Researching the Health Needs of Elderly Indian Migrants to New Zealand

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ABSTRACT

The older adult population in New Zealand is increasing and becoming more ethnically diverse. With this change comes a requirement for health and social service professionals to become more knowledgeable about the cultural needs of their clients and to provide care that is cognisant of language, culture and religion. Indians have a long history of settlement in New Zealand; however this has not been reflected in policy or service provision. The reasons for this include a focus on the bicultural relationship with indigenous Mâori and a relatively small Indian population. The Immigration Act 1987 has led to an increase in the cultural diversity of migrants and the number of Indians. Policy has not kept pace with demographic changes and there is a need to develop the health sector to work with Indians and other migrants. This article begins by tracing the changing demographics of age and ethnicity in New Zealand and the relationship with migration policy. Indian history, settlement and health in New Zealand are explored then a brief overview of existing research is presented along with the identification of gaps and recommendations for an expansion of current health research and practice agendas such as cultural safety and ethnicity data collection.

Keywords: Indians, health, settlement, Asian, older adults, New Zealand

The 2001 New Zealand Census highlighted significant trends in the ageing population; including the proportion of elderly would rise and that they would become increasingly diverse (Ministry of Social Development, 2001). There are now approximately 495,000 people aged 65 years and over in New Zealand, accounting for 12% of the

total population with the majority of this group women. In comparison with the under-65 population, the elderly population is less ethnically diverse, the result of a migration policy that has privileged migrants of working age with skills or who are entrepreneurs, and the unrestricted access to New Zealand by British migrants until the mid-1970s. Twenty nine percent of older people were born overseas, compared with 22% those aged under 65 with 14% of people aged 65 and over were born in the United Kingdom or Ireland, compared with 4.9% of the under-65 population (Ministry of Social Development, 2001).

This demographic is set to change again with the number of Asian (defined as from the Asian continent excluding central Asia and middle east) people aged 65 years and over projected to reach 55,000 by 2021. This is five times the 2001 population of 11,000 and, by 2010, older adults will account for 9% of all Asian people, compared with 4% in 2001. It is argued that the category 'Asian' lacks specificity and masks not only diverse languages, cultures, religious and political backgrounds but social and health needs as well (Workshop Organising Team, 2005).

The increase in ethnically, religiously and culturally diverse older adults will require health and social service professionals to become more knowledgeable about the cultural needs of this group and to provide care that is cognisant of language, culture and religion.

In 2001, 93% of the older Asian population were born overseas which has implications for language proficiency and access to services. Research shows that English language proficiency is critical in successful settlement outcomes (Fletcher, 1999) and that learning a new language is particularly difficult for older immigrants (DeSouza & Garrett, 2005; Ho, Au, Bedford, & Cooper, 2002). Again, due to past migration policy and labour market demands, the majority of the older adult population are English language speakers, with 40,000 of older people (9%) being able to speak two or more languages (Statistics New Zealand, 2002b) and the proportion of multilingual speakers declining from 12% among 65–74 year olds to 7% among 75–84 year olds and 5% of people aged 85 and over.

The Indian community is a growing minority in New Zealand, making up the second largest group in the category 'Asian' (26%), while Chinese communities make up 44% of all Asians (Statistics New Zealand, 2002a). Europeans/Pakeha (Mâori name for European)

make up 79.6% of the population, followed by New Zealand Mâori with 14.5%, Pacific Islanders 5.6%, Chinese 2.2% and Indian 1.2% (Statistics New Zealand, 2002b). Within the Asian group, Indians had the second highest numerical increase in population between 1991 and 2001 (after the Chinese ethnic group), up 31,194 or 102%. Most of the population growth within Indian communities has been from overseas born Indians, with numbers rising from 20,517 in 1996 to 43,923 in 2001 an increase of 23,406 (Statistics New Zealand, 2002a). In contrast, the population of New Zealand-born Indians rose from 9,501 in 1996 to 17,550 in 2001 an increase of 8,049 people.

Indian New Zealanders: Context

Indian-New Zealanders are highly qualified and more likely to receive income from wages and salaries than the total New Zealand population and are as likely as the overall New Zealand population to receive income from self-employment thus Indians have the second highest median annual income among the Asian ethnic groups, are involved in white collar employment and, at 77%, have the highest labour force participation rate of all the Asian ethnic groups (Statistics New Zealand, 2002a). This results in a relatively high level of home ownership (41%), and view of successful settlement. This profile of Indian New Zealanders is a recent development, early Indian migration was primarily derived from two rural areas of India, Gujarat and Punjab, and arrivals were mainly traders, farmers, artisans or small businessmen (Tiwari, 1980).

