Longevity

and SOCIAL CHANGE in AUSTRALIA

BOROWSKI « ENCEL » OZANNE

Longevity

and SOCIAL CHANGE in AUSTRALIA

Edited by

Allan Borowski, Sol Encel
and Elizabeth Ozanne

UNSW PRESS

A UNSW Press book

Published by
University of New South Wales Press Ltd
University of New South Wales
Sydney NSW 2052
AUSTRALIA
www.unswpress.com.au

First published 2007

National Library of Australia
Cataloguing-in-Publication entry

Longevity and Social Change in Australia.

Bibliography.

Includes index.

ISBN 9780868408897.

1. Older people - Government policy - Australia. 2. Older people - Legal status, laws, etc. - Australia. 3. Older people - Health and hygiene - Australia. 4. Older people - Australia - Finance, Personal. 5. Older people - Housing - Australia. 6. Older people - Education - Australia. I. Borowski, Allan. II. Encel, Solomon, 1925- . III. Ozanne, E. IV. Title.

305.260994

Design Di Quick
Cover photo Getty Images
Printer Ligare

This book is printed on Australian paper using fibre supplied from plantation or sustainably managed forests.

CONTEN

CONTENTS

LIST OF TABLES

CONTRIBUTORS

Ian Anderson is Professor and Director of the Centre for Health and Society and Onemda VicHealth Koori Health Unit in the School of Population at the University of Melbourne.

Mike Berry is Professor of Urban Studies and Public Policy in the School of Global Studies, Social Science and Planning at RMIT University.

Allan Borowski is Professor and a former Head in the School of Social Work and Social Policy at La Trobe University.

Catherine Bridge is Director, Home Modification Information Clearinghouse in the Faculty of Health Sciences at the University of Sydney.

Terry Carney is Professor and Director of Research in the Faculty of Law at the University of Sydney.

Philippa Cotter is Research Associate in the School for Social and Policy Research at Charles Darwin University.

Stephen Duckett is Executive Director, Reform and Development of Queensland Health and former Dean of the Faculty of Health Sciences at La Trobe University.

Sol Encel is Emeritus Professor and Honorary Fellow in the Social Policy Research Centre at the University of New South Wales.

Michael Fine is Associate Professor in the Department of Sociology and Deputy Director of the Centre for Research on Social Inclusion at Macquarie University.

Hal Kendig is Research Professor of Ageing and Health in the Faculty of Health Sciences at the University of Sydney.

Peter McDonald is Professor and Head of the Demography and Sociology Program in the Research School of Sciences at the Australian National University.

Colin D Mathers is Senior Scientist, Evidence and Information for Policy Cluster, in the World Health Organization, Geneva.

Diana Olsberg is Senior Lecturer and Head of the School of Sociology and Anthropology at the University of New South Wales.

Elizabeth Ozanne is Associate Professor and Head of the School of Social Work at the University of Melbourne.

Rob Ranzijn is Senior Lecturer and Program Director in the School of Psychology at the University of South Australia.

Sheila Rimmer is former President of both the New South Wales Council on the Ageing and the Australian Council on the Ageing, and is currently a member of the Medical Services Advisory Committee, Commonwealth Department of Health and Ageing.

Donald Rowland is Reader in the School of Social Sciences at the Australian National University.

Cherry Russell is Associate Professor in the Faculty of Health Sciences at the University of Sydney.

Len Smith is Associate of the Australian Centre for Population Research at the Australian National University.

Hal Swerissen is Professor and Acting Dean of the Faculty of Health Sciences at La Trobe University.

FOREWORD

This is a unique moment in human history. We have never lived longer. But the curious thing is that, anecdotally, when you talk to people, it seems they have never felt sicker. We are not necessarily happy in our extended mortal coils.

It is important to understand where these extra years of life have been coming from, because it perhaps helps to explain this apparent contradiction.

If you were to walk down the streets of Sydney or Melbourne in the mid-19th century, there would have been plenty of older people around. The main reason that life expectancy was about 40 years less than it is now was the appalling perinatal, infant and child mortality rates. They brought the average down. Over the next 100 years, though, better nutrition and housing, safer obstetric care, immunisation and, indeed, higher female literacy rates, ensured that the vast majority of babies reached adulthood.

So life expectancy at birth improved dramatically, but what did not change much right up to the Second World War was life expectancy at age 50 or 60. And it is that metric which has made the difference to life expectancy over the last 50 years. These days, if we reach middle age, we can expect it to be truly that: the middle of our lives, not the penultimate coda as our grandparents expected.

This has enormous implications.

Developmental psychologists, for example, have tended to stop their research at adolescence and, disturbingly, little is known about developmental stages in mid- and late-life. We tend to take an approach based on pathology and do not really understand normality. So, for example, we dismiss the male middle-age crisis as somehow pathetic, yet are relatively ignorant of the natural history of our minds into extreme old age. We are not prepared for these added years and issues, such as feeling economically squeezed with 40 years to go – a feeling that may be affecting our sense of wellbeing.

It is also time to reflect on why this expansion of life after middle age has occurred. There is not much doubt that, when you look at the 19th and early 20th centuries, the gains were made from public health and other sectors such as education rather than curative medicine. The story in the last 50 years, however, is far less clear. Some are suggesting that the impact of curative medicine on life expectancy is fast catching up on public health interventions where, arguably, most of the gains have been made with the exception of the poorest, least educated and especially Indigenous populations. But even there, medical care is having an impact that has not been properly measured.

For instance, a fascinating cohort study of obese people in the United States has shown that the BMIs (Body Mass Index) for obese people today are healthier, with lower blood pressures and blood fats, for example, than 30 years ago. Some of this may be increased fitness, but some of the difference will inevitably be from drugs, surgery and other things that health services do.

The argument that public health should have all the kudos is pervasive and perhaps allows politicians and bureaucrats to think that what is done in hospitals and doctors' surgeries does not matter that much, when it actually does.

If, for the first time in human history, medicine is having a large and measurable impact on how long we live as a population, then issues such as fairness, being able to receive good medical care and access to increasingly expensive, yet possibly life-extending, technologies will become even more explosive political issues than they are at the moment.

When the community realises what is really at stake, sit back and watch the fireworks.

What better time for a thorough review of ageing and the new longevity?

Dr Norman Swan
Host, *The Health Report*
ABC Radio National

INTRODUCTION

Like its predecessor, *Ageing and Social Policy in Australia* (eds Borowski, Encel & Ozanne 1997), the present volume has been designed to reflect the ever-increasing breadth and depth of research and discussion in the field of gerontology, as well as major developments in government policy at both national and state levels. The earlier book appeared shortly after the election of a Liberal–National coalition government in Canberra in 1996. The current book examines important policy shifts in the subsequent decade. The main themes covered in the succeeding chapters are summarised below.

In chapter 1, Allan Borowski and Peter McDonald trace the fertility and mortality revolutions that have produced the current demographic picture, one that departs radically from the traditional population pyramid. The chapter focuses upon the changes in the proportionate size, numbers and composition of the older population and the demographic processes that underlie population ageing. Borowski and McDonald also explore some of the policy implications of the demography of ageing in Australia. Colin Mathers extends this analysis in chapter 2 by reviewing changing health patterns. He notes that Australians are now second only to the Japanese and French in terms of life expectancy. Mathers reviews evidence on recent trends in mortality, causes of death and disability prevalence rates for older Australians. Chapter 2 also examines the extent

of health problems in older Australians, and the causes of those problems in terms of diseases, injuries and risk factors. The chapter concludes with a discussion of projected future health trends and implications for older Australians and for Australian society. International evidence, as well as Australian data, suggests that there will be further improvements in health, but with increasing levels of disability.

The next three chapters examine the impact of ageing on specific subgroups in the population – Indigenous Australians, women, and people of non-English-speaking background (now commonly referred to as 'culturally and linguistically diverse', or CALD). In chapter 3, Philippa Cotter, Ian Anderson and Len R Smith examine the radically different patterns of morbidity, mortality and life expectancy in the Indigenous population. Their discussion focuses on the links between health, community services and aged care policy at a national level. In chapter 4, Cherry Russell explores the differential impact of ageing on men and women and the unresolved issue of whether age or gender has the greater influence on the lives of older women. She also examines the specific problems of ageing in the case of homosexual couples. Donald Rowland deals with the 'ethnic aged' and the value of ethno-specific aged care services in chapter 5.

Another group with a distinctive profile are 'mature-age' workers, especially men and women over 50 years of age. In chapter 6, Sol Encel and Rob Ranzijn note how demographic and economic changes have forced a reconsideration of the role of paid work in later life. Pressure on the pension system because of sharp increases in longevity has led governments to introduce a range of policy incentives and disincentives designed to prolong labour force participation, to abandon previous policies aimed at encouraging early retirement, and to legislate against age discrimination in employment. The chapter also describes the damaging effects of long-term unemployment on older workers.

