



MUSLIMS IN AUSTRALIA AND
THEIR AGED CARE NEEDS:
AN EXPLORATORY STUDY WITH SPECIAL
REFERENCE TO SOUTH AUSTRALIA
(Revised and Updated)

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Adelaide
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TABLE OF CONTENTS

Part	Page
Executive Summary	iv
1. Introduction	1
2. Islam and Muslims	11
3. Muslims in Australia and Around the Globe	15
4. Religion, Spirituality, Ageing, and Aged Care	29
5. Culture, Ethnicity, and Integration in the Context of Muslims	38
6. The Aged Care System	49
7. Residential Care	76
8. Aged Care in South Australia	81
9. Aged Care Service Delivery Models	87
10. Ethnic Aged Care at Home and Abroad	94
11. The Case for Muslim Aged Care	99
12. Planning for Muslim Aged Care	110
13. Recommendations	118

Executive Summary

Research Purpose and Context

The Report “MUSLIMS IN AUSTRALIA AND THEIR AGED CARE NEEDS: AN EXPLORATORY STUDY WITH SPECIAL REFERENCE TO SOUTH AUSTRALIA” was prepared for the Islamic Information Centre of South Australia (IICSA) as an important step toward making aged care in general, and residential care in particular, responsive to the needs of the Muslim community in South Australia. Since the online publication of the Report in 2013, the Government has been implementing a range of aged care reform measures. The Report has been revised and updated to reflect the changes to the aged care sector as a result of these planned reforms. Other data and information in the Report have also been updated.

The Report seeks to make a case for enhancing the choice of Muslims when it comes to choosing the right care for their twilight years. Therefore, the main argument of this Report is that faith considerations must be recognised in care planning and delivery so that appropriate care can be offered to practicing Muslims. The overarching theme of the Report is the context in which this care can and should be provided. It seeks to explore the current status of aged care in Australia with regard to meeting the needs of Muslim older people and propose steps that would help in providing appropriate aged care for the growing number of Muslims in this country.

The Report provides insights into Islam and Muslims so as to put the issue of Muslim aged care into proper perspective; it also provides opportunity to clarify some concepts in the context of Muslims, such as culture, ethnicity, and spirituality. The Report contains background information on some of the basic details of aged care, particularly those pertaining to care in a residential setting.

The main sources of information for this Report are:

- Relevant books
- Articles published in professional/academic journals
- Government reports and reviews at federal and state levels
- Extensive online search and analyses of documents of national and international organisations and research bodies
- Information available from key service provider websites, and
- Discussions with the aged care industry.

Aged care, in general, is a complex issue for practising Muslims for whom religion is a central point of reference; what is more, to them Islam is neither just a religion nor just a part of cultural identity but a way of life that transcends, and takes precedence over, culture and ethnicity. Therefore, an aspect of care that is not always incorporated into the overall aged care regime must be considered in services planning and delivery for Muslims. This critical aspect is faith or religion which, in addition to the cultural and linguistic issues, has to be considered in conceiving and delivering aged care services for the Muslims, thereby offering

them a real choice as well as truly implementing government policies surrounding multiculturalism, inclusion, and diversity.

It can be safely assumed that when care is received at home, there is some degree of freedom in continuing with one's life patterns, but when care is received outside of one's home personal choices may have to be given up in many areas of life in order to accommodate and adjust to the rules, regulations, and routines of the aged care facility. This is why this Report discusses issues related to residential care in greater detail compared to issues surrounding other forms of care.

Points of Departure

Although the existing aged care programs and services assist the Muslim community albeit in a limited way, there is an absence of a holistic, faith-oriented aged care services spectrum. The Report stresses that religion has an enormous role in the planning, development, and delivery of aged care services and that such processes must reflect an increased focus on incorporating recipient needs based on their religious beliefs along with needs related to cultural and linguistic diversity.

This Report calls for a new approach to providing aged care to Muslims. In line with this approach, there are four major points of departure of this Report. *Firstly*, the Report contends that it cannot be just the right to access aged care information and services that needs to be ensured; the right to access *relevant* and *appropriate* aged care information and services is what is critical. Thus, merely increasing or facilitating access to existing services would not fulfil all of the important needs of those who adhere to Islam's prescribed way of life. *Secondly*, although the Report acknowledges the significant importance of culture and language in the provision of quality care, it strongly asserts that spirituality and religion are no less important. *Thirdly*, the Report argues that there needs to be a paradigm shift of spiritual care from the fringes of aged care services delivery such as in palliative or end-of-life care to the centre stage of aged care, covering its entire spectrum. *Fourthly*, the Report stresses the importance of understanding the relationships between spirituality and religion. In the western and secular societies, religion takes a backseat with culture and/or language at the centre of aged care services planning. In such societies, spirituality enjoys a more positive connotation compared to religion which is seen in a more negative light. For those outside the Islamic faith, the concepts of religion and spirituality may have separate meanings and may exist separately; not so for Muslims, for whom religion is a means to achieving spirituality and these two dimensions cannot be separated.

Key Findings and Discussions

According to the 2011 Census, Islam was the fourth largest of all religious groupings in Australia and the second largest among non-Christian faiths. Australian Muslims representing over 60 different ethnic groups and racial backgrounds are among the most ethnically and racially diverse religious groupings in the country. In this context, it is safe to say that the diversity of cultural and linguistic backgrounds of Muslims has one point of unity: Islam.

Between 2011 and 2026, the Muslim population in Australia is predicted to account for 4.0% of older 'culturally and linguistically diverse' (CALD) people. During this period, the growth rates for the 65 and over and 80 and over Muslim age groups are projected to be 159% and 222% respectively.

While Muslims, just like any other community, need to accommodate the cultural practices of the broader Australian society so long as these are not discordant with their faith beliefs and practices, they cannot be expected to negotiate their religious identity and those aspects of life that are considered essential to upholding their religious values. The question is not of being either a Muslim or an Australian but being both a Muslim and an Australian. The relentless negative depiction of Muslims and Islam in public discourse fuels concerns about the supposed inability of Muslims to acculturate. The fact is that, Muslims have generally been able to successfully reconcile their high degree of religiosity with their largely secular environments in order to live in harmony in their adopted countries in the West.

Just like any other community, Muslims have a right to an open, non-judgemental, and supportive environment that understands and provides for their legitimate needs. One very critical point to remember in this context is the responsibility that comes with enjoying rights. Although a microscopic minority, some Muslims have deviated from the message of Islam and, therefore, are easily motivated to adopt intolerant attitudes and resort to words and actions that are totally incongruent with Islam. Although such attitudes and behaviour may well come from ignorance, faulty assumptions, or misinterpretation of *Qur'an* (Islam's holy book), undoubtedly they do a great disservice to Islam and Muslims. Imams (prayer leaders), teachers of religion, parents, and Muslim community leaders need to play a stronger role in the dissemination of Qur'an's message and the teachings of Islam's Prophet Muhammad (May peace be upon him) without any distortions and misinterpretations, and set examples through their own conducts.

Although there is no specific data available on aged care services usage pattern and usage rate for Muslims, there is ample documented evidence on the under-representation of older CALD people in residential care services and their over-representation in community services. This can be explained, to a large extent, by the expressed preference of CALD communities for home care and by the perception with regard to home and community based services as being more culturally appropriate and responsive.

The importance of having services designed around linguistic and cultural diversity as a means to provide appropriate services to older CALD people feature prominently in discourses and debates surrounding aged care reforms. Consequently, there is an emphasis on recognising ethnic, cultural, and linguistic diversities as can be seen in the aged care regulatory framework, government policies and announcements, and government reports and reviews.

However, despite the government being keenly aware of many of the needs of older people from CALD communities, it seems that the importance and role of religion in aged care services provision is yet to be fully recognised. Even though religious affiliation is an important indicator of diversity, the implications of this form of diversity do not seem reflected in government policies and documents owing, perhaps, to an emphasis on secularism. When considering

cultural diversity of older CALD communities in services provision, the religious dimension thus seems to be strikingly absent as of now. Clearly, language and culture play vital roles in all aspects of care and treatment of older people; however, their spiritual needs must also be addressed. With the progress of age and accompanying reduction in abilities to function as before, many older people may become more aware of, and interested in, religious and spiritual matters-- perhaps for the first time in their lives-- and this journey must be supported by those who are responsible to care for them.

Although there is continuing debate surrounding the exact relationship between religion and health, it is widely accepted that the overall well-being of people is enhanced by religious beliefs and practices. As such, it is important for the government and the aged care industry to acknowledge that matters of religion and spirituality are important not just for those in palliative care.

As calls to provide spiritual care to care recipients become more and more strident, it is also essential not to paint the concepts of spirituality and religion with the same brush. There is a danger that focusing on spirituality would undermine the importance of religion or relegate it to the background. The danger is even greater in regards to Muslims; Muslim spirituality is religion-based and, therefore, the right care cannot be offered to them if it is not planned around their religious beliefs.

It is of critical importance to have the government and the aged care industry realise that their efforts to meet the language and culture needs of the CALD population do not necessarily and always coincide with satisfying the requirements of the Muslim older people. It is likely that the specific needs of Muslims may get subsumed within those of the older CALD people and within issues of culture and diversity. This may explain, in part, the paucity of appropriate aged care services for Muslims. In aged care facilities, such concerns take on greater significance as Muslims may feel isolated and marginalised among large non-CALD and non-Muslim resident groups. A small community such as the Muslims who constitute 2.2% of Australia's population, and the even smaller number from this community who will enter aged care, makes it more likely that their special needs may either be passed over or may seem as too problematic to fulfil. Considerations of equity should override any reluctance on the part of the government and the aged care industry to make a difference, a reluctance that may be brought about by the relatively smaller size of the Muslim population.

While there is an increasing trend and preference in Australia and elsewhere for older people to remain in their own homes, there is still a significant need for residential aged care, 'the refuge of last resort', because of complex health and social factors. A move into residential care can be triggered any time by a host of factors. Because of cultural practices, religious values, and negative stereotypes of residential care, many CALD families may be reluctant to put their loved ones in aged care facilities. This explains why, in many instances, there may be an unwillingness to seek assistance, to search for and access available services, or to identify additional services that may be needed; there may not even be awareness about services that exist. However, as the sense of responsibility and obligation towards one's family, the mainstay of informal care, diminishes and family structures change around us, caring for the aged at home may become increasingly difficult without the right kind of support.

A fundamental point to ponder is whether aged care for Muslims is an issue of creating appropriate services or accessing available services. This Report suggests that although the factors associated with limited accessibility of available services by CALD communities largely apply to Muslims, the concern in regards to Muslims is essentially driven not just by accessibility issues surrounding available services, but also by lack of appropriate aged care services that support their faith. This may cause some to dwell upon the 'triple jeopardy' of being ethnic, old, and Muslim, albeit one that can be overcome with adequate support from relevant quarters.

It is also important to consider the lower life expectancy in the major countries of origin of Muslims in Australia and the consequent possibility of older people from these countries requiring aged care and support at an earlier age than their Australian-born counterparts.

While religion contributes to shaping a Muslim's beliefs, values, and attitudes, not all of them would share the same needs or preferences in aged care. Just like any other religion, Islam has varying degrees of adherence and influence among its followers; however, Islam requires strict observance of its core beliefs and rituals and these should influence all aspects of a Muslim's daily life.

The ability of older Muslims to exercise their choice in selecting aged care services is limited in South Australia because Muslims have needs that require services that differ from, or are additional to, the 'mainstream' services offered by operational providers. While from 2015 a limited number of home care packages would be available, there is no residential care facility that offers care appropriate for Muslims. It is encouraging to note that in different States and Territories of Australia, efforts spearheaded by the Muslims are well underway to lay down the cornerstone of aged care services that cater to their community's needs.

The aged care industry, being a tightly regulated one, needs the support of the government to bring about changes in offering wider choices to consumers from different backgrounds. A significant development in this direction has been the *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds* launched in December, 2012 by the Department of Health (formerly the Department of Health and Ageing or DoHA) in partnership with the Federation of Ethnic Communities' Councils of Australia (FECCA). The Strategy underscores the importance of faith along with culture and language in designing aged care services to make such services appropriate to the needs of older CALD people.

It is pertinent to mention here that in September 2012, the authors had submitted the draft of this Report to IICSA and sent copies of it to the South Australian state government as well as relevant federal government departments and agencies and some aged care organisations. In addition, the authors had made a submission and provided comments on the draft *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds* (mentioned in the preceding paragraph) to FECCA. FECCA acknowledged that the draft report, together with the comments and the submission on the draft Strategy were important to considerations around the CALD Aged Care Strategy, and the key points of the draft report about the importance of faith and spirituality considerations in providing culturally appropriate aged care was included in FECCA's suggested redraft of the Strategy. To facilitate

greater understanding between services providers and the Muslims, the authors had organised an information session under the auspices of IICSA on February 15, 2013. This session was an important step in bringing the aged care industry and a cross-section of Muslims together in Adelaide, perhaps for the first time, where both parties had the occasion to exchange views and the Muslim community had the opportunity to obtain first-hand information on aged care. The authors had also organised a dementia information session for Muslims in Adelaide on August 09, 2014 with support from Alzheimer's Australia SA and the Islamic Students Society of the University of Adelaide.

Recommendations and Planning for the Future

For long, the Muslim community in Australia has been on the sidelines of aged care services planning and delivery. Consequently, their needs as dictated by their religious values may not have been on the agenda of most service providers. These needs ought to be understood in a more favourable cultural context which is difficult in an environment of limited choice and cultural barriers. Muslims, therefore, have an obligation to contribute to the cultural competence (the ability to understand and respond effectively in cross-cultural situations) of the government and the aged care industry. They can do this by articulating and advocating their needs in order to make those needs 'visible' and help the industry understand their religious values so that appropriate services can be planned, designed, and delivered. Instead of remaining passive recipients, Muslims must become proactive in seeking greater diversity of, and cultural appropriateness in, aged care services.

While Muslims must begin to articulate their own needs, their community leaders and organisations have a key role to play given their strong connections to, and understanding of, the community. A common and unified approach towards community issues such as aged care is vital for moving forward and delivering benefits. The aged care industry could engage with these leaders and organisations to receive direct input about the nature of services Muslims wish to receive.

It is very important for Muslims to understand that a dedicated facility for them may not be a reality as anti-discrimination laws would ensure that no provider of aged care services that receives Commonwealth funding, including religious organizations providing aged care, can discriminate people although such religious organisations can continue to prefer people of their faith. Setting up a separate wing for Muslims in an existing mainstream or ethno-specific facility may not be a viable option at present in South Australia and other places where there is a relatively smaller number of Muslim consumers. However, collaborative ventures between mainstream non-profit service providers and Muslim community organisations could pave the way for incorporating the special needs of Muslims into care planning.

Although there is no 'right' model of service delivery, the diverse culture and language of Muslims coupled with their relatively smaller number in South Australia seems to make the clustering model a reasonable one to apply as this would enable South Australian Muslims to benefit from appropriate services in a mainstream residential aged care facility. The Innovative Care Pool, which allows provision of services in new ways for clients for whom current services

are limited, may also be utilised. Regardless of the model that is followed, Muslims would benefit most from the person-centred approach to aged care.

Appropriate care for Muslims could be implemented in the short-term through extensions to existing programs or incremental refinements to existing programs and services. More fundamental changes, such as more care workers being trained to become more culturally competent, would be required if real enhancement of choice for the Muslim community is to be realised.

Any facility that seeks to provide appropriate care has to start with proper planning. The major areas that need to be addressed for providing aged care to Muslims are: physical facilities; toilets; hygiene and personal care; safe keeping of religious symbols and objects; daily prayers; fasting; food; privacy and modesty issues; health issues; chaplaincy; and end-of-life issues. Lack of attention to features such as requirements for privacy, making arrangements for meeting washing requirements according to Islamic teachings, dealing with intimate functions, providing for ablution facilities, prayer space, and diet, to name just a few, would make it difficult for Muslims residents to observe their religious practices in the prescribed manner. A carefully developed strategy would not only enable them to receive care that is sensitive to their religious beliefs but also encourage them to seek access to needed aged care support and services.

As spiritual care is a critical component of quality care regime, there is an important role for Muslim chaplains. A formal chaplaincy training program would, in addition to supplying Muslim chaplains, offer professional standing and recognition of competence.

Further research and analysis is required to determine the current and anticipated demands, user preferences of services, and the scope of services to be included in enhancing choice for Muslims. A need assessment would be an important starting point for planning Muslim aged care. The assessment can be based on prospective (rather than current) need especially for those at the low end of the care spectrum whose needs are expected to accelerate with time. The next step would be to pursue relevant government departments and agencies and enlist the support and cooperation of the aged care industry to further the cause of Muslim aged care.

This Report is the first in-depth inquiry into making a case for Muslim aged care in South Australia with relevance for the other States and Territories of Australia. Undoubtedly, with the ageing of the Muslim population, the need for aged care services for them will increase. Any proposition or plan in this regard needs to be made on the basis of careful study to ensure a high degree of success. In this context, it is hoped that this Report will generate new ideas as well as give directions for research in the future.

