

No Place Like Home: Comprehensive approach to
Improve Aging-in-Place for Ethnocultural Minority
Older Adults in British Columbia

by

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Ethics Statement



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Abstract

This capstone explores how British Columbia's (BC) policies can be more inclusive to the values and needs of ethnocultural minority older adults (EMOAs), such as aging-in-place, home and community services, and informal caregiver support. I first illustrate the BC context by explaining the service delivery model and the changes that occurred over time. Then, my literature review synthesizes the needs and service gaps ethnocultural groups experience. Finally, my research explores innovative policy options using insights generated from international and provincial jurisdictional analysis, expert interviews, and Canadian Institute of Health Information data. Through the interviews with service providers, I unpack how implementation affects EMOAs engagement. For example, I assess how specific targeting and tailoring styles meet the preference of local ethnocultural demographic and improve service utilization. My analysis recommends provincial policies that reflect the diverse values of ethnocultural groups and create flexibility for service providers to innovate according to local demographic demands.

Keywords: ethnocultural; Chinese; South-Asian; older adults; seniors; aging-in-place, home and community care; informal caregiver; policy; intersectionality; gerontology

Dedication

I want to dedicate this capstone to my parents for their selfless love and endless support. I witnessed the immense sacrifice they had to make as immigrants, from uprooting their livelihood in Hong Kong to leaving their friends and family just so my sisters and I could have a better education.

I also want to dedicate this capstone to the “por pors” (grandmas in Chinese) I met at the Vancouver Coastal Health’s Mental Health Adult Daycare program between 2014-15. Through our weekly meetings, I got to hear the por pors' stories. Why they had to immigrate to Canada, what they did to make ends meet, and now the daily challenges they face with declining mobility, social isolation, and language barrier. Through their stories, I learned how it feels to come to Vancouver in the 1950s and the discrimination they experienced. Or how ageism and ableism make them feel forgotten or ashamed for asking for help and burdening their children. Through their stories, I truly learned how the various forms of discrimination (racism, ageism, ableism, classism, sexism) amplify at old age and how harmful it might be for one's wellbeing. Through this capstone, I hope to shine a light the issue of community service access and how policies can become more inclusive to the range of older adults in our community.

Acknowledgements

I would like to thank the interviewees and the people who introduced me to the respondents of this capstone. This project would have been impossible without their help. They set aside time, out of their busy schedule, to share what they believe aging-in-place milestones are achieved and what future opportunities are forthcoming. I am in awe by the phenomenal work my interviewees do, and their efforts in improving the lives of immigrant older adults.

I also would like to extend my gratitude to the Directors and professors of the School of Public Policy for their dedication in our learnings. Their support has been transformative and helped shape this capstone in every way.

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List of Acronyms

IADL	Instrumental activities of daily living
ADL	Activities of daily living
BH	Better At Home
BC	British Columbia
CHCA	Canadian Home Care Association
CHSRF	Canadian Health Service Research Foundation
CIHI	Canadian Institution of Health Information
EMOAs	Ethnocultural minority older adults
ER	Emergency Room
HCC	Home Community Care
HRCNS	HR Council for Nonprofit Sector
NACA	National Advisory Council on Aging
OECD	Organisation for Economic Co-operation and Development
UK	United Kingdom
WHO	World Health Organization

Glossary

Activities of Daily Living (ADL)	<p>ADLs are routine activities that people tend to do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking) and continence.</p> <p>In the BC context ADLs are funded by the health authority.</p>
Better at Home (BH)	<p>Better at Home is a provincially funded service delivered by United Way of Lower Mainland. The organization delivers non-medical home support home care services in the communities and is continually increasing its reach across the province.</p>
Health Accord	<p>The Health accord is a legal agreement between the Federal and Provincial or Territorial governments on health care funding.</p>
Home and community care (HCC)	<p>Home and community care services help people to receive care at home, rather than in a hospital or long-term care facility, and to live as independently as possible in the community. Home and community care is delivered by regulated health care professionals (e.g., nurses), non-regulated workers, volunteers, friends and family caregivers.</p>

Instrumental activities of daily living (IADL)	<p>IADLs allow individuals to live independently. Activities include: housework, preparing meals, taking medications, and managing money.</p> <p>IADL services are primarily delivered by community groups and a subset of services are under the provision of BH.</p>
Informal caregiver	Spouse, family, neighbors or friends who provide unpaid support for an older adult
Long-Term Care	Long-term care refers to a continuum of medical and social services designed to support the needs of people living with chronic health problems that affect their ability to perform everyday activities. Long-term care ranges from residential care to home nursing and home and community care services.
Older adult	An individual who is 65 and older.
Reablement	Reablement means learning or re-learning day-to-day skills needed to encourage self-confidence, support independence and promote healthy living
Racialized person	Recognizing that race is a social construct, the Ontario Human Rights Commission describes people as “racialized person” or “racialized group” as opposed to more dated and potentially derogatory terminologies like “racial minority”. “visible minority”, “person of colour” or “non-White”.

Executive Summary

Policy Problem and Research Objectives

British Columbia (BC) is undergoing a two-fold demographic shift. First the population is aging; by 2030, one in four British Columbians will be over the age of sixty-five. Second, BC is becoming increasingly diverse. In 2013, Chinese and South Asians combined accounted for almost a quarter of BC's population (Statistics Canada, 2013a), and by 2036, BC's major metropolitan city, Vancouver will become a "major minority" with more than 60% of residents from an ethnocultural minority origin (Statistics Canada, 2016).

Although BC's aging population is becoming increasingly diverse, most home and community care services continue to treat this population as a monolith. As a result, the needs of many ethnocultural minority older adults (EMOAs) are unrecognized. This study focuses specifically on South Asian and Chinese older adults in BC since they tend to have lower English proficiency, face greater challenges in accessing services, and have poorer health outcomes than their white Canadian counterparts. My policy problem is the inadequacy of non-medical home support services, and informal caregiver supports to meet the needs of EMOAs – specifically, South Asian and Chinese older adults living in BC.

The objective of this study is to explore the challenges faced by South Asian and Chinese older adults, when accessing non-medical home support services (housekeeping, grocery shopping, etc.), and how their informal caregivers could be supported. The study aims to identify potential best practices BC could implement to develop an inclusive and cost-effective aging-in-place model. The study contributes to a growing body of research regarding diversity and aging-in-place with a focus on both formal services and informal supports in the BC context.

Methodology

My research involves three parts. First, an extensive literature review outlines the barriers South Asian and Chinese older adults experience in accessing non-medical home support services and explores how institutional barriers may exacerbate their

health inequities. The literature review also describes effective engagement strategies and program features that BC could consider in designing its policy.

Second, I conducted an international and provincial jurisdictional scan to examine policies used elsewhere to address the aging demographic shift. The scan generates a list of potential policy options, and the outcomes of the policy options help inform the policy analysis of this study. Since none of the jurisdictional literature examined how the policies impact ethnocultural minorities, the interviews are used to provide insight on how the options may perform in the BC context.

Finally, I conducted eight interviews with service providers, provincial management, and advocates in this field. The informants provide insight on existing practices organizations use in closing access gaps of EMOAs, as well as feedback on specific policy options the BC government could implement to improve the equal opportunity to age-in-place.

Research Findings

The service providers who work closely with South Asian and Chinese older adults are aware of the barriers EMOAs experience, namely the lack of language proficiency, limited availability of bicultural staff, inadequate outreach, and absence of culturally-appropriate services. Although the service providers are aware of how to mitigate the identified barriers, funding constraints limit the nonprofit organization's ability to innovate and address the access gaps. The interviewees also agree that the needs of South Asian and Chinese older adults are very different, but how they could resolve the differences is less well defined in their practice.

Policy Option and Recommendation

The literature review and the findings from my research generated the four policies analyzed in this study: expand provincial funding for non-medical home-support services; implement a province-wide reablement service, devise a market choice-based approach by providing support or paying eligible older adults to purchase services; and devise a market and non-market choice-based approach by providing support or paying eligible older adults and informal caregivers.

The four options are evaluated using a set of criteria and measures informed by my research. The criteria used are equity, effectiveness, stakeholder acceptability, cost, and administrative complexity, and by systematically evaluating each option with the same measures, I can consistently assess the strengths and the trade-offs of each option.

I recommend a set of short- and long-term policies that would work in concert to address the heterogeneity of the South Asian and Chinese older adults while ensuring the sustainability of service cost. First, deinstitutionalization has developed fragmented services in the community. The first recommendation address the fragmentation of services by expanding non-medical home support funding, specifically to Better at Home (BH), to fulfill the surplus demand for non-medical home support services in the community. The funding expansion also creates an innovation fund that enable providers to revolutionize services to respond to local demographic changes.

The second issue is the lack of prevention services. This problem can be mitigated through the second recommendation, which is to implement a reablement program. Reablement could help older adults regain the confidence and practical skills to live independently. This option could improve wellness and bend the cost curve associated with the aging population.

Lastly, the prescriptive approach to providing home and community care services (HCC) imposes homogenous values on heterogeneous users. When the preferences of EMOAs deviate from those defined by the mainstream services, their needs are often unmet in the community, thus creating reliance on informal caregivers. A choice-based approach that allows older adults to purchase market and non-market services corrects this dynamic by restoring agency to the service users, enabling them to choose whether to buy services or pay their informal caregivers. The three options work in concert to create a series of services that support older adults' independence in the community while recognizing the population heterogeneity.

Chapter 1. Introduction

With advances in health care, more Canadians are living longer than ever before. By 2030, one in four Canadians will be over the age of sixty-five. A demographic shift to an older population presents a host of complex social and economic challenges (Sinha, 2013). Older adults—individuals over the age of sixty-five—represent 16% of the population, but consume nearly half (46%) of provincial health care expenditures (CIHI, 2016). One in three older adults in Canada is living with a disability (Statistics Canada, 2013c). The existing health care system is being challenged by the emergent health and social needs of the aging population.

When the Canada Health Care Act (1984) was developed, home and community care (HCC) services were not included as part of the outlined health services provinces must provide (Government of Canada, 2003). The absence of home care provision in the Act allowed provinces considerable flexibility in determining which services they wish to provide. The prevailing policies in BC are now limited to medical services and institutional care and very few HCC are funded (Cohen & Franko, 2015). This pattern is at odds with the fact that 92% of older adults are living in their homes (Statistics Canada, 2015). Gaps in the services result in many older adults who cannot perform activities of daily living (such as preparing meals or using transportation) to prematurely entering residential care (Cohen & Franko, 2015). The current use of resources is very costly; instead, research suggests that supporting aging in place through an integrated HCC services is more cost-effective (Blom et al., 2016; Henderson et al., 2014; M. Hollander, Chappell, Havens, McWilliam, & Miller, 2002; M. Hollander & Chappell, 2001; Weissert, Lesnick, Musliner, & Foley, 1997).

In response to the demands of the aging population, the Liberal Party platform in the 2015 federal election promised a new Health Accord across Canada (Liberal Party, n.d.). The Health Accord would deliver a new funding regime specifically used for improving home care services, which aligns with BC's direction in promoting "aging in

place.” The concept of aging in place is to encourage older adults to live in their homes and communities as long as possible and to support them through health and social services (Employment and Social Development Canada, 2016). In February 2017, BC reached an agreement with the federal government to transfer \$785 million to the province over the next ten years to fund home care services (Vancouver Sun, 2017). This investment provides a policy window for BC to re-examine its aging-in-place policies.

What makes BC a particularly important case study is that it is one of the most ethnically diverse provinces in Canada and the diversity is expected to continue. By 2031 Metro Vancouver will become a “majority-minority,” with over 60% of residents coming from a ethnocultural minority background (Statistics Canada, 2016). The three largest ethnocultural minority groups in BC are South Asians, Chinese, and Filipino; combined, South Asians (10%) and Chinese (13%) represents nearly a quarter of BC’s population (Statistics Canada, 2013a, 2016). Despite BC’s diversity, most HCC programs and services continue to treat the aging population as a homogenous group and leave the needs of EMOAs unrecognized (National Advisory Council on Aging [NACA], 2005). This study focuses on older South Asians and Chinese who live in BC since many lack English proficiency, face greater challenges in accessing services, and have poorer health outcomes than their white Canadian counterparts (Koehn & Badger, 2015). The newly signed Health Accord creates an opportunity to examine how aging-in-place strategies could be inclusive of BC’s heterogeneous aging population.