The Indian connection with New Zealand began in the late 1800s through Lascars (Indian seamen) and Sepoys (Indian soldiers) on British East India Company ships that brought supplies to the Australian convict settlements. The earliest Indian to arrive in New Zealand is thought to have jumped ship in 1810 to marry a Mâori woman. The Indians that followed came mainly from Gujarat and Punjab, areas of India which had been exposed to emigration, and were driven by economic factors. Initially Indians were considered British subjects and could enter New Zealand freely. This changed with the passing of the Immigration Restriction Act 1899.

Indian migration increased until 1920, when the New Zealand Government introduced restrictions under a 'permit system' (Museum of New Zealand: Te Papa Tongarewa, 2004). In 1926, the White New Zealand League was formed as concern grew about the apparent threat

that Chinese and Indian men appeared to present in terms of miscegenation and alien values and lifestyle. Discrimination against Indians manifested in restrictions around joining associations and accessing amenities such as barbers and movie theatres. By 1945, families (mostly of shopkeepers and fruiterers) were getting established and marriages of second-generation New Zealand Indians were occurring. As well as Gujuratis and Punjabis, smaller numbers of Indians came from locations such as Fiji, Africa, Malaysia, the Caribbean, North America, the United Kingdom and Western Europe. The proportion of Fiji-born Indian immigrants to New Zealand rose significantly as a result of the Fijian coups of 1987 and 2000 (Swarbrick, 2004).

Indians have largely managed to evade the anti-Asian sentiment directed toward Chinese communities in New Zealand. Indians are mostly seen as positive contributors to the New Zealand economy and elements of Indian culture have been readily consumed in the form of festivals, food and restaurants. Furthermore, Sari material, yoga, mendhi, ayurvedic medicine and Eastern spirituality have joined the list of consumables that many New Zealanders enjoy without understanding their social, political, cultural and spiritual significance (DeSouza, 2004).

Despite this consumption of 'Indianness', little emphasis has been accorded to visibly different migrants in the debates over citizenship, which have become critical over recent years in New Zealand. These debates have emerged in part through a renaissance in Mâori sovereignty, increased migration. They are related to the global rise in indigenous movements in the 1970s that have seen the re-positioning of Mâori as indigenous to New Zealand and the evolution of a bicultural nationalism (Roscoe, 1999). Critics such as Thakur (1995) argue that the official rhetoric recognises the legitimacy of Mâori and Pakeha but excludes migrant cultures that are non-white and non-indigenous. Therefore, there is a need to acknowledge diversity and build policies that accommodate and capitalise on the diversity that older people present (Ministry of Social Development, 2001).

Research and service provision

Service gaps have been identified in a report commissioned by the New Zealand Immigration service (Ho, Cheung, Bedford, & Leung, 2000), which found that migrants had four areas of need:

everyday needs, learning English, employment, and supportive connections. Since this report was published, a range of settlement programmes have been established in the Auckland region (where half of the migrant population resides and where one in three residents is born overseas) to assist with these areas of need. However, what health innovation exists comes from advocacy from community groups and volunteers, rather than being driven from the top by policy.

Another area of concern is the future care of an aging ethnically diverse population who may require care outside the home. Kiata, Kerse, & Dixon (2005) argue that little is known about the experiences of people who live and work in long term care facilities in New Zealand. Evidence shows that the private sector is becoming more significant in delivering health care to the elderly and the New Zealand government has identified older adults as a significant group who are highly likely to require support from health disability and social services (Kiata et al., 2005). As the number of ethic elders increases it is likely that they will utilise such services. Kiata et al. (2005) shows that 28% of people over 85 live in long-term residential care and, based on the population projections, more Asians and other ethnic groups will potentially become users of such services. This in turn will increase the demand for care that is appropriate for each ethnic minority group (Kiata et al., 2005).