Although issues of government policy are touched on in most chapters, policy is the explicit concern of the next five chapters, which deal with health, retirement incomes, housing, transport and infrastructure, and the political process itself. In chapter 7, Hal Swerissen and Stephen Duckett examine the use of hospital and medical care services for older people and look at current problems, including access to services, waiting

times, and challenges to the continuity of health care arising from federalism. Allan Borowski and Diana Olsberg describe the evolution of retirement income arrangements in Australia and the shifting forces that have shaped them in chapter 8. They outline the main features of Australia's retirement income system prior to the 1980s and the objectives of the reform process that began in the 1980s. They describe some of the major changes that have been introduced, what they have achieved and how and why a number of objectives remain much further from being realised than was initially expected. The chapter, which concludes by outlining the challenges that remain for Australia's retirement income system, gives particular attention to an especially important distributive issue, that concerned with the economic security of older women.

Housing is another policy area that is attracting increased attention. In chapter 9, Hal Kendig and Catherine Bridge consider policy prospects as the large baby boom cohort enters old age over the next decades. A comparative perspective is used to illuminate the distinctiveness of the Australian situation and possible new policy directions. The influence of Commonwealth and state government policies is assessed in terms of single-family homes, higher-density housing, and specialised forms of housing including retirement homes, caravans and boarding houses.

Housing is closely related to transport and other public services. Mike Berry examines the relationships between housing, mobility and geographic location in chapter 10. Mobility depends on historical and current policies regarding transport, particularly public transport. Marginalised location and poor access to both private and public transport creates a class of 'transport poor'. The rapid growth in the numbers of older women living alone poses special problems in terms of the provision of safe, reliable and affordable transport services. Mobility and access are directly related to housing policies, transport and urban planning policies, and retirement incomes.

Changes in policies relating to aged care are discussed in detail by Michael Fine in chapter 11. He focuses on the concept of care, evidence of the need for care, political responses and building a new vision. Fine observes that aged care first emerged as a distinct field of policy in the 1950s. Residential aged care providers tend to exaggerate their role, whereas the cost of health care for the aged is much greater than that

of aged care. Further, the amount of care provided within families is also much more important than the activities of the aged care industry. He examines the findings of several recent reports dealing with nursing homes and community care, and concludes by describing attempts to develop a more imaginative approach to aged care than that presented by the rather limited range of options found in official policy discussions.

Political processes are the vehicle for the implementation (or non-implementation) of policy. In chapter 12, Sol Encel and Elizabeth Ozanne examine various aspects of this relationship. They review attempts to shift responsibility for aged care from the Commonwealth to the states, a political manoeuvre that has not succeeded. The Liberal–National coalition has, however, placed much more emphasis on 'user-pays' policies to meet the rising costs of aged care. They also examine the political preferences of older voters, noting that they continue to vote for conservative parties. Pressure groups representing older persons have increased in importance and have succeeded in obtaining benefits from both national and state governments. However, the notion of 'grey power' remains largely mythical.

The final three chapters deal with a range of matters including lifelong education, intergenerational relations, and legal issues. In chapter 13, Sheila Rimmer describes the historical development of institutions of adult and further education, and notes a shift of emphasis since the 1980s away from traditional concepts of adult education towards training and retraining in the workforce. Elizabeth Ozanne comments on changes in intergenerational relations as the result of increased longevity in chapter 14. Established ideas about the place of older people in society, and in family relationships, are under strain. Today, it is likely that four, or even five, generations of a family will survive together, moving in and out of what were previously much more age-standardised roles of child, parent, grandparent and great-grandparent. As a result of demographic shifts, the body of descendants available to support the growing number of elders has shrunk, while at the same time welfare provisions have been cut back because of pressure on state revenues.

In chapter 15, Terry Carney examines the role of the law in mediating social changes associated with population ageing, including the balance between work and retirement, and the provision of non-labour market

incomes. Demographic ageing, in combination with neo-liberal economic measures, are serving to dissolve historic boundaries between work and retirement, blurring choices between universal and selective policies, or public and private provision.

In the second part of the Introduction, we examine some of the outstanding issues arising from the ageing of the population. What are the justifications for the recurrent presentations of ageing as a crisis or a 'demographic time bomb'? Is it possible to view increased longevity as an achievement rather than a problem? What will be the impact of the impending retirement of large numbers of the baby boom generation? These and related topics are explored in detail in the various chapters of the book, to which the following pages constitute a brief prologue.

Ageing – threat or promise?

Contemporary society is faced with the dilemma of deciding whether increased longevity is a boon or a threat, so that much of the discussion about population ageing is couched in terms of crisis. The fact that people are living longer has come to be called the 'new longevity', or the ageing of the aged. Confronted with the new longevity, society appears less and less certain about the roles to be assigned to older people. One pessimistic conclusion is that older people, especially after retirement from the labour force, can only assume a 'roleless role' (eds Riley, Kahn & Foner 1994). The erosion of traditional communities and family networks increases the difficulty of establishing a harmonious relationship between the aged and the rest of society. Unfortunately, these difficulties encourage talk of a 'crisis'.

The language of crisis presents ageing as the new population problem of our times. Peter Peterson, an American investment banker who served as Secretary of Commerce during the Nixon presidency, has used the imagery of the *Titanic* to depict the imminence of the crisis which, he declares, will 'daunt the public policy agendas of developed countries and force the renegotiation of their social contracts' (Peterson 1999). The combination of a worldwide decline in birth rates and an increase in life expectancy has created what is sometimes described as a gerontological drift. Using the age dependency ratio (that is, the ratio between the

retired population and the working population), the proponents of crisis claim that, in a short time, Western-type industrialised societies will find it impossible to carry the burden of ever-growing numbers of elderly people.

Reinforcing these apprehensions is concern about declining fertility rates. The Australian Treasurer, Peter Costello, has developed this theme in several public statements. In 2004, he urged women to have 'one child for the husband, one for the wife, and one for the country'. He returned to the topic in a television interview before presenting the Budget to parliament in May 2006, announcing a cash incentive so that families would 'think about one for the country as well' (*Sydney Morning Herald* 2006).

The marginalisation of older people is reflected in the prevalence of age discrimination in the labour market, an issue examined in chapter 6. Older workers, particularly men, constitute a disproportionately large share of the long-term unemployed and the so-called 'discouraged job seekers'. In effect, the duration of working life has been shortened, which in turn increases the pressure on the welfare system. Although the policies of governments have moved towards an emphasis on retaining older workers in the labour force, little progress has been made in this direction because of the attitudes of employers, backed up by the arguments of some economists that the preference for younger workers is economically rational (Lazear 1995). To a large extent, employers reflect widespread social attitudes, epitomised by maxims such as 'You can't teach old dogs new tricks' and 'The old should make way for the young'.

British economist Phil Mullan has debunked the idea of a demographic time bomb. Societies are ageing, but this is not a major source of contemporary social problems. Populations have been ageing, he observes, since the beginning of the 20th century, and societies have coped without incurring apocalyptic crises as a result. Industrialised societies are already productive enough to generate sufficient wealth to provide for the present aged population, and even low levels of economic growth will satisfy the most extreme projections for the future rate of ageing. Furthermore, he stresses that most old people are neither ill nor disabled and do not need looking after. The improvement in living conditions during the 20th century is the main factor in increased

longevity, and a continued improvement will make contemporary and future generations of older people fitter and healthier than their predecessors (Mullan 2000).

Mullan's views are endorsed by a number of other demographers and economists. American demographer Richard Easterlin, among others (for example, Schulz, Borowski & Crown 1991), has criticised the use of the age dependency ratio as a basis for the notion of a crisis. Easterlin observes that use of the ratio is characterised by a lack of historical and comparative data and an excessive reliance on simple projections. He points out that dependency ratios in the 1880s were actually higher in the United Kingdom and the United States than in the 1980s. The real issue, he maintains, is not economic but political: 'how to capture via taxation the savings of households from supporting fewer younger dependants to fund the cost of more older dependants' (Easterlin 1991).

Easterlin was responding to the widespread talk of a crisis in the American social security (that is, social insurance) system, touched off by the report of a commission appointed by US president Jimmy Carter. A detailed critique of the Carter commission's report points out that its calculations ignore the contribution made by older people to the welfare of younger people in the form of direct services or of cash payments that drew upon accumulated capital or pension income. The real problems arose not from a crisis in the pension system, but from the effects of prolonged unemployment and inflation (Friedmann & Adamchak 1983).

The language of crisis also made a considerable impact in Australia, as pointed out in chapter 12. It was rebutted in terms similar to those quoted above. A report by the National Population Council argued that increased labour force participation by women would cut the dependency ratio (National Population Council 1991). Research by the Australian Institute of Family Studies has emphasised the extent to which older family members are involved in assisting other family members (Edgar 1991).

The fact that older people are no longer seen as rare survivors – a small minority within a fixed framework – has led to increasing emphasis on the possibilities of a healthy and productive life in later age. It is even claimed that active, successful and productive ageing has taken on a 'moral significance' (Daatland & Biggs 2003). Daatland and

Biggs argue that the 20th century welfare state has 'decommodified' later life, allowing for rising standards of living among retired people by creating a free-floating class of non-producers. This has led to changed expectations about the way in which later life should be spent.

