Health Status of Older Chinese in Canada

Findings from the SF-36 Health Survey

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ABSTRACT

Background: Despite the fact that the Chinese belong to the largest visible minority group in Canada, there is little research findings on their health status, particularly the aging adults. This research aimed at bridging the knowledge gap by examining the health status of this population and comparing the health status between the Chinese aging population and the general aging population in Canada.

Methods: Secondary data analysis of data obtained from a multi-site study, Health and Well Being of Older Chinese in Canada, and from the Medical Outcomes Study 36-item Short Form (SF-36). The SF-36 published scores obtained from the same age cohorts in the Canadian Multicentre Osteoporosis Study were used for comparison purposes. Independent samples t-tests were used to compare the statistical significance of the two groups.

Results: Overall, older Chinese-Canadians reported better physical health than all older adults in the Canadian population. However, the older Chinese in all age and gender groups scored lower in the mental component summary (MCS). Despite the age differences, Chinese women reported statistically poorer health than the Chinese men in all of the 8 health domains.

Conclusion: The data are useful for forming baselines for monitoring the effectiveness of future health interventions for this population. Efforts by service providers to address the health needs of older Chinese-Canadian women, the most vulnerable subgroup in this study, are essential. Interventions are also needed to address the poor mental health status in this ethnic minority group.

La traduction du résumé se trouve à la fin de l'article.

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Cultural diversity and population aging are two of the major trends in Canada's population composition. In 2001, visible minorities made up 13.4% of the Canadian population,¹ a 52.3% increase from 1991;² 13% of Canadians were 65 years and older, a jump of almost 12% from 1991.³ Although only 6.6% of the visible minorities have reached the age of 65, some groups reported a much higher aging population. For example, 10% of the Chinese-Canadian population reached the age of 65 in 2001, a 12.5% increase from 1996.³ Yet only a few research studies on health status-related topics of older Chinese-Canadians – such as depression,^{4,5} life satisfaction,⁶ quality of life,^{7,8} cancer,⁹ mental health and social adjustment,¹⁰ and stress and coping¹¹ – can be identified. These studies suggested that the older Chinese reported lower psychological well-being and more depressive symptoms than the general older adults.^{4,5,11} However, due to the use of small, non-random, and localized samples, the generalization power of the findings was often reduced.^{4,6,12-14} To further enhance understanding with regard to health status of the older Chinese-Canadians, this paper aimed to address the research question: How does the health status of the aging Chinese-Canadian population compare with that of the general aging population?

METHODS

Secondary data analysis was used by comparing the data on health status of the aging Chinese population from the Health and Well Being of Older Chinese in Canada Study¹⁵ and the published findings on health status of the general older adults in the Canadian Multicentre Osteoporosis Study (CaMos).¹⁶ The Health and Well Being of Older Chinese in Canada study was conducted between Summer 2000 and Spring 2001 with 2,272 randomly selected Chinese aged 55 and older from seven Canadian cities. It examined the relationships between culture and health among the older Chinese-Canadians. To identify the sample, Chinese surnames were randomly selected from telephone directories in the seven cities, which accounted for 88.9% of the Chinese population in Canada.² The support for using surnames as the identification keys for locating

Chinese and other Asian participants has been well established.¹⁷⁻²² From the 297,064 Chinese surname listings identified, 40,654 numbers listed under 876 Chinese surnames were randomly selected. Trained telephone screeners then called the randomly selected numbers and were able to identify 2,949 eligible participants who were ethnic Chinese aged 55 years or older. Among them, 2,272 completed a face-to-face interviewer-administered questionnaire in either English or a Chinese dialect of their choice, representing a response rate of 77%. The questionnaire consisted of questions on socio-demographic information, physical and mental health status, preference with respect to health-related caring arrangements, use of health services and related community support services, barriers to service use, health maintenance methods and practices, cultural values, health beliefs, ethnic identity, life satisfaction, and attitude toward aging.

