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Older Immigrants in the United States: The New Old Face of Immigration

Jing Tan

Between 1820 and 2007, the United States has admitted more than 73 million immigrants, including refugees and asylum seekers. To say we are a nation of immigrants is no cliché. Since the 1930s, the influx of immigrants in the United States has steadily increased reaching its highest point in the 1990s. The Current Population Survey (CPS) estimates that the non-institutionalized population in the United States includes 33.5 million foreign born, representing 11.7% of the U.S. population. Latin America contributes the highest number with 53.3%, 25% from Asia, 13.7% from Europe, and the remaining 8% from other regions of the world. Whereas immigrants to the United States in the late nineteenth and early twentieth centuries were mostly from European countries, the past five decades have seen rising numbers of immigrants from the Americas and Asia. This is due to the impact of the 1965 Immigration Act, which abolished the national origins quota system. Before the passage of this legislation, there were annual quotas based on nationality which applied to all countries except those in the Western hemisphere.

Immigrants to the United States have historically been younger than the native population but that trend has also been changing. Now, older adults make up America’s fastest-growing immigrant group. Since 1990 the number of foreign-born people over 65 living in the United States has grown from 2.7 million to 4.3 million, and the number is expected to increase to 16 million by 2050. The percentage of adults aged 65 years and older within the immigrant pool rose from 4.4% in 2005 to 5.6% in 2007; furthermore, those 60 years and older rose from 7.6% in 2002 to 8.6% in 2007. According to the Department of Homeland Security (DHS), over 60% of older immigrant adults live primarily in six states: California, New York, Florida, Texas, New Jersey, and Illinois.

Data from the New Immigrant Survey shows that 85% of older immigrants indicate their intention to live in the United States for the rest of their lives. Various geriatric service providers need to be aware of the fact that the population of older immigrants is in need and unlikely to return to their native countries.

Why Do They Come?

Literature on older immigrants classifies the older foreign-born population into two categories, based on their migration pathways. The “invited elderly” refers to late-life immigrants invited to reunite with their adult children and/or family members, while “the immigrated elderly” refers to those who immigrated in their 30s and 40s and have grown older in the U.S. The family-based system of immigration was precipitated by the 1952 Immigration Act with the entrenchment of the “immediate relatives” category that was not subject to quotas. Naturalized adult children over the age of 21 or siblings can petition for relatives in their native countries under “immediate relatives” category of the family-based preference system. Amendments in 1965 further changed the national origin quota formulae and increased the preference categories under which immigration could take place. These changes have contributed to the increase in the volumes of “invited elderly,” particularly from non-European countries. The vast majority of the 60 and older age group arrive in the United States under the category of “immediate relatives” of U.S. citizens.

There are not only differences among older immigrants from different regions or countries, but also within the same ethnic group. For example, although all are called ethnic Chinese older adults, those from the People’s Republic of China, Hong Kong, Taiwan and Singapore may have different values and ideologies, different educational and economic backgrounds, different levels of acculturation and English proficiency, and require different services once they are here in the United States. The intergroup and intragroup diversities in immigrant history and demographic, cultural norms and family value systems, health beliefs, religion and spirituality, and attitudes toward health and social services present challenges to social work and other health care professions to work with this population.

Stressors are endemic in the immigration and resettlement process. The inherently stressful nature of immigration and the concomitant stressors associated with living as an immigrant are well established in literature. Older adults are especially susceptible to these stressors and the ensuing mental health problems. When compared to immigrated elderly, the invited elderly are...
more likely to be new immigrants in their 60s and 70s, experiencing severe psychological, physical, and financial difficulties. Many of the invited elderly are aging parents of naturalized American citizens, and they are among the most isolated people in the United States. These older immigrants are a vulnerable population. Most of them speak little or no English and do not drive. As a result of language barriers, a lack of social connections and values that sometimes conflict with the dominant American culture, research has found a high prevalence of depression among recent elderly immigrants.

Immigrant families from developing countries have often been characterized by a strong family tradition of parental authority, mutual support, strong family ties, and filial piety. In most immigrant populations, families have played the most important role in caring for their elderly members. Intending to reunite with their children, the invited elderly come to the United States with their cultural expectations. American society isn’t organized in a way that meets their expectations, and life in America can be hard to navigate. After moving to the United States, most recent older immigrants, especially those from non-English-speaking countries, become dependent on their children and grandchildren for help with daily transportation are the most significant barriers to quality of life for older immigrants in the United States. Both Mr. and Mrs. Jiang can speak some simple English, but they could not understand medical terms and have difficulty reading newspapers and watching American TV. Mr. Jiang wanted to install satellite TV in their apartment in order to get Chinese television programs and made his request to the apartment manager, but he was unsure if the manager’s response meant that he could install the satellite dish or not and it went uninstalled.

The inability to drive is also a bigger impediment than it was in China. The public library within walking distance to their home does not carry Chinese-language books or DVDs. The apartment has transportation services for shopping every week; however, its services do not go to the Chinese grocery stores that older Chinese immigrants prefer to shop at. They depend on their daughter to drive them to the Chinese grocery stores and a bigger library that has a good collection of Chinese-language books and DVDs. Mrs. Jiang needs to go to the social security office for an interview that is part of the application process for Medicaid, but the office is only open on weekdays and there is no bus available. She says, “My daughter has to work, so it is a trouble for her. However she will find time to go in the end. I will not bother my manager if I can solve the problem.” Both Mr. and Mrs. Jiang feel that their children have their own lives. They do not ask for help from their children as long as they can handle a situation themselves. At the same time, they also believe that their children are their safety net.