The concept of 'positive ageing' owes much to the work of the late Peter Laslett, who popularised the idea of a 'Third Age' of life, which he described as one of personal fulfilment. The Third Age, he wrote, was a new phenomenon in human history, which could become an age of personal achievement and self-realisation (Laslett 1989). Similarly, American writer Ken Dychtwald described older people as an untapped resource for society (Dychtwald 1991). Echoing these views, well-known Australian public figure Barry Jones observes that 'the wealth of experience of the aged must be used as an asset rather than having the aged generally characterised as a liability' (Jones 1993: 19).

The baby boomers

The demographic future will be strongly influenced by the progressive entry of the baby boom generation (1946–64) into the age groups of the over-60s. The implications of this transition have been spelt out in detail in a study by British research centre Demos, in collaboration with Age Concern, the largest age-related charity in Britain. Their findings are summarised below (Huber & Skidmore 2003).

- Demographic trends are an insufficient basis for predicting the implications of an ageing society. Our assumptions about the future are rooted in the concepts applicable to past generations. The baby boomers have transformed every stage they have passed through, and show no sign of stopping in old age. We have to consider the values and attitudes that the baby boomers will take with them as they move into older age.
- Two particularly important characteristics of the baby boomers are their individualism and their liberalism. However, they do not conform to any single stereotype any more than previous generations. There are significant differences between them in affluence, longevity, education and ethnicity. It is essential to distinguish between baby boomers as a homogeneous cultural construct and baby boomers as

a heterogeneous, fragmented cohort.

- Current responses have tended to treat issues affecting baby boomers as an individual rather than a social matter. This narrows the range of policy instruments for the future. Policies that require baby boomers to remain longer in the labour force are likely to arouse resentment and animosity.
- In comparison with older generations, baby boomers have lower levels of social bonding or 'social capital' because of higher levels of divorce and separation, with serious implications for the provision of care and support. They also have fewer networks and are more likely to be disconnected from the wider community. This suggests the need to invest in a number of areas such as housing and neighbourhood design, health and fitness, lifelong learning, and online technologies. Investments like these could offset some of the costs of providing for old age by encouraging older people to be healthier and fitter.

In Australia, the cultural differences between baby boomers and their elders have been explored by MacKay (1997) and Salt (2003). Like the Demos researchers, Salt considers that baby boomers have 'forged new cultures at every stage of the life cycle' (2003: 94). He predicts that they will have enough political influence to steer budgets away from education to health. Ageist attitudes and stereotypes will be attacked, so that terms like 'pensioner' and 'senior citizen' will be viewed as patronising or downright offensive.

Conclusion

The picture of the older people as a dependent group, burdening society with excessive expenditures on health and aged care, is based on assumptions about biological inevitability. Social construction is probably more important as expressed through the introduction of pensions, compulsory retirement, institutional residential care, and other economic and social policies and practices that treat the 'aged' as a distinct group. Dependency and ageism go hand in hand.

While there may be problems arising from a 'mortality revolution'

that will generate significant numbers of very old people (90 years of age and over) in the medium term, such problems are exaggerated. This is especially because the current and expected population of people over 60 are better off in terms of health and material resources than any previous generation. In addition, concern about dependency ignores the substantial contributions made by older people, especially the 'young old', to family members in a wide range of areas of need. Such concerns also underrate the significance of increased labour force participation by women. Interdependence between generations is a much more appropriate description of the actual social situation, and provides a more equitable and realistic basis for social policies addressed to the growth in the proportion of older people in society.

As a recent study of population observes, the ageing of the population should be seen as a transition rather than a crisis, with opportunities as well as challenges. The main challenge is to promote healthy and productive ageing and to adjust social structures to include older people as contributors to society (Healy 2004). A similar view is expressed in a discussion paper issued by the Commonwealth Government in 1999 which stresses that population ageing presents both challenges and opportunities, observing that 'the fact that greater numbers of people are reaching old age is a major achievement reflecting improved living conditions and the control of disease' (Bishop 1999).

References

Bishop, B (1999) *The National Strategy for an Ageing Australia*, Background Paper, Minister for Aged Care, Canberra.

Borowski, A, Encel, S & Ozanne, E (eds) (1997) *Ageing and Social Policy in Australia*, Cambridge University Press, Cambridge.

Daatland, SO & Biggs, S (2003) *Ageing and Diversity*, Policy Press, Bristol.

Dychtwald, K (1991) *Age Wave: How the Most Important Trend of Our Time will Change Your Future*, Bantam Books, New York.

Easterlin, RA (1991) The Economic Impact of Prospective Population Changes in Advanced Industrial Countries, *Journal of Gerontology*, 46(6): S299–309.

Edgar, D (1991) Ageing: Everybody's Future, *Family Matters*, 30: 15–19.

Friedmann, EA & Adamchak, J (1983) Societal Aging and Intergenerational Support Systems. In A Guillemard (ed.) *Old Age and the Welfare State*, Sage, London, pp. 53–73.

Healy, J (2004) *The Benefits of an Ageing Population* (Discussion Paper no. 63), The Australia Institute, Canberra.

Huber, J & Skidmore, P (2003) *The New Old: Why the Baby Boomers Won't be Pensioned Off*, Demos/Age Concern, London.

Jones, B (1993) The Challenge of an Ageing Society. In K Sanders (ed.) *Ageing: Law, Policy and Ethics – Directions for the 21st Century*, School of Social Work, University of Melbourne, pp. 6–19.
Laslett, P (1989) *A Fresh Map of Life*, Weidenfeld & Nicolson, London.
Lazear, E (1995) *Personnel Economics*, MIT Press, Cambridge, MA.
MacKay, H (1997) *Generations: Baby Boomers, Their Parents and Their Children*, Pan Macmillan, Sydney.
Mullan, P (2000) *The Imaginary Time Bomb*, IB Tauris, London.
National Population Council (1991) *Population Issues and Australia's Future*, Australian Government Publishing Service, Canberra.
Peterson, PG (1999) Gray Dawn: The Global Aging Crisis, *Foreign Affairs*, January/February: 43–62.
Riley, MW, Kahn, RL & Foner, A (eds) (1994) *Age and Structural Lag*, Wiley, New York.
Salt, B (2003) *The Big Shift*, 2nd edn, Hardie Grant Books, Melbourne.
Schulz, JH, Borowski, A & Crown, WH (1991) *The Economics of Population Aging: The 'Graying' of Australia, Japan and the United States*, Auburn House, New York.
Sydney Morning Herald (2006) Tax Cuts for All, Cash for Families, *Sydney Morning Herald*, 8 May, p. 1.

5

ETHNICITY AND AGEING

Donald T Rowland

Introduction

Australia's commitment to immigration as a basis of nation-building has continuing consequences for the country's experience of population ageing. While immigration is currently having a small moderating effect on the percentage of older people in the population (Productivity Commission 2005), its long-run impact includes substantial increases in the numbers of older settlers. After three or four decades, working-age immigrants inevitably reach later life and most of them continue to value, or find essential, their identification with their cultural origins. At a time when population ageing itself is of growing importance in reshaping Australian society and its social and economic policies, the ageing of settlers is prominent because of the past high volume of immigration from diverse origins. It will long remain so because current trends in immigration guarantee, well into the future, a continuation of 'the migrant presence' at older ages.

Between 2001 and 2026, the numbers of the ethnic aged, or persons from culturally and linguistically diverse backgrounds, are projected to almost double from about 480 000 to 940 000, with particularly rapid increases occurring before 2016 (see table 5.1). Their share of the total population aged 65 and over will remain in the range of 20–22 per cent, since the total aged population will also be increasing substantially at the same time, from about 2.4 million to 4.4 million (Gibson et al.

Table 5.1 *Birthplaces of persons aged 65 years and over, Australia, 1996–2026*

Year	Culturally and linguistically diverse backgrounds	Main English-speaking backgrounds	Australian-born	Total
1996	392 800	288 749	1 521 445	2 202 994
2001	479 395	305 181	1 591 224	2 375 800
2006	567 944	336 619	1 681 553	2 586 116
2011	653 801	388 091	1 864 853	2 906 745
2016	780 743	458 686	2 178 779	3 418 208
2021	871 007	497 680	2 549 556	3 918 243
2026	939 822	535 355	2 957 845	4 433 022

Note: Although 1996 was the base year for projected figures in all the later years, the projected total figure for 2001 is only slightly below an authoritative estimate (2 440 600) of the total resident population, aged 65 years and over, in June 2001 (ABS 2002a: 85).

SOURCE Gibson et al. 2001: 4–5

2001: 4–5). The ethnic aged have long had numbers concentrated in the 'young-old' ages (65–74 years), because of expanding inflows from the working ages, but a significant change now occurring is the ageing of the ethnic aged, which is raising the proportions most likely to need aged care. The proportion aged 80 years and over could rise from 18 per cent in 2001 to 26 per cent in 2011, compared with corresponding figures of 24 per cent and 27 per cent for the total aged population.