The Medical Outcomes Study 36-item Short Form (SF-36) was used to measure health status. This assessment tool consists of 36 questions measuring 8 health dimensions including physical functioning (PF), role limitations due to physical health (RP), bodily pain (BP), general health perceptions (GH), vitality (VT), social functioning (SF), role limitations due to emotional problems (RE), and mental health (MH). The Likert-scale items in each of the health domains were summed and standardized so that each scale ranged from 0 to 100, with a higher score indicating better health status. The 8 domain scores were used to calculate the Physical Component Summary (PCS) and the Mental Component Summary (MCS), which represent the overall general physical and mental health status. Both summary scores range between 0 and 100, with a higher score representing better health status. The SF-36 is a widely used and psychometrically sound instrument for patients and the general population.²³ It has been adapted, translated into Chinese, and validated to fit the Chinese cultural context.^{24,25} In this study, a Chinese version of the SF-36²⁴ was used.

In Canada, the normative data for the SF-36 were collected in the Canadian Multicentre Osteoporosis Study (CaMos), a study of 9,423 randomly selected Canadian women and men aged 25 years

TABLE I
Demographics of the Older Chinese-Canadians

		Overall Sample N = 2,272	55-64 Years n = 694	65-74 Years n = 925	75 Years & Older n = 653
Age (in years), mean (SD)		69.8 (8.7)	59.9 (3.0)	69.5 (2.8)	80.7 (4.6)
Gender (%)	Male	44.2	43.9	50.2	36.0
	Female	55.8	56.1	49.8	64.0
Religion (%)	Having a religion	58.5	54.5	56.3	65.7
	Not having a religion	41.5	45.5	43.7	34.3
Marital status (%)	Married	66.0	85.9	68.2	41.7
	Not married*	34.0	14.1	31.8	58.3
Living arrangement (%)	Living alone	13.8	4.3	10.4	28.6
	Not living alone	86.2	95.7	89.6	71.4
Education (%)	No formal education	12.7	2.4	13.3	22.8
	Elementary	28.3	16.4	31.9	36.0
	Secondary	37.8	51.2	34.8	27.9
	Post sec. & above	21.1	30.0	20.0	13.3
Country of origin (%)	Born in Canada	1.6	1.3	1.1	2.8
	Mainland China	27.1	24.2	31.0	24.7
	Hong Kong	51.1	50.3	48.9	55.0
	Taiwan	4.4	5.1	4.7	3.1
	Vietnam	7.9	8.5	8.1	7.1
	Southeast Asia	4.0	5.1	3.0	4.3
	Other countries	3.9	5.5	3.3	3.1
Immigration status (%)	Born in Canada	1.6	1.3	1.1	2.8
	Immigrant	97.5	97.6	97.9	96.9
	Others	0.8	1.2	1.0	0.3
Length of residency in years, mean (SD)		19.0 (13.7)	18.0 (12.5)	18.3 (13.8)	21.1 (14.6)
Personal monthly income (%)	Less than \$500	16.4	19.6	17.4	11.6
	\$500-\$999	38.0	23.6	40.8	49.3
	\$1000-\$1499	34.2	35.4	32.9	34.8
	\$1500 & above	11.4	21.3	9.0	4.3

* Including divorced, separated, and widowed

or older in the Canadian population of nine cities.¹⁶ The study estimated the prevalence of osteoporosis and osteoporotic fractures among adults who lived within a 50-km radius of nine Canadian cities. Using the postal codes of the sites, a random sample of listed residential telephone numbers, stratified according to the age and gender distribution of each site, was generated by Info-Direct (Bell Canada). The eligible participants identified through telephone screening were asked to complete an interviewer-administered questionnaire, which covered socio-demographic information, medical, fracture, reproductive and family history, medication use, diet, alcohol and tobacco use, and physical activity. The SF-36 was self-administered by the participants at the end of the interview. Data for the CaMos were collected between February 1996 and September 1997, with a response rate of 42.0% for those who completed the SF-36.

