long-term care for disabled parents. For most of the elderly at that time, co-residence was not only the normatively approved way of living, but also the only possible way to sustain their lives through receiving financial aid and/or long-term care from children. Such conditions did not change for a few decades after the war. The situation started to change in the 1960s when the old age pension became effective and visible. In opinion polls, from the 1960s, the percentage of people with negative attitudes toward dependence on children in old age became higher than those with positive attitudes (Matsunari, 1991); in census data, the percentage of co-residence started to decrease.

While financial aid has been reduced in importance by the old age pension, long-term family care has long remained important and necessary. Because of the selectivism and the shortage of services under the traditional welfare service system, the vast majority of the disabled elderly have to be cared for by co-resident family members without any formal care services. This situation is widely known and causes anxiety about long-term care in old age to the average Japanese. However, the importance of family care may possibly be reduced by the introduction of IAC, as IAC acknowledges societal responsibility for long-term care of the disabled elderly. It seems possible to say that the growing reduction in the importance and necessity of instrumental support stressed in pre-war Japan would be completed by the introduction of IAC.

The anticipated necessity of family care is not the only factor leading to co-residence with adult children. However, if the IAC system can free family members from the burden of long-term care, just as the old-age pension freed adult children from

financial support for their elderly parents, the introduction of IAC may contribute to the further decrease of co-residence just as did old-age pension.

Due to the changes in family life, including those affected by the old-age pension, today's intergenerational relationships between elderly parents and their adult children are more affection-based, convenience-oriented, and free from the Confucian norms of filial piety than they used to be (see Koyano, 1996; Naoi, Okamura, & Hayashi, 1984; Sakamoto, 1996). With the enactment of IAC at the beginning of the 21st century, there may be witnessed a completion to the changes in the family life of the Japanese elderly which began in the 1960s.

References

Adachi, K., Lubben, J. E., and Tsukada, N. (1996) Expansion of formalized in-home services for Japan's aged. *Journal of Aging and Social Policy*, 8 (2/3), 147–159.

Dia Foundation for Research on Aging Societies (1998) *Survey Report on "Price of Care Services"*. Tokyo: Dia Foundation for Research on Aging Societies (written in Japanese).

Elliott, K. S. and Campbell, R. (1993) Changing ideas about family care for the elderly in Japan. *Journal of Cross-Cultural Gerontology*, 8, 119–135.

Hashimoto, A. (1966) *The Gift of Generations: Japanese and American Perspectives on Aging and the Social Contract*. NY: Cambridge University Press.

Koyano, W. (1996) Filial piety and intergenerational solidarity in Japan. *Australian Journal on Ageing*, 15, 51–56, and *Hong Kong Journal of Gerontology*, 10, 3–10, 1996 (joint issue).

Koyano, W., Hashimoto, M., Fukawa, T., Shibata, H., and Gunji, A. (1994) The social support system of the Japanese elderly. *Journal of Cross-Cultural Gerontology*, 9, 323–333.

Matsunari, M. (1991) Changes in family ideology in post-war Japan: Based on results of nation-wide public-opinion polls. *Japanese Journal of Family Sociology (Kazoku Shakaigaku Kenkyu)*, 3, 85–97 (written in Japanese with an English abstract).

Metropolitan Tokyo (1996) *Living Conditions of the Elderly: Report of the 1995 Basic Survey on Social Services*. Tokyo: Metropolitan Tokyo (written in Japanese).

Ministry of Health and Welfare (1997) *Health and Welfare White Paper 1997*. Tokyo: Gyosei, Co. Ltd. (written in Japanese).

Miyagi Prefecture (1998) *Report of the Pilot Study on Community Services in Depopulated Area*. Sendai: Miyagi Prefecture (written in Japanese).

Naoi, M., Okamura, K., and Hayashi, H. (1984) Living arrangements of old people and some comments about future change. *Social Gerontology (Shakai Ronengaku)*, 21, 3–21 (written in Japanese with an English abstract).

National Institute of Population and Social Security Research (1996) *Population Projections for Japan: 1996–2100.* Tokyo: Kosei Tokei Kyokai, Inc. (written in Japanese).

Prime Minister's Office (1993) *Report of the Opinion Poll on Images of Life in Old Age.* Tokyo: Prime Minister's Office (written in Japanese).

Sakamoto, K. (1996) Analysing the relationship between older people and their children in Japan. In V. Minichiello, N. Chappell, H. Kendig and A. Walker (eds.), *Sociology of Aging: International Perspectives,* 474–481, Melbourne: THOTH Design & Promotion.

Caregiving For and By Hispanic Elders: Perceptions of Four Generations of Women

JUANITA L. GARCIA

University of South Florida
College of Arts and Sciences

JORDAN I. KOSBERG

Florida International University
College of Urban and Public Affairs
School of Social Work

WILEY P. MANGUM

University of South Florida
College of Arts and Sciences

J. NEIL HENDERSON

University of South Florida
College of Public Health

COLLEEN CUERVO HENDERSON

Maternal/Child Health Coalition
Tampa, Florida

So as to learn about the experiences of acculturation among older Hispanic women, four generations were interviewed about their ethnic identity, perceptions of gender equity in the home, life satisfaction, and beliefs regarding family caregiving responsibilities. Findings reveal general differences between hopes for, and experiences with, gender equity and in their self-identification as a member of a minority group and their perceptions of others toward them. Differences were also found among the four age groups of Hispanic women.

Journal of Sociology and Social Welfare, March, 1999, Volume XXVI, Number 1

Introduction

Hispanic Population in the U.S. According to the 1990 Census, 6.4% of the population in the U.S. were considered to be Hispanic, and in 1995 Hispanics increased to slightly more than 10% of the U.S. population and will continue to have the highest proportion population increase among ethnic groups (U.S. Census, 1990, 1996). The Hispanic-origin population will add the largest number of people to the population in the next 50 years than all other racial or ethnic groups combined, and by the year 2050 they will constitute the largest ethnic group in the U.S. (Allinger &Causey, 1993). In Florida, earlier in the decade the proportion of Hispanics was 12.2% of all citizens in the state (Shermyon, 1990) and is slowly but steadily increasing. Indeed, they constitute the fastest growing minority in the U.S. and are expected to outnumber the Black minority by the year 2000 (Markides, 1987).

"Hispanic" actually refers to individuals of any race who have origins in a Spanish-speaking country (Crandall, 1991). The Hispanic label is frequently used to describe a subgroup of the general population. However, specific as to race, country of origin, and level of acculturation are important variables for understanding and describing various subgroups of the general population (including the aged) and particular groups as diverse as those identified as Hispanic (Burnette, 1998). The Hispanic population in the U.S. is largely made up of Mexican Americans (60%) who mainly reside in southwestern states. In addition, 14% of the Hispanic population are Puerto Ricans residing mainly in the northeastern states and 6% are Cuban residing mainly in Florida (Central and South Americans make up about 7% and "other" about 13%) (U.S. Bureau of the Census, 1990).

Hispanics may be of different races and have ties with many countries. Most Hispanics are Caucasian, but about 5% are Black, and some are carrying a heritage mixed with Arawak Indian, while others have Aztec, Mayan or Inca blood. They have ties with nations as geographically and politically disparate as Mexico, Chile, Cuba, the Caribbean Islands, Spain and Puerto Rico, to name a very few. Therefore, Hispanics are multi-racial, multinational, and—thus—multi-cultural.

Although the Hispanic population is composed of persons

from different countries, with different immigration and assimilation experiences, the role of the family appears to be common to all (Cox & Monk, 1993). In a study of Hispanics, funded by the Pan American Health Organization (PAHO), comparing Florida Hispanics in Tampa and Miami (Sheppard, Mullins, and Longino,1985), striking differences were found between the Hispanic populations living in these two areas of the state. A large number of Hispanics residing in Tampa were born in the U.S. Those born elsewhere were not recent immigrants, but had immigrated to Tampa many years ago. Immigration to the Miami area was more recent and a greater proportion of the population was foreign born.

As a whole, the Hispanic group is a young population (having a median age of 25.8 as opposed to 33.3 for the Non-Hispanics white population) and has a high birth rate. Consequently, the percentage of Hispanic elderly is relatively low: 5% of all Hispanics, as opposed to 12.4% for the total U-S. population (U.S. Bureau of the Census, 1990). The Hispanic elderly are generally in poor physical and mental health, undereducated (49% do not have a high school diploma and only 10% are college educated), almost one-quarter (23%) are living in poverty, and many have lost their family supports through the movement of their children. They have consistently been found to under-utilize formal support systems (Maldonado, 1975; Valle and Mendoza, 1978; Garcia, 1985; Torres-Gil and Negm, 1980; Garcia, et al., 1989; Lacayo, 1982). This is especially unfortunate, given research findings with regard to their higher rates of depression (Harwood, Barker, & Cantillon, in press), role strain (Cox & Monk, 1996), somatic symptoms (Escobar, Burnam, Karno, Forsythe, & Golding, 1987), and affective disorders (Kemp, Staples, & Lopez-Aqueres, 1987).

Acculturation. Hispanics are, thus, a quite heterogeneous group and a rapidly growing segment of the North American population (Krause & Goldenhar, 1992). With their increase in numbers, there has been increased interest in their process of acculturation. Vazquez, Garcia, and DeLeon (1987) state that the process of acculturation involves the changing of values, attitudes, behaviors and personality when two cultures come in contact. The work of Yancey (in Bean and Tienda, 1987) suggests that ethnicity forms

after immigration has taken place and is based upon a comparison with the dominant group. The boundaries become defined by the experience of the immigrants in the host society. Ethnic identity (with its psychological consequences and geographic boundaries) is strengthened in reaction to encountered hostility and discrimination directed to them by members of the dominant culture. It might be assumed that economically-deprived Hispanics, who face such prejudice, maintain a stronger identification with their ethnicity and minority status.

