4.1 Aboriginal Australians *A Kouris-Blazos*

*Somewhere* and *M Gracey*

4.1.1 Geography & climate

The elderly Aboriginal Australians studied in 1988 lived in an Aboriginal community called Junjuwa, located 2 km from the Fitzroy Crossing townsite, in a sparsely populated area in the far north of Western Australia. Non-Aborigines (most of whom provide services for the local Aborigines) live mainly in the Fitzroy Crossing townsite which include a 12-bed hospital, community health centre, community hall, supermarket, post office, hotel, butcher shop, electrical shop and road house. Few Aborigines lived in town as the homes were more expensive. (This situation has started to change in the 1990's).

Junjuwa is the closest Aboriginal community to the Fitzroy townsite. Junjuwa was the prime location for the research due to its accessibility from town and to its considerable numbers of elderly (see also Section 4.1.3). Other Aboriginal communities in the region include: Wangkatjunka (also known as Christmas Creek) 120 km from town, Mulledja 40 km, Bayulu 15 km, Nookanbah 180 km, Kurnangkie 10 km.

*Photo 4.1.* West Australia, Fitzroy Crossing, Junjuwa (1988): map of Australia showing the region from which elderly Aboriginal Australians were sampled.
Photo 4.2. West Australia, Fitzroy Crossing, Junjuwa (1988): Brooking Gorge; the Fitzroy area has many beautiful gorges with lush tropical vegetation.
The Kimberley region in the north-west (see map) is very large (approximately 1000 km by 450 km). It extends south and east from the coast of the Timor Sea (14°S) to the Great Sandy Desert (129°E, 21°S) in the south east and to the Eighty Mile Beach on the Indian Ocean Coast in the south west (121°E, 20°S). The Fitzroy Valley area is located in a riverine environment with predominantly well timbered or open savannah grassland (at 123-126°E, 18°S). The climate is tropical and rainfall is distinctly seasonal with a hot wet summer usually extending from November or December until April and warm, dry seasons in between the wet ones. It is an environment that sustains plenty of bush foods in good seasons: wild fruits, berries, tubers, and seeds, as well as birds (bush turkeys), reptiles (snakes, lizards), and some mammals (flying foxes). The Fitzroy river usually floods for a couple of weeks during the wet season and vehicles cannot enter or leave the townsite. Helicopters and the Australian Royal Flying Doctor Service may have to bring in food and medical supplies. In the dry season (April-October) temperatures can be as high as 25°C during the day and as low as 4°C in the morning. There is very little rainfall. Bush roots and tubers are dug up and certain species of fruit ripen. Fruit that has fallen to the ground during the wet season is gathered. The Aborigines were a successful group of mobile hunter-gathers who were well adapted to life in this open, uncrowded environment. Hunting and gathering of their food supplies and utilising local water sources were intermingled with the cycles of the seasons and the traditional practices and rituals to ensure abundance that were integral parts of their culture.

4.1.2 Culture, history and religion

Aboriginal people lived throughout the vast and varied environments of the Australian continent, isolated from contact with other peoples, for many thousands of years before British colonisation began in the late Eighteenth Century in a small convict colony which today is the city of Sydney. The geographical and climatic ranges of Aboriginal lands spread from tropical rain forests,
coastal and riverine environments and inhospitable, hot dry deserts in the north and centre of the continent to heavily timbered, moist and lush areas in the cool or cold environments in the south and south-east which is now heavily populated, urbanised and industrialised.

The Kimberley was one of the last large areas of Aboriginal Australia to be settled by Europeans, largely because of its remoteness from the population centres of the more settled and gentler, temperate areas of the south and south-east and because of the extreme conditions and climate of the Kimberley. Even today, with an upsurge in mining, tourism and other activities, the total population of the region is only 40,320 (26% of whom are Aboriginal) [1] spread over 420,520 square km. The earliest European settlement involved gold mining, diving for pearls, and raising cattle. The establishment of missions for Aborigines by Europeans also became a feature of the times which Hunter [2] crystallises as "gold, pearls, cattle and converts."

Photo 4.3. West Australia, Fitzroy Crossing, Junjuwa (1988): people of the region at the turn of the century; they were fit and strong with no signs of malnutrition.

The cattle industry used large tracts of the best land, which were fed by creeks and river systems and had abundant grass for grazing (or "ranching"). Naturally, this was the type of land that supported the abundant wildlife and bush foods on which the Aborigines lived. By the end of last century, large areas of previously traditional Aboriginal hunting and gathering lands were taken up by pastoral leases for raising cattle. Eventually, some areas became degraded due to the effects of overstocking hoofed animals. Groups of Aborigines lived on cattle stations and adapted to the new arrangements, including changing to a diet dominated by station rations that included refined tea, flour and carbohydrates, sugar and jam, and rations of meat. Traditional sources of food in the diet became decreasingly important except mainly for recreational purposes, such as fishing and shooting game.

From the late 1960's and early 1970's there have been many social and political changes in Australia that have influenced Aboriginal health and nutrition [2-4]. These include the granting
of citizenship rights, voting rights, equal access to alcohol and high levels of dependence on social security in areas like the Kimberley, where Aboriginal unemployment rates are generally very high. The so-called "lifestyle" diseases including cardiovascular disease, stroke, hypertension and type 2 diabetes mellitus as well as accidents and violence have become major causes of poor health, high hospitalisation rates, high death rates and premature Aboriginal deaths, particularly between the ages of 30 and 50 [5,6]. Adjustment to stress, financial and other obligations and pressures associated with their recent entry into the unsympathetic, wider cash society has been difficult for Aboriginal people who are also going through times of turbulent social and political change [4,7]. Elderly Aborigines also have special needs and problems that have so far been inadequately addressed. For example, four of the five main causes of death in 50 to 54 year-old Aboriginals occur at rates which are experienced 10 to 30 years later in life by non-Aboriginal people (M Gracey - unpublished observations). These include ischaemic heart disease or stroke, respiratory disorders, diabetes (in females) and digestive diseases (in males). Older Aboriginal people also often have serious dental problems that restrict their dietary intakes. These factors all need consideration with regard to the food habits of elderly Aborigines in the Fitzroy Valley.

Before the 1960's Fitzroy Crossing consisted of little more than a hotel located at the crossing in the river bed where cattle traversed the river, a post office, the Australian Inland Mission Hospital, a police station and a Christian Mission to the Aborigines. The town changed radically in the 1970's following the relocation of Aborigines from their homelands from many parts of the Kimberley area, some of them being re-located hundreds of kilometres from their traditional homes in the desert. Living conditions became crowded, often unhygienic and sometimes squalid.

Junjuwa was first established in the 1960's as a Christian mission. The mission closed down about 10-15 years ago when government housing was introduced. Aboriginal communities (including Junjuwa) are now run by Aboriginal councillors (including men and women of all ages). The council appoints non-Aborigines to help with project planning and book keeping. These employees have the responsibility of purchasing community vehicles, organising meals-on-wheels, paying and keeping records of social security cheques and collecting payments for electricity, water, housing and fuel supplies. There are seven tribes represented at Junjuwa, each with its own language.

Aborigines from six tribes moved to Junjuwa from cattle stations in the 1970's. They were originally from the Fitzroy Crossing and river area and are often referred to as 'river people'. These tribes are: Walmadjeri, Gunian, Bunaba, Mangala, Djaru, and Gidja. Each tribe occupied a specific area of land, with strict boundaries. Aborigines from Wonggadjunggu migrated from desert areas further to the east and are often described as 'desert people'. Aborigines from different tribes have since inter-married and often speak several languages. Mainly 'river people' were included in the study as they were the majority living at Junjuwa when the field work was undertaken.
4.1.3 General demography & health statistics of community

The 1986 Australian census enumerated a total Aboriginal population of more than 206,104, with Western Australia having a population of 37,110, the third largest (M: 18,473, F: 18,637). About 40% of Aborigines are younger than 15 years old, compared with 23% of the total population. Only 4% are over 60 years old, compared with almost 15% in the total population.

**Photo 4.4.** West Australia, Fitzroy Crossing, Junjuwa (1988): couple in their eighties.

**Photo 4.5.** West Australia, Fitzroy Crossing, Junjuwa (1988): the eldest man at Junjuwa aged in his eighties, still fit and healthy.
Life expectancy at birth for Australian Aborigines is 51 years for males and 59 years for females compared to 73.2 for men and 79.8 for women in the total Australian population. The Fitzroy Valley and Kimberley regions have the highest life expectancies for Aborigines: 61 years for men and 65 years for women. The longer life expectancies at birth in the Fitzroy Valley region enabled the inclusion of a relatively high number of elderly Aborigines in the study [3-5]. The Fitzroy Valley region has one of the largest concentrations of Aboriginal people in Western Australia. In 1986, there were 1,716 Aborigines and 194 non-Aborigines living in the Fitzroy area, the Aborigines comprised 80% of the total population. In January 1987 the population totalled 317 (M: 49%, F: 51%) while in 1986 it was 428 (M: 53%, F: 47%). This decrease in the population was due to the opening of another community (Kurnangkie).

The exact dates of birth were not known for many Aboriginal people. In 1987 health workers estimated the approximate age of individuals at Junjuwa so that they could be classified as: 'old' 14% (M: 7%, F: 7%), 'adult' 44% (M: 21%, F: 23%), 'left school' 13% (M: 6.5%, F: 6.5%), 'secondary school children' 9% (M: 4%, F: 5%), 'primary school children' 9% (M: 5%, F: 4%) 'pre-primary school children' 6% (M: 3%, F: 3%), or infants 5% (M: 2.5%, F: 2.5%). Figures were not available on birth or death rates at Junjuwa.

Aboriginal Australians were one of the world's largest group of hunter gatherers. However
Urbanisation, a dependence on welfare payments, westernisation of diet, loss of hunter-gatherer skills and increasingly sedentary lifestyles have been accompanied by a pronoeness to so-called lifestyle diseases, such as non-insulin dependent diabetes mellitus and cardiovascular diseases [3-7,10].