Another substantial change, emerging over several decades, will be the rising representation of elders of Asian origins, which will diversify ethno-specific needs in aged care (Andrews 2002: 4–5). In 2001, Australia had seven overseas-born groups from non-English-speaking countries whose numbers aged 65 and over exceeded 20 000 (ABS 2003: 112–13). The largest groups were from Italy, Poland, Germany, the former Yugoslavia, Greece, the Netherlands and China. By 2026, population projections indicate that there will be 16 such groups, six of which will be from Asian countries (Vietnam, China, Philippines, India, Malaysia and Sri Lanka) (Gibson et al. 2001: 4–5). A particular feature of Australia's immigrant population, however, is the representation of around 200 different birthplaces and languages (DIMIA 2005), which

reates diversity far beyond that implied in any count of the largest roups. Accordingly, recognition of ethnic diversity and adaptability to aried changes will be important prerequisites for effective responses to he ongoing procession of former immigrants into older age groups.

Overseas-born populations typically have relatively high percentages in he older ages, mainly because their locally born children and grandchildren re counted as part of the Australian-born population. Birthplace, however, s an inaccurate measure of cultural ties, such as when the Australian-born ons and daughters of immigrants identify with their parents' origins, or hen religious or regional affiliations take precedence. Identification with people' or 'nation' (Greek *ethnos*) is an essential characteristic of a person's thnicity, but more specific definitions of ethnicity are problematic. This eflects that ethnicity is multidimensional and includes culture, language, irthplace and religion as well as other dimensions, although 'culture' s sometimes taken to subsume all of these. Australian policy-makers in he field of ageing have mostly preferred not to define ethnicity but, in ociology, self-identification is the preferred approach to defining ethnicity, ince it denotes a sense of belonging. Complications arise when people of ixed descent have dual or multiple ethnicities, or identify with different roups in different circumstances. Also, it has been argued that the concept f ethnic 'community' too can be problematic, since a high proportion of ormer immigrants from non-English-speaking backgrounds have little or o contact with organisations of people who speak the same language, whether through choice, lack of time, or geographical isolation (Deasey 988: 42).

For social policies, the ageing of people from diverse cultural nd linguistic backgrounds is a particular concern because they are ecognised as a 'special needs' group requiring culturally appropriate ervice provision and accommodation (Department of Health and Family ervices 1995; Minister for Ageing 2005: 19). Accordingly, this chapter ives particular attention to special needs, their nature, prevalence and ssociated policy and program responses. The chapter also discusses the mportance of including the ethnic aged in mainstream policy provision, uch as that concerning healthy ageing, and the desirability of future olicy directions towards fostering social capital-building and personal utonomy. Multiculturalism and policy-related concepts from ethno-erontology provide the setting for the chapter as a whole.

The setting

Australia's principal contemporary response to the presence of settlers from diverse backgrounds is the policy of multiculturalism, the emergence of which heralded the beginning of social policies for the ethnic aged. Governments have redefined community relations in Australia at different times, in light of changing perceptions of the essential bases of national unity and social justice. Expectations that settlers should and could assimilate – that is, become absorbed into the host population – were predominant from Federation until the early 1970s, when integration, a blending of cultures, became the official policy. Multiculturalism followed soon after, in 1973, as the official policy, but has itself undergone rethinking and modification since then (Borowski 2000).

In aged care policy, the assimilationist model and the dominance of people of Anglo-Celtic origins in the older ages formerly overshadowed other priorities. By the 1970s, both of these obstacles to public recognition of ethnic ageing were receding. Large cohorts of settlers from Europe were then entering the older ages and the proportion of the total aged population born in non-English-speaking countries was rising, probably passing 10 per cent in 1986 and 20 per cent in 2001 (Borowski 1985; Rowland 1991: 18; Gibson et al. 2001: 4).

Multiculturalism is a key point of reference, given its importance as an ideology underpinning policies to ensure equitable approaches to aged care. Multiculturalism recognises the rights of groups to preserve their own cultures in Australia. It further implies equal access to programs and services, as well as entitlement to special provision where necessary. However, when describing the characteristics of the population, the concept of multiculturalism has the potential to create exaggerated impressions of ethnic pluralism and cultural maintenance. Living in Australia has made older settlers different from their peers who stayed in the country of birth, and different from each other because of their varied experiences. Many are well integrated into Australian society: they speak English, they identify with their Australian-born offspring – among whom marriage outside the ethnic group is common – and they value participation in the structures and organisations of Australian society. As a descriptive concept, multiculturalism is relevant only in the

popular sense of denoting cultural diversity. Its stricter meaning of a pluralist society (Lewins 1988) does not adequately represent the nature of the ethnic aged population in which processes of mixing and change are influential.

Coinciding with the beginnings of multiculturalism was a period in which overseas theories of ethnic ageing were background influences in Australia. Developed predominantly in the United States, the main theories describing and explaining the circumstances of ethnic aged population, as well as providing guidance for policy-making, were 'double jeopardy' and 'institutional discrimination'. Double jeopardy has been one of the best-known theoretical perspectives to emerge from the study of ethnicity and ageing. It postulates that occupying two stigmatised statuses brings more negative consequences than occupying either status alone (Chappell & Havens 1980: 157). The expectation is that being old and a member of a disadvantaged ethnic group has more adverse effects than being younger, or being an older member of the majority population (Coon 1986). An opposing perspective is the 'age-as-leveller hypothesis', according to which ageing reduces the relative social and economic distinctions between ethnic groups (eds Gelfand & Barresi 1987: 10–11). Both hypotheses, however, are oversimplifications since vulnerability, or 'jeopardy', is multidimensional; focusing on age and ethnicity may cause neglect of additional sources of variation, such as gender inequality.

'Institutional discrimination' focused not on the characteristics of the aged, but on policies themselves, referring to inequalities resulting from policies and practices of institutions (Palmore & Manton 1973: 364). For example, in the past, social policies in the United States generally considered the aged to be white, English-speaking and relatively well educated, which either denied access to minorities or confronted them with culturally insensitive programs (Bengtson 1979: 13). This reflected differences between bureaucratic perceptions of needs and those of the minority groups themselves (Meyers 1980: 73). The policy of assimilation in Australia gave grounds for claims about institutional discrimination as growth occurred in the non-Anglo-Celtic component of the overseas-born population, but such concerns began to recede with the adoption of more enlightened approaches. For similar reasons, interest in double

jeopardy has waned and there is less concern for conscious attempts to construct theories to underpin 'ethno-gerontology' as a distinctive field. Instead, ethnic disadvantage seems to be more commonly considered now with reference to the influence of social inequality and cultural differences.

Special needs

The significance of ethnicity in ageing arises from the benefits to quality of life of being able to maintain continuity with life patterns established at younger ages (Holzberg 1982: 253; Gelfand, 1982: 41). Thus, in the first instance, special needs originate from the importance to the ethnic aged of their distinctive cultural and social circumstances and associated incompatibilities with attitudes and expectations that influence the provision of mainstream care. The ethnic aged have been considered a special needs group in aged care since the 1980s, and are identified as such in the *Aged Care Act 1977*. They are one of the largest special needs groups. Specific policies and programs seek to enhance their access to aged care services, as well as build capacity for aged care providers to deliver culturally appropriate care (Department of Health and Ageing 2005). The many cultural factors thought to be significant to the ethnic aged include language and communication, religious observance, support systems, dietary needs and preferences, roles within the family, values, traditions and norms. However, progress towards the development of a culturally relevant theoretical framework for the study of ageing (see box 5.1) is thought to have been impeded on account of the greater emphasis given to social inequality (Torres 1999). Indeed, the prominence of social inequality probably reflects a degree of scepticism about the relevance of culture as a consideration in planning, because its influence can vary by age, gender, class, level of education, and urban or rural background (Deasey 1988: 42).

Discussions of special needs sometimes take for granted that the population 'at risk' is equivalent to the total numbers born in non-English-speaking countries. Population size necessarily makes the ethnic aged a major interest group in planning and policy development, but total numbers cannot be equated with the population at risk of having

Box 5.1 Culture and ageing

There has been little progress towards the development of theories concerned with culture and ageing, but Torres' (1999) ideas about culture and successful ageing illustrate possible directions, as well as the complexity of the task. She emphasised that in order to understand ageing in ethnic minorities, it is necessary to be informed about the specific culture – its distinctive way of life, beliefs, values and shared meanings. For example, ease of adaptation after migration depends on the fit between the immigrants' value orientations and that inherent in the culture of the host society. Also, to Americans, self-perceptions of being 'optimistic, courageous and motivated' signify successful ageing, whereas to the Chinese aged it resides in others thinking of them as 'tolerant and easy-going'. Torres argued that the way social groups perceive successful ageing depends on their value system and it is misleading to interpret the perceptions of one culture according to the values of another. In light of this, Torres proposed a theoretical framework for investigating successful ageing through understanding differences in value orientations, as illustrated in figure 5.1.