Yancey (in Bean and Tienda, 1987) maintains that even those Hispanics who have experienced positive reactions from members of the dominant society continue to maintain a "symbolic connection" to their ethnic heritage. This is manifested by their observance of traditional holidays, preparation of ethnic foods, and friendships with those with similar ethnic backgrounds. An example of this preference for ethnic-specificity is found in the work by Crawford (cited in Krause, Bennett and Van Tran, 1989) who has indicated that an overwhelming majority of older Mexican-Americans prefer to speak Spanish.

The PAHO study (Sheppard, Mullins, and Longino, 1985) had found more Hispanics in Tampa were bilingual and preferred to speak English than those residing in Miami. In general, the degree of acculturation among Hispanics residing in Tampa was significantly greater than for those residing in the Miami area. The difference in immigration patterns may account for some of these findings. Early immigrants from Cuba came to the U.S. for mainly political reasons. They tended to be wealthier, better educated and more likely to be professionals. This is in contrast to the more recent immigration by whose wishing to leave their poverty behind and seek better economic opportunities in the U.S.

One important area of inquiry, with respect to acculturation, is the changes in gender-related attitudes and behaviors. Indeed, changes in gender-related attitudes have occurred among members of the dominant culture over the past decade or two; yet, the changes occurring within the Hispanic group may be more abrupt and traumatic, due to the strength of cultural norms and the relative recency of immigration to the U.S.

The present study is an effort to learn about the experiences of acculturation from a sample of four age cohorts of Hispanic

women. These women were questioned about their behavior, role expectations, life satisfaction, and perceptions of themselves and their place in the community. This article reports on the differences and similarities in dealing with the cultural assimilation of gender-related roles, behaviors and expectations (including familial strength and supports) among four generations of Hispanic women in the Tampa Bay Area.

Methods

Sample. A sample of 89 Hispanic women aged 18 to 89 was drawn in a two-phase sequence. First, a random selection was obtained from every 20th Hispanic-sounding surname in the local phone book (Tampa Area). Second, another group of Hispanic women was obtained from an earlier study and from women known by project staff.

All respondents were contacted by trained interviewers (thus, there was no personal connection between members of the sample and the principal investigators). The sample was initially contacted by phone, so as to determine whether the women met the criterion for inclusion in the study (being a Hispanic woman) and to solicit their agreement to be interviewed within their homes. Some potential respondents, otherwise meeting the criterion, refused to have an in-home interview.

Instrument. The 136-item interview schedule, constructed for this study, was based upon the investigators' previous research with a similar target population (Garcia, et al., 1989) and current literature regarding acculturation, ethnicity, and aging.

The instrument consisted of multiple forms of inquiry: Likert-type scales, fixed-option responses, and a case-based set of fixed-response questions pertaining to a hypothetical situation. It had been pre-tested on 15 Hispanic women, 60 and older, residing in adult congregate-living facilities (Garcia, et al., 1991). On the basis of the pre-test, slight modifications were made in the content and structure of the instrument.

Interview Schedule Language. The interview schedule was developed in English, then translated into Spanish by a panel of four Hispanic professional women for whom Spanish was their

native (first) language and/or who had bilingual Spanish-English capability. Translation difficulties were considered minimal by the field interviewers whose interviewing experiences discerned no problems from idiomatic usages or lack of clarity in the interview instrument.

Respondents chose which language (English or Spanish) to use in the interview. Although most respondents were bilingual, there was a fairly even division between those who chose to complete the interview in Spanish and in English.

Project Interviewers. Three women interviewers, fluent in English and Spanish, were recruited and trained in standardized administration of the instrument. Only one of the interviewers was age-matched to the subject. The other two were in their 20s and 30s. Anecdotally, the older interviewer reported that respondents seemed very comfortable with her, whereas the younger interviewers reported smoothly-conducted interviews, but with some formal social behaviors and courtesies marking generational status and social distance. Nonetheless, all respondents were judged to be quite forthcoming in their responses. The respondents were, of course, self-selected for the final in-home interview contact. The interview completion time ranged from 40 to 60 minutes. Respondent fatigue was not a factor.

Findings Regarding the Sample of 89 Women

Demographics of the Hispanic Women

General. The sample was predominantly Catholic (78.7%) and almost one-fifth (19.1%) were Protestant. While one-fifth had a yearly income of less than $10,000, 29.2% had a yearly income of greater than $30,000. The majority of the women were married (59.6%), almost 8% had never married, 10.1% were either divorced or separated, and 22.5% were widowed. Almost 80% of the women lived in, and owned, their own home.

Education. As a group, the 89 Hispanic women were fairly well-educated. While almost one-fifth (18%) had less than a high school education, over one-quarter (28%) had a high school education, and one-third (33.7%) had at least a college degree.

Employment. It was found that over one-third (39%) of the women were employed full-time, almost one-third (32.6%) were retired, and 16.9% had never worked outside the home.

Health. The sample of Hispanic women indicated that they believed they were in fairly good health: over four-fifths (80.9%) reported good or excellent health, 17.9% reported fair health, and only 2.2% indicated that they were in poor health.

Children. A large proportion (79.8%) of the Hispanic women had living children. However, 39.3% of the women did not have a son and 41.6% had no daughter(the implications of this will be discussed).

Ethnic Background. Nine percent of the women indicated that they were of Puerto Rican background, almost one-quarter (24.7%) were of Cuban background, and the majority (52.8%) identified themselves as having Spanish ancestry.

Nativity. It was found that the largest percentage of women were born in the United States: 47.2% in Florida and 22.5% elsewhere in the States. Over ten percent (11.2%) were born in Cuba, 9% were born in Puerto Rico, and 10.1% were born in another Latin American country. The great majority of foreign born women had been in the States for a long time; only 5.6% had come within the past ten years.

Satisfactions in Life

The 89 women were questioned about their satisfaction with components of their lives. Their levels of satisfaction were high, but the relative distribution of areas of satisfaction provide insight into how they viewed their lives.

The women were most satisfied with their families (96.6% of all), friendships (95.5%), and overall lives (91%). Slightly less satisfaction was felt for running a home (89.9%), religious activities (87.6%), leisure time activities (83.1%), being a wife (83.1%), and raising children (82.0%).

Those areas in which the women were least satisfied included their occupations or major roles in life and in their spouse or lover (each 79.8%). The lowest area of satisfaction was with one's community.

Ethnic Identification

The maintenance of cultural norms of behavior (including caregiving responsibilities) necessitate some identification with the traditional culture. The Hispanic respondents were asked about their identification with their Hispanic heritage and it was found that over half (57.3%) of the women did identify themselves as Hispanic; 42.7% identified themselves as American. A much larger percentage of the women believed that the American community saw them as Hispanic (73%) and that the Hispanic community saw them as Hispanic (76.4%). It is unknown what the implications of such views are for those women who identified themselves as American.

The majority of the women felt either somewhat close (43.8%) or very close (46.1%) to the Hispanic community. Only 10% indicated that they did not at all feel close to this community. And while one-third of the women indicated that most or all of their friends were Hispanic, 39.3% indicated that friends were evenly divided between Hispanic and non-Hispanic. Slightly over one-fourth of the women (28.1%) indicated that they had few Hispanic friends.

Perceptions Regarding Gender Equity

Questions were posed to the sample of Hispanic women regarding their perception of equity between men and women in the home, at work, and in caregiving responsibilities.

Employment. It was found that 13.5% of the women did not believe that women should work outside the home. Only 39.3% of the women believed that raising children can satisfy the needs of women. And 30% of the respondents indicated their belief that the children of working women are less-well adjusted than those children of mothers who stay at home. Almost one-quarter of the women (23.6%) felt that women are less reliable in jobs outside the home.

Family Obligations. The women were asked about their perceptions regarding the sharing of responsibilities between men and women in certain areas and 94.4,% believed that such equity should exist in child care, 77.5% in housekeeping tasks, and 73% in cooking responsibilities.

The women were asked about whether or not children should always celebrate holidays with their parents and almost one-quarter (23.6%) said they should not. Yet, very high percentages of the Hispanic women felt that adult children, not formal service agencies, should care for their elderly parents that children should share their homes with elderly parents (83.1%), and that no matter how inconvenient, contact should be maintained between children and their elderly parents (97.8%).

Actual Gender Equity in Their Lives

To determine actual gender equity, the women were questioned about who undertakes certain tasks and decision-making: male or female members of the family or shared responsibilities. Table 1 shows the gender of the family members most likely to be responsible, and the percentage for whom shared responsibilities were mentioned, for each task.

Clearly, the reality of gender equity is at some odds with the ideal relationships perceived by the women. Traditional sex-specific roles were reflected between men (e.g., income earners, repairs, car maintenance) and women (e.g., cooking, child care, grocery shopping). There were some examples of changes by way of shared responsibilities (e.g., financial decisions, choosing vacations, funeral arrangements). Yet, the lack of shared responsibilities for cleaning, cooking, laundering, doing dishes, and grocery shopping would indicate that the women continued to be engaged in traditional activities.

Findings Regarding the Four Cohorts of Women

Table 2 indicates the distribution of the four age groups comprising the 89 Hispanic women who participated in the study. To assess expectations between the four generations of Hispanic women, chi-square statistics were computed by age group. Although none of the statistics was significant, there were interesting differences.

Demographic Differences Between the Four Cohorts. While it is useful to describe the overall characteristics of Hispanic women who participated in this study, the description of each of the four cohorts adds important information regarding age differences.