The SF-36 scores from the CaMos were stratified and published according to different age and gender groups with detailed mean scores and confidence intervals.¹⁶ For comparison purposes, the researcher regrouped the means and confidence intervals of the SF-36 scores from the Chinese-

Canadian older adults in the same way. As this paper focussed upon the aging groups, only the data of three older age groups – 55 to 64 years, 65 to 74, and 75 years and older – stratified by gender, were compared. Independent t-tests were performed to test whether there were any statistically significant differences between the scores reported by all older Canadians and the older Chinese-Canadians. The scores of the two groups were considered as significantly different when the p value was less than 0.01.

RESULTS

The demographic findings in Table I indicated that the older Chinese-Canadians were a diverse group from different socio-demographic backgrounds and countries of origin. The SF-36 scores of both the older Chinese-Canadians and all older Canadians in the CaMos¹⁶ were compared in Tables II to IV. The findings in Table II indicated that when compared with all the older Canadian population of the same ages, the older Chinese-Canadians, regardless of their ages, reported better overall physical health (higher PCS scores) (under 65: 51.7 vs. 49.0; 65-74: 51.2 vs. 47.2; 75 and older: 50.6 vs. 42.0) but poorer overall

TABLE II

Age-standardized Mean Scores (SD) for the 8 Domains and 2 Summary Scales of the SF-36 for Older Chinese and Overall Canadians

Domains	55-64 Years			65-74 Years			75 Years & Older		
	Chinese Canadians	Overall Canadians	p-value	Chinese Canadians	Overall Canadians	p-value	Chinese Canadians	Overall Canadians	p-value
Physical functioning	87.9 (16.1) (n=692)	82.3 (19.3) (n=2282)	<0.01	81.2 (19.3) (n=922)	75.7 (22.2) (n=2925)	<0.01	64.3 (27.0) (n=652)	59.1 (27.4) (n=1613)	<0.01
Role-physical	83.0 (33.4) (n=692)	81.3 (33.1) (n=2282)	0.23	78.1 (36.6) (n=924)	76.2 (36.5) (n=2925)	0.16	65.8 (43.0) (n=651)	62.6 (41.9) (n=1609)	0.11
Bodily pain	83.2 (24.3) (n=692)	74.9 (23.7) (n=2282)	<0.01	82.2 (24.6) (n=924)	74.0 (23.9) (n=2927)	<0.01	76.3 (29.0) (n=652)	69.8 (25.1) (n=1614)	<0.01
General health perceptions	63.3 (19.7) (n=691)	74.8 (19.4) (n=2276)	<0.01	62.2 (20.5) (n=923)	73.5 (18.4) (n=2921)	<0.01	56.6 (20.6) (n=648)	71.2 (17.9) (n=1611)	<0.01
Energy/vitality	68.0 (21.6) (n=694)	68.3 (17.7) (n=2280)	0.69	65.4 (22.4) (n=921)	67.7 (18.1) (n=2921)	<0.01	60.1 (23.2) (n=647)	61.1 (19.6) (n=1613)	0.32
Social functioning	89.7 (17.6) (n=693)	88.1 (18.8) (n=2282)	0.05	87.3 (20.2) (n=925)	87.0 (19.8) (n=2926)	0.69	79.5 (26.5) (n=652)	83.2 (22.5) (n=1612)	<0.01
Role-emotional	84.4 (33.0) (n=690)	87.8 (28.3) (n=2282)	0.01	83.7 (33.9) (n=922)	83.4 (32.8) (n=2924)	0.84	75.2 (40.4) (n=649)	80.3 (34.3) (n=1612)	<0.01
Mental health	79.2 (17.1) (n=693)	79.5 (14.7) (n=2279)	0.61	79.2 (17.3) (n=922)	79.3 (15.0) (n=2922)	0.84	77.0 (18.0) (n=648)	79.4 (15.1) (n=1613)	<0.01
Summary Scales									
Physical Component Scale	51.7 (8.0) (n=686)	49.0 (9.2) (n=2271)	<0.01	51.2 (8.6) (n=896)	47.2 (9.7) (n=2910)	<0.01	50.6 (9.3) (n=642)	42.0 (10.3) (n=1603)	<0.01
Mental Component Scale	48.7 (10.5) (n=686)	53.7 (8.2) (n=2271)	<0.01	48.9 (10.1) (n=896)	53.7 (8.3) (n=2910)	<0.01	47.5 (10.7) (n=642)	54.5 (8.6) (n=1603)	<0.01

