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Informal care and older Native Canadians

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ABSTRACT
The number and relative proportion of older Native people in Canada are both increasing rapidly. So also is a social problems discourse asserting that informal care of older Native people by family and kin is traditional, and highly appropriate today. However, neither this discourse nor previous research satisfactorily address the informal care requirements of older Native people nor the gendered implications that high levels of informal care provision may have for Native caregivers. Informal care is provided to Canada's non-Native elderly people primarily by resident wives and non-resident daughters, and secondarily by husbands and sons. Data from the pan-provincial Alberta *Native Seniors Study* demonstrate that Native people aged 50 or more have comparatively high overall care requirements. Older Native Albertans are poor, and make extensive use of some government income support programmes. They also make moderate use of medical services. Extensive dependence on informal care, institutional barriers and local service unavailability lead Native seniors to under-utilise other formal programmes aimed generically at the older provincial population. Native seniors are much more likely to live with kin than are other Canadians. Informal care appears equally available to older women and men, and is provided chiefly by resident daughters, sons and spouses, and by non-resident daughters, sisters and sons. Extensive elderly caregiving requirements may impose a growing, double burden on many, who are also providing care for dependent children. Without further support, current and future requirements may significantly limit the options of caregiving women and men.

KEY WORDS – Aboriginal, ageing, Indian, Native, informal, caregiving, health, Canada.

Introduction

It is widely appreciated that elderly people in North America are in the process of being constructed as a major 'social problem'. While most

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demographers are more sanguine, pessimists predict that soon a dramatically increasing proportion of older people will have a dire impact on labour force participation rates, tax revenues, pension sustainability and the cost of medical services. With the number of elderly Canadians requiring informal assistance estimated by the National Advisory Council on Aging to triple by 2031 (NACA 1990: 6), much social-problems attention is focusing on a predicted radical increase in the amount of care required from society by older people. This discourse has interacted with another high-profile, and often ideological, debate about what structures of care are most appropriate, economical and accountable, and which structures older people are likely to prefer and use.

In this, Canadian federal and provincial governments have both exploited a set of fortuitous circumstances. Institutionally-provided care is expensive, and governments face a growing potential demand for further funding at a time when expenditure and deficit reduction are politically fashionable. Yet as much as 75–85 per cent of care for older Canadians is now provided informally (NACA 1990: 6), in particular by spouses (Chappell 1990; Kaden and McDaniel 1990), and by children and siblings (McDaniel and McKinnon 1993). This care is delivered at little financial cost to the state (NACA 1990: 6; Stone and DeWitt 1991: 213; Chappell and Havens 1985; Canadian Medical Association 1987). Also, older Canadians typically prefer to be assisted informally when this is possible and practicable. Spouses and children, potentially the key (unpaid) informal caregivers, regard this as highly ethical and appropriate. Moreover, advocacy groups, reacting against the spectre of the 'mass warehousing' and institutional domination of dependent older Canadians (Corelli 1986), have vigorously supported informal care arrangements in principle. This presents a win-win situation for government, which can point to both political interest group support and a range of national policy studies affirming the value of informal care. Government therefore can, and often has, advocated the 'substitution' of informal for institutional care (*e.g.* see Government of Alberta 1988).

Thoughtful observers have suggested that this may be the next development in a long tradition of offloading key government responsibilities onto communities, families and individuals: first debtors, then orphans, mentally ill and disabled people, and now elders. A greater emphasis on informal care may put increasing pressure on spouses, relatives, friends and volunteers (McDaniel and McKinnon 1993; Dowler *et al.* 1992: 133). In North America, deeply entrenched folk ideologies associating women with emotion work, the

management of personal and familial relations, and a wide range of unpaid, often unrecognised helping activities render natural the expectation that women will carry most of this informal care burden in the future. These expectations are reinforced by the class-dependent pattern of women's employment and volunteer activity, especially in institutional settings frequented by older people (Dowler *et al.* 1992: 128–9).

Canadian national and provincial studies in Canada support these concerns. They show that while men and women report that they offer broadly similar levels of support for older people (Lapierre 1992: 357), the receivers of that care claim to rely heavily upon women, chiefly daughters and wives (McDaniel and McKinnon 1993; Chappell 1992; Wister and Strain 1986; Dowler *et al.* 1992; Crawford *et al.* 1994; Stone and DeWitt 1991; Garant and Bolduc 1990). As McDaniel and McKinnon note:

> A recurrent pattern in this analysis is the reliance of elders, both men and women, on women relatives for informal support … [and] the informal support women provide as spouses, daughters, daughters-in-law, sisters, nieces, friends and volunteers, can leave women with little time and energy or resources to care for themselves and to work outside the home and family. In the longer term, this very embeddedness in family which so many policy-makers laud at the same time as they deride women for not doing enough caring, may result in policy challenges in the future. (1993: 95)

Governmental support for informal caregiving is currently meagre and indirect. Moreover, it is not clear that increased levels of formal care consistently lessen the burden on the informal caregiver (Chipperfield 1994: 436).

Native seniors

Discourse on *Native* seniors in Canada now appears to be on a similar 'social problems' trajectory. As with Canadian seniors in general, the pressing needs, concerns and difficulties of older Native people were ignored or under-emphasised for a long time.[1] One finds almost nothing in the literature about older Native Canadians before 1985 – unlike the US, where initial discussion and research date back to the early 1970s. True, shamefully high mortality rates ensured that older Native Canadian people were comparatively few, but both demographic patterns and public interest have shifted rapidly. In the last general Census of 1991, about one million Canadians considered themselves Native in some degree.[2] Of these, about 11 per cent were aged 50 years or older. The number of Canadians who identify

themselves as Indian, Metis or Inuit is projected to increase by 53 per cent between 1991 and 2016. Those aged 65 or more will triple, and those aged 35–64 will more than double (Norris *et al*. 1996). Predictions of similar increases have been made for the US (Siegel 1996).

Demographically, Alberta parallels Canada as a whole.[3] One can identify three approximately equal-sized populations of Native seniors in Alberta: in cities, chiefly Edmonton, Calgary and Lethbridge; on reserves and Metis settlements, including large populous reserves in the South and much smaller ones in the far North; and in towns, hamlets and very small rural communities. This roughly parallels the availability of local formal services for older people: cities and large towns with access to a full suite of services; communities with some local facilities and many more at a drivable distance; and those (chiefly in the North) with few local services and significant transportation barriers to those elsewhere.

