Ageing & Society **24**, 2004, 51–74. © 2004 Cambridge University Press
DOI: 10.1017/S0144686X03001375 Printed in the United Kingdom

The views of older Chinese people in Melbourne about their quality of life

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ABSTRACT
This paper reports the findings of a study using both quantitative and qualitative approaches of the quality of life of older Chinese people in Melbourne. A total of 60 participants was recruited: 30 were residents of three Chinese hostels and 30 were members of a Chinese welfare society. Along with the established scales of health status, functioning and self-reported life satisfaction, to give a broader perspective the participants were asked about their general health, level of depressive mood and independence. In-depth interviews were conducted with a convenience sub-sample of six informants to explore other important aspects of their quality of life. The hostel group was found to be less healthy, less independent, more depressed and less satisfied with their lives than the community group, but nonetheless were generally satisfied with their lives, as revealed during the in-depth interviews. A good quality of life was found to be associated with good health, independence, secure finance, a meaningful role, strong ethnic community and family support, low expectations, no worries, and a sense of the family's love and respect. The findings reinforce the notion that the quality of life is truly multi-dimensional. They also demonstrate that a high self-rated quality of life in old age is achievable and, indeed, was being enjoyed by most of the participants. The research has made a substantial contribution to understanding the circumstances of Chinese-origin older people in Australia and has useful lessons for studies of other ethnic groups.

KEY WORDS – quality of life, Chinese older people, immigrants, Australia.

Introduction

The quality of life of older people has become an important topic in gerontology research (*e.g.* Ferris and Bramston 1994; Testa and Simonson 1996; Bond 1999; Barnes and the Design in Caring Environments Study Group 2002; Thumboo *et al.* 2003). Given the deterioration of health and other related events that often accompany ageing, a negative impact upon a person's quality of life seems a natural outcome, as extra efforts are

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required to maintain normal life. In addition, the negative stereotypes of older people, often reinforced by mass media coverage of old age, have created a widespread 'ageing-phobia' even among older people (Imel 1996; Grant 1996; Government of Victoria, Family and Community Development Committee 1997; Minichiello, Browne and Kendig 2000).

As we live longer than our ancestors did, we are also challenged to maintain the quality of our lives in old age. Eventually some individuals lose their independence and depend on external resources for quality living. Rapid social change undermines the value of the experience gained by living for many years (Shank and Keith 1995); older people, therefore, are relatively better off in countries where the rate of social change is relatively slow. Older people in countries with rapid social change require specific social policies to cope with their needs. A government's efforts to introduce social policies that meet people's changing needs often override its efforts to maintain a slow rate of social change. The status and roles of older people in a society depend to a large extent on the resources that they have (Sokolovsky 1990; Shank and Keith 1995; Ingersoll-Dayton and Saengtienchai 1999; Kendig *et al.* 1999; Oldman and Quilgars 1999; Vo-Thanh-Xuan and Liamputtong Rice 2000; Keasberry 2001; Oh and Warnes 2001; La Grange and Lock 2002; Vo-Thanh-Xuan and Liamputtong 2003). Research by social gerontologists has shown that income security, changes to the retirement age, the support of family and friends and independent living are the main elements required for older people to enjoy a fulfilling life (Kilmartin 1989; Arber and Ginn 1991, 1993; Ginn and Arber 1998; Irwin 1999; Milne and Williams 2000). While values and beliefs also influence the quality of life, sufficient services and support are key determinants for older people (Blakemore 1999; Kendig *et al.* 1999; Chiu and Yu 2001; Keasberry 2001; Thumboo *et al.* 2003).

Attempts to define the quality of life have an extended history (Schipper, Clinch and Powell 1990; Arnold 1991; Raphael *et al.* 1994). It has been shown conclusively that the physiological, psychological, social, behavioural and intellectual functions are fundamental determinants of quality of life, and that other factors, such as ethnicity, gender and socioeconomic status are influential (Overberg 1984; McKenzie and Campbell 1987; Haga *et al.* 1991; Lan 1995; Thumboo *et al.* 2003). The vulnerability of older people, however, places them at risk of a poor quality of life, and the combination of disability and social loss is most likely to occur in advanced old age (Kendig 1990). Will this be especially so for older immigrants, who often experience enormous cultural differences between their old and new countries? Minichiello *et al.* (1992) have remarked that there is little information about the experiences and perceptions of older service recipients from various ethnic groups that make up a substantial

proportion of the Australian population. Although there have been some recent studies on older immigrants (Blakemore 1999; Vo-Thanh-Xuan and Liamputtong Rice 2000; Chiu and Yu 2001; Torres 2001; Vo-Thanh-Xuan and Liamputtong 2003), studies of Chinese-origin older people in Australia have been few, even for Melbourne where the Chinese are a relatively large and long-established ethnic group and the number of older people has recently increased rapidly (Victorian Elderly Chinese Welfare Society 1984; Chinese Community Social Services Centre 1996).