MUSLIMS IN AUSTRALIA AND THEIR AGED CARE NEEDS: AN EXPLORATORY STUDY WITH SPECIAL REFERENCE TO SOUTH AUSTRALIA

1. Introduction

1.1 Origin

At the Annual General Meeting of the Islamic Information Centre of South Australia (IICSA) held at the Centre in January 2012, IICSA President Dr Hani Abul Khair outlined his vision for the year. One of the areas of significant importance and relevance to the Muslim community that he thought required to be researched was Muslim aged care in South Australia (SA). The authors were aware that not much research was done on Muslim care needs in Australia and none in the context of South Australia. This study titled *Muslims in Australia and their Aged Care Needs: An Exploratory Study with Special Reference to South Australia* was undertaken to find out if, and to what extent, the Australian aged care services framework meets the specific needs of Muslims and why it is important for Muslims to have aged care services that support their faith requirements. Since the online publication of the Report in 2013, the Government has been implementing a range of aged care reform measures. The Report has been revised and updated to reflect the changes to the aged care sector as a result of these planned reforms. Other data and information in the Report have also been updated.

1.2 Problem and its Nature

Through the ages, Islam has been not just a religion to millions of Muslims all over the world but a complete code of life that influences every aspect of how they ought to live. Religion and spiritual issues tend to take on greater significance for Muslims as with other faith followers as they approach old age; such people will need aged care facilities and services that help them to go on practicing their religion the way they are required to.

Over the years, there has been a growing realisation that the Muslim community in Australia faces challenges in terms of the care preferences and needs of its older members; these challenges will be magnified over time as people move into older age cohorts. Although filial piety is a religious edict, issues such as migration, changes in lifestyles and in family structures, and other compelling factors may overstretch the ability of many Muslim families to look after their loved ones in their homes. Residential aged care, in general, therefore, becomes a complex issue for those Muslims who try to observe their faith; it is very important for them, to the extent possible, to be able to continue a lifestyle that follows the tenets of Islam even when they become old and frail. Since there is no aged care facility that caters to Muslims in South Australia, it is deemed imperative that steps are taken so that older Muslims can have a credible choice in terms of services and facilities that fulfil their requirements as dictated by their religious beliefs. Therefore, in addition to the cultural and linguistic issues pertaining to aged care, there is the very critical religious or spiritual aspect that must be included in

services planning and delivery. This aspect of care needs to be addressed in its own right to ensure that aged care services would be more responsive to the needs of Muslims now and into the future.

1.3 Objective

How responsive is the Australian aged care sector to the needs of Muslims? Many Muslim elders may find the prospect of moving into aged care facilities more depressing because of the very fact that they cannot be confident that they will get the right environment and support to practice their religion and maintain their Islamic lifestyle. Muslims in South Australia, as elsewhere, would want to be assured that they will have appropriate aged care; this assurance needs to cover a range of needed services. To this end, the study seeks to find out the current status of aged care in Australia with regard to its suitability and sensitivity to the needs of Muslims, and propose a general scheme that would constitute a more appropriate care for this community. The Report seeks to make a case for enhancing the choice of Muslims when it comes to choosing the right care for their twilight years. Therefore, the main argument of this Report is that faith considerations must be recognised in care planning and delivery so that appropriate care can be offered to practicing Muslims.

1.4 Scope

Aged care is structured around either residential care, or caring for the aged while they remain at home in the general community. This Report covers both home and residential aged care with particular focus on the state of South Australia.

It can be safely assumed that when care is received at home there is some degree of freedom in continuing with one's life patterns, but when care is received outside of one's home, personal choices may have to be given up in many areas of life in order to accommodate the rules, regulations, and routines of the aged care facility. This is why this Report discusses issues related to residential care in more detail compared to other forms of care. Many of the issues raised and discussed in the Report will be of relevance to other aged care services and packages, such as home care. In home care, workers need to go into the homes of older people who come from a range of cultural backgrounds and, therefore, it is important that the workers must respect the needs and ways of living of the care recipient. Although the Report discusses South Australia in particular, the issues covered are also largely relevant for other States and Territories of Australia.

This Report has been prepared for two different audiences: for the Muslims who may not be familiar with the aged care system in Australia and what it offers, and for the policy makers and providers of aged care who may not be aware of the central role that religion plays in everyday life of a practicing Muslim. To this end, the Report includes background information on the Australian aged care system and what it provides, offers insights into Islam and Muslims so as to put the issue of Muslim aged care into proper perspective, and highlights the critical importance of making appropriate aged care available for practicing Muslims. This Report also provides an opportunity to revisit, in the context of Muslims, some concepts such as culture, ethnicity, and spirituality. For putting the issue of aged care for Muslims in a

broader context, the Report also discusses the association of religion and spirituality with health and well-being, as well as aspects of policies concerning diversity, inclusion, and multiculturalism.

1.5 Points of Departure

This Report calls for a new approach to providing aged care to Muslims. In line with this approach, there are four major points of departure of this Report. *Firstly*, the Report contends that it cannot be just the right to access aged care information and services that needs to be ensured; the right to access *relevant* and *appropriate* aged care information and services is what is critical. Thus, merely increasing or facilitating access to what is now available would not fulfil all of the important needs of those who adhere to Islam's prescribed way of life. *Secondly*, although the Report acknowledges the significant importance of culture and language in the provision of quality care, it strongly asserts that spirituality and religion are no less important. *Thirdly*, the Report argues that there needs to be a paradigm shift of spiritual care from the fringes of aged care services delivery such as in palliative or end-of-life care to the centre stage of aged care, covering its entire spectrum. *Fourthly*, the Report stresses the importance of understanding the relationships between spirituality and religion. In the western and secular societies, religion takes a backseat with culture and/or language at the centre of aged care services planning. In such societies, spirituality enjoys a more positive connotation compared to religion which is seen in a more negative light. For those outside the Islamic faith, the concepts of religion and spirituality may have separate meanings and may exist separately; not so for Muslims, for whom religion is a means to achieving spirituality and these two dimensions cannot be separated.

1.6 Limitations

Although the literature about aged care and cultural diversity is vast, there is a paucity of research on Muslim aged care in Australia and no relevant information is available on South Australia. There is no published information on Muslim residents in aged care facilities in Australia as most aged care provider databases and other reports do not capture religious affiliation. The topic of this Report interfaces with several areas such as ageing, religion, diversity, multiculturalism, inclusion, and health with actors ranging from government departments and agencies at federal and state levels to private operators. Hence, the available information had to be compiled from a wide array of sources, including websites. Wherever possible, the 2011 Census data was used but since much of the analyses contained in major reports, publications, and other documents were based on earlier censuses, a few of the data in this Report are from the 2006 Census.

1.7 Methods and Sources of Collecting Information

The Report employs the qualitative research method and relies heavily on library research. The Report utilises both primary and secondary sources of information. These are:

- Relevant books
- Articles published in professional/academic journals

- Government reports and reviews at federal and state levels
- Extensive online search and analyses of documents of national and international organisations and research bodies
- Information available from key service provider websites, and
- Discussions with the aged care industry.

Reference lists were also scanned for relevant documents.

Another source of this Report is the 'grey literature'. This is mostly the opinions and experiences of planners, policy makers, or service providers who have direct contact with the aged care industry and/or with CALD communities and, as such, makes a valuable source of information.

The key search terms included: Muslims; CALD; cultural diversity; ageing; aged care; residential aged care; home and community care; religion; spirituality and well-being.

The organisations visited and the persons met with are:

- Mr Richard Hearn, CEO; Ms Lynn Openshaw, Manager Service Development; Ms Julie Kuhne, Project Officer Business Support Community Service; all from Resthaven
- Ms Marilyn Crabtree, CEO; Ms Jane Northey, Team Leader; Ms Deborah Bluntish, Team Leader Home and Community Care; all from Aged Rights Advocacy Service Incorporated
- Ms Maria Johns, Manager Training and Services Development, Multicultural Aged Care Incorporated
- Mr Franco Parenti, Manager Community Services, Resthaven Incorporated
- Ms Sherifa Khan, Chairperson, Muslim Women's Association of South Australia
- Ms Helena Kyriazopoulos, Team Leader Access and Equity Unit, Alzheimer's Australia SA Inc.
- Associate Professor Angela Scarino, Director of Research Centre for Languages and Cultures, University of South Australia.

The following organizations were contacted by phone:

- Islamic Women's Association of Queensland
- BASMA, South Australia
- Ottoman Village Aged Care, Victoria
- Moran Health Care Group, Victoria
- ISOMER Retirement Home, Victoria
- Tripoli and Mena Association Limited, New South Wales.

The following person/organizations were contacted by email:

- Mr Bruce Shaw, Senior Policy Officer Aged Care, Federation of Ethnic Communities' Councils of Australia (FECCA)
- Dr Peter Braun, Ageing and Aged Care Unit, Continuing and Specialised Care Group, Australian Institute of Health and Welfare (AIHW)
- Revd. Professor Elizabeth MacKinlay, Director, Centre for Ageing & Pastoral Studies, Canberra
- Dr Robert Crotty, Emeritus Professor, School of Education, University of South Australia
- Dr Kate Barnett, Deputy Executive Director, Australian Workplace Innovation and Social Research Centre, University of Adelaide
- Ms Patrizia Kadis, Relationship Manager, Italian Benevolent Foundation
- Ethnic Communities Council of Victoria Incorporated (ECCV)
- National Information and Referral Service, Australian Bureau of Statistics
- Department of Health
- Islamic Councils in all States and Territories sourced from Multicultural SA website
- Ozcare, Queensland.

The authors gratefully acknowledge the late Professor Graeme Hugo, ARC Australian Professorial Fellow, Professor of Geography and Director of the Australian Population and Migration Research Centre at the University of Adelaide and his computer analyst Ms Margaret Young, in getting access to much of the Australian Bureau of Statistics (ABS) 2011 Census data contained in this Report in regards to Muslims in Australia and South Australia.

1.8 Definitions

There is no agreed definition of 'older people'. The Aged Care Act does not specify an age when a person becomes an aged person. However, the Australian Institute of Health and Welfare (AIHW), an independent national statutory agency, uses the term to refer to people aged 65 years and over.¹ For the purpose of this Report, the terms '*older*', '*elderly*', and '*aged*' have been used interchangeably to include people who are 65 years and over and who may need some form of care, unless otherwise stated.

Groups and individuals differ according to religion and spirituality, racial backgrounds, ethnicity, culture, as well as language. The term '*culturally and linguistically diverse*' (CALD), although taken literally would include all Australians is, however, used to describe those groups that are different from the English-speaking majority. This Report adopts the AIHW

¹ Australian Institute of Health and Welfare (AIHW), Department of Health and Ageing, *Older Australia at a Glance*, 4th edition, Cat. No. AGE 52 (Canberra: 2007) p. 2.

definition of ‘older persons from CALD backgrounds’² as those aged 65 or over and born overseas in countries where English is not the main language spoken.

The concept of diversity figures prominently in this Report when discussing Muslims in particular and the CALD communities/population in general. For the purpose of this Report, *diversity* refers to the non-health attributes of people which can affect the appropriateness of care services planning and delivery.

The *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds* defines ‘culturally and linguistically appropriate care’ as “targeted care which is reflective of and responsive to the cultural, linguistic and spiritual needs of the person. It uses cultural and linguistic characteristics, experiences and perspectives of ethnically diverse people to deliver aged care services more effectively”.³ For the purpose of this Report, in the context of Muslims, ‘culturally appropriate care’ or ‘appropriate care’ would mean care that meets the needs of Muslims as defined by their religion. This leads to the question: what is religion?

The most important Australian source on the question of what constitutes a religion is the decision made in 1983 by the High Court of Australia in the *Scientology* case. The term ‘religion’ was defined as a mixture of beliefs, practices, and a Supernatural Being. The High Court in its ruling stated: “For the purposes of the law, the criteria of religion are twofold: first, belief in a Supernatural Being, Thing or Principle; and second, the acceptance of canons of conduct in order to give effect to that belief, though canons of conduct which offend against the ordinary laws are outside the area of any immunity, privilege or right conferred on the grounds of religion”.⁴

In addition to ‘religion’, the words ‘spirituality’ and ‘faith’ are widely used in this Report. ‘Spirituality’ generally describes the feeling of connectedness with a higher power or consciousness and the search for answers to questions about the meaning and purpose of life. For Muslims, religion and spirituality are neither mutually exclusive nor stand-alone concepts; these two concepts are covered in greater detail in chapter 4. The term ‘faith’ is used to mean strong belief and trust in the doctrines of a religion, based on spiritual conviction. The words ‘religion’ and ‘faith’ are used synonymously in this Report.

The terms ‘care’ and ‘aged care’ are defined in this Report according to the Aged Care Act 1997⁵ where ‘care’ means services, or accommodation and services, provided to a person

² Diane Gibson, Peter Braun, Christine Benham and Frieda Mason, *Projections of Older Immigrants: People from Culturally and Linguistically Diverse Backgrounds, 1996–2026, Australia* (Canberra: AIHW, 2001, Cat. no. AGE 18), p. xvii.

³ Department of Health and Ageing, Australian Government, *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*, (Commonwealth of Australia, 2012) p. 7.

⁴ Australian Bureau of Statistics (ABS), 1266.0 - *Australian Standard Classification of Religious Groups (ASCRG)*, 1996, <http://www.abs.gov.au/ausstats/abs@.nsf/0/775012EF0058A77DCA25697E00184BDC?opendocument> (Last accessed December 20, 2014)

⁵ Commonwealth Consolidated Acts, Aged Care Act 1997, Schedule 1, Dictionary,

who cannot maintain himself or herself independently because his or her physical, mental or social functioning is affected and 'aged care' means care of one or more of the following types:

- residential care
- home care (formerly known as community care), and
- flexible care.

The Aged Care Act 1997 defines '*residential care*' as follows:⁶

Residential care is personal care or nursing care, or both personal care and nursing care, that:

- (a) is provided to a person in a residential facility in which the person is also provided with accommodation that includes:
 - (i) appropriate staffing to meet the nursing and personal care needs of the person; and
 - (ii) meals and cleaning services; and
 - (iii) furnishings, furniture and equipment for the provision of that care and accommodation; and
- (b) meets any other requirements specified in the Subsidy Principles.

According to the Act, the following are excluded from the definition:

- (a) care provided to a person in the person's private home;
- (b) care provided in a hospital or in a psychiatric facility;
- (c) care provided in a facility that primarily provides care to people who are not frail and aged;
- (d) care that is specified in the Subsidy Principles not to be residential care.

'*Home care*' is care consisting of a package of personal care services and other personal assistance provided to a person who is not receiving residential care.⁷

For the purpose of this Report, community care (or services) and home care (or services) are used interchangeably as generic terms. These are used to refer to personal care services and other personal assistance that are received at home, enabling the recipient to continue to live in, and be part of, the community for as long as possible. The term 'community care' has been replaced by the term 'home care' from July 2013 under the aged care reform measures, and accordingly, the care packages under community care have been replaced by new home care

http://www.austlii.edu.au/au/legis/cth/consol_act/aca199757/sch1.html (Last accessed December 20, 2014)

⁶ Australian Government ComLaw, *Aged Care Act 1997, Act No. No. 112 of 1997*, Section 41-3, <http://www.comlaw.gov.au/Details/C2014C00698> (Last accessed December 20, 2014)

⁷ *ibid.* Section 45-3

packages. However, Home and Community Care (HACC) is a particular care package (described in chapter 6) and is treated accordingly.

'Flexible care' refers to care that is offered in a residential or community setting through an aged care service that provides for the needs of care recipients in alternative ways to the care provided through residential care and home care services.⁸

In this Report, 'services' is used to mean an act or acts of assistance or benefit in response to need or demand and the term 'aged care services' is used broadly to include any such assistance or benefit to support the aged person at home or in a residential aged care facility. The Residential Care Manual uses the term 'aged care service'⁹ to describe a residential aged care service operated by an approved provider.

The term 'consumer' is used in this Report to refer to the person receiving aged care and services. The National Aged Care Alliance (NACA) prefers 'consumer', over other terminologies such as 'client', 'customer' or 'care recipient'. A 'care recipient'¹⁰ is one who is receiving Australian government- funded care and support either at one's own home or in an aged care facility; however, in this Report the expression 'care recipient' is used much more broadly to include anyone who receives care. The term 'resident'¹¹ is used to refer to someone living in a residential aged care facility.

'Approved providers'¹² are organisations approved by the Australian Government to receive subsidies for provision of care, services, and accommodation to residents in an aged care home, or care and services to people in the community.

The following definitions are sourced from the Department of Health:¹³

An 'operational provider' is an approved provider of residential or community aged care who has at least one operational service.

⁸ *ibid.* Section 49-3

⁹ Department of Social Services, Australian Government, *The Residential Care Manual*, (Commonwealth of Australia, 2014) p. 5.

¹⁰ Department of Health and Ageing, Australian Government
<http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+C> (Last accessed April 01, 2013)

¹¹ Department of Health and Ageing, Australian Government
<http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+R> (Last accessed April 01, 2013)

¹² Department of Health and Ageing, Australian Government
<http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+A> (Last accessed April 01, 2013)

¹³ Department of Health and Ageing, Australian Government
<http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-rescare-servlist-providers-services.htm> (Last accessed April 02, 2013)

A *'service'* or *'facility'* is the unit of an approved provider that delivers a particular aged care funded service type at or from a discrete location.

An *'operational service'* is a service operated by an approved provider of residential or community aged care who has at least one operational place.

