"Health and Social Care for Older Persons from Culturally and Linguistically Diverse Backgrounds: Australian Policy and Practice"

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Introduction

In an increasingly globalised world, the challenges of meeting the health and social needs of older people from culturally and linguistically diverse (CALD) backgrounds is becoming increasingly important, with the World Health Organisation stating that designing for diversity is a primary characteristic of an age friendly city (World Health Organization [WHO], 2007). In Australia, the importance of meeting the needs of CALD older people has been recognised at all levels of government and is one of the features of the current proposed Australian Government aged care reforms (Chenoweth, Jeon, Goff & Burke, 2006; Commonwealth of Australia, 2012; Radermacher, Karunarathna, Grace & Feldman, 2011). This paper explores the challenges and opportunities of CALD ageing, building on an earlier scoping study of ageing and cultural diversity (Bartlett, Rao & Warburton, 2006) which included a comprehensive review of the literature (Rao, Warburton & Bartlett, 2006) and analysis of the implications for policy and practice (Warburton, Bartlett & Rao, 2009). In addition to consideration of the health and social needs of diverse groups, this paper reviews a range of other factors impacting upon the wellbeing of CALD older people, outlines selected innovation and good practice, and highlights areas for further research, policy and practice development.

CALD population trends

Australia is experiencing population ageing as a result of decreased fertility rates, increased life expectancies, and migration patterns. The number of people aged 65-84 years is expected to more than double in Australia by 2050 (rising from 2.6 million in 2010 to 6.3 million in 2050, with a trebling in those aged 85 years and over (rising from around 400,000 in 2010 to 1.8 million in 2050) (Commonwealth of Australia, 2010). Australia has a diverse population with, 26.8% of the total population born overseas (Australian Bureau of Statistics [ABS], 2011), making it one of the most diverse countries in the Organization for Economic Cooperation and Development (OECD, 2011). As a result of the timing of migration waves, the CALD population is ageing at a faster rate than the general community, with 17.9% of the overseas-born population aged 65 years and over compared to 11.8% of the total population (ABS, 2011). The advanced ageing of migrant groups is predominantly in those cohorts which emigrated from European countries following World War II (e.g. 56% of Italian-born Australians are aged 65 years and over), with those from later migration waves from Europe and Sub-Saharan Africa having a younger age profile. These migration waves have been influenced by changing migration policy, including the abolition of the White Australia Policy in the mid-1970s (Warburton et al., 2009). A recent report has emphasised the level of diversity within older CALD groups in Australia and that these differences should be considered when planning service delivery (National Seniors Australia Productive Ageing Centre, 2011).

Current policy approaches

Under the Aged Care Act 1997 (2012), people from non-English speaking backgrounds were identified as a special needs group in terms of residential and community care. In addition, the 2007 Home and Community Care (HACC) National Program Guidelines (Commonwealth of Australia, 2007) identify people from CALD and ATSI backgrounds as special needs groups. There are two main Australian Government programs related to the provision of culturally appropriate care - the Community Partners Program (CPP) and the Partners in Culturally Appropriate Care (PICAC) Program (Department of Health and Ageing, 2009).

The CPP was established in 2005 to provide funding for organisations supporting CALD communities to help make aged care services more accessible and supportive. The first round of CPP funding saw $2.4M provided to 40 organisations across the country (Bishop, 2005). The demand for CALD aged care services has clearly grown since then with $15.6M in funding over three years provided in 2009 to 77 CPP projects (Elliot, 2009b).

The Partners in Culturally Appropriate Care (PICAC) Program was developed to improve the capacity of aged care services to respond to the differing needs of older people from CALD communities (Department of Health and Ageing, 2009). Through the PICAC program one organisation is funded in each Australian State and Territory to provide this support to aged care providers, CPP projects and CALD communities. This includes the provision of training for the aged care sector on quality culturally appropriate care. Like the CPP, PICAC funding has increased, rising from $2.7M over two years in 2009 (Elliot, 2009a) to $6.6M over three years in 2011 (Butler, 2011). The CPP and PICAC programs primarily play a linkage role in connecting community organisations, service providers and government and while the programs funded direct costs such as training, they did not cover indirect costs such as those associated with staff and back filling (Aged and Community Services Australia, 2007).