TABLE III

Age-standardized Mean Scores (SD) for the 8 Domains and 2 Summary Scales of the SF-36 for Older Male Chinese-Canadians and Overall Male Canadians

Domains	55-64 Years			65-74 Years			75 Years & Older		
	Chinese Canadians	Overall Canadians	p-value	Chinese Canadians	Overall Canadians	p-value	Chinese Canadians	Overall Canadians	p-value
Physical functioning	92.0 (13.3) (n=303)	84.7 (17.7) (n=645)	<0.01	86.2 (16.1) (n=462)	78.6 (20.5) (n=799)	<0.01	75.3 (22.7) (n=234)	65.1 (27.2) (n=442)	<0.01
Role-physical	87.9 (29.0) (n=304)	85.4 (29.6) (n=645)	0.23	82.6 (33.2) (n=464)	78.7 (35.1) (n=799)	0.06	75.3 (37.6) (n=235)	67.7 (40.2) (n=440)	0.02
Bodily pain	87.5 (21.2) (n=303)	77.8 (22.5) (n=645)	<0.01	86.9 (21.6) (n=463)	77.2 (22.9) (n=800)	<0.01	86.7 (21.2) (n=234)	73.1 (24.7) (n=442)	<0.01
General health perceptions	67.6 (18.1) (n=303)	74.4 (18.9) (n=644)	<0.01	64.6 (19.6) (n=463)	73.7 (18.6) (n=799)	<0.01	62.1 (19.3) (n=232)	70.9 (18.1) (n=442)	<0.01
Energy/vitality	71.1 (19.6) (n=305)	70.8 (15.9) (n=645)	0.76	68.3 (22.4) (n=462)	70.2 (17.2) (n=799)	0.09	66.0 (21.5) (n=232)	64.9 (19.2) (n=441)	0.48
Social functioning	92.3 (15.6) (n=304)	89.8 (17.2) (n=645)	0.03	90.4 (18.4) (n=464)	87.7 (19.0) (n=800)	0.02	86.4 (21.6) (n=234)	84.8 (21.7) (n=442)	0.37
Role-emotional	88.5 (29.0) (n=302)	91.9 (22.9) (n=645)	0.05	87.1 (30.2) (n=462)	85.4 (30.8) (n=798)	0.32	82.6 (35.2) (n=234)	82.4 (32.4) (n=442)	0.92
Mental health	81.1 (15.2) (n=304)	81.7 (13.4) (n=644)	0.55	81.7 (16.6) (n=462)	82.1 (13.9) (n=798)	0.61	82.4 (15.2) (n=232)	81.0 (14.1) (n=442)	0.16
Summary Scales									
Physical component scale	53.1 (7.3) (n=300)	49.7 (8.5) (n=643)	<0.01	52.5 (7.8) (n=449)	48.1 (9.1) (n=796)	<0.01	52.5 (7.9) (n=231)	43.7 (10.3) (n=440)	<0.01
Mental component scale	48.3 (10.4) (n=300)	54.8 (7.2) (n=643)	<0.01	49.1 (10.3) (n=449)	54.6 (7.7) (n=796)	<0.01	49.3 (10.0) (n=231)	54.9 (8.0) (n=440)	<0.01