Table 1

Degree of Gender Equity in Various Familial Responsibilities

Responsibility	*Gender*	*% Responsible*	*Shared %*
Provides Income	Males	70.8%	18.0%
Cleans the House	Females	84.3	10.1
Cooks Meals	Females	85.4	13.5
Does Laundry	Females	87.6	10.1
Child Care Tasks	Females	57.3	21.3
Helps Child with Homework	Females	40.4	29.2
Does House Repairs	Males	57.3	13.5
Washes Car	Males	65.2	15.7
Handles Car Care	Males	76.4	6.7
Does Yard Work	Males	51.7	19.1
Makes Financial Decisions	Males	24.7	67.4
Pays Bills (Keeps Checkbook)	Females	41.6	20.2
Decides Where to Live	Males	13.5	79.8
Selects Furniture	Females	47.2	48.3
Shops for Groceries	Females	66.3	28.1
Decides to Have Children	Females	12.4	70.8
Selects Name for Children	Females	24.7	60.7
Makes Funeral Arrangements	Males	25.0	49.0
Chooses Vacations	Males	10.1	77.5

Table 2

Age Groups of Four Generations of Hispanic Women

Group	*Age Range*		*Number*	*Percentage*
1	18–39		32	36.0
2	40–59		23	25.8
3	60–75		23	25.8
4	76 and over		11	12.4
		Total	89	100.0

Table 3 vividly shows the expected inverse relationship between age cohort and income levels. While two-thirds of the oldest group of women have incomes under $5,000 a year, none have incomes of over $50,000. For the youngest group of women

Table 3

Income Levels by Age Groups for Four Generations of Hispanic Women

Age Group	*Income Less Than $5,000*	*Income More Than $50,000*
1	15.6%	53.1%
2	26.1	30.4
3	50.0	18.2
4	66.6	0.0

the opposite relationship was found; only 15.6% have incomes less than $5,000 while over half have incomes more than $50,000. In analyzing the data, the relationship between income and such variables as health, employment, and ability to afford alternatives to family care will need to be considered.

An expected inverse relationship was found between age group and proportion married: 84.4% for Group 1, 69.6% for Group 2, 40.9% for Group 3, and 8.3% for Group 4. A similar relationship was found between age group and the percentage who graduated high school and/or attended college or trade school: 100% for Group 1, 91.3% for Group 2, 68.2% for Group 3, and 41.7% for Group 4.

A rather clear difference was found between the youngest two cohorts and the oldest two cohorts in the perception of health as being either good or excellent: 96.9% for Group 1 and 91.3% for Group 2; 59.1% for Group 3 and 58.3% for Group 4. The differences were to be expected.

A somewhat surprising finding was the relationship between age cohorts and percentage who were born in Florida. The youngest two groups of cohorts were more likely to be born in Latin countries outside the U.S. (seen in Table 4).

Table 4 implies that assumptions should not be made about the relationship between chronological age and likelihood of foreign birth. Clearly, the oldest two age cohorts were born in the State within which they live in their old age. And though they might have grown up in Hispanic neighborhoods, the influence of the dominant society was constantly apparent to them. Conversely, the younger two age cohorts, who might be considered

Table 4

Place of Birth for Four Generations of Hispanic Women

Age Group	*Florida*	*Born Outside U.S.*
1	31.3%	31.3%
2	26.1	47.8
3	72.7	22.7
4	83.3	8.3

to be more likely to reflect contemporary values and behaviors regarding gender equity, would have been influenced by the traditional norms of the native country of birth (although the age at which a woman came to the U.S. is an important consideration).

The general levels of satisfaction were assessed by age cohort and are presented in Table 5. To highlight those who felt strongly about their levels of satisfaction, shown are the percentages of women who felt very satisfied with the various dimensions of their lives. Clearly, general analysis glosses over important distinctions observed between different age groups of Hispanic women.

Table 5

Percentages of Hispanic Women Reporting Being Very Satisfied, by Age Group

Dimensions	*Group 1*	*Group 2*	*Group 3*	*Group 4*
With Life	21.9	21.7	18.2	25.0
Running a Home	18.8	21.5	50.0	50.0
Being a Wife	31.3	34.8	63.2	75.0
With Spouse or Lover	34.4	47.8	45.5	58.3
Raising Children	28.1	52.2	59.1	66.7
With Occupation	9.4	17.4	36.4	41.7
With Family	62.5	43.5	63.6	50.0
With Friendships	37.5	43.5	63.6	50.0
With Leisure Time	12.5	30.4	50.0	50.0
With Religion	21.9	43.5	22.7	25.0

While there were not major differences in satisfaction with life, the older two age cohorts received more satisfaction from running a home, being a wife, raising children, occupation, friendships, and leisure-time. The youngest group was generally not as satisfied as the other three; the only appreciable distinction of the second group was their satisfaction with religion. While 22% of groups 1 and 2 were either dissatisfied or very dissatisfied with their communities, none of the women in the oldest two groups was so dissatisfied.

The Role of Women. One-third of the youngest group of women disagreed that women should work and develop careers outside the home. None of the second group, 15% of the third group, and only ten percent of the fourth group disagreed with such a contention.

In response to the statement that raising children as a full-time job cannot keep most women satisfied, 53% of the youngest group of women disagreed and felt that such a responsibility could, in fact, be satisfying. This was in contrast with 26% for the second group, 34% for the third group, and 36% for the fourth group.

In response to the statement that the children of working women are less-well adjusted than those children of women who remain at home, one-quarter of the group 1 women agreed, 17% of group 2 agreed, and 30% from group 3 agreed. More than half of the women from group 4 (55%) believed that the adjustment of children was affected by the employed status of their mothers. Similarly, it was the oldest group of women who most felt (36%) that women were less reliable on the job than were men. Each of the other three groups had less than one-quarter (22%) who agreed with such a statement.

Family Relationships. All the women from the oldest group believed that children were obliged to celebrate holidays with their elderly parents. The level for the other three groups of women were 78% for Group 2, 60% for Group 2, and 78% for Group 3. All of the oldest women believed that children should share their homes with their elderly parents. This view was shared by 91% of Group 1, 67% of Group 2, and 78% of Group 3. All the women from the youngest group felt that it should be children, and not social agencies, who should care for their parents. The level for

the three other groups of women were 87%, 78%, and 91%, in ascending age group order.

Ethnic Identity. The four groups of women were asked whether they considered themselves to be Hispanic or American. It was found that over half of the samples from Group 1 (59%), Group 2 (78%), and Group 3 (52%) considered themselves to be Hispanic.Such Hispanic identity was the case for only 18% of the oldest group of Hispanic women.

Although the oldest group was most likely to identify themselves as Americans, they (and those from Group 2) were more likely to believe that Americans saw them as Hispanic (82%), in contrast to Group 2 (66%) and Group 3 (70%). Similarly, it was the women from Group 4 who were more likely to believe that Hispanics saw them as Hispanics, compared to 78% from Group 1, and 74% from both Groups 2 and 3.

While slightly more than half of the women from Groups 2, 3, and 4 felt very close to the Hispanic community, this was true for only one-third of the women from the youngest group. About a third of the women from Groups 1, 2, and 3 indicated that most or all of their friends were Hispanic. This was true for only one-quarter of the oldest group of women. Finally, those who admitted to having few or no Hispanic friends were represented by one-third of those women from Groups 1 and 2, one-quarter of the women from Group 3, and only one-tenth of those from Group 4 (the oldest group of women).

Interpretations

In considering a "Hispanic population," it is necessary to consider their unique as well as common features. Indeed, whether young or old, the Hispanic women who participated in this study share little more than having a Spanish surname and an ability to speak Spanish. Indeed, as seen in this study, not all Hispanic women speak Spanish, or wish to speak Spanish, or see themselves as Hispanic.

General Conclusions. There seems to be a significant weakening of the marital bond. Along with the anticipated proportion of women who are widowed, this study found a surprisingly larger group of women who were divorced. Perhaps this is a reflection of

acculturation and/or living in the U.S. for lengthy periods of time. One might also project the likelihood that divorce will increase among successive cohorts of Hispanic women in the future.

Another finding from this study is that education and employment did provide the Hispanic women with a means for a more comfortable life. It is suspected that education and employment not only translate into greater economic security and good health, but might also result in a greater likelihood of acculturation and assimilation into the dominant culture (and adoption of less-traditional attitudes and expectations).

Differences Between Groups. This study found differences between the four groups of Hispanic women which beg for further research and study. The youngest group (18–39) held some traditional views. They were more likely to believe that women should not work outside the home. They were more likely to believe that child-rearing can satisfy women. They all felt that children, rather than formal agencies, should provide care for elderly parents. And they were less-likely to feel very close to the Hispanic community. It is not known whether their views are reflections of the fact that they have not, as yet, faced the challenges resulting from having elderly parents or as a result of their maintenance of traditional norms for familial caregiving responsibilities.

Group 2, those women between the ages of 40 to 59, can be considered members of the "Sandwich Generation." All of these women believed that women should work outside the home. it was also this group of women who were more likely to feel that child rearing was not satisfying to women and were more likely to believe that the children of working women were less well-adjusted. In addition, it was this group of women who were less likely to agree that adult children had an obligation to celebrate holidays with their elderly parents. The women in Group 2, somewhat paradoxically, had the highest proportion who identified themselves as Hispanic; yet, on the other hard, were less likely to indicate that most or all of their friends were Hispanic.