The aim of the present study is to examine the quality of life of Melbourne's Chinese older people who are living either in residential accommodation or in the community. This paper is based on a larger study that employed both quantitative and qualitative approaches. The intention was to generate findings that would contribute to understanding and improving the lives of not only Chinese older people but also other ethnic groups and the general elderly population in Australia and other developed nations.

Concepts and theories

Lawton (1983) defined the quality of life as the multi-dimensional evaluation of an individual – in past, current and anticipated time – by both intra-personal and social-normative criteria derived from the person-environment system. Quality of life basically reflects subjective and objective evaluations of the major dimensions of the person's life (George and Bearon 1980). Spilker (1990) supported the view that clinicians could not accurately assess a patient's quality of life in all or most situations. He cited the study by Slevin *et al.* (1988) which reported a poor correlation between patients' own perceptions of their quality of life and physicians' assessments. Thus to arrive at reliable and comprehensive descriptions of the quality of life, it is important to consider both self-perceptions and the perceptions of others.

Lawton (1983) suggested that there were four dimensions of a good quality of life: psychological wellbeing, perceived quality of life, behavioural competence and objective environment. Schipper, Clinch and Powell (1990) agreed that links between physiological functions and psychosocial states influenced the quality of life. Most previous papers have asserted that any definition of quality of life should consider physical, cognitive, intellectual, social and emotional functioning, life satisfaction, health perceptions, economic status, the ability to pursue interests and recreations, sexual functioning, energy and vitality (Arnold 1991). Raphael *et al.* (1994) argued that the conceptualisation of the quality of life should be

the same for all people regardless of illness or disabilities, and should be holistic in that both the person and the environment in which he or she lives are considered. Consequently, the quality of life of older people should contain domains beyond health-related issues including aspects of social, emotional and physical functioning as well as life satisfaction.

Methodology

The participants

The study participants comprised older people who lived in two contrasting settings in Melbourne. The 'hostel group' lived in residential hostels for Chinese older people and in the Chinese wing of a multi-ethnic community hostel; the 'community-living group' were members of the Victorian Elderly Chinese Welfare Society. The purposes and methods of this study were communicated to the management of the four facilities to gain their approval and support. Approval was also given by the La Trobe University Faculty of Health Sciences Human Ethics Committee. Consistent with ethical requirements, written consent was obtained from each participant after providing a clear and thorough explanation of the study.

With the help of the managers of the facilities, residents younger than 65 years, the cognitively impaired, those with dementia, and those who were unable or unwilling to sign the informed consent form were excluded from the study. The Mini-Mental State Examination was the initial screening tool but was abandoned because of its inapplicability to illiterate, poorly educated and vision-impaired individuals. As some of the older people with physical and literacy disadvantages were considered to be cognitively sound by the staff of the hostels or association and by the researcher, exclusion of a cognitively impaired person depended on the individual's capability to participate in the study and a staff recommendation. The number and gender ratio of the hostel and community samples were equalised to maximise the comparability of the two groups. There were in fact 19 females and 11 males in each group. The gender ratio reflects the ratio of females to males in the ethnic group population aged over 65 years.

All 60 participants completed a self-report questionnaire that quantified several factors related to the quality of life. Additionally, three participants from both the hostel resident group and from the community group were interviewed after the researcher explained to them the nature, procedure and purpose of the encounters and obtained their informed consent. Convenience sampling was used for the interview component: the participants were men and women who were willing to share their opinions.

Measurement scales

The scales employed concerned the participants' self-reported health status, independence in instrumental activities of daily living, emotional status and life satisfaction. Other details, including age, gender, place of birth, country of origin, marital status, languages, education, type of accommodation, living arrangement and sources of income were collected to analyse the participants' social, economic and cultural backgrounds. Four self-report scales were translated into Cantonese and used to explore the multiple dimensions of the quality of life. These were the Medical Outcome Survey-36 (MOS-36), also known as the Short-Form Health Survey-36 or SF-36 (Ware and Sherbourne 1992), the Life Satisfaction Index Z (LSI-Z) (Wood *et al.* 1969), the Geriatric Depression Scale (GDS) (Yesavage *et al.* 1983), and the Older Americans' Resources and Services, Instrumental Activities of Daily Living scale (OARS IADL) (Fillenbaum 1988). These scales have been widely used by researchers and clinicians in previous studies of quality of life (Markides and Martin 1979; Osberg *et al.* 1987; Steinkamp and Kelly 1987; Morganti *et al.* 1988; Thompson, Futterman and Gallagher 1988; Arnold 1991; Mui 1996; Pit *et al.* 1996; Bowling and Grundy 1997).

