

# COVID-19 and “ageing well” for the older migrants and refugees in rural Australia: the case of Bhutanese elders in Albury, New South Wales

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## Abstract

**Purpose** – *The purpose of this study is to highlight the challenges and opportunities for the well-being of older migrants and refugees in rural Australia by learning from the example of the Bhutanese community in Albury, New South Wales.*

**Design/methodology/approach** – *This viewpoint focusses on health and aged care barriers that affect the well-being of older migrants and refugees in Australia. It also demonstrates how these can be intensified due to the COVID-19 pandemic.*

**Findings** – *Engagement through agriculture, and a sense of “belonging” strengthen the cultural well-being of the Bhutanese older adults in Albury. However, major issues remain as health-related resources and information are lacking in rural Australia. How this group’s meaningful activities in Albury enabled collaborations to be built is shown in this working example and can provide lessons for other communities that experience similar problems of disconnection as they get older.*

**Research limitations/implications** – *The information regarding the Bhutanese older adults in Albury is primarily based on the authors’ personal communication with the General Secretary of the Bhutanese Australian Community Support Group in Albury Wodonga Inc.*

**Originality/value** – *Australia’s older population is growing rapidly, and older adults from culturally and linguistically diverse migrant and refugee backgrounds face numerous barriers such as limited linguistic, health and digital literacy. The authors describe common health and aged care issues that affect the well-being of older adults in rural Australia. They particularly emphasize those that occurred or intensified due to the COVID-19 pandemic. This novel information is now especially relevant to the health and aged care sectors in changing and diverse communities not only in Australia but also overseas.*

**Keywords** *Cultural well-being, Aged care, Culturally and linguistically diverse, Elderly, Ethnic group, Rural health*

**Paper type** *Viewpoint*

## Introduction

Australia is a preferred destination for many older adults (65 years old and over) from culturally and linguistically diverse migrant and refugee backgrounds. In 2018, the Australian Institute of Health and Welfare released a report which projected that both the absolute number and the proportion of older adults in the Australian population will continue to grow over the next decades. One study estimated that by the year 2100 around 25% of the total Australian population will be older adults, and that due to Australia’s immigration-driven population growth, many of these will be from culturally and linguistically diverse backgrounds (AIHW, 2018). Given this prediction, the health and aged care sectors should be further advanced to meet the growing needs and address the on-going challenges and unexpected crises (e.g. COVID-19).

According to recent literature findings, older adults from culturally and linguistically diverse migrant and refugee backgrounds face a range of issues when interacting with the Australian social welfare and health systems. Common barriers that affect perceptions and overall well-being for elderly culturally and linguistically diverse communities include limited understanding of the English language, lack of social interaction and/or engagement and unfamiliarity or misuse of available digital services and technology tools (Atwell, *et al.*, 2007; Blunden *et al.*, 2019; Caidi, *et al.*, 2020; Du and Xu, 2020; ECCV, 2012; FECCA, 2015; Kobayashi *et al.*, 2009; Miyawaki, 2015; Rao, *et al.*, 2006; Royal Commission into Aged Care Quality and Safety, 2019b). These are major contributors to loneliness, social isolation, mental health issues and incidence of suicide (Blunden *et al.*, 2019; Kobayashi *et al.*, 2009; Miyawaki, 2015).

During the COVID-19 pandemic, such issues were repeatedly reported amongst older adults, not only in Australia but also overseas – e.g. the USA (Kotwal *et al.*, 2021). Those of migrant and refugee backgrounds struggled even more, as extended periods of lockdowns and self- or forced isolation intensified pre-existing negative mental health conditions.

This viewpoint examines important health and aged care issues that affect well-being. It aims to draw attention to the factors that affect the quality of services, particularly as Australia is making efforts to prevent the COVID-19 virus from spreading. It focusses on older adults from culturally and linguistically diverse migrant and refugee backgrounds in rural areas of Australia by discussing the example of the Bhutanese community in Albury, a rural city New South Wales (NSW) with a notable older refugee population from Bhutan. The information regarding the Bhutanese older adults in Albury is primarily based on the authors' personal communication with the General Secretary of the Bhutanese Australian Community Support Group in Albury Wodonga Inc.