Respiratory diseases are a major cause of death. Death rates from respiratory diseases are 4.2 times higher for Aboriginal men and 6.8 times higher for Aboriginal women compared to non-Aboriginal death rates. In the Northern Territory in 1980, respiratory diseases comprised 53.8% of morbidity. Other communicable diseases such as ear and eye diseases, rheumatic fever, gastrointestinal infections, leprosy and tuberculosis have declined but are still prevalent. Sexually transmitted diseases have increased, including HIV[3]. Circulatory diseases are the leading causes of death for Aborigines, with rates 5.4 times higher for men than the total population and 3.9 times higher for women. In the West Kimberley and Fitzroy Valley region of Western Australia, 6.7% of Aboriginal men and 12.6% of Aboriginal women showed evidence of "probable" coronary heart disease, compared with 6% of non-Aboriginal men and 4.8% of non-Aboriginal women studied in Busselton, Western Australia in the 1960s. Electrocardiograms showed that 7% of Aboriginals studied had cardiac ischaemia compared with 4% of non-Aboriginals subjects [8].

The main recognised risk factors that contributed to the high prevalence of coronary heart disease were hypertension (Aborigines M: 40%, F: 34%; non-Aborigines M: 15%, F: 12%), diabetes mellitus (Aborigines M: 14.5%, F: 21%; non-Aborigines: 2.3%) and obesity (BMI > 30), which is very common in adult Aborigines, particularly in women [9]. Aboriginals have the highest incidence of diabetes in Australia and one of the highest reported rates in the world; 8-20% compared to 2.3% in non-Aborigines in Busselton, Western Australia [10]. The elderly Aborigines in Junjiwa were also found to have a high prevalence of diabetes, heart disease, hypertension and obesity.

4.1.4 Housing

Government housing was initially provided for Aborigines at Junjiwa about 15 years ago. They pay a small amount for rent, power and water (about $20.00/ week). There are 56 houses at Junjiwa, each with a toilet, shower, bathroom with hand basin, kitchen, living area, 2 bedrooms, laundry, outside tap and hot and cold water. The houses are made from weather board. In the January 1987 census, there were 35 rooms with holes, 14 doors missing, 152 windows broken, 382 window catches broken, 159 door catches damaged and 48 taps and 28 toilets were leaking.

Photo 4.6. West Australia, Fitzroy Crossing, Junjiwa (1988): public housing and a pet pig. Most homes have pet dogs. Between 5-10 people live in these houses. Solar water heating.
4.1.5 State of development (rural, urban & industrial)

See Section 4.1.2

4.1.6 State of economy of community & elderly

There is marked unemployment in the Fitzroy valley region. Of a total potential workforce of 882 (those aged between 15-55) only 51, or 5.8%, were in permanent employment in 1986 [11]. At Junjuwa only 8% of the community were employed, 34% were unemployed, and 22% were receiving welfare payments. There is little work available in the area. Some Aborigines are employed as health workers, welfare officers, cooks (in the hospital, hotel and primary school), cleaners, gardeners, stockmen and in the supermarket or community store, but most exist on social security payments or without an income of any kind.
4.2 Anglo-Celtic Australians

W Lukito

4.2.1 Geography and climate

Victoria covers an area of about 227,600 square kilometres, which is slightly smaller than Great Britain. The southernmost point of mainland of Victoria (and the mainland of Australia) is at Wilsons Promontory. The western boundary of the State, which meets the Murray River, constitutes the northernmost point. The point furthest east is Cape Howe and the westerly boundary is a distance of 451 kilometres. Based on the Australian Standard Geographical Classification (ASGC), each geographic area (or spatial unit) in the classification (such as the Melbourne Statistical Division) constitutes a particular 'category' of the classification, and all spatial units of a particular type which together cover a defined area, for example, all statistical Divisions in Australia constitute a particular 'hierarchic level' of the classification [12,13].

Photo 4.7. Australia, Melbourne (Anglo-Celtic) (1992): map of Australia showing Melbourne where elderly Anglo-Celts were sampled.

There are 6 statistical districts in Victoria [12]:

1. Albury-Wodonga
2. Ballarat
3. Bendigo
4. Geelong
5. Morwell
6. Shepparton-Mooroonpa

The hottest months in Melbourne are normally January and February, when the average temperature is 26°C. The average annual number of days over 30°C is approximately twenty-nine. Nights are coldest far away from the sea, and away from the city where heat retention by buildings, roads and pavements may maintain the air at a slightly higher temperature. In Melbourne the overnight temperature remains above 20°C on about 4 nights per year. Minimal temperatures below -1°C have been experienced during the months of May to August, even as late as October there have been temperatures as low as 0°C. During the summer, minima have never been below 4°C. Snow, which is a common winter occurrence at similar latitudes on the eastern seaboard of the great land masses of the northern hemisphere, is rare in Victoria below elevations of 600 metres. Average rainfall ranges from 250 mm for the driest parts of the Mallee to 2,600 mm at Falls Creek in the Australian Alps. The average annual number of wet days ranges from 200 (over the Otway Ranges) to 100 at a distance of approximately 160 km inland from the coast.

4.2.2 Culture, religion and history

Less than one-fifth (17.5%) of the population claims Australian-only ancestry. The major ancestry response (over 40%) to the 1986 Census of Population was of Anglo-Celtic descent, with English-only ancestry accounting for 31.6%. Other single ancestries amounting to more than 1% of the population were Italian, Greek, German, Chinese, Dutch and Maltese [12]. The proportion of the population stating their religious denomination as Christian declined from 75.9% in 1976 to 68.8% in 1986. This decline was due to an increase in the non-Christian population (from 1.4% to 2.6%), the proportion who stated no religion (from 9.4% to 13.9%) and those defined as other, who include non-theistic groups, inadequately described response, or not stated (13.4% to 14.7%).

4.2.3 General demography and health statistics

The estimated resident population of Australia was 16.5 million in June 1988. Victoria's estimated resident population was 4.3 million, which represented 26.0% of Australia's population [12]. Over the 5 years from 1983 to 1988, the rate of growth of Australia's population averaged 1.44% per year. There has been a sustained decline in the proportion of the population living in Victoria, with Victoria's rate of population growth averaging 1.1% per year over those 5 years. Victoria is the most densely populated State with an average of 18.7 persons per square kilometre as of 30 June 1988. This population density is nearly 3 times that of New South Wales. The Australian average is just over 2 persons per square kilometre. Victoria's population is also highly concentrated. On 30 June 1988, an estimated 3,001,200 persons lived in the Melbourne
Statistical Division, representing 70.0% of Victoria’s population and a population density of 490 persons per square kilometre [12].

The 1986 Census of Population and Housing showed that 31.7% of all people in Victoria were aged 19 years or under. Almost 600,000 or 14.9% of the total population were aged 60 or over, almost double the 8% who were aged 60 or over in 1901. On the other hand, 50.8% of Aboriginal and Torres Strait islanders were aged 19 years or under, and only 3.8% were aged 60 years or over [12]. In the 5 years between 1983 and 1988 the natural increase reached around 30,000 per year, and net overseas migration increased steadily from a low of 14,730 in 1984 to a high of 37,224 in 1988. The smallest loss was in 1984 (3,340 persons) and the largest loss in 1988 (14,802 persons). The total population increase in the 1983 to 1988 period was lowest in 1984 (41,986 persons) and highest in 1988 (52,999 persons) [12].

In 1988 there were 62,134 live births registered to women resident in Victoria. This represented an increase of 1.0% on the 61,507 births recorded in 1987. The 1988 CBR in Victoria was 14.6 per 1,000 population for the second successive year. The Australian CBR was 14.9 per 1,000 population in 1988. In 1988 there were 30,726 deaths of Victorian residents registered in Australia. This was a decrease of 2.6% from the 31,549 deaths recorded in 1987. The CDR fell from 7.5 per 1,000 population in 1987 to 7.2 in 1988. The IMR (Infant mortality rate) dropped from 8.1 per 1,000 live births in 1987 to 7.8 in 1988. The mortality rate for male infants was consistently higher than that for females. In 1988 the rate was 9.2 for males and 6.4 for females. There were 760 perinatal deaths (stillbirths and deaths within 28 days of birth) in 1988. This represents a death rate of 12.1 per 1,000 live and stillbirths. The decline in the death rate was reflected in increased life expectancy at birth. In 1988 the life expectancy for males was 73.6 years and for females it was 79.8 years [12].

There were 30,687 marriages registered in Victoria during 1988, an increase of 3.4% from 29,682 marriages registered in 1987. The crude marriage rate rose from 7.1 in 1987 to 7.2 in 1988 per 1,000 population. Of the total marriages in 1988, first marriage for both partners accounted for 21,531 (70.2%), first marriage for one partner totalled 5,224 (17.1%), and remarriages for both partners numbered 3,912 (12.7%). Age at marriage continued to increase slightly. In 1988 the median age of bridegrooms was 27.6 years and the median age of brides was 25.4 years.

The number of divorces granted in Victoria in 1988 was 10,250; an increase of 6.5% from 1987. The crude divorce rate rose from 2.3 to 2.4 per 1,000 population. Victoria's crude divorce rate was generally below the Australian rate which, in 1988, was 2.5 per 1,000 population. The median age at marriage for divorcing husbands or wives continued to increase marginally (24.4 and 21.9 years, respectively). For divorcing husbands, the median ages at final separation and at divorce were 34.9 and 37.5 years, respectively. For divorcing wives, the corresponding median ages were 32.2 and 34.9 years.
There were 30,726 deaths of Victorians registered in Australia during 1988 [13]. Diseases of the circulatory system accounted for 43.5% of all deaths. Of these diseases, ischaemic heart disease (IHD) and cerebrovascular disease (CVD) were most prevalent. IHD accounted for a slightly higher percentage of male deaths than female deaths (25.0% and 23.2%, respectively). In contrast, CVD represented a much higher percentage of female deaths than male deaths (12.8% and 7.3%, respectively). Malignant neoplasms caused 25.5% of all deaths in 1988, comprising 26.9% of male deaths and 24.0% of female deaths. Of the 4,419 male deaths from this cause, 1200 (27.2%) were from neoplasms of the trachea, bronchus, and lung, which were the most frequent sites of neoplasms in males. The most frequent site of neoplasms in females was the breast which comprised 644 (18.8%) of the 3,429 female deaths from malignant neoplasms. Other common sites of neoplasms in females were the colon (12.2%) and the trachea, bronchus and lung (12.4%). Other major causes of death during 1988 were: diseases of the respiratory system (7.9%), motor vehicle and other accidents (6.0% and 3.6% of males and females deaths respectively).