The selection of measurement scales was constrained by the requirement that they should be culturally appropriate and by the languages of the participants. All but one of the participants were fluent in Cantonese but most were illiterate or had limited writing ability; and only one was fluent in English. Of the measures used in previous studies, only the Geriatric Depression Scale (GDS) has been translated into a Chinese language and used with Chinese older people (Mui 1996; Chiu 1993, cited in Mui 1996). Unfortunately, translations are not provided in the Mui paper. The constraints on scale choice precluded the use of an overall quality-of-life scale, as the concepts, which are central to these measures, did not translate successfully into Cantonese. The four instruments were translated into Cantonese by the researcher. The translations were tested and affirmed by a bi-lingual Cantonese-English speaker who was independent of the study.

The administration of the scales in Cantonese (and occasionally Mandarin) overcame the inability of participants to provide written self-reports and took 30–40 minutes for each encounter. For one participant who spoke English but little Cantonese, the scales were administered in English. Written records of the answers were made to facilitate the scoring of each scale. Privacy was maintained throughout the procedures and anonymity was stressed to encourage the disclosure of genuine responses. For the MOS 36, the LSI-Z and the OARS IADL items, higher scores

mean better health, more satisfaction with life and more functional independence. For the GDS, higher scores mean a higher level of depressive mood. In each of the two participant groups, the mean scores of males and females on each measure were compared using *t*-tests. Inter-correlations between measures were examined using Pearson correlation coefficients. A multiple analysis of variance test was used to compare the scores of the hostel and community groups.[1]

In-depth interviews

The purpose of the qualitative component of the study was to explicate various elements of a good quality of life, as well as to extend the understanding of the participants' experiences, perspectives, perceptions and feelings about their own way of living. George and Bearon (1980) suggested that the most crucial subjective assessment of life quality was relative satisfaction with life in general, and argued that both clinicians and researchers might wish to know whether older people were satisfied with the progress of their lives, their current situations, their future prospects and whether they were generally happy and had a sense of wellbeing. This can be achieved through inviting the informants to tell their stories and share their opinions. Mukherjee (1989) has argued that the theoretical validity of a measure of the quality of life depends upon how successfully it recognises differences between objective behaviour and subjective perception. Subjective assessments by individuals undoubtedly carry as much value as objective evidence gathered by researchers.

There has been increasing awareness that the assessment of quality of life should not only reflect levels or states of health, functioning or wellbeing but also incorporate information on the values and preferences of the respondents (Stewart and King 1994). The exploration of the quality of life of older Chinese people therefore requires understanding of their feelings and thoughts. In-depth interviewing was undertaken for this purpose: it is a form of qualitative research that helps to clarify the significance of human experiences from the actor's point of view (Gubrium and Holstein 2001).

Partly because older Chinese people tend to be reserved, individual in-depth interviews were preferred to group discussions or focus groups (Liamputtong Rice and Ezzy 1999). Semi-structured interviews facilitated a focus on the research questions and allowed more flexibility than entirely structured questionnaires (Minichiello *et al.* 1995). The questions guided the interviewees to explore their inner world without restricting their trains of thought. The first author used Cantonese, or Mandarin when required. Most interviews lasted 45–60 minutes, and each was tape-recorded

and transcribed. The interviews were terminated when new data were no longer forthcoming. The data were analysed as case studies and for common themes, as expressed in single words, phrases, sentences, paragraphs or even entire documents. Such thematic analysis was appropriate for this research because it primarily searches for the expression of an idea (quality of life) irrespective of its grammatical location (Minichiello *et al.* 1995; Liamputtong Rice and Ezzy 1999; Ezzy 2002).

Findings

Profiles of the participants

Among the 30 participants in the hostel group, 21 had been born in China, three in Vietnam, two in Malaysia, and one each in Hong Kong, Macau, Singapore and Queensland. As to marital status, 27 were widows or widowers, and there was one couple and one married man. All participants spoke Cantonese fluently, except the Queensland-born man who was only fluent in English. The others were unable to speak English well, and a few not at all. There were seven entirely illiterate individuals, while five had had only a few years informal education. Among those who had had formal education, for 10 it was at primary school level, for four it reached high school level, while four had received tertiary education. Other than two self-financed residents and one supported by Veterans' Affairs, the participants' sources of income were mainly from the age-pension or the (Australian government social security) Special Benefits Scheme.

In the community group, there were 22 Chinese-born participants, and three had been born in Hong Kong, two in Macau, one in Holland, one in Singapore and one in Vietnam. Nine were married and all others widowed. None were able to speak English well. The education levels were similar to the hostel group. There were six illiterate participants, two had received informal education, 11 had been educated to primary school level, eight to high school level, and three had a tertiary qualification.