An interpretation of the interesting, and somewhat conflicting, responses of this group of women is that they are truly caught

between their own needs, that of their children, and those of their elderly parents. For the women in this group, the needs of their parents are not hypothetical but are very real. These women might face economic realities of competing demands which can necessitate the need for employment outside the home. This group of women appear to be less-traditional in their views regarding women remaining in the home and in the caregiving responsibilities for children and for elderly parents.

Group 3 included women who were the young-old, ages 60 through 75. The responses of these women were not especially distinctive, in contrast with those from the other three groups. A somewhat smaller proportion of the Group 3 women, in comparison to the other three groups, believed that children, rather than social agencies, should care for elderly parents. Perhaps it is the heterogeneity of the women in Group 3 which has precluded any major tendency in perceptions and expectations of this group.

Group 4 includes the old-old, those who are between 76 and 89 years of age. Women in this group were more likely to believe that the children of working women are less-well adjusted and that women are less reliable on the job. Clearly, such views can be interpreted to be traditional (in that women should remain at home).

The elderly women in Group 4 also reflect a concern for the maintenance of family responsibility. For example, all the women believed that children have an obligation to celebrate holidays with their elderly parents and all believed that children should share their homes with their elderly parents. Over 90% of these women felt that children should care for their elderly parents, rather than having them cared for by social agencies.

The women in Group 4 were less likely to identify themselves as Hispanics, yet were more likely to believe that both the American and Hispanic communities saw them as Hispanic. Paradoxically, a greater proportion of these women felt very close to Hispanics and had a much smaller number of women who had few or no Hispanic friends. More research is needed to determine the reasons for the fact that these elderly women, as a group, do not consider themselves to be Hispanic and yet feel, and are a part of the Hispanic community (by virtue of their friendships).

Final Thoughts. Hispanic women represented in this study are a heterogeneous group. In many ways they are a "marginal group," less-likely to identify themselves within a Hispanic lifestyle, yet believe both the dominant non-Hispanic community and the Hispanic community perceive them to be Hispanic (and distinct). Thus, there may be reason for greater attention to the adjustment of these women. This attention is not only a call for continued research, but for the practice community to provide needed counseling and support services for such "marginal" individuals.

The overall purpose of this study was to determine the degree to which values and attitudes vary between different generations of Hispanic women with regards to gender-related roles and relationships. Indeed, Brody, et al. (1983) had explored perceptions and expectations between three cohorts of women from the general community, and she found that each generation had different perceptions regarding their responsibilities for children and for elderly parents. Continuation of the research reported in this article will add the dimension of Hispanic ethnicity to Brody's findings.

While such information will be interesting in-and-of itself, so too will it be related to the identification of emerging needs among this group of females. This study has documented the distinctions between groups of Hispanic women by age group and within age groups. No longer should Hispanic women (regardless of ethnic origin or chronological age) be regarded as a homogeneous group. To do so would be wrong and sustain erroneous stereotypes of Hispanic women. To do so would also result in the failure to address emerging needs and pressures being faced by Hispanic women who are in the process of change from traditional to more contemporary (and American) ways.

References

Allinger, R. L. & Causey, M. R. (1993). Home health service utilization by Hispanic elderly immigrants: A longitudinal study. *Home Health Care Services Quarterly, 14,* (2/3), 85–95.

Brody, E. M.; Johnson, P. T.; Julcomer, M. C.; and Lang, A. M. (1983). Women's changing roles and help to elderly parents: Attitudes of three generations of women. *Journal of Gerontology,* 38, 597–607.

Burnette, D. (1998). Conceptual and methodological considerations in research with non-white ethnic elders. In M. Potocky & A. Farmer (Ed.), *Social Work Research with Minority and Oppressed Populations*. 71–91. New York: The Haworth Press.

Cox, C. & Monk, A. (1993). Hispanic culture and family care of Alzheimer's patients. *Health and Social Work, 18*, (2), 92–100.

Cox, C. & Monk, A. (1996). Strain among caregivers: Comparing the experiences of African American and Hispanic caregivers of Alzheimer's relatives. *International Journal of Aging and Human Development, 43*, (2), 93–105.

Crandall, R. (1991). *Gerontology: A Behavioral Science Approach*. New York: McGraw-Hill.

Crawford, L. (1989). Quoted In Krause, N.; Van Tran, F.; and Bennett, J. (1989). Age differences in the acculturation process. *Psychology of Aging*, 3, 321–332.

Escobar, J. I., Burnam, M. A., Karno, M. Forsythe, A. & Golding, M. (1987). Somatization in the community. *Archives of General Psychiatry, 44*, 713–718.

Garcia, J. L. (1985). A needs assessment of elderly Hispanics in an inner city senior citizen complex: Implications for practice. *Journal of Applied Gerontology*, 4 (1), 72–85.

Garcia, J. L., Kosberg, J. I., Henderson, J. N., & Cuervo Henderson, C. (1991). Elderly Hispanic women in cultural transition: Implications for practice. Paper presented at the 44th Annual Scientific Meeting of the Gerontological Society of America, San Francisco, California.

Harwood, D. G., Barker, W. W., Cantillon, M., et al. (In press). Depressive symptomology in first degree family caregivers of Alzheimer's disease patients: A cross-ethnic comparison.

Kemp, B. I., Staples, F. & Lopez-Aqueres, W. (1987). Epidemiology of depression and dysphoria in an elderly Hispanic population. *Journal of The American Geriatric Society, 35*, 920–926.

Krause, N. & Goldenhar, L. M. (1992). Acculturation and psychological distress in three groups of elderly Hispanics. *Journal of Gerontology, 47*, S279–S288.

Lacayo, C. (1982). Triple jeopardy: Under-served Hispanic elders. *Generations*, 6, 25, 58.

Maldonado, D., Jr. (1975). The Chicano aged, *Social Work*, 20, 213–216.

Mangum, W. P., Garcia, J. L., Kosberg, J. I., Mullins, L. C., & Barresi, C. M. (1994). Racial/ethnic variations in informal caregiving. *Educational Gerontology, 20*, 715–731.

Markides, K. S. (1987). Hispanic Americans. In G. Maddox, (Ed.), *The Encyclopedia of Aging*. New York: Springer, 322–323.

Sheppard, H., Mullins, L., & Longino, C. (1985). Epidemiology of aging in Latin America and the Caribbean: A comparative perspective for the adoption of policies for the health care of the elderly (A survey in Tampa and Miami). Report for the National Institute on Aging.

Shermyen, A. H. (ed.) (1990). *Florida Statistical Abstract*. Gainesville, FL: The University Press of Florida.

Social Security Administration (1990). Cited in Torres-Gil, F. (1992). *The New Aging: Politics and Change in America*. New York: Auburn House.

Torres-Gil, F. and Negm, M. P. (1980). Policy issues concerning the Hispanic elderly. *Aging* (March-April), 2–5.

U.S. Bureau of the Census (1990 & 1996). Statistical Abstract of the United States. Washington, D.C.: U.S. Government Printing Office.

Valle, R. and Mendoza, L. (1978). *The Elder Latino.* San Diego, CA: Campanile Press.

Vazquez, N.; Garcia, R. I.; and DeLeon, B. (1987). Sex roles and Perceptions of femininity and masculinity of Hispanic women. *Psychology of Women Quarterly*, 11, 409–425.

Yancea, W. (1987). Quoted in Bean, D. F. and Tienda, M. *The Hispanic Population of the United States.* New York: Russell Sage Foundation.

Book Reviews

Yanick St. Jean and Joe R. Feagin, Double Burden: Black Women and Everyday Racism. Armonk, NY: M.E. Sharpe, 1998. $35.00 hardcover.

Double Burden expands the growing body of literature with African American perspectives on racism and race relations by describing the negative experiences of well educated, middle-class black women. The book primarily addresses what the authors have termed "gendered racism", but ties the discussion into the general issues of discrimination against the African American community and its impact on family life. As is characteristic of the well-known and extensive scholarship on race relations by co-author Joe Feagin, the content of this book challenges the denial of those who minimize the "continuing significance of race" and documents racial barriers which occur daily in American culture. Given some of the economic gains made by African Americans within the last thirty-five years, many would like to believe that race is no longer a problem in American society. Such social perceptions make this book particularly significant.

This work documents African American women's continued perceptions of racial discrimination with anecdotal accounts drawn from a qualitative research study involving more than 200 interviews of African American women living in various parts of the United States. Focus groups were utilized to obtain data about racist encounters of African American women and to elaborate on the "double burden" or the varied manifestations of both sex and racial discrimination in the workplace. Negative media stereotyping and issues associated with white standards of beauty as well as the longstanding stigmatization of black women in relation to sexuality and family life are also covered. Reactions based on group identity and collective memory are illuminated. Primarily, the book brings to the social science literature a sentiment about the double burden which has heretofore primarily been conversation confined to the African American community and among middle-class African American women themselves. While the book is based on qualitative research, it does not appear

to be telling the African American reader anything new. Rather, it confirms prevailing African American folklore about the dominant culture in America, about the threat of race, about white privilege, and the range of negative interpersonal and institutional encounters with white America.

The book does expand what exists in folklore beyond the African American community. No doubt, readers unfamiliar with African American folklore about race will be shocked by such intense reactions to white society. Four issues associated with isolation and exclusion which are discussed in the book are worthy of special note for readers: feelings of lack of human recognition, the personal consequences of stigmatization, the social response to single marital status, and the buffering role of the extended family.

Lack of full human recognition was described as one of the costs of discrimination. St. Jean and Feagin expand the documentation in recent field research reports about workplace discrimination against African American women by describing stereotyping about incompetence, social isolation because of being "the only one", expectations based on white images of physical appearance, being the spokesperson for the racial group and so on. Negative feelings as well as subtle and overt insensitive behavior toward African American women prevail in the workplace. Workplace humiliation, downgrading of ability and insensitive behavior and remarks are examples here. All of these behaviors on the part of whites cause undue job-related stresses which may also translate into physical symptoms. Medical research studies at Harvard University, for example, document the correlation between hypertension in blacks and discrimination. The best examples of the costs of discrimination given in the book are insensitive comments by whites associated with affirmative action.