In the financial year 1988-1989 Medicare processed over 19 million GP attendances. This number represented 57.6% of all services processed, but only 39.5% of the payments for services made by Medicare. The next most utilised service was pathology, with over 6.8 million services (20.2%). Pathology accounted for 13.1% of Medicare payments. The service with fewest claims was dental (1,042 claims). There were 285 approved hospitals in Victoria on 30 June 1987, of which 166 were public hospitals. These include 2 repatriation hospitals of Heidelberg and MacLeod and the Victoria Police Hospital. The number of public hospital beds totalled 14,846. The 119 private hospitals accounted for 6,132 (29.2%) of hospital beds. The total of 20,978 hospital beds represented 5 beds per 1,000 population.

4.2.4 Housing

About 90% of older people lived in private dwellings. Private dwellings available are: occupant owned/ being purchased, rented from government, and rented from private landlord. However, with increasing age, dependency on non-private accommodation also increased. Around 50% of older people living in non-private dwellings were aged 80 years or more. Many older people lived only with their spouse or alone in quite large dwellings. Approximately 7% of older people lived in non-private dwellings. Of these, 39% were in nursing homes and 24% in homes for the aged. Non-private dwellings available are: hotel/ motel or boarding house, hospital, psychiatric hospital or institution, nursing home, home for aged and other [12].

4.2.5 State of development

The gross value of agricultural commodities produced (GVACP) provides a measure of the output from farming. In 1987-88, the GVACP for Victoria was $4,608 m, or 23% of the Australian total of $20,152 m. In terms of value, Victoria produced 22% of Australia's crops, 22% of livestock slaughtered, and 27% of livestock products (wool, milk, eggs and honey) [12].

In 1987-88, Victorian manufacturing industry contributed 50% or more of the Australian manufacturing industry's turnover in transport equipment (53%), clothing and footwear (52%), and textiles (50%) ASIC subdivisions. Victorian based establishments accounted for 54% of employment within Australian textiles, clothing and footwear manufacturing industry during 1987-88 [12].

Wholesale and retail trade contributed 14.9% of Australia's and 14% of Victoria's Gross Domestic Product (GDP) at factor cost in 1986-87. The Australian share of GDP at factor cost held by retail and wholesale trade declined from 14% in 1981-82 to 13.2% in 1983-84 before rising to 13.8% in 1984-85. A slight decrease from 14.1% to 14% occurred between 1985-86 and 1986-87. The Victorian share declined gradually from 14.1% to 12.9% between 1981-82 and 1983-84 before rising again to the 1986-87 level [12].

Almost three-quarters (73.5%) of Victoria's construction establishments were engaged primarily in special trade construction, while the remaining 26.5% were engaged primarily in general construction. Of the general construction, almost 90% were engaged in building construction. Within the building construction category, 98.4% were engaged in residential building construction [12].
4.2.6 State of economy of community and elderly

Although the 65th birthday is both the traditional age of retirement and the age for eligibility for the age pension for men, many men take up options of early retirement, which leads to a decrease in income between the ages of 55 and 64 years. The median annual income for men aged 55 to 59 years in Victoria was about $15,600. This decreased to $10,900 for men aged 60 to 64, and to $5,400 for men aged 65 or over. For women, the median annual income varied between the 55 to 59, 60 to 64 and 65 or over age groups (from $4,300 to $4,500). Over 60% of older people were in receipt of income support from a Commonwealth Social Security pension. Two-thirds of these payments were made to women, a reflection of their greater longevity and probably of their more restricted earnings from paid work, investments or superannuation [12].
4.2.7  Older people in Victoria

The socio-demographic characteristics of the elderly in Victoria are summarised in Table 4.1.

<table>
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<th>Characteristics</th>
<th>60-64 ('000)</th>
<th>65-74 ('000)</th>
<th>75-79 ('000)</th>
<th>80+ ('000)</th>
<th>aged 60+ ('000)</th>
<th>60+ %</th>
<th>Population ('000)</th>
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<td>Victoria</td>
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<td>Projected number of older people, 2021:</td>
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<td>Victoria</td>
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<td>213.6</td>
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<td>Never married</td>
<td>10.9</td>
<td>16.8</td>
<td>6.7</td>
<td>8.1</td>
<td>42.5</td>
<td>44.2</td>
<td>899.5(a)</td>
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<td>161.3</td>
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<td>23.6</td>
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<td>13.5</td>
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<td>1.7</td>
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<tr>
<td>Men</td>
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**Number receiving Commonwealth**

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a) All figures are for 1986 Census unless otherwise indicated. Some of the components will not add to the total population as not all categories have been shown.

b) Excludes people who were under 15 years of age.

c) Excludes people in non-private dwellings who were owner/manager and family or employee and family.
4.3 Greeks in Melbourne, Australia A Kouris-Blazos

Antigone Kouris-Blazos

4.3.1 Geography & climate

See Section 4.2.1

4.3.2 Culture, history and religion

Australia's immigration program after the Second World War has directly defined the ethnic dimension of population ageing in Australia. From 1950 to the early 1960s Dutch, German and Italian immigration was predominant, followed by Greek and Yugoslav immigration, which continued until the early 1970s. Most migrants arriving in the 1950s were in their twenties. By the year 2000, the proportion of the population aged 60 years and over formed by these diverse groups will double from 20 to 40%. The increase will be greater within the groups that arrived in Australia in the 1950s, specifically groups from the Baltic states, eastern Europe, Greece and Italy. There will be a rapid increase in those aged 75 years and over with a corresponding fall in the group aged 60-74 years [14,15].

The majority of Greeks migrating to Australia came from villages in rural mainland Greece, particularly from the north (e.g. Macedonia) with little or no formal education but with experience in farming. A minority migrated from major cities, such as Athens and Thessaloniki with higher levels of education. The level of education of Greek-born in Victoria as a whole is much lower than that of the total Victorian population-- 64.2% of Greek-born Victorians left school before the age of 16 with the majority having less than 5 years of primary school, compared with 39% for the Victorian population as a whole [14].

First generation Greeks in Australia are still preparing traditional Greek foods (particularly the elderly) typical of the region they migrated from. The traditional Greek cuisine has a large variety of 'vegetarian' style dishes-- red meat was eaten only on special occasions but white meat (especially fish) was eaten often. Southern and island Greeks consumed a lot of olive oil, a large variety of legumes and vegetables (especially wild greens and tomatoes), olives, limited meat (mainly lamb less than once a week) and plenty of fruit (especially grapes and figs but little citrus fruits) and fish [16,17]. When Greeks migrated to Australia in the 1950s, meat was comparatively cheap resulting in drastic changes to traditional food habits with meat being part of meals on a daily basis. This over consumption of meat occurred in the first twenty years of migration. Meat intake has now been curtailed given the 'bad' publicity it has received over the years and the rising prevalence of heart disease in Greek Australians.

Culture retention is associated with maintaining the language as well as the religion and cuisine. In this respect, the Greeks in Australia have retained many aspects of their culture. According to
the 1986 census, 95% of people claiming Greek ancestry in Victoria spoke Greek at home and 89.6% gave their religion as Greek Orthodox [14]. The elderly Greeks in Melbourne are staunch followers of the Greek Orthodox religion. However, they do not follow the fasting practices as strictly as the elderly Greeks in Greece. For example, the Church recommends that animal products be avoided during Easter (40 days), Christmas (40-60 days), Virgin Mary celebration (15 days in August) and Saint Apostollos (15 days). In place of animal products legumes, seafood, olives, olive oil, rice, pasta and bread are eaten. The church also encourages the consumption of legumes every Wednesday and Friday in remembrance of Christ's suffering during Easter.

4.3.3 General demography & health statistics of community

Over 30% of Melbourne's population of 3 million are either foreign-born or the children of foreign-born parents. Melbourne has been the most common destination for Greek migrants to Australia (world's third largest Greek city) making it the third-largest overseas-born community in the state. Almost half the Greek-born community live in Victoria, with 96.6% residing in Melbourne. The Victorian Greek-born community comprises 49.3% of the total Australian Greek-born community [14,18].

At the 1986 census there were approximately 130,553 in Victoria who claimed Greek ancestry, of which 65,515 were born in Greece. The percentage of Greek-born elderly in Victoria in 1986 (78%: 15-54, 6.3%: 65+, 2%: 70+, 0.5%: 80+) was considerably lower than the total percentage of elderly in Victoria in 1991 (57.4%: 15-54, 11.6%: 65+, 7.7%: 70+, 2.3%: 80+) [14].

Photo 4.9. Australia, Melbourne (Greek) 1990-91: Greek navy sea captain aged in his late eighties.
The largest proportion of Greek-born have been resident in Australia for between 15 and 39 years (83.5%) and therefore migrated to Australia between 1947 and 1971. The Greek-born population is gradually moving away from the inner areas of Melbourne (Richmond, Prahran, Brunswick, Footscray and Northcote) although numbers in many of these areas remain high. Areas of increasing settlement include the outer eastern area (Doncaster, Templestowe, Waverley) and Keilor in the West [14].

According to the 1982 mortality data, Greeks in Australia were deemed the 'second longest lived population in the world', after the Japanese in Hawaii and followed closely by Greeks in Greece [19]. This mortality advantage was spread over the major causes of death categories in which diet plays a major causal role-- cardiovascular disease and cancer [18,43,44]. These health advantages were particularly pronounced in the younger age groups, but appeared to be lost in the elderly.