The key policy problem to this study is, too few non-medical home support services and informal caregiver supports are available to meet the needs of South Asian and Chinese older adults in BC. Non-medical home support services help sustain daily activities that are essential for independent living, like housekeeping, grocery shopping, and meal preparation. Since non-medical home support services provided in the community is scarce, informal caregivers—spouses, family members, friends, and/or neighbors—often have to fill the void; 70-75% of care older adults who live in the community receive support from an informal caregiver (Health Council of Canada, 2012). Other research questions that inform this study are: What are the key challenges South Asian and Chinese older adults face when they access non-medical home support services? What supports do informal caregivers want? How might provincial government

policies support the inclusion of EMOAs' needs? Although South Asians and Chinese are loosely grouped for the purpose of this policy analysis, there are important differences between and within ethnocultural minority groups. Policymakers and program planners should caution overgeneralizing the experience and needs of ethnocultural minorities, and ensure adequate consultation is conducted during the policy design and implementation phase.

The study results indicate that EMOAs, particularly those who are not English-proficient, experience an access gap. Many nonprofit organizations attempt to reach South Asian and Chinese older adults through targeted outreach strategies and pilot projects, but informants reveal that the inadequate funding limits their ability to sustain the targeted initiatives. This analysis proposes that BC should expand its funding to non-medical support services (like Better at Home) and allot funds to harness the local expertise of non-profit organizations. Another significant finding is the UK's reablement program¹ which is specialized in training or retraining older adult's daily activity skills to remain independent, delay service utilization, and contain cost (Tessier, Beaulieu, Anna McGinn, & Latulippe, 2016). The second recommendation is to implement a provincially-wide reablement aimed to close health literacy gaps of older adults and particularly favorable for South Asian and Chinese older adults. Eventually, BC should legislate a Care Act, similar to the UK's. Older adults and informal caregivers are assessed and are provided support and financial support. Through this mechanism, eligible older adults in BC can either purchase services from the market or pay their informal caregiver, if they wish to do so. Within each recommended policy, it is important to consult the South Asian and Chinese older adults or other EMOAs in the area to ensure the services are appropriate. This study does not intend to criticize the dedicated work of those who provide for the aging population; it aims to identify systemic barriers to effective use of

¹ The reablement program is one-on-one training introduced before an older adult receives services. The reablement program offers older adults practical skills training to perform personal care and daily activities independently. Through the reablement program service users are encouraged to develop the confidence and skills to carry out activities on their own, so they can live at home as long as possible

support services and suggest policy options that strengthen BC's approach to care for the South Asian and Chinese aging population and their informal caregivers.

Chapter 2. Background

Overview

This chapter provides background information for this study's policy problem. First, I describe the policy context and stakeholders involved in providing care to the community. Then I outline the rationale for investigating non-medical home support services and informal caregiver support as well as discuss why the ethnocultural minority experience should be explored. Finally, I identify the policy gaps and opportunities pertaining to this capstone study.

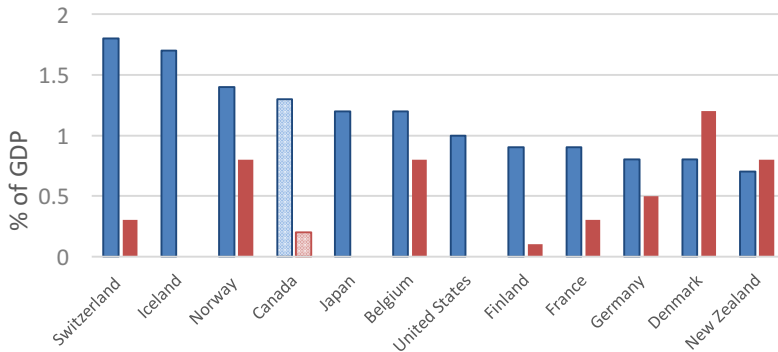
Aging Internationally

The ways that societies provide services and care for the aging population is strongly linked with their social, moral, and ethical norms (Ngai & Pissarides, 2009). In some places, caring for older adults is fully supported by the private sphere of families and friends, whereas in other countries care is identified as a collective responsibility of the society (Organization for Economic Cooperation and Development [OECD], 2010). The most recent international comparison (from 2008) indicates that Canada provides significantly less HCC support than other OECD countries (see Figure 1) (OECD, 2010). Since Canada allocates the majority of its funds to institutional care which is costlier than HCC, Canada's spending on the aging population is above the OECD average (Figure 2) (OECD, 2010).

The aging demographic shift is an international trend. The World Health Organization (WHO) recognized this issue and developed a global response in May 2016: the Global Strategy and Action Plan on Ageing and Health (WHO, 2016). Through this report, the WHO has urged international governance to undergo a fundamental shift so that health and social policies can develop sustainable and equitable systems of

support for the aging population in the areas of home, community, and institutional care (WHO, 2016).

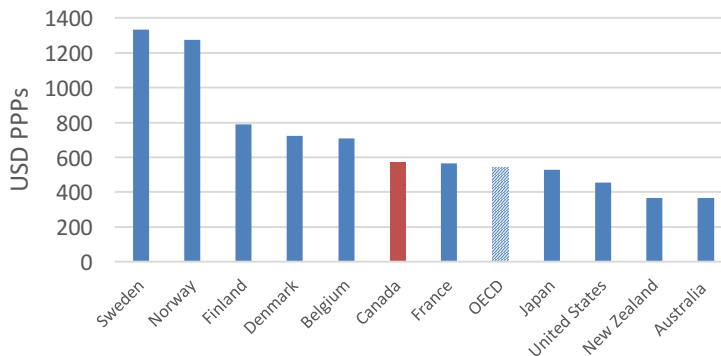
Figure 1. Canada's spending on institutional care is higher than its expenditures on home care services relative to other OECD countries (Percentage of GDP, 2008)



Note: Blue is spending on institutional care; red is spending on home care services.

Source: OECD Health Data, 2010 (<http://dx.doi.org/10.1787/888932400741>)

Figure 2. Per capita spending on long-term care in each country in USD PPPs in 2008 (latest available year)



Note: PPPs stands for purchasing power parities.

Source: OECD Health Data 2010 (<http://dx.doi.org/10.1787/888932400760>)

Canadian and BC Response to the Aging Demographic Shift: Why Aging-in-Place?

The aging population in Canada has brought many issues to the forefront: older adults are living longer than in past generations, and they are costly to support through

the medical system. Since the inception of the country's health care system, Canada's aging demographic has grown substantially, and now the health care system must adapt to the population's changing health care needs. Among the foreseeable health and social challenges, key questions are how the aging population might prefer to age and whether resources to support these preferences are available.

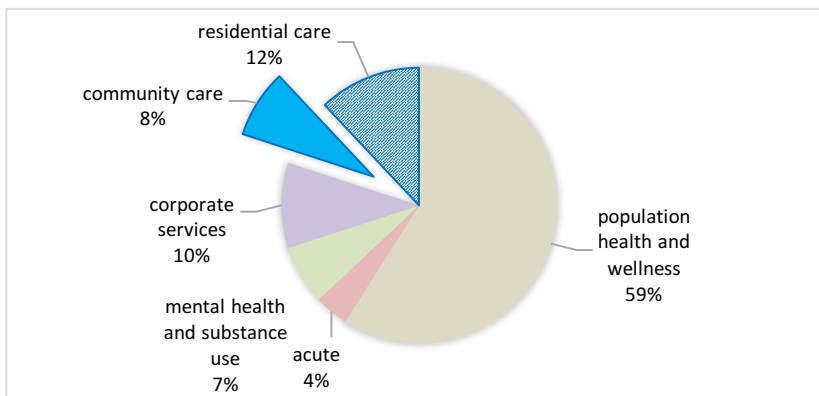
According to the latest available census data (from 2011), the vast majority (92%) of older adults in Canada live in their own homes (Statistics Canada, 2015). Most older adults prefer to age in their homes and remain independent as long as possible. However, one in three older adults (33.2%) reported having a disability in 2012 (Statistics Canada, 2013c). The life-long disabilities (pain, arthritis) may limit older adults' mobility and require formal and/or informal support for them stay independent (Cohen & Franko, 2015). Formal support is only the tip of the iceberg; the majority of care (70-75%) is provided by unpaid informal caregivers—family members, friends, and neighbors (Health Council of Canada, 2012). Older adults who wish to continue to live in their homes require some assistance to do so. The policy of aging-in-place, therefore, aligns with the aging population's preferences and should be a priority in the current health care landscape.

In response to this demand, in 2005 the federal/provincial/territorial ministers responsible for seniors endorsed a healthy aging framework, which encouraged provincial governments across Canada to develop their own healthy aging strategies (Government of Alberta, 2008; Ministry of Health and Long-Term Care, 2013; Nova Scotia Health, 2008; Premier's Council on Aging and Seniors' Issues, British Columbia, 2006). In 2010, the Federal Chief Public Health Officer indicated priority areas for provinces to improve in, including increased access to care and services, and improved data collection on seniors' health (Butler-Jones, 2010). In the same year, the Canadian Health Services Research Foundation held a series of roundtable discussions across the country to identify ways to integrate health and social services for older adults who are living longer and with more chronic diseases (Canadian Health Services Research Foundation [CHSRF], 2011). The report noted that the current health care delivery model focuses on acute services but that priorities would need to shift as the population grows older and develops increasingly complex health care needs (CHSRF, 2011).

After BC's first Aging Strategy Report in 2006, the Ombudsperson published a three-year investigation in 2012 examining BC's health and social service response to the aging population. The comprehensive report (2012) suggested that a substantial service gap exists in the community (Ombudsperson, 2012). It contained 143 findings and 176 recommendations, including criticism of the BC Ministry of Health (MoH) for not providing seniors and their families adequate assistance in navigating the complex HCC system, and for not analyzing what HCC programs older adults who are aging in place need (Ombudsperson, 2012). The report noted that although continuing to provide acute care services is important, the lack of essential and integrated services for older adults in the community could speed up the deterioration of age-related disabilities and lead to an increase in health care spending (Ombudsperson, 2012).

While the health authorities and MoH have responded to some of the recommendations in the BC Ombudsperson report, according to its 2015/16 budget report (Figure 3), BC continues to spend only a fraction of its health care budget on HCC services (Auditor General of BC, 2017). Although the majority of older adults live in the community, out of BC's total 15.6 billion dollar health care expenditures in 2015/16, 1.8 billion was allocated to residential care and only 1.2 billion spread across home nursing, rehabilitation, and home support services—services to support activities of daily living (ADLs) like eating, toilet use, and hygiene (Auditor General of BC, 2017). It is unclear how much of the 1.2 billion was allocated to ADL needs, but the services the health authorities provide are only a fragment of the services older adults living in the community require.

Figure 3. Allocation of BC's Health Care Expenditure (2015/16)



Adapted from BC Auditor General (2016)

(http://www.bcauditor.com/sites/default/files/publications/reports/FINAL_HFE2.pdf)

Other support services that older adults need are instrumental activities of daily living (IADL) services or non-medical home support services—like housekeeping, shopping, meal preparation, and home maintenance. These services are primarily provided by informal caregivers and on certain occasions by charitable organizations funded by the government (like Meals on Wheels and Better at Home [BH]) (Sinha, 2012).

BH, established in 2012, plays a crucial role in providing non-medical home support services for older adults in the community. Considering that 92% of older adults are living in their own homes, government spending on support services like BH is relatively insignificant (Statistics Canada, 2015). The organization receives about 10 million dollars a year to disseminate their services across its 67 nonprofit partners, which is 150th times less than the 1.8 billion dollars allocated to residential care (in 2015/16) (Auditor General of BC, 2017; BH, 2015). This disproportionate spending demonstrates the inadequacy of services in the community. This report will focus on how non-medical home support services, namely BH, could provide more holistic services to help older adults age in place.

How much are informal caregivers contributing?

Informal caregivers provide the majority of care for the aging population in the community. Based on the most recent national statistics, there are 5.4 million informal caregivers in Canada, and they provide nearly 70–75% of the care older adults in the community receive (Health Council of Canada, 2012). One study conservatively estimates that the economic contribution of unpaid caregivers for older adults is approximately 25–26 billion dollars per year in Canada (M. J. Hollander, Liu, & Chappell, 2009). Although informal caregivers' contributions are substantial, they are relatively invisible and unsupported, creating a “shadow workforce” in long-term care (Gonyea, 2008).