A *'place'* is the capacity within an aged care service for the provision of residential, home, or flexible care to an individual.

'Residential aged care facility', *'aged care facility'*, and *'aged care home'* are terms used interchangeably to refer to a place which offers aged care and accommodation to the elderly. These newer terms have largely replaced the term *'nursing home'* in Australia although the latter term is still more familiar in many other countries.

'Re-ablement' is the use of timely assessment and targeted interventions to assist people to maximise their independence, choice, and quality of life and to minimise the support required so as to enable people to actively participate and remain engaged in their communities.¹⁴

The *'wellness'* approach encourages people to do as much for themselves as possible to enhance their quality of life and independence and improve their social, emotional and physical functioning. This involves having strengths, abilities and individual needs assessed, setting goals which promote strengths and abilities, and reviewing progress against these goals. People are, however, continued to be assisted with the tasks they are unable to do themselves.

In the context of care or services provided, the term *'culturally sensitive'*, also referred to by many as *'culturally aware'*, means recognising and adjusting to the cultural characteristics of the care recipient. Cultural sensitivity or cultural competence is a skill that involves an awareness and acceptance of cultural differences and allows providers and carers to understand, appreciate, and work with individuals who are from cultures different to their own.

1.9 Report Preview

This Report is divided into thirteen chapters. The Introduction chapter provides the purpose and scope of the study, including the structure of the Report. Chapters 2 to 13 present the relevant literature, lay out the discussions, and make the analyses in an integrated way before concluding with recommendations.

Chapter 2 provides an insight into Islam and the way of life of its adherents. Chapter 3 provides historical and demographic information on Muslims in Australia and South Australia, with a snapshot of Muslims elsewhere. It discusses the obligations of, and protections offered by, a multicultural Australia and touches upon the impediments to inclusion efforts in Australian society. Chapter 4 delineates the concepts of religion and spirituality, their

¹⁴ Department of Social Services, Australian Government, Part K – Appendices, Appendix A – Glossary of terms, *Home Care Packages Programme Guidelines*, July 2014

profound influences on health and well-being of the aged, and how religious belief strengthens resilience in the face of adversity. The chapter also clarifies these concepts in the context of the Islamic faith. Chapter 5 clarifies the relationship between culture and ethnicity in the context of Muslims and discusses the debate surrounding Muslim integration in Western societies. It also discusses the inadequate protection offered to Muslims under discrimination and vilification laws in Australia.

Chapter 6 details various important aspects of the aged care system, including care provision and funding, available care packages, the significant role of carers, responsibilities of relevant departments and agencies, and the policy and regulatory frameworks. Also discussed here is the changing profile of older Australians, the care of older CALD people, access issues, and the new aged care reform measures. Chapter 7 describes residential care and the enormous need for it at some point in time for many older people and also includes a section on retirement villages. Chapter 8 focuses on aged care in South Australia with particular focus on residential care. Chapter 9 outlines the different services delivery models in use for aged care in order to find out a feasible model for Muslims; it also briefly discusses person-centred care and how it differs from consumer-directed care.

Chapter 10 provides a general idea of aged care for ethnic population in Europe and the US. It includes a section on organisations that are providing aged care to Muslims in Australia and covers other related developments. Building upon the aged care needs of older people from CALD communities, Chapter 11 constructs a rationale for aged care for Muslims by linking the spiritual component of care with issues of availability and accessibility. It also stresses upon the need for an attitudinal shift by Muslims toward aged care. Chapter 12 highlights the importance of proper aged care planning and presents the key elements of planning for Muslim aged care in general and for residential care in particular. The Report ends with Chapter 13 where recommendations for both short-term and long-term Muslim aged care are provided including research direction for the future.

2. Islam and Muslims

This chapter introduces Islam, the religion followed by Muslims, by briefly describing the pillars and fundamental beliefs upon which the faith is based.

2.1 Origin of Islam

Islam is the second largest religion in the world with over 1.6 billion followers that is projected to reach 2.2 billion by 2030.¹⁵ The word *Islam* means submission or surrender; it is derived from the root word *salaam* which is the word for peace in Arabic. A follower of Islam is called a *Muslim* which means one who submits to *Allah*; Allah is the Arabic word for God. The cornerstone of Islam and its most profound tenet is a belief in absolute Monotheism, a belief in the One God.

Muslims base their laws on the *Qur'an* and the *Sunnah*. The *Qur'an* is their holy book containing God's message revealed in Arabic to Prophet Muhammad (May peace be upon him¹⁶) over 1400 years ago in Mecca (Makkah), Saudi Arabia, by Archangel Gabriel (Jibril). *Sunnah* includes the specific words, habits, practices, and silent approvals of Prophet Muhammad (May peace be upon him). Muslims refer to *Sunnah* for guidance and direction on issues of daily lives which are not directly addressed in the *Qur'an*. Islam is one of the three Abrahamic religions that emanate from the same source--God, and whose adherents worship the God of Abraham. Islam shares not only the same origins with Judaism and Christianity but also many of the same beliefs. Jews and Christians are described as "People of the Book" in the *Qur'an* because they are considered recipients of the same revelation of the One God. Muslims believe that Islam is not a new religion preached by Prophet Muhammad (May peace be upon him) but the culmination of the same message, a belief in the One God, preached by all prophets since Adam.

2.2 Five Pillars of Islam

While they follow a multitude of cultures depending upon their region and ancestry, being a Muslim is the overarching identity among the followers of the Islamic faith. To be a Muslim means that one must believe and follow the tenets of Islam, which are also referred to as the Five Pillars of Islam. These five pillars are:

1. ***Shahadah*** or the Declaration of Faith: "There is no deity save Allah, and Muhammad is the Messenger of Allah". The first part of this declaration of faith asserts the Oneness of God; the second part refers to Muslims' belief that Prophet Muhammad (May peace be upon him) was sent with the divine message. The absolute monotheism or Oneness of God as expressed in this declaration is the fundamental concept in Islam.

¹⁵ Pew Research Centre, Forum on Religion and Public Life, *The Future of the Global Muslim Population: Projections for 2010-2030*, (Washington, DC: 2011) p.13.

¹⁶ When their prophet's name is mentioned, Muslims use the phrase 'peace be upon him' to show their respect. They are also encouraged to use a similar salutation when other prophets' names are mentioned.

2. **Salaah** or praying is a direct link between the worshipper and God. There are five obligatory daily prayers, which are fixed sets of standing, bowings, prostrations, and sittings which are combined with recitation from the Qur'an and supplication, at five set times as follows:
 - i. *Salat al-fajr*: dawn, before sunrise
 - ii. *Salat al-zuhr*: midday, after the sun passes its highest point
 - iii. *Salat al-'asr*: the late part of the afternoon
 - iv. *Salat al-maghrib*: just after sunset, and
 - v. *Salat al-'isha*: when the sky is completely dark until midnight.

*Qibla*¹⁷ or the direction of all prayers is towards the Kaaba, the cubical building built by the Prophet Abraham as the first House of Worship and located inside the Holy Mosque in Makkah. In addition to the five obligatory prayers, a Muslim may offer voluntary prayers any number of times during the day or night. It is necessary to be in a state of cleanliness which means that the person and place of prayer must be free of all impurities before one can perform the Salaah.

In addition to the daily prayers, there is the weekly Friday noon prayer or *jum'a* prayer that is obligatory for men and must be offered in congregation. There are also the special congregational prayers offered on the two great festivals in the Muslim calendar-- *Eid-ul-Fitr*, marking the end of the month of Ramadan (please see below under *Sawm*) and *Eid-ul-Adha* commemorating the willingness of Prophet Abraham to sacrifice his son when God ordered him to do it.

3. **Sawm** or fasting for one month is obligatory for every adult, sane, and healthy Muslim. During daylight hours in the Arabic month of Ramadan (ninth month of the Muslim calendar, which is based on the lunar cycle and does not correspond with the Gregorian calendar), a fasting Muslim abstains from food, drink, smoking, and sex. Islam also prescribes other days on which Muslims may choose to observe voluntary fast. *Sawm*, however, is more than just fasting; it is abstinence from all evil thoughts, words, or deeds. Fasting is also one of the methods of self-purification.
4. **Zakaat** (obligatory charity) is the compulsory annual excise of 2.5% of one's average annual net savings or accumulated wealth. This is different from voluntary charity which is at the discretion of the individual. Muslims believe that all things belong to God and wealth is held in trust by human beings. That is why the poor and the needy have a right to this levy which is used entirely for them.
5. **Hajj** or pilgrimage to Makkah is compulsory at least once in a lifetime for every mentally competent adult Muslim if he or she can afford it and is physically able to undertake the journey and fulfil the obligations of Hajj.

¹⁷ Qibla direction in Adelaide would be approximately 283.529568° from North clockwise.

There are exemptions for special circumstances with regard to the pillars described above except the Declaration of Faith. Islam is a constant presence in the life of a Muslim--the Shahadah is intended to be in the hearts of Muslims all the time; they pray five times every day; they pray in congregation every week; every year, they fast for one month during Ramadan; they give Zakaat annually; and at least once in a lifetime they perform Hajj. In Islam, worship includes but is not limited to particular rituals; it includes anything a person does to seek God's pleasure.

2.3 Articles of Faith

There are seven fundamental beliefs or articles of faith that Islam requires every Muslim to have:

1. One God: There is no other god besides the One God.
2. Omnipotence of God: The universe and everything in it were created by God alone. He is the Cherisher and the Sustainer of all things and has authority and sovereignty over all things. He has full knowledge of the past, present, and future.
3. Prophets: God sent prophets and messengers to all the nations of the earth to spread His Message and to teach people how to live life according to His Will. The first of the many prophets was Adam and the last was Prophet Muhammad (May peace be upon him). All prophets (May peace be upon them), including Noah (Nuh), Abraham (Ibrahim), Ishmael (Ismail), Isaac (Ishaq), Job (Ayyub), Moses (Musa), Aaron (Harun), Lot (Lut), Jacob (Yaqub), David (Dawood), Solomon (Sulaiman), Jonah (Yunus), Joseph (Yusuf), and Jesus (Isa) are revered by Muslims.
4. Scriptures or Holy Books: God gave scriptures to a few prophets such as Moses, David, Jesus, and Muhammad (May peace be upon all of them). The Qur'an mentions the Torah (Tawrat) given to Moses, the Psalms (Zabur) of David, and the Gospel (Injil) given to Jesus. The final scripture is the Qur'an that was revealed to Prophet Muhammad (May peace be upon him).
5. Angels: There are beings called angels such as Gabriel (Jibril) and Michael (Mika'il). Each angel has been given a function by God and, unlike human beings, they do not disobey God.
6. Day of Judgment: One day, the universe and everything in it will come to an end. God will then bring back to life all human beings and gather them on the Day of Judgment, also known as the Day of Reckoning, when each person will be held accountable for every thought or action of that person in this world.
7. Life after Death: Those who lived on the whole a 'good' or moral life according to God's commands will be rewarded with life in Paradise. Those who lived a 'bad' life, or did not believe in God, or rejected His prophets' teachings, will be

condemned to Hell. Of course, Islam also teaches that if a person truly repents and stays away from evil, God may forgive him or her. Muslims believe that after human beings are resurrected on the Day of Judgment, they will have eternal life in the Hereafter.

This brief introduction to Islam, the religion followed by Muslims, sets the stage for the rest of the Report, particularly for the ensuing discussion on the importance of religion in planning and delivery of aged care services for Muslims.

3. Muslims in Australia and Around the Globe

This chapter highlights some key aspects of Australia's multicultural policy through which the nation seeks unity and strength in diversity. It draws on the policies and programs related to issues of diversity and multiculturalism to focus on the obligations of the government to provide protection and services to all Australians. It also discusses the intolerance and insensitivity toward Muslims, viewed as 'the Other', by some in Australia. The chapter also includes a demographic profile of Muslims in Australia and South Australia and provides a snapshot of Muslims in other parts of the world.

3.1 Multicultural Australia

A planned migration program has transformed Australia from a primarily Anglo-Celtic society to a multi-faith nation, a country of immigration, a multicultural land. The following list of statistics¹⁸ paints the diversity kaleidoscope of its almost 22 million people:

- Since 1945, seven million people have journeyed to Australia and made it their home.
- One in four Australians was born overseas.
- 44 per cent of Australia's population were either born overseas or have a parent who was born overseas.
- Four million Australians speak a language other than English.
- Australians speak more than 260 languages.
- Australians identify with over 270 ancestries.

Citing ABS data that almost 400 different languages are spoken in Australian homes and 79 per cent of Australians are affiliated with more than 16 religions, the Federation of Communities' Councils of Australia (FECCA) argues:

"This diversity is a defining feature of Australian life and has and continues to contribute to defining what it means to be an Australian."¹⁹

Intermarriages between Australians of different backgrounds are so common that less than half the population is of pure Anglo-Celtic descent. Over 60% of Australians can claim at least two different ethnic origins, and 20% four or more. About one-quarter of Australians have no Anglo-Celtic background at all.²⁰

¹⁸ Department of Immigration and Citizenship (DIAC), Australian Government, *The People of Australia- Australia's Multicultural Policy* (Canberra: 2011) p.2. DIAC has been renamed as the Department of Immigration and Border Protection.

¹⁹ Federation of Ethnic Communities' Councils of Australia (FECCA), *The Bigger Picture: Joining Up Solutions to Achieve Access and Equity* (Canberra: 2010) p. 19.

²⁰ Department of Immigration and Citizenship [DIAC], *National Agenda for a Multicultural Australia: Sharing Our Future* (Canberra: 1989) p. 6.

The top five birthplaces of Australia's overseas born population in 2011 were in descending order: the United Kingdom (UK), New Zealand (NZ), China, India, and Italy. Except for the UK and NZ, the rest three are countries whose first language is not English.²¹

Australia has embraced multiculturalism because it is woven into the very fabric of its identity. The Commonwealth Government has selected the dimensions of the country's multicultural policy as follows:²²

1. cultural identity: the right of all Australians, within carefully defined limits, to express and share their individual cultural heritage, including their language and religion;
2. social justice: the right of all Australians to equality of treatment and opportunity, and the removal of barriers of race, ethnicity, culture, religion, language, gender or place of birth; and
3. economic efficiency: the need to maintain, develop and utilize effectively the skills and talents of all Australians, regardless of background.

The United Nations Development Program (UNDP) puts forward strong arguments in favour of multiculturalism when it says:

“One way or another every country is a multicultural society today, containing ethnic, religious or linguistic groups that have common bonds to their own heritage, culture, values and way of life. Cultural diversity is here to stay—and to grow.... Policies recognizing cultural identities and encouraging diversity to flourish do not result in fragmentation, conflict, weak development or authoritarian rule. Such policies are both viable, and necessary, for it is often the suppression of culturally identified groups that leads to tensions.”²³

The People of Australia--Australia's Multicultural Policy launched in 2011 by the Department of Immigration and Citizenship (DIAC) asserts:

“Multiculturalism is in Australia's national interest and speaks to fairness and inclusion. It enhances respect and support for cultural, religious and linguistic diversity. It is about Australia's shared experience and the composition of neighbourhoods. It acknowledges the benefits and potential that cultural diversity brings. Australia's multicultural policy embraces our shared values and cultural traditions. It also allows those who choose to call Australia home the right to

²¹ Australian Bureau of Statistics, *Cultural Diversity in Australia, 2011.0--Reflecting a Nation: Stories from the 2011 Census, 2012–2013* (Canberra: 2012)
<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2011.0main+features902012-2013> (Last accessed December 25, 2014)

²² *National Agenda for a Multicultural Australia: Sharing Our Future*, op. cit. p. vii.

²³ United Nations Development Programme, *UNDP Human Development Report 2004: Cultural Liberty in Today's Diverse World* (New York: 2004) p. 2.

practise and share in their cultural traditions and languages within the law and free from discrimination.”²⁴

Among the four principles contained in the Multicultural Policy, Principle 2 assures:

“The Australian Government is committed to a just, inclusive and socially cohesive society where everyone can participate in the opportunities that Australia offers and where government services are responsive to the needs of Australians from culturally and linguistically diverse backgrounds.”²⁵

South Australia has its own *Declaration of the Principles for a Multicultural South Australia*. One of the four principles is affirming “the right of all individuals to maintain, develop, express and share their cultural heritages within the legal and social framework of our State”.²⁶

The Australian Multicultural Advisory Council’s statement on cultural diversity and recommendations to government states that “...multiculturalism constitutes the nation’s resolve to provide opportunity and security for every citizen, regardless of background, culture, religion or gender; and to assure all who live here of the right to live in keeping with their cultures and languages”.²⁷ The Advisory Council’s statement further asserts:

“All Australians in need of assistance from government and qualified for it are equally entitled to receive it. Culture, language and religion should in no way compromise this right. Guaranteeing this principle of fairness is helpful to both the people in need and the cause of social justice and harmony. It is a practical demonstration of good governance and good policy, for a multicultural Australia.The cultural, linguistic and religious diversity of Australia’s population should not mean that programs and services are less accessible. It is the duty of government to see that all citizens are able to participate in programs and receive the services to which they are entitled, regardless of their cultural background. Where programs and services are not being used by Australians because of cultural or language difficulties, such programs need to be delivered by organisations culturally and linguistically able to do so. That is not a matter of providing an advantage not available to all Australians, but rather ensuring that all Australians are treated equally”.²⁸

²⁴ *The People of Australia- Australia’s Multicultural Policy*, op. cit. p.2.