Turning to their incomes, 26 of the participants were pensioners or received Special Benefits, while the rest relied on private resources. Half of the participants lived in Housing Commission accommodation, nine of them with one of their children and six in their own property. Apart from the 14 respondents who lived alone, five lived only with their spouse. Contrary to the Chinese traditional belief that the son's responsibility is to look after (by co-residence) his elderly parents, only four participants were living with a son (only), while five lived with a daughter (only).[2] The remaining two participants lived with their spouses and other family members. As most participants were not living in a large, extended family

TABLE 1. *Quantitative measures of the quality of life of the hostel and community living samples*

Scale	Mean	Standard deviation	Range
Hostel residents			
Age (years)	82.4	7.4	68–97
GDS	7.6	4.2	0–17
IADL	8.2	3.3	2–13
LSI-Z	21.2	3.2	13–26
MOS-36	12.2	15.2	70–131
Community dwelling group			
Age (years)	75.0	8.3	65–99
GDS	3.3	3.3	1–18
IADL	12.9	2.0	7–14
LSI-Z	23.7	2.0	16–26
MOS-36	22.2	15.0	89–147

Key to scales: GDS: Geriatric Depression Scale. IADL: Instrumental Activities of Daily Living. LSI-Z: Life Satisfaction Index Z. MOS-36: Medical Outcome Survey-36. For explanation and source references, see text.

household, they had had to face the challenge of living alone in a 'foreign land', with limited support from relatives or their social network. Most had striven to maintain their independence for as long as they could. For some, when they became physically or mentally impaired and living independently became problematic, they had sought institutional residence even though most considered the arrangement as 'second best' to being cared for by their family. Other non-Chinese elderly minority group residents share these experiences and attitudes (Biedenharn and Normoyle 1991).

The mean, standard deviation and the range of the functioning and wellbeing measure scores for the participants are shown in Table 1. They show marked differences between the hostel residents and those living in the community in health status, functional ability, depressive mood and perception of life satisfaction. These differences are to be expected given the older age of the former, and the likelihood that placement in the hostel was triggered by increasing dependence.

Case discussions

The functioning and wellbeing scores of the six in-depth interviewees are presented in Table 2. It can be seen that the hostel-based informants (cases A–C) were less healthy, less independent and more depressed than the community group (cases D–F). Interestingly, however, their self-rated life satisfaction was similar or even higher (as for Case A) than their

TABLE 2. *Quantitative profile of the six interviewees*

Case	MOS-36	GDS	LSI-Z	IADL
Hostel residents				
A	126	4	26	11
B	101	5	25	9
C	130	4	23	13
Community dwelling group				
D	123	4	25	14
E	134	2	24	14
F	139	1	25	14

Key to scales: GDS: Geriatric Depression Scale. IADL: Instrumental Activities of Daily Living. LSI-Z: Life Satisfaction Index Z. MOS-36: Medical Outcome Survey-36. For explanation and source references, see text.

community counterparts. The situations of the six participants are considered in turn.

Mrs A was highly satisfied with her life yet a little depressed, a common conjunction among the hostel residents. Of the six, she was the most satisfied with her life (despite her depressive mood and low functional ability and health status). She entered the hostel because of the fear of staying at home alone and a wish to be independent from her daughter. She made her own decision to move into the hostel and was very pleased with the arrangement. Mrs A was active in the life of the hostel and helped in many ways, which probably made her feel useful and needed. Her satisfaction with life might also be attributed to the support of her daughter, religious group, ethnic community and the residential facility, all of which helped her to maintain the style of living to which she was accustomed. Her quality of life was reasonably represented by the four measurements, taking into consideration that she was a hostel resident who was frailer and less independent than the typical community dweller. The high life-satisfaction ranking was consistent with her perception of her life. Other elements, such as financial security, having a meaningful role and strong ethnic community and family support, compensated for the deterioration of health and lack of independence and made her days happier.

Mrs B had the lowest health and functional ability scores among the six informants, a further demonstration of the association of health with functional ability. Her profile exemplified the inter-correlations of these variables among the whole group. While she was the oldest of the six participants, her functional ability was the poorest, supporting Kendig's (1990) observation of a negative correlation between age and functional ability. Her health state and depressive mood were also negatively correlated, consistent with the findings of Namazi *et al.* (1989). Her high life satisfaction rating was, however, inconsistent with a relatively high level of

depressive mood. Assuming that the well-validated GDS tapped the actual emotional state of the respondent, there must have been other compensatory factors that elevated her life satisfaction. Tellingly, her steady and secure financial state, sense of love and respect from family, low expectation and strong ethnic community and family support may well have been strong factors in Mrs B's overall evaluation of her quality of life.

Mr C was the healthiest and most independent of the hostel group. He was satisfied with his life, though he had the lowest score on the LSI-Z. Slightly depressed, as many of his peer hostel residents were, the negative correlation between health and depression did not apply in his case. In addition to his good health and independence, Mr C had strong ethnic community and family support, financial security, meaningful roles, low expectations, and a sense of love and respect from his son and grandchildren that ensured him a good quality of life.

Mr D was the youngest participant in the two groups, but nevertheless had the lowest score for health and the highest GDS score in the community group – a strong example of the negative correlation of health status and depressive mood. The negative scores probably arose from intermittent bone pain and his comparison of his situation with that of his peers – who were generally healthier physically and emotionally. His independence in IADL and self-reported life satisfaction provided a better description of an independent community dweller. Enjoying his participation in social networks, Mr C also found meaning and satisfaction in his role as a committee member of the Social Welfare Society. He was very satisfied with his life, and certain that his quality of life was better in the Australian environment and welfare system than in his native land. Moreover, his philosophy of a good life was manifest in his willingness to help others, through which in return he gained plenty of friendship, care and support that made his life meaningful and increased his life satisfaction.

