implied in 'race', were responsible for differences between countries in life expectancy and infant mortality rates.

The relationships between socioeconomic status, specifically poverty, and ill health are well-known and well-documented (Wilkinson, 1996; Hay, 1994). Similarly, the social gradient in health has also been well-documented and is receiving widespread acceptance. The social gradient refers to the fact that those with less socioeconomic resources than others have more ill health; those on the second highest rung of society are in better health than those on the third highest rung, but less healthy than those on the highest rung. This refers not simply to having more income or education, but to the distribution of inequality in a society. In other words, inequality per se is bad for health, irrespective of the absolute income level or material standards of living. As has been obvious throughout this paper, many of the seniors who require assistance are those who are living at or near the poverty line. Those in poor health with higher income, have the means to be able to receive needed care. The issue of affordable health care, two-tier health care, is dealt with in the companion paper by Evans and Barer so is not pursued here.

Research on aging among other subcultural groups in Canadian society is scant at best, and much of the research in this area from the United States focusses on blacks and hispanics, two groups which are not prominent in Canadian society. Research which is available suggests the common assumption that cultural minorities utilize fewer health care services is not warranted, at least among some groups. It is commonly believed that subcultural minorities have extensive social network that provide needed care and, due to preference as well as system barriers, do not use established services to a large extent. However, a representative sample of (N=870) Chinese seniors in greater Vancouver and greater Victoria (Chappell & Lai, 1998), reveals that they utilize formal health care services to the same extent as do seniors in general, even when controlling for a number of health variables. Furthermore, they overwhelmingly embrace and believe in the effectiveness of Western medicine. Among this cohort of seniors, a minority understand English well so they see practitioners who have Chinese staff.

That research also suggests the falsity of the assumptions that seniors within subcultural groups extensively use traditional or alternative medicines, and that such use is instead of the use of Western medicine. Rather, Chinese elderly in Vancouver and Victoria use traditional Chinese medicines in addition to Western medicine, not as a substitute. Those who use traditional medicines the most are those who also embrace traditional ancestor worship. Despite the fact that the use of alternative medicines and therapies is associated with subcultural groups, mainstream 'white' society also has their folk remedies and beliefs (such as the health benefits of chicken soup and the illness effects of staying in wet clothing). While data are starting to be collected in national health promotion surveys, we do not know whether subcultural groups differ substantially from the host society in this regard.

The issue of long-term institutional care targeted to subcultural groups lacks consensus in Canada. Even where there are sufficient numbers to warrant dedicated nursing homes, or wings of homes, there are differing views as to the appropriate course of action. In the province of Manitoba for example, such targeting is considered responsiveness to subcultural need where specialized food, language, furniture, timetabling, activities, etc. can be provided. In contrast, the province of British Columbia has responded to such requests as unacceptable because they are discriminatory (a nursing home for Chinese seniors for example would exclude non-Chinese seniors and would therefore be discriminatory).

There are many other areas of diversity that are equally relevant to an aging society. One area of diversity that has received little attention in the gerontological literature is that of geographical differences. Canada not only has vast geographic expanse, but also tremendous diversity of terrain (mountains, lakes, inlets, islands, coast plains) and as well, extremes of