In response to concerns about the current aged care system in Australia and its capacity to respond to the expected increases in demand resulting from increasing numbers and expectations of older people, the Australian Government requested that the Productivity Commission conduct a wide ranging review of the aged care sector (Productivity Commission, 2011). One of the key recommendations of the Commission was that access to aged care should be simplified through the introduction of a single gateway. The Commission recognised that one of the drivers for change in the aged care sector was the increasing diversity of the older population including people from CALD and ATSI backgrounds, recommending that:

The proposed Gateway should cater for diversity by establishing access hubs for older people from CALD backgrounds, providing interpreter services and ensuring its diagnostic tools are culturally appropriate for the assessment of care needs. Greater recognition in aged care standards of the rights and needs of older people from diverse back-

grounds. (Productivity Commission, 2011, p. LXXXVII)

In response to the Productivity Commission Review, the Australian Government has released its proposed Living Longer Living Better - Aged Care Reform package (Commonwealth of Australia, 2012) which includes an increase in funding for services for people from CALD backgrounds ($24.4M), ATSI backgrounds ($43.1M), as well as further assistance for veterans, older people from sexually diverse groups and the homeless. The reform package has received qualified support from the aged care sector but has yet to be passed by Parliament.

The health and social needs of CALD older people

Health needs

The health of migrants to Australia is noted to be better than their Australian-born counterparts (Australian Institute of Health and Welfare, 2010; Draper, Turrell & Oldenburg, 2004). This 'healthy migrant effect' is due in part to selective nature of immigration policies which favour those in good health and, in some cases, higher socioeconomic status.

Nevertheless, the circumstances surrounding migration can have an impact on healthy ageing. There is evidence that those people who migrated to Australia because of war, political and economic unrest, or religious conflicts, find it harder to adapt to their new country and this impacts on their future health (Rao et al., 2006). Furthermore, the reason for migration, based on visa type (refugee, family reunion, and skilled labour) has been linked to level of psychological distress (Chou, 2007). The length of time in Australia post- migration can also impact on health and social outcomes – both positively and negatively. While Terry, Ali, and Le (2011) report that it can take 2-3 years to become acculturated to the health system, Alizadeh-Khoei, Mathews, and Hossain (2011) found that the level of psychological distress was associated with acculturation (as indicated by whether or not they spoke English at home) but not by length of time in Australia. Interestingly, it has been noted that small migration groups and those from earlier migration waves which have not been replenished are more at risk of isolation (Warburton et al., 2009).

While generally in better health, socioeconomic, cultural and genetic factors mean that certain immigrant groups do face particular health issues. For instance, recent studies have found that older people from Northern European countries and Asia are more likely to be diagnosed with diabetes mellitus (AIHW, 2010); older Iranian immigrants had higher levels of psychological distress, lower feelings of well-being, greater functional limitations and need for help or assistance with activities of daily living (Alizadeh-Khoei et al., 2011); and older Italian-born men suffering from back pain were more likely to report that it was more frequent, severe and debilitating than that reported by Australian-born men (Stanaway et al., 2011). With regards to the latter findings about self-reported back pain, the authors suggested that these differences could be explained by socioeconomic factors such as years of education and occupation history.

Generally, the evidence suggests that CALD older people are more likely to require greater levels of hospitalisation during the final year of life, have a higher rate of mental disorders, particularly psychological distress, and are more likely to present to the health system in advanced stages of dementia (Rao et al., 2006). Increased levels of psychologi-

cal distress have been confirmed in longitudinal research of people aged 50 years and over who migrated to Australia in 1999-2001, which found that their levels of distress increased over the course of the following year and that this increase was closely related to their country of origin (categorised as Western and Developed, Asian, and other) and visa type (refugee, family reunion, and skilled labour) (Chou, 2007).