Mrs E was in good health, independent, satisfied with her life and not depressed. In short, she enjoyed her life and had fun, despite the great distance from her only son and other family in Hong Kong. The bonds between them were sustained by regular visits and telephone calls. Moreover, financial security, strong ethnic community and family support, low expectations, a worry-free attitude, having a meaningful role, and a sense of love and respect from her family enabled Mrs E to live the free and happy life that she cherished.

Mrs F was the healthiest, least emotionally disturbed and one of the most independent interviewees among the six. Her profile on the four measurements was compatible with previous findings, and exemplified the positive correlations between health and functional ability (Lan 1995), between health and life satisfaction, and between life satisfaction and

functional ability (Markides and Martin 1979). Furthermore, these positive states co-exited with a low depressive mood (Namazi *et al.* 1989; Llewellyn-Jones 1995; Mui 1996). She was not financially disadvantaged, although she received only a partial pension. Savings from years of hard work made her life much easier after retirement. Her supportive family and social network, low expectations of life, and the sense of love and respect from family appeared to be the framework of her happy life.

Key dimensions of the quality of life

By examining each older person's narrative, it became apparent that several common themes occurred in the interview responses. These are reviewed in the following sections.

Health

Poor health was the main reason behind the three hostel informants entry to residential accommodation. Two had experienced falls and were afraid to stay at home alone, while the third had undergone major operations, after which they were much frailer. As Mr C explained, 'I was living with my wife who had a previous stroke before hostel placement. After the operations, I think we would be better off to have someone look after us'. Predictably, the main or only reason why the three community-based interviewees would seek residential placement in the future would be an increased need for care. Mr D put it like this, 'When I become older and need [physical care] that my wife cannot manage, I will consider this option'. All informants considered health as one of the most important determinants of their quality of life. Mrs F said:

> If you are not healthy, you cannot take care of things. I have a medical check-up every two years and when necessary to ensure my health is in a good state. Besides, I can detect any medical condition earlier so that there won't be any delay in treatment. I am very conscious of my health.

The wish to be independent

It is clear that the Chinese older people in this study defined their independence as not being dependent on their family physically and even financially. Mrs A regarded her entry to the hostel as a way to stay independent. She used to live with her daughter who is a nurse and the youngest child:

> My daughter has a very hot temper. I know she cares very much for me, but I used to live with my husband before he passed away and I found it difficult to

adjust to the new living arrangement. I prayed to God for a way out, because I dared not tell my daughter about my feelings. I don't want to upset her and I still need her help to settle in Australia. Thank God for the fall accident, after which I gathered all my courage to tell her that I wanted to move into the hostel.

Mr C did not want to depend on his son and thereby put him in an embarrassing situation. He said, 'My wife's and my life will be better if my daughter-in-law cares more for us. I know my son has to look after his family. I understand that I have to think for my wife and myself. We even have planned our funeral arrangements.' A different emphasis was expressed by Mrs E who enjoyed her life although she did not have any family in Australia: 'I am so independent that I can do anything I like and enjoy whatever I do. I only wish that I could be as independent as long as I can. Life has so much fun.'

Financial security

All informants were living on social security payments including the age pension (full or part) or Special Benefit. They were all satisfied with the financial support from the government, although some claimed that they would be happier if they had more money. As Mr C said, 'We receive Special Benefit, and basically we can manage. It's just that after my wife's recent surgery that I asked my son to give me extra money to buy some Chinese traditional nutritious food to enhance her recovery.' For Mrs A, her financial security had made her life in Australia easy: she was able to pay her daughter for picking her up for church every Sunday and for other outings. This made her very proud of herself. As she put it, 'I use most of my pension to pay the residential fee and I spend the interest on my savings. I insist on [giving money to] my daughter because she helps me a lot. It's only a small sum of money, I think it's a right thing to do, and I am proud to do it.' Mrs F admitted that she would not be able to enjoy her life as it is now without the hard work she had undertaken prior to her retirement: this had made her financial situation secure. She said, 'We didn't have any holiday at all, working in our own restaurant day in and day out. But nevertheless, we were able to pay off two mortgages. We are now living on partial pensions and rental income. I shouldn't have any complaints.'

Having a meaningful role

While striving to live healthily and independently, the ability to help or care for others made these older peoples' lives more fulfilling and happier than they would otherwise have been. As the carer of his wife after her first

stroke and her recent surgery, Mr C was keen on maintaining his wife's health as best as he could manage. He said, 'It will be sad if my wife has to move to a nursing home. I'm doing my best to care for her, hoping that she can be healthy again soon. We also plan to go back to Malaysia in a couple of years [when] we have saved enough money.' Mrs A had a better life living in the hostel than in her daughter's house, partly because she enjoyed helping in the hostel. She explained:

I [became] much more active after I moved into the hostel. I help set the tables, distribute pieces of fruit and operate the television and videotape recorder. I also help organise the mobile hostel library to make sure all the books, magazines and videotapes are not missing. My daughter wouldn't allow me to do a thing in her place.