Figure 5.1 Torres' value orientation approach to the study of successful ageing

Understanding of successful ageing

Value orientations regarding ...

Human nature

Whether the innate character of human nature is thought to be predominantly good, evil or a combination of the two

Man-nature

Whether man wants to surrender to, live in harmony with, or master nature

Relations

Whether a culture orients itself in terms of its past, present or future

Time

Whether the modality of a culture is predominantly characteristic of being, being-in-becoming or doing

Activity

Whether linearity, collaterality or individuality is the preferred type of relation that man has to others.

The foundations of value orientations

(Political, economic and religious systems)

SOURCE Adapted from Torres 1999: 43, 45

ethno-specific needs in aged care at some time in their lives. This is partly because ethno-specific needs can be related to socioeconomic position and the extent of integration into the host society. Special needs in home and community care are likely to be especially pronounced among those with poor knowledge of English and low engagement with the wider community. Special needs in nursing home care are further related to having severe or profound disabling illnesses and conditions that, fortunately, the majority of people seem to avoid. For the Australian population as a whole, estimates suggest that only about a quarter of men and a third of women will ever be admitted to a nursing home (Liu 1998: 12). Although such figures imply that many of the ethnic aged will never require the highest levels of support, the proportions ever needing hostel care and care at home will be greater.

Many characteristics enter into the assessment of vulnerability and special needs, but a first approximation of the numbers with different levels of risk can be obtained from Census statistics on duration of residence in Australia and proficiency in English, together with details of income and other characteristics. Based on 2001 Census data, table 5.2 provides estimates of the percentages of the ethnic aged in four groups differentiated according to their likelihood of ever having special needs in aged care. The table updates a more detailed analysis from the 1996 Census (Rowland 1999).

Table 5.2 *Groups of the ethnic aged according to recency of arrival and proficiency in English, 2001*[a]

Group	%
'More vulnerable' groups	
Group 1: New arrivals 1996–2001	3.5
Group 2: Settlers with little or no English[b]	26.7
'Less vulnerable' groups	
Group 3: Settlers with good English[b]	42.0
Group 4: Settlers who speak only English at home	22.0
Inadequately described[c]	5.9
Total born in non-English-speaking countries[d]	100.0

(a) Australian residents, aged 65 years and over in 2001, who were born in non-English-speaking countries. Includes persons in private and non-private dwellings, but excludes overseas visitors.

(b) Arrived before 1996; excludes persons who did not state their year of arrival.

(c) Persons who did not state their year of arrival and/or their proficiency in English.

(d) The Census sample figures did not permit an estimate of the total population from non-English-speaking countries, because some countries in aggregated regions, such as 'the Americas', could not be included. The raw figures referred to about 91 per cent of the ethnic aged. The numbers may also differ from complete Census figures because of sampling error.

SOURCE ABS 2001 Census, *Household Sample File* (1 per cent sample of Census returns). In accordance with the requirements of the ABS on the use of confidentialised unit record files, it is stated that the results or views expressed are those of the author, and not necessarily those of the ABS.

The more vulnerable ethnic aged consist of recent arrivals (Group 1) together with longer-established settlers who speak little or no English (Group 2 in table 5.2). Immigrants who move in their later years face particular difficulties in adapting to life in Australia and are sometimes unusually reliant on relatives for support. Nevertheless, the new arrivals were a small group comprising less than 4 per cent of the total ethnic aged in 2001 (Group 1 in table 5.2). Nearly two-thirds were from Asian countries, since family reunion migration has similar origins to recent migration waves. The immediate implications of their coming are minimal for aged care programs in Australia, but in the long run may generate the highest usage rates for ethno-specific services. This reflects a lesser likelihood of integration into mainstream society and often more limited personal resources for living independently. Close to

60 per cent spoke little or no English – a similar proportion spoke Asian languages at home – and 30 per cent had no income.

Far more numerous than the new arrivals were the others in the 'more vulnerable' category, namely, established settlers (arriving before 1996) who spoke English 'not well' or 'not at all' (Group 2 in table 5.2). Their numbers boosted the size of this category to 30 per cent of the ethnic aged population. Even after decades of residence in Australia, many settlers have learnt little English. This limits their ability to live independently in their later years and probably reinforces preferences for maintaining ethnic lifestyles. This second group is likely to be the main source of demand for ethno-specific aged care, because of their numbers and because they share the same vulnerabilities as the new arrivals, including low incomes. In 2001, 62 per cent of them received individual weekly incomes of less than $200 and more of them were living alone or in institutions. It is also notable that southern Europe and Asia were their main birthplaces. Whereas around 30 per cent of the total ethnic aged in 2001 did not speak English well, the figure for all older settlers from Italy and Greece was 43 per cent, while for those from Asia it was 48 per cent. Overall, at the 2001 Census, there were 141 587 overseas-born residents, aged 65 and over, who spoke English 'not well' or 'not at all'; 60 per cent of them were women (ABS 2003).

The other two groups – comprising the 'less vulnerable' category – had good proficiency in English. English language skills in the client population lessen the need for special staffing in aged care services and facilities. This does not mean that ethnic culture is unimportant among those proficient in English, only that communication with clients and provision of care confronts fewer difficulties. Where there are no language barriers, many aspects of care are less complicated, including: obtaining support, engaging in conversation, satisfying dietary choices, recognising religious observances, facilitating medical consultations and responding to cultural preferences regarding activities, entertainment and décor. Beyond this, English language skills are sometimes associated with other characteristics that denote greater integration into Australian society as well as greater relevance of mainstream care.

Within the less vulnerable category, it is appropriate to distinguish between a third group who speak English well, but use another language

at home – mainly European languages – and a fourth group who speak only English at home (see table 5.2). Both had characteristics more similar to those of the Australian aged generally as well as relatively high levels of home ownership (Rowland 1999). Nevertheless, many members of Group 3 might prefer some degree of ethno-specific support and accommodation if the need for care arose. The large numbers in Group 3 from countries, such as Germany, Italy and Greece, gives enhanced opportunities for support from their own ethnic community that may be unavailable to smaller communities. The least probable candidates for special provision are the fourth group, comprising settlers who speak only English at home. This characteristic, however, undoubtedly disguises a range of differences. Some arrived as children, some had an English-speaking mother and/or father, some married an English-speaking spouse, while others wish to use the language of their adopted country and that of their children and grandchildren.

Census data provide only a first approximation of 'the likelihood of special needs' in aged care at some point in time, but the figures illustrate that members of the ethnic aged population are not equally vulnerable. The great majority are in the less vulnerable groups. Not all of the ethnic aged could be placed in a group, however, because about 6 per cent of them did not indicate their year of arrival and/or their proficiency in English (see table 5.2). Heightened needs for ethno-specific support are particularly related to adverse life events – especially widowhood, serious illnesses and the onset of disabilities. Even for some in the currently 'less vulnerable' groups, such support may be particularly welcome in certain circumstances, such as if language regression, mental impairments or profound disabilities intervene. Finally, it should not be overlooked that the ethnic aged have many similarities with the rest of the aged population: most prefer to remain in their own homes with outside help if they become dependent (Kendig 1986: 20); their reliance on spouses for support, followed by children and other family, parallels the general pattern of family support for the aged; and when faced with long-term disabilities most want dignity and autonomy without undue dependence on their offspring (Jakubowicz 1989: 450–52).

Policies

The implementation of the range of policies supporting the ethnic aged occurred relatively late and was greatly constrained by costs, the complexities of responding to diverse ethnic groups and insufficient knowledge about potential target populations and their needs. The mid-1980s brought official recognition in Australia 'that ethnic communities have enjoyed less than equitable access to services and facilities', and the government made a commitment 'to reducing the current service imbalance and to ensuring that general service programs meet their needs' (Ethnic Aged Working Party 1987: 1).

Care of the ethnic aged faces all of the issues in 'grey policy' generally, together with the complexities of supporting a clientele that is culturally and linguistically diverse, comprised of ethnic groups that vary greatly in size and spatial distribution, are continually changing in numbers and characteristics and, on a local scale, bring forth sudden shifts in demand for specialised services and support as individuals confront frailty, disabilities and illnesses. Yet the need has been not so much for new types of services, apart from translation and interpretation, but rather for cultural appropriateness in the provision of support. Providing culturally appropriate care in all cases requires a support system that is highly sensitive to small changes, highly flexible in funding arrangements in order to target specific needs, and highly competent in tailoring responses to individual requirements. These tasks are lessened where ethnic communities are large and spatially quite concentrated, but more fraught for recently arrived, smaller, dispersed and less cohesive groups, more so since the same groups usually lack experience in liaising with government to obtain assistance.