Social needs

While it is commonly believed that CALD older people live with their family, Warburton et al. (2009) have suggested this is a myth. In particular, recently migrated families may be too busy establishing themselves to have the time to care for their parents. In an increasingly urbanised world, traditional approaches such as filial piety are breaking down, with multigenerational families being replaced by nuclear ones (Bartlett & Liu, 2009). Nevertheless, CALD families are more likely to have greater levels of involvement with their older family members and, in some cases, this can reduce the capacity of older people to access the care and support they need because of the reticence of their family members to seek external support or their lack of awareness of available resources (Boughtwood et al., 2011; Warburton et al., 2009; Xiao, Haralambous, Angus & Hill, 2008).

The language barriers faced by those from non-English speaking backgrounds and the loss of former social networks can place CALD older people at greater risk of social isolation (Rao et al., 2006). The level of isolation may be increased in cases where isolated older people revert to their first language (Warburton et al., 2009). Other risk factors identified for increased social isolation related to migration, with people from new and small migration groups and those from past waves which are now ageing and not being replenished by new migrants, having less opportunity to connect to peers from their cultural group. It has also been found that language barriers are likely to deter CALD older people from volunteering to work in for mainstream volunteer organisations (Warburton & McLaughlin, 2007).

Use of health and community services

There is ample evidence to show that CALD older Australians do not receive adequate health and community services (Johnstone & Kanitsaki, 2008; Millichamp & Gallegos, 2011; Rao et al., 2006). While there is a general reduction in the uptake of services by CALD older people, where they do utilise services, there is a preference towards community-based over residential care services (Rao et al., 2006). CALD older people are also less likely to have had Aged Care Assessment Team (ACAT) referrals which are often the precursor to admission to residential care, perhaps because families are not aware of services or reluctant to use them. Some differences have been identified with specific groups, for example, while older Iranians were found by Alizadeh-Khoei et al. (2011) to have greater health and psychological needs compared to the general population, they were less likely to use services. It was also reported that those with lower levels of English language competency had more health problems and greater need for services but that language level was not related to service usage level, perhaps because of a general lack of awareness in the Iranian community of available services or a cultural predisposition towards family-based care.

There is also evidence that geographic location has an influence on service use, specifically that there may be less

capacity to provide culturally appropriate care in rural and remote locations (Rao et al., 2006). In a review of service use of older Asian migrants in the Australian state of Tasmania, it was reported by Terry et al. (2011) that some participants found the Tasmanian health care system to be inferior to that of mainland Australia, with limited CALD-specific care options, leading some participants to travel to the mainland and even to their homelands for better and more culturally appropriate care. It has also been reported that participants with lower levels of English competency have more difficulty navigating the complicated health care system (Terry et al., 2011). In another study of Asian migrants, Xiao et al. (2008) found that older Chinese immigrants were less aware of health services, particularly allied health services, perhaps because these services were less common in their birth countries.

The provision of culturally appropriate care

As noted earlier, the importance of providing culturally appropriate aged care services has been accepted by all levels of Australian government. This involves taking into consideration a number of factors, including the following:

Perceptions of ageing

Cultural differences in the way that ageing is perceived can also play a role in how CALD older people respond to ageing and take up health and community services. A study of older Chinese Australians found that they viewed ageing as an inevitable process and identified a belief-system that encourages self-enforced seclusion and introversion, including a reluctance to engage in physical activity (Koo, 2011). The concept of 'successful ageing' is a Western one which may have little meaning in other cultures. This point is illustrated by the work of Tan, Ward, and Ziaian (2010) which compared Anglo- and Chinese-Australians. It was found that the former group focused on growing old gracefully, whereas the latter were more concerned with financial security and active and meaningful lifestyle. As the concept of 'active ageing' can marginalise those in non-dominant cultures, including aboriginal elders, Ranzijn (2010) suggests that the focus should be on 'ageing well' or 'authentic ageing'.