mental health (lower MCS scores) (under 65: 48.7 vs. 53.7; 65-74: 48.9 vs. 53.7; 75 and older: 47.5 vs. 54.5) than all the older Canadians. Among those 55 to 64 years old, the older Chinese-Canadians reported better health in the 'physical functioning' (87.9 vs. 82.3) and 'bodily pain' (83.2 vs. 74.9) dimensions than the overall older Canadians in the same age group. The same differences were reported in the two older age groups. Such differences were also observed among both men and women between 55 and 64 years, both men and women between 65 and 74 years, and men 75 years and older (Tables III and IV).

The older Chinese-Canadians reported lower scores in 'general health perceptions' than the overall Canadian older adults, no matter which age and gender group they were in (under 65: 63.3 vs. 74.8; 65-74: 62.2 vs. 73.5; 75 and older: 56.6 vs. 71.2). The Chinese-Canadians between 65 and 74 years of age also reported poorer health than the overall Canadian older adults of the same age in the 'energy/vitality' dimension (65.4 vs. 67.7). The same differences were reported among Chinese-Canadian women of the same age (62.4 vs. 65.6). For the Chinese-Canadian women aged 75 and older, their health status in 'social functioning,' 'role emotional,' and 'mental

health' dimensions was poorer than that of their overall Canadian counterparts (75.7 vs. 82.2; 71.1 vs. 79.0; 73.9 vs. 78.4, respectively).

Consistent with the gender differences identified in the Canadian normative data,¹⁶ the older Chinese-Canadian women were less healthy than their male counterparts in the overall sample (Table V). They scored significantly lower than their male counterparts in all 8 domains and the 2 summary components, with t-values ranging from -2.0 to -14.0 ($p < 0.01$). Similar gender differences were observed in all three age groups. Among those 55 to 64 years old, and those aged 65 to 74 years,

TABLE IV

Age-standardized Mean Scores (SD) for the 8 Domains and 2 Summary Scales of the SF-36 for Older Female Chinese-Canadians and Overall Female Canadians

Domains	55-64 Years			65-74 Years			75 Years & Older		
	Chinese Canadians	Overall Canadians	p-value	Chinese Canadians	Overall Canadians	p-value	Chinese Canadians	Overall Canadians	p-value
Physical Functioning	84.7 (17.3) (n=389)	79.9 (20.4) (n=1637)	<0.01	76.1 (20.8) (n=460)	73.3 (23.3) (n=2126)	0.02	58.2 (27.2) (n=418)	55.5 (26.9) (n=1171)	0.08
Role-Physical	79.3 (36.0) (n=388)	77.4 (35.7) (n=1637)	0.37	73.4 (39.3) (n=460)	74.1 (37.6) (n=2126)	0.69	60.5 (44.9) (n=416)	59.5 (42.6) (n=1169)	0.69
Bodily Pain	79.9 (26.0) (n=389)	72.1 (24.5) (n=1637)	<0.01	77.6 (26.6) (n=461)	71.4 (24.4) (n=2127)	<0.01	70.6 (31.1) (n=418)	67.8 (25.1) (n=1172)	0.07
General Health Perceptions	60.1 (20.2) (n=388)	75.3 (19.8) (n=1632)	<0.01	59.8 (21.1) (n=460)	73.3 (18.3) (n=2122)	<0.01	53.5 (20.7) (n=416)	71.4 (17.8) (n=1169)	<0.01
Energy/Vitality	65.6 (22.8) (n=389)	65.9 (19.0) (n=1635)	0.76	62.4 (22.0) (n=459)	65.6 (18.5) (n=2122)	<0.01	56.7 (23.4) (n=415)	58.9 (19.6) (n=1172)	0.06
Social Functioning	87.7 (18.9) (n=389)	86.4 (20.0) (n=1637)	0.23	84.2 (21.5) (n=461)	86.4 (20.4) (n=2126)	0.04	75.7 (28.1) (n=418)	82.2 (23.0) (n=1170)	<0.01
Role-Emotional	81.2 (35.5) (n=388)	83.8 (32.2) (n=1637)	0.16	80.2 (36.9) (n=460)	81.8 (34.3) (n=2126)	0.37	71.1 (42.5) (n=415)	79.0 (35.4) (n=1170)	<0.01
Mental Health	77.7 (18.3) (n=389)	77.4 (15.5) (n=1635)	0.76	76.8 (17.7) (n=460)	77.0 (15.6) (n=2124)	0.84	73.9 (18.8) (n=416)	78.4 (15.6) (n=1171)	<0.01
Summary Scales									
Physical Component Scale	50.5 (8.3) (n=389)	48.3 (9.7) (n=1637)	<0.01	49.9 (9.2) (n=460)	46.5 (10.2) (n=2126)	<0.01	49.5 (9.8) (n=418)	40.9 (10.2) (n=1171)	<0.01
Mental Component Scale	49.0 (10.6) (n=386)	52.6 (9.0) (n=1628)	<0.01	48.7 (9.9) (n=447)	53.0 (8.8) (n=2114)	<0.01	46.4 (10.9) (n=411)	54.3 (8.9) (n=1163)	<0.01