These informants truly understood the privileges of being helpful and caring at their age, and drew much joy out of it. Mr D confirmed that it was the ability to help people that, he believed, could enhance his quality of life:

All my friends are those of the Welfare Society and other Senior Citizens' Associations. We get along very well. They like to ask me for help whenever they need someone to renovate, massage, accompany driving and give advice. I really enjoy helping them out, that's what friends are for.

Strong ethnic community and family support

Having limited ability in English, the informants could hardly manage living on their own. They relied mostly on the Chinese community and their own family to overcome the language barrier and to fit into an English-speaking country. As Mrs F said:

My daughter is the closest child to me. She is a pharmacist and she cares for me more than I can think of. I can rely on her entirely. Like my mum [had been] to me, the relationships between mothers and daughters are excellent.

On the other hand, without any family members by her side, Mrs E had to rely on her social network in dealing with her daily affairs:

I always have friends (from the Welfare Society) to turn to. They help interpret, read correspondence, and give advice. Besides, I am getting used to some simple English gradually and I am able to go for a blood test in the laboratory without a companion [escort].

Mr D, having realised the importance of social support to maintain his quality of life, explained how he involved himself in various ethnic welfare groups: 'I have plenty of support from these organisations, including religious, welfare, social and so on. They provide different sorts of help that are appropriate to my different needs. Moreover, I meet my friends in

these places for social gathering and we care for one another.' By continuing to learn English through attending English classes at the Welfare Society and watching education programmes and news bulletins on a television channel (SBS) for ethnic groups in Australia, Mr C believed that better communication would improve his own and his wife's lives. For the time being, he was satisfied with his social network: 'I seek help from the hostel's staff, from friends at my church and the Welfare Society for any physical and emotional problems that I can't solve. [If I get into] financial difficulty, I would bother my son.' Mrs A, however, did not worry about her ability to speak English well. She was happy to just say 'Hi', 'Bye' and other greetings:

I don't need to speak English at all. My daughter takes care of everything and I won't go out without her. I shop in Chinese groceries. I attend Chinese church and the Welfare Society. I live in a Chinese hostel and my doctor is also Chinese. I am doing the same things as I was in Hong Kong, *yum cha*, playing *mahjong*, going to church and shopping.

Mrs B had been living in Australia for more than three decades, and an active member of ethnic organisations and was now a resident of the Chinese hostel. He suggested that the support was basically satisfactory; 'We benefit from having a Chinese nursing home. I used to have a friend in the hostel who was relocated to a nursing home because of her loss of independence. She can't even ask for water because of her poor English. They don't have Chinese staff working on every shift.'

Having low expectations and no worries

To be happy, most informants agreed that they had to put aside their worries and not expect too much. Mrs B viewed herself as a person from the past:

We are people from a different century. How can my children or grandchildren understand what I went through and put up with? I don't expect them to play an important part in my life. It's me who's living my own life. They have their own difficulties. I keep telling myself not to worry or to take any burden to them. After all, I experienced the worst of life.

Mr C compared his life in Australia with that in Malaysia. He felt that he must be content with his life, because life in Australia was much better than in Malaysia:

Comparatively, I am living a much better life here. Back in Malaysia, the government wouldn't provide any welfare of any kind to my wife and me. We would have died if we were still there. We could hardly afford the charges [for] my wife's and my medical treatments. I feel very secure now and I don't have much to worry about.

Sense of love and respect from family

Although none of the informants were living with their children or grandchildren, the close relationship and psychological reliance on them were demonstrated well in their responses. Mrs B had no difficulty with the mixed marriages of her grandchildren, and was enjoying the respect of these grandchildren as well as their non-Chinese spouses. She explained: 'My two grandsons-in-law are Australians, and they respect me very much. I used to advise them not to drink too much alcohol, and they kept telling me that they only drank a very small quantity. I was happy though I knew that they still drank.' Mr C, being loved by his son and respected by his grandchildren, felt that his wife's and his life would be happier if his daughter-in-law treated them with love and respect. As he said, 'My wife still cries at times when she thinks of the way our daughter-in-law treated us. I always reassure her that we have loving sons and grandchildren, and that means a lot to us.' Mrs F could not be happier when she mentioned her loving and caring daughter, for she said: 'I am so blessed to have such a daughter. The way she loves and cares for me is much more than I expect.' The relationships with her children's spouses were also harmonious:

> They come to our house every weekend and we have dinner together. That's the time we catch up with one another. We are no strangers, though we don't live together.