²⁵ *ibid.* p. 5.

²⁶ Government of South Australia, *Declaration of Principles for a Multicultural South Australia* (Adelaide, 1995), http://www.multiculturalaustralia.edu.au/doc/multicultsa_1.pdf (Last accessed January 23, 2015)

²⁷ Australian Multicultural Advisory Council, *The People of Australia: The Australian Multicultural Advisory Council’s statement on cultural diversity and recommendations to government* (2010) p. 12.

²⁸ *ibid.* p.18.

The Australian Government's *Access and Equity Policy* is an integral part of the country's Multicultural Policy. The Access and Equity Strategy was the name first given to Access and Equity policy. This policy originated in the late 1970s and is currently expressed through an *Access and Equity Strategy and Framework*; this framework provides a key tool for incorporating cultural diversity in government services delivery.

The Access and Equity Policy states: "Access means that Australian government services and programs should be available for CALD clients and accessible by them. *Equity* means that these services and programs deliver outcomes for CALD Australians that are on a par with those other Australians can expect to receive. Access and Equity is primarily about existing Australian government programs and services adapting to the needs of all Australians, rather than providing special and separate services to clients from CALD backgrounds. It requires that cultural diversity principles be incorporated into policy and program design, and into the implementation of program and service delivery."²⁹

The specific target groups for Access and Equity policy are:³⁰

- migrants with low levels of English proficiency
- refugees and humanitarian entrants
- visibly different migrants
- newly arrived communities and individuals with low levels of knowledge of the Australian system, and
- other migrants experiencing difficulties in accessing services based on age, gender, disability, youth or coming from collectivist cultures.

The Access and Equity Policy focuses on the systemic inequalities that impact on Australia's CALD communities. It requires that cultural diversity principles be incorporated into policy and program design, implementation, and service delivery through an understanding of, and respect for, cultural and linguistic diversities by government departments. The Access and Equity Strategy and Framework apply to all government-funded services, irrespective of whether they are delivered by government agencies, community organisations, or commercial enterprises. It has four principles or indicators, each with three associated strategies developed to help identify key areas of government responsibility for addressing the needs of the CALD population. The four Access and Equity indicators are:³¹

1. Responsiveness
2. Communication
3. Accountability, and
4. Leadership.

²⁹ Department of Immigration and Citizenship, *Access and Equity for a Multicultural Australia*, Access and Equity Inquiry Panel (Canberra: 2012) p. 13.

³⁰ *ibid.* p. 28.

³¹ *ibid.* p.17.

The Framework defines *Responsiveness* as the extent to which programs and services are accessible, fair and responsive to the needs of an individual; *Communication* is having open and effective channels of communication with all stakeholders; *Accountability* is effective and transparent reporting and review mechanisms; and *Leadership* is broad approaches to managing issues arising from Australia's cultural and linguistic diversity.

In its 2010 report, FECCA unveiled its consultation findings with regard to the above four performance indicators as applied to aged care services. With regard to Responsiveness, the FECCA report states, "CALD communities continue to identify unmet needs and feel marginalised within mainstream service provision. Communities perceived that CALD specific/ethno-specific providers were better able to appropriately assess and meet the diverse needs of these communities".³² The problem with regard to Communication is "Lack of clear identification and advertising of sources of information on services and service providers"³³ and with regard to Accountability, FECCA says, "The accessibility and equity of services and service delivery remains difficult to ascertain and substantiate due to the absence of appropriate data collection for outcomes in service areas for CALD clients".³⁴

For improving access and equity across the country, it is "essential that the Australian Government engage effectively with, and be responsive to, cultural and linguistic diversity both in the national interest and in the interests of the communities and individuals concerned".³⁵

FECCA's National Multicultural Agenda dismisses the notion that multiculturalism has failed, belying the criticisms of, and arguments against, multiculturalism by some European nations. FECCA maintains that it is "the lack of an authentic and courageous engagement with cultures and their many aspects including religion and customs"³⁶ that has given rise to an unfortunate situation in many societies.

3.2 Social Inclusion

Social Inclusion in Australia: How Australia is Faring is a report card on social exclusion, and its 2012 edition contains a dismal picture of Australia going backwards on a few indicators³⁷ thus signifying greater discrimination and less access to services. This portrayal supports the Scanlon Foundation's Mapping Social Cohesion Survey findings; the latter covers a range of

³² *The Bigger Picture: Joining Up Solutions to Achieve Access and Equity*, op. cit. p. 12.

³³ *ibid.* p. 13.

³⁴ *ibid.*

³⁵ *Access and Equity for a Multicultural Australia*, op. cit. p. 38.

³⁶ Federation of Ethnic Communities' Councils of Australia, "*Different but Equal*" FECCA'S National Multicultural Agenda (Canberra: 2010) p. 5.

³⁷ For detailed survey results on exclusion, social inequality, and discrimination, see Australian Social Inclusion Board, *Social Inclusion in Australia: How Australia is Faring*, 2nd Edition (Canberra: Department of the Prime Minister and Cabinet, 2012)

social cohesion and population issues. The 2011 survey shows a continued decrease in levels of acceptance of cultural diversity between 2007 and 2011. It found that the percentage of people who 'strongly disagreed' that the government should help ethnic minorities to maintain their customs and traditions increased from 26% in 2007 to 31% in 2010.³⁸ The proportion of people reporting experiences of discrimination based on skin colour, ethnic origin, or religion had also increased between 2007 and 2011, from 9% to 14%.³⁹

South Australia mirrors the national picture in that there has been a downward trend in the percentage of South Australians who viewed cultural diversity as a positive influence in the community. According to the *2012 South Australia Strategic Plan (SASP) Progress Report*, 85.9% of respondents in the 2012 SASP Household Survey viewed cultural diversity positively; this figure was 87.7% in 2008.⁴⁰

Although efforts have been made by the governments at both federal and state levels to address issues such as social cohesion and alienation among the ethnic communities across Australia and to build cross-cultural respect and inter-faith dialogues, it is at the community level that the social tensions are felt and experienced. It may be because "Social cohesion operates not in the abstract, the realm of the 'nation', but at the community level, where people of different backgrounds and cultures make their lives".⁴¹

In 2010, the Australian Multicultural Advisory Council cited a study where one in four people said they had experienced discrimination in Australia.⁴²

A twelve-year national study,⁴³ funded by the Australian Research Council, was conducted by researchers from universities across Australia who polled thousands of people about their attitudes to different cultures. The study showed that around one in ten Australians were prejudiced against other cultures.⁴⁴

³⁸ Andrew Markus, *Mapping Social Cohesion, The Scanlon Foundation Surveys, Summary Report 2011* (Melbourne: Monash University with Scanlon Foundation and Australian Multicultural Foundation, 2011) p. 18.

³⁹ *ibid.* p. 17.

⁴⁰ Audit Committee Secretariat, Department of the Premier and Cabinet, *South Australia's Strategic Plan: Progress Report 2012* (Adelaide: 2012) p.23.

⁴¹ Andrew Markus, *Mapping Social Cohesion, The Scanlon Foundation Surveys, Neighbourhoods Report: areas of immigrant concentration 2012* (Melbourne: Monash University with Scanlon Foundation and Australian Multicultural Foundation, 2012) p. 4.

⁴² *The People of Australia: The Australian Multicultural Advisory Council's statement on cultural diversity and recommendations to government* op. cit. p. 17.

⁴³ Kevin Dunn et. al., *Challenging Racism: The Anti-Racism Research Project National Level Findings* (Sydney: School of Social Sciences and Psychology, University of Western Sydney, undated)
http://www.uws.edu.au/__data/assets/pdf_file/0007/173635/NationalLevelFindingsV1.pdf (Last accessed December 26, 2014)

⁴⁴ Australian Broadcasting Corporation (ABC), <http://www.abc.net.au/news/2011-02-23/nearly-half-of-australians-are-anti-muslim-study/1954194> (Last accessed December 26, 2014)

In an inspiring move, the Australian Football League (AFL) has made a landmark decision in April 2012 to make prayer rooms available at AFL venues, and so provide Muslims and other religious adherents with a quiet place to pray in accordance with their faiths, a result owed to the efforts of football player Bachar Houli and AFL chief Andrew Demetriou. The Muslim community welcomed the decision as it would enable them to enjoy a game as well as fulfil their obligation of daily prayers should the prayer time coincide with the match time. However, there have been people and organizations including Victoria's former Premier Mr Jeff Kennett who have denounced the move. Nonetheless, many see it as an initiative that would help make the game more accessible for people coming from different backgrounds.

3.3 Muslim Demographics of Australia

The first of the Afghan cameleers arrived in South Australia in the 1830s and they were the founders of Islam in Australia. The rail links across the Australian outback and Australia's overland telegraph lines were all built with the assistance of these Afghan cameleers, thus opening up Australia's vast interior. It was their descendants who built Australia's first mosque in 1861 in South Australia at Marree, then known as Hergott Springs. Australia's first large mosque was also built in South Australia's capital city Adelaide in 1890.⁴⁵

The 2011 ABS Census reveals the following figures for Muslim population by States and Territories:

States and Territories	Number	Per cent
New South Wales	219,378	46.1
Victoria	152,779	32.1
Queensland	34,048	7.1
South Australia	19,511	4.1
Western Australia	39,116	8.2
Tasmania	1,708	0.4
Northern Territory	1,587	0.3
Australian Capital Territory	7,434	1.6
Other Territories	729	0.1
Total	476,290	100

According to the Census, the most common non-Christian religions in 2011 were Buddhism (accounting for 2.5% of the population), Islam (2.2%, up from 1.7% in 2006) and Hinduism (1.3%); Islam was the fourth largest religious grouping. Among non-Christian religions, Hinduism had experienced the fastest growth since 2001, followed by Islam (increased by 69%). Between 2006 and 2011, the number of Muslims in Australia increased by 28.5 per cent.⁴⁶ Between 2010 and 2030, the Muslim population in Australia is forecast to grow by

⁴⁵ Department of Immigration and Citizenship, *The Australian Journey – Muslim Communities* (Canberra: 2009) p. 7.

⁴⁶ Government of Western Australia, *Culture and Religion Information Sheet--Islam* (Perth: Office of Multicultural Interests, Department of Local Government, 2012) p. 3.

78.9%.⁴⁷ A higher proportion of recent arrivals compared to longer-standing migrants reported their affiliations to Islam (8.4% compared to 4.7%).⁴⁸ Among non-Christian overseas-born population, 5.4% are Muslims and the proportion of Muslims born overseas was 61.5%.⁴⁹ According to the 2006 Census, there were over 1000 Indigenous Muslims;⁵⁰ since then, the number has increased to 1140 according to the 2011 Census.⁵¹

The percentage of Muslims who is “not well” in terms of proficiency in spoken English is 13.4 and those with no proficiency at all are 4.9.⁵² Although a little over 86 per cent of Muslim Australians speak a language other than English at home, more than 70 per cent of them can speak English either well or very well. Arabic-speaking Muslims represent under a third of all Muslims (31.8 per cent); besides Arabic, other common languages spoken at home are English (13.3 per cent), Turkish (11.1 per cent), Urdu (7.5 per cent) and Bengali or Bangla (5.9 per cent).⁵³

A significant feature of Muslim communities in Australia is their overwhelmingly migrant character. The list of top ten countries of origin of Muslims in Australia according to the ABS 2011 Census appears below:

Australia	38.5%
Lebanon	7.2%
Pakistan	5.7%
Afghanistan	5.6%
Turkey	5.4%
Bangladesh	5.1%
Iraq	3.3%
Iran	2.7%
Indonesia	2.6%
India	2.2%

⁴⁷ *The Future of the Global Muslim Population: Projections for 2010-2030*, op. cit. p. 78.

⁴⁸ *Cultural Diversity in Australia, 2011.0--Reflecting a Nation: Stories from the 2011 Census, 2012–2013*, op. cit.

⁴⁹ *ibid.*

⁵⁰ *The Australian Journey – Muslim Communities*, op. cit. p.8.

⁵¹ BBC News Magazine, *When Islam Came to Australia*, <http://www.bbc.com/news/magazine-27260027> (Last accessed January 27, 2015)

⁵² ABS 2011 Census.

⁵³ *ibid.*

The countries of origin or birth of Australian Muslims are greater in number in Australia than in any other country in the world.⁵⁴ Australian Muslims representing over 60 different ethnic groups and racial backgrounds are among the most ethnically and racially diverse religious groupings in this country.⁵⁵ Although 0.5% of the older Australian population are Muslims, the number is greater at 2.5% among those aged under 65 years.⁵⁶

According to an AIHW projection report,⁵⁷ as of 2011, Muslims in the age cohort of 65-79 were to have accounted for 2.6% and those aged 80 and over were to have made up about 1.0% of the CALD population. By 2026, the figures are projected to be 4.7 and 2.1 percentages respectively. Between 2011 and 2026, the percentage would increase from 2.2% to 4.0% for those aged 65 years and over. At 1.4 per cent, the actual 2011 Census figure for Muslims in the 80+ age cohort as percentage of total CALD population in the same age cohort is greater than the projected AIHW figure.

Further, the AIHW report projected that between 1996 and 2011, the growth rates for the 65 and over and 80 and over Muslim age groups would be 242% and 307% respectively. Between 2011 and 2026, the Muslim population is predicted to account for 4.0% of older CALD people. During this period, the growth rates for the 65 and over and 80 and over Muslim age groups are projected to be 159% and 222% respectively.⁵⁸

Muslim migrants are better educated than the average Australian yet twice as likely to be unemployed.⁵⁹ At 12.1 per cent, the unemployment rate among Muslims is the highest and participation rate of 53 per cent is the lowest among all religious groups in Australia.⁶⁰ With 36 per cent Muslims earning an income of less than \$400 per week,⁶¹ they are among the most economically vulnerable groups. Having an adequate income to meet their daily needs may be yet another challenge for Australia's older Muslim population.

⁵⁴ James Haire, "The interrelationship of Spirituality, Culture and Community in International Perspective", in *Ageing and Spirituality Across Faiths and Cultures*, ed. Elizabeth MacKinlay (London: Jessica Kingsley Publishers, 2010) p. 30.

⁵⁵ *Islam in Australia: Demographic Profile of Muslim Youth*, p.1. http://www.immi.gov.au/gateways/police/resources/_pdf/building_bridges.pdf (Last accessed December 27, 2014)

⁵⁶ Australian Bureau of Statistics, *2011.0--Who are Australia's Older People? Reflecting a Nation: Stories from the 2011 Census, 2012-13* (Canberra, 2011), <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2011.0main+features752012-2013> (Last accessed December 27, 2014)

⁵⁷ *Projections of Older Immigrants: People from Culturally and Linguistically Diverse Backgrounds, 1996-2026, Australia*, op. cit. p. 31.

⁵⁸ *ibid.* p. 29.

⁵⁹ Natasha Bitá, *Fear and Loathing on the Home Front*, *The Australian*, September 20, 2014.

⁶⁰ Department of Immigration and Border Protection, Australian Government, *The People of Australia: Statistics from the 2011 Census* (Canberra: 2014)

⁶¹ *ibid.*

An ABC News report says that there may be under-reporting by Muslims of their religion in official surveys like the Census because they fear persecution. In such case, the actual number of Muslims in Australia is likely to be much more than the official figure. The report quotes an ABS official who acknowledges that there are groups of people who are reluctant to reveal their backgrounds.⁶²

3.4 Muslim Demographics of South Australia

As seen in the table on page 21, South Australia is home to 4.1 per cent of the total Muslim population of Australia and, thus, comes fifth after New South Wales, Victoria, Western Australia, and Queensland. There are 10,589 male Muslims and 8,922 female Muslims in South Australia, giving a total of 19,511; this figure is almost double the number in 2006. At 11 per cent, the Adelaide suburb of Gilles Plains is home to more Muslims than anywhere else in the State.⁶³

The majority of older South Australians (65 years and over) were affiliated with the Anglican Church of Australia, Western Catholicism, or the Uniting Church. In this same age bracket, people with no religion ranked as the second largest group and those who did not state their religious affiliation made up the third largest group. According to the 2011 Census, among the three largest non- Christian religions amongst people aged 65 years and over in the State, Islam was second to Buddhism.