Discussion in Canada about how care should be delivered to older Native people has been even more powerfully affected by prevailing ideologies than has the more general discourse on older Canadians. Over the last 20 years, advocacy groups, spokespersons and leaders have been very effective in promoting positive public images of Native people and their traditional cultures, defined in reactive opposition to representations of Euro-Canadians as individualised, isolated, secular and out of touch with everything from personal feelings to nature. Images of Native people that are held by many Native and other Canadians emphasise several things of relevance here: continuity of intense familism and grounding in kin and community; profound respect for 'elders', who are identified as key sources of tradition and wisdom; and rejection of further 'white' institutional domination – domination seen to be historically instrumental in Native cultural genocide and loss of identity. Both in Canada and the US, these representations seem to have strongly emphasised the centrality of informal care in an authentically Native system of effective support for older people, reflecting practice in an imagined 'golden age' before European contact (Weibel-Orlando 1989: 331). Similar images are often used to characterise 'traditional' families in other Canadian ethnocultural populations, such as Quebecois, Ukrainians, Chinese and South Asians (Payne and Strain 1991: 125). The availability of informal support systems for older people in such groups is often idealised (Lockery 1991: 59).

A linked but bipolar discourse on care and older Native Canadians is now arising. On one front, advocates and some researchers insist with increasing urgency that there is a rapidly increasing unfilled demand

for care. On the other, while some major reports still ignore informal care completely (*e.g.* OACSC 1993; Royal Commission on Aboriginal Peoples 1997), many Native Canadian spokespersons now assert that informal care is authentically Native and the main culturally appropriate way to fulfil the need for care. This is widely claimed (*e.g.* by Red Horse 1980) to be consistent with tribal values that have traditionally emphasised familial obligation and interdependence. There is also a consensus (backed by little hard data) that household and community-based kin remain the primary, and often the sole, providers of long-term care for functionally dependent relatives in rural Native American and Canadian contexts (John 1988).

Despite this developing discourse, what is actually known about caregiving and the need for care – indeed, what is known about Native seniors in Canada generally – remains highly impressionistic. Empirical studies have chiefly focused solely on select populations of older 'Status Indians' in the West (SCPC 1988; Blandford and Chappell 1990; Harvey 1986; Strain and Chappell 1989). Elsewhere, major reports on older Native people continue to be based almost entirely on anecdotal evidence (*e.g.* OACSC 1993). In contrast, several US studies have focused on caregiving and Native people (Versen 1981; Strong 1984; Weibel-Orlando 1989; Hennessy and John 1995; Robert John 1985, 1986, 1990, 1991; Randy John 1995; Kramer 1991: 212). However, the service delivery systems, legal and political relations, numbers, locales and living patterns of Native people in the US are so different that American data are of limited relevance to Canadian contexts.

On the need for informal care

It was our objective in the *Alberta Native Seniors Study* to undertake the first pan-provincial, wide-ranging survey of non-institutionalised people aged 50 years or more who claimed being Native as their primary ethnic identity. While an understanding of health status and health promotion ideas and activities were central goals, we also sought to encompass a wide range of topics bearing on these issues: residence patterns; social and cultural life; health, wellbeing and illness; economic conditions and material life; and current service access and felt needs. Working with the active support of participating Native communities, the entire survey team was Native, and most interviews were conducted by people from the same community. In the end, we achieved a sample of 858 individuals drawn from 17 locales across the province: 69 per cent were status Indians and 28 per cent Metis. The

average age of the sample was 63 years for both women and men, and 76 per cent were aged 50 to 69 years.

A pernicious, if incidental, effect of the uncritical and sole use of narrowly-framed quantitative surveys is that the concomitant 'etic'/ outsider, normalising framework almost inevitably supports an image of a 'fallen' Native 'other'. In a day when popular images of Native people are rapidly becoming more positive, the uncritical use of survey findings continues to support older characterisations of the Native population as powerless, disadvantaged, ill, broke, disorganised and dependent, and renders it self-evident to many that: 'Elderly Indian people form the most deprived group of individuals in the United States [and Canada]' (Saravanabhavan *et al.* 1994: 20). When used alone, survey data also naturalise largely unproven assumptions that the individuals concerned are best characterised first as Native people, and only secondarily as husbands, wives, citizens and older people. Surveys also tend to ignore how Native people themselves frame and prioritise their lives. Accordingly, we complemented our quantitative questions with a wide range of open-ended ones aimed at securing the views of seniors in their own words.

This is not to suggest that insider significance should be foregrounded to the exclusion of other data when considering the potential informal care requirements of Native seniors. Someone with a serious heart condition or too little income to meet their basic monthly requirements for food and shelter may reasonably be considered to benefit from assistance. In what follows we try to flag some findings of this definitive sort, to identify what proportion and kinds of individuals are in potential need of informal care, and to indicate who is currently or potentially available to provide that care. Throughout, we follow the point espoused repeatedly by many advocates of informal care systems: that whether an 'objective' need exists or not, or whether there is already someone potentially available to fill it, it is also critical to know the views of the individuals concerned and how they are socially organised to provide care.

Material conditions that increase the need for informal care

> But when you go down to smaller isolated communities – and I have been through quite a few in Alberta – and when you look at the shambled existence some of the old people are living in – and my father is one of them and other older gentlemen in Calling Lake – it hurts me to see the injustice because the injustice to me is starting to become a heart ache to watch them live in a third world state. Robert Gambler, Calling Lake.[4]

We found that very few Alberta Native seniors in our sample are

financially prepared for independent living in old age or have the means to purchase private care of any sort. Some receive critical financial support services: federal Old Age Security (OAS), Guaranteed Income Supplement (GIS), provincial social assistance, disability payments and worker's compensation benefits in particular. However, OAS and GIS are not available to the majority of seniors, who are younger than 65.[5] Some get other services which cover significant personal costs: the mixed national/provincial medical plan, Medical Services Branch non-insured health benefits and, for some on reserves, housing assistance. Still, reflecting the findings of previous studies (SCPC 1988; Blandford and Chappell 1990: 394), overall individual income levels were very low, averaging $860 a month among those in our sample giving an exact figure ($912 for men and $827 for women[6]). A striking 88 per cent of the 225 who did not volunteer their exact income said that it was less than $500. By way of comparison, the average income of non-institutionalised Albertans aged 65–74 years in 1990 was $2,335 a month for men and $1,220 for women, and the Statistics Canada low income 'poverty line' in 1991 was $1,180 a month for a single urban person living alone (Seniors Advisory Council for Alberta 1993: 25–27). The formal education that Native seniors had received was much less than the 10 years of schooling typical of the general seniors population: women received an average of six years and men, five. Only 17 per cent reported being employed, chiefly in the 50–64 age group. Moreover, as Native seniors have a history of poorly paid, episodic and informal jobs, almost none receive (or will receive) a significant company or governmental social insurance (CPP) pension.

We found that 59 per cent claimed that their income was inadequate for their needs, and 63 per cent said that they had no money left at the end of a month. Their important expenses were all for necessities: food, utilities, rent (where relevant), telephone and transportation. Access to more money was by far the most frequent response to an open-ended question about what would best improve seniors' own lives; having better health and housing tied for second, followed by having more personal help and assistance.