In contrast, 1989 morbidity data [21] suggests that the health profile of Greek Australians may have changed in an adverse direction since 1982. The prevalences of heart disease, hypertension and hyper-cholesterolaemia were equally high or higher than Australian-born in all age groups (especially the women). Interestingly, however, protection against cancer continued for this ethnic group, with prevalences being lower in all age groups (men only). They also appeared to be losing their protection against these diseases (except stroke) at a faster rate than their counterparts in Greece [20,22].
Studies on small samples of elderly migrants in Australia [45-47] indicated that Southern-European migrants compared to Australian-born reported worse health and well-being, suffered more nervous and mental disorders, had a higher prevalence of smoking, obesity and disability and lower exercise levels.

The current study also found elderly Melbourne Greeks to have worse health, more disability, more obesity and lower exercise levels than Anglo-Celtic Australians. They also appeared to be losing their protection against heart disease (especially women) and approaching the higher prevalences found in elderly Anglo-Celtic Australians, but were retaining some protection against cancer (men only).

The reasons for the deterioration in health amongst elderly Greek Australians and the persisting protection against cancer are not adequately understood. It has been suggested that retention of some 'protective' elements of the traditional Greek diet (e.g. more fruit, vegetables, legumes, olive oil, less animal foods, moderate wine) may help to preserve such health advantages, exemplified in a public health message to ethnic groups 'stay with what you've got; the mainstream Australian way of life is not likely to be as good for your health' [18]. Adherence to the traditional Greek diet has also been shown to reduce the risk of death in the elderly [54].

### 4.3.4 Housing

A significant proportion of elderly Greeks in Melbourne did not live with their children; they either lived alone and received home help or they lived with their spouse. A minority lived in granny flats or in dwellings adjacent to their children's homes, or in units built on the grounds of Greek Churches. The elderly that lived alone or with their spouse resided in the original family dwelling purchased in the 1950s on arrival to Australia from Greece. These homes tended to be made of weather board and to be located near the city centre where employment was available upon migration. Elderly that lived with their children resided in more modern and affluent homes which tended to be located further from the city centre. Vegetable gardening was a favourite pastime of the elderly with more than 70% of the gardens containing a large variety of vegetables.

**Photo 4.10.** Australia, Melbourne (Greek) 1990-91: a typical weather board home in the northern suburbs of Melbourne, belonging to elderly Greeks, since migrating to Australia in the 1960's.
4.3.5 State of development & economy of community

In recent years Greek immigrants have tended to move out of the inner city suburbs where they initially congregated until they were established and able to afford better homes in the outer suburbs. Greek food shops are common in the metropolitan areas and Greek people can buy many of their own specialty food stuffs. The majority of Greek immigrants are found in the food business in Australia—characteristically in "fish-and-chip" shops, as well as in factories.

Only a minority of Greek immigrants entered the farming industry in Australia even though they were familiar with this kind of work in their homeland. Impressions suggest that the majority of Greeks in Melbourne are above average for "affluence" [16]. According to the 1986 census, the largest proportion of Greek-born were employed as labourers and related workers (M: 27.5%; F: 30.5%).

The proportions of Greek-born who were self-employed, employers or unemployed were slightly higher than those for the Victorian population as a whole. The Greek-born community earned less per annum than the Victorian population as a whole—34.6% of Greek-born males earned between $12,000 and $18,000 and 26.4% of Greek-born females earned between $6,000 and $12,000 [14].
4.4 Greeks in Spata, Greece A Kouris-Blazos

Antigone Kouris-Blazos

4.4.1 Geography & climate

Spata is located about 20 km from Athens in the Greek state of Attiki. There is very little rain in summer and the rocky terrain presents limited opportunities for modernised agriculture. In winter the temperature is around 10°C and in summer about 30°C. Humidity ranges from 50% in summer to 70% in winter.

Photo 4.11. Greece, Spata 1988: map of Greece showing Spata in the far right, east of Athens.

4.4.2 Culture, religion and history

Greece provides an unusual opportunity because several regions (particularly rural areas) still follow a more traditional Greek diet and lifestyle, whereas city regions have adopted a more 'affluent' way of life [48,49]. Spata is located in a rural region of Greece and inhabitants still follow a more traditional lifestyle. Such a 'traditional' Greek town would act as a standard by which to determine the degree of lifestyle and dietary changes made on migration by elderly Greeks to Australia. The majority of Greeks living in Melbourne migrated from rural villages in Greece in the 1950s and 1960s, such as Spata.

Historically the traditional Greek diet consumed in this town was typical of foods and dishes eaten by southern Greeks and islanders which contained mainly vegetarian style dishes (see Section 4.3.2). In Spata today the traditional Greek diet is still evident except that meat is now eaten more frequently and legumes less often. The elderly in this community are staunch followers of the Greek Orthodox religion performing most religious practices, namely fasting (see Section 4.3.2).

4.4.3 General demography and health statistics of community

In 1991, the total population of Greece was 10,063,000 persons with about 14% aged 65 or over [22]. Return migration and repatriation of Greeks from abroad has resulted in significant changes to the population. According to the 1981 census results, 233,900 persons had returned to Greece during 1976-80 [23]. Greece is one of the healthiest countries in the world (see also Section 4.3.3).

Age adjusted mortality from all causes in Greece is among the lowest in the world. This is particularly true with respect to men, and is accounted for by very low cause-specific mortality rates from coronary heart disease and several cancers, notably those of the large bowel, prostate and breast [24]. The age standardised death rates per 1,000 in 1989 for ischaemic heart disease
were almost half that of Australian rates, but for cerebrovascular disease the rates were almost double. Death rates for cancer were lower for Greece, with rates being higher for stomach cancer and lower for breast and colon cancer compared to Australia [22].

**Photo 4.13.** Greece, Spata 1988: one of the eldest and fittest women in the Spata sample, aged in her early 90s. She has the food belief that eating garlic with meat will prevent the meat from raising her blood pressure.

Recently, mortality and morbidity from heart disease has been shown to be increasing in a steady and alarming way in Greece [22,50,51], as well as the common risk factors, such as hypercholesterolaemia and obesity [52]. Age adjusted mortality rates from colon and breast cancer have also been shown to be steadily increasing in Greece, but not to the same extent as heart disease [53]. Similarly to the elderly Melbourne Greeks, Spata Greeks were found to be to be losing their protection against heart disease and approaching the higher prevalences found in other European countries [51], but were retaining some protection against cancer.

The reasons for the deterioration in health of elderly Greeks in Greece and the persisting protection against cancer are not adequately understood. It has been suggested that retention of some 'protective' elements of the traditional Greek diet (e.g. more fruit, vegetables, legumes, olive oil, less animal foods, moderate wine) may help to preserve such health advantages [50]. Adherence to the traditional Greek diet has been shown to reduce the risk of early death in the
Age structure, demographic characteristics and morbidity statistics for Spata were not available. The only data available was from the electoral rolls (see Section 5.47). Mortality data was available only for 1981 from the local council. In 1981 there were 52 deaths. Based on 1981 data, the sex specific mortality rate for men was 3.6 per 1000 per year and for women 4.2 per 1000 per year.

4.4.4 Housing

The housing in Spata ranged from two storey ostentatious homes to more modest traditional white washed ground level dwellings. Overall, the housing was an indication of relative affluence in this community. Gardening (including vegetable gardening) was not a preoccupation of the residents. However, most homes had chickens (for fresh eggs) as well as goats (for fresh goats milk) whereas dogs and cats were not evident in homes.

Most residents of this community still owned a small piece of land on which they would grow mainly grapes (to make wine and for consumption) and olives (to make olive oil and for consumption) and occasionally figs and almonds. Grandparents in most cases lived with their children in a separate more traditional looking dwelling which was originally the family home; when the children got married they would build their more modern and affluent home adjacent to the family home on the same block of land.

Photo 4.14. Spata, Greece (1988): a traditional style abode, which would have been occupied by workers of the land, now occupied by elderly parents, with a modern home adjoining for their children.
4.4.5 State of development & economy of community

The economic basis of this semi-rural area is subsistence agriculture. Olive oil, olives for eating, grapes and wine are the main products supplemented by figs, nuts (almonds), pomegranates, pulses, goats milk and chicken eggs. Impressions suggest that Spata is above the rural Greek average for "affluence" and "modernisation" given that 10 years ago the Greek Government encouraged residents to sell their land so that the new Greek airport could be built in the vicinity.

**Photo 4.15.** Spata, Greece (1988): main road going through the town of Spata.
Photo 4.16. Spata, Greece (1988): view from the outskirts of Spata, the mountain ‘IMITOS’ in the background, behind which lies Athens.

Photo 4.17. Spata, Greece (1988): grapes are sent to the local ‘grape presser’ in Spata, to extract the juice which is returned to the owner for the making of wine. Spata sells wine, mainly RETSINA to the rest of Greece.
4.5 Swedes in Gothenburg Sweden E Rothenberg

Elisabet Rothenberg

4.5.1 Geography and climate

Gothenburg is the second largest city in the Sweden with a population of 433,000 inhabitants, (5% of the total Swedish population). The metropolitan region of Gothenburg is comprised of eleven municipalities with a population of 731,000 inhabitants (9% of the Swedish population). Gothenburg is situated on the Swedish west coast near 58° north latitude. The city covers a total area of 734 square kilometres of which approximately 60% is land. Of the land area, approximately 19% is covered by residential housing and 6% by industry and markets.

Photo 4.18. Gothenburg, Sweden (1991): map of Sweden showing Gothenburg where elderly Swedes were sampled.

Sweden as a whole has a continental or subarctic climate and is situated within the temperate climate zone. Gothenburg, in the southwest part of the country, is situated within the continental zone. Average winter temperature (January) is around 0°C, and the corresponding summer temperature (July) about 16°C. In January, the monthly average hours of sunlight are 20-50, and in July 250-300. Rainfall is on average 800-1000 millimetres and an average 10-15 days have
some fog. Average number of days per year with snow is below 50, compared with 250 days in the northern part of the country.