The breakdown of Muslim population in the State by gender and three age cohorts is shown below:

Gender	65-74 years	75-84 years	85+years	Total
Males	177	57	18	252
Females	132	51	8	191
Total	309	108	26	443

(Source: ABS 2011 Census)

The top ten countries of origin of Muslims and the top ten languages spoken by them in South Australia are listed on the following page:

⁶² Annie Guest, "Guarded Muslims 'have census figures'", *Australian Broadcasting Corporation*, July 18, 2011 <http://www.abc.net.au/news/2011-07-18/muslim-population-census-fears/2798462> (Last accessed December 27, 2014)

⁶³ Ken McGregor, "Census Data Reveals Where Religious Groups Tend to Congregate", *The Advertiser*, August 05, 2012, <http://www.adelaidenow.com.au/news/south-australia/census-data-reveals-where-religious-groups-tend-to-congregate/story-e6frea83-1226443456306> (Last accessed December 27, 2014)

Top Ten Countries of Origin	Top Ten Languages Spoken
1. Australia	1. Arabic
2. Afghanistan	2. Dari
3. Pakistan	3. English
4. Iran	4. Urdu
5. Bangladesh	5. Persian(excluding Dari)
6. Iraq	6. Hazaraghi
7. Indonesia	7. Bengali
8. Malaysia	8. Bosnian
9. Saudi Arabia	9. Malay
10. Bosnia and Herzegovina	10. Indonesian

(Source: ABS 2011 Census)

The top ten Local Government Areas (LGAs) in Adelaide with the highest concentration of Muslims are:

Adelaide LGAs	Number of Muslims
Port Adelaide Enfield (C)	3846
Salisbury (C)	3088
Charles Sturt (C)	2034
West Torrens (C)	1415
Marion (C)	1324
Tea Tree Gully (C)	1004
Playford (C)	925
Mitcham (C)	803
Onkaparinga (C)	655
Adelaide (C)	628

(Source: ABS 2011 Census)

The table on the following page gives the number of Muslims living in regional local government areas (LGAs) of South Australia. No data is available on the number of older Muslims living in these places. It is possible that owing to their small number in regional areas, some Muslims may have been reluctant to state their religious affiliation on the Census form. This means not only that the actual figures could be higher but it also means that some regional LGAs have not been able to record in their population breakdown by religions any Muslims under 'Islam'.

Regional LGAs	Number of Muslims	Regional LGAs	Number of Muslims
Alexandrina	25	Naracoorte and Lucindale	155
Barossa	16	Northern Areas	12
Berri and Barmera	19	Port Augusta	37
Cooper Pedy	21	Port Lincoln	18
Copper Coast	14	Port Pirie City and Districts	40
Light	20	Renmark Paringa	215
Loxton Waikerie	27	Roxby Downs	18
Mallala	12	Tatiara	36
Mid Murray	13	Victor Harbor	12
Mount Barker	49	Wattle Range	11
Mount Gambier	45	Whyalla	38
Murray Bridge	220		

Source: Department of Immigration and Border Protection, Australian Government, *The People of South Australia: Statistics from the 2011 Census* (Canberra: 2014)

3.5 Life Expectancy in Countries of Origin of Muslims in Australia

The average age of entry into permanent residential care in Australia is 82 for both sexes.⁶⁴ This figure generally refers to the total population and not to any particular segment, such as the overseas-born Muslims, thus obscuring the lower life expectancy in countries where most of them come from. It is interesting to note how factoring in life expectancy could potentially paint a completely different picture for aged care planning. Life expectancy is an indication of how many years a person can expect to live.

The table on the next page provides figures for life expectancy at birth as of 2012 for males and females in the top ten countries of origin of Muslims in Australia. These figures may make one wonder if the Muslim aged care recipient profile would be different to that from the mainstream or even from other CALD communities in terms of the average age at which Muslims coming from these countries would require formal aged care and support.

Of the ten countries in the table, Afghanistan and Bangladesh are low income countries in terms of income levels. Only Australia is a high income country while Lebanon, Turkey, Iraq, and Iran are all classified as upper middle income countries. The rest three countries, Pakistan, Indonesia, and India, fall in the lower middle income grouping.⁶⁵ It is pertinent to note here that the economic condition of a country has an impact upon the health and life expectancy of its people; higher national income (as measured by GDP per capita) is generally associated with higher life expectancy at birth and better quality of life.

⁶⁴ *Ageing and Aged Care in Australia*, op. cit. p.7.

⁶⁵ The World Bank, <http://data.worldbank.org/country> (Last accessed December 27, 2014)

Life Expectancy at Birth, 2012

Country	Male	Female
Australia	81	85
Lebanon	78	82
Pakistan	64	66
Afghanistan	58	61
Turkey	72	78
Bangladesh	69	71
Iraq	66	74
Iran	72	76
Indonesia	69	73
India	64	68

Source: World Health Organisation <http://www.who.int/countries/ind/en/> (Last accessed December 27, 2014)

3.6 Snapshot of Muslims around the Globe

Although the Muslim faith is widespread covering many nations, colours, cultures, and languages, the common denominator has always been religion and a religious culture. Muslims are, therefore, a group that is defined mainly by reference to religion.

The table below gives some details about the Muslim population in the top ten Muslim-majority countries:

Countries	Muslim population	% of population that is Muslim	% of world Muslim population
Indonesia	202,867,000	88.2	12.9%
Pakistan	174,082,000	96.3	11.1
India	160,945,000	13.4	10.3
Bangladesh	145,312,000	89.6	9.3
Egypt	78,513,000	94.6	5.0
Nigeria	78,056,000	50.4	5.0
Iran	73,777,000	99.4	4.7
Turkey	73,619,000	98.0	4.7
Algeria	34,199,000	98.0	2.2
Morocco	31,993,000	99.0	2.0

Source: Pew Research Centre, *Mapping the Global Muslim Population, A Report on the Size and Distribution of the World's Muslim Population* (Washington, DC: 2009), p. 5.

Here are some statistical facts about the global Muslim population:⁶⁶

- Muslims constitute 22% of the world's population.
- Approximately, two-thirds of the world's Muslim population live in Muslim majority countries and the rest one-third live in non-Muslim majority countries.
- There are 56 states with Muslim majority.
- Arab Muslims comprise approximately 20% of the total Muslim population; the rest 80% are non-Arabs.

A comprehensive demographic study of 232 countries and territories by the Pew Research Centre reports the following findings:⁶⁷

- In 2009, there were 1.57 billion Muslims representing 23% of an estimated 2009 world population of 6.8 billion.
- More than 60% of the global Muslim population live in Asia and about 20% in the Middle East and North Africa.
- The highest percentage of Muslim-majority countries can be found in the Middle East-North Africa region where 17 out of the 20 countries and territories have populations that are approximately 75% Muslim or greater with Israel, Lebanon, and Sudan being the exceptions. Asia has 12 out of 61 countries with Muslim population of 75% or more, Sub-Saharan Africa has 10 of 50 countries with that percentage while Europe has just two of 50 countries (Kosovo and Albania) with 75% or more Muslims.
- More than 300 million Muslims, or one-fifth of the world's Muslim population, live in countries where Islam is not the majority religion. Notable among these are India, China, and Russia. India, a Hindu-majority country, has the third-largest Muslim population. China has more Muslims than Syria, while Russia has more than Jordan and Libya combined.
- Two-thirds of all Muslims worldwide live in ten countries of which six are in Asia (Indonesia, Pakistan, India, Bangladesh, Iran and Turkey), three in North Africa (Egypt, Algeria and Morocco) and one in Sub-Saharan Africa (Nigeria).

Despite the long presence of Islam in the socio-political landscape of Australia, the size of the Muslim population may not have had a notable influence on service planning by aged care service providers. But the projected growth rates for older Muslims and the commitment of the Australian government towards multiculturalism as discussed earlier calls for a fresh and expanded approach to aged care by incorporating the needs of Muslims based on their faith doctrine.

⁶⁶ Abdullah Saeed, *Muslim Australians Their Beliefs, Practices and Institutions*, A Partnership under the Australian Government's Living In Harmony Initiative (Canberra: Department of Immigration and Multicultural and Indigenous Affairs and Australian Multicultural Foundation in association with the University of Melbourne, 2004) p.12.

⁶⁷ For more details, see Pew Research Centre, Forum on Religion and Public Life, *Mapping the Global Muslim Population, A Report on the Size and Distribution of the World's Muslim Population* (Washington, DC: 2009)

4. Religion, Spirituality, Ageing, and Aged Care

The religious and spiritual beliefs adopted by people influence the way that individuals, families, and community groups respond to significant life events such as ageing. The heart of this Report is the association of religion and aged care with regard to those who follow Islam. It is important, therefore, to analyse the concepts of religion and spirituality and understand what influences these are seen to have on positive ageing and well-being of an individual in general, and a Muslim in particular.

4.1 Concepts of Religion and Spirituality

The ageing process, accompanied by physical and cognitive decline, leads to a search for meaning in life and people seek comfort in religion and spirituality. While spirituality and religion have much in common and are intertwined, they are not synonymous although they are often perceived as being one and the same thing. Scholars have sought to define them as separate concepts but these are highly complex terms and are multidimensional in nature making it very difficult to construct a comprehensive single definition of either term. *Religion* refers to a personal or institutional system of organised beliefs, practices, rituals, or ways of worship; *spirituality* generally describes the feeling of connectedness with a higher power or consciousness and the search for answers to questions about the meaning and purpose of life.

Spirituality is more difficult to define than religion; it may form an important component of religiosity, yet many people who see themselves as 'spiritual' may not follow any particular religion or doctrine⁶⁸. For many others, religion is part of spirituality. According to Eckersley, "Spirituality is a deeply intuitive, but not always consciously expressed, sense of connectedness to the world in which we live. Its most common cultural representation is religion, an institutionalised system of belief and ritual worship that usually centres on a supernatural god or gods".⁶⁹ Commenting on the similarities between religion and spirituality, MacKinlay argues, "It is possible to be spiritual without being religious, but to some extent, the person who is religious is also spiritual".⁷⁰ She says, ".....religion cannot be completely divorced from spirituality; spirituality is the dimension from which religion arises. Put another way, religion is part of spirituality."⁷¹

In the western and secular societies, spirituality enjoys a positive connotation compared to religion which is seen in a somewhat negative light. This could be because spirituality is considered personal, something individuals define for themselves, that gives wide berth to

⁶⁸ C. J. Nelson, B. Rosenfeld, W. Breitbart, and M. Galietta, "Spirituality, Religion, and Depression in the Terminally Ill," *Psychosomatics*, 43/3 (2002) pp.213–220.

⁶⁹ Richard M Eckersley, "Culture, Spirituality, Religion and Health: Looking at the Big Picture, *MJA The Medical Journal of Australia*, 186/10 (2007) p. S54.

⁷⁰ Elizabeth MacKinlay, "Practice Development in Aged Care Nursing of Older People: The Perspective of Ageing and Spiritual Care", *International Journal of Older People Nursing* 3/2 (2008) p. 155.

⁷¹ Elizabeth MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life* (London: Jessica Kingsley Publishers, 2006) p.13.

the individual element or individual experience, that may be free of the rules and regulations associated with religion and, therefore, is broader and more inclusive. Religion may be less favoured, partly because of its seeming rigidity arising out of a demand to adhere to norms, rituals, and traditions, thus appearing to focus on institutional elements at the expense of individual experience.

4.2 Relationship of Religion and Spirituality with Resilience

Several research supports widely held views that people draw upon their religious beliefs more as they face illness and aging, and that religion may serve as an anchor in the face of adversity.

MacKinlay discusses two important concepts of spirituality that have empowered people who suffer chronic diseases: *spiritual resilience* and *transcendence*. Spiritual resilience is the ability to resist or endure the 'slings and arrows' of life and still maintain a sense of well-being. Transcendence is the ability to move on with life and to function effectively even after experiencing loss or disability. These two abilities define a person's well-being and sometimes defies medical prognosis.⁷²

Religion and spirituality are important components of the 'resilience repertoire' (to borrow the term from Clark et.al.⁷³) of an individual and provides a 'buffer' in old age against adversity and grief. Gilligan and Furness emphasise the importance of cultural competence among service providers when offering services especially to those for whom religion plays a significant role. Their study also showed that Muslims viewed religious and spiritual interventions for care recipients as being an important part of the overall care regime. On the question of the use and appropriateness of religious and spiritually sensitive interventions, Muslim respondents were found to be more positively inclined than Christians.⁷⁴

While discussing the various views on the relationship between religion and resilience, Faigin and Pargament opine that the very nature of religion and spirituality offers people an avenue to look beyond the limits of their own power for solace or solutions to life problems, even complementing 'non-religious coping' when pushed beyond their resources.⁷⁵ "The solutions may come in the form of spiritual support when other forms of social support are lacking, explanations when no other explanations seem convincing, a sense of ultimate control

⁷² Elizabeth MacKinlay, "*Practice Development in Aged Care Nursing of Older People: The Perspective of Ageing and Spiritual Care*", op. cit. p.154.

⁷³ See Phillip G. Clark, Patricia M. Burbank, Geoffrey Greene, Norma Owens and Deborah Riebe, "What Do We Know About Resilience in Older Adults? An Exploration of Some Facts, Factors, and Facets" in *Resilience in Aging Concepts, Research, and Outcomes*, Ed., Barbara Resnick, Lisa P. Gwyther, Karen A Roberto (Springer, 2011) pp. 51-66.

⁷⁴ See Philip Gilligan and Sheila Furness, "The Role of Religion and Spirituality in Social Work Practice: Views and Experiences of Social Workers and Students", *The British Journal of Social Work*, 36/4 2006) pp.617-637.

⁷⁵ See Carol Ann Faigin and Kenneth I. Pargament, "Strengthened by the Spirit: Religion, Spirituality, and Resilience Through Adulthood and Aging", in *Resilience in Aging Concepts, Research, and Outcomes*, Ed., Barbara Resnick, Lisa P. Gwyther, Karen A Roberto (Springer, 2011) pp.163-180.

through the sacred when life seems out of control, or new objects of significance when old ones are no longer compelling”.⁷⁶

Drawing upon multiple studies and empirical data which underscore the notion that religion serves a ‘distinct and compelling role’ in resilience, coping, and quality of life, Faigin and Pargament posit that more often than not people are positively benefited from their faith experiences.⁷⁷

A growing body of literature has also demonstrated the salient effects that religion has in combating physical and mental suffering and age-related stressors. Koenig⁷⁸ as well as Faigin and Pargament⁷⁹ cite works that have demonstrated the association of religiousness and spirituality with decreased levels of depression, anxiety, chronic pain, and elevated levels of happiness, increased well-being, greater life satisfaction, as well as improved mental and physical health. Koenig also refers to multiple other research that have established that the elderly who are religious or spiritual tend to experience lower rates of depression and death anxiety than their counterparts who do not turn to religion.

4.3 Faith (Spiritual) Journey and Implications for Ageing and Well-Being

Although there is continuing debate surrounding the exact relationship between religion and health, it is widely accepted that the overall well-being of people is enhanced by religious beliefs and practices. People seek meaning in life at a variety of levels; however, the most gratifying form of connectedness can be found at the most fundamental, transcendent level, which is spirituality.

In her award-winning book, MacKinlay shows that despite ill health, loneliness and depression, older people in general find meaning and support by (re)discovering their spirituality. She explains:

“A continuing search for what makes a difference in recovery from illness and healing has unearthed a missing and unexplained phenomenon, the spiritual dimension. This search has traversed the disciplines of medicine, nursing, social work, chaplaincy and pastoral care⁸⁰Well-being in later life has to include the spiritual dimension too, and it is through this that people may work towards

⁷⁶ K. I. Pargament, *The Psychology of Religion and Coping: Theory, Research, Practice*, New York (New York: The Guilford Press, 1997) p.310.

⁷⁷ Carol Ann Faigin and Kenneth I. Pargament, “*Strengthened by the Spirit: Religion, Spirituality, and Resilience Through Adulthood and Aging*”, op. cit.

⁷⁸ See Harold G. Koenig, “Religious Attitudes and Practices of Hospitalized Medically Ill Older Adults”, *International Journal of Geriatric Psychiatry* 13/4 (1998) pp. 213–224.

⁷⁹ See Carol Ann Faigin and Kenneth I. Pargament, “*Strengthened by the Spirit: Religion, Spirituality, and Resilience Through Adulthood and Aging*”, op. cit.

⁸⁰ Elizabeth MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life*, op. cit. p.11.

attaining greater quality of life and still live life to the full, even with chronic illness”.⁸¹

Australians generally have a low religious involvement compared to many other countries such as the US. Megalogenis wrote in *The Australian*, “Our more diverse population is surprisingly less religious”.⁸² Between 2001 and 2011, there has been a significant increase in the number of people who reported ‘No religion’, jumping from 15% to 22% of the population.⁸³ However, it has been found that a higher proportion of older people involve themselves in religious activities compared to people in younger age groups.⁸⁴ According to the 2011 Census, a majority of Australians (69%) and particularly older Australians (81%), identify with a religion whether they practise it or not, or with some form of spirituality; not surprisingly, only 10% of older Australians reported no religion⁸⁵ compared to 22% in the total population and 28% among people aged 15-34.⁸⁶

An ABS survey revealed that religious or spiritual group or organisations were the most popular social or support group among people aged 75-84 and the second most popular among those who were 85 and over.⁸⁷ The theme of this Report that service providers should consider widening consumer choice and contribute to overall well-being of care recipients by attending to their religious needs finds validation in a report prepared by Graeme Hugo and his team where they state: “At older ages, religion may increase in importance for many people and religious preferences should be accommodated in residential aged care facilities and by service providers wherever possible”.⁸⁸ Expanding the service portfolio in such ways is important since everyone values the opportunity to make choices about, and maintain control over, things that are important to them.

An important factor influencing the quality of a person’s life is the extent and nature of his or her involvement in family and community. This involvement needs to be supported as much as possible when the person moves into residential care. Residents may have experienced grief and isolation prior to entering an aged care facility; they may have suffered significant

⁸¹ *ibid.* p.17.