Eighty per cent lived in single family homes. Seniors also lived in accommodation that they often claimed to be too small, old and in need of maintenance and renovation. Many such homes lacked labour-saving and activity-reducing conveniences that other Canadians view as necessities: 26 per cent were without telephones, 23 per cent a washing machine, 25 per cent an indoor plumbed toilet, 12 per cent central heating and 51 per cent a clothes dryer.

Both these low income figures and the poor state of Native housing

TABLE 1. *Self-assessed health status of Native seniors*

Health status	Alberta Native seniors	All Canada Ages 55–64 1988	All Canada Native All ages 1991
		%	
Excellent	0	20	12
Very good	15	28	20
Good	24	30	33
Fair	42	14	26
Poor	15	7	9
Very Poor	4	0	0
N (= 100%)	854		

have direct implications for informal care. The strength of familial ties among Native people notwithstanding, many older people appear to live with their children and other adult relatives at least in part because they are poor and frail (as shown in Table 1), and lack the economic and physical means to maintain an independent household. Indeed, those reporting that they did not have enough income to meet their needs, or that they had no money left at the end of the month, were considerably more likely to live in families with several other adults or several children.

Levels of health, chronic medical problems and activity limitations

Our findings on health, medical problems and physical limitations strongly support the conventional use of a 50-year-old criterion for defining a Native senior. As can be seen in Table 1 assessments of their own health contrasted sharply with Albertans in the general population aged 55–64.[7] They were approximately three times more likely to report their health as 'fair' or 'less than fair' than other Albertans of comparable age. While levels of perceived health do not vary with age (as also found in urban Saskatchewan, see SCPC 1988: 98), men did report better perceived health than women (as found among Canadians in general aged 65 or more, Lapierre 1990: 25). Similarly, seniors in the North (who are typically further away from comprehensive services) reported better health, as did those who use tobacco products compared with those who did not. Northern residents were more than three times more likely to say that their health was 'very good' than those further South. We attribute this to a strikingly lower incidence of certain reported medical problems in the North (see below), which may in turn reflect significant differences in lifestyle and social support.

John notes that US reservation-based Indians have poorer health and report more medical problems and needs than older urban Indians (1985: 236–7). We did not find so simple a relationship between urban and rural populations in Alberta. Instead, self-assessed levels of health in rural areas appear more bipolar than in cities. Higher proportions of seniors in rural locales reported that their health was 'very good' or 'good' (39.3 per cent, as compared with 36.5 per cent in cities), or 'poor' or 'very poor' (20.1 per cent, compared with 17.5 per cent). The proportion of rural Native seniors who claimed that their health was 'very good' was roughly twice that in cities.

People believed that their health had declined significantly over the past 10 years and saw failing health as the most significant problem they faced as Native seniors. Even so, they were very optimistic about maintaining current levels of health through the next decade. Seniors were asked to graph their health over the last 10 years and to project this line 10 years into the future. The average decline over the previous 10 years was 2.6 on a 12 point scale. The average projected decline over the next 10 years was only 0.8.

As noted by McPherson (1983: 185) and Maddox and Douglass (1973), subjective perceptions of health strongly correlate with assessments derived from medical examination. When used comparatively, self-perceived health status data for Native people may even underestimate the frequency of medical conditions found through direct diagnosis (Young 1994). A good predictor of hospital use and mortality, this study and others (Blandford and Chappell 1990: 396; Weibel-Orlando 1989: 166; Harris *et al.* 1989: 113) have found that perceived health status strongly correlates with a wide range of economic, psychological and social factors. While we did not collect medical data as such, we solicited extensive information on reported medical problems and treatment patterns. Only 26 per cent did not identify a current medical problem. Thirty-two per cent reported one, 21 per cent two, and 21 per cent three to six. Table 2 shows that it was women, those in the South, city dwellers and those reporting poor or very poor health, who tended to report more medical problems.

When the hundreds of different medical problems that the interviewees spontaneously listed in a set of open-ended questions are grouped into larger categories, they cluster strongly in three, each with significant implications for informal care: orthopaedic and rheumatic conditions (43 per cent reporting at least one such problem, 45 per cent of women and 40 per cent of men), endocrine disorders (24 per cent, with 25 per cent of women and 17 per cent of men specifically indicating diabetes), and cardio-peripheral vascular disease (25 per

TABLE 2. *Average number of reported medical problems*

Women	1.7
Men	1.3
Southerners	1.8
Northerners	0.9
Very poor health	2.8
Poor health	2.2
Good or very good health	0.4
Urban residents	2.0
Rural residents	1.3
N	858

TABLE 3. *Clusters of medical conditions by location*

	North	South	Total
		%	
Orthopaedic and rheumatic conditions	33	47	43
Endocrine disorders	7	32	24
Cardio-peripheral vascular disease	9	32	25
N (= 100%)	266	588	854

cent, 30 per cent of women and 18 per cent of men). These findings broadly reflect those of the SCPC (1988: 101) and several US studies (Kramer 1991: 210). All three are dramatically higher in the South (see Table 3).[8] When asked specifically, 32 per cent said that they had some kind of dental problem, 42 per cent a vision problem, and 26 per cent some difficulty in hearing.

Save for a range of orthopaedic and rheumatic diseases and dental, vision and hearing problems, seniors usually indicated that they were being treated for the medical problems they identified. While other studies show that elderly Native people have a high incidence of untreated dental, vision and hearing problems (*e.g.* SCPC 1988: 112–115; Bienvenue and Havens 1986: 245), 77 per cent, 83 per cent and 77 per cent respectively who reported such difficulties here, claimed they could secure adequate treatment. While about half were infrequent users of medical services, another quarter were heavy users. Twenty-four per cent saw a physician once a month or more frequently, and 23 per cent took three or more prescription drugs. Heavy users typically reported poor health, psychological problems, disability, isolation and a need for increased help.

Poor health often has its attendant psychological difficulties. An earlier Saskatchewan study found that 82 per cent reporting poor health claimed often to be sad or depressed (SCPC 1988: 100), and Blandford and Chappell (1990: 395) found that 26 per cent in urban Winnipeg were lonely. We asked Alberta Native seniors the same questions, and a significant proportion appeared to face psychological challenges that could be lessened by additional psycho-social support. Of those responding, 49 per cent stated that they were often lonely (56 per cent of women and 40 per cent of men), 24 per cent were often stressed (women 29 per cent and men 17 per cent) and 38 per cent were often depressed (women 41 per cent and men 32 per cent); there was no association with age in responses. Among those reporting either poor or very poor health, 63 per cent often felt lonely, 32 per cent stressed and 54 per cent depressed. Even so, when asked a set of open-ended questions about why they were lonely, stressed or depressed, four of the five reasons most often given expressly reflected *social* needs and concerns: first with their social isolation; then, feeling the loss of a dead spouse or child; third, poor health; fourth, the loss of close kin and friends; and fifth, concern with their children drinking (see also SCPC 1988: 156; Blandford and Chappell 1990; 396).