Discussion and conclusions

This individual study (for a Masters degree) has conceptual and methodological limitations. Time and resource constraints prevented more wide-ranging, or a larger number of, in-depth interviews, which would have enabled fuller analysis of variations by gender, class and migration history. Nor was a longitudinal design possible, or interviews with more relatives and community support workers. While the six in-depth interviewees were not representative, the responses were informative and offered important insights that supplemented the scores of the four standard scales. They provided clear indications of what the respondents saw as important for a good quality of life. The participants identified health as one of the most important determinants, replicating the findings of previous studies (Markides and Martin 1979; Ferris and Bramston 1994; Ho *et al.* 1995; Bond 1999; Thumboo *et al.* 2003). As the main reason for the institutional placement of the hostel informants was the deterioration of their health, it was consistent that the three community-living interviewees would only

consider residential accommodation when they became frailer and were unable to look after themselves. This reasoning alludes to another common theme, independence, which is closely linked with health status and functional ability.

The hostel respondents attached as much importance to their independence as the community-living interviewees. As White and Groves (1997) found, the participants were proud of their independence though they still relied on their family to access both public and private resources. For the free-spirited Mrs E, for example, her friends had taken on the role of her family (who were overseas), and helped her live an independent life. On the other hand, the participants' health consciousness was expressed, more or less, as the drive to minimise the related disabilities that hindered their ability to perform daily tasks independently and to move around freely. This is consistent with previous observations that functional ability is a predictor of a good quality of life (Markides and Martin 1979; Osberg *et al.* 1987; Steinkamp and Kelly 1987; Thumboo *et al.* 2003).

A stable and adequate source of income has been shown to be an important factor in a happy life (McKenzie and Campbell 1987; Ho *et al.* 1995; Mui 1998; Irwin 1999; le Grange and Lock 2002). An understanding of the life experiences and backgrounds of the informants helps explain both why the interviewees were pleased with their current financial status, and why they placed so much emphasis on continued financial security to maintain their quality of life. Several had originated from China, Vietnam and Malaysia, where political instability had compromised the population's welfare. In contrast, the welfare system in Australia and particularly state financial support provided a sense of security. Most of the informants had never had a 'good' job in their lives, and had earned barely enough to pay for basic daily necessities. Less than the poverty-line pension income was enough to make them happy (Selby and Hall 1983). The age-pension, financial support from family and, for a few such as Mrs A and Mrs F, savings, enabled them to live a comfortable life. They were no longer suffering from the poverty or deprivation that many had experienced in their younger years.

Regardless of their physical health, having a meaningful role undoubtedly offered the participants a sense of wellbeing that enhanced their self-image and hence the feeling of living a better life. It did not matter if they were caring for their partners, friends or peers, for they took this as something they were willing to give and probably still able to achieve. The feeling of usefulness and meeting the needs of those whom they cared for strengthened these helping relationships (Keller 1999). Indeed, the respondents abundantly demonstrated that older people as volunteers possessed considerable resources to support community and residential aged

care services. Their acute understanding of their own needs enabled them to be competent and committed in helping roles.

The informants did not consider language differences to be a problem in their daily life, although previous studies have found such barriers to be a negative influence on people's quality of life (Kabala 1986; Victorian Elderly Chinese Welfare Society 1984; Chinese Community Social Services Centre (CCSSC) 1996). The lack of concern about language barriers could be mostly a result of their intensive involvement with ethnic organisations and service providers. As they tend to seek help from people who speak their own language in close-knit social and personal networks, they were able to get the support they needed (CCSSC 1996). Moreover, the availability of both interpreters in mainstream services and Chinese-speaking health and social professionals helped overcome their language deficiencies, even when their family or friends were not available. Having been exposed to a multi-cultural environment for extended periods (their length of stay in Australia ranged from six to 32 years), they were not threatened at all by their inadequate language ability. Seemingly they have their own ways of communication, although as Mr C recognised it would be improved if they spoke English well.

After their past experience of stressful events, most informants did not hold high expectations of life. They recognised that high expectations led to being let down and could make life miserable. This supports Mui's (1998) suggestion that there is a positive relationship between high expectations and depression. The most bitter past experiences were described by Mrs B, and she had learnt that worrying did not stop her from being helpless. There was strong agreement among the informants that to live happily one has not to worry.

The traditional cultural values of the Chinese, which place the responsibility for looking after aged parents with their offspring, preferably the son, was still rooted in some of our informants' value systems, but in reality these have markedly changed.[2] Many participants were no longer living in a large extended family household as was traditional for Chinese family life (Chiu and Yu 2001; Matsudaira 2003). In the traditional society, the family was perceived as the most important element of an individual's life. A single household may have had a large extended family with a few sons and their families living together. A family member's status and authority increased with age, so elderly parents had seniority and were respected. Most were confident that they would be looked after by their sons and daughter-in-laws (Chiu and Yu 2001). These traditions were however differentiated by class status. As Chiu and Yu (2001) caution, Chinese élites tended to hold these normative values more than other families: their economic situation allowed them to do so. But for less

well-off families, economic constraints often prevented them following the traditional norm. It may not therefore be surprising that some Chinese older people in contemporary societies, as in Australia, do not wish to live with their children.