### 4.5.2 Culture, religion and history

Gothenburg was founded in 1621 by King Gustavus II Adolph. Throughout the centuries, the city has been influenced by people from the Netherlands, Germany, Scotland and especially England. Development has been strongly influenced by the town's seaside location. Trade and shipping have been important. Marked changes and new developments started towards the end of the nineteenth century when the population grew rapidly. New areas were incorporated into the city and industrial expansion started. Large scale emigration of Swedes, especially to the United States, started from Gothenburg. During the 1890's an average 20,000 Swedish people emigrated annually. Expansion continued until the 1970s when the population started to decrease moderately, as many people began to move to their own houses in small communities neighbouring the city. Sweden has a Christian Lutheran church. On the west coast the "Schartauanism" - a fundamentalist and conservative part of the Lutheran church - was very dominant, especially during the 19th century and into the beginning of this century.

### 4.5.3 General demography and health statistics

During the last four decades the relative and absolute number of elderly people has rapidly increased. Currently, about 18% of the Swedish population are aged 65 years or older and the proportion and number of the "very old" is increasing rapidly. During the period from 1980 to 1987 the proportion of individuals 90 years of age and older increased by 46%, and during the same period the proportion of younger people and children decreased. Life expectancy at birth is increasing, being presently about 81 years for females and 75 years for males [22].

Results from gerontological and geriatric population studies in Gothenburg have shown that mortality does not strictly follow socio-economic levels, indicating that lifestyle and other environmental factors might have a greater importance. The differences between low-risk and high-risk occupations seem to be more pronounced after retirement. It seems that social network and associated factors have an increasing impact on morbidity and mortality patterns in Sweden. Living alone is often, especially among elderly men, a risk indicator.

Johanneberg is a very central area of Gothenburg, with a high proportion of elderly. Thirty-one per cent of the population are 65 years of age or older, compared to 19% in Gothenburg as a whole. Furthermore, Johanneberg is a very stable area, and most people have lived there for between 30-60 years. The majority can be characterised as middle or upper middle class. The proportion of immigrants in the Johanneberg area is very low compared to the city as a whole (4.4 and 10.3%, respectively). The few immigrants in the area have been living there for a long period of time, and they immigrated mostly from the Nordic countries.
4.5.4 Housing

Johanneberg, an apartment house area, is situated in the middle of the city. The houses were built between 1936 and 1940. Most of the apartments have three bedrooms or less, a kitchen and bathroom. About 13% own their apartment and 63% live in houses owned by others. During the last three years many of the houses and apartments have been cleared out and renewed. All apartments have elevators and most of them have modern kitchens with both a refrigerator and freezer.


4.5.5 State of development

The population of the urban areas in Sweden is 7.2 million (83%) compared to 1.4 million (17%) in rural areas. About ¼ of the Swedish urban population live in the four largest cities and only 7% live in communities with less than 1,000 inhabitants. Sweden is mainly an industrial nation with basic as well as high technological industry. From 1940 to 1970 the country was characterised by marked economical growth. From 1970 to 1990 growth was less marked and in fact lower than comparable OECD countries. The average (GDP) was SEK 157,066 in 1990 (approximately US$ 26,178) - the eighth highest figure in the world.

4.5.6 State of economy of community and elderly

The geographical position of the city has made Gothenburg an important transport and
communication link between the Scandinavian countries and the rest of the world. Gothenburg and the west of Sweden have always been more dependant on foreign trade than the rest of the country. Gothenburg is responsible for 27% of Swedish imports and 19% of the exports. At the moment, a change within trade and industry is underway. The manufacturing industry currently accounts for only 17% of total employment, and private services is the fastest growing sector. More than half of the employment in the private services sector is engaged in services related to industry. Heavy industry has, to some extent, been complemented by small and medium-sized companies in the service sector, which is becoming increasingly important to Gothenburg. Currently this sector provides employment for more than 70% of the working population. Industry in Gothenburg has always been characterised by technical skill and innovation. Research at Gothenburg University and Chalmers University of Technology is often carried out in close collaboration with industry. The Volvo car factory with 25,000 employees, the Swedish Ball Bearing Company with 40,500, the Celcius Industries with 3,400, and Ericsson Radar Electronics with 3,300 are some of the most important industries in the Gothenburg region.

About 80 shipping companies operate in and out of Gothenburg on a regular basis, and about 25 million tonnes of goods are annually shipped through its port-- the largest in Scandinavia. Landveter International Airport can handle 4 million passengers and 110,000 tonnes of cargo annually. In the metropolitan area of Gothenburg the public sector accounts for 29% of employment. The agriculture sector is very small, providing around 1% of the employment.
4.6 Filipinos in Manila P de Guzman

P de Guzman

4.6.1 General demography and health statistics of community

Nutrition and human development programs in the Philippines have always addressed the young population, particularly infants, pre-school and school children, as they are "tomorrow's hope". In developing countries such as the Philippines where the population is young and the national budget is meagre, not many programs and policies address the welfare of the elderly. The few bills introduced in the 1988-92 Philippine Congress which sought to provide the elderly with minimum benefits to enjoy their twilight years did not attain legislative approval because of budgetary limitations and the lack of solid data to back the urgency of programs for this group. The government in the meantime, finds consolation in the Filipinos' strong family ties and extended family structures for the care of the elderly.

Nutrition research in the Philippines has recently begun to direct attention to the nutritional status of the elderly. Nutrition scientists recognise the ageing population in the country is growing to larger proportions. In 1978, 4.71% of the population was elderly; four years later, the proportion increased to 4.76%. In 1987, there were approximately three million ageing Filipinos or 5.3% of the total population. In 1992, this group which includes all individuals who are 60 years old and over is estimated to be seven million or 11.7% of the total population.

By the year 2000, the elderly are expected to increase by five million more. Clearly, the elderly are becoming major users of the country's health services and there is increasing concern about the limited information base to plan relevant programs for the promotion of the health, nutrition and welfare status of the elderly. A four-country study of ageing in the Western Pacific was conducted in Fiji, Malaysia, Philippines and in the Republic of Korea [25]. The study was particularly concerned about the health and socio-economic well-being of the elderly.

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<tr>
<td>1992</td>
<td>7,178,317</td>
<td>64,258,611</td>
<td>11.17</td>
</tr>
</tbody>
</table>

Source: National Statistics Office

An evaluation of the health status of the elderly population was conducted. Results showed that at least half of the subjects reported that they felt quite healthy. The proportion was lower in the...
case of Fiji and the Republic of Korea and significantly higher for Malaysia and in the Philippines. Although Filipinos reported higher levels of satisfaction with their health status than other countries, they also had the highest prevalence of health problems. Two-thirds of the Filipinos indicated that they had accidents, injuries or chronic illness that impinged on functional ability. The most commonly reported illness was hypertension or "high blood" and arthritis or "rayuma". Age related problems were poor hearing, poor sight, dental problems and problems of mobility. All showed a consistent trend towards increasing prevalence with ageing.

4.6.2 Housing and institutionalisation

In the 4 country study [25], the living conditions of the study groups were also observed, and the findings showed that it was unusual for respondents in the western pacific to live alone; most elderly subjects lived in houses of at least four people. In the Philippines, four out of five lived with their children. The respondents, through not totally adverse to the idea of institutionalisation (75% said it is a good idea) reported that they would not like to live in "Homes for the Aged" because they expect to be cared for by their children or other relatives. Furthermore, decision making within Filipino families is participated in by about 80% of the elderly.

4.6.3 State of development and economy

While the government recognises that the elderly are members of the population it is mandated to protect and safeguard, it has relied on the Filipino's traditional kinship based system for the support of the aged. Children, to Filipino parents, are sources of financial, health care and emotional support during old age; and this expectation has largely been met. A profile of the Filipino family as reflected in the Third National Nutrition Survey of FNRI-DOST in fact shows that 6.3% of the total family members were elderly. Because of the series of disasters experienced by the country in 1989-91 (failed coup attempts, long droughts, July killer earthquake, Middle East crisis, Mt. Pinatubo eruptions and typhoons that brought about heavy damages) the government's commitment to look after and improve the overall well-being of the elderly group was side-tracked by other more affected parts of the population but it was, nevertheless, sustained.

Programs are now being developed and implemented which primarily promote the family as providing care for the elderly in their home. Golden Acres, a home for the aged is another major program for the elderly. Twenty-one institutionalised homes for the aged are said to be presently operated by both government and religious or charitable institutions with residents who are at least 60 years of age, neglected, abandoned with no relatives to turn to, and free from any communicable disease. Due to the limited space, a total number of 900-1000 elderly are estimated to be housed in these homes, clearly showing that only a very minimal part of the population has benefited despite it always being filled to capacity. Total cases served by the DSWD's Golden Acres from 1984-1988 were only 318, 314, 343, 360 and 423, respectively.
Both the Government Service Insurance System and the Social Security System provide social security benefits to the retired workers of the government and private agencies/ self-employed, respectively. This benefit ensures that the retiree is well provided for during the time when he can no longer work (due to old age) for his daily needs. And through the payment of pensions and gratuities, the members are furnished with much needed resources that can either be used for their basic needs or rechanneled to a more productive concern that could generate income for the retiree.
Chinese in Beijing, PRC  YF Wang & D Roe

4.7.1  Geography and climate

Beijing, the capital city of China, is located in northern part of China. The whole city area is about 17,000 square kilometres, of which about 62% is mountainous. The total population of Beijing (urban and rural areas) is 10,819,407 (10.8 million) which consist of 51.7% males and 48.3% females. The majority nationality in Beijing is Hen which accounts about 96.2% of total population, the rest of the population consists of all 55 minority groups (3.8% of total population).

Photo 4.20.  Beijing, China (1991): map of Northern China showing Beijing where elderly Chinese were studied.