Conservatively, about one in four seniors faced serious chronic physical or mental health difficulties requiring either institutionalisation or high levels of informal care if they were to be addressed adequately.

Significant difficulties in performing a range of everyday activities

Roughly one-third of Canadians aged 65 to 74 report some kind of health-related activity limitation (McDaniel and McKinnon 1993: 87; Lapierre 1990: 258, Chappell *et al.* 1986). Accordingly, we asked seniors specifically about their ability to perform a wide range of household-based everyday tasks involving physical activity. While 51 per cent said that they have difficulty with at least one activity, such difficulties, as Table 4 shows, centred in a few important domains.

Native seniors who reported having difficulty doing one activity (like lifting) were very likely to report others (such as difficulty in walking), especially among those in poor health. For example, among those claiming that their health was poor or very poor, 68 per cent had trouble with lifting, 52 per cent with walking, 28 per cent with fine work and 34 per cent doing household chores. Those reporting very poor health listed 4.2 activity limitations on average, compared to 0.6 among those reporting very good health. Women reported roughly one-third more areas of activity limitation (averaging 1.7 compared to

TABLE 4. *Reported everyday activity limitations of Native seniors*

Activity	Percentage reporting limitation
Lifting things	40
Walking	27
Using hands for fine work	13
Doing household chores	13
Getting water or fuel	13
Shopping	11
Doing laundry	11
Cooking	7
Bathing or grooming	5
Getting dressed	4
Total (= 100%)	858

1.1 for men), as did rural dwellers (1.6 compared with 1.1 in cities), paralleling a higher frequency of disabilities among US reservation Indians (John 1985: 238). Roughly in accord with the findings of Strain and Chappell (1989: 110), we suggest that at least 20 per cent of those surveyed require significant ongoing assistance to perform important household activities, and that over a third more would benefit from periodic assistance. These estimated figures are roughly similar to the levels of help needed to perform key activities in the general population aged 65 to 74 in Alberta (Seniors Advisory Council for Alberta 1993: 40) and Canada (McDaniel and McKinnon 1993: 87).

Even so, when queried, only 54 per cent claimed to get all the help they needed to assist them in their everyday chores, 32 per cent received less help than they wanted, and 24 per cent claimed to get none at all. Many seniors also felt that they were limited in their recreational options and their ability to follow their personal interests. Women and men identified 230 activities that they liked to do, an average of three per person. These were strongly linked to gender. Women most frequently identified sewing, bingo, reading, cooking, cleaning up, knitting and crochet as key desired activities. Men cited hunting, bingo, watching television, fishing and visiting. Forty-four per cent of women and 35 per cent of men claimed they were not capable of performing some of these 230 activities as often as they would wish. They identified poor health, 'old age', expense and vehicle availability as important constraints. This is consistent with the specific activities Native seniors indicated they could not do as often as they wished, as these involved either vehicular travel (bingo, dancing, attendance at powwows, visiting) or else significant strength or endurance (house-

work, hunting, carpentry and woodwork). Besides walking, 57 per cent depended on a household car or truck and 33 per cent on a car or truck in another household to get around. Only 46 per cent reported that they were able to drive, and few individuals both owned and drove their own cars or trucks.

At the same time, 92 per cent considered their current locale to be their 'real home', and 28 per cent of Native seniors were involved in community-based groups and organisations. Most of these activities are ones well suited to elders. These roles include helper-volunteers, counsellors, and participants in important cultural groups, traditional and non-traditional religious organisations, and boards.

Current informal care personnel and practices

For the population as a whole, the informal care that Canadian seniors receive comes chiefly from a resident spouse or child, or from a non-resident child living nearby. Whether individuals receive such assistance and who does the assisting are both strongly gender-dependent: women are the primary informal caregivers (chiefly as spouses and daughters), but because they are far more often living without an active spouse, women are less likely than men to be the recipients of such care. In short, informal care appears to be a strong function of the local availability of culturally appropriate kin.

Many studies in the US and a few in Canada have either asserted or demonstrated that Native seniors' residence arrangements on reserves are often large and extended, and that these households therefore are rich potential sources of informal caregivers. However, in our experience, many Alberta Native seniors do not live in such households, residing instead either singly, with a spouse, or with an adult child and grandchildren. Inasmuch as we anticipated that resident kin would be an important source of informal support, we carefully mapped household composition as a function of age, gender, folk kin categories and biological 'pedigree'. For example, a resident 'cousin' would be recorded specifically as one's mother's brother's daughter or one's father's sister's daughter, and so on. We also collected extensive data on who visited seniors and who they themselves visited.

We found that resident arrangements were extremely variable, and that both past and present residence and kinship structures often diverged strongly from the Canadian norm – though not always in conformity with the highly familial stereotype of traditional Native life. While 94 per cent had one or more long-term partners during their life

(and 36 per cent more than one), only 54 per cent were living with one at the time they were interviewed. This proportion is strongly age-dependent; 60 per cent of those 50–64 had a resident partner, falling to 32 per cent for those over 75. The proportion living with a long-term partner is much less gender-dependent than in the general population: 64 per cent of men had a partner, as compared with 47 per cent of women. By way of comparison, 76 per cent of men and 41 per cent of women in Canada aged 65 or more have a resident partner (McDaniel 1994: 112). Forty-nine per cent of Native senior women had been widowed at least once, compared with 26 per cent of men. Seniors rarely remarried in later life, and those with a current long-term partner had been with that individual on average for 31 years.

Seniors in the sample had an average of 6.3 children of their own, and had raised a remarkable 7.1. This rises to 7.5 for women. In having many children, today's Native seniors reproduce rural Canadian practice typical of the 1920s and 1930s: while only 22 per cent of Canadians aged 65 and over report five or more children (McDaniel 1994: 112–113), 53 per cent of them have five or more siblings. Ninety-four per cent of the children that the sample have raised are still living, providing yet another indication that the number of Native seniors will increase dramatically in the future. Although only 63 years old on average, they already have an average of 18 grandchildren and great grandchildren. Only 8 per cent of all Canadians aged 65 and over have 15 or more grandchildren (McDaniel 1994: 114).