Stigmatization and stereotyping involve negative societal images based on physical appearance, sexual behavior, media depicted images and in relation to the welfare dole. African American women are burdened with the tasks of warding off negative images by coming to grips with the fact that they may not win white society's approval. Focusing on their talents and abilities beyond these stereotypes help black women develop themselves as " complete human beings."

The discussion on the social response to single African American women who succeed in the workplace is worthy of note. Experiences of the women in the study are reminiscent of the right wing double message to women. That is, welfare mothers are viewed negatively for staying home with their children and not working while simultaneously, middle-class white women are made to feel guilty for going to work and not staying home with their children. Similarly, African American women who are single and successful are treated punitively for not being married rather than being respected and rewarded for not being on the welfare dole. Additionally, the successful black woman may be seen as symbolic of the failure of black men (and others) and this can spill over negatively into family and community life.

African American men and women alike must continue to use the extended family as a buffer. As noted by the authors, "Closeness to extended families can help black women and men absorb and counter the many damaging impacts of racial oppression." (p. 151). This African American tradition is being diminished somewhat by the American value of individualism and the focus group respondents expressed this concern. Networking among relatives and "fictive kin" provide support for African American men and women alike and serve as a buttress in the face of continued stigmatization, dehumanization, and discrimination in the workplace and other aspects of daily life.

Double Burden is a more public statement of what has been primarily expressed in closed African American circles and as such, serves to enlighten a broader population about the ever presence of negative racial occurrences in black life.

Wilma Peebles-Wilkins
Boston University

James I. Charlton, Nothing About Us Without Us: Disability, Oppression and Empowerment. Berkeley, CA: University of California Press, 1998. $27.50 hardcover

By the year 2000, approximately 850 million people worldwide will experience some degree of disability, 13% of the world population. Eighty percent of people with disabilities live in Third

The discussion on the social response to single African American women who succeed in the workplace is worthy of note. Experiences of the women in the study are reminiscent of the right wing double message to women. That is, welfare mothers are viewed negatively for staying home with their children and not working while simultaneously, middle-class white women are made to feel guilty for going to work and not staying home with their children. Similarly, African American women who are single and successful are treated punitively for not being married rather than being respected and rewarded for not being on the welfare dole. Additionally, the successful black woman may be seen as symbolic of the failure of black men (and others) and this can spill over negatively into family and community life.

African American men and women alike must continue to use the extended family as a buffer. As noted by the authors, "Closeness to extended families can help black women and men absorb and counter the many damaging impacts of racial oppression." (p. 151). This African American tradition is being diminished somewhat by the American value of individualism and the focus group respondents expressed this concern. Networking among relatives and "fictive kin" provide support for African American men and women alike and serve as a buttress in the face of continued stigmatization, dehumanization, and discrimination in the workplace and other aspects of daily life.

Double Burden is a more public statement of what has been primarily expressed in closed African American circles and as such, serves to enlighten a broader population about the ever presence of negative racial occurrences in black life.

Wilma Peebles-Wilkins
Boston University

James I. Charlton, Nothing About Us Without Us: Disability, Oppression and Empowerment. Berkeley, CA: University of California Press, 1998. $27.50 hardcover

By the year 2000, approximately 850 million people worldwide will experience some degree of disability, 13% of the world population. Eighty percent of people with disabilities live in Third

World countries. Approximately 40 million people with disabilities live in the United States. People with disabilities worldwide are the poorest of the poor, the most marginal of the marginal, the outcasts of the outcasts, the most politically powerless of the politically powerless. People with disabilities are killed by their families, institutionalized by their governments, exiled from their villages, and left to beg in the streets. People with disabilities are viewed as less than human, looked upon with pity, and offered paternalism.

Nothing about us without us . . . What does it mean? It means the disability community has had enough of being put aside and powerless. Nothing about us without us is about self-determination and the disability community making its own decisions. Nothing about us without us is about a social movement focused on liberation from systemic worldwide oppression for people with disabilities. These are the topics of James Charlton's book.

Nothing About Us Without Us is an important contribution in the analysis of the disability rights movement. The disability rights movement is a relatively new social movement. It began in the early 1970's in the United States, coming out of the social activism of the 1960's. The movement really gained momentum worldwide in the early 1980's with the United Nations declaring 1981 the International Year of Disabled Persons. Charlton describes the movement in the following manner:

> Out of the difficult and often hard realities of everyday life, organizations of people with disabilities have appeared in virtually every country in the world. Most of these organizations embrace the principles of empowerment and human rights, independence and integration, and self-help and self-determination, and these organizations form the core of the international disability rights movement (1998, p. 130).

Numerous books and articles chronicling the disability rights movement in North America have been written, but Charlton's book is unique because it offers the reader a comprehensive look at the international disability rights movement and takes the important step of placing disability rights in its broader political/economic and sociocultural context. He demonstrates how

the disability rights movement comes from a place of resistance to systematic oppression of people with disabilities worldwide.

Over the course of ten years, Charlton interviewed disability rights activists from thirteen countries in the Americas, South Africa, Asia, and Europe. He was interested in the experiences of activists and the organizations within which they worked. He was also interested in how they came to personally be involved in disability rights and how their consciousness was raised to confront the discrimination they experienced. Charlton looks at the similarities and differences in disability rights issues in numerous countries and develops a theory of disability oppression that cuts across geographical boundaries.

In the body of the text, the author outlines three dimensions of disability oppression. The first concept is the political/economic dimension that addresses how people with disabilities are marginalized economically and politically throughout the world. The second dimension is concerned with culture and belief systems that include mythological beliefs about people with disabilities, stereotyping of people with disabilities, and the pitying of people with disabilities. The third dimension explores consciousness and alienation with particular emphasis on how people with disabilities internalize their oppression and remain alienated from themselves and others. The focus of the book shifts in the last section and Charlton explores the empowerment of people with disabilities through the disability rights movement and raised consciousness. Charlton also provides a detailed history of the organizations developed in the last 25 years by people with disabilities to fight their oppression. The chapters are interesting because the author uses excerpts from his interviews with disability rights activists from around the world to support his arguments and to give examples. Their personal stories give the book more depth and they give the reader a good sense of the complex issues facing different countries. The similarities and differences worldwide are also made clearer through the excerpts.

This book is a scholarly work. The author uses a broad literature base to support his arguments. At times, this depth can be difficult for the reader because the point the author is trying to make can be lost. However, this comprehensive book is well worth reading because it provides understanding into the causes, extent,

and impact of oppression and discrimination against people with disabilities worldwide. Nothing About Us Without Us is a critical analysis of the disability rights movement. The book gives the reader a good grounding in the history of the international disability rights movement and where it is today. The author leaves the reader with many question about where the disability rights movement will go in the future. Wherever the movement goes, Charlton is clear, nothing about us without us. The future will depend upon people with disabilities determining the course of their destinies and claiming their power against formidable economic/political and sociocultural barriers.

Stephanie Brzuzy
Arizona State University

Susan D. Holloway, Bruce Fuller, Marylee F. Rambaud and Constanza Eggers-Pierola, Through my own Eyes: Single Mothers and the Cultures of Poverty. Cambridge, MA: Harvard University Press, 1998. $35.00 hardcover.

In an era of welfare reform, when poor families' lives are being transformed by large-scale public policy, it is easy to lose track of the personal stories and lived experiences of women and children in poverty. Federal and state policymakers have attempted to fashion a new approach to income support that reflects changing public sentiments about government's role in the lives of families, while also imposing obligations on adult women to look for work, find work, and exit the welfare roles promptly. How women will respond to these new requirements is as yet unknown, in part because we understand little about the struggles low income families already face coping with crushing poverty, dangerous neighborhoods, few steady work opportunities and limited child care resources. More important, we know even less about women's personal perspectives on the joys of raising young children while coping with the challenges of doing so in poverty. Through my own eyes attempts to give voice to women whose considerations on child rearing, child care, and other broad-ranging issues are too infrequently heard in the clamor of debate about welfare reform.

The book uses ethnography to capture the personal experiences and viewpoints of 14 low-income women. In doing so, the

and impact of oppression and discrimination against people with disabilities worldwide. Nothing About Us Without Us is a critical analysis of the disability rights movement. The book gives the reader a good grounding in the history of the international disability rights movement and where it is today. The author leaves the reader with many question about where the disability rights movement will go in the future. Wherever the movement goes, Charlton is clear, nothing about us without us. The future will depend upon people with disabilities determining the course of their destinies and claiming their power against formidable economic/political and sociocultural barriers.

Stephanie Brzuzy
Arizona State University

Susan D. Holloway, Bruce Fuller, Marylee F. Rambaud and Constanza Eggers-Pierola, Through my own Eyes: Single Mothers and the Cultures of Poverty. Cambridge, MA: Harvard University Press, 1998. $35.00 hardcover.

In an era of welfare reform, when poor families' lives are being transformed by large-scale public policy, it is easy to lose track of the personal stories and lived experiences of women and children in poverty. Federal and state policymakers have attempted to fashion a new approach to income support that reflects changing public sentiments about government's role in the lives of families, while also imposing obligations on adult women to look for work, find work, and exit the welfare roles promptly. How women will respond to these new requirements is as yet unknown, in part because we understand little about the struggles low income families already face coping with crushing poverty, dangerous neighborhoods, few steady work opportunities and limited child care resources. More important, we know even less about women's personal perspectives on the joys of raising young children while coping with the challenges of doing so in poverty. Through my own eyes attempts to give voice to women whose considerations on child rearing, child care, and other broad-ranging issues are too infrequently heard in the clamor of debate about welfare reform.