### ***Case of Albury, New South Wales***

*Community description.* Albury is a regional NSW city of approximately 50,000 residents located on the border of NSW and Victoria. The first Bhutanese refugees settled in the area in 2008 under the facilitation of the Multicultural Council of Wagga Wagga, and were funded by the NSW Department of Social Services (O'Regan, 2015). Currently 1,064 Bhutanese reside in the area. Within this community, there are 84 older adults who arrived in Australia between 2008 and 2014. Prior to arriving, the Bhutanese older adults had lived in refugee camps in Nepal for more than 19 years (H. Bista, personal communication, April 26, 2021). Most of them had experience in farming so agriculture is now a key component of activities which now link Bhutanese with other ethnic groups in the community. To a degree, this shared interest in agriculture has strengthened otherwise limited engagement (H. Bista, personal communication, April 26, 2021; O'Regan, 2015).

*Past experiences and well-being.* Before migrating to Albury, the Bhutanese older adults were tortured, persecuted, forcibly expelled and traumatized in their home country. As a result, they developed post-traumatic syndrome experiencing fear, isolation and stigmatization. This population migrated to Australia relatively later in life. In general, they have limited education and training, and low levels of literacy and numeracy. This affects their interaction with non-co-ethnics and further limits their ability to access social, welfare and settlement services. Other barriers affecting the Bhutanese older adults are associated with ageing, such as a loss of mobility or other disability issues, lack of awareness about what services are locally available for them, and poor public transport infrastructure (H. Bista, personal communication, 26 April 2021). These barriers make them highly dependent on younger relatives, particularly when seeking assistance for health and aged care services (H. Bista, personal communication, 26 April 2021; O'Regan, 2015).

### *Understanding the challenges for culturally and linguistically diverse older adults*

Research suggests these issues are common for many other older adults from culturally and linguistically diverse migrant and refugee backgrounds who reside in rural Australia (Atwell *et al.*, 2007; Caidi *et al.*, 2020; Du and Xu, 2020; ECCV, 2012; FECCA, 2015; Rao *et al.*, 2006; Royal Commission into Aged Care Quality and Safety, 2019b; van Gaans and Dent, 2018; Winterton, and Warburton, 2012). Table 1 draws information from the relative literature and summarizes the major challenges this group faces when seeking health and aged care assistance.

Older migrants and refugees may find it difficult to access affordable specialized medical services, as their communities may lack experienced personnel and equipment, so they may either have to travel or remain untreated, making them dependent on relatives and friends and undermining trust in the health system. Dependency on others and lack of trust in the health system may also be noted when they face issues with general services, such as booking appointments online due to their limited digital, linguistic and health literacy or unfamiliarity with information seeking, particularly when rural hospitals use automated phone answering machines or other similar modern services, and lack interpretation for “unpopular” languages and dialects. Concerns may also arise when existing facilities are unsuitable for upholding cultural values and religious practices, or if there is a lack of understanding of previous traumatic experiences, such as war or genocide. A common perception that all older adults could be treated the same is incorrect and could lead to inappropriate treatment, negative feelings, self-isolation and other impacts.

### *Older adults and COVID-19 response*

At the time of writing (August 2021), Australia has been one of the few countries globally to have successfully restricted COVID-19 outbreaks to a satisfying degree. From the beginning of the pandemic, Australian state governments, and to a lesser extent the Commonwealth (Federal) government, responded relatively quickly to the COVID-19 threat compared to some other countries – e.g. the USA (Georgeou and Hawksley, 2020, p. 132; Schismenos *et al.*, 2020) – and applied necessary measures (e.g. social distancing, lockdowns, closed borders, isolation of infected patients, etc.) to prevent the virus from spreading.