Australia's policies and programs have sought responsive and affordable approaches in this challenging environment. For individuals and families, the overarching goal should be to sustain wellbeing, while for communities and the whole society a prerequisite is that approaches should be economically and socially sustainable. Domiciliary support, through the Home and Community Care (HACC) program and Community Aged Care Packages, for example, serve the wishes of many to live at home for as long as possible, thereby contributing both to individual wellbeing and to national affordability of aged

care. Policy-makers have long sought an appropriate balance between 'mainstreaming' (that is, meeting needs through general programs and services for the whole community) and ethno-specific provision catering for the distinctive needs of groups in relation to matters such as language, meals, living environment, activities and pastoral care. In recognition of the diversity of approaches needed, Victoria now has three models of policy response – generic, ethno-specific and partnership – with the choice of model depending on the best outcome for the consumer. This is indicative of the diversity of approaches used nationally (Department of Health and Aged Care 1999: 8). Between 1996 and 1999, about 1800 places were allocated nationally for services for the ethnic aged (Podesta 2002: 4). The services include provision of day care, social support, community options, respite, home care, meals, personal care, visiting, carer support, information, outreach and advocacy (Department of Health and Aged Care 1999: 8–9).

There are also about 160 ethno-specific aged care homes covering 34 communities together with many 'clusters' of ethnic clients within mainstream aged care homes (Podesta 2002: 5). Formal support for smaller or geographically spread populations occurs chiefly within the mainstream aged care setting (Andrews 2002: 13), with 'clustering' providing a means of achieving culturally appropriate residential care (see box 5.2). On 30 June 2001, there were approximately 9000 aged permanent residents of nursing homes whose preferred language was not English (especially southern and eastern Europeans), together with only 173 respite residents (AIHW 2002: 41, 43).

The Department of Health and Aged Care described good service provision as: providing services that are sensitive to individual cultural needs, fostering consultation with ethnic communities and their participation in service development and delivery, accurate targeting and assessment, effective promotion of service availability, employment of culturally responsive staff, use and availability of language services, ongoing staff training, funding of diverse approaches to service provision, and accountability for outcomes (Department of Health and Aged Care 1999: 8). 'Grassroots' input from communities is essential in identifying issues and designing strategies to preserve or enhance the quality of life of the ethnic aged.

Box 5.2 Clustering

Clustering provides a basis for meeting ethno-specific needs for small numbers of the ethnic aged in mainstream nursing homes. The first cluster projects began in New South Wales and Western Australia in the late 1980s. At this time, clustering, together with the establishment of small-scale, ethno-specific residential facilities, became recommended ways of meeting needs of the frail and disabled aged from smaller and spatially dispersed ethnic communities (Ethnic Aged Working Party 1987: 71–72; Gregory 1991: 130). Clustering entails locating together a small number of clients with the same ethnic background so that culturally appropriate care can be provided. It offers advantages in terms of planning food, staffing, pastoral care, bilingual support, entertainment and visits to social clubs. Also, cross-cultural training is easier to accomplish for nursing homes with clusters, since it can be tailored to particular requirements. Future growth in the numbers of the frail ethnic aged will increase the need for such arrangements, while making them easier to accomplish. Implementing clustering programs also raises new issues, however, such as the shortage of bilingual staff and the need for higher funding in recognition of the greater time spent in communicating with non-English-speaking residents.

In 2002, there were 125 such clusters in residential care facilities in Australia; they each had at least three clients and covered 31 communities (Andrews 2002: 9). A training video, funded by the Commonwealth Department of Community Services and Health (1991) and entitled *A Home for All: Cultural Care in a Nursing Home*, provides valuable insight into the nature of a residential cluster.

Clustering has potential applications in other areas as well, such as respite care, education and recreation. For example, senior citizens centres could run 'ethnic days' for small numbers of people from particular groups, while cluster groups for English language classes are more economical than home tutoring. The viability of clustering as a planning concept deserves to be explored further, examining its acceptability, advantages and disadvantages in a range of settings.

A basis for improving the ethnic aged's access to services is the Commonwealth's Ethnic Aged Care Framework. This 'seeks to improve partnerships between aged care providers, culturally and linguistically diverse communities and the Department of Health and Ageing and ensure that the special needs of older people from culturally and linguistically diverse backgrounds are identified and addressed' (Senate Community Affairs References Committee 2005: 134). The Framework fosters a range of initiatives, including information and resource development, encouragement of best practice, improvements in choice and access to aged care services, and culturally sensitive assessment of aged care needs (Andrews 2002: 10). Elements of the Framework have been the Partners in Culturally Appropriate Care (PICAC) program, established in 1997, and the Ethnic Aged Services Grants (EASG). The latter operated from 1992 until the end of 2004, providing funding to specific communities to identify and reduce barriers in accessing aged care services (Department of Health and Ageing 2005).

PICAC provides funding for eight organisations, one in each state and territory, to work with aged care providers and ethnic communities to improve choice and participation in the use of services, identification of special needs, dissemination of information among the aged care industry about high-quality culturally appropriate care practices, and provision of training and resources. PICAC–Victoria, for example, has produced the 'Cultural Diversity Resource Kit for Residential and Community Aged Care Based Services'. This is a directory of information to assist service providers in responding to needs in culturally appropriate ways (Partners in Culturally Appropriate Care, Victoria 2004).

Concerns

Despite progress, criticisms of the effectiveness of ethnic aged care have continued. One persistent concern has been the apparent under-representation of the ethnic aged among the clientele of community services and residential care. In 2001, 19 per cent of people aged 70 and over were from a non-English-speaking background, but only 7.1 per cent of people in residential aged care had such origins (NSW Council of Social Service 2004: 8). In 2004, only 9 per cent of HACC

clients were people who spoke a language other than English at home (Senate Community Affairs References Committee 2005: 157). Under-representation is commonly perceived as evidence of unmet needs, cultural inappropriateness, preferences for family care and the better ability of more socially advantaged people to access formal sources of support. Some alternative explanations are becoming less relevant. One is the observation that overall demand might be expected to be lower because the age distribution of the ethnic aged is somewhat younger than that of the Australian-born aged – increasing flows over time into the young-old ages have kept the numbers in such ages relatively high. Yet, by 2001, age structure convergence was mounting: an estimated 18 per cent of the ethnic aged were more than 80 years old, compared with 26 per cent for the Australian-born (Gibson et al. 2001: 4–5). Another suggested reason for lower service usage is the health selectivity of migration (Andrews 2002: 7). This occurs through self-selection and screening at the time of migration, and can be reinforced through some healthy lifestyle practices, such as the 'Mediterranean diet'. Nevertheless, the question of whether the ethnic aged have better or worse health has long been open to conflicting interpretations (Rowland 1997: 84); recent evidence suggests that they have poorer health and a greater need for assistance (Benham & Gibson 2000: 69–75).

Negative factors curtailing the use of aged care include cultural inappropriateness, lack of paid staff and volunteers proficient in the community language, lack of access to information about services, and unavailability of needed services in particular locations – such as for shopping, housekeeping, meals and respite care. Similar factors affect access to residential care. The usage of permanent residential care by the non-English-speaking aged is substantially below that of the English-speaking aged, a situation indicative either of poor access to appropriate support or of reluctance to use it. For example, in 2001, at ages 75–79 and 85 and over, the usage rates of residential care by non-English-speaking people were less than half those of non-English speakers (see table 5.3).

Preferences for family support potentially lead to adverse consequences for the aged and their families. Such preferences can arise from culturally based expectations about family roles and responsibilities, especially the caring role of women. Lack of income and assets also limit the option of

Table 5.3 *Age and sex-specific usage rates (per 1000) for permanent residential care by English-speaking status, 2001*

Age	Non-English-speaking			English-speaking		
	Females	Males	Persons	Females	Males	Persons
50–64	0.5	0.5	0.5	1.8	1.9	1.9
65–74	4.9	3.8	4.3	12.4	11.9	12.2
75–84	32.0	18.7	25.9	74.1	45.5	62.4
85+	140.2	74.2	114.6	322.0	180.6	279.4

SOURCE AIHW 2002: 50

purchasing accommodation in a retirement village and accessing higher levels of care in a similar environment if needed. Yet, preferences for family care probably contribute to a solid uptake of Community Aged Care Packages (CACPs) in the ethnic aged population, a sign that some of the burden is being shared. The ethnic aged receive around 23 per cent of the CACPs, of which a total of nearly 29 000 were funded at 30 June 2004 (NSW Council of Social Service 2004: 8; Minister for Ageing 2005: ix).

Further concerns came to light in a national stocktake of HACC policy and service provision for people with a diverse cultural and linguistic background (Department of Health and Aged Care 1999: 1–4), as well as later in submissions to a Senate inquiry (Senate Community Affairs References Committee 2005: 157). These included: (1) rising demand for HACC services among the ethnic aged; (2) inadequate access to services, partly because policies lack clarity about the roles and responsibilities of the Commonwealth, the states, mainstream organisations and ethnic organisations; (3) insufficient skills and training for effective provision of services to the ethnic aged with many, or most, generic mainstream providers having difficulties in responding to this rapidly growing client group; (4) lack of HACC standards or indicators enabling comprehensive measurement of outcomes for ethnic aged clients; (5) lack of cost-effective and efficient language services; (6) insufficient funding of ethno-specific social support and in-home respite programs; (7) insufficient data collection and reporting.