The median age of the population in the urban area is 28.2 years old and the percentage of people aged 65 and above is 5.4% (270,000). The birth rate of Beijing is 13.35 per thousand and death rate in 1990 was 5.4 per thousand according to 1990 National Population Survey [26]. Administratively, the Beijing municipality includes four urban districts, four semi-urban districts and 11 rural counties where most of the residents are farmers. Among the total population, 5 million are urban (non-agricultural) population and another 5 million are rural (agricultural) population. When the term Beijing is used, it usually refers to the urban districts in the central part of Beijing.
The grassroots level of administration is called the Neighbourhood unit, which is responsible for overseeing policy implementation, safety and co-ordination of community programs. This level of administration directly interacts with households and surveys and studies can only be carried out with their corporation. Usually, one neighbourhood committee is set up for each residential area of 100 to 700 households. Its administrators are chosen from local residents, mostly retirees in good health and housewives who are popular in the neighbourhood, who have the time and the desire to serve the public interest wholeheartedly. Every year, the government allocates funds for each committee to carry out its work and to cover allowances for the administrative personnel.

4.7.2 Culture, religion and history

The basic dietary pattern of high-cereal, high-vegetable intake was developed for the common people in ancient times in China. In the earliest medical classics, a dietary guideline based on experience was given as: "cereals- the basic, fruits- the subsidiary, meat- the beneficial, vegetable- the supplementary". The Chinese eat a wide variety of foods and avoid very few. The Chinese diet largely reflects the food habits and preferences of the Han people. In China, few dairy products, whether fresh or fermented, are eaten. Rice is the staple food in Southern China, and wheat is used more often in the north than south. The Chinese eat a variety of animal protein foods. Although they eat all kinds of meat, fish, and poultry, they eat less at any one meal than is customary in the West. Most Chinese food is cooked; very little raw food is eaten, except fruit. Cooked foods may be eaten cold. Common cooking methods are stir-frying, steaming, deep-fat frying, simmering, and roasting. Processed foods are rarely eaten by the Chinese population, especially among the elderly.

Traditionally, Chinese prefer to shop for fresh foods in order to prepare their meals. The other reason which prevents Chinese from using processed foods is that the availability of processed foods is still limited and they are relatively expensive. Seasonal availability and geographical distances are very important factors which affect the food patterns of Chinese. The Chinese customarily eat three meals a day, plus numerous snacks. Breakfast in the north often includes a hot rice porridge. Hot steamed bread, dumplings, or noodles are served for breakfast also. In urban areas lunch is a smaller version of dinner; soup, a rice or wheat dish, vegetables, and fish or meat.

Traditional medicine, as is well known, plays an important role in China. Several important types of traditional medicine are practised-- including Chinese, Mongol, Ugyur and others. Because over 93% of China's population are of the Han ethnic group, Chinese traditional medicine predominates, although official policy does not discriminate in favour of any particular system of traditional medicine. The term 'traditional medicine' is used to include all forms of traditional medicine, and 'Chinese traditional medicine' is used when referring to that particular variety.
All forms of traditional medicine share two characteristics. The first is that their theoretical and diagnostic bases are not (at least for the present) explicable in terms of modern biology. The second is their wide variety of therapeutic measures. These include acupuncture and moxibustion in Chinese traditional medicine and a wide variety of herbal and other medical preparations in each of the traditional systems. Traditional Chinese medicine and the combined use of traditional Chinese and Western medicine has proved effective in a wide range of clinical practices. Satisfactory results have been obtained in treating coronary heart disease, angina pectoris, acute myocardial infarction and cerebrovascular occlusion by the use of methods of promoting blood circulation to remove blood stasis. In the study of traditional Chinese drugs, efforts have been made not only to improve their variety, quality, prescriptions and effect, but also on pharmacology, chemical analysis and extraction of effective components by using the modern methods. About 560 kinds of effective elements have been found in traditional drugs [35].

4.7.3 General demography and health statistics

China has the largest population in the world-- the recorded population at the end of 1990 was 1,143,33 million [26]; this exceeds by 74% the total recorded in the People's Republic of China's (PRC) first census, conducted in 1953. The increase of population is mainly due to the reduction in mortality and concomitant increase in life expectancy, which resulted from a major overall improvement in health status and major decline in infant mortality. The average life expectancy at birth for both men and women in China now is 70 years [22]. Life expectancy has increased more than 32 years since the early 1950s. Life expectancy of the Chinese from some urban cities has almost reached the level of developed counties. Table 4.3 compares the life expectancy of the US and other countries with that of three major cities of China -- Beijing, Shanghai and Tianjin in 1981; life expectancy for people in those cities has already come to the forefront among developing countries, being higher than the average figures of Africa, Asia and Latin America.
Table 4.3. Life expectancy of selected population in China and in some other countries [27].

<table>
<thead>
<tr>
<th>Country</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>69</td>
<td>77</td>
</tr>
<tr>
<td>Japan</td>
<td>73</td>
<td>78</td>
</tr>
<tr>
<td>Britain</td>
<td>69</td>
<td>75</td>
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<tr>
<td>France</td>
<td>70</td>
<td>78</td>
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<td>Canada</td>
<td>70</td>
<td>77</td>
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<tr>
<td>India</td>
<td>50</td>
<td>49</td>
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<tr>
<td>Indonesia</td>
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<td>49</td>
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<tr>
<td>Egypt</td>
<td>54</td>
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<td>Nigeria</td>
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<td>Mexico</td>
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<td>67</td>
</tr>
<tr>
<td>Brazil</td>
<td>60</td>
<td>64</td>
</tr>
<tr>
<td><strong>China</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beijing</td>
<td>71</td>
<td>74</td>
</tr>
<tr>
<td>Shanghai</td>
<td>71</td>
<td>75</td>
</tr>
<tr>
<td>Tianjin</td>
<td>70</td>
<td>72</td>
</tr>
</tbody>
</table>

Source: Gu XY, 1986 [27]

Photo 4.21. Beijing, China (1991): elderly in their 80’s; woman had stroke and was being looked after by her friend.

The rapid growth of population aged over 65, which resulted from an increase in life expectancy, has made China the country with the largest ageing population in the world; although the proportion of the aged is much lower than that in western countries. Data from the 1982 National Census showed that about 49.3 million of the Chinese were older than 65 years which accounted
for 4.9% of the total population in 1981. However, this population has reached 63 million at the present time, representing 5.5% of the total population [26]; compared with 12% in the United States. It has been projected that people aged 60 and over will increase to 102-108 million by the year 2000, continuing, to 232 million by the year of 2040, making up 20.3% of the total population.

The ageing of the Chinese population has the following characteristics as described by one of the Chinese social scientists [28]:

1. The absolute number of Chinese elderly will rank number one in the world. It has been projected that the ageing population (60 and above) will reach 390 million accounting for 28% of the total population by the end of 2025.

2. The ageing process of the Chinese population will be faster than the industrial countries experienced in the past. The elderly population will be increasing at a much higher rate than the total population. By the year 2025, one of every five people in China will be elderly, whereas one of seven people in the world will be elderly. This rapid process of population ageing is mainly caused by a sharp decrease in mortality and in the birth rate.

3. The percentage of elderly requiring external financial support will increase by 33% by the middle of next century. This high dependence ratio will certainly increase the financial burden on the family and society.

4. Rapid ageing is occurring at an inopportune stage of economic development. Economic capacity will lag behind the increased demands of an ageing population. This is different from developed countries where early economic development provides the wealth that makes population ageing more affordable for them.

The improvement of health in China is reflected by a shift in the disease pattern. Throughout much of China's recorded history, periodic epidemics of plague, cholera, smallpox, etc. swept the land-- which combined with frequent famine, some times decimated whole populations. Since the early 1950s, the overall mortality in China has declined significantly from 20 per thousand in 1949 to 7 per thousand in 1990 [26]. Meanwhile, it is obvious that disease pattern has changed in China-- most infectious diseases that were the main causes of death in the past have been eliminated or reduced in frequency; under-nutrition and nutrition deficiency diseases are no longer a major problem for most adults or for the aged population. Instead, chronic diseases have become a leading cause of death, accounting for more than 70% of all deaths in China.

According to incomplete data on the causes of deaths due to disease and injury in city and county residents in 1957, the order of the major causes of deaths in cities were:

• respiratory system diseases,
• acute communicable diseases,
• pulmonary tuberculosis
• and digestive system diseases.

Respiratory system diseases and communicable diseases accounted for 34.3% of total deaths. However, the order has now become:

• heart diseases,
• cerebrovascular diseases,
• malignant tumours,
• respiratory system diseases
• and digestive system diseases.

Cardiovascular diseases, cerebrovascular diseases and malignant tumours account for 64.9% of the total deaths [22]. Results from World Bank study [30] show that the cause of death for selected urban and rural areas, is similar to that in high-income countries, where heart disease, cancer, stroke and chronic obstructive lung disease are the first four leading causes of death.

In the case of the elderly population, the leading cause of death is already the same as the United States [31] although the age-specific mortality rate in China is still low (5046/100,000) compared to the US in earlier periods. The world Bank report [28] indicates "this is most likely because those Chinese who have survived to old age up to now have been physically healthier than their US counterparts. Strong natural health selection forces in China may result in a few more years of relatively low mortality rates amongst the elderly. As the cohort size grows and ages, however, and as the impact of longer exposure to risk factors begins to become apparent, death rates amongst the elderly can be expected to increase.”

Changes in the category of heart disease is a good example of changes in the disease pattern. In the first half of this century, cardiovascular diseases among Chinese were rarely reported [32]. In the 1950s and 1960s, the relative incidence of cardiovascular diseases were as follows:

• rheumatic heart disease 35-50%;
• hypertensive heart disease 11-14%;
• atherosclerotic heart disease 7-17%;
• chronic pulmonary heart disease 6-10%;
• syphilitic heart disease 2-6%
• and congenital heart disease 4-7% [32].

In the 1970s, while the percentage frequency of rheumatic heart disease declined to 30%, the coronary heart disease increased in frequency to 26%. The decline in the occurrence of rheumatic fever was due to improvements in living environment and adequate use of antibiotics to control streptococcal infections. Remarkable increases in the incidence of coronary heart
disease are explained in terms of prolongation of life span, which in turn might have increased the probability of certain risk factors for atherosclerosis.