Mr. and Mrs. Jiang admitted that they have fewer friends and are less active socially in the U.S., but, in the end, they report that “there is nothing in our lives to complain about.” They are both actively taking English classes to prepare their citizenship exam. They never think of returning China and believe the United States is their home and look forward to holidays in order to have a family reunion with all their children and grandchildren.

Mr. and Mrs. Jiang

Mr. and Mrs. Jiang had a life that everyone in China wished to have. Both of them were successful chemical engineers who had retired to a comfortable life in a city in the south of China. Moreover, Mr. and Mrs. Jiang have three successful children, a son and two daughters. All three children came to the United States for graduate study in the 1980s and stayed. Their son is currently a tenured professor and associate dean of business at a university in California. One daughter works at the University of Wisconsin and the other works for a company in St. Louis, Missouri. All three children became naturalized citizens of the United States and sponsored green cards for their parents. At the ages of 71 and 73 respectively, Mr. and Mrs. Jiang immigrated to the United States with legal permanent residency status.

Mr. and Mrs. Jiang first stayed with their son’s family in California and wished to apply for public housing there, but the waiting list for public housing in California was too long. After living with their son for a month, they moved to Wisconsin to live with their oldest daughter for a while, finally, moving to St. Louis where their younger daughter was living. They have lived in a government sponsored senior apartment in St. Louis for more than 3 years.

After a few months at the senior apartment in St. Louis, Mr. Jiang experienced some health problems but did not have any health insurance that would allow him to seek treatment. Although Mr. and Mrs. Jiang have green cards they do not qualify for most government aid including Medicare, Medicaid and Social Security until they obtain citizenship. Fortunately, the social worker in their apartment complex helped him to find a local hospital that provided free medical services. He was diagnosed with prostate cancer and received free treatment and medicine. Meanwhile, Mr. and Mrs. Jiang are counting the days until they can apply for citizenship. They are about two months shy of the 5 years of residency they need before they can apply.

Mrs. Jiang said that “everything is good in the U.S. However, there are two important things: English and car.” Language and transportation are the most important role in caring for their children. They never think of returning China and believe the United States is their home and look forward to holidays in order to have a family reunion with all their children and grandchildren.
Despite greater needs, older immigrants, especially among those recently arrived from non-English-speaking and less developed countries, underutilize various health and social services. There has been little research on health care utilization of immigrants. However, research has reported that older immigrants are less likely to have a regular source of care and underuse preventive services, inpatient care, primary health care, nursing home, home and community long-term care, hospice care, and mental health services.

Many researchers have tried to explain the reasons of underutilization and identify the barriers against health service use among older immigrants. The characteristics associated with low usage of health services among older immigrants include personal characteristics and structural characteristics. Older immigrants who have language difficulties, negative attitudes and cultural beliefs toward western services, and prefer informal helping resources are less likely to utilize health services. There are also structural characteristics that relate to underutilization among older immigrants, such as the accessibility and cost of formal services, health insurance eligibility, and cultural appropriateness of service delivery.

As a vulnerable population, older immigrants face numerous challenges and barriers. Researchers summarize three major types of potential barriers to service utilization that older immigrants face: (1) institutional or structural barriers, such as unavailability of services, eligibility restrictions related to noncitizen immigrant status, cost of service, and racism; (2) instrumental or functional barriers, such as the lack of transportation and service information, and (3) cultural and linguistic barriers, such as conflicting health beliefs, a lack of English skills, and, on the part of the health service provider, insensitivity to cultural norms of interactive behavior.

The most fundamental barrier is the lack of knowledge about available services. Available but unknown services become meaningless to the intended population. Research on the lack of knowledge and understanding of health and social services suggest an urgent need for effective dissemination of information about available services to older immigrants. As for service providers, it is important to become knowledgeable about legal and other eligibility requirements of service and programs that are applicable to different immigrant groups. Regardless of the type of services and agency offering them, increasing service utilizations among older immigrants requires that services are available, accessible, and acceptable to them. Furthermore, service providers need to be aware of the special vulnerability of newly arrived older immigrants with less than 5 years of residence in the U.S. due to their ineligibility for public assistance and social services in most states, including SSI and Medicaid.

Even when immigrant elders are eligible for and aware of services, those with limited English skills or lack of transportation still cannot access the services they need. Concrete services, such as transportation, and resources for learning English, are needed to help older immigrants access health and social service systems. Service providers need to actively reach out to the intended ethnic immigrant elderly population and provide information about available services in culturally and linguistically sensitive ways.

For an effective approach to service delivery for the immigrant elderly population, services also need to be culturally responsive or acceptable. For example, social activity centers and residential facilities that serve typical American-style meals will not draw older immigrants who have strong preferences for their ethnic foods. Similarly, health and social service providers’ lack of knowledge about cultural norms of interpersonal behavior and patterns of relationship formation that are different from the American norms can result in dissatisfaction with the services and consequent underutilization of services by older immigrants. Cultural differences can create misunderstandings and tension between service providers and their elderly clients. Due to the vast diversity, it becomes important to understand the intergroup and intra-group difference among immigrant elderly population in their religious and spiritual beliefs, in their attitudes toward health and social services, in the appropriateness of involving family caregivers in service planning, in cultural norms for effective interpersonal behavior, and in other cultural preferences, such as food and type of program activities.

The multiplicity and complexity of older immigrants demand a multidimensional approach to social work practice. As a profession that is dedicated to helping people in need and to address social problems, growing numbers of older immigrants in the United States call for social work practice with cultural competence and the ability to understand the target population’s special issues and needs in service delivery.

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