Clearly, the number of concerns is considerable and will require varied responses. A way forward is to provide a substantial increase in funding for special needs groups, as recommended in the report on Quality and Equity in Aged Care (Senate Community Affairs References Committee 2005: 159).

The future

Awareness of concerns about current policies and programs is vital for future progress, but so too is debate about the potential for alternative approaches. An inherent disadvantage of current policies for the ethnic aged is their emphasis on dependency and special needs rather than fostering independence and the overall sustainability of population ageing. Continuing growth in the numbers of the ethnic aged will make these increasingly important considerations in the future. An initial framework for identifying future strategies here focuses on needs and responses for four levels at which policy interventions may be targeted, namely, the society, communities, families and individuals. Initiatives supporting the welfare of the ethnic aged, as well as that of the population generally, need to be taken at different scales, since there are necessarily varying priorities and approaches for each.

As noted earlier, at the level of the whole society, Australia's current main policy response to the presence of settlers with diverse backgrounds is multiculturalism. Other society-level policies, however, are as important to the welfare of the present and future ethnic aged as to the population at large, such as healthy ageing. A focus on culture-specific needs can divert attention from more general prerequisites for sustaining individual wellbeing and reducing the social and economic costs of individual and population ageing. For example, practices that can prevent or delay ill health need to be better known, such as where unhealthy aspects of traditional diets place people at heightened risk of disease and early mortality. Thus, in securing the welfare of former migrants, implications for ethnic communities of mainstream national policies warrant equal prominence with culture-specific concerns.

While national-level policy-making aims to meet the greatest needs of the greatest numbers, it is at the community level – be it the ethnic community or a spatially defined community such as a town or

municipality – that the consequences of ageing are most immediate and are necessarily part of everyday concerns for families, local residents, service providers, planners and administrators. The community is the level at which many of the consequences of individual and population ageing become prominent and it is the main level at which national policies are implemented, such as the provision of HACC services and residential care. This being so, there is scope for policies to seek to support communities in order to lessen adverse consequences of ageing and bolster local resources for responding to it. In relation to community resources, there has been rising interest in social capital.

Social capital, a concept subject to a wide range of interpretations, is used here in the sense of 'networks, together with shared norms, values and understandings which facilitate cooperation within or among groups' (OECD 2001, cited in ABS 2002b: 4). For individuals, social capital consists of 'the resources that emerge from one's social ties' (cited by Astone 2003: 901). The OECD definition is currently influential in the design of data collections on social capital both within Australia and internationally (ABS 2002b: 4).

The importance of social capital resides in its recognition of networks and relationships as a resource (Field 2003: 40). Social capital is an explanatory factor in migration itself because social networks provide linkages between origins and destinations and the movement of individuals and families is facilitated through their membership of such networks (Massey 2003: 550). Similarly, participation in ethnic groups and networks in Australia helps some to avoid social isolation, to experience the social and health benefits of social engagement, and to obtain additional and compatible forms of assistance when needed. Conspicuous manifestations of social capital in ethnic communities are initiatives in developing retirement and aged care facilities for compatriots – undertakings requiring not only active participation in a community life but also civic-mindedness to work towards collective goals. Volunteering to visit compatriots and assist in other ways are also manifestations of a community's social capital.

In the social policy field, social capital is seen as having potential to reduce expenditure on social problems, encourage cooperation and trust, and enhance quality of life. It assists in explaining why communities with similar resources may diverge in terms of social

cohesion, initiative, mutual support and adaptability to change. Although causal links are difficult to confirm, social capital in the form of social and civic engagement and cooperation appears to bestow advantages of wellbeing and resilience on communities, as well as on individuals. Some go so far as to say that 'social capital is the most fundamental resource a community requires in the creation of economic, social and political wellbeing' (Winter 2000: 9). For the ethnic aged, it represents a promising avenue for policy development in the future. Recognition of positive, as well as negative, consequences of group membership are important for understanding ethnic minority ageing, discerning lessons relevant to the wider society, and formulating culturally appropriate interventions. As Field stated:

> ... people's ability to access resources through their social capital can make a considerable difference to their life chances. In so far as the state is expected to intervene in the distribution of resources more generally, in areas such as health or education, social capital represents a tool of policy. In so far as social capital can itself be seen as a public good, it represents a goal of policy. Policies which promote social capital can therefore directly influence the well-being of the wider community. (Field 2003: 121)

Thus, the community is not merely the context in which aged care policies are implemented. It is also a domain in which there is scope for initiatives that can enhance social resources, promote independent and co-dependent living and lessen the need for aged care.

As 'the fundamental group unit of society' the family is also an important component of people's social capital; most people belong to a family network, and participation in family life is a major source of life satisfaction. Policies that support family life – including public endorsement of the value of the family to society and the need for employers to recognise the significance of family roles and responsibilities – may support welfare generally, contributing to life-long benefits. Opposite tendencies, however, including never marrying, separation, divorce and childlessness, are eroding the potential of the family to maintain its vital supportive role in later life as well as in younger years (Rowland 2003).

For the ethnic aged, the greater prevalence of co-residence of the aged and their relatives (Benham & Gibson 2000: 23) and preferences

for family care make policies that support family roles more than usually important. In particular, support for the carers of the ethnic aged, and provision of services that support the frail and disabled aged at home, are essential components of the range of policies with impacts at the family level. While the family resources of the ethnic aged are currently relatively favourable because of a greater prevalence of intact marriages (Benham & Gibson 2000: 23), investment in sustaining family life and family stability in younger generations will benefit the family support networks of the present and future ethnic aged. Finally, although the family is a significant form of social capital for the ethnic aged, the extra burdens on family members due to gender inequality and social inequality in some ethnic communities deserve particular attention.

The final level at which social policies can impact is the level of the individual. Just as policies enhancing social capital offer practical benefits for communities and families, so too may enhancement of human capital benefit individuals; both have potential to contribute to improving wellbeing and preventing or delaying aged dependency. Social capital and human capital are commonly thought to be complementary and mutually advantageous (Field 2003: 9). Whereas social capital arises from people's interrelationships with others, in families, groups and networks, human capital arises from characteristics of the individual. During the 1960s, Becker developed the concept of human capital in economics to denote the economic value – to individuals, firms and the general public – of skills, knowledge and good health (Field 2003: 9). In relation to older people, economic value is one aspect of human capital – especially in relation to voluntary work and productive activities – but important also is human capital conducive to independent living. For the aged generally, the latter includes education and health, both of which are associated with higher levels of social engagement and wellbeing. In relation to the ethnic aged, it may be argued that human capital further includes proficiency in English and knowledge of Australian society, since these enhance opportunities for independent living and social participation. For ethnic communities, the fostering of human capital earlier in life, such as through English language classes, has benefits in enhancing autonomy and functioning in later years. Similarly, the

promotion of healthy lifestyles can be viewed as part of human capital development that benefits individuals.

Conclusion

Some directions for future policy development, and the potential for innovation, might be approached through considering four domains in which policies impact. Associated concepts of social capital and human capital suggest a broad view of relevant concerns beyond culture and special needs. Some emphasis on the means of enhancing the resources of communities, families and individuals could lessen the personal, social and economic costs of ageing in the future for ethnic minority populations, as well as for Australia's population generally.

The ethnic aged population has such a varied mix of characteristics that they cannot be regarded as a single group in relation to issues of ageing and aged care. Ethnicity and ageing is a complex field for social policy, entailing support for a diverse and changing ethnic population in addition to all of the issues and concerns in aged care generally. At any point in time, the numbers requiring aged care are but a small proportion of the total ethnic aged population. Whether the numbers receiving ethno-specific care match the numbers requiring it is always uncertain because needs are diverse and difficult to measure. Yet, given the adverse consequences for individuals and families of culturally inappropriate care, from an individual welfare perspective it is better to err on the side of a small oversupply of services and facilities. Otherwise, there will inevitably be harmful shortfalls as demand fluctuates.

In forecasting the demand for services and aged care, projections for the total ethnic aged population are but a general starting point. The most useful refinement would be projections of potential client populations in ethnic groups, as may be developed from Censuses and surveys (Rowland 2006). The issues of measuring need and unmet need are difficult to address; a practical approach is to develop indicators of disability levels and vulnerability to having special needs. Unmet need is a problem in aged care generally, partly because of budgetary constraints and partly because planning has to contend with anticipating demand within very many local areas and allowing adequate lead time in building

accommodation, recruiting and training staff, establishing services and providing information to the public.