women were less healthy than men in all the 8 health domains and general physical health (PCS). The t-values ranged from -2.6 to -6.3 ($p<0.01$) for those 55 to 64 years old, from -3.1 to -8.2 ($p<0.01$) for those 65 to 74 years. The Chinese-Canadian women 75 years and older were less healthy in all aspects measured, with t-values ranging from -3.33 to -8.6 ($p<0.01$).

DISCUSSION

Using the SF-36 as a health measure, the older Chinese-Canadians reported similar or better physical health, but poorer mental health than their overall older Canadian counterparts. In the findings of another study on health status of the older Chinese-Americans in Boston²⁴ obtained using the same instrument (SF-36), a similar pattern was observed. The older Chinese-Canadians were in better health than the overall older Canadians in terms of physical functioning and bodily pain, probably due to the socio-cultural characteristics of the older Chinese-Canadians who have a longstanding tradition of withstanding hardship, a high tolerance for distressing circumstances, a strong sense of interdependence with family and social support.²⁴ As previous literature has suggested, the highly selective immigration policy of admitting only the healthy immigrants and those with social support from families and relatives¹⁰ could be the crucial factor for the older Chinese-Canadians to

TABLE V

Comparison of the SF-36 Scores Between the Older Chinese Men and Women

	Male			Female*		
	55-64 Years n=305	65-74 Years n=464	75 Years & Older n=235	55-64 Years n=389	65-74 Years n=461	75 Years & Older n=418
Physical functioning	92.0	86.2	75.3	84.7	76.1	58.2
Role-physical	87.9	82.6	75.3	79.3	73.4	60.5
Bodily pain	87.5	86.9	86.7	79.9	77.6	70.6
General health perceptions	67.6	64.6	62.1	60.1	59.8	53.5
Energy/vitality	71.1	68.3	66.0	65.6	62.4	56.7
Social functioning	92.3	90.4	86.4	87.7	84.2	75.7
Role-emotional	88.5	87.1	82.6	81.2	80.2	71.1
Mental health	81.1	81.7	82.4	77.7	76.8	73.9
Physical Component Scale	53.1	52.5	52.5	50.5	49.9	49.5
Mental Component Scale	48.1	49.1	49.3	49.0†	48.7†	46.4

* All the scores reported by the women were significantly smaller than the ones reported by the men in the respective age group unless specified otherwise.

