

## Review Article

# Mainstream versus ethno-specific community aged care services: It's not an 'either or'

Harriet Radermacher, Susan Feldman and Colette Browning

Healthy Ageing Research Unit, Monash University, Victoria, Australia

*Approximately 16% of the Australian population speak a language other than English at home. Older people from culturally and linguistically diverse (CALD) backgrounds face many barriers to accessing services which may explain their under-utilisation of community aged care services. The aim of this review is to critique the literature related to the delivery of community aged care services to people from CALD backgrounds. The merits of a partnership model approach are highlighted, in addition to key points for future policy and planning. Understanding the complexities of delivering services to older people from CALD backgrounds is challenging, and requires a stronger empirical base.*

**Key words:** community aged care services, community-dwelling, ethnicity, health services for the aged, older people.

### Introduction

The ageing of populations is an important demographic phenomenon that has created significant challenges for many countries including Australia. In addition, Australia has the added challenge of a multicultural society with diverse health, policy, funding and service needs. In 2006, the number of all overseas-born Australians reached nearly five million, representing almost a quarter [22%] of the total population [1]. The proportion of people 65 years of age and over is greater among the overseas born population [17.7%] than for the Australian-born population [10.9%] [1], which reflects past immigration trends and policies.

Culturally and linguistically diverse (CALD) communities vary according to how and when individuals arrived in Australia, particularly in relation to specific immigration programs, or whether they arrived as refugees or skilled migrants. The older CALD community is a heterogeneous group, currently comprising people who came to Australia when they were young and have aged in Australia, as well as those people who have migrated in older age for reasons of family reunion or retirement [2]. Service development and delivery approaches for older migrants need to be responsive to these migration patterns and the consequent community and individual needs. Over the past 30 years, a number of important government and non-government documents addressing policy, funding and

service delivery strategies for CALD communities have been developed. These documents have guided strategies to reform the provision of community care within a multicultural framework.

Immigrants form the majority of Australia's population. Their numbers have been determined according to the evolving immigration policies over the last 200 years. Since the Second World War, the social consciousness of government has moved from assimilation, to integration and finally to multiculturalism [3]. Multiculturalism is now the prevailing policy direction, used by the governments to promote a society that values and celebrates diversity [4] which has, in many respects, paralleled international experiences [3].

The multicultural policy framework has resulted in the promotion of mainstream services as the best way to cater for the needs of CALD older people [5,6]. However, because of the plethora of ways in which the concept of multiculturalism has been interpreted, both mainstream and ethno-specific services have developed as a response to the ageing of CALD communities. This particular observation provides a critical context for the findings of this review.

There is a need to build upon current aged care policy to promote the development of more effective and efficient community and aged care services for people from CALD backgrounds. The Council of Australian Governments has recently focused on access to community care by endorsing one stop Access Point Demonstration projects that will provide information, assessment and referral for older people in need of community care [7]. There is recognition in this approach of addressing the needs of older CALD people within a mainstream approach. However the debate among policy makers and service providers has often focused on arguments for or against mainstream vs. ethnic specific services for older people. We argue that this debate needs to be conducted within an evidence-based framework. The aim of this article is therefore to critique the literature related to community aged care service delivery models to people from CALD backgrounds. Through this examination of the evidence, the authors identify the key considerations for future policy and planning strategies.

### CALD as a 'special' needs and heterogeneous group

Older people from CALD communities share many of the same support needs as other older Australians. However, they have also been identified as being a special needs group, due to various factors including being separated from their place of birth, speaking a language other than English, and having to adapt to a different culture [8,9]. Rowland, however, highlighted that only about a third of older CALD people will have

Correspondence to: Dr Harriet Radermacher, Research Fellow, Healthy Ageing Research Unit, Monash University, Primary Care Research, Notting Hill, Vic. 3168, Australia.  
Email: harriet.radermacher@med.monash.edu.au

special needs that require ethno-specific services [10]. His analysis was based on the assumption that it was those new arrivals and settlers with little or no English who were probably the most in need of ethno-specific services. English proficiency does not mean that older CALD do not require ethno-specific services, it simply means that they will come up against less barriers and challenges on account of being able to communicate in English. This analysis supports the formal recognition and use of indicators such as languages spoken at home and English language proficiency for identifying the needs of CALD older people in relation to the provision of Home and Community Services (HACC).

Rowland's [10] distinction between different levels of need among CALD older people supports the body of evidence that older CALD people are not a homogenous group. Indeed, the majority of the literature highlights the heterogeneity of experience and needs among people from different CALD groups (for e.g. Refs [11–13]). Heterogeneity has obvious implications and challenges for developing effective service delivery models.