The book uses ethnography to capture the personal experiences and viewpoints of 14 low-income women. In doing so, the

authors follow the qualitative methods of others who have also attempted to convey life on welfare from an intensely personal experience. Other books such as, Lives on the Edge (Polokow, 1993, University of Chicago Press), Living on the Edge, (Rank, 1994, Columbia University Press), and Faces of Poverty, (Berrick, 1995, Oxford University Press), all attempt to add humanity to an otherwise colorless and faceless debate about the fate of millions of poor women and children. The authors' goal in composing Through my own eyes varies little from these previous titles. They write:

> In writing this book we are motivated by a singular aim: to ensure that mothers and their young children living at the edge of poverty will no longer be faceless strangers. This book is an invitation to get to know fourteen of these women and to learn about their lives (p. 2).

Having introduced the reader to the general framework and methods (chapters 1 & 2), the authors utilize the women's narratives and their own augmentations to describe common concerns regarding motherhood (chapter 3), children's behavior, child rearing, and discipline (chapter 4, 5 & 6), education (chapter 7) and child care (chapter 8). An additional chapter written by Bruce Johnson-Beykont, describes preschool educators' perspectives on education based on his interviews with 37 teachers. And the final chapter summarizes the implications of the authors' research for policy change, community practice, and scholarship.

The book is based upon a convenience sample of 14 low-income women with at least one child under the age of five, living in Boston, Massachusetts during the early 1990s. All of the women had used AFDC for several months at some point during their young child's life, and most were working by the time the study began. The study was conducted over a three year period and included semi-structured and unstructured in-person interviews along with women's entries in written journals.

The authors use the term "cultural models" to describe women's tacit experiences of raising their children. These models may be thought of as common sense practices, or notions of parenting largely influenced by the context of friends, kinship networks, and important others in one's community. Using this

cultural model, the authors attempt to explain parenting choices made by women in poverty—parenting choices that sometimes maximize children's well-being, and choices that are sometimes lost in the other exigencies of life on the edge. Some parents, when offered assistance and information from others outside the cultural context, may consciously form alternatives to their cultural script—developing a "declared model" of parenting that stretches beyond the confines of community context.

The authors' framework of a cultural model is best used as a descriptive tool for conveying the meaning behind poor women's choices; it is less useful as an analytic device for leveraging policy and community practice, however. The cultural model may help to explain parenting choices (even choices that are not always in children's best interests) but it leaves the reader uncertain about how public policies can help promote new models that optimize child development under extremely distressing circumstances, and how community practitioners can effectively offer alternative scripts to parents who might benefit from a different approach.

While providing very useful information about the daily practicalities of life in low-income households, and doing so within a sound theoretical framework, there is little in the way of a research base to support the authors' work. Women's eloquence in describing the struggle to be both mother and provider could have been strengthened using the body of research on role strain from the sociological literature. Throughout the volume there is little quantitative data to support the authors' fine qualitative methods. The inclusion of such an empirical backdrop would have provided an added dimension to the volume.

Nevertheless, Through my own eyes is a thoughtful book that adds to our knowledge about poverty in America. By utilizing women's voices throughout, the volume offers a rich texture of ideas that is both compelling and creative. The book is a useful addition to the field of education, social welfare, and social policy and adds special meaning to one of the most challenging issues of our time.

Jill Duerr Berrick
University of California at Berkeley

Nancy Naples (Ed.), *Community Activism and Feminist Politics*, New York: Routledge, 1998. $75.00 hardcover, $23.99 paper-cover.

Community Activism and Feminist Politics is a fascinating and impressive collection of scholarship on women's efforts to secure some measure of social and economic justice. With feminist theory as the foundation, this book sits at the intersection of research on social movements, community building, empowerment, and grassroots mobilization. Perhaps more important, the contributing authors demonstrate how to theorize across race, class and gender in integrative and dynamic ways.

The book is organized into four sections: challenging categories and frameworks, transforming politics, networking for change, and constructing community. A broad array of issues is covered—domestic violence, wage equity, labor organizing, housing, immigration rights and the environment. While all cases are set in the United States, there is remarkable diversity of populations and experiences. The reader learns of attempts to organize a Korean women's hotline, build and sustain lesbian culture, engage in school reform in an African American community, challenge toxic dumping through the actions of white working class women, fight for decent labor conditions as Latina immigrants and domestic workers, and so forth. Even though these campaigns occur on the community level, one is struck by the impact that globalization has on everyday lives.

The shared thread among these cases is that all "challenge deeply rooted patriarchal and heterosexist traditions, [and] confront the limits of democracy in the United States". Not all efforts, however, are successful; though one is amazed (and perhaps humbled) by the continuing struggles in the face of sometimes widespread adversity. It should be noted that because of the condition of including campaigns that "challenge patriarchy", mobilization by women of the New Right is absent from the book. While not suited for this collection, the organizing efforts of this population are also worthy of study. The rightwing has experienced considerable success on local, regional and national levels; gender politics, specifically the role and participation of women, has been central to these efforts.

It is obvious that this book is well suited for macro practice in social work. The many facets of grassroots social change can be quite complex and the efforts presented help in understanding the intricacies of organizing. This collection successfully challenges the traditional community organization models within social work. These accounts do not fit into neatly defined paradigms that seem to be the mainstay of many c.o. texts.

Many of the chapters are also appropriate for HBSE, policy and research. There is, for example, considerable attention paid to the development of new relationships (as women join together) and the renegotiation of others (mostly with husbands and children). Many of the struggles aim at changing policy on organizational, community or state levels. The contributors employ qualitative techniques and in doing so demonstrate the depth of insight that can come from this methodology. Virtually all are activists and scholars, thereby bringing a unique perspective to the research.

Perhaps the greatest use that this book has for social work is in its multicultural framework. Gender, race, class, sexual orientation and citizenship are woven together, not treated as separate categories. The contributors illustrate how, through these collective struggles, the various facets of culture inform, challenge, and subvert one another. Much of the research on cultural identity within social work tends to treat these dimensions as "add-ons" (first women, then women of color, etc.). This collection suggests the power of a more holistic approach, in which no one signifier is reified. This is a much more complicated, and often slippery, means of conveying and understanding multicultural identity. In the end, it provides greater depth and insight.

Despite this dovetailing with social work, there is little use of relevant social work scholarship. In fact, none of the recent work of women's community organizing is cited (social work is similarly guilty, since that research often neglects sociological research). This is more than an unfortunate lack of borrowing across disciplines. Ultimately, the lack of an interdisciplinary lens, on both sides, means a loss in fully understanding the struggles of grassroots activists.

Nonetheless, as editor, Nancy Naples should be commended for assembling this collection. It is a compelling blend of theory

and practice through a feminist lens. It demonstrates the richness of using a truly multicultural framework for analysis. This book is a testament to the hard fought struggles for justice by "everyday" women.

Cheryl Hyde
San Francisco State University

Meredith Minkler and Carroll L. Estes (eds.), *Critical Gerontology: Perspectives from Political and Moral Economy.* New York: Baywood Publishing co., 1999, $ 35.00 hardcover.

Some contemporary social science research and policy analyses seeks to explain who gets what, when, where, how, and why by examining the interdependency of social, economic, political, and cultural factors that shape policies. The emphasis on systemic factors is characteristic of various models used to analyze social policies for economically vulnerable populations, such as welfare recipients and many of the elderly. One impetus for comprehensive macro analytical frameworks in research and analysis is the growing recognition of dynamic and complex processes that form the basis of poverty for any population, including: inadequate social programs, low wages, single parenthood, mental illness, drug and alcohol addictions and abuses, discrimination, inadequate education, and other factors that contribute to marginalization. Thus, macro analytical tools are helping to reshape conceptualization of poverty by examining the characteristics of low-income individuals who are "socially excluded." While there is no single explicit definition of social exclusion, it generally refers to an individual's restricted access to employment, cash transfers and personal social services, as well as to avenues of participation in decisions about programs and policies that affect them.

Analytical frameworks, such as those concerned with issues of social exclusion, examine diverse causal factors that tend to view the concept of poverty as multidimensional. They are particularly attentive to the constantly evolving environmental factors that can prolong economic and social dependency. Recent studies on social exclusion of low-income groups in Europe, for example, use analytical methods that seek to understand social features

and practice through a feminist lens. It demonstrates the richness of using a truly multicultural framework for analysis. This book is a testament to the hard fought struggles for justice by "everyday" women.

Cheryl Hyde
San Francisco State University

Meredith Minkler and Carroll L. Estes (eds.), *Critical Gerontology: Perspectives from Political and Moral Economy.* New York: Baywood Publishing co., 1999, $ 35.00 hardcover.

Some contemporary social science research and policy analyses seeks to explain who gets what, when, where, how, and why by examining the interdependency of social, economic, political, and cultural factors that shape policies. The emphasis on systemic factors is characteristic of various models used to analyze social policies for economically vulnerable populations, such as welfare recipients and many of the elderly. One impetus for comprehensive macro analytical frameworks in research and analysis is the growing recognition of dynamic and complex processes that form the basis of poverty for any population, including: inadequate social programs, low wages, single parenthood, mental illness, drug and alcohol addictions and abuses, discrimination, inadequate education, and other factors that contribute to marginalization. Thus, macro analytical tools are helping to reshape conceptualization of poverty by examining the characteristics of low-income individuals who are "socially excluded." While there is no single explicit definition of social exclusion, it generally refers to an individual's restricted access to employment, cash transfers and personal social services, as well as to avenues of participation in decisions about programs and policies that affect them.