Support from informal caregivers enables older adults to stay in their own homes longer and provides them the social support they need (Health Council, 2012). However,

these benefits come at a cost. Informal caregivers are frequently under chronic stress, which leads to caregiver burnout (Lyons, Cauley, & Fredman, 2015), increased incidents of physical and mental illness (Schulz, Visintainer, & Williamson, 1990), increased use of health care services (Schulz, O'Brien, Bookwala, & Fleissner, 1995), and increased mortality risks (Schulz & Beach, 1999). Adverse effects of caregiving burden and stress on caregivers have not been quantified in economic studies, but evidence reveals that the absence of informal caregiver support generates substantial social costs and may directly or indirectly increase government expenditures.

Who are these informal caregivers and how might intersectional identities underpin the strains in their unpaid care? According to Singha (2012), nearly two-thirds of informal caregivers are women. Although increasingly more men are participating in unpaid care, women tend to provide more strenuous and frequent support. Women routinely provide support related to daily living, such as meal preparation and housekeeping responsibilities, whereas men have a greater propensity to provide support that is less time-sensitive, such as yardwork or home repairs (Singha, 2012). Therefore, although increasing numbers of men are providing informal caregiving, the type of support they contribute is less demanding, resulting in less frequent chronic stress than the stress women may experience.

Working-age women are predominantly socialized into care, which could perpetuate the social injustices they experience. Hooyman (2014) posits that the underlying power differential created by the gender-based wage gap results in women having lower incomes and less social power than men (Hooyman, 2014). Theoretically, when women earn less than men, their labour participation is viewed as more expendable than that of their spouses (Hooyman, 2014). The earning differential, where women earn less, reinforces women to give up or cut back on their poorly paid job to provide unpaid care. (Hooyman, 2014). The role they play as caregivers thus decisively and permanently affects women by furthering the gendered wage gap and economic disparities, including a lower retirement income at old age (Calasanti, 2010; Hooyman, 2014). Cruikshank (2003), and Meyer & Herd (2007) explain how the social determinants of poverty, caregiving, and widowhood contribute to older women's higher rates of illness and functional impairment (rather than biology or individual health behaviors). Lifelong

socialized gender-specific roles and expectations influence working-age women while they provide care, and health and financial inequities amplify as they age.

Feminist gerontology recognizes that this disparity is not only a gender issue; it is often compounded by racial and economic inequities. Racialized² individuals, on average, earn less than non-racialized individuals, even when all other factors (education, work-time, etc.) are held constant (Grant & Townsend, 2010). Racialized individuals tend to experience greater unemployment rates and are over-represented in precarious, low paying positions (Block & Galabuzi, 2011). Racialized Canadians earn 81.4 cent per dollar for every dollar non-racialized Canadians earned (Block & Galabuzi, 2011). The gap is at its worst when it compares the earnings of racialized women to non-racialized men: racialized women earn 55.6 cents for every dollar non-racialized men earned in 2005 (Block & Galabuzi, 2011). In addition to labour market inequities (e.g. gender wage gap and racism), the social institutions within the family (e.g., norms regarding who should provide care) also reinforce the income disparities (Calasanti, 2010). These factors combine put pressure on ethnocultural minority informal caregivers to provide the majority of unpaid care for EMOAs in the community, which could have negative long-term health and financial impacts that intensify in old age (Adams, Aranda, Kemp, & Takagi, 2002; Dilworth-Anderson, Williams, & Gibson, 2002; Lai, 2012; Lai & Leonenko, 2007).

Race, gender, economic, and social class are social locations upon which individuals' lives pivot; these factors limit women's choices, whether as caregivers or care recipients, and predetermine their place in the social order (Freixas, Luque, & Reina, 2012). It is important to examine how informal caregivers—especially subgroups like ethnocultural minority informal caregivers—are affected by policies that encourage older adults to age in place while offering a very limited amount of HCC and informal caregiver supports.

²Recognizing that race is a social construct, the Ontario Human Rights Commission describes people as "racialized person" or "racialized group" as opposed to more dated and potentially derogatory terminologies like "racial minority", "visible minority", "person of colour" or "non-White".

What challenges do EMOAs face when they access services?

Equal access and use of community services among South Asian and Chinese older adults are essential to attaining the same health status level as the dominant population. Research finds that South Asian and Chinese older adults disproportionately live in poverty, receive less income support through pensions, display notably poorer health outcomes, and access fewer medical services than white older adults (Grant & Townsend, 2010; Koehn, 2006). The perverse effects decline over time as the first-generation immigrant resides in Canada longer, but factors like public pension income and access to health service, although improve, continue to be lower than non-immigrant Canadian counterparts (Grant & Townsend, 2010). The health gaps provide an impetus for this capstone study to investigate what barriers restrict South Asians and Chinese older adult's access to services and how policy makers and service providers could develop policies and services that are more inclusive to an increasingly pluralistic society.

There is a plethora of factors that contribute to the health disparities experienced by ethnocultural minorities. The factors that constrain service utilization are often linked to personal, cultural, or systemic barriers. The next section will explain how various factors contribute to the health inequities and approaches research have shown to close access gaps. First, policymakers' misconception of filial piety might neglect EMOAs' needs and why further investigation is required. Second, how South Asian and Chinese older adult's cultural values and level of health literacy affect their health- and service-seeking behavior. Third, how the lack of English proficiency reinforces social isolation and reliance on informal caregivers. Fourth, what institution barriers, other than language, contribute to South Asian and Chinese older adult's access gap. Lastly, what are some practical approaches that EMOAs are responsive to?

A. Idealizing filial piety might neglect EMOAs' needs

There is also a common assumption that most South Asians and Chinese highly value the cultural belief of filial piety and therefore take on a bigger role in caring for aging family members than white counterparts. Yet the definition of filial piety is constantly changing—across time, in Canada, and in immigrants' countries of origin (Bryant & Lim, 2013; Chappell & Funk, 2011). Canadian literature reveals that although

EMOAs is more likely than non-racialized Canadians to reside in the same home as their children, the degree of family support provided within these arrangements varies (Keefe, Rosenthal, & Béland, 2000). Many people assume that South Asian and Chinese older adults reside with their adult children because of their culture, but in many cases, it is because of economic necessity; adult children who sponsor their parents in the immigration process are financially responsible for them for ten years after their arrival in Canada (NACA, 2005). Little is currently known about the quality of support provided to South Asian and Chinese older adults in this setting or the ways in which their dependency might impact their well-being. Idealizing ethnic minority families as highly supportive informal caregivers could increase the risk of neglecting EMOAs' needs for community programs and the wellbeing of the informal caregiver (NACA, 2005).

B. Cultural values and health literacy are determinants of health-seeking behaviors

Research demonstrates that seeking health care services is strongly associated with cultural values and health knowledge. Less acculturated immigrants might be less aware of the public services available in Canada and may view their personal needs as a private matter. According to Stewart et al. (2011), an array of factors contributes to EMOAs' lack of health-seeking behaviors. Some Chinese older adults emphasize that they wish to be independent, hard-working, and self-reliant and do not want to be a financial burden to the government (Stewart et al., 2011). Other factors specifically related to Chinese culture is being reluctant to seek external help, out of the fear that family's financial secrets or dependency on public subsidies would bring "shame" to the family and because older adults do not want to burden their family and friends with their health problems (Steward et al., 2011). Those who came to Canada as refugees (e.g., Chinese-Vietnamese refugees) are often fearful or even suspicious of government services due to traumatic experiences in their country of origin and often avoid engaging in government programs because they fear that their care may warrant investigations (Steward et al., 2011). South Asian and Chinese older adults are a diverse population, and no single reason accounts for their lack of health-seeking behavior. Regardless, the outcome is the same—the lack of health-seeking behavior either results in increased

informal caregiver burdens or if an informal caregiver is not available, the well-being of the older adult is compromised until a more acute health issue manifests (Miner, 1995).

C. Language barrier engender social isolation and reliance on caregivers

Language obstacles reinforce EMOAs' social isolation and dependency (NACA, 2005). South Asian and Chinese immigrants, mainly women who immigrated to Canada through family reunification, tend to have lower English proficiency (Anisef, Sweet, & Adamuti-Trache, 2012). Language barriers prevent many EMOAs from being able to explain their needs, ask for the type of services they need, or ascertain whether these services exist (NACA, 2005). Language barriers are especially pertinent for South Asian women and occasionally Chinese women who are socialized to stay at home and provide caregiving responsibilities, which in turn limits their opportunities to learn and practice the mainstream language (Diwan, 2008; Lai & Surood, 2008; Manthorpe et al., 2009; Manthorpe & Hettiaratchy, 1993). This reality affects not only new immigrants but also those who have lived in Canada for years. The lack of language proficiency engenders reliance; a study found that the Punjabi older women residing in BC depend on family members for transportation because they are less likely to drive, might not be able to afford taxis, and may avoid public transit due to lack of English proficiency (Grewal, Bottorff, & Hilton, 2005). The language barrier thus shifts power away from South Asian and Chinese older adults and generates a sense of guilt each time they seek help or might downplay their health needs to reduce the burden on others (Grewal et al., 2005; Koehn, 2009). When institutions are not accommodating to language constraints, South Asians and Chinese older adults become reliant on their family members or peers who give them a voice – thus increasing their vulnerability to neglect or abuse.

D. Service's insensitivity to cultural beliefs, values and practices

The health and community care systems also introduce institutional barriers that reinforce the health disparities for those who lack or have inadequate access to services (Zhan, Clutterbuck, Keshian, & Lombardi, 1998). While Lai and Chau (2007) and Lai and Suroon (2010) surveyed Chinese (n=2,214) and South Asian (n=220) older adults separately, the top four challenges both cohorts experienced were shared albeit in

different orders. The primary challenge most older Chinese respondents identified was the "administrative problems" in service delivery; related to issues like wait lists being too long, office hours being inconvenient, and procedures being too complicated. The second factor is the "lack of cultural compatibility" of services, including factors like professionals not speaking the users' language or understanding the users' culture and programs are not specialized for Chinese. The "personal attitudes" was the third factor, which includes items such as feeling ashamed, uncomfortable with asking for help, and not believing that the professionals can help. Lastly, "circumstantial challenges" was the fourth factor out of 21 potential service barriers, including items such as the lack of transportation, the weather being too cold to get out, and not knowing about existing services. Although there are significant differences between Chinese and South Asian older adults, Older South Asian participants identified the same factors but ranked in different order: (a) "cultural incompatibility," (b) "personal attitudes," (c) "administrative problems" and (d) "circumstantial challenges."

These two studies are the only studies that quantitatively examined institutional barriers in Canada. Comparing the two studies, personal attitude of the respondent is only one of the four factors, instead there are a few institutional factors that discourage older adults from using the public services. South Asian and Chinese older adults in the study indicate experiencing pronounced challenges in seeking culturally-appropriate services in a timely manner and being consistently supported by a bicultural staff who understand his or her language and culture. Policy makers and program makers should be more attentive to these institutional barriers and engage South Asian and Chinese users during the program design phase to illuminate potential barriers.

E. Policymakers misconception of filial piety thereby not providing adequate support for groups conceived to have strong familialism

Research show that responsive programs are attentive to cultural needs and close communication gaps by pairing EMOAs with bicultural staff. Lai (2004) and Lai & Chau (2007) found that South Asian and Chinese older adults had a challenging time navigating or even knowing what health and social services were available. Lai and Surood (2008) have indicated that ethnic media channels, namely television, radio, and newspaper, are very effective ways of overcoming this challenge and reaching EMOAs

who are illiterate in English or even in their own language. Aside from outreach, it is essential to ensure users are consistency engaged with bicultural staff. Lai (2008), and Koehn, Habib, and Bukhari (2016) propose that partnering with agencies that have bicultural staffs and are adept at providing services to ethnocultural minorities could effectively close access gaps. However, the non-profit organizations (NGOs) interviewed in this study found it challenging to ensure bicultural staffs are consistently available to support the older adult. The issue is particularly pertinent when NGOs deliver housekeeping services through a private company since the NGOs do not have oversight to scheduling appointments. On the other hand, NGOs that contract independent service providers experience high turnovers because the hourly payment structure makes it challenging for retain staff. In summary, having bicultural staff consistently deliver service is ideal, but in practice, the hourly funding model and the human resource constraints on small NGOs make it challenging to provide bicultural staff consistently.

Policy Gaps and Opportunities

Policies that could enhance EMOAs engagement are underexplored in existing literature and practice. The absence of publicly available data on race and non-medical home support services limits our ability to examine whether an access gap exists in BC. However, the literature and the interview provided by qualitative data are reliable indicators that a health gap and institutional barriers exist. The barrier might also result in either elevating the responsibilities of EMOAs' informal caregivers or compromising EMOAs' well-being.