There is a growing body of research concerning the health of Asian people living in New Zealand and this is largely the result of lobbying by community organisations such as the Asian Network and the Asian Public Health Service. However, little is known specifically about the Indian elderly. The Asian Public Health Service commissioned a report to systematically examine the data collected from over 1,200 Asian participants in the 2002/03 National Health Survey funded by the Ministry of Health (Scragg & Maitra, 2005). This survey provided the opportunity to examine health status in a large representative sample of Asian people, and in particular to examine health status within Asian communities such as South Asians, within which Indians are subsumed. The key findings reveal that South Asians had the highest rates of obesity, were more likely to be overweight and obese than other Asian people and have significantly higher rates of diabetes and asthma than the overall population. South

Asians also have a higher prevalence of treated high cholesterol and diabetes.

Physical activity is thought to be one of the main protective factors against a wide range of diseases including cardiovascular, diabetes and some cancers, however, South Asians (and South Asian women in particular) had the lowest rate of physical activity, which makes for sobering reading.. In terms of housing, South Asians were more likely to live in the low socio-economic areas than other Asian people (Scragg & Maitra, 2005).

Other survey data from Scragg & Maitra (2005) considers Asians as a homogenous group and notes some findings that are a cause for concern:

- Asian people were less likely to have visited a health practitioner (or health service) when they were first unwell than other New Zealanders.

- Asian people were less likely than Europeans to visit a health practitioner (doctor, specialist, nurse or complementary healer) about a chronic disease.

- Asian women were less likely to have had a mammogram or cervical screening test in the last three years than other New Zealand women.

- Asians were less likely to use any type of telephone helpline than all New Zealanders.

- Asians tended to visit their GP only for a short term illness or a routine check up, and were less likely than other New Zealanders to visit after an injury or poisoning or for mental or emotional health reasons.

Expanding health practice and research agendas

Invariably, given the relatively small population size, Indians in New Zealand are aggregated together with other ethnic groups; however, there is a need for research that investigates and policy that informs the health status of Indians in New Zealand. Duncan, Schofield, Duncan, Kolt, & Rush (2004) argue that despite their population growth, Asian ethnic groups have been largely neglected by New Zealand health and research policies. They provide an instance of both over sampling and separate analysis of Mâori and

Pacific Island children in the 2002 National Children's Nutrition Survey, while Asian children were subsumed with New Zealand Europeans. Large-scale studies are needed to determine health risk across all major ethnic groups in New Zealand, which will in turn enable development of ethnic-specific data. Even more critical is the need for data concerning ethnic variation in other areas of health so that effective interventions can be developed and implemented (Duncan et al., 2004). This omission and exclusion is by no means a rare occurrence in national surveys and prevents the development of an understanding of the public health needs of Asian communities in New Zealand. Such an understanding is necessary for the development of appropriate preventative health strategies, which Scragg and Maitra's (2005) examination of the National Health Survey suggests is needed, showing that Indians in New Zealand have different health priorities to other ethnic groups.

Expanding health practice and research agendas

Researchers and practitioners need to develop an evidence base to guide health service development and provision. This in turn must lead to the expansion of the bicultural policy imperatives, so that the needs of the growing multi-ethnic and religious communities in New Zealand are considered.

There is a paucity of research focussing on older migrants and refugees. Indians are often subsumed into the category 'Asian' and little is known of the experiences of elderly Indians who accompany their skilled children to New Zealand, whereby losing their peer groups and networks in the process. There are support agencies available that offer companionship and support but only to those already engaged in community and social organisations. Research among migrant Indians has identified health problems related to acculturation and lifestyle changes such as reduced physical activity, dietary changes and isolation which can result in diabetes, cardiovascular disease and mental health problems. It is thought that elderly Asians are vulnerable to mental health problems and suicide because of poor language skills, limited support networks and isolation (Ho et al., 2002). Research is also required into barriers and facilitators of health maintenance.

Future research offers some possibilities for rectifying this gap. A new longitudinal study of New Zealand children and families is being

developed by the Ministry of Social Development (MSD) with the support of the Health Research Council of New Zealand (HRC). The study is currently being investigated with a view to informing the government about whether to invest in the study, which would continue for up to 25 years.