To better support older adults and improve medical facilities, the Federal government recently announced the Commonwealth Budget 2021–2022 which summarizes financial packages for COVID-19 response, including an AU\$630.2m grant to “improve access to quality aged care services for consumers in regional, rural and remote areas including those with Indigenous backgrounds and special needs groups”. This is managed by the Royal Commission into Aged Care Quality and Safety and will be spent on governance and regional access needs (BD, 2021, p. 7). The government also approved a grant of AU \$879m for improving services and equipment in telehealth, respiratory clinics, Indigenous community support, mental health care, etc., hoping to minimize any issues in remote and inaccessible areas (BD, 2021, p. 6)

Despite the positive steps in the pandemic response, there was a lot of criticism of how the Federal and NSW Governments managed the situation with respect to aged care residents. This criticism peaked in June 2020 after the Newmarch Nursing Home COVID-19 outbreak incident in Western Sydney, NSW, in which 19 elderly aged care residents died, and another 34 were infected, as were 34 aged care personnel (Connolly *et al.*, 2020).

After this incident, the NSW government ordered all aged care residents to be isolated in their facilities or homes for several weeks without having any (at least in the beginning) or much physical interaction with relatives and friends (Sydney Morning Herald, 2020). This controversial measure proved to be effective at protecting the elderly in aged care from COVID-19, but it came with a price – many older adults faced social isolation and

**Table 1** Issues with the current health and aged care services/facilities in rural Australia

<i>Demand/Need</i>	<i>Raising Issues</i>	<i>Common Reasons</i>	<i>Current Solutions</i>	<i>Potential Impacts</i>
Specialized/Advanced medical service (e.g. operation for rare condition)	<ul style="list-style-type: none"> <li>– Unavailability of services</li> <li>– Higher cost (compared to the expenses for the same service in a city)</li> </ul>	<ul style="list-style-type: none"> <li>– Lack of experienced personnel</li> <li>– Lack of equipment and/or supplies</li> </ul>	<ul style="list-style-type: none"> <li>– Travel to another, more distant facility</li> <li>– Avoid seeking help/ issue remains untreated</li> </ul>	<ul style="list-style-type: none"> <li>– Increased cost</li> <li>– Time-consuming process</li> <li>– Poor accessibility</li> <li>– Dependency on relatives/ friends</li> <li>– Feeling of being a 'burden'</li> <li>– Lack of trust in the health system</li> </ul>
General service (e.g. book an appointment online)	<ul style="list-style-type: none"> <li>– Poor digital literacy (e.g. use of computer/ internet)</li> <li>– Poor linguistic literacy (e.g. patient cannot explain the problem)</li> <li>– Unfamiliarity with seeking appropriate information</li> <li>– Lack of health literacy</li> <li>– Accommodation services are not designed for patients with disabilities (e.g. visual or hearing impairment)</li> </ul>	<ul style="list-style-type: none"> <li>– Rural facilities use modern services (e.g. automated phone answering machine) to minimize costs</li> <li>– Rural hospitals do not always provide interpreting services for less common languages and dialects</li> </ul>	<ul style="list-style-type: none"> <li>– Travel to another, more distant facility</li> <li>– Avoid seeking help/ issue remains untreated</li> </ul>	<ul style="list-style-type: none"> <li>– Increased cost</li> <li>– Time-consuming process</li> <li>– Poor accessibility</li> <li>– Dependency on relatives/ friends</li> <li>– Feeling of being a 'burden'</li> <li>– Lack of trust in the health system</li> </ul>
Upholding cultural values and religious practices (e.g. to be examined by a doctor of the same gender)	<ul style="list-style-type: none"> <li>– Unsuitability of existing facilities</li> <li>– Common perception among personnel that all older adults can be treated the same ('homogenous' elderly group)</li> </ul>	<ul style="list-style-type: none"> <li>– Personnel's unfamiliarity with different cultures/ religions</li> <li>– Barriers (e.g. language) which lead to misunderstanding or lacking knowledge</li> </ul>	<ul style="list-style-type: none"> <li>– Travel to another, more distant facility</li> <li>– Avoid seeking help/ issue remains untreated</li> </ul>	<ul style="list-style-type: none"> <li>– Fear, shame, stress and other negative feelings</li> <li>– Inappropriate treatment which could bring traumatic experiences/memories to surface</li> <li>– Dependency on relatives/ friends</li> <li>– Feelings of loneliness and being a 'burden'</li> <li>– Lack of trust in the health system</li> </ul>
Understanding of previous traumatic experiences (e.g. war and genocide traumas)	<ul style="list-style-type: none"> <li>– Unsuitability of existing facilities (e.g. long halls and small rooms that bring back traumatic experiences)</li> <li>– Common perception among personnel that all older adults can be treated the same ('homogenous' elderly group)</li> </ul>	<ul style="list-style-type: none"> <li>– Personnel's unfamiliarity with different cultures/ religions</li> <li>– Barriers (e.g. language) which lead to misunderstanding or lacking knowledge</li> </ul>	<ul style="list-style-type: none"> <li>– Travel to another, more distant facility</li> <li>– Avoid seeking help/ issue remains untreated</li> </ul>	<ul style="list-style-type: none"> <li>– Fear, shame, stress and other negative feelings</li> <li>– Inappropriate treatment which could bring traumatic experiences/memories to surface</li> <li>– Dependency on relatives/ friends</li> <li>– Feeling of loneliness/ tendency for self-isolation</li> <li>– Lack of trust in the health system</li> </ul>