Gender differences

Gender can play an important role in healthy ageing for CALD older people. For example, older CALD women have been found to rely more on their husbands for financial dealings, transport etc. and have had less access to English language classes, leading to considerable barriers should they lose that spousal support through death, ill-health or divorce (Warburton et al., 2009). Conversely, a study on the impact of translated public health messages noted that Asian men were more likely to rely on their wives for health information (ThuyTrinh, Stephenson & Vajda, 2011). Different perceived barriers to participating in physical exercise have also been identified in research of women from different cultural backgrounds, with Vietnamese-born women reporting that they were too self-conscious about their looks whereas Italian-born women reported being too unhealthy, too tired or not liking exercise (Bird et al., 2009). Another gender-related aspect of ageing is the increased expectation that CALD women will take on caring responsibilities (Boughtwood et al., 2011).

Access to culturally appropriate food

The available research is limited, but suggests that the provision of culturally inappropriate foods can be discriminatory in community and residential care services and that greater flexibility is needed (Warburton et al., 2009). Inability to access appropriate foods has been identified as a cause of food insecurity and poor nutrition in older CALD people (Millichamp & Gallegos, 2011; Radermacher, Feldman & Bird, 2010). This can be compounded by other factors such as financial pressure, poor health and mobility, and lack of social support (Radermacher et al., 2010). CALD people may drive long distances to locate culturally appropriate food, and have concerns about being able to access suitable foods should they enter residential care. A recent review of the literature on CALD food needs (Millichamp & Gallegos, 2011) found that while some Australian states have made food supplied through the Home and Community Care (HACC) program more culturally appropriate, a greater effort was needed, including the development of culturally appropriate food services and more research to evaluate the effect of such services and to direct future service delivery.

Needs of indigenous Australians

The challenges of providing culturally appropriate care to older people of Aboriginal and Torres Strait Islander (ATSI) descent, particularly those living in remote communities, are increasingly recognised. A fundamental issue is the cultural dissonance that exists between the values of the HACC program, service, community and clients. In the Northern Territory, inconsistent assessment procedures across HACC service providers and a minimal evidence base to inform practice have been identified (Lindeman & Pedler, 2008). Community initiatives to address such cultural dissonance include the establishment of a 'family model' of aged care within the indigenous Warlpiri community in Yuendumu in the Northern Territory (Smith, Grundy & Nelson, 2010). The 'hands on' care services are generally provided by local community members who speak Warlpiri and are known to the clients. This close connection allows them to be sensitive to local needs such as gender roles and avoidance relationships (i.e. the need for community members within a specific kinship or ceremonial relationship to avoid coming face-to-face). In order to navigate these complex issues, 'common sense' solutions have been adopted such as separate areas for men and women and the provision of two doors with viewing windows in each room to enable those in avoidance relationships to avoid entering the same room.

Language barriers

The language barriers faced by many CALD older people have been clearly identified as a major hurdle in navigating the health system and accessing appropriate care. Communication barriers are known to impact on all facets of care including access, diagnosis, assessment, treatment, and the ultimate level of care provided (Wish Garrett, Forero, Grant Dickson & Klinken Whelan, 2008). A need for the provision of more translated documents, access to translators, and greater access to English-language lessons has been identified (Warburton et al., 2009) and the need for professional translation assistance appears to increase with the level of complexity of the healthcare interaction (Wish Garrett et al., 2008).

In addition to providing access to professional translators, access to bilingual care staff within community and resi-

dential care services has become a priority (Boughtwood et al., 2011; Howe, 2009; Millichamp & Gallegos, 2011; Warburton et al., 2009). Between 25 to 33 per cent of the aged care workforce has been estimated to be born overseas, with migrants from the earlier European migration waves found to be more likely to work in the community care sector, while more recent Asian migrants were more likely to work in residential care. Unlike other countries where there is a large unskilled migrant workforce in aged care, it has been noted that there are no differences in the skills and training of Australian and overseas-born aged care workers (Howe, 2009). It has also been pointed out that that existing bilingual staff could be better utilised, including having input into aligning care procedures with cultural preferences (Chenoweth et al., 2006; Warburton et al., 2009).