Analytical frameworks, such as those concerned with issues of social exclusion, examine diverse causal factors that tend to view the concept of poverty as multidimensional. They are particularly attentive to the constantly evolving environmental factors that can prolong economic and social dependency. Recent studies on social exclusion of low-income groups in Europe, for example, use analytical methods that seek to understand social features

within a systems framework that focus on the interdependence and interactive patterns among people, groups, and institutions.

This edited text makes a significant contribution to the discussion on systemic analytical models that seek to explain interdependency. It particularly builds on the notion of "critical gerontology" as an analytical approach to social gerontology that seeks not only to understand the social construct of aging, but to alter it by challenging assumptions that are often based on individual, rather than structural causes. While the text focuses on gerontology within a comprehensive and interdependent context, the theoretical basis is applicable to any population.

This text has two primary goals. One is to enhance the properties of critical gerontology as an analytical method, the foundation for which was laid by an earlier volume in 1991. The new text updates the evolution of critical gerontology by embracing a political economy perspective of complex diverse issues that impact the interaction between race, class, gender, and aging. A political economy framework is also used to better understand the administrative devolution of health and welfare policies for the elderly; the gendered nature of work, poverty, and retirement; and the myths and realities of political power of the elderly.

The second goal of the text is theory building. This entails both the discussion and the application of current uses of political economy in gerontological studies. In addition, the introduction and several subsequent chapters examine the role of using a model of moral economy to complement the political economy analytical framework. Moral economy is effectively used to examine differences in health programs cross nationally, between the United States and Canada. A moral economy framework is also used to explore differences in moral assumptions relative to fundamental decisions regarding policies and programs based on notions of social reciprocity and shared responsibility. One chapter on the moral economy of interdependence is notably illuminating on this topic.

Five topic areas are covered in the text: 1) theoretical frameworks; 2) rethinking dependence, interdependence, and the political power of the old; 3) devolution, crisis mentality, and the transformation of health and social programs for the old; 4) race, class, gender, and aging; and 5) work, retirement, social security,

and productive aging. The material covering each of these topic areas is well balanced and well presented.

One relatively minor critical observation is that nearly half of the chapters in the text are reprints from earlier works. While most of these chapters are a good fit, there is some lost cohesion in that they were not composed specifically for this book and, thus, do not necessarily adhere to an overall edited framework. For example, a chapter on women's retirement income from an adapted and updated 1995 report, while providing very useful information, deviates from the use of a political or moral economy framework.

This text is a very welcome addition to the study of gerontology and the advancement of viable macro analytical frameworks. It would be particularly useful for research and for graduate curricula both as a content and a methods text. Because of the universal applicability of the analytical models to virtually any social welfare system, its appeal is not limited to aging studies.

Martin B. Tracy
Southern Illinois University at Carbondale

Book Notes

Patricia L. Ewalt, Edith M. Freeman and Dennis L. Poole (Eds.), *Community Building: Renewal, Well-being and Shared Responsibility*. Washington DC: NASW Press, 1997. $ 37.95 papercover.

Although community organizing featured prominently in social work in the 1960s, interest in the field waned and it is only in recent years that soical workers are again emphasizing the importance of community practice. More research is being undertaken in the field and the leterature on the subject is expanding. This is creating a substantive body of knowledge which practitioners can draw on as they work with communities.

This collection of previously published articles on community practice topics reveals the extent to which community practice has become an important topic in social work. The articles, which appeared in the journal *Social Work* over the last few years, cover a diverse range of issues. Some are relatively familiar but others show the nre directions that community social work practice has taken. Traditionally, community practice has been concerned with local social service delivery or community activism. While both continue to be important elements of community social work, they have been enhanced by a new emphasis on economic development projects which address pressing material needs. This new emphasis is reflected in the inclusion of several innovative articles on community economic development. They deal with asset development, self-employment, community enterprises and urban reinvestment. The inclusion of these articles in the book shows that social workers are finally recognizing the need for linking tradtional social work practice approaches with economic development strategies.

The book also contains valuable material on the role of community participation in problems prevention and management. These articles reveal that community involvement in dealing with child abuse, youth gangs, interpersonal violence and other critical social problems enhances the effectiveness of social work intervention, and should be regarded as an integral part of any attempt to manage these problems.

This is a useful collection which should be widely consulted by all social workers irrespective of whether they are engaged in community practice or not. It shows the importance of linking community interventions with other forms of social work so that social work can respond effectively to all social needs.

James D. Smith and Ronald J. Mancoske (Eds.), *Rural Gays and Lesbians: Building on the Strengths of Communities*. New York: Haworth Press, 1998. $ 29.95 hardcover, $ 14.95 papercover.

This unique book deals with the much neglected topic of how gay people in rural communities deal with the many challenges they face, and how social workers can best assist them. It consists of eight chapters that examine different aspects of the gay experience in rural areas. It also contains three moving poems on the subject. It is the first of its kind and its simple message is an important one.

The central theme of the book is that gay people living in rural areas face a high degree of ostracism and discrimination. While all gay people are subjected to these pressures, those in urban communities have been able to organize and establish networks which sustain, protect and nurture them to a greater extent than is possible in rural areas. Rural gays and lesbians do not have networks of this kind and they often remain hidden, isolated and threatened knowing that they face significant risks if their identity is revealed. Their very location in the rural environment creates unique challenges which social workers need to understand and be willing and and able to address. The various chapters of the book either expand on this theme or provide specific examples of how social workers can work with gay people in rural areas to enhance their functioning and better cope with these challenges.

The book is often poignant showing how flagrant prejudice, discrimination and even hatred continues to permeate communities that are no longer isolated, uneducated and ill-formed. These problems are exacerbated by a lack of social services and supports in rural areas. Gay people with HIV, victims of discrimination and violence, and even those with routine emotional and social needs face particular challenges. The authors and editors of this collection deserve recognition for their attempt to bring the issue ot the attention of the wider social work community.

This is a useful collection which should be widely consulted by all social workers irrespective of whether they are engaged in community practice or not. It shows the importance of linking community interventions with other forms of social work so that social work can respond effectively to all social needs.

James D. Smith and Ronald J. Mancoske (Eds.), *Rural Gays and Lesbians: Building on the Strengths of Communities*. New York: Haworth Press, 1998. $ 29.95 hardcover, $ 14.95 papercover.

This unique book deals with the much neglected topic of how gay people in rural communities deal with the many challenges they face, and how social workers can best assist them. It consists of eight chapters that examine different aspects of the gay experience in rural areas. It also contains three moving poems on the subject. It is the first of its kind and its simple message is an important one.

The central theme of the book is that gay people living in rural areas face a high degree of ostracism and discrimination. While all gay people are subjected to these pressures, those in urban communities have been able to organize and establish networks which sustain, protect and nurture them to a greater extent than is possible in rural areas. Rural gays and lesbians do not have networks of this kind and they often remain hidden, isolated and threatened knowing that they face significant risks if their identity is revealed. Their very location in the rural environment creates unique challenges which social workers need to understand and be willing and and able to address. The various chapters of the book either expand on this theme or provide specific examples of how social workers can work with gay people in rural areas to enhance their functioning and better cope with these challenges.

The book is often poignant showing how flagrant prejudice, discrimination and even hatred continues to permeate communities that are no longer isolated, uneducated and ill-formed. These problems are exacerbated by a lack of social services and supports in rural areas. Gay people with HIV, victims of discrimination and violence, and even those with routine emotional and social needs face particular challenges. The authors and editors of this collection deserve recognition for their attempt to bring the issue ot the attention of the wider social work community.

Bennett Harrison and Marcus Weiss, *Workforce Development Networks: Community Organizations and Regional Alliances*. Thousand Oaks, CA: Sage Publications, 1998. $ 21.00 papercover.

The profound changes that have taken place in the American economy over the last two decades have significantly altered the nation's labor markets. De-industrialization, corporate acquisitions and mergers, and the challenges of globalization have permanently modified conventional patterns of work. While many workers could previously expect a lifetime of employment in skilled or semi-skilled jobs, the trend towards short term employment in smaller businesses or even in self-employment is clear. Similarly, the levels of education and skills that employers now require far exceeds previous norms. While the demand for low skilled workers remains bouyant, those in unskilled or semi-skilled occupations earn incomes far below those with higher levels of formal education.

While it is now recognized that formal educational skills, continual educational upgrading and an ability to adapt to a rapidly changing economy is a pre-requisite for success, the authors of this important book contend that education is not enough. Sizable numbers of young people do not acquire the formal education qualifications they need and, in adulthood, face a lifetime of disadvantage. Adult education can, to some extent, cater to their needs by even here, there is a need to link adult education with workforce development programs, particularly in low income urban communities where the problems of unemployment and poverty are all to visible. These programs have a vital role to play in addressing the needs of these communities, and in offering new opportunities for effective participation in the productive economy.

The book examines ten workforce development projects in cities such as San Jose, Chicago, Pittsburgh, New York and San Antonio. These projects are not only concerned with job training but with recruitment, job placement, workforce orientation, mentoring, support, and other services that ensure effective, long term labor force participation. The projects are classified and their activities are documented in some detail. In addition, the book describes the way they create and sustain community networks

that facilitate labor force participation both locally and at the regional level.

This is a useful book which provides a concise summary of a complex field. It demonstrates that community based workforce development activities can make a real difference. As more community groups organize not only to address local social needs but to enhance local economic development, the role of organizations that are specifically committed to workforce development deserve serious academic scrutiny. While the authors recognize that their case studies do not comprise a formal or systematic evaluation or workforce development programs, the book shows that community groups, planners, political leaders and even social workers have much to learn from these efforts. Since employment now dominates current welfare policy, the book is particularly relevant to social workers and others engaged in the human services.

