Joint Submission into Victorian Parliamentary Inquiry into the Support Needs for Older Victorians from Migrant and Refugee Backgrounds

By

The National Ageing Research Institute Ltd. (NARI) | Carers Victoria | Seniors Rights Victoria |Multicultural Centre for Women's Health (MCWH)

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Key recommendations

1. Reduce disparities in migrant and refugee communities by:
   1.1. Implementing initiatives that educate, upskill and support migrant and refugee family carers to ensure sustainable care relationships with older people.
   1.2. Implementing intergenerational programmes to increase older migrant and refugees digital literacy, noting their need to access equipment and stable internet connection.
2. Improve the system by:
   2.1. Enacting legislation and policy that support multi-lingual and culturally appropriate service delivery that recognises the impact of systemic inequality and the impacts of gender, race, and age discrimination, and the challenges of social isolation, language barriers, and cultural disconnection.
   2.2. Investing in care models that facilitate community-level integration of services (e.g. between family violence, elder abuse, and the variety of cultural groups and services in Victoria).
   2.3. Building capacity in the health, aged care, and community care sector on how to develop and adapt resources in order to deliver culturally and linguistically responsive services.
   2.4. Adequately upskilling, resourcing and embedding bilingual workers across health, aged care, and community care sectors.
   2.5. Engaging migrant and refugee communities, including older people and carers, in the co-design of services through active outreach and consultation by bicultural staff.
3. Improve data quality by:
   3.1. Improving the consistency of routinely collected data about older migrants and refugees. For example, collecting gender-disaggregated data and adopting relevant FECCA recommendations[1] on data collection.
   3.2. Investing in participatory research that uses co-design and co-production methods to increase the evidence-base for older migrant and refugee Victorian's health and wellbeing in Australia.

An increasingly ageing and multicultural nation

Australia is unique in being one of the most multicultural countries in the world, more so than the US, Canada, and New Zealand.[2] About 30% of Australians aged 65+ were born overseas, mainly in non-English speaking countries, and >24% speak a language other than English at home.[3] Demographic projections show that in coming decades the proportion of older migrant and refugee Australians will increase with the highest growth rates projected for the Asia-born populations (>200% growth).[4]

Structural burden

Australia's care systems are notoriously fragmented. Government subsidized care involves a confusing array of different programs and levels, bureaucratic applications, and long waiting times. Older people and their family carers' encounters with these systems can be often unproductive and increase distress. For migrants this is further amplified by cultural and linguistic minority status. Language barriers, cultural differences, and restrictive migration conditions increase the structural burden associated with engaging with the systems in ways not experienced by the Anglo-Australian majority. This makes it impractical and expensive for many new migrants to access suitable aged care for their parents in Australia, especially in the South Asian communities.[5]

Ethno-specific services and community organisations play an important role in integrating roles for older people from migrant and refugee backgrounds, and their carers to bridge divides between services, systems and cultures.[5,6] However, community supports are not equally distributed between different migrant groups, being strongest among migrant populations with longer histories in Australia (such as Chinese-, Greek-, and Italian-speakers).[4,7]

In order to improve the health and wellbeing of older migrant and refugee Victorians, there is a need to embed an intersectional framework to examine the impact of specific policy approaches on different groups of people including migrant and refugee women, migrant and refugee carers, and migrant and refugee people with disabilities. There is practical need for community-level integration of services and legislation and policy that supports multi-lingual and culturally appropriate provision of these services.[8]

Key issues

Carers

In migrant and refugee communities, the majority of care for older people is undertaken at home by family carers, especially women. Evidence from a two-year project called *Dealing With It Myself* conducted by MCWH demonstrates that migrant and refugee women carers, including older carers, faced unique challenges, including long-term financial vulnerability into old age, being more likely to engage in multiple caring/ intergenerational caring responsibilities, with lack of high quality, culturally appropriate and accessible support services.[9]

As highlighted by Carers Victoria in *Dealing With It Myself*,[9] while an older spouse within a couple might be recognised (by medical staff and Centrelink) as a primary carer, many older couples are co-dependent on each other and in turn dependent on their adult children, who take on a significant caring role because they are more confident in English and in navigating the health system. It is thus important that the care system adopt family centred practises that recognise shared care.