Ethno-specific versus mainstream services

The debate about whether services should be ethno-specific or mainstream has highlighted the different value systems between Australian health care workers (characterised by Western values) and their CALD clients (Chenoweth et al., 2006). For example, the Western focus on client-centred care and self-determination can be a source of conflict for people from cultures which are more family or community focused.

While the majority of CALD older people continue to receive care from mainstream services (Howe, 2009), there is support for both mainstream and ethno-specific services (Radermacher, Feldman & Browning, 2009). In Australia, the CALD population is so diverse, including within different cultural groups, that it would be impossible to provide separate services to meet all their needs (Radermacher, Feldman & Browning, 2008). They also highlight the debate that funding ethno-specific services can perpetuate marginalisation and racism, while mainstreaming services can marginalise CALD groups by overlooking their specific needs. Even cultural competency guidelines may run the risk of stereotyping cultures (Radermacher et al., 2009; Warburton et al., 2009). The recent evidence would suggest that a balanced partnership of mainstream, multicultural and ethno-specific services is required to ensure the best possible services for aged care clients in the future.

Examples of good practice and innovation

Development of screening tools for CALD groups

It is increasingly recognised that measurement tools developed for and validated on the wider community may not be adequate for CALD groups (Anderson, Sachdev, Brodaty, Trollor & Andrews, 2007; Low et al., 2009). With the increasing prevalence of dementia in Australia in both the general and CALD populations (Access Economics, 2009), there is particular interest in the development of screening tools appropriate for CALD groups, with two distinct approaches being taken. One approach to this issue provides correction strategies for the Mini-Mental State Examination, taking into consideration CALD status, age, socioeconomic status etc. (Anderson et al., 2007). In contrast, LoGiudice (2011) outlines the development and validation of a culturally appropriate screening tool for Aboriginal people living in remote and rural areas of Australia - the Kimberley Indigenous Cognitive Assessment (KICA) scale. Another innovative screening tool is the Communication Complexity Score, Ethnicity and Health, developed by Wish Garrett et al. (2008) to help clinicians working with CALD patients identify when translation support is required.

The New South Wales (NSW) CALD Planning Ahead Strategic Model:

The NSW Department of Ageing, Disability and Home Care (DADHC) recognised that older CALD people faced serious barriers in making plans in the eventuality of declining health and death (e.g. wills, enduring power of attorney, and advanced health care directives) and so established the Planning Ahead in CALD Communities project (Cultural and Indigenous Research Centre Australia, 2008). This project included a review of the literature, development of a strategic model, and development of communication frameworks and associated resources for three target groups (Italian, Arabic and Croatian older people). These materials, along with related materials for people from ATSI backgrounds and the general community, are available on the DADHC website (http://www.adhc.nsw.gov.au/individuals/ageing_well/planning_for_the_future) and there are plans in place to develop the resources for other communities.

Promoting health to CALD groups

In response to evidence that CALD older people have more adverse medicine events due to language and literacy barriers, radio marketing campaigns targeting Italian, Mandarin and Cantonese speakers were delivered (ThuyTrinh et al., 2011). Radio advertisements and interviews were run on ethnic-language programs on radio stations broadcasting in Sydney, Melbourne and nationally. Households in the three language groups in Sydney and Melbourne were randomly surveyed before and after the marketing campaign and it was found that there was an increase in awareness of quality use of medicines, particularly in the Cantonese and Italian-speaking communities (ThuyTrinh et al., 2011). It was noted by the researchers that even within these language groups the populations were too diverse and that different messages may need to be developed for those of more advanced years (aged 70 years and over).