4.7.4 State of development and economy of community

The increase in the numbers of elderly will have a significant effect on the public health services and on China's economic development. In the United States, health expenditures made up 29% of the nearly $270 billion paid by the government for programs and services for the older population in 1986, but older Americans still disbursed an estimated average of 15% of their personal income for health care [29]. This situation may be seen in China very soon, and the importance of early disease prevention in the elderly can not be overemphasised. A study done by the World Bank [30] warned that, many forces which are shaping China's future are inexorable, such as:

- demographic shifts to a more dependent, elderly population;
- changing risk of chronic diseases as a result of lifestyles, habits and environmental trends;
- and consequent epidemiological shifts to increased morbidity and mortality from disabling and medically complex, chronic non-communicable diseases.

In all countries, the dietary pattern changes with socio-economic development. Today's China has been changed by economic reform and changes in agricultural policy during the past 10 years. Agricultural and industrial development have resulted in increases in both food availability and per capita income. During the past 30 years intakes of energy and protein have being increasing continuously. The average energy intake in the whole of China had reached 2,485 Kcal per capita, and it had increased to over 2,500 Kcal in some urban areas. Protein intake also increased from less than 50 g/ person/ day in 1959 to about 70 g/ day in 1982 [33,34].

There has been a rapid increase in the consumption of foods of animal origin from 26.5 Kg/ year per capita in 1957 to 47.7 Kg/ year in 1984. Cooking oil consumption has also increased as a result of excellent harvests of oil-seed crops. Thus, the national dietary pattern is moving toward larger quantities of animal food, higher fat intake, and smaller quantities of cereals. Although, the amount and proportion of animal foods and fat intake by Chinese people is still quite low compared to the typical western dietary pattern, there are significant geographical and urban-rural variations. First, the changes in food consumption in urban areas are faster and more profound than those in the rural areas. In Beijing and Tianjin, the trends toward a high consumption of meat and fat has been marked, with 30% of energy being derived from fat. However, in a most general sense, rural China is characterised by eating foods that are not only low in fat but also low in protein, particularly animal protein, as well as high in fibre. Secondly, China is unique in its huge geographical variation, both in dietary pattern and in disease patterns. These differences are mainly associated with differences in economic development and industrialisation.
In the traditional Chinese family structure, age was a key determinant of authority, and the aged held particularly high status [36]. During recent years, education and modern technology gradually became widespread in urban areas, and this gave the young an advantage. However, the elderly continue to command a high degree of respect, and the traditional patterns of interdependence between generations have been largely maintained [36]. Legally, the position of the aged is defined by the Constitution of 1982 [38]: "Children who have come of age have the duty to support and assist their parents." The Marriage Law of 1980 also incorporates this position and goes further to stipulate that, "When children fail to perform the duty of supporting their parents, parents who have lost the ability to work or have difficulties in providing for themselves have the right to demand that their children pay for their support" [39]. This traditional cultural influence means that the Chinese elderly have a very close relationship with their children. Most elderly are not living alone, and many get support from their children. Also, urban elderly have free medical care, even free medications. These systems make their life easier than in western countries. Therefore, their social-economic status may differ from elderly in other countries. The influences of those factors on dietary patterns, nutritional status, and health situation may also be different from others.
4.8 Chinese in Tianjin, PRC S Xi

SD Xi and MT Sun

4.8.1 Geography and climate

Tianjin is located at north latitude 38°34'-40°15' and east latitude 116°43'-118°4', 137 km south of Beijing. Total area is 11,000 square kilometres, covering 6 boroughs and 5 affiliated counties. The length from north to south is 186 kilometres and 101 kilometres from west to east. The Haihe River runs across the downtown area. Tianjin is a coastal city, with very low terrain. The average height above sea is about 2-5 m. Five per cent of the northern most part is hilly land. Seasons, on the whole, are distinct, being a temperate zone, with a semi-moist and continental monsoon climate. The yearly average temperature is about 12°C, with the hottest time from July to August and the coldest from December to February. Total yearly precipitation, on the average, is about 550-650 cm.

Photo 4.22. Tianjin, China (1989): map of Northern China showing Tianjin, where elderly rural and urban Chinese were studied.

4.8.2 Culture, religion & History

Tianjin is one of three municipalities in China. Culture and science are well developed, second only to Beijing and Shanghai. There are several nationally famous universities. According to the national census in 1990;
• 4.7% of the population received a college education,
• 15.9% high school,
• 20.4% middle school and
• 29.6% primary school education.

The illiteracy rate (>12 years old) has declined from 24% (1964) and 14% (1982) to 9% (1990).

Tianjin's population is composed of 31 nationalities. Among those, the Hai nationality is the
largest, accounting for 97.8% of the total population. Religions include Islam, Catholicism,
Christianity, Buddhism and Taoism (one of the chief religions in old China) and the Orthodox
Eastern Church. Most of the disciples of Islam are of Hui and Uygur nationality. In this religion,
pork cannot be eaten, because the pig is worshipped. The disciples of the other religions mainly
are of Han nationality and there are no religious limits on their diets. Unfortunately, few people
follow religions and most of them are old persons.

4.8.3 General demography and health statistics of community

China is a country with a large population. The ratio of the aged increased rapidly with the
improvement of economic and health protection. At present, the number of the aged over 60
amounts to 76.6 million and makes up 50% of the Asian aged, or one fifth of the world's aged. It
is forecasted that China will have similarly high populations of elderly people as in many
developed countries by 1996. Tianjin is the third largest city on the basis of population. Total
population is 8.52 million (1989), with 4.76 million urban and 3.85 million suburban and rural
residents (or 4.33 million male, 4.19 million female) [22]. Of the above, 21.8%, 10.49%, 6.69%
are aged <14 years, >60 years and >65 years, respectively.

There are 2.49 million households in total, making an average of 3.42 persons per household.
The average population density is 756 persons/ km, with downtown regions heavily inhabited
(23,187 persons/ km) and affiliated counties much more sparsely populated (408 persons/ km).
In order to limit the expansion of the downtown regions, the governments have adopted a series
of measures to control immigration from suburban or rural areas. Unlike western countries,
immigration from the countryside to city area is strictly limited. People can travel from one place
to another, but cannot change their living place from the countryside to the city or vice versa.

Photo 4.23. Tianjin, China (1989): 90 year old man, working as a
'mountain guard'.
With improvements in living conditions and medical care, people's life expectancy at birth has increased greatly, from 69.91 (1982) to 72.37 (1989) years for males and 71.90 (1982) to 74.37 (1989), for females, which is close to the level of some developed countries [22]. This increase has been contributed to by a low birth rate (18.07%, 1989), decreasing from 4.94 (1982) to 3.42 (1989) per household. The national increment rate of the total population is 12.12% (1989) and the death rate of the total population is 5.94%.

The pattern of disease distribution has also changed greatly. The death rate from respiratory system diseases and infectious diseases has dropped from the leading position during the 1950s to the 6th or even lower position at present, while heart and blood vessel diseases have become the main causes of death. Heart diseases account for 31.56% of total death (specific death rate-SDR 184.42 per 100,000), cerebro-vascular disease for 21.37% (SDR 124.90) and malignant tumour for 16.24% (SDR 94.87). There is an urban incidence rate of cancer per 100,000 population of 160, CHD of 759 and stroke of 779. In the affiliated counties, the rates are 55, 116, 366 respectively (1989). The incidence rate of hypertension in those aged 35 years and over is 22.90% in urban areas and much less (12.23%) in affiliated counties (See also Section 4.7.3).

4.8.4 Housing
Housing conditions in the urban area are not as good as in some of the small cities. Average house space for the total population (urban residents) is about 8 square meters. Although most of the residents have moved from simply-built houses to well-equipped buildings since the 1976 earthquake, some of them are still living in simply-built houses. Many of our subjects lived in poor conditions while their offspring lived in more spacious room. Bathrooms (toilets) were often shared by quite a few households. At the end of the 1980s, more than 93% of the total households had been equipped with liquefied gas, thus making housework less heavy, cleaner and more convenient for cooking. In rural areas, housing conditions were generally without problems. Elderly subjects generally shared rooms with their children. The typical form of housing was a compound, with the house around a courtyard (see Photo 4.24). They had enough room to walk around.

**Photo 4.24.** Rural Tianjin, China (1989): a typical courtyard of homes in the rural area.

### 4.8.5 State of development and economy of community

Urban Tianjin is highly developed in commercial and light industry, only second to Shanghai. Industrial gross value of output in 1988 was 480.58 billion RMB Yuan. Average yearly increment rate is about 9%. Resident yearly income per capita has increased to about 800 RMB Yuan. Before 1979, the suburban area was undeveloped. But since 1980, because of development in the township industry, the suburban area is urbanising. Most of these people gave up farm work, and are currently engaged in productive works.

**Photo 4.25.** Rural Tianjin, China (1989): a running water station.
Differences between urban areas and the areas surrounding them are decreasing. For some people, more spacious houses, more easily available fresh foods and higher incomes, has meant that life has proved to be better than downtown. Further from the urban areas, inhabitants still engage in farming, mainly planting vegetables. Further from the area we studied, people maintained a much more typical farming life, less influenced by the urban area.

The communities in urban locations that we studied are Heping and Hedong, two of the six boroughs. One represents the typical commercial business district and the other represents the typical industrial district of Tianjin. Generally, people in Heping district are better educated and
thus engaged in intellectual professions, whilst people in Hedong district are less educated and do manual work. This situation is similar for the elderly population. Because of the difference in educational background, other factors such as income, living conditions and retirement also differ.

Photo 4.27. Rural Tianjin, China (1989): solar energy facility.