† Not significantly different from the men in the same age group.

have better overall physical health status (PCS) than the overall Canadian older adults.²⁴ However, what is unknown is why the mental health status of the older Chinese-Canadians, regardless of age and gender, was not as good as that of the overall Canadian older adults. While the findings in this paper probably did not provide the answer to this, they certainly point to the fact that the older Chinese-Canadians have clear and present mental health needs.

Although the older Chinese had lived in Canada for an average of 19 years, as immigrants they may still be vulnerable to stress and related mental health problems. As echoed by other researchers, language barriers, lack of knowledge and understanding of the existing service system, acculturation stress, cultural shock, and other adjustment issues continue to exist.²⁶⁻³⁰ Therefore, mental health promotion and

development of better support for the aging immigrants are recommended. Due to cultural differences and service barriers, many of the mental health issues of elderly immigrants have not been addressed, a phenomenon reflected by findings on the low utilization of mental health services among the elderly Chinese immigrants.³¹ Services provided to enhance the mental health of the older Chinese-Canadians should also take into account their cultural uniqueness and language needs to understand the mental health issues.

Older Chinese-Canadian females, despite their age, were less healthy than their male counterparts. The gender differences were consistent with the findings in the Canadian study as well as in studies conducted in other countries.¹⁶ However, the Chinese-Canadian women, especially the older group, also reported poorer

health in a number of health domains and the MCS than did the overall older Canadian females in the same age group. Although examining the reasons for the gender differences was not within the scope of the paper, it is an important direction that future research and further analysis should focus upon. Nevertheless, strategies and policies should be developed to address the gender-related health issues faced by the vulnerable older Chinese-Canadian women.

The SF-36 scores from the older Chinese-Canadians were based on a representative sample from seven Canadian cities and therefore could be established as the norms for this population group. These scores can be used as health indicators for measuring outcomes and effectiveness of health interventions and policies that aim at improving the health status of this subpopulation.

Finally, this study has several limitations. The comparison of the findings from two different studies has to be interpreted with caution. As this paper failed to ascertain the reasons for the health differences between the two groups, further research in this area is needed. As a cross-sectional study, the findings are not able to establish the stability of the norms identified. Future research using a longitudinal method is recommended.

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RÉSUMÉ

Contexte : Bien que les Chinois représentent la plus importante minorité visible au Canada, il existe très peu de données sur leur état de santé, surtout celui des adultes vieillissants. Pour combler cette lacune, nous avons examiné l'état de santé de la population sino-canadienne et comparé l'état de santé de ses membres vieillissants à celui de l'ensemble de la population vieillissante au Canada.

Méthode : Analyse des données secondaires d'une étude multisite (Health and Well Being of Older Chinese in Canada) et de la version abrégée du questionnaire sur l'état de santé en 36 éléments pour les études des résultats cliniques (SF-36). Pour fins de comparaison, nous avons utilisé les scores publiés du questionnaire SF-36 pour les cohortes du même âge de l'Étude canadienne multicentrique sur l'ostéoporose. Des tests t sur un échantillon indépendant ont ensuite servi à comparer la signification statistique dans les deux groupes.

Résultats : Globalement, les Sino-Canadiens âgés se disent en meilleure santé physique que les personnes âgées dans l'ensemble de la population canadienne. Cependant, les Chinois âgés, dans tous les groupes d'âge, hommes et femmes, ont obtenu des scores plus faibles à la composante santé mentale du SF-36. Malgré les différences d'âge, les Chinoises étaient statistiquement en moins bonne santé que les Chinois dans les huit domaines de santé évalués.

Conclusion : Ces résultats seront utiles comme données de base pour surveiller l'efficacité des futures interventions sanitaires auprès de la population sino-canadienne âgée. Il est essentiel que les prestataires de services fassent des efforts pour répondre aux besoins de santé des Chinoises âgées, qui composent le sous-groupe le plus vulnérable de l'étude. Des mesures d'intervention sont également nécessaires en réponse au piètre état de santé mentale dans cette minorité ethnique.