Caring is rewarding but also very challenging. For example, primary carers who communicate with an older Australian care recipient in a non-English language are 83% more likely to experience psychological distress compared to primary carers who communicate with the older care recipient in English (O.R=1.83).[10] Migrant and refugee family carers of people living with dementia experience more than double the rates of psychological distress compared to the Australian born (OR=2.45).[11] Research shows that older Greek and Italian communities experience higher rates of psychological distress than other migrant and refugee communities in the 65+ cohort.[12]

Some of the factors that predict psychological distress in primary carers of older migrant and refugee Australians include not speaking English at home (O.R=3.64), higher weekly income (OR=3.59), and higher self-rated health (OR=0.40).[10]

Alongside the physical and psychological distress associated with care, the provision of unpaid care also leads to loss of household productivity and income[13] and less opportunities to socialise. Carers aged 65+ are the least likely to engage in social and cultural activities outside their homes, which can increase social isolation and adversely affect mental health.[14] Caring is also highly gendered across all cultural contexts, and women are overwhelmingly meeting the demand for informal care. The *Dealing With It Myself*[9] report also showed that migrant and refugee carers experience high levels of social

isolation and loneliness and this presented a significant challenge for people, as they were also excluded from formal support services.

Therefore, Government needs to invest in community-led, culturally responsive initiatives that educate, upskill and support migrant and refugee carers to improve their mental health and well-being, and ensure care relationships are sustainable. Improving informal carers' skills and knowledge can reduce over-prescription of psychotropic medications, avoidable hospitalisation, and institutionalisation for care recipients.

Digital literacy

Digital technologies, such as animation and chat-bots, hold considerable potential to improve care because they are available 24/7, offer instant and consistent answers, promote participant engagement, and help to navigate services. Such technologies also overcome barriers of limited time, geographic isolation, and limited literacy. Via smartphones, tablet devices, and/or computers people can access information online, learn where to seek help, and how to provide care.[15]

More than 20 million Australians or 88% of the population already use the internet, often spending >40 hr/week online.[16] Rates of digital inclusion are even higher in *younger* migrant and refugee communities (2.8 points above the national average).[17]

Investment in initiatives to increase digital literacy among older migrant and refugee Australians has the added benefit of increasing health and financial literacy and reducing social isolation and loneliness. Intergenerational programs could help achieve such outcomes. However, such programs should be carefully implemented to minimise the risk of older people from migrant backgrounds being subject to online scams. Additionally, older people from migrant communities will need to be provided with resources to go online this includes not only the hardware (e.g. tablets, modems) but also accurate information in-language, and support for viable internet connection.

The COVID-19 pandemic showed that many services could be delivered online or over the phone, extending the geographic reach and sometimes increasing efficiencies by cutting out travel time for professionals. However, it is important to recognise that many older people, particularly those with any communication difficulties or low digital literacy, may struggle with online options. It is important that services are still resourced to conduct face-to-face services, particularly in instances such as giving legal advice where documents need to be viewed, and decision-making capacity assessed.

Data quality

Understanding of the issues facing older Victorians from migrant and refugee backgrounds relies on high-quality data collection. Unfortunately, the collection of cultural and linguistic information is inconsistently captured and reported across many Victorian services and agencies, and also omits important aspects of cultural diversity such as ancestry and ethnicity. This issue has been highlighted in the Victorian Family Violence Data Collection Framework in examining the collection of culturally and linguistically diverse (CALD) variables.[18] Similarly, the Victorian Admitted Episodes Dataset (VAED) and the Victorian Emergency Minimum Dataset (VAED) do not include any mandatory indicators about ethnicity, ancestry, and religion – all well-known influencers on older migrant and refugee peoples' healthcare use. It is also important that data is disaggregated by gender and other sociodemographic variables to ensure a more meaningful understanding of health inequity, and to develop evidence-based responses to issues.

Additionally, often family carers from migrant and refugee backgrounds do not identify as 'carers' on account of traditional ageing, family values and gender roles and are therefore likely to be 'hidden carers'.[19] Questions used in routine data collection should refer to definitions captured with the Victorian Carer Recognition Act 2012 and focus on care responsibilities.

Finally, we note the Federation of Ethnic Communities Council of Australia (FECCA)[1] recently listed 10 key recommendations to improve the national collection of data relating to cultural, ethnic and linguistic diversity. Adoption of relevant recommendations (see Box 1) will improve the standards of data collection in Victoria, particularly in mandating the collection of cultural, ethnic and linguistic diversity within administrative datasets.