Generally, the elderly who received education when they were young, often had a good job during their working life, and have financial security in their retirement. Unfortunately, most elderly were not educated and many of them did not have a regular job. Their standard of living is comparatively lower than those who had a good job and retirement pay. Although the government has tried to subsidise the retired elderly, the situation is still far from the satisfactory. On the whole, this age group is considered the low income class. Fortunately, most elderly can depend on family support, which is the traditional way to care for the elderly. The majority of the elderly live together with their children. Although they are respected by their offspring, they do not tend to dominate financial problems inside the family.
4.9 Summary

Aboriginal Australians (Junjuwa, Western Australia)

- Western Australia has the third largest population of Aboriginal people in Australia and the Fitzroy Valley region has one of the largest concentrations in the state. Less than 5% of Aboriginal Australians are aged over 60 years (life expectancy M: 51, F: 59), compared with almost 15% for non-Aboriginals (M: 73.6, F: 79.8), except in the Fitzroy Valley region where life expectancies are higher (M: 61, F: 65), resulting in greater proportions of elderly Aborigines aged over 60 (>10%).

- Junjuwa is found in the Fitzroy Valley Region, located in the north-west of Australia; this region has a riverine environment, tropical weather, with a wet and dry season.

- The majority of elderly Aborigines in the Fitzroy Valley were raised and worked on cattle stations as children and young adults, before moving to public housing at Junjuwa.

- The prevalences of 'lifestyle' diseases associated with 'urbanisation' of Aboriginal Australians, such as heart disease, hypertension, diabetes and obesity are more than double the prevalences found in non-Aboriginal Australians.

- There is marked unemployment in the Fitzroy Valley; social security payments are an important source of income for Aboriginal people.

Anglo-Celtic Australians (Melbourne)

- Melbourne is located in Victoria - the southernmost point of the mainland of Australia.

- Temperatures are variable within seasons and humidity is moderate; Melbourne can experience 4 seasons in one day.

- Over 40% of the population in Victoria claim Anglo-Celtic ancestry and less than 20% claim Australian-only ancestry.

- Victoria is the most densely populated State in Australia (4.3 million); 15% of the population was aged 60 and over at the 1986 census. In 1988 the life expectancy at birth for males was 73.6 years and for females it was 79.8 years.

- Diseases of the circulatory system accounted for 43.5% of all deaths, followed by cancer (25.5%). Of these diseases, ischaemic heart disease (IHD) and cerebrovascular disease (CVD) were most prevalent. IHD accounted for a slightly higher percentage of male
deaths whereas CVD represented a higher percentage of female deaths.

- About 90% of older people live in private dwellings and 10% lived in non-private dwellings (39% nursing homes, 24% homes for the aged, 37% hospital/boarding house. Between 20-40% live alone.

- Over 60% of older people received income support from a Commonwealth Social Security pension, of which two thirds were women. The median annual income for men aged 60+ ranged between $5000-10000 and for women <$5000.

Greek Australians (Melbourne)

- Immigration from Greece was predominant in the 1950s and 1960s. The majority of Greek migrants were aged in their twenties and came from villages in rural Greece.

- The Victorian Greek-born community comprises 49.3% of the total Australian Greek-born community. At the 1986 census there were approximately 130,553 in Victoria who claimed Greek ancestry, of which 65,515 were born in Greece and only 6.3% aged 65+ and 2% aged 70+ (compared to 11.6% and 7.7% respectively for Australian-born).

- The Greek community in Melbourne will experience the most rapid ageing of their community in the years to come. By 2001, the proportion of elderly will rise by about 35%, with more than 40% being aged 60+.

- According to the 1982 mortality data, Greeks in Australia were deemed the 'second longest lived population in the world', mainly due to lower death rates from heart disease and cancer. In contrast, 1989 morbidity data indicated that the health profile of Greek Australians may have changed in an adverse direction since 1982. The prevalences of heart disease, hypertension and hyper-cholesterolaemia were equally high or higher than Australian-born in all age groups. (Cancer was an exception).

- The majority of elderly Greek Australians (>95%) live in private dwellings, either with their children or with their spouse; less than 15% live alone.

- According to the 1986 census, the largest proportion of Greek-born were employed as labourers and related workers (M 27.5%; F 30.5%). Impressions suggest that the majority of Greeks in Melbourne are above average for "affluence".

Greeks in Greece (Spata)

- Spata is located about 20 km east from Athens in the Greek state of Attiki. It is situated on the mainland, however the east coast is less than 10 km away.
• In contrast to other areas of Greece, there have been only one or two families from Spata that migrated to Australia in the 1950s.

• The traditional Greek culture was strongly evident in Spata, as opposed to more urban areas of Greece (e.g. Athens). Spata is a semi-rural town with subsistence agriculture; olive oil, olives for eating, grapes and wine are the main products.

• In 1991, the total population of Greece was 10,063,000 persons with about 14% aged 65+. The population of Spata is about 10,000 of which 6.4% are aged 70+.

• Age adjusted mortality from all causes in Greece is among the lowest in the world (1989 life expectancy at birth M: 74.3, F: 79.4). This is accounted for by very low- cause specific mortality rates from coronary heart disease and cancer (colon, prostate, breast). Recently however, age adjusted mortality rates from colon and breast cancer have been shown to be steadily increasing in Greece, but not to the same extent as heart disease.

• Almost all of the elderly live in private dwellings, either with their children or with their spouse; less than 15% live alone.

• Impressions suggest that Spata is above the rural Greek average for "affluence" and "modernisation".

Swedes (Gothenburg)

• Gothenburg is situated on the west coast; it is the second largest city in the country with a population of 433,000 inhabitants, (i.e. 5% of the total Swedish population).

• Sweden as a whole has a continental or subarctic climate and is situated within the temperate climate zone.

• During the last four decades the relative and absolute number of elderly people has rapidly increased. Currently, about 18% of the Swedish population are aged 65 years or older. During the period from 1980-1987 the proportion of individuals aged 90+ increased by 46%.

• Life expectancy at birth is increasing, and is presently 81 years for females and 75 years for males.

• Johanneberg is an apartment house area and is a very central area of Gothenburg, with a high proportion of elderly (31% aged 65+ compared to 19% in Gothenburg as a whole). The majority of residents can be characterised as middle or upper middle class.
Filipinos (Manila)

- The ageing population in the Philippines is growing to larger. In 1978, 4.7% (3 million) of the population were aged 60+; in 1992 the proportion increased to 11.7% (7 million).
- The most commonly reported illnesses by elderly Filipinos include hypertension and arthritis and two thirds indicated they had accidents, injuries or chronic illness that impinged on functional ability.
- Four out of five elderly Filipinos live with their children; most elderly subjects live in houses of at least four people - they rarely live alone.
- The Government relies on the Filipino's traditional kinship based system for the support of the aged; the children are sources of financial, health care and emotional support. Social security benefits/ pension is provided to retired workers of the government or private agencies.
- Homes and institutions for the aged (total bed space 1000) are reserved for neglected elderly, abandoned with no relatives to turn to, and free from communicable disease.

Chinese (Beijing)

- The average life expectancy at birth in China for men is 72 and for women 74; it has increased more than 32 years since the early 1950s. The rapid growth of the population aged 65+, has made China the country with the largest ageing population in the world (5.5% aged 65+ or 63 million, which will increase to 105 million by the year 2000).
- Beijing is located in northern China, it is comprised of both urban and rural areas (62% is mountainous) with a population of 10.8 million (50% located in urban areas, 50% in rural areas), of which 5.4% are aged 65+.
- Since the early 1950s, the overall mortality in China has declined significantly from 20 per thousand in 1949 to 7 per thousand in 1990.
- Most communicable diseases prevalent in the past have been reduced and replaced by chronic diseases.
- Cardiovascular diseases (31%), cerebrovascular diseases (21%) and malignant tumours (16%) collectively account for 69% of total deaths in China. However, the age specific mortality rate in China is low, especially in the older age groups, compared to the US.
The traditional Chinese family structure and the Chinese Constitution reinforce the responsibilities of children to support their parents. This ensures that the elderly are not neglected and rarely live alone. They also receive free medical care and medications.

**Chinese (Tianjin)**

- Tianjin is located 137 km south of Beijing. Tianjin is a coastal city, with very low terrain, with a semi-moist and continental monsoon climate.

- The total population of Tianjin is 8.52 million (4.76 million urban and 3.85 million rural residents), of which 10.5% are aged 60+.

- Housing conditions for the elderly tend to be better in rural areas (house with a courtyard) than in the urban areas (small apartments).

- Although the government has tried to subsidise the retired elderly, the situation is still far from satisfactory. On the whole, this age group is considered low in income. Fortunately, most elderly depend on family support and the majority live with their children.
4.10 REFERENCES


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4.11 ILLUSTRATIONS

Photo 4.1. West Australia, Fitzroy Crossing, Junjuwa (1988): map of Australia showing the region from which elderly Aboriginal Australians were sampled.

Photo 4.2. West Australia, Fitzroy Crossing, Junjuwa (1988): Brooking Gorge; the Fitzroy area has many beautiful gorges with lush tropical vegetation.

Photo 4.3. West Australia, Fitzroy Crossing, Junjuwa (1988): people of the region at the turn of the century; they were fit and strong with no signs of malnutrition.


Photo 4.5. West Australia, Fitzroy Crossing, Junjuwa (1988): the eldest man at Junjuwa aged in his eighties, still fit and healthy.


Photo 4.7. Australia, Melbourne (Anglo-Celtic) (1992): map of Australia showing Melbourne where elderly Anglo-Celts were sampled.


Photo 4.9. Australia, Melbourne (Greek) 1990-91: Greek navy sea captain aged in his late eighties.

Photo 4.10. Australia, Melbourne (Greek) 1990-91: a typical weather board home in the northern suburbs of Melbourne, belonging to elderly Greeks, since migrating to Australia in the 1960's.

Photo 4.11. Greece, Spata 1988: map of Greece showing Spata in the far right, east of Athens.


Photo 4.13. Greece, Spata 1988: one of the eldest and fittest women in the Spata sample, aged in her early 90s. She has the food belief that eating garlic with meat will prevent the meat from raising her blood pressure.

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by workers of the land, now occupied by elderly parents, with a modern home adjoining for their children.


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