#### Needs and barriers to service use for CALD people

The range of physical, social and support needs of people from CALD communities in Australia has been comprehensively documented (for e.g. Refs [14–16]). For example, in Orb's review of the literature, three areas of concern for ageing CALD migrants were identified: physical health; mental and psychological wellbeing; and socioeconomic welfare [16]. In addition, a Queensland scoping project identified the major issues as: economic and financial needs; social needs, social isolation and quality of life; transport; housing; health needs; and aged care [17]. This project outlined how the issues faced by older people in general may become exacerbated by cultural and language barriers, migration circumstances, age at the time of migration, gender and geographical location, along with age-friendly housing, transport and infrastructure facilities [17]. While the circumstances of CALD older people may vary according to age on arrival and reason for immigration, certain common demographic factors have been identified as sources of stress (e.g. existing community support, marital status, rural or urban backgrounds, English competency, and dispersion of children) [4]. There is also anecdotal evidence to suggest that as people age, they seek more social interactions with those from similar CALD backgrounds [14,15].

Perceived barriers for CALD groups accessing respite services, for example, include either not having knowledge about services, cultural inappropriateness of services, language barriers, cultural barriers (e.g. food/religious requirements), lack of links between organisations and CALD groups, as well as a lack of available bilingual staff [18–20]. Above all, language and communication consistently emerge as the primary barrier to accessing services [4,17].

#### Methodology

A comprehensive literature search incorporating the relevant peer reviewed published and grey national and international literature was undertaken. Electronic database searches

included Ageline, ProQuest, CINAHL, Informit, HSTAT, Web of Science, Embase, and Google Scholar. Key funding and service organisations websites (e.g. Department of Human Services, Joseph Rowntree Foundation, Federation of Ethnic Communities' Councils of Australia, Department of Health and Ageing, and Centre for Culture Ethnicity and Health) were also accessed. Several key journals (e.g. Journal of Cross-Cultural Gerontology, Health and Social Care in the Community, Ethnicity and Health) were also separately searched, and the key reference lists were scanned for relevant documents. Literature accessible in the English language from 1980 to February 2008 was included in the review. The key search terms included: ethnic; CALD; cultural; ethno-specific; ethno; ageing; aged care; services; community; and service delivery. A total of 207 items were retrieved and deemed relevant to the field of study; 23 of which were considered key documents [3,8–11,13,21–37].

#### Outcomes of the review

Overall, the review of both the Australian and international literature indicates that no single model of community aged care service delivery can meet the needs of all older people from CALD backgrounds [3,8,9,11,25,33,36]. There is widespread support for the roles of ethno-specific, multicultural, and mainstream services, working independently and in partnership. Some models of care may be more suitable to some locations and communities than others, depending on many factors, such as CALD population profile and dispersion and geographical characteristics [25]. Although there is a demand for greater flexibility of service models to enhance choice for clients, there is also a need to reduce fragmentation and confusion and increase ease of access to the system.

A study in the UK highlighted mainstreaming, targeting, engagement and benchmarking as the four key elements of effective service provision for CALD groups [36]. This supports Hanen's proposal that if the core functions of aged care services are identified and implemented into practice then the need to ask an 'either or' (mainstream or ethnic specific) question about models of service delivery becomes less pertinent [38].

#### Ethno-specific services

During the 1970s in Australia, several groups lobbied for the development of ethno-specific health services [3]. In 1978, the Galbally report, *Review of Post-Arrival Programs and Services for Migrants*, recommended funding by the Commonwealth Government to Ethno-specific Agencies (ESAs). The report argued that immigrant settlement should be based on self-help, subsidised by the State through ESAs run by immigrants themselves [22].

The advantages and disadvantages of an ethno-specific service model have been outlined by Barnett [8]. Despite being written two decades ago, the issues are still relevant today. High rates of service utilisation and satisfaction are associated with culturally specific and relevant services [26]. An American study sought to investigate why people from CALD backgrounds used ethno-specific services, and concluded that ESAs

were critical components of multicultural service delivery systems [24]. Indeed, '... no matter how much some generalist (mainstream) organisations adapt, people may want to be served by ethno-specific organisations where they feel more comfortable and can easily communicate, and where their needs may be understood in a more favourable cultural or racial context' [22] (p.50).

Providing services based on cultural background, however, can be problematic as it may obscure other factors that determine a person's preferences and care needs [39]. Furthermore, a service delivery model that only focuses on ESAs is unrealistic and unfeasible, due to the heterogeneity within CALD groups and ethnic identity [11]. Assumptions that ESAs share the same ideologies as their clients can also be problematic [34].