The development of practice guidelines for working with CALD older people

As noted earlier in the paper, there have been various attempts to develop practice guidelines for different aspects of the aged care sector and that it is important to avoid cultural stereotyping. One such approach focuses on the clear exchange of information and provides a useful guide to the information staff need to provide clients and their families, as well as the information that they need to seek from them, and highlights the use of available resources, including from overseas trained staff (Chenoweth et al., 2006). Based on their discussions with service providers and policymakers, Warburton et al. (2009) identified the following key elements of culturally appropriate practice:

- Recognising the diversity within - noting that diversity can be a strength as well as a challenge;

- Building on existing strengths - including utilising the expertise from existing services, community champions and older people themselves - many of whom are caring for others;

- Developing cultural competencies - including capitalising on bilingual staff

- Cultivating tolerance and antidiscrimination – noting that we can't assume that racism doesn't exist;

- Providing information and improving communication - including English lessons, translated documents and access to translators;

- Working in partnership – in the earlier scoping study report

(Bartlett et al., 2006), a range of key stakeholders involved in providing support services to CALD older people were identified (Figure 1).
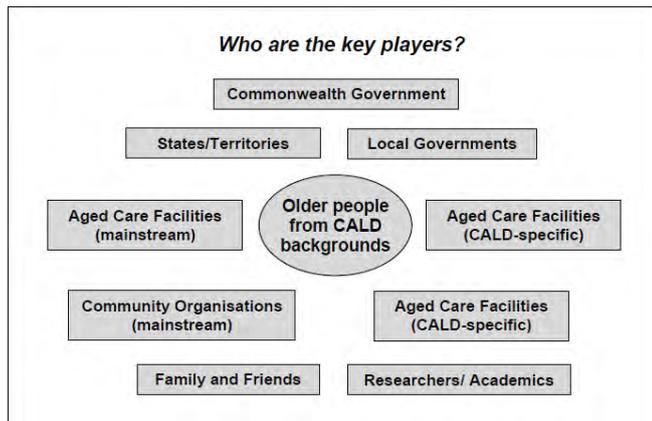
Figure 1. Key players in the provision of services to older people from CALD backgrounds (Bartlett et al., 2006, p. 51)

These broad principles have been incorporated into a practice briefing paper developed for the community aged care sector (Social Policy Research Centre & The Benevolent Society, 2010).

Conclusions

It is clear from this review that CALD older Australians face serious challenges now and into the future. A continuing cause of the disparities in the health and social care of CALD older Australians is recognised to be cultural racism and this needs to be systematically addressed as a structural problem (Johnstone & Kanitsaki, 2008; Warburton et al., 2009). It will require the concerted effort of government, researchers, care providers, community organisations and CALD older people and their families to address these issues. The Australian Government has recognised the diverse nature of ageing in Australia and made commitments to significant reform of the aged care system. First and foremost among these challenges is breaking down the language barriers faced by CALD older people. This includes greater access to translated materials (Cultural and Indigenous Research Centre Australia, 2008; ThuyTrinh et al., 2011), as well as greater access to professional translation services, and to English-language courses.

There is a paucity of research in the area of CALD health and social services with much of the evidence drawn from grey literature which may lack scientific rigour (Radermacher et al., 2008). It is imperative that a research agenda be developed in consultation with policy, practice and the CALD community to address the gaps in our knowledge, particularly with regards to the community care (Radermacher et al., 2009) and dementia issues (Boughtwood et al., 2011; Low et al., 2009).

In the same way as a partnership approach has been emphasised in the development of CALD ageing services (Radermacher et al., 2011; Warburton et al., 2009), it is important that a robust partnership approach is adopted to ensure that the policy and practice outcomes meet the needs of all stakeholders. These efforts could include strategies to develop greater links between CALD communities and researchers (such as a consumer network), and increased access to relevant materials through the establishment of a clearing house.

While the issues and responses outlined here are focused on CALD older Australians, these experiences offer useful insights for other countries. Many of the themes identified in this paper are likely to resonate elsewhere as the challenges of population ageing give rise to a similar range of consequences for aged care policy, planning and service provision across the world.