David G. Gil, *Confronting Injustice and Oppression: Concepts and Strategies for Social Workers.* New York: Columbia University Press, 1998. $ 49.50 hardcover, $ 22.50 papercover.

Although most social workers are committed to a therapeutic role which advocates the treatment of personal and social problems through direct practice, a minority argue that the profession ought to be committed to the eradication and injustice and oppression. Although this position is not actively endorsed by many rank and file practitioners, it had been adopted by mainstream professional organizations such as the National Association of Social Workers, the International Federation of Social Workers and the Council on Social Work Education. These and other organizations have all stressed the profession's role in combating injustice and oppression.

Although this has created a paradoxical situation in which an official commitment to progressive social change is not widely supported, David Gill believes that it is possible to inspire all social workers to accept the need to confront injustice and oppression in their daily practice. It is necessary, he suggests, to demonstrate that many of the problems they deal with can be attributed to wider societal inequalities. Illustrating this argument with reference to his previous studies of child abuse, Gil points out

that facilitate labor force participation both locally and at the regional level.

This is a useful book which provides a concise summary of a complex field. It demonstrates that community based workforce development activities can make a real difference. As more community groups organize not only to address local social needs but to enhance local economic development, the role of organizations that are specifically committed to workforce development deserve serious academic scrutiny. While the authors recognize that their case studies do not comprise a formal or systematic evaluation or workforce development programs, the book shows that community groups, planners, political leaders and even social workers have much to learn from these efforts. Since employment now dominates current welfare policy, the book is particularly relevant to social workers and others engaged in the human services.

David G. Gil, *Confronting Injustice and Oppression: Concepts and Strategies for Social Workers.* New York: Columbia University Press, 1998. $ 49.50 hardcover, $ 22.50 papercover.

Although most social workers are committed to a therapeutic role which advocates the treatment of personal and social problems through direct practice, a minority argue that the profession ought to be committed to the eradication and injustice and oppression. Although this position is not actively endorsed by many rank and file practitioners, it had been adopted by mainstream professional organizations such as the National Association of Social Workers, the International Federation of Social Workers and the Council on Social Work Education. These and other organizations have all stressed the profession's role in combating injustice and oppression.

Although this has created a paradoxical situation in which an official commitment to progressive social change is not widely supported, David Gill believes that it is possible to inspire all social workers to accept the need to confront injustice and oppression in their daily practice. It is necessary, he suggests, to demonstrate that many of the problems they deal with can be attributed to wider societal inequalities. Illustrating this argument with reference to his previous studies of child abuse, Gil points out

that many of these cases are a direct consequence of poverty and deprivation. Instead of blaming abusive parents, social workers should help them to understand the wider societal etiology of the problem and use this explanation as an essential element in formulating an therapeutic response. They should also campaign for the remediation of the conditions that create abusive situations in the first place. This does not involve condoning abuse but offers a more incisive and effective means of addressing the problem.

While many will disagree with Gil's approach, his book is one of the most readable and practical statements on radical social work practice to date. Unlike many others of its genre, the book does not merely engage in critical analysis but offers tangible proposals for implementing a practice agenda that confronts social injustice and oppression. It is entirely consonant with the current emphasis on strengths based practice in social work. It does not chastise clinical social workers for neglecting social justice issues but instead shows how these can be incorporated not only community practice but in all forms of social work. Its humanistic focus is appealing and it should be widely read by both social work students and practitioners alike.

CORRESPONDING AUTHORS

Pallassana R. Balgopal, D.S.W.
Professor of Social Work
University of Illinois
Urbana, Illinois 61801

Amanda Smith Barusch
Professor
Graduate School of Social Work
University of Utah
Salt Lake City, UT 84112

Nelson W.S. Chow, Ph.D.
Professor
Department of Social Work and Social Administration
University of Hong Kong
Hong Kong

Iryna M. Dulka, M.S.W.
Research Projects Coordinator
The Centre for Applied Family Studies
School of Social Work
McGill University
3506 University Street, Suite 106
Montreal, Quebec
Canada H3A 2A7
imdulka@wilson.lan.mcgill.ca

John McCallum Ph.D.
Professor and Dean
Faculty of Health
University of West Sydney
Campbelltown, New South Wales 2560
Australia

Juanita L. Garcia, Ed.D.
Associate Professor
Department of Gerontology
College of Arts and Sciences
University of South Florida
Tampa, Florida 33620

Colleen Cuervo Henderson, M.P.A
Maternal/Child Health Coalition
Tampa, Florida

J. Neil Henderson, Ph.D.
Department of Community and Family Health
College of Public Health
University of South Florida
Tampa, Florida

Ik Ki Kim, Ph.D.
Professor
Department of Sociology
Dongguk University
Seoul, Korea

Jordan I. Kosberg, Ph.D., ACSW
Professor
School of Social Work AC1-Suite 245
Florida International University
3000 N.E. 145th Street
North Miami, Florida 33181-3600

Wiley P. Mangum, Ph.D.
Department of Gerontology
College of Arts and Sciences
University of South Florida
Tampa, Florida

Joan M. Rawlins, Ph.D.
Lecturer, Community Health Unit
Faculty of Medical Sciences
University of the West Indies
Mount Hope, Trinidad, West Indies

Wataru Koyano, DHSC
Professor of Gerontology
School of Nursing and Social Services
Health Sciences University of Hokkaido
Tobetsu-cho, Hokkaido 061-0293
JAPAN

JOURNAL OF SOCIOLOGY AND SOCIAL WELFARE
1999 PUBLICATION INFORMATION & SUBSCRIPTION RATES

Volume: XXVI
Volume Year: 1999
Publication Period: 1/99 to 12/99
Frequency of Publication: QUARTERLY
Publication Dates: MARCH, JUNE, SEPTEMBER, DECEMBER

Subscription Rates:

	RETAIL COST	COST TO SUBSCRIPTION SERVICES
1. INDIVIDUAL IN U.S.	$35	$35
2. INDIVIDUAL OUTSIDE U.S.	$40	$40
3. INSTITUTION IN U.S.	$75	$65
4. INSTITUTION OUTSIDE U.S.	$85	$75

Postage: INCLUDED IN PRICE
Currency: U.S. DOLLARS (Firm Exchange Rate Not Available)
Payment: PREPAYMENT (Must accompany order)
Effective Price Start Date: June 1996
Multiple Year Sub. Rate: NOT AVAILABLE
Cancellation Policy: NONCANCELLABLE
Claim Policy: FREE REPLACEMENT WITHIN SIX (6) MONTHS OF PUBLICATION
Back Issues: $15.00 PER ISSUE
ISSN: 0191–5096
Tax-Free Registry No.: A-154961
Federal Tax I.D. No.: 386007327
Index: INCLUDED IN ISSUE NUMBER 4 AT NO EXTRA COST

Contact Person: Frederick F. MacDonald, Ph.D.
Managing Editor
Journal of Sociology & Social Welfare
Western Michigan University
School of Social Work
Kalamazoo, MI 49008-5034 U.S.A.
Tel. – (616) 387-3191
Fax – (616) 387-3217

INSTRUCTIONS FOR AUTHORS
(Revised June, 1995)

JSSW welcomes a broad range of articles which analyze social welfare Institutions, policies, or problems from a social scientific perspective or otherwise attempt to bridge the gap between social science theory and social work practice.

Submission Process. Submit manuscripts to Robert Leighninger, School of Social Work, Louisiana Sate University, Baton Rouge, Louisiana 70803. Send *three* copies together with an abstract of approximately 100 words. Since manuscripts are not returned by reviewers to the editorial office, the editorial office cannot return them to the authors. Submission certifies that it is an original article and that it has not been published nor is being considered for publication elsewhere.

Reviewing normally takes 120 days.

Preparation. Articles should be typed, doublespaced (including the abstract, indented material, footnotes, references, and tables) on 8½ x 11 inch white bond paper with one inch margins on all sides.

Anonymous Review. To facilitate anonymous review, please keep identifying information out of the manuscript. *Only the title* should appear on the first page. Attach cover pages that contain the title, authors, affiliations, date of submission, mailing address, telephone number and any statements of credit or research support.

Style. Overall style should conform to that found in the *Publication Manual of the American Psychological Association,* Fourth Edition, 1994. Use in-text citations (Reich, 1983), (Reich, 1983, p. 5). The use of footnotes in the text is discouraged. If footnotes are essential, include them on a separate sheet after the last page of the references. The use of italics or quotation marks for emphasis is discouraged. Words should be underlined only when it is intended that they be typeset in italics.

Gender and Disability Stereotypes. Please use gender neutral phrasing. Use plural pronouns and truly generic nouns ("labor force" instead of "manpower"). When dealing with disabilities, avoid making people synonymous with the disability they have ("employees with visual impairments" rather than "the blind"). Don't magnify the disabling condition ("wheelchair user" rather than "confined to a wheelchair"). For further suggestions see the *Publication Manual of the American Psychological Association* or *Guide to Non-Sexist Language and Visuals,* University of Wisconsin-Extension.

BOOK REVIEWS

Books for review should be sent to James Midgley, Office of Research and Economic Development, Louisiana State University, Baton Rouge, LA 70803.

Western Michigan University
JOURNAL OF SOCIOLOGY AND SOCIAL WELFARE
School of Social Work
Kalamazoo, MI 49008

Non-Profit Org.
U.S.Postage Paid
Kalamazoo, MI
Permit #478