Accurate ethnicity data collection is required. The New Zealand Health Strategy (Ministry of Health, 2000) guides the development and provision of new services in the health and disability sector to improve the health of New Zealanders. The strategy aims to reduce inequalities in health status for Mâori, Pacific peoples and people from lower socio-economic groups. One of the ways to do this is to focus on quality, as to ensure that health outcomes are improved and health disparities reduced through several mechanisms, primarily information management and technology. Improving the quality of information assists health outcomes by providing timely and relevant clinical information. Providing communities with better access to information about their health or health care services can contribute to improved decision-making regarding local health services. A standardised national approach to ethnicity data collection is being used and the Health and Disability Sector Ethnicity Protocols (Ministry of Health, 2003)have been developed to assist in this which will go some way to providing more information about the needs of growing ethnic communities, however evidence to date has been that in practice, data has not been collected accurately (Klajakovic, 1993; McLeod et al., 2000; McPherson, Harwood, & McNaughton, 2003; Ministry of Health, nd).

Expanding the bicultural framework to a multi-cultural framework is necessary. Despite the significant shift in our ethnic make-up, New Zealand has yet to encompass multiculturalism as a social policy framework. According to Bartley & Spoonley (2004), this is because the United Kingdom and Ireland have traditionally been New Zealand's source of migration, which in turn has shaped the development of activities and concerns (as they argue, racist and Anglocentric assumptions of a colonial New Zealand) and, when the time did come to explore issues regarding the nation and nationality, this coincided with a rise in concerns over indigenous rights and the Treaty of Waitangi (signed by and defining of the relationship between Mâori as the indigenous people of Aotearoa/New Zealand and Pakeha

(European), New Zealand's founding document. Thus while countries such as Canada and Australia was developing multicultural policies, New Zealand was debating issues of indigeneity and the relationship with tangata whenua (Mâori). As a result, New Zealand has yet to develop a locally relevant response to cultural diversity (multiculturalism) that complements or expands on the bicultural (Mâori and Pâkehâ) and Treaty of Waitangi initiatives that have occurred (Bartley & Spoonley, 2004).

Cultural safety needs to encompass new and growing ethnic communities. Durie (1994) suggests that the contemporary application of the Treaty of Waitangi involves the concepts of biculturalism and cultural safety, both of which are at the forefront of the delivery of health services. Cultural safety encompasses both a conceptual framework for understanding the power inequalities that structure the relationships between Mâori and health professionals and practical strategies that can be utilised. This means incorporating the "principles of partnership, participation, protection and equity" (Cooney, 1994, p.9) into the care that is delivered. There is an expectation that health professionals in New Zealand will ensure that care is culturally safe for Mâori. Cultural safety needs to be expanded to apply to any person or group of people who may differ from the health professionals because of socio-economic status, age, gender, sexual orientation, ethnic origin, migrant/refugee status, religious belief or disability (Ramsden, 1997). However, the focus has largely been on the relationship between Pâkehâ and Mâori, rather than migrants (DeSouza, 2004) and other communities (Giddings, 2005).

Conclusion

Indian communities have played a significant part in the development of New Zealand, in particular from a labour market point of view, migrating as traders, farmers and more recently professionals and business people. However, they are largely invisible in health policy and practice. There is a need for responsive health, disability and social services. In addition there are significant gaps in the knowledge about the health status of Indian communities in New Zealand. This prevents the development of appropriate policy, service development and interventions, made worse by the lack of robust New Zealand data. Research within Asian communities has largely been driven from the communities themselves, through their lobbying to the

Ministry of health and funding of research. There is a need for some strategic momentum and for a concerted research agenda to be developed. The analysis of the 2002-2003 New Zealand Health Survey data goes some way towards highlighting some of the areas where Indian health priorities differ from those of other populations and where interventions are required. While the Indian population in New Zealand is currently comparatively youthful, there is a need for some future planning to develop appropriate and responsive services.

References

Bartley, A., & Spoonley, P. (2004). Constructing a workable multiculturalism in a bicultural society. In M. Belgrave, M. Kawharu & D. V. Williams (Eds.), *Waitangi revisited: perspectives on the Treaty of Waitangi* (2nd ed., pp. 136-148). Auckland, N.Z: Oxford University Press.

Cooney, C. (1994). A comparative analysis of transcultural nursing and cultural safety. Nursing Praxis in New Zealand, 9(1), 6-12.

DeSouza, R. (2004, October). *The Art of Walking Upright Here: Realising a Multicultural Society*. Paper presented at the Kiwi India Seminar Series, Auckland and Wellington.