⁸² George Megalogenis, “Australia’s 2011 Census Shows a Nation Going Places”, *The Australian*, June 22, 2012.

⁸³ *Cultural Diversity in Australia Reflecting a Nation: Stories from the 2011 Census*, op. cit. Answering questions about religious affiliation in the Australian Census form is optional. One very common reason for many who do not fill it in is because they do not want their religious affiliation known. For the same reason, all who tick the “no religion” box on the census form may not be all atheists or secularists.

⁸⁴ See Annette Moxey, Mark McEvoy, Steven Bowe, and John Attia, “Spirituality, Religion, Social Support and Health among Older Australian Adults”, *Australasian Journal on Ageing*, 30/2 (2011) p. 82.

⁸⁵ *Who are Australia’s Older People? Reflecting a Nation: Stories from the 2011 Census*, op. cit.

⁸⁶ *Cultural Diversity in Australia Reflecting a Nation: Stories from the 2011 Census*, op. cit.

⁸⁷ Australian Bureau of Statistics, *4159.0 - General Social Survey: Summary Results, Australia, 2010*, p. 15.

⁸⁸ Graeme Hugo et. al., *State of Ageing in South Australia*, A Report to the South Australian Office for the Ageing (Adelaide: Department for Families and Communities, Government of South Australia, 2009) p. 310.

losses both real and symbolic, in terms of losing loved ones, their homes, possessions, and social networks. Such painful experiences are compounded by uncertainty in the face of continuing disability and the consequent loss of independence and control. Residents also face the daunting task of building new relationships in a new place (the facility). There may be death anxiety and then there is the inevitable: death itself. A study by the Centre for Ageing Studies at the Flinders University in South Australia points out: “Transitions to residential care are associated with increased depressive symptoms among the elderly, independent of functional and cognitive decline”.⁸⁹ That is why, it is important to try to offset some of the consequences of depression by providing opportunities to residents to interact with others and to seek hope, meaning, comfort, and solace through religion and spirituality.

In a 2000 report by the World Health Organization (WHO) and the Milbank Memorial Fund, the following key factors were identified as important for the long-term care of older people:⁹⁰

- maintenance of involvement in community, social, and family life
- environmental adaptations in housing and assistive devices to compensate for diminished function
- assessment and evaluation of social and health care status, resulting in explicit care plans and follow-up by appropriate professionals and paraprofessionals
- programs to reduce disability or prevent further deterioration through risk-reduction measures and quality assurance
- care in an institutional or residential setting when necessary
- provision for recognizing and meeting spiritual, emotional, and psychological needs
- palliative care and bereavement support as necessary and appropriate
- support for family, friends, and other informal caregivers
- supportive services and care provided by culturally sensitive professionals and paraprofessionals.

The preceding list is yet another affirmation of the importance of incorporating the elements of religion and spirituality in quality care design. *Quality of care* refers to high quality care and accommodation consistent with best practice and provided in accordance with the care needs of an individual.⁹¹ This broad definition encompasses both the ‘quality of care’ and the ‘quality of life’ dimensions of aged care and thus embraces the concept of ‘holistic care’.

⁸⁹ Centre for Ageing Studies, *The Australian Longitudinal Study of Ageing: 15 years of Ageing in South Australia* (Adelaide: Centre for Ageing Studies, Flinders University, 2006) p. 90.

⁹⁰ See World Health Organisation and the Milbank Memorial Fund, *Towards an International Consensus on Policy for Long-Term Care of the Ageing* (New York: 2000) p. 6.

⁹¹ Department of Health and Ageing
<http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Glossary+Index+Q> (Last accessed April 03, 2013)

Holistic care, in the context of aged care, is care that includes the four dimensions of appropriate physical, mental, social, and spiritual care. Physical care has always dominated the care spectrum; social care has also been looked after; mental care is being addressed. However, it is the spiritual dimension that remains the forgotten component of care although it needs to be taken seriously by anyone who seeks to offer holistic care.⁹² Recent research has affirmed the enduring significance of spiritual care as part of holistic health care.⁹³

MacKinlay's study of aged care home residents convinced her that spiritual care should be developed as a critical component of care in aged care facilities as it contributes to residents' well-being.⁹⁴ MacKinlay has further articulated this issue in another research article where she argues, "If spiritual care is part of holistic care, then spiritual care is no longer optional. It must be intentional, planned, available, offered, evaluated and documented".⁹⁵ It is in this context that religion, too, needs to be appreciated, as Ann Harrington points out: "... if religion is considered the 'vertical' arm of spirituality..., then ascertaining the religious practice of another person may be an important aspect of spiritual care".⁹⁶

Pointing out the barriers to making spiritual care an integral part of overall aged care regime, MacKinlay remarks that spiritual care is seen as an optional extra whereas physical care is thought to be the mainstay of care needed by frail old people. Many regard religion and spirituality as too private to be intruded and thus not to be brought into the realm of aged care. Also, spiritual care may still be thought about in terms of providing a trip to the church.⁹⁷ Talking about ethics and spiritual care, MacKinlay⁹⁸ opines that just as it is unethical to involve a person with a particular religious or spiritual activity where the person has none or a different religious affiliation, it is equally unethical to fail to address the religious and spiritual needs of an individual who has these needs.

Ron Mitchell, Director of the Multicultural Council of the Northern Territory (MCNT), put the need to address spirituality succinctly when he said, "In residential aged care each individual is a spiritual being and entitled to support and care of their spiritual needs".⁹⁹

⁹² For details on this, see John Swinton, *Spirituality and Mental Health Care: Rediscovering a 'Forgotten' Dimension* (London: Jessica Kingsley Publishers, 2001) pp. 64-92.

⁹³ Elizabeth MacKinlay, "Practice Development in Aged Care Nursing of Older People: the Perspective of Ageing and Spiritual Care", op. cit. p.152.

⁹⁴ Elizabeth MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life*, op. cit. pp. 20-22.

⁹⁵ Elizabeth MacKinlay, "Practice Development in Aged Care Nursing of Older People: the Perspective of Ageing and Spiritual Care", op. cit. p. 153.

⁹⁶ Ann Harrington, "Spiritual Well-being for Older People", in *Ageing and Spirituality across Faiths and Cultures*, Ed. Elizabeth MacKinlay (London: Jessica Kingsley Publishers, 2010) p.189.

⁹⁷ Elizabeth MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life*, op. cit.

⁹⁸ *ibid.* pp. 17-18.

⁹⁹ Ron Mitchell, *The Spiritual Imperative in Multicultural Aged Care – Multiculturalism, Mainstreaming and Marginalism*, 4th International Unity in Diversity Conference (Darwin : Multicultural Council of the Northern Territory Inc., 2011), <http://www.unityindiversityconference.com/fck/file/IUDC%20Paper%20->

Citing studies on the perceived needs of older people from ethnic minority groups and the mainstream population, Iliffe and Manthorpe¹⁰⁰ say that the variance were in terms of language, food, and religious beliefs and practices. They also found that the following were significant to ethnic minority older people: language, religious belief and observance, cultural factors (including food and personal care practices), social support, and coping mechanisms.

The importance of focusing on spiritual needs as part of a culturally inclusive aged care system was recognised at the 2011 FECCA Forum in Adelaide.¹⁰¹ The argument for incorporating religion into planning and delivery of aged care for Muslims can be strengthened by the following statement by FECCA: “We may also need to expect reform not just from the new cultures and communities that arrive in Australia, but in some of our own institutions and structures, where we can add value by embracing some of the practices of new communities.”¹⁰²

4.4 Religion and Spirituality in the Muslim Context

It is important to dwell on the concepts of religion and spirituality with respect to Muslims. Although spirituality is generally seen as providing meaning in life and relationships, it is much more for Muslims. It has been stated earlier in this Report that Islam, the religion that Muslims follow, literally means submission to the Will of God and that Islam influences all aspects of daily lives as Muslims regard their religion as the ‘complete code of life’. Therefore, it is difficult to conceive of a Muslim as being spiritual without being religious. Muslims believe that true happiness and peace can only be found in the “cleansing of one’s heart and self”¹⁰³ of all evil and malice. This is spirituality in Islam and a central concept of its teachings. While Muslims must carry out the external practices of their religion, such as daily prayers, fasting, and so on, it is the inner sincerity in turning to God that is the core of Islamic spirituality and is rooted in the Qur’an and Sunnah. Those who adhere to Islam in their everyday lives see both their religious beliefs and their spirituality coming together. A report exploring ways to address the needs of Australian Muslim families also brought into focus the central value of religion in the everyday life of Muslims;¹⁰⁴ this has also been echoed in studies done on Muslims in the UK.¹⁰⁵

%20Multicultural%20Aged%20Care%20-%20Ron%20Mitchell,%20August%202011.pdf (Last accessed December 28, 2014)

¹⁰⁰ Steve Iliffe & J Manthorpe, “The Debate on Ethnicity and Dementia: From Category Fallacy to Person-Centered Care?” *Aging and Mental Health*, 8/4 (2004) p. 286.

¹⁰¹ Federation of Ethnic Communities’ Councils of Australia, *FECCA Pre-Conference Forum: Culturally Responsive Aged Care Reform*, November 16, 2011, Adelaide, Report of Findings (Canberra: 2011) p. 4.

¹⁰² Federation of Ethnic Communities’ Councils of Australia, *The Quest for ‘A Level Playing Field’, FECCA Access and Equity Report 2010-11* (Canberra: 2010) p. 6.

¹⁰³ See Mohamad Abdalla and Ikebal Mohammed Adam Patel, “An Islamic Perspective on Ageing and Spirituality”, in *Ageing and Spirituality across Faiths and Cultures*, ed. Elizabeth MacKinlay (London: Jessica Kingsley Publishers, 2010) pp.112-123.

¹⁰⁴ See Rogelia Pe-Pua, Sandra Gendera, Ilan Katz and Alison O’Connor, *Meeting the Needs of Australian Muslim Families: Exploring Marginalisation, Family Issues and ‘Best Practice’ in Service Provision*, Final Report (2010)

4.5 Role of *Imams* (Muslim religious leaders)

Traditionally, an Imam is one who leads congregational prayers and delivers sermons during Friday and Eid prayers. Imams also help Muslims in personal and spiritual development by providing information and advice. A study in the US has identified four central roles of Imams in Muslim healthcare¹⁰⁶. These are (1) promoting healthy behaviours based on Qur'an and Sunnah during sermons (2) performing religious rituals during life events such as birth and death, as well as supplicating during illnesses (3) advocating for Muslim patients and helping to improve cultural competence of care providers, and (4) assisting in health care and end-of-life decisions for Muslims and their families. The study also mentions the additional roles of the Imam as a spiritual adviser, a counsellor, and a religious adjudicator on "ethical challenges around medical care".¹⁰⁷

In this context, it is important to distinguish the roles of Imams and chaplains. Chaplaincy is typically practiced within the contexts of the Jewish and Christian traditions. Though originally the word 'chaplain' referred to representatives of the Christian faith, it is now applied to men and women who provide pastoral (spiritual) care, emotional support, and religious advice including the conduct of religious services in places such as residential aged care facilities, hospitals, prisons, and elsewhere.

Worship is an individual responsibility in Islam and there is no intermediary between Allah and the individual; on the contrary, the relationship is direct. For Muslims, spiritual care is a religion-based care. The goal of Muslim spiritual care is to help the person attain hope and joy by trying to find the meaning and purpose of life. Such care has as its main source the Qur'an and Sunnah. Therefore, it follows that any caregiver who does not have a proper education in Islamic religious studies cannot provide effective Islamic spiritual care. To equip caregivers to provide such care, a study by Graham et. al. suggests that service providers gain at least a basic knowledge of Islam.¹⁰⁸ It is likely that non-Muslim chaplains may not be able to fulfil the needs of Muslims simply because they may lack adequate knowledge about the Muslim faith.

Although it is still not clear what the role of a Muslim chaplain should be, Imams formally and informally carry out many of the chaplaincy roles even though they may not have the medical knowledge or formal counselling training. In the absence of any formal Islamic chaplaincy

Prepared for the Australian Government Department of Immigration and Citizenship (Social Policy Research Centre, University of New South Wales: 2010)

¹⁰⁵ See Tariq Modood, "Culture and identity", in *Ethnic Minorities in Britain: Diversity and Disadvantage*, Ed. Tariq Modood et. al. (London: Policy Studies Institute, 1997)

¹⁰⁶ Aasim I Padela, Amal Killawi, Michele Heisler, Sonya Demonner and Michael D Fetters, "The Role of Imams in American Muslim Health: Perspectives of Muslim Community Leaders in Southeast Michigan", *Journal of Religion and Health*, 50 (2011) p. 364.

¹⁰⁷ *ibid.* p. 361.

¹⁰⁸ See John R. Graham, Cathryn Bradshaw and Jennifer L. Trew, "Adapting Social Work in Working with Muslim Clients", *Social Work Education*, 28/5 (2009) pp. 544-561.

program in Australia, Muslims have to make do with either the Imams or part-time volunteers wearing the chaplaincy hat. It is, therefore, worthwhile to consider professional training and certification of Muslim chaplains.

The preceding detailed discussion brings together the distinctions between religion and spirituality and clarifies their place in the care equation. In the context of practicing Muslims, it is imperative to understand the inextricable link between their well-being and an enabling environment in aged care facilities where they can continue to practice their religion. The core issue for Muslim aged care, therefore, is around emphasising religion and not just language and culture in planning and delivering care.

5. Culture, Ethnicity, and Integration in the Context of Muslims

In order to argue effectively in favour of emphasising religion and not just culture and language or ethnicity in aged care planning, it is important to separate religion from culture. This chapter explains culture and ethnicity and importantly, puts them in a frame of reference together with religion so as to better understand what all these concepts mean to the Muslims. The chapter focuses on a related discourse on 'dual identity' of Muslims while bringing in the broader debate surrounding Muslim integration into Western society and culture in general, and Australian society in particular.

5.1 Culture, Ethnicity, and Religion

Although there is no standard definition of *culture*, it can be viewed as including the thoughts, actions, beliefs, and values of a social, ethnic, or racial group. Culture is a way of identifying groups of people who share common characteristics such as language, social practices, attitudes, and values. Culture influences us in ways that help shape how we see the world, what we value, what we believe in, and how we communicate.

According to Eckersley, "Cultures are about how we think the world "works": the language, knowledge, beliefs, assumptions and values that shape how we see the world and our place in it; give meaning to our experience; and are passed between individuals, groups and generations".¹⁰⁹

Lederach¹¹⁰ understands culture "... to be rooted in the shared knowledge and schemes created by a set of people for perceiving, interpreting, expressing, and responding to social realities around them".

Citing others, Banks¹¹¹ explains culture by noting:

"Most social scientists today view culture as consisting primarily of the symbolic, ideational, and intangible aspects of human societies. The essence of a culture is not its artefacts, tools, or other tangible cultural elements but how the members of the group interpret, use, and perceive them. It is the values, symbols, interpretations, and perspectives that distinguish one people from another in modernized societies; it is not material objects and other tangible aspects of human societies".

¹⁰⁹ Richard M Eckersley, "Culture, Spirituality, Religion and Health: Looking at the Big Picture", op. cit. p. S54.

¹¹⁰ John Paul Lederach, *Preparing for Peace: Conflict Transformation Across Cultures* (Syracuse University Press, NY, 1995) p. 9.

¹¹¹ James A. Banks, "Multicultural Education: Characteristics and Goals", in *Multicultural Education: Issues and Perspectives*, Ed. J.A. Banks and C.A. McGee Banks (John Wiley & Sons, USA, 2010) 7th ed., p. 8.

Banks believes that people in a culture usually construe the meanings of symbols, artefacts, and behaviours in either the same or similar ways.¹¹²

Sheridan defines culture as:

“...an open, complex, systemic whole of human behaviour acquired and transmitted by symbols, constituting the distinctive achievement of human groups. The essential core of culture consists of traditional ideas and values. A culture is both a product of action and conditions further actions.... Culture, although systemic, is open and continually being modified through time by individual and group behaviour, which, however, never takes place in a cultural vacuum”.¹¹³

MacKinlay¹¹⁴ supports this view when she points out that not only cultures but also the symbols and rituals that support culture may change over time. She further holds out the proposition that new cultures may form within the wider society.

Ethnicity, on the other hand, refers to cultural practices and attitudes that characterise a given group of people. Those within a group have certain background characteristics such as language, religion, ancestry and other shared cultural practices which provide them with a distinctive identity and distinguish them from other groups. By conferring an individual with a basic identity, a sense of belonging, and a sense of self, ethnicity becomes significant to how people are perceived and how they describe themselves. There is a danger, however, in treating certain groups of people 'differently' because of ethnocentrism which means unthinkingly judging other people or cultures by viewing one's own culture as superior or absolute. A related term, *race*, is defined in the next section.

Focusing on the negative influence of culture on religion, Eckersley asserts that materialism and individualism, especially in combination, are two powerful cultural factors that work against spirituality in Western societies. He says, “Cultural messages can create tension, conflict and confusion within individuals when they run counter to religious beliefs and teachings, making it harder to integrate religion into their lives.... Cultures can “hollow out” the spiritual content of religion and fill it, instead, with other things, including materialism....”¹¹⁵ Eckersley decries the detrimental effects on health and wellbeing brought about by the modern Western culture that accentuates personal consumption and self-gratification, and, therefore, he emphasises the role of spirituality to offset such negative consequences.