Progress in understanding and responding to care issues in ethnic ageing has been particularly due to the period of intensive activity in research and policy and program development during the late 1980s and early 1990s. Continuation of this effort is evident in many reports originating from state, territory and Commonwealth government departments (see Department of Health and Aged Care 1999: 27–29) as well as from the Australian Institute of Health and Welfare. Yet, the overall intensity of research activity in this field seems to have diminished, not least because of the decline in funding designated specifically for research on immigration and related issues following the demise of the Bureau of Immigration, Multicultural and Population Research (BIMPR) in 1996. This has raised the prospect of a mounting deficit in knowledge, despite the growing importance of population ageing as a trend affecting Australia's future, the changing ethnic composition of Australia's immigration intake, and the need for innovation in approaches to minimising adverse consequences of individual and population ageing. Current policy-related research issues on ethnicity and ageing include: the present and future size and composition of the aged care clientele, the role of the family in aged care, factors increasing or decreasing the need for ethno-specific care, the reasons for the under-representation of the ethnic aged in residential care, the role of social and human capital formation in delaying or preventing dependency, factors conducive to client satisfaction with ethno-specific care, the significance of ethno-specific support in dementia care, and approaches to maintaining efficiency in service provision for diverse and changing local area populations. Australia has entered a time of unprecedented growth in the numbers of its aged from diverse cultural and linguistic backgrounds; it is important that this also be a time of sustained research activity on ethnicity and ageing.

References

Andrews, K (2002) Culturally Appropriate Care in the New Millennium, Address by the Minister for Ageing to the Summit on the Provision of Culturally Sensitive Aged Care, Australian Multicultural Foundation, Melbourne.

Astone, NM (2003) Social Capital. In P Demeny & G McNicoll (eds) *Encyclopedia of Population*, Macmillan Reference, New York, pp. 901–03.

Australian Bureau of Statistics (ABS) (2002a) *Births, 2001* (Cat. no. 3301.0), Australian Bureau of Statistics, Canberra.

—— (ABS) (2002b) *Social Capital and Social Wellbeing: Discussion Paper*, Australian Bureau of Statistics, Canberra.

—— (ABS) (2003) *Migration, 2000–01 and 2001–02* (Cat. no. 3412.0), Australian Bureau of Statistics, Canberra.

Australian Institute of Health and Welfare (AIHW) (2002) *Residential Aged Care Services in Australia 2000–01: A Statistical Overview* (AIHW Cat. no. AGE 22; Aged Care Statistics Series no. 11), Australian Institute of Health and Welfare, Canberra.

Bengtson, VL (1979) Ethnicity and Ageing: Problems and Issues in Current Social Science Inquiry. In DE Gelfand & AJ Kutzik (eds) *Ethnicity and Ageing: Theory, Research and Policy*, Springer Publishing Company, New York, pp. 9–31.

Benham, C & Gibson, D (2000) *Independence in Ageing: The Social and Financial Circumstances of Older Overseas-Born Australians* (AIHW Cat. no. AGE 15), Australian Institute of Health and Welfare, Canberra.

Borowski, A (1985) Review essay of *Ageing in a Multicultural Society: The Situation of Migrants from Non-English-Speaking Countries* by the Australian Institute of Multicultural Affairs, *Australian Journal on Ageing*, 4(4): 25–27.

—— (2000) Creating a Virtuous Society: Immigration and Australia's Policies of Multiculturalism, *Journal of Social Policy*, 29(3): 459–75.

Chappell, RL & Havens, B (1980) Old and Female: Testing the Double Jeopardy Hypothesis, *Sociological Quarterly*, 21(2): 157–71.

Coon, R (1986) A Theoretical Examination of Double Jeopardy: Using Theory as Guide to Concept Analysis, *Mid-American Review of Sociology*, 11(1): 67–90.

Deasey, M (1988) *Home and Community Care in a Multicultural Society: A Training Package for Direct Care Staff, Supervisors and Planners in HACC Services in Victoria*, Ecumenical Migration Centre, Melbourne.

Department of Health and Aged Care (1999) *Report on the National Stocktake of HACC Policy and Service Provision for People with a Diverse Cultural and Linguistic Background*, HACC Outcomes Section, Department of Health and Aged Care, Canberra.

Department of Health and Ageing (2005) *Partners in Culturally Appropriate Care (PICAC)*, Department of Health and Ageing, Canberra, <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-specneed-picac.htm>.

Department of Health and Family Services (1995) *The Ethnic Older Persons Strategy: Meeting the Care Needs of Frail Older People from Non-English Speaking Backgrounds*, Australian Government Publishing Service, Canberra.

Department of Immigration, Multicultural and Indigenous Affairs (DIMIA) (2005) *Australia the Country: Facts about Australia*, <http://www.immi.gov.au/settle/states/aust_the_cntry.htm>.

Ethnic Aged Working Party (1987) *Strategies for Change: Report of the Ethnic Aged Working Party*, Australian Government Publishing Service, Canberra.

Field, J (2003) *Social Capital*, Routledge, New York.

Gelfand, DE (1982) *Ageing: The Ethnic Factor*, Little, Brown & Company, Boston.

Gelfand, DE & Barresi, CM (eds) (1987) *Ethnic Dimensions of Aging*, Springer Publishing Company, New York.

Gibson D, Braun P, Benham C & Mason F (2001) *Projections of Older Immigrants: People from Culturally and Linguistically Diverse Backgrounds, Australia 1996–2026* (AIHW Cat. no. AGE 18, Aged Care Series no. 6), Australia Institute of Health and Welfare, Canberra.

Gregory, R (chairman) (1991) *Aged Care Reform Strategy: Mid-Term Review, 1990–91, Report*, Australian Government Publishing Service, Canberra.

Holzberg, C (1982) Ethnicity and Ageing: Anthropological Perspectives on More than Just the

Minority Elderly, *The Gerontologist*, 22(3): 249–57.

Jakubowicz, A (1989) Community Care and the Needs of the Ethnic Aged, *Advances in Behavioural Medicine*, 6: 435–59.

Kendig, HL (1986) Informal Support Networks. In Australian Institute of Multicultural Affairs, *Community and Institutional Support for Aged Migrants in Australia: Research Findings*, Australian Institute of Multicultural Affairs, Melbourne, pp. 16–52.

Lewins, F (1988) Assimilation and Integration. In J Jupp, (ed.) *The Australian People: An Encyclopaedia of the Nation, Its People and Their Origins*, Angus & Robertson, Sydney, pp. 856–60.

Liu, Z (1998) *The Probability of Nursing Home Use Over a Lifetime* (Australian Institute of Health and Welfare Working Paper no. 16), Australian Institute of Health and Welfare, Canberra.

Massey, DS (2003) International Migration. In P Demeny & G McNicoll (eds) *Encyclopaedia of Population*, Macmillan Reference, New York, pp. 548–53.

Meyers, AR (1980) Ethnicity and Aging: Public Policy and Ethnic Differences in Aging and Old Age. In EW Markson & G Batra (eds) *Public Policies for an Aging Population*, Lexington Books, Toronto, pp. 61–79.

Minister for Ageing (2005) *Report on the Operation of the Aged Care Act 1997*, Department of Health and Ageing, Canberra, <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-reports-acarep.htm>.

NSW Council of Social Service (NCOSS) (2004) *NSW Aged Care Alliance, Federal Election 2004 Issues Kit*, NSW Council of Social Service, Sydney.

Organisation for Economic Co-operation and Development (OECD) (2001) *The Wellbeing of Nations: The Role of Human and Social Capital, Education and Skills*, OECD Centre for Educational Research and Innovation, Paris.

Palmore, EB & Manton, K (1973) Ageism compared to racism and sexism, *Journal of Gerontology*, 28(3): 363–69.

Partners in Culturally Appropriate Care, Victoria (2004) *Cultural Diversity Resource Kit for Aged Care Residential and Community Based Services*, Benetas, Melbourne, <http://www.benetas.com.au/about_cultural.htm>.

Podesta, L (2002) *A Government Perspective*, Address to the Summit on the Provision of Culturally Sensitive Aged Care, Australian Multicultural Foundation, Melbourne.

Productivity Commission (2005) *Economic Implications of an Ageing Australia*, Productivity Commission, Canberra.

Rowland, DT (1991) *Pioneers Again: Immigrants and Ageing in Australia*, Australian Government Publishing Service, Canberra.

—— (1997) Ethnicity and Ageing. In A Borowski, S Encel & E Ozanne (eds) *Ageing and Social Policy in Australia*, Cambridge University Press, Cambridge, pp. 75–93.

—— (1999) The Ethnic Aged and the Likelihood of Special Needs, *Australasian Journal on Ageing*, 18(3, Supplement), pp. 50–54.

—— (2003) An Ageing Population: Emergence of a New Stage of Life? In S Khoo & P McDonald (eds) *The Transformation of Australia's Population 1970–2030*, UNSW Press, Sydney, pp. 238–65.

—— (2006) Ageing and the Future. In N Peters (ed.), *The Dutch: The Move Downunder 1606–2006*, Wolters Kluwer, Sydney, pp. 350–63.

Senate Community Affairs References Committee (2005) *Quality and Equity in Aged Care*, Commonwealth of Australia, Canberra, <http://www.aph.gov.au/senate/committee/clac_ctte/aged_care04/report/index.htm>.

Torres, S (1999) A Culturally-Relevant Theoretical Framework for the Study of Successful Ageing, *Ageing and Society*, 19: 33–51.

Winter, Ian (ed.) 2000 *Social Capital and Public Policy in Australia*, Australian Institute of Family Studies, Melbourne.