As Strain and Chappell (1989: 112) note, Native core kin networks may be more than twice as extensive as non-Native networks. Even so, the residence patterns of those surveyed range between the two stereotypic extremes of large multigenerational households and of living alone. This makes it difficult to generalise about which family members might be available on a day-by-day basis to seniors in need. At one end of the continuum, 15 per cent of women and 21 per cent of men across Alberta live entirely alone. This comparatively un-gendered pattern contrasts sharply with the 42 per cent of women and 16 per cent of men 65 and over who live alone in Canada (McDaniel 1994: 112). Previous studies in Manitoba and Saskatchewan (Strain and Chappell 1989: 111–112; SCPC 1988; viii) have found that 21 to 24 per cent of older Natives in cities live by themselves. We found that living singly is not restricted to urban contexts: 19 per cent of urban dwellers in Alberta live alone, but so do 15 per cent of those in rural areas. Another six per cent live with children, having no one else in the household over the age of 18. One out of four therefore must rely entirely on young children or people living elsewhere for informal support.

At the same time, those interviewed on average had 2.7 others living with them, 1.1 adults and 1.5 children. This household size average is roughly twice that of those aged 65 and over in the general Canadian population, in many other ethnocultural populations, and in rural areas (Payne and Strain 1990: 104).[9] Critically, our data indicate that household size is *not* lower for older Native women, as it is for their non-Native counterparts. Taking women and men together, only 21 per cent lived solely with one other adult, who in rough terms was equally likely to be a husband, wife, son or daughter. Thirty-six per cent lived in households where there was one other adult; 39 per cent in households where there were two or more other adults; and 27 per cent where there were two or more sub-adult children. In contrast, only 21 per cent of Canadians have living arrangements other than living alone or with a spouse (McDaniel 1994: 112). Native seniors had much smaller households in the southern part of Alberta (averaging 3.4 people) and in cities (2.8) than in the North (4.2), where household size is bolstered by more under-age resident children.[10] Though it is widely accepted in the US that rural Native seniors are being isolated or abandoned by the urban migration of their children and other younger adults (Versen 1981: 516–518; Blanchard and Unger 1977), we found no evidence to support this.

Native seniors' households therefore *do* contrast remarkably in several important ways with those of other older Canadians. First, there are no strong gender disparities in resident family size and structure. Far fewer older Native women live alone than do their non-Native peers, and a much smaller proportion of women and men live solely with a partner, as do 64 per cent of men and 37 per cent of women across Canada (McDaniel 1994: 112). Overall, there is an equal number of male and female persons in these households. Secondly, far fewer Native Canadians than other older Canadians live in such small households that they are necessarily dependent on themselves, institutionalised care or one other person for everyday assistance. At the same time, they are far more likely to be in household situations where there are young children, for whom they themselves are often significant caregivers; 28 per cent of women and 22 per cent of men in our sample cared for small children at home, and 21 per cent of women and 13 per cent of men did so outside their own homes.[11]

Seniors identified over 50 different familial relationships to people living with them. Even so, most lived with some combination of grandchildren, sons and daughters, and spouses, in this order of frequency. Sons and daughters were each roughly twice as likely to live with a senior than that person's spouse. In turn, grandchildren were

roughly twice as commonly resident as either sons or daughters, and almost twice as many grandchildren were daughter's children as son's.

Several factors may account for these patterns. Historically high death rates have equalised the number of older Native men and women, and Native senior men are not much older on average than their spouses. While 35 per cent of seniors voiced a strong preference for independent living with formal in-home support if their health were further to decline, 27 per cent hoped to have the option of being able to live with kin rather than be institutionalised (see Harvey 1985: 43 for similar results from a study of a large Manitoba reserve). Only 17 per cent would have preferred institutional residence to their current living arrangements, although 32 per cent said that they would have liked to move into a seniors' lodge or nursing home if their health declined further.

In fact, either through choice or impediment, Native seniors rarely make use of non-medical, institution-based, functional replacements for informal care. This appears to be part of a bigger picture for, as John (1985: 231) asserts in reference to the US, Natives in general 'have low formal service utilisation, a condition that is not simply attributable to lack of availability or awareness of services'. A Senior Citizens Secretariat report (1987) lists over 100 programmes across Alberta that provide services to older people, yet few are used by Native seniors. Only four to five per cent of the sample visited Native or seniors' centres more frequently than once a month. Just eight per cent received homemaker services, seven per cent medical equipment or supplies, and three per cent handyman services. In regard to care, this may illustrate a 'substitution effect' (Chipperfield 1994: 435) operating in reverse. Instead of family and friends offloading responsibilities onto institutions when formal programmes become available, resident and non-resident kin shoulder a high care burden in part because Native seniors make little use of the formal services that *are* currently available (SCPC 1988: 143; Bienvenue and Havens 1986: 245; see also Kramer *et al.* 1990 and Manson 1989, 1993 on the situation in the US). Not institutionalising people outside the community also appears to be a strong cultural value, deriving in part from a belief that non-Natives do not care for their older people and lack true family feeling. Those interviewed perceived a healthy person as one who is active and involved, and saw institutionalisation as profoundly limiting, restricting their ability to care for others (SCPC 1988: 143).

The residence of seniors with their children or other adults often produces reciprocal benefits. It may also place significant care demands on others, especially women. Key gender statuses and roles in Native

households roughly mirror those found among other Albertans who are similarly situated with respect to class and locale. While the households in which Native seniors live are gender-balanced in personnel, resident women nevertheless are primarily responsible for meal preparation, housework, childcare, 'emotion work' and, it would appear, most day-to-day informal care of older people.

According to John (1991), in assessing the strength of familial support for Native seniors, most researchers have restricted their focus to the individual's immediate, biological family; in the general population they are those most likely to provide assistance to ageing family members (Scott 1983; Shanas 1979). For older Native people, a second but equally important issue is the availability of non-resident kin and others; important considerations here are residential proximity (Rosow 1969), frequency and types of interaction, forms of mutual aid, and who is most involved in family and kin contacts (John 1991).

Our data support the common perception that Native seniors are highly social in several senses that extend beyond the large households in which they typically live (Weibel-Orlando 1989: 163). They strongly value visiting and being visited by others, and going to places where they have an opportunity to socialise with others (most often identifying stores, bingo halls, clinics and other health care centres, band offices, shopping centres and churches as key extra-household sites of visiting). Seniors typically spoke with an average of 31 different individuals over the course of the week prior to being interviewed (27 for women and 36 for men). This rises to a remarkable 51 different weekly contacts in the small but close-knit communities of the North. Southerners and urban people are visited or visit others roughly half as often as their northern peers and those living in small communities.[12] The latter finding contrasts with US data (John 1985: 237), suggesting that older reservation-based Indians there have fewer social contacts than those in urban areas. Those with very good health report more than three times the number of inter-personal contacts than those with very poor health.