Many differences exist between South Asian and Chinese older adults and even within each ethnocultural minority group, as well as shared experiences that limit their access. So far, limited research has explored how policies might address the unique cultural values, beliefs, and language of older Chinese and South Asian immigrants who might have a different worldview from the Western culture. The policies introduced in this study provide a starting place to overcome some systemic issues that limit organizations' ability to engage or implement changes South Asian and Chinese older adults want. However, ultimately, policymakers and organizations would need to engage South Asian

and Chinese older adults in their communities to devise the best programs and implementation strategies to engage these subpopulations. This capstone does not attempt to erase the differences of South Asian and Chinese older adults, but it seeks to start a dialogue on how to use flexible and adaptable provincial policies to address such differences.

This study aims to delineate the key challenges and benefits associated with providing EMOAs and their informal caregiver's appropriate services and support. The study incorporates interviews with front-line workers who provide services to EMOAs to unravel how non-medical home support programs could include ethnocultural needs and potential reasons why EMOAs might decide not to use publicly funded services. Finally, this study aims to add to the body of gerontology literature by analyzing policy options that could encourage inclusivity. Ultimately, the key policy objective is to promote social inclusion for South Asian and Chinese older adults and their informal caregivers by lowering barriers to accessing service and designing a system that permits their values to be respected.

Chapter 3. Methodology

Political Theory: Intersectionality

Intersectionality examines the interconnected nature of social categorizations, such as race, class, and gender, as they apply to a given individual or group (Hankivsky et al., 2012). This study incorporates the intersectionality lens in acknowledging that inequities are never the result of single, distinct factors (Hankivsky, 2014). Instead, inequities are the outcome of intersections of different social locations, power relations, and experiences. Individuals' lived realities are composed of a constellation of identities, which compound to create privilege and oppression (Hankivsky et al., 2012). With this theory in mind, my analysis attempts to acknowledge the array of lived realities and not overgeneralize the experience of South Asian or Chinese older adults. The purpose of this study is to design policies that are responsive to local demographic needs.

Mixed Method Approach – International and Provincial Jurisdictional Scan and Interviews

This study uses a mixed-method approach to examine potential policy options and their respective strengths and weaknesses. International best practices and innovative provincial policies are highlighted in Appendix A, while expert interviews are presented in the “Results” section. Given the limited literature on this topic, the mixed-method approach allows the capstone to balance a broad jurisdictional scan with in-depth interviews with experts familiar with the BC context. Combining policy trends and local expertise allows me to examine the potential challenges and benefits of each policy option and how these may relate to the BC context.

Ethics approval was granted by SFU's Office of Research Ethics before interview recruitment and data collection. Prospective interview participants were recruited via

email using snowball sampling techniques. Each interviewee either signed a consent form or provided verbal consent before the interview. All interviews were digitally recorded and transcribed. Participants were given the opportunity to review direct quotes before the publication of this study and also provided the option of having their names disclosed or remaining anonymous.

Data Analysis for Expert Interviews and Transcribed Data

The interviews were analyzed using a qualitative thematic analysis framework created by Vaismoradi, Turunen, and Bondas (2013). This framework was selected for its flexibility and potential to provide a rich, detailed, and complex account of data. The thematic analysis process involved reading the interview transcripts, becoming familiar with the transcription content, recording patterns (or themes) within the data, and interpreting the outcomes of the research.

Research Limitations

The small sample size limits this study since the interviewees are not representative of the populations of nonprofit providers and policymakers in BC. Nevertheless, the interviewed respondents are providers in ethnoculturally diverse communities in BC, which provide them unique experiences that are not found in homogenous communities. The insights of these providers allow the research to compare how front-line providers' experiences may differ from interviewees who examine the issue from a provincial governance perspective.

Chapter 4. Results

International Best Practices

This section examines countries that have shared political structure as Canada, the countries reviewed were: Australia, United Kingdom, United States, Germany, Japan, Italy, and Finland. This analysis discusses only three of the most innovative jurisdictions (See Appendix A for lessons learned from international jurisdictional scan). First, Japan provides examples of the most provocative systemic policy changes. Second, Denmark demonstrates progressive policies that align with the Vienna Ministerial Declaration on Aging (United Nations, 2002). Lastly, the United Kingdom (UK) shares the most similarities with Canada and BC (in political, economic and legal structure), but pursued a very different approach on the issue.

None of the jurisdictions examined identified how policies impact racialized groups, such as Chinese and South Asian older adults. The absent of ethnocultural and intersectional analysis appear to be a recurring theme that impedes researchers and decision makers from understanding how implemented policies affect a non-monolithic population. The jurisdictional scan only provides an overview of effective policies that could address the aging population and the interviews address the constraint of the jurisdictional scan by assessing how the policies implemented in other jurisdictions may affect Chinese and South Asian users in BC.

Japan

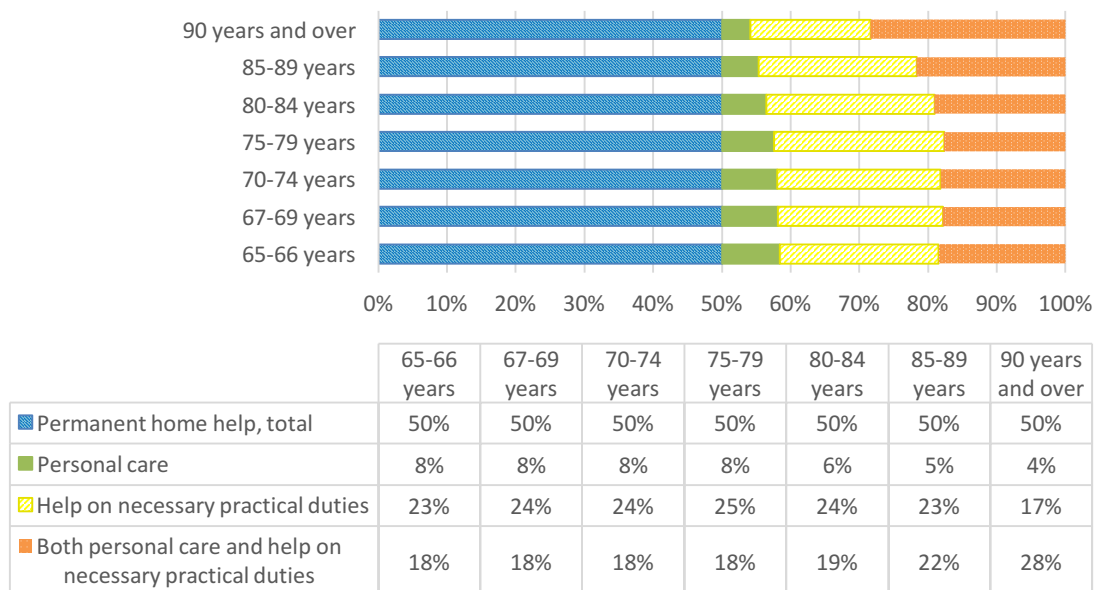
Japan is undergoing a drastic demographic shift; one in three Japanese will be over the age of sixty-five by 2025, and single-person households are on the rise (OECD data, 2017). Given the dual challenge of a shrinking labor force and a decline in informal caregivers, Japan's approach is to restructure its social security and tax systems to fund the formal HCC services. Workers begin to contribute an annual premium at age forty,

and they pay only a tenth of the cost of HCC services when received in old age, and the balance of the cost is covered by the premiums and national and municipal government contributions. Japan's HCC system provides integrated services ranging from medical to non-medical home support services, and the care manager liaises clients to services.

Denmark

Denmark provides a comprehensive list of universally covered services for older adults, and formal services provide a majority of the care in the community. Older adults often require a broad range of services. As shown in Figure 4, a majority of older adults residing in the community need both personal care (medical, or ADL) and non-medical home support services (IADL).

Figure 4. Share of Persons Receiving Personal Care and Help with Practical Tasks in 2015 (percentage)



The proportion of older adults who require practical duties is much greater than those who need personal care (ADL services, e.g. baths and eating support). Proportionally less older cohorts require practical duties only, instead more shift to requiring both personal and practical support.

Source: Statistics Denmark (2017) www.statbank.dk/AED06

Aside from the universal services, Denmark also established a mechanism to assess older adults and allow older adults to hire a personal helper or an informal caregiver to provide the care they need. These services may range from a few hours a week to full-time work, depending on the needs and preferences of the care recipient. In Denmark, informal caregivers are paid comparable to the average market price of formal care providers. Care recipients are required to contribute 8% of the caregiver's pay to prevent excess use of the resources.

United Kingdom (UK)

In the last decade, UK's private-public model failed to increase access or contain service cost. Now, the UK along with New Zealand and Australia have “reablement” programs that train or retrain older adults personal daily living activities. The six- to eight-week training allows the older adult to regain strength in areas like supporting personal hygiene practices, preparing meals, prompting medical intake, establishing social contact, rebuilding confidence to go out for activities, and learning about local community resources. If the older adult is unable to support the task after the training, he or she will receive the HCC service needed.

Through the newly legislated UK Care Act (2014), the Act provides a standardized process for all adults who needs care and support to be assessed and provided funds to purchase formal services or pay their informal caregivers. It also creates the first ever entitlement to support for carers, on a similar basis. The Act clearly outlines the procedures to assess one's level of need. It begins with an assessment of the care recipient's needs and a decision about whether their needs are eligible, including a financial assessment to determine whether people need to pay for their own care. The Care and Support plan determined by the evaluation provide individuals—who use services or are carers—a clear set of legal entitlements to a care and support plan and guarantees the plan are personalized to the users (N.H.S. Choices, 2017).

Older adults receive a needs assessment and financial assessment to identify entitlement to funds. The older adult then gets to choose if they would like to receive the fund directly or to have the local health authorities help them arrange and pay for services or pay their informal caregivers.

The Care Act (2014) is the first legislation that ensures informal caregivers are provided support. Whereas in the past, the support informal caregivers receive varied depending on where they live and on local health authority's discretion. The new Care Act is a revolutionary step towards supporting informal caregivers by providing them legal entitlement to financial aid and services. This way, informal caregivers are guaranteed similar support as the older adults they support.

Provincial Scan

HCC and informal caregiver support policies do not vary substantially across most Canadian provinces except for three provinces: Manitoba, Quebec, and Nova Scotia. The following section will discuss the what those policies are.

Manitoba

Manitoba is the only province in Canada that legislated a Caregiver Recognition Act to define who informal caregivers are. According to the Bill, informal caregivers are not only family and spouses but are also friends and neighbors. The inclusive definition expands the eligibility of benefits to members other than family members who take on a caregiving role.

Informal caregivers are eligible for the Primary Caregiver Tax Credit if the care recipient is deemed eligible by a health professional. Unlike BC, where caregivers receive a non-refundable tax credit, caregivers in Manitoba receive \$1400 a year as a refundable tax credit. Refundability of the tax credit expands eligibility for the subsidy to caregivers who earn little to no income. In contrast, a non-refundable tax credit that benefits only those who have a positive income tax liability.

Quebec

Other than Manitoba, Quebec is one of the few provinces that provide a refundable tax credit for caregivers. The Quebec government subsidizes services and informal caregiver support through a series of boutique refundable tax credits: respite, home support, and for caregivers. The respite and home support tax credits allow

individuals to claim up to 30% of the out-of-pocket expenses on respite and home support services.

Unlike Manitoba, Quebec's caregiver tax credit is quite restrictive. The tax credit is available only for family members who live in the same residence as the care recipient confirmed by a health professional to have "high-needs." Family caregivers who fulfill both criteria receive a refundable tax credit of \$1000 a year.

Nova Scotia

Nova Scotia provides the most generous informal caregiver benefit out of all the provinces. Much like Manitoba and Quebec, a health care professional must identify the care recipient to be qualified for the subsidy. Once qualified, the informal caregiver may receive \$400 a month to provide the caregiving support.

However, other criteria must also be fulfilled to be qualified for this subsidy. The care provider must have an income below the low-income threshold (less than \$22,125 net income if single, or \$37,209 if married or in a common-law relationship). Additionally, the informal caregiver is expected to provide 20 or more hours of support weekly and cannot already be paid for their services.

Summary

None literature examined how the policies affect South Asian and Chinese informal caregiver and older adults. Since charitable organization delivers most HCC services and service access data is less readily available, there is a significant constraint on examining how HCC services are systematically delivered across the different provinces or the characteristics of those were granted services. In summary, even the most innovative Canadian provinces appear to significantly lag behind European policies in regards to services available for the aging population and support for informal caregivers.