loneliness, conditions that although pre-existing (Blunden *et al.*, 2019), were intensified due to the restrictions.

Australia's COVID-19 community transmission rate is currently (August, 2021) low – less than 500 daily cases nationwide. Some states have loosened many of their COVID-19-related orders, and the Commonwealth has initiated the vaccine rollout plan for priority groups, including older adults, nursing staff and first responders (DoH, 2021). Despite this

positive development, on-going problems in rural areas remain, and these impact the overall success of the national COVID-19 suppression strategy. Initially, the Federal government planned to use general practitioners to deliver vaccines; however, many medical clinics in remote communities suffer from a shortage of general practitioners, so local residents were required to travel to other areas to receive vaccination. For example, about 2,000 older adults in Murrayville, Victoria, could not be vaccinated in local clinics and had to travel to more distant facilities elsewhere, regardless of their condition (e.g. disability or chronic health problems that do not permit long travel) (Crabtree, 2021). This situation highlights that in rural and remote communities, significant barriers remain to receiving health services exacerbated further by the COVID-19 outbreak, demonstrating the particular need to find ways to keep service levels high for vulnerable and more isolated populations.

Besides the aforementioned barriers, misinformation regarding the potential impacts of the available vaccine jabs (i.e. AstraZeneca) amongst the culturally and linguistically diverse migrant and refugee communities further perplexes the vaccination process. A recent study commissioned by the NSW Council of Social Service emphasized that culturally and linguistically diverse communities hesitated to receive vaccination for three main reasons:

1. there were a lot of conflicting and mixed messages on media;
2. the available information was complex even when translated to other languages; and
3. any targeted information campaigns to migrant and refugee groups were poorly planned (Razik, 2021).

With respect to the Bhutanese community in Albury, only a few older adults were vaccinated after visiting their local medical clinic. Same as with other culturally and linguistically diverse communities, the available information was poorly delivered or not translated, and there was a wide fear of health side effects after being vaccinated.

The current COVID-19-related restrictions in NSW and overall uncertainty may, to some extent, bring back bad memories and affect the mental health of the Bhutanese older adults. Extended lockdowns and limitations in socializing may increase the feelings of social isolation, depression and stigma for this sensitive group. The Bhutanese Australian Community Support Group in Albury Wodonga Inc. assists in connecting Bhutanese older adults in Albury with the wider local community to reduce social isolation. It also plans to organize educational sessions about the importance of receiving vaccination against COVID-19, so that Bhutanese older adults become more aware of why, when and where to obtain COVID-19 vaccination in the near future (H. Bista, personal communication, 26 April 2021).

## Discussion

The challenges in Australia's health and aged care sectors are large and concerning, and pre-exist long before the COVID-19 crisis. There is a need to address them in a way that improves the well-being of older migrants and refugees. Attention should particularly be paid to the rural areas that are in general, a preferred retirement destination for many culturally and linguistically diverse older adults, primarily due to nature, local history, pace of living and housing affordability (Heenan, 2010; Winterton and Warburton, 2012).