Although none of the in-depth interviewees lived with their children, they often referred to their happiness with the love and respect that they received from their offspring. Although Mr C did not have the love and respect of his daughter-in-law, he was consoled by such bonds and affirmation from his son and grandchildren, and these made him content. As many of our respondents' expressions confirmed, the different cultural and social environment of their new country had resulted in many of the participants losing traditional roles, but, on the other hand, it had enabled pride in being independent and in not being a burden to their offspring (Gutman, cited in Coleman 1994; Vo-Thanh-Xuan and Liamputtong Rice 2000; Chiu and Yu 2001; Torres 2001; Vo-Thanh-Xuan and Liamputtong 2003).

Overall, the outcomes of the four measurements provided an impression that the participants were living well, especially in conjunction with the evidence of their self-reported life satisfaction. The more advanced age of the hostel group could explain their poorer health and lower independence. Apart from the fact that they were frailer and less functionally capable, they also presented with generally higher levels of depressive mood. Their community counterparts were, on the other hand, healthier, more independent and more satisfied with their lives. With their involvement in the social welfare organisations, they appeared to be enjoying their independent living and intended to maintain it as long as they could. Many of them did not want to depend on their family both physically and financially. To be independent was a source of pride as well as stress, as they began to realise that the younger generation had been subjected to western culture and social norms.

The common themes that emerged did not discriminate hostel residents from community dwellers. While the three community inhabitants considered residential care to be an option only if they became physically incapable of living independently, the hostel participants admitted that they entered the hostel mainly because their health had deteriorated. The importance of health and independence in determining one's quality of life was corroborated. Together with other common themes that have already been discussed, a bigger picture of the informants' quality of life emerged. The difficulties that are commonly believed to occur among ethnic-minority older people, such as language barriers, isolation and loneliness seemed to be absent (*cf.* Plunkett and Quine 1996; Thomas 1999). While this finding is surprising, the respondents' tightly-organised

social networks and the support of their own ethnic community provides a protective environment. The availability of Chinese-speaking medical, social and community staff and of interpreters in some mainstream facilities ensured the delivery of quality services. Having experienced suffering or deprivation in the past, they appreciated the Australian welfare system and knew that their parents had never had comparable benefits.

It was notable that the participants were reluctant to express their emotional problems. They claimed that they were able to solve them with or without assistance from their families, friends and social networks, although the GDS scores told a different story. Although the GDS has been validated for Chinese-origin older people, its failure to disclose emotional problems probably lies in the characteristics of the participants and the study design: it could however be because of the high value placed on maintaining 'face' (Mao 1994; Jiang 2000). As Matsudaira (2003: 345) suggests, 'the concept of face refers to the impression one makes on others as a result of their appraisals of one's behaviour'. This cultural value underlies the reserved demeanour of the Chinese, who often hide their feelings and even withdraw their emotion during times of sharing private and deep feelings (CCSSC 1996). The fear of allowing other people to be aware of their unresolved emotional problems might have restrained them from discussing such matters, which in many cases involved family tensions. The admission of depression could be more than threatening, for in Chinese society mental illness is commonly associated with shame and stigma (Martin 1998). Although the validity or reference of old Chinese sayings is debatable, the well-known aphorism 'disgraceful family matters should not be spread outside (the family)' is pertinent.

The concepts and theories that have informed this study need to be revisited. The multi-dimensionality of the quality of life was confirmed by the present study. The participants reported high life satisfaction, in spite of unfavourable signs, such as their relatively high level of depressive mood. A one-dimensional measure of the quality of life might show overall satisfaction with life but fail to indicate their emotional discontent. Although the sharing of feelings and thoughts about the informants' quality of life did not explicate their depressive mood, it did point clearly to some bases of the perceived good quality of life, such as social connections and financial security. Moreover, the differences in the level of quality of life between the two groups supported the importance of the environment. In conclusion, the four measurements of quality of life employed in the present study provided a foundation for the exploration of the factors of the quality of life through in-depth interviews. Common themes were identified from the in-depth interviews, and systematic differences in the

quality of life of hostel residents and community living respondents were found.

Acknowledgements

We wish to thank all the Chinese older people who took part in this study, and the management and staff of the Elderly Chinese Home, the Victorian Elderly Chinese Hostel, Nunawading Community Hostel (Chinese House), and the Victorian Elderly Chinese Welfare Society for their kind co-operation.

NOTES

1 More details of the procedures and analysis of quantitative aspects are provided in Tsang 2001.
2 For discussions of the normative view, see Parish and Whyte 1978; Ikels 1993; Croll 1995; Verschuur-Basse 1996; Cheung 1997; Whyte 1997; Edwards 2000; Tang *et al.* 2000; Chiu and Yu 2001; and Holroyd 2003.

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Accepted 31 March 2003

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