Patterns of visiting are strongly gendered in ways that have implications for informal care. In particular, seniors are much more likely to visit women than men. When asked which five people they visit most often, daughters predominated, being mentioned more than twice as often as any other type of person overall, and as the first or second most frequently visited person. The homes of sisters were visited as frequently (and are more frequently first mentioned) as those of sons. Brothers' homes were visited no more often than those of male or female friends. It is interesting that US Pueblo Indian focus groups composed

of active caregivers also stress the centrality of daughters and sisters to successful caregiving (Hennessy and John 1995: 219). Overall, of those individuals whom Native seniors visit most frequently and whose gender could be determined, 70 per cent were women and 73 per cent were kin. Rates of visiting of nearby kin appear to be considerably higher than among the general population aged 65 or more (Bienvenue and Havens 1986: 245). Even so, women visited others only half as frequently as men: once every 9.2 days, as compared with 4.6 days.

In addition, Seniors typically could expect to *be* visited much more often than they visited others, especially in the South. They reported being last visited 2.9 days previously (3.3 days before in the South and 1.8 days in the North), but last visiting others 7.3 days before (9.0 days in the South and 3.4 days in the North). While about a quarter were rarely visited by anyone, seniors typically could count on two or three people to visit them at least once a week. They were likely to visit one or two others with regularity. Older women were no less frequently visited than were men.

The requirement to visit older people falls most often on daughters, who were 50 per cent more often identified as most frequent visitor than were sons. At the same time, daughters were only 20 per cent more often than sons ranked among the top two and the top five most frequent visitors. The third most frequent visitors were sisters, who visited their elderly siblings almost twice as often as did brothers, female friends and male friends. These patterns are not radically different from those found in the general population aged 65 or more (Payne and Strain 1991: 128).

Among those aged 65 or more in the general population, women claim to get much more informal assistance than men (Lapierre 1990: 265). Among Native seniors, however, the reported disparity is much smaller: 56 per cent of women respondents claimed that they received all the help they needed, as compared with 50 per cent of men. Twenty per cent of both women and men reported that their partners helped them, but women more often claimed to receive assistance from others, particularly from resident and non-resident daughters and sons (see also SCPC 1988: 128 and Harvey 1986: 43). Twenty-nine per cent of women reported assistance from daughters or sons living with them, and 11 per cent from daughters and sons living elsewhere; comparable figures for men are 19 per cent and 9 per cent, respectively. This appears to reflect a more general Canadian pattern of older women being more deeply embedded in family and kin (McDaniel and McKinnon 1993: 95).

Those in the North, those far from a full complement of formal services and those living rurally, were much more likely to say that they

received help from others, including, ironically, from formally organised sources. Those living near a full complement of services were three times more likely to report that they got no help at all than those living where such services were few. This cannot be read as a case of substituting formal for informal services where the former are more available, as the reported use of some services (for example, homemaker or handyman services, visits by health workers, and home improvement grants) is also much higher in isolated areas than in cities.

Discussion

This study provides support for many of the concerns reviewed at the beginning of this article.

Care needs

The objective conditions described here predict a high current overall care requirement for the older Native population. While there is much variability in every pertinent measure, Native seniors typically contend with much poorer health than do others of their age and with associated medical problems, physical limitations and psychological challenges. In part causing and exacerbating their health problems are very limited personal economic resources: meagre incomes, sparse class resources, poor housing, few household conveniences and limited transportation. Monthly incomes are typically exhausted on life's basics, a pattern of expenditure more characteristic of Southern countries. Almost all of these things more often or more severely affect women, those in the southern part of the province and those in cities. Moreover, depending on the particular domain of life or subject under consideration, between a quarter and three-quarters of women and men claimed that they faced significant limitations and needs. These ranged from the very concrete to socio-cultural factors affecting their quality of life.

The overall care needs of the older Native population will increase dramatically in the future. Arguments in support of particular levels of need for given populations are almost infinitely expansible, depending on how priorities and values are assigned to them and how effectively such arguments detach discussion from a comparative base of assessment and from the zero-sum nature of resource reallocation. Even so, the number of older Native people in Alberta will almost triple in

the next 25 years, and there is nothing on the immediate horizon which will mitigate the factors currently producing a disproportionately high level of need among them.

With two significant exceptions, Native seniors do not use formally organised means to address their current needs as often as do other older Canadians. These exceptions are government income support programmes upon which almost all who qualify depend, and government-supported medical services, which are extensively used by about a quarter. Many Alberta reserves, settlements and informal Native communities are small, isolated or both, and often lack formal community-based services. However, community services are also underdeveloped on larger southern reserves, when compared with non-Native communities of equal size. Formal service availability therefore *is* an important issue. Even so, the relative unavailability of local programmes cannot account for the low rates of service use, particularly among seniors living in cities, or for the higher use rates for some services in small, more healthy, northern communities. Very significant barriers appear to prevent Native seniors from making use of institution-based programmes which are aimed generically at the older population. This pattern is found across the gamut of programmes, from those designed to maintain older people's independence in their own homes (like homemaker services), to those of a more informational or social-recreational nature (like those based in local senior citizen centres).

Informal care

Extensive informal care partially compensates for many of the disadvantages and disabilities that Native seniors face, as well as for their under-utilisation of extant services. Informal care meaningfully deals with a diversity of needs: for example, for economic support, for assistance in everyday activities, and for psychological and social grounding. Care provided by resident family members may also significantly reduce the rate at which older relatives are institutionalised (Manson 1989, 1993). Most Native seniors appear significantly advantaged in their access to people likely to provide informal care. They currently benefit from a very broad-based population pyramid and from culturally-grounded familial orientations. As a consequence, they are much more likely to live with others and to live in a large household; they are more likely to be able to draw on a large reservoir of close non-resident kin; they are more often long-established in social

communities with which they are closely identified and in which they play important roles; as elders, they may more often be able to command some of the more positive culturally-grounded status attributes of being old than those of similar class in the general population. The thesis that there has been an across-the-board weakening of the kinship system and erosion of family relationships among Native people in North America (Carson 1995: 22) is challenged by the data presented here. Nevertheless, we must make two important caveats. This, and virtually all other pertinent Canadian research on older Native people, has been based primarily on attitudinal interview data and not on direct observation. Much more research of an ethnographic nature needs to be undertaken in order to map out the everyday activities and reciprocal structures of exchange between women, men and children in these households, and to establish more definitively the relationship between Native informal care beliefs and actual behaviour. The second caveat is consistent with what John (1991) found in his study of a US reserve: that despite the importance of family relationships in Native communities, it is incorrect to assume that every senior has an extensive family support network on which to rely. The high percentage of Native seniors who now live alone, or with just a spouse or child, belies the notion that extended families are universal.