¹¹² *ibid.*

¹¹³ Daniel P. Sheridan, “Discerning Difference: A Taxonomy of Culture, Spirituality, and Religion”, *The Journal of Religion*, 66/1 (The University of Chicago Press, 1986) p. 40.

¹¹⁴ Elizabeth MacKinlay, “Ageing and Spirituality: Living and Being in Multifaith and Multicultural Communities”, in *Ageing and Spirituality Across Faiths and Cultures*, Ed. Elizabeth MacKinlay (London: Jessica Kingsley Publishers, 2010) p.12.

¹¹⁵ Richard M Eckersley, “Culture, Spirituality, Religion and Health: Looking at the Big Picture”, *op. cit.* p. S 55.

It is relevant to mention here that sensitivity to religious beliefs and practices is not necessarily reflected or included in cultural sensitivity. It is pertinent here to quote Barnett on a parallel issue, “Cultural appropriateness is usually, but not of necessity, linked to linguistic appropriateness, ... and the absence of one or both of these factors constitutes a critical impediment to service provision for older Australians of non-English speaking background”.¹¹⁶

5.2 Discrimination and Vilification

In a landmark decision on the *Mandla v Dowell Lee* case in 1983, the UK House of Lords gave new meaning to the term *ethnic origin* based on seven criteria out of which two were deemed to be essential in every case for a group to be 'ethnic', and the rest five were termed 'relevant'. Applying these seven criteria, the UK courts have decided that Muslims do not belong to ethnic groups but Jews and Sikhs do.¹¹⁷ The Australian courts have followed the UK's example in embracing the *Mandla* criteria to identify ethnic origin. The question then arises: Are Muslims viewed in Australia as an ethnic group or a religious group or both? No Australian cases have yet decided on that.¹¹⁸

The *Human Rights and Equal Opportunity Commission Act 1986* and the *Racial Discrimination Act 1975(RDA)* are Commonwealth laws that provide protection against discrimination. The RDA makes discrimination and vilification based on race, colour, descent, national or ethnic origin, and immigrant status unlawful; importantly, it does not cover discrimination or vilification based on religion. Thus, although religious discrimination is not, per se, made unlawful by the RDA, the Act prohibits discrimination on the grounds of 'ethnic origin'. The twist in safeguarding Muslims under this Act comes from the way the term 'ethnic origin' has been interpreted.¹¹⁹ “There have been no cases decided on the question of whether Muslim people constitute a group with a common 'ethnic origin' under the RDA”.¹²⁰ (For more details on lack of religious protection laws in Australia and how it affects Muslims in particular, see Human Rights and Equal Opportunity Commission's report *Combating the Defamation of Religions*.)

It is helpful to understand how racial discrimination and vilification are described in Australia.¹²¹ “Racial discrimination is when a person is treated less favourably than another person in a

¹¹⁶ Kate Barnett, “Aged Care Policy for a Multicultural Society”, *Australasian Journal on Ageing* 7/4 (1988) p. 8.

¹¹⁷ For more on this and discrimination and vilification, see Neil Rees, Katherine Lindsay and Simon Rice, “*Australian Anti-Discrimination Law: Text, Cases and Materials*” (Federation Press, 2008)

¹¹⁸ For more information on this, visit the Australian Human Rights Commission homepage, http://humanrights.gov.au/racial_discrimination/forum/Erace/islamaphobia/islam_rda.html (Last accessed April 04, 2013)

¹¹⁹ For an understanding of how the absence of clear laws against religious hatred and vilification in Australia affects Muslims, see *Islamic Council of Victoria v the Catch the Fires Ministries* case.

¹²⁰ Human Rights and Equal Opportunity Commission, *Combating the Defamation of Religions*, A Report of the Australian Human Rights and Equal Opportunity Commission to the United Nations High Commissioner for Human Rights (Sydney: HREOC, 2008) p. 14.

¹²¹ Australian Human Rights Commission, *Racial Discrimination: Know your rights*, 2012, pp.2-3

similar situation because of their race, colour, descent, national or ethnic origin or immigrant status.” This is described as ‘direct discrimination’. ‘Indirect discrimination’ occurs “when there is a rule or policy that is the same for everyone but has an unfair effect on people of a particular race, colour, descent, national or ethnic origin or immigrant status.” “Racial hatred (sometimes referred to as racial vilification) is doing something in public – based on the race, colour, national or ethnic origin of a person or group of people –which is likely to offend, insult, humiliate or intimidate.” The Racial Discrimination Act protects against discrimination in areas of public life, such as employment, education, accommodation, getting or using services, and accessing public places. The Act also provides protection against harassment because of race. Although vilification is described and defined differently across Australia, all States and Territories make race discrimination unlawful and include ethnicity or ethnic origin in the definition of ‘race’.

In South Australia, discrimination is unlawful in the following areas: education, employment, goods and services, accommodation, disposal of land, superannuation, clubs and associations, and conferral of qualifications. Although certain racial vilification is unlawful in South Australia, discrimination and vilification on grounds of religion are not expressly covered. “The South Australian law defines *race* to mean ‘nationality, country of origin, colour or ancestry’. As such in South Australia a person who is subject to religious discrimination is probably left without any remedy.”¹²² It is no surprise then that, “The Full Court of the Supreme Court of South Australia has confirmed there is no legal remedy available to any person who believes his or her right to freedom of religion or belief has been violated by that State’s Parliament or Government.”¹²³ South Australia assures commitment to the “principle of access and equity for all South Australians and to the prevention of discrimination on the basis of race, ethnicity, religion, language and culture”.¹²⁴ This stands in sharp contrast to the absence of legal provision to protect against religious discrimination and religious vilification in the State.

5.3 Muslims and the Question of Integration

Cultural liberty should be an important feature in the CALD services landscape. *Cultural liberty* is “the capability of people to live and be what they choose, with adequate opportunity to consider other options.”¹²⁵ As UNDP says in very strong terms:

https://www.humanrights.gov.au/sites/default/files/document/publication/rda_guide.pdf (Last accessed January 02, 2015)

¹²² Human Rights and Equal Opportunity Commission, *Combating the Defamation of Religions*, op. cit. p. 16.

¹²³ Human Rights and Equal Opportunity Commission, *Article 18 Freedom of Religion and Belief* (Sydney: HREOC, 1998) p. 14.

¹²⁴ Government of South Australia, *Declaration of Principles for a Multicultural South Australia* (Adelaide, 1995)

¹²⁵ United Nations Development Programme, “*Human Development Report 2004. Cultural Liberty in Today’s Diverse World*” (New York) p. 4.

“Cultural liberty is a vital part of human development because being able to choose one’s identity—who one is—without losing the respect of others or being excluded from other choices is important in leading a full life. People want the freedom to practice their religion openly, to speak their language, to celebrate their ethnic or religious heritage without fear of ridicule or punishment or diminished opportunity. People want the freedom to participate in society without having to slip off their chosen cultural moorings.”¹²⁶

The UNDP terms cultural liberty as a human right and, thus, an important aspect of human development that needs the support of governments and societies. At the same time, it warns against *cultural exclusion* that “comes from a simple lack of recognition or respect for the culture and heritage of people—or from some cultures being considered inferior, primitive or uncivilized.”¹²⁷ The UNDP Report refers to two forms of cultural exclusion that are found to be practiced in the world: *living mode exclusion* and *participation exclusion*. Living mode exclusion is experienced when a group and/ or its lifestyle is not recognised or accommodated and when there is a pressure to conform exactly to the mainstream society. Participation exclusion, on the other hand, takes place when people cannot benefit from or participate in social, political, and economic opportunities because of their cultural identities.

While Muslims, just like any other community, need to accommodate the cultural practices of the broader Australian society so long as these are not discordant with their faith beliefs and practices, they cannot be expected to negotiate their religious identity and those aspects of life that are considered essential to upholding their religious and moral values. The *National Agenda for a Multicultural Australia* puts this tension into proper perspective when it says:

“Fundamentally, multiculturalism is about the rights of the individual— the right to equality of treatment; to be able to express one’s identity; to be accepted as an Australian without having to assimilate to some stereotyped model of behaviour”.¹²⁸

Underpinning multiculturalism is the acceptance of, and respect for, diversity not only in culture and language but also in religion, and the recognition and acceptance of the rights of people to an open, non-judgemental, and supportive environment that understands and supports their needs so long these needs are not incongruent with national values.

One very critical point to remember in this context is the responsibility that comes with enjoying rights. Although a microscopic minority, some Muslims have deviated from the message of Islam and, therefore, are easily motivated to adopt intolerant attitudes and to resort to words and actions that go against the teachings of Islam. Although such attitudes and behaviour may well come from ignorance, faulty assumptions, or misinterpretation of the Qur’an, undoubtedly they do a great disservice to Islam and Muslims. Imams (prayer leaders),

¹²⁶ *ibid.* p. 1.

¹²⁷ *ibid.* p.6.

¹²⁸ *National Agenda for a Multicultural Australia: Sharing Our future*, op. cit. p. 16.

teachers of religion, parents, and Muslim community leaders need to play a stronger role in the dissemination of Qur'an's message and the teachings of Islam's Prophet Muhammad (May peace be upon him) without any distortions and misinterpretations, and set examples through their own conducts.

Kopec and Han's remarks ¹²⁹ reflect the general Muslim perception that, "Islam and the Muslim population are often the source of much misunderstanding and media-influenced misconceptions". Although this comment is made in the context of the US, it is relevant for Muslims in any non- Muslim majority country, particularly in post-9/11.

Based on Gallup's past global research, the Abu Dhabi Gallup Centre (ADGC) developed the Muslim-West Perceptions Index (MWPI) in an attempt to measure how favourably people in Muslim-majority and Western countries viewed relations between their societies.¹³⁰ The MWPI measures three key dimensions by using four simple questions:

1. A Personal Priority
 - i. Is it very important to you for Muslim societies and Western societies to get along, or is this something that is not very important to you?
2. Mutual Respect
 - ii. Do you believe Muslim societies respect Western societies, or do you believe Muslim societies do not respect Western societies?
 - iii. Do you believe Western societies respect Muslim societies, or do you believe Western societies do not respect Muslim societies?
3. Mutual Interests
 - iv. Do you believe that greater interaction between Muslim and Western societies is more of a threat or more of a benefit?

The study found that piety or devoutness of Muslims does not appear to be a barrier for the six African Muslim-majority countries that comprised the index's top quartile; in general, in Muslim-majority countries, there seems to be a positive correlation between religiosity and higher MWPI ranks. Interestingly, in the West it is just the reverse with people who see religion as important ranking low on the MWPI, and people who do not see religion as important scoring higher.

Although most of the existing literature on Muslim integration is either based in the United States or in Britain, a growing number of studies have focused on the status of Muslims in Australia. One of these is a report aiming to map the interrelationship between religion and

¹²⁹ D.A.K Kopec, and Li Han, Islam and the Healthcare Environment: Designing Patient Rooms, *Health Environments Research & Design Journal*, 1 /4 (2008) p. 111.

¹³⁰ Abu Dhabi Gallup Forum, *The Abu Dhabi Gallup Forum: Research, Dialogue, and Solutions* (Abu Dhabi: 2011) pp.5-9.

cultural diversity in the Australian context. This report concedes that, “A level of antipathy and misunderstanding against Islam is now a reality in Australia”.¹³¹

A report of the Australian Social Inclusion Board cites¹³² the Scanlon Foundation Survey 2011 data revealing that more than two-thirds of Australians possess negative attitudes towards Muslims. In a 2007 survey of racism in South Australia, almost 50% of respondents revealed some degree of concern regarding marriage of a close friend or relative to a Muslim followed closely (32%) by similar concerns in case of marriage to a person of Aboriginal background.¹³³ In a decade-long national study, about 48.6 per cent of respondents said they held anti-Muslim sentiments.¹³⁴

Another Australian Research Council funded project found:

“... the stereotyping (or ‘racialisation’) of Islam is perhaps the most significant factor impacting on the ability of Australian Muslims to fully participate in Australian society. Within public opinion, stereotypes and constructions of Islam are constantly reproduced through negative media coverage which then manifest in discrimination”.¹³⁵

To gauge the state of knowledge and attitudes about relations between Muslims and non-Muslims in Australia, a comprehensive research was undertaken by Issues Deliberation Australia / America (IDA) in 2005-07. The research¹³⁶ showed that nearly half of the mainstream Australian respondents rarely or never have contact with Muslims, and only 20% experience contact on a regular basis. It also revealed that a staggering 94% of Australians blame the media for the deteriorating relations between Muslims and non-Muslims.

A report on the two-year *Inquiry into Multiculturalism in Australia*, tabled by the Joint Standing Committee on Migration at the 43rd Parliament on March 18, 2013, has decried the

¹³¹ Desmond Cahill, Gary Bouma, Hass Dellal and Michael Leahy, *Religion, Cultural Diversity and Safeguarding Australia*, A Partnership under the Australian Government's *Living In Harmony* Initiative (Canberra: Commonwealth of Australia, 2004) p. 85.

¹³² Australian Social Inclusion Board, *Social Inclusion in Australia, How Australia is Faring*, 2nd ed. (Department of the Prime Minister and Cabinet, 2012) op. cit. p. 55.

¹³³ Kevin M Dunn, Abbie White & Vidhu Gandhi, *Understanding Racism and Cultural Diversity: 2007 South Australia Racism Survey*, A Report Prepared for the Equal Opportunity Commission South Australia, Final Report (Sydney: University of Western Sydney, 2010) p. iii.

¹³⁴ Australian Broadcasting Corporation (ABC), <http://www.abc.net.au/news/2011-02-23/nearly-half-of-australians-are-anti-muslim-study/1954194> Updated Wed Feb 23, 2011 (Last accessed January 02, 2015)

¹³⁵ *Meeting the Needs of Australian Muslim Families: Exploring Marginalization, Family Issues and ‘Best Practice’ in Service Provision*, op. cit. p. 24.

¹³⁶ Issues Deliberation Australia / America, *Australia Deliberates Muslims and Non-Muslims in Australia Final Report Summary* (Austin/Texas: IDA, 2007) pp. 4-5.

threat perception of Islam in Australia and called for greater respect for cultural diversity and social cohesion. *The Australian* cites from the report:¹³⁷

"The committee's analysis has revealed that the perception of Islam as a threat has led to serious concerns within the community, which in turn is sometimes used as a justification for aggressive racist attacks and intensifying the marginalisation of Muslims. This results in and springs from a consolidation of conservative attitudes both within Islamic communities and across the mainstream, with public discussion entrenching fear and alarmist views."

The Australian report of the committee findings reaffirms the UNDP position on multiculturalism cited earlier in chapter 3: "The committee says it does not believe that viewing Muslims or multiculturalism through a prism of distrust will lead to a stronger, richer, or safer community". The report further says that the committee advocates "a supportive and flexible approach by respecting other cultures, languages and practices".

In 2005, the Australian federal Government presented nine *Values for Australian Schooling*.¹³⁸ These are:

1. Care and Compassion
2. Doing Your Best
3. Fair Go
4. Freedom
5. Honesty and Trustworthiness
6. Integrity
7. Respect
8. Responsibility, and
9. Understanding, Tolerance and Inclusion.

In 2007, the Howard Government determined the following ten as Australian core values:¹³⁹

1. Respect for the equal worth, dignity and freedom of the individual
2. Freedom of speech
3. Freedom of religion and secular government
4. Freedom of association
5. Support for parliamentary democracy and the rule of law
6. Equality under the law
7. Equality of men and women
8. Equality of opportunity

¹³⁷ Patricia Karvelas, "Call to Quell Rising Tensions Over Islam", *The Australian*, March 19, 2013

¹³⁸ See Department of Education, Science and Training, *National Framework for Values Education in Australian Schools* (Commonwealth of Australia, 2005)

¹³⁹ Attorney General's Department, *Becoming an Australian Citizen: Citizenship, Your commitment to Australia* (ACT: Commonwealth of Australia, 2007) p. 5.

9. Peacefulness, and
10. Tolerance, mutual respect and compassion for those in need.

As one can see, these values are not 'uniquely Australian' as many countries and cultures uphold them. In this context, it is relevant to mention the text developed through partnership between the Department of Immigration and Citizenship and the Community Relations Commission for a Multicultural New South Wales. This text for young people and teachers of Islam in Australia¹⁴⁰ seeks to diffuse the perceived tensions between Islamic theology and Australian citizenship by focusing on Islamic teachings that relate to the rights and responsibilities of citizens living in democratic, pluralistic, multi-faith countries such as Australia. The text demonstrates that there is, in fact, no basic clash between Islamic faith and Australian citizenship as both are underpinned by similar values. This project is an outcome of joint community efforts; such efforts were championed by religious leaders of various faith communities in consultations across Australia¹⁴¹ as one of the best ways to achieve inter-religious co-operation.