Stakeholder Interviews

This section will discuss the thematic findings generated from eight interviews in BC with nonprofit service providers, a social worker, the provincial manager of BH (Kahir

Laliji), the Deputy of Seniors Advocate (Nancy Gault), and a policy advisor from Seniors Advocate. From a provincial perspective, interviewees agree that there are high unmet needs in the community, and such pressing needs often overshadow the different institutional barriers South Asian and Chinese older adults face. Next, all interviewees also agree that older adults should have the agency to choose the services they want, but the degree of client-centered care varied depending on whether the interviewee is a policy expert or a service provider. Lastly, NGOs that work directly with South Asian and Chinese older adults seem to have the greatest knowledge on how to engage these individuals and the services they require. However, many providers are unable to sustain the targeted outreach and targeted services due to funding constraints.

High unmet needs for older adults in the community

Interviewees from different backgrounds appear to set different priorities in addressing the myriad needs of EMOAs in the community. First, Kahir Laliji, the Provincial Manager of BH acknowledges how there are high acute needs that must be addressed, but the province should also invest into older adults who are healthy to extend the length of their wellbeing. In Kahir's opinion, he believes that existing funding is constrained and to overcome this constraint, programs need to harness community's social capital when they tackle the issue of an aging demographic shift.

We need to find ways to support both older adults who live in communities—through health promotion and preventative mechanisms—as well as those who need acute interventions.

What we do find is that when we invest in the community-based sector and non-medical home support services, we see a lot of offshoots, because they [older adults] are still at this point where they can engage with people, increase their sense of belonging, develop skill sets, and become more aware of how to age in a healthier way. – Kahir Laliji, BH Provincial Manager

Living in the digital age, it is important to recognize the strength and assets embedded in the community... Financial resources at the existing levels are not able to support the aging population. We need to be innovative and creative in supporting our aging population. So, one of the ways that a lot of people and I feel that we can achieve this is to move from a paid system of support to a natural system of support. The Better-at-Home model is predominantly based on volunteers. – Kahir Laliji

The Seniors Advocate explains how their organization is relatively new and as the

provincial advocates for seniors, they need to start somewhere. That is why the analysis they have done to-date only examine issues to affect the most seniors.

We looked at the broad things, like the health authority (HA) variations and urban/rural issues. We haven't gotten to the point of looking at specific cultural groups. Mostly that is because we are trying to do the biggest thing for the most seniors... It doesn't mean the other stuff isn't important or shouldn't be looked at; it is just you must start somewhere. – Nancy Gault, Deputy Seniors Advocate

Service delivery needs to be client-centered

The focus on how the delivery of client-centered care should be differed depending on what role the interviewee play and who the respondents work in close collaboration with. BH service providers work closely with older adults and are familiar with how programs may be insensitive to the different groups of older adults. Kahir explains how as an organization that delivers services, they attempt to address the institutional barriers by having different weights in the funding algorithm thereby empowering their non-profit partners who work with hard to reach groups (e.g. rural, ethnocultural minority).

In my opinion, there is not a lot of room and flexibility to meet the needs of different types of seniors: Seniors with different language barriers, LGBTQ, deaf of hearing, culturally blind, culturally unaware of the need to see a medical doctor, etc. Our [BH] funding model is based on a few different characteristics of the community: the number of older adults that live in the community, low-income older adults, geographic nuances such as distance and weather, and population density. We use these individual weighted variables to determine the funding allotment to the community. – Kahir Laliji

From a policy perspective, Nancy explains how client-centered care could move beyond incremental change. Instead, the funding and payment structure should allow older adults the liberty to choose what services suit their needs the most.

Right now, the model is, the care providers identify the level of care you will need. We think clients should have more choice and flexibility; if the clients determine that they want to use the money to hire somebody for housekeeping or something different, they should have the flexibility to arrange those services for themselves. – Nancy Gault

Targeting and tailoring services to meet EMOAs' needs

The following statements are drawn from the five interviews with service providers who work in close collaboration with older adults in culturally diverse communities. The interviews reveal that implementation and communication strategies are integral to the success of engaging EMOAs. The most successful nonprofit organizations try to meet South Asian and Chinese older adults where they are at, by tailoring outreach and program to respondents' preferences. The interviewees explain how the changes in the implementation strategies increased service uptake in Chinese and South Asian seniors and what are some of the challenges are still present in closing the access gap.

- a. Bicultural staffs with a shared language and culture are important in attracting EMOAs who were previously not engaged.

When we first started, the Caucasian population was well-connected and used the program, but we didn't see a lot of interest from other groups.

Sometimes it is very hard for people without the same language to communicate with these [non-English speaking] seniors. It is very hard to understand what they are saying, where they are coming from; in that respect, there is room for improvement.

- a. The NGOs explain how conventional advertisements are often inappropriate for South Asian and Chinese older adults; since they are more receptive to informal modes of communication, like through word of mouth. The NGOs that modified their outreach and advertising strategies were more successful in engaging South Asian and Chinese older adults (e.g. using ethnic television shows, radio shows, and embedding bicultural coordinator in community centers to explain what services are available). These methods were also able to overcome the stigma in using publically funded services, which might encourage South Asian and Chinese older adults who need services to seek for help.

For the South Asian and Chinese population, news spreads through word of mouth. So, once a few people received service from us and liked their experience, they will ask us, 'my friend lives in my apartment complex and wants the service too,' and from there on, we spread the word. It is gaining momentum, there is help available, and we can contact them.

We hired a Chinese coordinator who speaks Chinese and is a senior himself... He went to community centers and where people gathered and told them about

the BH program. The Chinese seniors will get interested and ask if they too can use this service. This was when it started to change.

We use social media, Chinese media, staff will go on the radio, we pay for newspaper ads and run press releases to advertise our services

- b. Aside from advertising services, organizations must tailor services to meet cultural preferences.

'Shop-by-phone' often doesn't suit the Asian clients. It is not the language but culturally appropriate food.

We piloted a project that was very popular in the summer; we took people to the Asian grocery shop for group shopping. We are hoping to establish a group shopping program for the Asian senior population... Some people stayed to have lunch at the mall, and some people didn't, but it was very popular.

- d. Despite the benefits they offer, organizations face challenges recruiting bicultural staffs that are less represented in the community.

We have almost every other staff who speaks Punjabi and English. We do not find it challenging with that. At times, it was difficult to find someone who speaks both Mandarin and Cantonese.

We do not have that many referrals for South Asian clients and [when we do] we sometimes need to scramble to find a [bicultural volunteer for] the friendly visits or senior peer counseling services. We do need more South Asian volunteers...and I don't know why we don't have more South Asian clients.

Chapter 5. Policy Options

The following four policy options have been generated from the existing literature, national and international case studies, and stakeholder interviews. They are not mutually exclusive. The focus of the policy options is twofold: to increase access to appropriate, timely, and responsive formal services for South Asian and Chinese older adults as well as those who need care, and to improve support for the informal caregivers who play such an integral role in the care of the aging population. Although the options focus on addressing some of the gaps experienced by South Asian and Chinese older adults discussed in the “background,” the benefits of the choices are not limited to these two subgroups. Instead, the policies could potentially provide important directions to address the diversity of other EMOAs in the province and elsewhere.

The BC and the Federal governments currently provide informal caregivers a non-refundable tax credit to subsidize some of informal caregivers’ out-of-pocket expenses. Unlike Quebec and Manitoba’s refundable tax credit, the BC and Federal government’s non-refundable tax credit are only beneficial to informal caregivers who needs to pay tax on their income. The non-refundable tax credit has been critiqued for being regressive and for not being responsive to the demographic of informal caregivers: who tend to be women, earn less income, or have left employment to provide care (Sinha, 2013; Statistics Canada, 2013b). If BC is to modify the tax credit to a refundable tax credit, informal caregivers who are unemployed or are earning a low wage could also benefit from the subsidy. A modified status quo that amends the non-refundable tax credit to a refundable tax credit is not considered in this analysis because it represents the amount provided to informal caregivers, under \$300, is too insignificant to change informal caregiver’s behavior. Instead, the following section will examine a more targeted approach to supporting informal caregivers.

Option 1: Expand provincial funding for non-medical home support services

Expanding BC's funding to the Better at Home (BH) program would help meet the needs of older adults in the province. Currently, BH receives funding from the BC government and partners with local nonprofit organizations to deliver non-medical home support services, namely light housekeeping, yard work, transportation, group shopping, friendly visits, and more (BH, 2012). However, due to funding constraints, BH is currently not available in all communities (including many communities in the interior, the islands, and northern BC) and when it is available, there are long waitlists for subsidies. Option 1 would expand funding to develop more community partnerships so that BH service could be offered across the province. The second part of Option 1 is to extend funding to existing non-profit partners so that the supplied of subsidized services would meet the demand.

Aside from expanding service access, Option 1 proposes the development of an innovation fund that would enable nonprofit organizations to develop new programs that are responsive to local demographic demands, particularly services unique to South Asian and Chinese older adults' needs. Many nonprofit organizations recognize a gap in the services they provide, including in the services appropriate to EMOAs. Yet the current funding is inadequate, and providers are unable to sustain their pilot projects. Option 1's innovation fund must overcome this challenge by providing continuation of funds for successful projects. In sum, Option 1 would require the province to expand BH's funding to increase service access, ensure timely service delivery, and support the development of innovative programs designed to meet local South Asian and Chinese demographic needs.

Option 2: Implement a province-wide reablement service

This option involves introducing a reablement program before older adults receive home and community care services. Reablement, used in Australia, New Zealand, and the UK, is a tool to meet the needs and contain costs associated with the aging population (Tessier et al., 2016). The one-on-one training offers older adults the practical skills to perform personal care and daily living activities. Reablement encourages service users to develop the confidence and skills to carry out activities on their own so that they can live independently at home as long as possible. A study by the UK's Department of

Health found that up to 68% of program participants no longer required home care after a period of reablement, and up to 48% continued not to require home care two years later (Glendinning et al., 2010). Reablement support is delivered by in-house council care teams and provides home care staff working in tandem with other health professionals. The six-to-twelve-week training includes, but is not limited to, the following exercises:

- Attending to personal care and hygiene;
- Providing practical help, such as meal preparation;
- Prompting medication intake;
- Providing advice and information on geriatrics topics, such as preventing falls;
- Identifying availability of local community services;
- Establishing and maintaining social contacts;
- Rebuilding confidence to go out for activities like grocery shopping and visiting local community centres.

Implementing Option 2 in the BC context would require substantial planning since the government will need to engage the health authorities to create new curriculums and departments to implement this policy. Learned from other studies, it is possible to deliver reablement services through non-professionally personnel who received specialized training to provide reablement services. Reducing the educational requirements could lower the cost of providing the reablement program and allow more bicultural staff to enter this profession thus increasing the cultural appropriateness of services to EMOAs, particularly South Asian and Chinese older adults. The reablement program has already been implemented in a few countries for over a decade and provides BC plenty of resources to examine and tailor to the BC context.

Option 3: Market choice-based approach by paying eligible older adults to purchase services

This option would increase senior's autonomy by allowing them to choose which services they need while making them aware of the cost constraints of available resources in funding those services. Currently in BC, health authority and BH service providers go to care recipients' homes to assess the level of need and determine the

type and frequency of services a beneficiary is eligible to receive. With this approach, the provider has full control over determining the nature and amount of services an older adult receives. Option 3 would ensure more empowerment for older adults by granting funding directly to care recipients, providing them with the opportunity to make decisions regarding their own care needs.

Option 4: Market & non-market choice-based approach by assessing needs of older adults & informal caregivers (UK Model)

This option, based on the UK's Care Act (2014), involves a client-centered approach that considers the needs not only of older adults but also their informal caregivers. The intent of the Act is to identify the needs of both those receiving and giving care, as well as to provide funds to support these needs. Similarly to the Option 3, eligible older adults are given funding that reflects the amount of care they need and which can be allocated according to their preferences. What sets this option apart from Option 3 is the ability to establish a contractual agreement with family caregivers and make payments to the informal caregivers' services. Thus, this option allows South Asian and Chinese families with strongly filial piety to proceed with their practices without financially penalizing the household.

An innovative component of the Act is the assessment of the caregiver independently from the care recipient. Unlike the current BC system, the caregiver assessment identifies the degree of mental, physical, and economic challenges the caregiver experiences, since those who provide care often juggle other responsibilities (including child-rearing and employment). This option suggests expanding BC's informal caregiver assessment to include other stressors caregivers experience beyond the caregiving responsibilities. After a caregiver is assessed, following the UK's model, BC must provide services to help the caregiver cope with challenges, as well as a monthly payment to help offset economic hardships. A Care Act similar to the UK's would need to be legislated to make the implementation of this policy possible and establish a standardized process to provide equal opportunity for service recipients.