DeSouza, R., & Garrett, N. (2005). *Access issues for Chinese people in New Zealand*. Auckland: Auckland University of Technology.

Duncan, E., Schofield, G., Duncan, S., Kolt, G., & Rush, E. (2004). Ethnicity and body fatness in New Zealanders. *Journal of the New Zealand Medical Association, 117*(1195).

Durie, M. (1994). Whaiora : Maori health development. Auckland ; Oxford: Oxford University Press.

Giddings, L. S. (2005). A theoretical model of social consciousness. Advances in Nursing Science, 28, 224-239.

Fletcher, M. (1999). *Migrant settlement; a review of the literature and its relevance to New Zealand*. Wellington: New Zealand Immigration Service, Department of Labour.

Ho, E., Au, S., Bedford, C., & Cooper, J. (2002). *Mental health issues for Asians in New Zealand: A literature review* (Commissioned by the Mental Health Commission). Waikato: University of Waikato.

Ho, E., Cheung, E., Bedford, C., & Leung, P. (2000). *Settlement assistance needs of recent migrants* (Commissioned by the NZIS). Waikato: University of Waikato.

Kiata, L., Kerse, N., & Dixon, R. (2005). Residential care workers and residents: the New Zealand story. *The New Zealand medical journal, 118*(1214), 9.

Klajakovic, M. (1993). Is it easy collecting ethnicity data in general practice? *New Zealand Medical Journal, 106*, 103-104.

McLeod, D., Harris, R., Bailey, T., Dowell, A., Robson, B., & Reid, P. (2000). The collection of patient ethnicity data: a challenge for general practice. *New Zealand Family Physician, 27*(3), 51-57.

McPherson, K. M., Harwood, M., & McNaughton, H. K. (2003). Ethnicity, equity, and quality: lessons from New Zealand. *BMJ, 327*(7412), 443-444.

Ministry of Health. (2000). *The New Zealand Health Strategy*. Wellington: Ministry of Health.

Ministry of Health. (2003). *Health and disability sector ethnicity data protocols*. Wellington: Ministry of Health.

Ministry of Health. (nd). *Environmental scan: Ethnicity data collection issues*. Wellington: Ministry of Health.

Ministry of Social Development. (2001). *Positive ageing in New Zealand: Diversity, particpation and change*. Wellington: Ministry of Social Development.

Museum of New Zealand: Te Papa Tongarewa. (2004). *Indians in New Zealand*. Retrieved 28th November, 2005, from http://www.tepapa.govt.nz/LEARNING/AAINAA/ceremonies/indians_nz.html

Ramsden, I. (1997). Cultural Safety: Implementing the concept - The Social Force of Nursing and Midwifery. In P. T. Whaiti, M. McCarthy & A. Durie (Eds.), *Mai i rangiatea*. Auckland, NZ: AUP.

Roscoe, J. (1999). Documentary in New Zealand: an immigrant nation. Palmerston North, New Zealand: Dunmore Press.

Scragg, R., & Maitra, A. (2005). *Asian health in Aotearoa: An analysis of the 2002-2003 New Zealand Health Survey*. Auckland: The Asian Network Incorporated.

Statistics New Zealand. (2002a). *2001 Census: Asian People*. Retrieved 25th January, 2005, from http://www.stats.govt.nz/people/communities/asianpeople.htm

Statistics New Zealand. (2002b). *Census snapshot : cultural diversity*. Retrieved 25th January, 2005, from http://www.stats.govt.nz/products-and-services/Articles/census-snpsht-cult-diversity-Mar02.htm

Swarbrick, N. (2005, 11 July 2005). Indians. Retrieved 8th October, 2005, from http://www.TeAra.govt.nz/NewZealanders/New ZealandPeoples/Indians/en

Thakur, R. (1995). In defence of multiculturalism. In S. W. Greif (Ed.), Immigration and national identity in New Zealand: One people, two peoples, many peoples. Palmerston North, New Zealand: Dunmore Press.

Tiwari, K. N. (Ed.). (1980). *The Indian Community in New Zealand: A Historical Survey in Indians in New Zealand: Studies of a sub-culture*. Wellington: Price Milburn.

Workshop Organising Team. (2005). *Issues and options paper: The use of the term 'Asian' in New Zealand and implications for research, policy development and community engagement.* Auckland: University of Auckland.