People from CALD backgrounds have been identified as a special needs group, but 'antiracism' advocates warn against cultural approaches to difference, as they are in danger of homogenising people and their needs [40]. Some authors believe that funding ethno-specific service provision will simply serve to continue to allow ESAs to be poorly resourced, perpetuating marginalisation and endorsing 'de facto racism' in modern society [13, Jayasuriya, 1985: 22, 29]. Thus, the key question that remains is: do the benefits of categorisation according to cultural background (e.g. culturally specific and appropriate care) outweigh the disadvantages (e.g. potential segregation and exclusion) for providing community care to older CALD people?

### Mainstream services

Cost effective use of resources, linking older CALD communities to the wider community, and having the potential to provide a longer term response to the changing need of CALD older people over time, are just some of the advantages of a mainstream model [8]. Another Australian study also revealed a much higher level of satisfaction for mainstream services by older CALD people than was conveyed by the existing literature from CALD lobby groups at the time [27]. In the UK, Patni identified culturally competent mainstream teams as the best option for future service delivery systems, although she notes that they are neither currently in operation; nor are there clear policy guidelines about the appropriate way to provide services to diverse groups [30].

The literature indicates that while ESAs have been criticised for their potential to marginalise CALD groups, so too has mainstreaming, but for different reasons. Xynias, for example, has cautioned that mainstreaming can marginalise CALD people due to their relatively small numbers and their specific needs being overlooked [37]. Furthermore, Fuller identified how a mainstream service system, whilst appealing, simply serves to advantage those whose values most closely fit with the dominant social norms [23]. Importantly, Fuller [23] proposes that if people from CALD backgrounds participate in health system processes, it is more likely that they will be better served under a mainstream model. Similarly, there is a considerable drive in

the UK to support the involvement and engagement of older people themselves in research, policy and service development [29,36,41,42].

### Cultural competence in health services

Shortfalls in efficacy and accessibility of mainstream services for CALD people has resulted in the production of a plethora of guidelines for delivering culturally competent care, specifically relating to health services [43]. The definition of cultural competence adopted by the National Health and Medical Research Council is 'a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations' [43]. While cultural competence has demonstrated an increase in access to health care for at-risk older people in the US [12], problems have arisen, as no universally agreed definition of cultural competence exists [44]. Despite the need to inform services of cultural differences, CALD groups have expressed frustration with the stereotypic and essentialising tone of many of the guidelines [6]. In general, evidence suggests that cultural competence needs to be addressed at several levels (individual, professional, organisational and systemic) for mainstream services to be effective [43,44]. This is probably the case for home and community care services also.

### Partnership model

The need for cooperation and partnership between mainstream, multicultural and ethno-specific agencies has been recognised for at least two decades. Through experiencing the limitations of a mainstream system, particularly for meeting the needs of refugees and recently arrived migrants, the importance of a combined approach became evident [45]. Doyle emphasised the potential for partnerships to better meet the needs of a constantly changing, dynamic population [22]. However, developing effective protocols for effective networking between mainstream, multicultural and ethno-specific agencies, which includes valuing one another's contributions, are vital [22,35].

To maximise the advantages of both of these models, Barnett called for a balance between the two options, with the ultimate objective being 'the promotion of an integrated care system, rather than a dual system involving a central and a peripheral system of aged care' [8] (p.21). Barnett demonstrated that the balance between the two approaches may not always be the same for all service types – for example, food services may be enhanced by an ethno-specific approach, and respite may be better delivered through a combination of approaches. Barnett et al.'s 'Linkages' model of service is one which involves the linking of two or more partners to deliver culturally appropriate care [9]. It therefore appears to mirror the partnership model discussed by Rowland, and provides a viable option for smaller CALD communities, as do Migrant Resource Centres [9,33].

In the same vein as Sakamoto's Canadian study, which investigated the effectiveness of social service agencies for Chinese

skilled immigrants [34], Patni in the UK cautions against assuming that ESAs can provide the most effective services to CALD groups [30]. 'Race-specificity does not equal cultural competence, just as mainstream teams do not equal culturally incompetent teams' [30] (p.166). Like Sakamoto, Patni promotes an anti-oppressive approach, emphasising the importance of dialogue, coexistence, and partnerships between professionals and users/carers. This approach supports the findings of a recent review by Johnstone and Kanitsaki which identifies cultural racism as a significant contributor towards ethnic aged disparities in health and social care [46].