Chapter 6. Objectives, Criteria, and Measures

This chapter provides the evaluation framework of this study, which includes the objectives, criteria, and measures used to compare policy options. The evidence derived from the background research and data collection informs the formulation of important objectives and measures. Table 1 provides the matrix of criteria and measures that will systematically evaluate the options in the “Policy Analysis” chapter and generate the portfolio of policy recommendations in the “Recommendations” chapter. This analysis applies equal weight to the societal and governmental objectives and formulates the same number of measures for each objective. The overall purpose of this evaluation is to conduct a robust analysis that strikes a balance between closing the ethnocultural inequity gap in BC and limiting the burden on provincial finances.

Societal Objective - Criteria

1. Equity and Fairness

As discussed in the “Background” chapter, there is an inequitable distribution of formal services and informal support in BC. The feminist theory, intersectionality, identify that different factors intersect and compound to create one’s lived experiences. For instance, factors like ethnicity and culture, language barriers, income, and geographic location impact an individual's experience of service availability, appropriateness, and affordability. The measure, equity, thus aims to provide equal opportunity for disadvantaged groups depict in the literature (ethnocultural minorities (specifically South Asian and Chinese), low-income individuals, and those living in rural areas. Although the equity analysis may produce spill-over effects on other groups, the study will only focus on the three cited groups.

2. Effectiveness

This criterion examines whether or not the option incrementally increases appropriate service access, which in this context measures the older adults' and caregivers' access to responsive, high-quality support. Characteristics measured include timeliness of service delivery and the ability to fill the gaps.

Governmental Objectives – Criteria

3. Stakeholder Acceptability

Stakeholder acceptance determines the potential adherence to and sustainability of the policy options. Although is relevant stakeholders to include in this analysis, they are already considered under the criterion of equity. This measure will examine acceptability from the perspective of just two stakeholders: the regional health authorities and local nonprofit organizations.

4. Cost

Cost is a crucial governmental consideration. Costs associated with the aging population are triggering concerns regarding the return on investment of government services. This criterion will examine two cost components: the direct cost of implementing the program and the return on investment accrued in other areas of health and social services, including cost savings concerning preventing hospitalization, institutionalization, and utilization of home care services. The two measures are measured separately since the assessments are qualitatively determined. If a net difference is used, the assessment might conceal the nuances, such as the upfront cost involved with the program and the return on investment each policy option presents.

5. Administrative Complexity

This criterion measures the burdens involved for the province to implement the policy option. More precisely, it measures whether legislative amendments or the

creation of new legislation is needed, and the amount of coordination required across ministries and stakeholders. This criterion serves as a proxy for the potential risk and setbacks an evaluated policy may encounter, since barriers and complexities may arise when many stakeholders are involved. Moreover, timelines may be delayed when new legislation is introduced or amended.

Measures

Provided below are the measures used to evaluate how the policy options perform in relation to societal and governmental objectives. This analysis will draw upon outcomes and considerations revealed in the literature, in other jurisdictions, and in interviews.

Table 1. Criteria/Measures for non-medical home support services for older adults

Criteria	Definition	Description and Considerations	Ranking and Measures
Equity and Fairness	Ethnocultural groups Socioeconomic Regional	• Increased meeting of ethnocultural, regional, or socioeconomic client’s needs. Is there an empirical rationale?	High (3): substantial improvement to access Medium (2): some access Low (1): limited access
Effectiveness	Availability of services Availability of support (IC)	• Increase availability of service or support (e.g., no waitlist and services/supports are accessible)	High (3): Increase Availability Medium (2): Some increase Low (1): Does not address supply of service/support
Stakeholder acceptability	Health Authority Nonprofits	• Increase financial capacity to provide services • Introduce administrative burden by requiring new staff, collaboration, etc.	High (3): No change & increase funding Medium (2): No change to structure or funding Low (1): Change to structure & no additional funding
Cost	Provincial funding to run program	• Program spending relative to baseline	High (3): reduce spending Medium (2): no change

	Cost-containment in other areas (e.g., hospitalization, institutionalization)	<ul style="list-style-type: none"> • Degree of cost-saving in other areas over a 5-year period (relative to baseline spending) 	<p>Low (1): increase spending</p> <p>High (3): decrease incidence and therefore reduce costs of tertiary services</p> <p>Medium (2): some health promotion included, and may or may not reduce cost of tertiary services</p> <p>Low (1): no means of delivering health promotion, therefore no ability to reduce cost</p>
Administrative complexity	Administratively complex	<ul style="list-style-type: none"> • Require legislative changes • Degree of coordination with ministries and/or stakeholders 	<p>High (3): no administrative changes required</p> <p>Medium (2): some changes required</p> <p>Low (1): extensive changes required</p>

Chapter 7. Policy Analysis

Overview

The analysis provided below is based on findings generated from the research. The following matrix summarizes the key strengths and weaknesses of each policy option with the criteria outlined in the previous chapter. The three options that perform the best are options 1, 2, and 4, as shown at the bottom of the matrix.

Table 2. Summary Matrix of Policy Option Analysis and Ranking

	Option 1	Option 2	Option 3	Option 4
Criteria & Measures	Expand BH funding	Re-ablement	Market choice-based approach	Market & non-market choice-based approach
Ethnocultural groups	2	3	1	2
Socioeconomic	2	3	2	3
Regional	2	2	2	3
Availability of services	3	3	2	2
Availability of support	2	2	1	3
Health Authorities (HA)	2	1	1	1
Non-profits	3	1	1	1
Cost				
Incremental spending to run service/support	1	1	1	1
Incremental cost reduction in other areas	2	3	1	2
Administrative Complexity				
Administrative burden to implement	3	2	2	1
Total	22	23	14	19

Please see Appendix A for detailed matrix with justifications

Analysis of Option 1

Why expand provincial funding for non-medical home support services?

This option—to expand provincial funding to the BH program—performs the best out of all the options because of its effectiveness in increasing service access, ease of implementation, and for being comparatively cheaper to implement than other options. Another benefit is the ability to increase older adult's independence in the community and reducing premature entry into cost, publically-funded residential homes.

Expanding funds to BH could overcome the issues in implementing culturally-sensitive strategies discussed by the nonprofit organizations. First, increased funding would help reduce the wait lists for subsidized services and provide older adults in the community timely access to services they need. Second, expanding BH services across the province could reach South Asian and Chinese older adults who live in rural areas and face amplified access gaps, namely less access to community infrastructure, less adept in navigating and accessing community services, and lower socioeconomic status to pay premium for markets to provide services in the region(Lai & Chau, 2007; Lai & Surood, 2008, 2010; Sedziafa, Flood, & Mullings, 2015). By expediting the expansion of BH as a province-wide program, funding could help nonprofit organizations establish services in isolated areas.

Most nonprofit organizations are very ethnically diverse and have a wealth of knowledge about local needs. These groups acknowledge that some of their services are not culturally sensitive and would like to design new programs if the funds are available. The interviewed organizations that are most successful in engaging Chinese and South Asian older adults use “non-traditional” outreach strategies, such as planting a coordinator at places EMOAs gather or discussing services on ethnic television or radio talk shows (Koehn et al., 2016; Mukadam, Waugh, Cooper, & Livingston, 2015; Rauf, 2011). These findings suggest that expanding BH's financial capacity could close the service access gap EMOAs face. By designing a start-up and continuation innovation fund, BH could create a culture that is conducive to harnessing nonprofit organizations' wealth of knowledge while experimenting with new programs responsive to emergent community needs.

Since non-medical support services only alleviate caregiver burdens for those whose care recipients chose to utilize BH services, this option does not benefit all

informal caregivers. This option is unable to support the subset of South Asian and Chinese informal caregivers who are obliged to provide care due to strong filial piety beliefs. The concern with inadequate informal caregiver support must be mitigated by implementing this option in tandem with an option that strengthens informal caregiver support.

Analysis of Option 2

Why Reablement?

The reablement option performs the best in managing the health care costs of the aging population while assisting older adults in regaining independence. Numerous studies ranging from randomized control trials to qualitative studies in the UK, Australia, and New Zealand found that the reablement program is effective in reducing costs in other areas of health care: delaying the use of home care services, reducing visits to the emergency room, reducing entries to residential care, and reducing mortality rates (Lewin *et al.*, 2014; Senior *et al.*, 2014; Tinetti *et al.*, 2002). Reablement was cost-neutral within the first year of delivering the program (Glendinning *et al.*, 2010). Effects on delaying the use of services are also long-lasting. A study by the UK's Department of Health found that 68% of participants who received reablement training no longer needed home care support, and two years later, 48% continued not to need home care support (Glendinning *et al.*, 2010). The cost-saving effect of the reablement program extends into the other areas of health care, including a reduction in emergency room visits and hospital services visits (Lewin *et al.*, 2014). In Australia, reablement recipients were 30% less likely to use the ER or hospital services than their counterparts who did not receive reablement training (Michael Smith Foundation for Health Research, 2014). As shown in the empirical evidence, reablement is very effective in reducing ongoing home care support and associated costs.

Although current studies have not examined the implications of reablement on South Asian and Chinese older adults or ethnocultural groups in general, the potential outcomes of this program can be inferred from existing literature. First, research and interviews indicate that South Asian and Chinese older adults, particularly those who face language barriers, prefer to engage with bicultural staff and are more likely to enroll and adhere to programs when offered by bicultural staff (Koehn & Badger, 2015; Lai,

2004; Lai & Chau, 2007; Lai & Surood, 2010). A benefit to the reablement program is the ability to increase bicultural staff in front-line work since a professional degree is not required to enter into this profession. Immigrants who received education from another country could attend training at trades school and be qualified as a reablement staff. The lowered educational requirement increases the availability of bicultural staff and expand the service's linguistic and cultural-appropriateness. Literature indicates that South Asian and Chinese older adults face challenges navigating health services (Lai & Chau, 2007; Lai & Surood, 2010; Stewart et al., 2011). The reablement program would close this knowledge gap by introducing older adults to services in their community through the training and help them develop the necessary skills and confidence to participate in these services.

Finally, this option is more inviting than HCC services since it is universally available. By disassociating reablement from a subsidized services, there is less stigma towards utilizing this service (Lai & Chau, 2007). Attested by interviewees and by the literature, South Asian and Chinese older adults sometimes do not want to utilize services because they do not want others to perceive them as experiencing financial problems. Another benefit to the reablement program is the ability to increase South Asian and Chinese older adults' independence, thereby reducing the shame in "burdening" friends and family member with their health issues, a theme also cited in the literature (Lai, 2004, 2012). The reablement program could meaningfully engage South Asian and Chinese older adults and close the health literacy gap within this population.

As alluded to in the "Options" chapter, a key constraint of Option 2 is the administrative complexity of implementing this program. This policy can be successful only if there is a buy-in from the regional health authorities. BC's Ministry of Health must engage the health authorities at the onset of policy planning and design since the health authorities dictate whether or not the program would be offered in their regions. The health authorities are also regional experts who can foresee potential challenges and potential problem-solving strategies.

Analysis of Options 3 and 4

Both options use a choice-based approach, but why does Option 3 (using a market approach) perform much worse than Option 4 (using a market and non-market approach)?

According to economic theory, the market approach available in Option 3 could theoretically increase competition in the HCC market, which would force providers to improve quality and reduce prices. Yet this expected outcome was not found in the jurisdictions that implemented this policy. Users in Finland and Denmark were more satisfied with their services than before, but they were uninformed about their options and favored big corporations (OECD, 2010). Some users were unaware that they could choose providers and often hired the provider recommended to them (OECD, 2010). In Finland and Denmark, the mega-providers' dominance in the market allows them to set prices rather than compete and lower their prices (OECD, 2010). This evidence from other jurisdictions suggests that the theoretical cost-saving outcome is likely unachievable, making Option 3 less favorable.

Another issue in Finland and Denmark was a lack of market incentives for providers to correct regional and ethnocultural inequities (OECD, 2010). No providers were willing to establish services in rural regions because of the low return on investment. In this case, communities are dispersed, and very few older adults live in rural areas. The characteristics of rural regions make service delivery costly and reduces companies' profits. For similar reasons, companies are unlikely to provide services for diverse ethnocultural groups. Reaching ethnocultural groups requires companies to advertise services in different languages and hire bicultural staff, which reduces profit margins. Option 3 performs relatively poorly on the equity criterion, since there is no financial incentive for markets to provide services for marginalized groups, including but not limited to South Asian and Chinese older adults.