Box 1: Relevant FECCA recommendations to improve data quality

1. The collection of data on cultural, ethnic and linguistic diversity should be nationally consistent, comparable and compatible, and apply the FAIR Data Principles.
2. Administrative data sets (including primary health care and general practice) should include appropriate measures of cultural, ethnic and linguistic diversity in order to inform evidence-based policy development, resource allocation and service planning. Only then can we ensure that services are accessible, inclusive, and responsive to the needs of all people in Australia.
3. In order to be representative of the Australian population as a whole, general population surveys should ensure that sampling methodologies and collected data are inclusive of people from culturally, ethnically and linguistically diverse backgrounds.
4. (a) Funding bodies for social and health research (including clinical trials) should require applicants to demonstrate how the proposed research will be inclusive of people from culturally, ethnically and linguistically diverse backgrounds so as to not compound health inequities.
   (b) Health, including disease onset and outcomes, and health risk factors and determinants are clearly patterned by ethnicity internationally, yet Australian data are severely lacking in this area. Australian data should include, where relevant, an indicator of ethnicity.
5. The Government should:
   (a) refresh its Multicultural Access and Equity Policy and include mandated cultural, ethnic and linguistic data collection requirements from Government departments and agencies.
   (b) establish a robust mechanism for oversight of implementation and reporting.
6. Consideration should be given to the feasibility and usefulness of introducing a self-identifier of culture and/or ethnicity similar to the Aboriginal and Torres Strait Islander self-identifier.
7. Consideration should be given to the feasibility and usefulness of introducing a variable relating to race/ethnicity, particularly in health and medical research.

Access to healthcare

Older people from migrant and refugee communities experience barriers to accessing essential healthcare services. Barriers include: lack of culturally and linguistically appropriate services, language barriers, mobility and transport difficulties, and lower socio-economic status.[20] In addition, preliminary findings reveal lower rates of primary health care utilisation amongst older migrant and refugee Australians when compared to older Australians born in Australia (IRR=0.94).[10] Significant barriers to accessing dental care have also been reported amongst larger migrant communities in Victoria[21-23] with gender, time lived in Australia, and health insurance coverage being significant predictors of barriers.[10]

To overcome these longstanding structural barriers, Government must ensure that services are affordable for everyone, regardless of visa category, build capacity in the health, aged care, and community care sector on how to culturally adapt resources in order to deliver culturally-appropriate services. Additionally, bilingual workers need to be adequately resourced and embedded across these sectors.

Elder abuse

Older people face multiple barriers to recognising elder abuse and accessing services to address the abuse they have experienced, including feelings of shame and stigma as well as fear of adverse consequences for the perpetrator.[24] These barriers can be even more challenging when the perpetrator is the older person's own child, as is common for clients of elder abuse services such as Seniors Rights Victoria.[25] Older people from refugee and migrant backgrounds, particularly those who do not speak English and those who have more recently arrived in Australia, will often have their children assisting them to access services and interpret information. For this reason, if the adult child is responsible for the abuse, the older person has even more limited options for accessing support. Additionally, older women are more likely to experience elder abuse, which suggests that gender is an important factor to consider.[25]

In order to ensure that older people from all cultures and ethnicities are properly supported, elder abuse services need to be resourced to provide culturally appropriate services that can be accessed in multiple ways and are not reliant on the involvement of younger family members, English-speakers or those with a high degree of digital literacy. There needs to be a commitment to face-to-face services, the provision of bilingual workers where possible, and the active building of relationships between family violence and elder abuse services with the variety of cultural groups and services in Victoria.

Who we are

The National Ageing Research Institute (NARI) is an independent research institute focused on translational research in ageing. A key focus of NARI's work is research with culturally and linguistically diverse (CALD) older people, conducted in partnership with communities, health professionals, and service providers.

Carers Victoria is a not-for-profit organisation that helps families and friends in our community who are caring for someone who needs support due to ageing, disability, mental illness, or other significant health issues. We are the state-wide peak body for all unpaid family and friend carers.

Seniors Rights Victoria (SRV) is a specialist community legal centre that works to prevent elder abuse and safeguard the rights, dignity and independence of older people. SRV operates under the principles of empowerment of older people, working with individuals to increase their degree of self-determination, enabling them to represent their own interests and claim their rights.

Multicultural Centre for Women's Health (MCWH) is a community-based, national organisation led by and for migrant and refugee women. MCWH provides tailored, responsive, accessible and equitable wellbeing programs for migrant and refugee women across Victoria. MCWH also delivers training for service providers, provides input into policy and builds capacity of employers, community service organisations, local councils and health services to adapt their programs to better respond to migrant and refugee women's needs.

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