Native seniors have many concerns about their ability to maintain personal control and to maintain their socio-cultural environment. The situations of older people are often 'medicalised' or 'economised', and a reductionist medical or economic grid is arbitrarily placed over the discussion. Medical and economic issues are important, yet many issues of concern to Native seniors have nothing to do directly with either illness or its treatment, or with material standards of living. Native seniors clearly value their social ties and attach great importance to the cultural context in which they are embedded. Fundamental social change is now differentially affecting many Native communities and families, often in ways that have influenced non-Native people: most clearly in cities, but also in large southern reserves and communities. The small, isolated communities of the North – with respect to which this study reports a more positive result on virtually every measure – alone remain bastions of sociality. One of the most critical chronic problems facing a growing minority of Native seniors who live further south may be the 'loss of continuity in their lives' (Holzberg 1982). There are some indications in the American literature that Native people are becoming more individualistic and less kin- and community-oriented, and that older individuals, especially those in urban settings,

are more often left to fend for themselves (Cooley *et al.* 1979). As the number of Canadian Native seniors increases in proportion to younger people, there is no guarantee that sustainable social networks will be there to support them as they advance into old age and increasing levels of dependency.

Women and men appear to have very similar access to both the type and level of informal care they receive, and to the informal care resources that are available to them. Older women are not more likely to live alone than men, as are their non-Native counterparts. Indeed, women live in households whose composition is in most respects like those of men. Women may be somewhat more socially isolated from those outside the home than are men, but they claim to get more assistance from a wide range of close kin.

A large minority of Native seniors in Alberta either fall through the informal care net entirely, or else have specific important needs which they feel are not being addressed adequately. About one-quarter of seniors fall into *each* of the following nine at-risk categories: those who have poor health; have many medical problems; are very poor; face psychological difficulties; live alone; are socially isolated; have major activity limitations; lack ready transportation; or say that they get no help at all. Most of these are strongly correlated but the overlap is far from perfect. Accepting for the moment the *status quo* in the level, kind and quality of resources effectively transferred to Native seniors, we estimate that at least one out of three would greatly benefit from more ongoing informal assistance.[13] The proportion of those with unfilled needs is largest among those in poor health, as the consequences of poor health appear to ramify in all directions. This proportion is also larger among those in cities, in the South, among those living alone, and in some contexts, among women.

There are indications that women strongly predominate in the provision of informal care to older Native people, as they do in the population at large. In traditional times, women were the primary caregivers in many of the Native societies that inhabit what is now Alberta (Manneschmidt and Crowshoe 1997). It is our informal impression that the co-residence of older Native women and men typically increases the everyday round, and extent, of gender-based tasks that other household women perform. Older household members may reciprocate by providing childcare, doing housework and pooling incomes but, on balance, the exchanges between the young and the old, and particularly between younger women and older co-residents, are asymmetrical. This asymmetry extends outside the home, as women are both the main visitors of older people and the people they most

often visit. Daughters, sons, wives, husbands and sisters carry much of the overall informal care load.

It appears that those providing informal care to older Native Albertans will face increasing demands in the future. The proportion of potential primary caregivers (such as daughters and sons) to older potential recipients has been decreasing quickly for a long time. Everything else being equal, there easily could be a further 50 per cent increase in the informal care responsibilities such individuals shoulder over the next 20 years. This increased load may also fall disproportionally on women, which would have many implications for their other aspirations and obligations.

Non-Native Canadian women face on average 20 years of supporting dependent children, followed by 25 years of comparative freedom from caregiving, followed by the likelihood that they will spend another 15 years or more caring for aged parents and spouses. The experience for many Native women is already quite different. A Native person aged 55 years can have many needs associated with old age that lead them to come dependent on daughters and sons who are only in their 20s or early 30s, and who are caring for their own young children. Typical Alberta Native seniors (who have an average age of 63) may depend on children in their late 30s, almost all of whom have dependent children. The prevalence of such arrangements is reflected in the household residence patterns presented earlier, which show twice the number of their own grandchildren in residence as sons or daughters. Many Native women in the US are reported to be serial caregivers (Hennessy and John 1995: 220), and many in Alberta never have those 25 years of comparative freedom from caregiving that their non-Native contemporaries enjoy. Caregiving women and men often care for older relatives while they care for children. As Mount Pleasant-Jetté observes,

> extended family structures provide support systems for Native people, but at the same time, they can also constitute additional burdens when the phenomenon known as the 'sandwiched generation' effect occurs. Responsibilities for care of infants and the elderly has a disproportionately negative effect on women. (1994: Section 4.6.1)

Cultural expectations

The provision of caregiving to elders appears to be culturally framed as desirable and ethical across a wide range of Alberta Native groups. This cultural consensus should not lead one to conclude that informal caregiving is unproblematic or stress-free. Bunting (1989) identifies family obligation as a key stressor for caregivers, and this must extend

to Native people. Primary caregivers participating in focus groups drawn from highly familial US Pueblo communities note that they had 'fear and uncertainty' in the early phases of assisting older people (Hennessy and John 1995: 221). Moreover, culturally-formed responses to these stresses themselves are an issue. Native North American cultures remain diverse, despite a long history of colonisation and forced acculturation. Nevertheless, a broad cultural dichotomy was identified by Wax and Thomas long ago (1961: 308). Europeans, they believed, have been torn between the right of people to enjoy freedom and make up their own minds, and a felt need to be their brother's keeper and not to abstain from giving advice or helpful action. They considered 'the' Indian society as unequivocally different: '[overt] interference of any form is forbidden, regardless of the folly, irresponsibility, or ignorance of your brother' (1961: 308). Wax and Thomas may be accused of being captivated by the North American folk stereotype of the taciturn Indian, but the values of 'inter-dependency' (Red Horse 1980, in Hennessy and John 1995: 219) and of 'passive forbearance' (Strong 1984: 254) in caregiving, do appear prevalent. In a study of US Indian and 'white' primary caregivers, Strong observed that while both Indians and 'whites' shared basic concerns, Indians did not think that they had, or ever would have control over their caregiving situations, and did not exhibit overt anger over the frustrations these situations entailed (1984: 253). Moreover, there is some evidence that the pressure of helping activities may lead to depression, higher role conflict, lower self esteem and lower life satisfaction among Native women (Napholz 1995: 68). Caregiving stress may also contribute to abusive family relationships (Carson 1995: 23).

Culturally-framed current and future caregiving expectations and values may also have personal economic and class mobility implications. In this regard, Mount Pleasant-Jetté states that:

> Lack of adequate child care services and eldercare services particularly in urban environments, makes it practically impossible for large numbers of potential employees to occupy full-time positions. While these family pressures are a fact of life for many Canadian workers, Aboriginal people may experience greater levels of absenteeism, and more importantly, higher levels of unemployment, because of the intensity of the role that family plays in Aboriginal cultures.... At present, many Aboriginal working women rely on relatives and extended family members to provide childcare or eldercare service because they are unable to locate quality public caregivers. This situation creates a 'trickle down effect', effectively keeping the caregivers out of the regular labour force. Furthermore, when such caregivers are unavailable, the burden of responsibility on working women frequently results in their leaving positions of employment (1994: Section 4.6.1).