A benefit of Options 3 and 4 is their ability to ensure accountability and the service quality. The contractual agreement between the provider and the older adult establishes a set of standards the provider must meet. The project coordinators would ensure the standards are met through periodic evaluations, which could also diminish the possibility of elder abuse, for instance, preventing older adults from being forcefully detained at home by their informal caregivers when their care needs could be better met

in a facility. The periodic evaluations could increase the point of access for elder abuse, an issue pertinent for South Asian and Chinese older adults. Elder abuse is a highly stigmatized issue in Chinese and South Asian communities and is considered a matter that should not be discussed outside the confines of the family (Daniel W.L. Lai, Gabrielle D. Daoust, & Lun Li, 2014; Walsh et al., 2007). It is often a silenced problem, and through the regular visits, the services could potentially build awareness to prevent, recognize, and respond to elder abuse in BC's two largest ethnocultural minority communities (BC Law Institute, 2017).

Although Options 3 and 4 share many of the same market shortcomings, what sets Option 4 apart is the ability to pay informal caregivers. When markets do not provide the appropriate services, older adults are likely to pay informal caregivers in their social networks to provide care. For instance, people seeking care in rural areas could access support by paying their neighbors or family members, assuming that the payments are sufficient to induce people to provide this care. Likewise, EMOAs could receive culturally appropriate services by hiring friends or family members who share their language and culture. The ability to compensate informal caregivers, particularly family members, could reduce any sense of shame and guilt for burdening others South Asian and Chinese older adults may feel (Lai, 2004, 2012).

A benefit of Option 4 not measured by the matrix, but is worth mentioning, is the ability to offset adverse impacts of unpaid care. Informal caregiving duties are often unremunerated and providers often face financial hardships when they provide unpaid care (Sinha, 2012). These financial difficulties are especially prevalent in South Asians and Chinese due to the wage gap between racialized workers and non-racialized workers (Block & Galabuzi, 2011). The poverty is frequently perpetuated into retirement since the Canadian pension system relies on paid earnings over an individual's lifetime (Grant & Townsend, 2010). Option 4 corrects issues of unpaid care by remunerating the informal caregiver and by incorporating this payment into pension benefits as part of the Care Act. This remuneration would also be available for individuals who provide care because of social factors like cultural beliefs and filial piety (the duty to care for one's parents and elderly family members). Although the remuneration may remain inadequate for compensating informal caregivers for their support, this option could still improve

informal caregivers' conditions. To put it simply, Option 4 could help BC become a provincial leader in ending the systemic oppression of unpaid care.

To implement Option 3 or 4, BC would need to take on substantial administrative responsibilities. First, this would require health authorities' engagement to implement policies and support programs. The Ministry of Health would need to engage the health authorities early on to incentivize them to adopt this policy while respecting their autonomy. Another constraint on this option is the high cost of funding older adults and developing health authority units. This constraint, however, could be mitigated if this option is implemented in tandem with Option 2, Reablement, which helps contain costs by reducing service utilization. Option 4—the Care Act—presents greatest administrative complexity because it requires a new law to be enacted. Enacting and passing a law, at times may take up to a year or two years to finalize the law since the bill is reviewed by the House of Commons and Senate multiple times before it becomes a law. In summary, restructuring payment methods could improve access outcomes, but implementing this policy would be costly and administratively complicated.

Chapter 8. Recommendation

This chapter proposes a set of short- and long-term policies that could increase access to non-medical home support services and informal caregiver support for EMOAs in BC. BC's non-monolithic aging population require systems that are inclusive of different values, including previously ignored South Asian and Chinese older adults' needs. The recommendations here attempt to interrogate the structural barriers that limit organizations from addressing the issues faced by these groups. This set of recommendations present a starting point for policies to be inclusive to diversity, but further research and collaboration with South Asian, Chinese and other EMOAs is needed to tailor services to their unique needs.



Short-term recommendation

1. *Expand funding for non-medical home support services*

Before the inception of BH, private sector delivers most non-medical home support services. Since its establishment in 2012, BH has been improving older adults' ability to age in place by providing publically subsidized non-medical home support services. Expanding BH's funding in two areas is recommended. First, access should be broadened by increasing funding to develop BH as a province-wide program and reduce the waitlist for existing BH providers. Second, an innovation fund could increase the

service's appropriateness by harnessing local non-profit organization's local expertise. This innovation fund would allow the development of new programs that could increase culturally appropriate services to address the needs of EMOAs. According to the literature and interviewees, South Asian and Chinese older adults who arrived later in life may experience particular difficulties navigating health and social systems due to a history of reliance on informal means of information gathering in their country of origin (L. Zhan, Cloutterbuck, Keshian, & Lombardi, 1998). Some EMOAs, particularly those who immigrated to Canada through family reunifications, are illiterate in their own language, which makes written advertisement (like pamphlets) inappropriate (Koehn & Badger, 2015). Services such as shopping by phone or group shopping are offered through Safeway, which often does not carry ethnic food selections. Nonprofits are aware of the strategies and changes that need to be made; through the innovation fund, BC could harness this knowledge and implement changes that are responsive rather than reactive to the needs of BC's changing demographics (Koehn et al., 2016).

Another benefit of this recommendation would be the ability to create localized innovation hubs to test different types of services and engagement strategies. BH currently hosts quarterly regional meetings where providers meet, share their experience, and learn from content experts. These meetings are a great way to translate knowledge and encourage nonprofit providers to seek help from each other rather than "re-inventing the wheel" each time they test a new engagement strategy or create a new program. Knowledge transfer hubs can facilitate more efficient use of the innovation fund by increasing access to knowledge and allowing service providers to build on one another's experiences.

A concern with this option could be the high upfront cost. This concern would be mitigated by implementing the next recommended policy option, reablement, to increase older adults' independence and manage service costs. This proposed short-term recommendation will be phased out when the long-term recommendation choice-base recommendation is put into effect. The innovation fund that subsidizes special projects (e.g. programs and services for South Asian, Chinese and other minority groups) will continue to ensure that the non-profit sector provides services that the market would not otherwise provide. When the long-term recommendation takes effect, the innovation

fund and engagement fund will remain and the ethnocultural-specific programs would be partially sustained through users' payments.

2. Design and pilot reablement program

The short-term recommendation of this study is to pilot the reablement program in ethnically diverse different communities. Pilot projects provide great opportunities to validate benefits and gain insight into service designs and delivery before scaling up (Partners for Health Reform *plus*, 2004). The reablement option has been chosen because it fits well with BC's emphasis on prevention and early intervention. This option has also been widely tested and implemented in the UK, New Zealand, and Australia, and has demonstrated the ability to help older adults regain independence and improve quality of life while containing costs (e.g., emergency room visits, hospital services, HCC service utilization, etc.) (Glendinning et al., 2010; Lewin et al., 2014; Tessier et al., 2016).

While this option demonstrates strengths in restoring older adults' well-being and containing costs in service utilization and health services, there are a couple of considerations crucial to the implementation of this project. One of these is the necessity of establishing a healthy working relationship with regional health authorities. The Ministry of Health encourages health authorities to implement policies through directions described in their mandate letter and through the strategic priorities outlined in their service plans, but ultimately the health authorities dictate which programs are implemented (Government of BC, n.d.). What the Ministry could do is engage the health authorities early in the strategic planning phase and ensure the acceptability of the reablement program (Government of BC, n.d.). Because the reablement program requires high upfront costs to implement, the Ministry should establish a fund to incentivize regional health authorities to pilot and scale up this project. The allotted fund must consider regional differences and incorporate these factors into the funding algorithm. For instance, the algorithm should apply different weights to variables, so funds reflect the additional costs of providing services for dispersed populations or ethnically diverse communities, thereby preventing the perpetuation of access inequity in rural and ethnically diverse regions. The government's mandate, strategic priorities,

engagement, and funding could signal the Ministry's emphasis on this policy and encourage health authorities to implement this recommendation.

Another consideration is to ensure South Asian and Chinese representations in curriculum development. Curriculum development must involve older adults, particularly South Asians and Chinese, to ensure the success of the reablement program (Together UK, 2014). User involvement could inform whether the content of the program is applicable and acceptable, increasing the likelihood of service success (Together UK, 2014). The curriculum should also consider designing chapters that review practices specific to South Asian and Chinese needs and discuss the diversity within ethnocultural minority groups. The purpose of increasing representation is to ensure providers are culturally competent and training material would not reinforce ethnocentric practices that previously constrained South Asian and Chinese older adults.

Lastly, the professional development training for the reablement program should not require providers to have a professional degree. As discussed by one of the social workers interviewed, the requirement of a professional degree in areas (like case management) limits bicultural staff from entering the profession. New immigrants are often trained elsewhere making them not professionally qualified in Canada. If the requirements for entering the reablement profession are lowered, the demographic of reablement providers could be more responsive to changes in the ethnic makeup of communities. In conclusion, the design of the reablement program presents an opportunity to correct some of the institutional racism South Asian and Chinese older adults may experience by offering services delivered by bicultural staff and services that could actively close their health literacy gap. This recommendation demonstrates how institutional change requires a paradigm shift descending from government priorities and funding models to representation and staff training.

Long-term recommendation

1. Province-wide implementation of reablement

As discussed in the "short-term" recommendation, the reablement program could systematically incorporate prevention of acute care and provide restorative coaching to the aging population (Glendinning et al., 2010; Newbronner et al., 2007; Tessier et al.,

2016). Instead of “giving” older adults help—which disempowers recipients—reablement training focuses on dignifying older adults by teaching them how to help themselves. Reablement’s emphasis on restorative care aligns with the objectives of the 2015 World Health Organization’s World Report on Aging, which aims to foster healthy aging by enabling older adults’ ongoing participation in their well-being (World Health Organization, 2015).

A benefit of making reablement a province-wide program is the ability to contain costs within the health authorities, as demonstrated in the literature (Glendinning et al., 2010; Newbronner et al., 2007). Reablement could decrease costs in other areas of health services, namely by reducing HCC service utilization and emergency room visits, which is paramount to containing the rising health costs associated with the aging population (Glendinning et al., 2010). This long-term recommendation should be implemented in tandem with the other proposals in this chapter to maximize BC’s ability to provide for a broad range of care needs in the diverse aging population.

Reablement must be accessible to all older adults in the community to maximize this policy’s cost-containment potentials. Clients who are living in the community and are in relatively good health should be able to refer themselves or be referred by neighbors, family, or friends. Health professionals should also refer discharged patients, to support their transition back into the community. As highlighted in the literature, a successful reablement program must have multiple points of access, be universally available, and be free of charge (Tessier *et al.*, 2016). The ultimate purpose of the reablement service is to ensure that older adults in the community develop a universal level of health literacy and to integrate disjointed services in the community, ensuring that older adults can smoothly transition from one service to another.

2. *Legislate the Care Act*

The last long-term recommendation is to change the core values of BC’s service delivery model by legislating a Care Act. Under a Care Act, older adults who need additional help receive funding to purchase their choice of services—either formal services or informal caregiver support. This policy recommendation introduces a shift away from a prescriptive approach to a choice-based approach. Older adults are allowed agency over their own care; in other words, they can exert control over their choice of

services—the central value of client-centered care (Epstein & Street, 2011). This option puts older adults and their families at the forefront of their wellbeing, and positions clients' values and preferences as the top priority (Epstein & Street, 2011). Shifting away from a paternalistic model could allow the various preferences of a heterogeneous population to coexist (Epstein & Street, 2011).

As discussed in the “analysis” chapter, the success of this option depends on a strong nonprofit organization foundation so that services not normally supplied by the market would be available, namely culturally sensitive services and services in rural areas. The availability of culturally appropriate services in the market reduces the possibility of informal caregivers incurring all the caregiving responsibilities for older adults because the market does not provide the services. South Asian and Chinese older adults and their informal caregivers, including those who hold strong cultural beliefs concerning filial piety, would be able to use the funding to support the informal caregivers' services.

This study did not conclude on which payment level to use for the informal caregiver, but future studies should examine how the various payment levels introduce tradeoffs. First, if informal caregivers are paid an hourly rate comparable to the average price of service providers, it will make this option very costly even when the reablement program reduce the number of users. Second, if BC pays informal caregiver less than market services, there is a risk of exploiting informal caregivers and shifting the excess burden onto this cohort. Since we have not implemented the reablement program in BC, it is hard to model the potential cost two payment model presents. Theoretically, it is most favorable to pay informal caregivers equal rates as market price, but the high upfront cost could present a fundamental challenge to this recommendation.