In the UK, the Policy Research Institute on Ageing and Ethnicity (PRIAE) has conducted and coordinated a considerable body of Europe-wide research around the long-term care needs of black and ethnic minority older people. An analysis of empirical studies in the 1980s concluded that CALD organisations were central in the supply of care and were acting as primary providers in place of mainstream providers, as opposed to being complementary providers [13,28]. The inadequacies and 'patchiness' of mainstream services were noted to have continued on into the late-1990s [28]. Recent recommendations in the UK have included working in partnership to recognise the importance of ESAs, and to direct more funding to strengthen the infrastructure of the multicultural voluntary sector [31].

Partnership approaches should also include the views and aspirations of consumers. For maximum efficiency and effectiveness it is important that services for older people align with their expectations and personal objectives and that patient and practitioner goals are also aligned [47]. In Victoria the HACC Active Service Model provides a person centred and health-promoting model of community care that has the potential to incorporate the views of older people and their carers [48]. However the peer reviewed evidence base concerning older people's views and aspirations about the support they need to age well is limited especially where older CALD seniors are concerned.

### The way forward

Developing culturally appropriate services is challenging, as indicated by the range of different models that have evolved over the last 30 years. The responses to this challenge range from the provision of ESAs, to increasing the capacity of mainstream services to become more culturally sensitive and inclusive [9]. While mainstream services appear to be the current prevailing model of community aged care service delivery, the evidence indicates that these services are still not able to meet the needs of older CALD people. The literature offers some evidence to support the value and effectiveness of ESAs for CALD older people. However, it also provides evidence that it is not feasible for ESAs alone to respond to the needs of all Australia's CALD communities.

Reviewing the literature highlighted that the critical question to be asked is not about the comparative efficacy of ethno-specific vs. mainstream services, but rather how the various

different models can best complement each other. Consequently, it is not a question of an 'either or' approach. Both the published and grey literature indicate that the future of community aged care service delivery lies in the coexistence of mainstream, multicultural and ethno-specific agencies working together and in partnership.

Considering the worldwide demographic phenomenon of increasing numbers of older people from CALD backgrounds, it is most timely to reflect upon the delivery and planning of community aged care services. While this review has indicated that, in Australia, developing culturally appropriate and responsive community aged care services has been on the agenda for the last 30 years, it also highlights that it needs to remain on the agenda.

There remains very little systematic, published evidence-based research that has as its focus the delivery of community aged care services to people from CALD backgrounds. A clear outcome of this review demands more evidence-based research, which is conducted in partnership between service deliverers (both ESA and mainstream) and research institutions. The expertise and experiences of both consumers and providers needs to be accessed and harnessed by research institutions to inform evidence-based design and evaluation of community services and models of care. A stronger empirical base will encourage the development of more consistent and coherent aged care policy and planning. It may also serve to elucidate the tensions that exist in promoting policy around ill-defined concepts of cultural competence, multiculturalism and cultural diversity.

Partnership models offer great potential to address the future needs of older CALD groups. However, anecdotal evidence gleaned from the authors' communication with key informants in the sector cautions that partnership models can be time-consuming, ineffective and frustrating when incorrectly implemented. We recommend extending the evidence base in the area of partnership models of service delivery to CALD older people. We suggest:

- identifying the key principles upon which these partnerships should be based;
- developing appropriate practice guidelines to build and foster effective and equitable partnerships and relationships between government, peak bodies, mainstream, multicultural and ethno-specific services;
- developing strategies that capitalise on the knowledge and experience of ESAs and bilingual/bicultural workers, ensuring that their contributions are valued by mainstream agencies; and
- translating evidence into policy and practice by addressing the local community context.

### Limitations of review

Conducting this review has highlighted that evidence based research in this field is scarce. The grey literature appears to predominate, but it is difficult to access and may lack scientific

rigour. Of the literature that was accessed, it must be emphasised that it is produced in a social and political context. It is not surprising therefore that the findings of this review may align with current government funding, policy and political frameworks. In addition, there is also the likelihood that many of the planning and policy documents written by agencies are never released into the public domain on account of being controversial and a challenge to the current political direction.

There are other pockets of literature that may also have promoted understanding about service delivery models, particularly in relation to refugees and smaller immigrant groups, caregivers of CALD people, residential aged care accommodation and mental health services. Unfortunately, however, it was not within the scope of this article to include them here.

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### Key Points

- The future of community aged care service delivery lies in the coexistence of mainstream, multicultural and ethno-specific agencies working together and in partnership.
- The evidence base for partnership models between ethno-specific and mainstream service providers needs to be extended and translated into local community contexts.
- Partnerships between research institutions, consumers and practitioners have the potential to improve the evidence base for the design and delivery of community care services for older CALD people.

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