Facilitating access to care

The identification and removal of barriers to the more extensive use of formal analogues to informal care would seem to be of the highest priority. Particularly, in the absence of adequate incomes, we cannot assume that the future economic, social and psychological needs of Native seniors can be met by family support and local social networks alone. Many seniors today are greatly concerned that their ability to remain independent and to engage in everyday activities is, or may become, increasingly compromised by progressive frailty or disease. They wish to stay in their homes and communities for as long as possible. This has important implications for formal services and for family members, friends and other unpaid caregivers. These are especially relevant at the end of the 1990s, when both federal and provincial governments are committed to institutional downsizing and to increased levels of community-based care. Clearly, further culturally-appropriate, formally-delivered support will be required to keep overall informal care requirements from increasing dramatically, and from falling more inequitably on a few. Native seniors polled in this study were almost unanimous on what would most improve their lives: more money. This should be taken seriously, given their very low incomes. There are at present no supplementary income programmes directed specifically towards older Native people. Tax benefits provided to some of those who care for dependent older people are virtually irrelevant to most Native caregivers,[14] and few have their caregiving obligations significantly reduced by formally provided care.

In this light, the expansion of two domains of service provision may complement, and possibly reduce, current caregiving loads in individually acceptable, culturally appropriate, community-based ways. In reserve, settlement and other rural contexts where coherent local Native communities exist and where the older individuals are identifiable and known, more community-staffed and community-run programmes could be provided. These would mirror what non-resident daughters, sons and others do: providing homemaker and handyman services, transportation and venues for socialising, for example. The need for more programmes of this sort is a recurrent theme in testimony before the recent Royal Commission on Aboriginal Peoples (1997). Establishing and expanding such programmes in urban contexts would *not* duplicate 'mainstream' services, which often are not tailored to the needs of Native seniors, and sometimes are structurally biased against them (Acharya 1996). Such programming, however, would face much greater difficulty in gaining access to, and building trust among, a

much more diverse, geographically dispersed and mobile population than those found in rural contexts.

The other functional analogue that merits greater attention is the provision of community-based, multi-care facilities for those older people who are more infirm or unwell. A number of such facilities have been planned and built across the country, and the construction of more of these facilities has been very strongly advocated before the Royal Commission.

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NOTES

1 Life expectancies remain about six years lower for Native people in Canada than for others. However, according to Hill (1970), the greatest difference between Native people and others is average age of death. In Canada, this was below 50 years in 1976. Disabling degenerative diseases commonly associated with old age affect Native people earlier and with greater intensity. Some social and psychological changes frequently identified with a 'mainstream' progression into old age such as loss of status, independence, friends, spouses, and other relatives either come earlier or else are part of everyday life throughout adulthood (SCPC 1988: 27). For the purposes of certain programmes, some US states consider 'American Indians' old at the age of 45 years (Weibel-Orlando 1989: 151), as do some researchers (Kramer 1991: 208).

2 Estimates for the number of Native people in Canada vary dramatically as a function of the criteria used. Key Census results summarise answers to an ethnic origin question, which allows multiple responses. The 1,002,675 figure cited here includes these multiple responses. Single response figures much lower (470,610 in total): 365,375 'North American Indian', 75,150 'Metis' and 30,085 'Inuit'. The *Aboriginal Persons Survey* provides intermediate national figures for those who identified with a specific Aboriginal group: 460,680 as Indian, 135,265 as Metis and 36,215 as Inuit: 625,710 in total (Northwest Territories Bureau of Statistics 1993: 1).

3 Census figures for 1991 report 158,790 Native people in Alberta (out of a provincial population of 2,519,180), of whom 63 per cent were self-defined as Indians, 35 per cent as Metis and two per cent as Inuit (Statistics Canada 1993). 103,645 Albertans were then considered to have 'Aboriginal identity' (Northwest Territories Bureau of Statistics 1993: 1). Given the more or less inclusive ways in which people can reasonably be enumerated as Native, between 11,000 and 17,000 Native people in the province were aged 50 or older at that time. There will be no fewer than 20,000 in 2000, and 25,000 in 2010.

4 Presentation to the Royal Commission on Aboriginal Peoples, Slave Lake, Alberta, 92-10-27.

5 Old Age Security is a federal programme providing up to $400 a month to low income older Canadians over age 65. Guaranteed Income Supplement is a federal programme that ensures that every senior (aged 65 or more) has a minimum income. It provides up to $480 a month, $310 if married. A few provinces have bridging programmes to assist low income people aged 60–64.

6 All sub-categorical discriminations (percentages, averages or counts) made in this article are significant at the 0.001 level or greater.

7 Pan-Canadian data for 1988 are from Health and Welfare Canada (1988: 189). Those for the total Native population in 1991 are derived from Young (1994).

8 The SCPC (1988) study also found lower rates of diabetes in the North. Doing direct testing among older Cree-Ojibwa in northern Ontario and Manitoba, Young *et al*. (1988) found a diabetes rate of about 9 per cent. Citing no evidence, a major report on older Native people in Ontario (OACSC 1993) suggests that 40–50 per cent of those aged 45 and older have diabetes.

9 There is a general belief in the existence of an ethnic advantage in relation to support from, and involvement with, family. The extent to which such an ethnic advantage holds for Native seniors or any other ethnocultural population in Canada is not well established (Strain and Chappell 1989).

10 Strain and Chappell (1989: 111) indicate that in 1984 the average household size of Native seniors in Winnipeg aged 50 and over was only 2.25, but SCPC (1988: 65) data suggest an average household of 3.0–3.3 for seniors in urban Saskatchewan.

11 The SCPC (1988: 136) estimates that 42 per cent of their southern sample and 60 per cent of their northern one 'often' care for others, most frequently grandchildren. Harris *et al*. (1989: 108) report that 50 per cent of women and men aged 65 and older in their Southwest US sample care for children. In 1990, 22 per cent of Canadian women and 15 per cent of men aged 65 or more claimed to provide childcare services outside the home (Lapierre 1992: 558; see Lapierre 1990: 266, for 1985 data).

12 Urban people last visited another household 11.0 days previously, and were last visited 3.9 days before. Figures for those living in small communities are 5.3 days and 2.3 days, respectively.

13 Assuming the *status quo* is of course a dangerous practice when considering minority groups, inasmuch as it can have the effect of masking a wide range of structural factors determining the general conditions of these groups, such as those which now render most Native seniors poor.

14 Canadian taxpayers can receive a tax deduction of up to $2,400 for their support of resident older relatives, but Native caregivers' incomes are often so low that this deduction does not significantly reduce their taxes.

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