Summary

The recommended three policies must be implemented in the stated order. The first recommendation ensures services firms will not otherwise provide available through the non-profit sector. Second, the reablement aims to retrain older adults early on so they could remain independent as long as possible and contain the cost of service utilization. Lastly, the choice-based approach grants users the ability to choose what

services they need most and how they prefer to receive it. Together, the set of recommendations could reduce the fragmentation of services by seamlessly transferring older adults from reablement to subsequent services, an essential component of an integrated aging-in-place model.

Chapter 9. Conclusion

This research study explored potential best practices BC could implement to develop an inclusive and cost-effective aging-in-place model. This study contributes to a growing body of research regarding diversity and aging-in-place and represents one of the first policy studies in BC to focus on both formal services and informal supports. The recommendations use legislation and programs to improve existing services' responsiveness to diversity and support the caregivers who are the backbone of supporting the aging population. The results of this study will be disseminated to interviewees engaged in this study: Seniors Advocate, Better at Home, and the local NGOs. An abbreviated version of the results will also be synthesized into a poster and will be presented at an upcoming poster presentation to an audience of policymakers, stakeholders, and researchers.

The specific contributions of this study address the following problems. First, deinstitutionalization has developed fragmented services in the community (Cohen et al., 2006; Cohen & Franko, 2015). The first recommendation is to expand funding to non-medical home support services, specifically BH, to support the overwhelming number of older adults who wish to age in their own communities. This increased funding would also allow for the creation of an innovation fund to encourage providers to revolutionize services and be responsive to local demographic changes, such as the distinctive needs of South Asian and Chinese older adults. The second issue is the lack of prevention services in HCC services; this problem can be mitigated through a reablement program, which could help older adults regain the confidence and practical skills to live independently. This option could improve wellness and bend the cost curve associated with the aging population. Lastly, the prescriptive approach to providing HCC services imposes homogenous values onto South Asian and Chinese older adults and caregivers (NACA, 2005). If the preferences of EMOAs deviate from those defined by mainstream services, their needs are often unmet in the community, thus creating reliance on

informal caregivers. The choice-based approach that allows older adults to purchase market and non-market services corrects this dynamic by restoring agency to the service users, enabling them to choose whether they want to buy. The specific contributions of this study address the following problems: The specific contributions of this study address the following problems: services or pay their informal caregivers. The three options work in concert to create a series of services that support older adults' independence in the community while recognizing the population's heterogeneity.

Further Research Considerations

Several important future research considerations emerged from the process of conducting this study. The central constraint of this study is the absence of South Asian and Chinese service users' voices. Unfortunately, recruiting older adults and translating South Asian and Chinese interviews is a large undertaking, given an eight-month timeline. Instead, this study used the literature to illuminate the intersectional experience of South Asian and Chinese older adults. The policies recommended in this study acknowledge the lack of South Asian and Chinese older adults' voices and integrate flexibility in both the design and implementation phases to allow for future refinements. The benefits generated from this engagement strategy are not limited to South Asian and Chinese older adults; inclusivity concerning indigenous people in BC and other ethnocultural groups can also be improved.

Drawing from the learning experience of this study, strategies to optimize future research are as follows. An interesting theme that arises from the interviews was the use of social media to reach family members of hard-to-reach seniors who are currently not engaged with the system. One interviewee explained how her organization is very involved on Facebook and Twitter. On multiple occasions, informant received calls from family members abroad who would like to get their aging family members in BC involved with services. It appears that social media presents a potential mode of outreach for hard-to-reach seniors by reaching concerned family members. Moreover, research has demonstrated that the new cohort of older adults is increasingly technologically advanced and an internet presence could potentially reach users who are not yet involved (Inkster, Stillwell, Kosinski, & Jones, 2016; Melgar & Elsner, 2016; Quan-Haase, Mo, & Wellman, 2017). As a provincial-wide service, BH should consider how

social media could be capitalized and potentially consider maximizing human resource efficiency by hiring one public relations staff that market services on behalf all of their non-profit partners

A key hindrance on this study was the lack of available data. Data on non-medical support services and ethnicity were either not collected or not publically available. According to the Deputy of the Seniors Advocate, the data health authorities sent to the Seniors Advocate do not include race or ethnicity variables. The absence of data has thus limited their ability to monitor discrimination and uncover inequality. Although there are some concerns about data regarding race or ethnicity being used in a discriminatory manner, the Ontario Human Rights Commission (OHRC) endorses the collection of race-based data as a means of uncovering inequality and better understanding the needs of racialized groups (Ontario Human Rights Commission, n.d.). BC should request race- and ethnicity-based data and use it to monitor access gaps. In a cultural environment that values statistics and data, limiting this data collection could continually discredit diversity research.

Another consideration is reexamining the conventional evaluation method since it might not be reflective of all users' lived experiences. The intersectional lens recognizes that the conventional evaluation method creates a power dynamic between researchers and participants (Parken, 2010). As explained in the literature, EMOAs often faces indirect or direct discrimination, namely racism, classism, sexism, ageism, and ableism, and these factors compound to create the particular social positions of EMOAs (Hooyman, 2014). Perpetual oppression, in some cases, may engender caution in EMOAs when they provide feedback about their needs (Koehn & Badger, 2015). Confirming this phenomenon, the Provincial Manager of BH noted in an interview that BH is experiencing a challenging time eliciting the voices of older adults. He speculates that older adults might be hesitant to express their complaints because of fear that services would be taken away from them, even though surveyors clearly indicate that services would not be withdrawn. This situation makes it challenging for program planners to collect unbiased feedback and transform programs to meet the needs of marginalized groups. This constraint compromises the effectiveness of services that are implemented to safeguard users, such as complaint lines and program evaluations. Future researchers should practice self-reflexivity and attempt to correct power

imbalance in the evaluation method. In some cultures, this may require the use of less “robust” methods, and resort to conversational qualitative data. The province should also acknowledge the limitations of evaluation methods and how these may embody institutional racism by perpetually misrepresenting EMOAs. Resources future researchers could consider incorporating into their inquiries include the examples outlined in Parken (2010), Hankivsky *et al.* (2012), and Palencia, Malmusi, & Borell (2014)

Concluding statement

The World Health Organization (WHO) defines active aging as “allowing people to realize their potential for physical, social, and mental well-being throughout the life course.” The WHO also emphasizes that “‘active’ refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active” (WHO, n.d.) The WHO’s active aging definition alludes to the importance of inclusion by referring to the practice of cultural values. This study’s set of recommendations offers older adults a say in how they wish to age in the community, as well as increasing inclusivity in BC’s heterogeneous society. Not only does this study reveal BC’s opportunity to reexamine key social constructs related to aging—paid and unpaid care, it also examines how a responsive, integrated aging-in-place model while being conscious of BC’s spending constraint is possible. South Asian and Chinese older adults and their families are part of the social fabric of Canada and accounts for nearly a quarter of BC’s population (Statistics Canada, 2013a). As a province, we ought to support not only older adults but also South Asian and Chinese older adults and their caregivers who are the backbone of the aging community.

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Appendix A.

Lessons learned from international jurisdictions

BC should consider some of the common features presented in the international case studies:

- **Care must be integrated** - Successful case studies demonstrate an integrated and interdisciplinary model where funded services are not only limited to medical support or ADL support. Instead, a broad range of services including, IADL support are provided to support older adult's independence (e.g., housekeeping, meal preparation).
- **Detailed evaluation reduces the quality of care** - In Denmark, a detailed evaluation was initially used to ensure service efficiency, but it led to significant decline in service quality and scope of practices. To overcome this issue, Denmark shifted their evaluation process to an itemized evaluation which allows service provider the flexibility needed to provide comprehensive services older adults require.
- **Legislate a Care Act or legislation that recognizes caregiver** - Most European jurisdictions legislated an Act to recognize the care older adults require and support informal caregivers need. The legislation also allows the public agency to compensate caregivers for their time (either hourly or as a set monthly or annual value that is below market price). Another benefit to the Act is the ability to set precedence and encourage labor market changes to accommodate the increasing number of informal caregivers within the workforce.
- **The human resource (HR) challenge in recruiting and retaining HCC care providers** - Care work does not pay well and is often stigmatized. Japan's and Denmark's are investigating how they might overcome the HR issues. Potential solutions they are examining includes creating upward career mobility options that could attract care provider into this sector and retain the trained talent (Michael Smith Foundation for Health Research, 2014). Another change Denmark and Japan adopted was to remove the entry requirement of a professional degree since it introduces a barrier for individuals to enter this profession. Instead, care providers are provided specialized training specific to the service they provide. In summary, it is too soon to tell how effective the HR changes were in Denmark and Japan. Nonetheless, it is worth noting that these issues

are common theme other jurisdictions experience and BC should revisit how effective the initiatives were in the near future.

Appendix B

Policy Matrix

Multi-Criteria Analysis on increasing services and support for EMOAs

Low = 1 point
 Medium = 2 points
 High =3 points

Criteria		Market Choice-based approach	Market & Non-market Choice-based approach	Increase BH funding	Re-ablement
Equity	Ethnocultural groups	Increase option for market, but does not guarantee that market provide service they need. Clients do not have the option of hiring family members.	Increase options for EMOAs, but market might not necessarily provide culturally appropriate services. However, clients are able to hire family members if they want <i>(able to reduce the 'guilt' many EMOAs experience when they rely on their adult children)</i>	Increase capacity to do outreach, tailor services to meet EMOAs needs. But unable to reach clients who want to utilize services from IC	Generally EMOAs have lower understanding of services available in community & how to access, mechanisms to promote wellness, and other health literacy. This can close health literacy gap and attract EMOAs who are reluctant to use services because of cultural stigma.
	Socioeconomical	Clients may choose to consume less units, but cannot compensate caregivers for their time.	Clients may choose to consume less unit of services, if they do not have the income, whereas status quo require partial payment per unit consumed. Capacity to compensate caregiver.	Income-tested but long-wait time makes benefit an insider and outsider benefit. Where those who receive service pay based on income, but those who are waiting for services do not benefit at all	Universally free for all users
	Regional	When service is not available, client can only hire other people to help	When services are not available in the community, older adult may hire their family or	Able to expand services in rural areas, but staff recruitment and retention is still questionable	Uncertain about ability to recruit staff, but can train local community member to deliver services since it

			other people in community to provide services (enable local employment)		does not require professional degree. Overcome regional challenges, where individuals are unable to access services because older adults are trained how to cope with new functional needs.
Effectiveness	Availability of services	Limited impact on supply of services	Limited impact on supply of services. Some people may provide services privately, but likely minimal	Reduce wait-list and increase access	Reduce demand of services
	Availability of support	Benefits does not improve caregiver compensation	May increase incentives for caregivers to provide care	Some impact on caregivers who's service provision decreased because of BH services, but have no impact on households where IC support is preferred	Reduce demand of IC support but does not compensate IC who still needs to provide support
stakeholder acceptability	Health Authorities (HA)	Increase workload for HA, need to assess clients and also track usages		No change to HA spending or structure	Current privacy law makes it challenging for HA to connect clients to services like this, will require some changes to link HA to NGO delivering services
	Non-profit	Does not resolve financial constraint BH face. Also some clients might not chose to use BH service which can reduce predictability of funding & impact service delivery.		Resolve financial constraints, therefore able to increase reach across province and within communities	Increase responsibility of non-profits
Cost	Provincial spending to run support/service	Increase spending but can reduce spending on charitable organization. Tax-credit remains in place	Increase spending but can reduce spending on charitable organization & tax credit	Increase spending for BH	Increase spending on training staff, in providing re-ablement But might reduce spending on BH services, home-care services, home support services, etc.

	Cost containment in other areas	No oversight on health promotion and no capacity to reduce caregiver burnout	No oversight on health promotion but can reduce burden on caregivers	Staff can be trained to promote health promotion and potentially reduce hospitalization & institutionalization	Able to train older adults in skills they lack to age-in-place well. Shown in studies to reduce hospitalization and institutionalization
Administrative complexity	Administrative burden to implementation	Need to establish new educational institutions and new systems to integrate reablement services	Require legislative change and restructuring to help evaluate eligible clients	No administrative or legislative changes	No legislative changes Requires Ministry to work with HA in developing structure to delivery reablement
TOTAL		\$5 = 14	#3 = 19	#1 = 22	#2 = 21