While relocation to cities for older adults with chronic or serious health conditions is a realistic solution to "rural-based" issues, it is not always a "smart" decision. The feelings of "belonging" and acceptance are often absent amongst older migrants and refugees who live in urban areas, largely as they engage less frequently with non-co-ethnics (Caidi *et al.*, 2020). In contrast, rural communities provide better support and engagement as culturally and linguistically diverse older adults feel part of local networks (Anderson *et al.*, 2018). For

example, [Winterton and Warburton \(2012\)](#) investigated the reasons some older migrants chose to age in Hume region in Victoria. Their findings highlighted the importance of social support and inclusion. In the same study, participants also stated that they developed a sense of “belonging” and acceptance in Hume, even though they were not born or raised in their “now host community”. When they were asked about the major issues they faced, their responses were similar to the issues commonly experienced by other older migrants and refugees residing in rural Australia ([Table 1](#)), including the Bhutanese older adults in Albury.

### *Towards cultural well-being*

The current pandemic has brought our society to an ethical dilemma – “safe” isolation or active engagement for the ageing culturally and linguistically diverse migrants and refugees? [McGregor and Ragab \(2016\)](#) highlighted the value of shared cultures and experiences in diverse societies as a means of promoting of understanding and cultural well-being. Cultural well-being can be briefly defined as a dynamic concept seeing values which can be related to culture, beliefs, identity, society, home and relationships ([Mackay, 2016](#)). In “healthy” societies, isolation, discrimination and prejudice, particularly against migrants and refugees have no place, whereas the freedom and right to connect with “origin roots”, to self-determine, and to belong in a community are central for developing a sense of “belonging” and social cohesion in the host country ([WHO, 2010](#)).

For the Bhutanese older adults in Albury, these rights, as well as involvement in agriculture are seen as essential for gaining and sustaining their cultural well-being. Agriculture is in particular the dynamic link that bring this group together, makes them feel useful in local community, and connects them with non-co-ethnics. This example of cultural well-being should be taken into serious consideration, as it can be adopted in other elderly culturally and linguistically diverse communities that experience social isolation and feel that they age in the “wrong place”.

Engaging older migrants and refugees in local communities through meaningful collaborative activities offers a working example for how community cohesion can be implemented ([Schismenos et al., 2021](#)). The case of Albury demonstrates that even if language and digital literacy barriers exist, Bhutanese older adults are motivated to engage with others through a shared experience of agricultural activities. However, it also contrasts with and helps explain the concerns, and lack of information and preparedness for health and aged care services which were also observed in other ageing communities as seen in the Murrayville example given.

Initiatives that allow engagement and social inclusion need to be further investigated, as they could encourage collaboration between different community members, and thus support cultural well-being. Furthermore, state and Federal governments, as well as other involved entities should more pro-actively focus on identifying specific ways to support culturally and linguistically diverse minorities in rural areas, and so provide the necessary and possibly distinct sociomedical, financial, educational and digital tools that they require to overcome any barriers.

### *Current and future work*

In order to further investigate the challenges facing culturally and linguistically diverse older adults in Australia, the Humanitarian and Development Research Initiative at Western Sydney University has partnered with SydWest Multicultural Services in a project entitled “Better Elder Care: Culturally appropriate care and service provision for older migrants 65+ in Greater Western Sydney”. The study explores the experiences of ageing and well-being among elderly culturally and linguistically diverse migrants and refugees using participatory creative expression interventions and interviews. While currently focussed on Western

Sydney, there is potential for the scaling up of findings relating to the key role of cultural well-being to rural Australia.

## Conclusions

The main concern for many culturally and linguistically diverse older adults in Albury and other communities remains broadly in both pre- and intra-COVID-19 conditions but have been intensified by COVID-19 pressures; rural Australia is affected by a lack of specialized health personnel and has fewer services than urban Australia. This adds to the on-going issues that are related to language, technology and social barriers.

Despite the limitations on facilities experienced in remote areas, culturally and linguistically diverse older adults prefer living in small communities. This cohort feels safer, healthier outside of large cities, and has a stronger sense of “belonging” to the community. It is important to understand their perceptions regarding the current health and aged care services to provide better care that addresses common needs while also supporting cultural well-being.

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