5.4 Muslims and 'Dual Identity'

Jacobson, while exploring the concept of 'social boundaries' in shaping identities in terms of religion and ethnicity, tried to analyse why religion is a more significant source of social identity than ethnicity for the young second-generation British Pakistanis.¹⁴² She suggests that whereas ethnicity relates to a particular place and its people, Islam's universal relevance has greater significance for Muslims than ethnicity. One view of ethnicity is that it is a matter of loyalty or feeling connected to a set of traditions or customs that are non-religious in origin and are associated with the minority group. One needs to then distinguish between 'the universal applicability of religious teachings and the limited relevance or usefulness of 'culture'. This distinction can be termed as the 'religion-ethnic culture distinction'. The other view perceives ethnic identity in terms of one's attachment to a place of origin whereas religious identity would make one a member of a broader community. This is the 'religion-ethnic origins distinction' which would help to partially explain the Islamic concept of *Ummah*¹⁴³ that while a Muslim's ethnic identity links him or her to a country or region of origin, the religious identity as a Muslim would make him or her a member of the global Muslim community.

Although relentless negative depiction of Muslims and Islam in public discourse fuels concerns about the supposed inability of Muslims to acculturate, the fact is, in order to live in harmony in their adopted countries in the West, Muslims try to reconcile their high degree of

¹⁴⁰ See Community Relations Commission for a Multicultural NSW, *My Religion, Our Country: a Resource for Islamic Religious Education in Australia* (Sydney: CRC, 2012)

¹⁴¹ For an elaboration, see *Religion, Cultural Diversity and Safeguarding Australia*, op. cit. p. 83.

¹⁴² Jessica Jacobson, "Religion and Ethnicity: Dual and Alternative Sources of Identity among Young British Pakistanis", *Ethnic and Racial Studies*, 20/2(1997) pp. 238-256.

¹⁴³ An Arabic word meaning 'nation' or 'community'.

religiosity with their largely secular environments. In multicultural Australia, the question is not of being either a Muslim or an Australian but being both a Muslim and an Australian. This is akin to what Waleed Aly referred to as 'dual authenticity'.¹⁴⁴

Although Muslims, like any other religious groups, are heterogeneous by way of culture, language, and ethnicity, most of them agree on the five pillars and seven fundamental beliefs of Islam as these are the core elements of their faith. Culture does play a large role in how Islam is translated into daily lives and, like people from any other community, Muslims may emphasise their own ethnicity and culture. However, for practicing Muslims, their religion would take precedence over any cultural issues or practices that may be in conflict with core religious beliefs. This helps prevent the domination of religious principles by culture and protects the observant, practicing Muslim from the resultant detrimental consequences of such domination cited earlier in this chapter that Eckersley had warned of.

A Gallup World Poll-ThinkForum study¹⁴⁵ on Muslim residents in three major European cities demonstrated that while religion remains an important part of Muslim identity, followers of the Islamic faith in these places also identify strongly with the country they live in. A significant finding of this study was that, like the rest of the general populace a large majority of Muslims in these cities prefer living in racially and ethnically diverse neighbourhoods. This is in sharp contrast to the popular association of Muslims with enclaves or ghettos which has also been largely disproved in Australia as can be seen from the Local Government Area (LGA) data on distribution of Muslim population as gleaned from the ABS Census. In each of the three European cities, religion was found to be an important part of daily lives of a significant proportion of Muslims (68% in Paris, 85% in Berlin, and 88% in London), which is divergent to how religion is viewed among the general population. The fact that Muslims can have 'dual authenticity' even while having dual identity was a major finding of this study:

“... the idea that their higher religiosity implies a weaker sense of national identity is simply false. In London and Paris, when Muslims were not forced to choose between religious and national identity, they tended to associate themselves with both. In fact, in none of the three countries were Muslim residents less likely than the populations at large to say they identify strongly with their country (in the United Kingdom, they were actually somewhat more likely to do so)”.¹⁴⁶

The UNDP reiterates the legitimacy of dual identity in its 2004 Human Development Report: “Individuals can and do have multiple identities that are complementary—ethnicity, language, religion and race as well as citizenship”.¹⁴⁷

¹⁴⁴ Waleed Aly, “*Multiculturalism, Assimilation and the Politics of Terrorism*”, Papers on Parliament No. 56, 2011 http://www.aph.gov.au/About_Parliament/Senate/Research_and_Education/pops/pop56/c05 (Last accessed January 02, 2015)

¹⁴⁵ See Zsolt Nyiri, *Muslims in Berlin, London, and Paris: Bridges and Gaps in Public Opinion*, Gallup World Poll-ThinkForum: Muslims in Europe (Princeton, NJ: The Gallup Organization, 2007)

¹⁴⁶ *ibid.* p.2.

¹⁴⁷ UNDP *Human Development Report 2004*, op. cit. p. 2.

A research by the Centre for Muslim Minorities & Islam Policy Studies of Monash University found that practicing Muslims see themselves as both good Muslims and good Australians; they believe that their religious teachings encourage them to make positive contributions to the Australian society. Importantly, the research found that while they value their ethnic and Australian identities, their religious identity is most important to them.¹⁴⁸ Mirroring the Gallup World Poll-ThinkForum findings mentioned in this chapter, data from the Monash study discredited the general perception in Australia that Islamic religiosity isolate Muslims. However, their integration may have been impeded to a certain extent by unfavourable depiction of them as 'the Other'.

Muslim participation in Australia has certainly been aided by supportive policies and public resources which increased their sense of belonging. Different departments, agencies, research organisations, universities, and institutes have been conducting consultations and research to identify problems and issues and to increase understanding and improve harmony between Muslims and non-Muslims in Australia. Sadly, the same cannot always be said about the government of the day, the political parties, and the media.

As the foregoing discussion shows, religion is a far more significant source of identity for Muslims than ethnicity. Although Muslims, in general, do not experience dissonance with forging a national identity in Australia or in other Western countries, it must be acknowledged that their efforts to integrate has not been helped, in many cases, due to a deep-seated prejudice against them and their religion that is constantly being manifested in public discourses.

¹⁴⁸ See Centre for Muslim Minorities & Islam Policy Studies, *Muslim Voices: Hopes & Aspirations of Muslim Australians* (Melbourne: Monash University, 2009)

6. The Aged Care System

The aged care system encompasses all services specifically designed to meet the care and support needs of older people. Older people are also users of other government services, including specialised mental health services, disability services, and financial and housing assistance. They receive payments from the Australian Government through the aged and service pensions and through superannuation concessions. This chapter touches upon different aspects of the aged care system relating to residential and home care including available care packages, the providers, funding arrangement, the role played by carers, aged care reform measures, regulatory framework, and how all these affect the CALD community.

6.1 Changing Profile of the Aged

In 1901, people aged 65 years and over constituted 4.0% of Australia's population. There has been a significant increase since then; at June 2012, 3.22 million people aged 65 years and over accounted for 14% of the total population.¹⁴⁹ In 2011, women in this age cohort constituted 15% of the total female population while older men constituted 13% of the total male population. Women far outnumber men in the aged population, comprising 54% of all those aged 65 years and over and 66% of those in the 85 years and over age group.¹⁵⁰

An emerging trend in the aged care sector is the growing size and diversity of the aged population and, consequently, their expectations of greater choice in the availability of services. The 2011 census shows that 36% of Australia's older people were not born in Australia.¹⁵¹ In its projection report,¹⁵² the AIHW predicts that by 2026, one in four people aged 80 and over will be from culturally and linguistically diverse backgrounds. Between 1996 and 2026, according to the AIHW projections, there would be a massive 321% growth rate in the migrant population age cohort of 80 and over compared to 90% growth rate for Australian-born population in the same cohort during the 30-year period. It is estimated that by 2021, the birth places of more than 30 per cent of Australia's older population will be outside Australia.¹⁵³ In fact, an analysis by DoHA reveals that in 2006, the proportion of older overseas-born people from non-English-speaking backgrounds was highest among the 65–74

¹⁴⁹ Australian Bureau of Statistics, *3235.0 - Population by Age and Sex, Regions of Australia, 2012*, (Canberra, 2012) <http://www.abs.gov.au/ausstats/abs@.nsf/Products/3235.0~2012~Main+Features~Main+Features?OpenDocument#PARALINK2> (Last accessed January 31, 2015)

¹⁵⁰ *Who are Australia's Older People? Reflecting a Nation: Stories from the 2011 Census*, op. cit.

¹⁵¹ *ibid.*

¹⁵² *Projections of Older Immigrants: People from Culturally and Linguistically Diverse Backgrounds, 1996–2026, Australia*, op. cit. p. 2.

¹⁵³ *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*, p. 4.

and 75–84 age cohorts at 62% each, with the comparable figure for those aged 85 and over being 53%.¹⁵⁴

One in five older Australian comes from a non-English-speaking country; this segment of older population is growing faster than other segments.¹⁵⁵ Representing 21% of the older population, older people from non-English-speaking countries make up around 15% of older permanent residents in aged care accommodation, a doubling of the percentage from 2001.¹⁵⁶ However, people from these countries are not only more likely to prefer home-based rather than residential services but, in reality, they use permanent residential aged care at lower rates than people from other backgrounds.¹⁵⁷ Among factors that may partly explain this are cultural preferences and practices related to caring for the aged and concerns about availability of residential care which is perceived to be culturally appropriate.¹⁵⁸ About one-third of aged care consumers across Australia at 30 June 2013 were born overseas. Community care had a greater proportion of clients from this group (36%) compared to permanent residential care (30%).¹⁵⁹

6.2 Challenges of the Industry

The current Chair of Age Services Australia and former Defence Chief, General Peter Cosgrove, asserts that the incongruence between the growth of the ageing population and that of the aged care sector means that the latter would struggle to provide adequate services as the number of people aged over 65 doubles to six million by 2050. It translates into a grim picture for the aged. Cosgrove further makes the point:

“In Australia there is no natural safety net for older Australians. When you need assistance for daily living, if you don't have able family you're in quite a vulnerable position. Every 71 minutes, another Australian cannot access services because those services don't exist. The capacity isn't there.”¹⁶⁰

Another challenge is the complex nature of the aged care system that is highlighted in the 2008 Interim Report of the National Health and Hospitals Reform Commission:¹⁶¹

¹⁵⁴ *Older Australia at a Glance*, 4th edition, op. cit. p. 4.

¹⁵⁵ *ibid.* p. 146.

¹⁵⁶ *ibid.* p. 147

¹⁵⁷ *ibid.*

¹⁵⁸ *ibid.*

¹⁵⁹ Australian Institute of Health and Welfare, <http://www.aihw.gov.au/aged-care/residential-and-community-2012-13/diverse-background/> (Last accessed January 02, 2015)

¹⁶⁰ Parliament of New South Wales <http://www.parliament.nsw.gov.au/prod/parlment/hansart.nsf/V3Key/LC20130911045> (Last accessed January 02, 2015)

¹⁶¹ National Health and Hospitals Reform Commission, *A Healthier Future for All Australians - Interim Report*, December 2008 (Canberra: Commonwealth of Australia, 2009) p. 166.

“The aged care system is incredibly complex, with people having to make difficult, life-changing decisions, often at short notice. Older people seeking support themselves, and younger people who have had to navigate the aged care system on behalf of a parent or relative know only too well the complexity of the decisions and the immense amount of information that has to be quickly absorbed. ...Older people and their families often do not know what services are available, and have difficulty finding out how to obtain information on services, let alone the services themselves”.

Mark Butler, the then federal Minister for Mental Health and Ageing, in his presentation at the 2011 FECCA Pre-Conference Forum held in Adelaide, cited¹⁶² international research where people from different countries identified what they believed to be the major social challenges (for example, climate change and the global financial crisis). Ageing was one of the major challenges that 31 per cent of Australians identified, in contrast to the lower percentages of respondents in other countries who did so (for example, in the USA, only seven per cent identified ageing as a major social challenge). The Minister also recognised the urgency of providing CALD consumers with services that are culturally inclusive. He saw the task as having two components:

1. Determining how best to support communities to develop ethno-specific services, and
2. Determining how best to support mainstream service providers to provide culturally and linguistically sensitive care.

The tasks will require concerted efforts on the part of all major players while dealing with an aged care system that is “overly fragmented and difficult to access and navigate”.¹⁶³ Multiple programs involving multiple government departments and agencies across different tiers of government have made the aged care system difficult to traverse for those who need to access it.¹⁶⁴

HelpAge International publishes the Global AgeWatch Index on the UN International Day of Older Persons on October 1. Based on international data sets, the Index measures the quality of life and wellbeing, and social and economic welfare of people aged over 60 and ranks countries by how well their ageing populations are faring. The Index is based on the following four domains:

- Domain 1: Income security
Assesses people's access to sufficient income and their capacity to use it independently in order to meet basic needs in old age

¹⁶² FECCA Pre-Conference Forum: *Culturally Responsive Aged Care Reform*, op. cit. p.2.

¹⁶³ Productivity Commission, *Trends in Aged Care Services: Some Implications*, Productivity Commission Research Paper (Canberra: Commonwealth of Australia, 2008) p. xix.

¹⁶⁴ *ibid.*

- Domain 2: Health status
Provides information about physical and psychological wellbeing
- Domain 3: Capability
Assesses empowerment of older people using indicators such as employment and education, and
- Domain 4: Enabling environment
Using data from Gallup World View, this domain assesses older people's perception of social connectedness, safety, civic freedom, and access to public transport - issues older people have identified as particularly important for them.

The *2014 Global AgeWatch Index* ranked 96 countries representing 91 per cent or nine out of ten people over 60 across the world. Australia ranks 13 overall in the Index; on income security it ranks 61, on health status 5, on capability 2, and on enabling environment it ranks 26. This mixed report card on Australia is a wake-up call that more needs to be done to ensure that aged care is affordable and accessible to all Australians who need it.

6.3 Aged Care Reform Measures

The Australian Government acknowledged the need of aged care services to become more responsive to the needs of older people and their families.¹⁶⁵ Thus, it is viewing enhanced consumer choices and flexibility as priority issues and is undertaking steps to assist people to remain at home independently, and for longer.

On April 20, 2012, the Prime Minister and the Minister for Mental Health and Ageing announced a package of significant aged care reforms titled *Living Longer Living Better*.¹⁶⁶ These reforms are largely based on the Productivity Commission Report, *Caring for Older Australians*.¹⁶⁷

The Foreword of the Commonwealth's aged care reform document, *Living Longer. Living Better*, highlights the challenges that lie ahead:

“Today, too few people are able to access care and support in their own home where they want it, not enough nursing homes are being built, employers are having trouble recruiting and keeping aged care workers they need and many older Australians have to conduct a fire-sale of their home to pay large bonds to get into residential care. The aged care system is no longer meeting our needs....Through the Government's aged care reform package we will deliver important benefits to older Australians,

¹⁶⁵ *A Healthier Future for All Australians – Interim Report*, op. cit. p. 161.

¹⁶⁶ See Department of Health and Ageing, *Living Longer. Living Better* (Canberra: Commonwealth of Australia, 2012)

¹⁶⁷ Productivity Commission, *Caring for Older Australians*, Report No. 53, Final Inquiry Report (Commonwealth of Australia, 2011)

that includes more support and care at home, better access to residential care should you need it, increased recognition of carers and those from culturally diverse backgrounds, more support for those with dementia and better access to information”.¹⁶⁸

Focusing heavily on consumer-directed care, the aged care reforms are being implemented in three phases over the period 2012-2022 with the objective of making the aged care system fairer, sustainable, and affordable, and offering Australians more choice, easier access, and better care. The major regulatory changes in the reform package involve residential care providers. Among other key changes planned are the provision of additional aged care places with an increasing share of aged care to be provided in the community, increase in government supplement that will help more aged care homes to be built or refurbished, increased investment in the aged care sector, better transparency for residential aged care, and changes to how people pay for accommodation and services. Under its reform measures, the government plans to expand and improve home support services for older people to receive care and support at home for as long as possible. This is in line with government efforts to reduce pressure on residential care.

As part of these measures, the Government plans to progressively establish a gateway to aged care services for improving access, understanding, reliability, and transparency of aged care related information. The gateway will be an online integrated information and assessment entry point that would help older Australians and their families and carers make informed decisions about the right type of care and who provides it. The first of several steps toward this end has been the establishment of the *My Aged Care* website and a national contact centre (**1800 200 422**) that are operated by the Department of Social Services. Together, the website and the contact centre will help people to get access to needed information and to navigate the seemingly daunting aged care system. With information on pricing and description of services and facilities made available on *My Aged Care* and service provider websites, prospective residents and their families will be able to compare different aged care homes.

While acknowledging that older Australians with diverse needs, in particular older CALD people, continue to find it difficult to access information and services that are responsive to their backgrounds and circumstances, the reform package puts in additional funding that seeks to address some of the needs of such older people, including providing a flexible and unified arrangement that offers greater choice and control to them. The *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds* has been developed as part of the aged care reforms to better serve the CALD community. (This Strategy will be discussed later in the chapter.)

¹⁶⁸ *Living Longer Living Better*, op. cit.

6.4 Who Provides and Funds Aged Care

Many older people receive assistance from both formal aged care services and informal sources, such as family, friends, and neighbours. Some of them also purchase support services in the private market.

While formal care or support is provided by government or private agencies and organizations, informal care or support is unpaid care in the form of material or practical assistance and emotional nurturance that is provided by family members, relatives, neighbours, and friends.

Older people and their carers largely fund the provision of informal care, although the Australian Government funds a range of care support programs. Formal aged care, though, is primarily funded and regulated by the Commonwealth; for more than 40 years now, it has funded the provision of aged care by providing capital grants to assist in the establishment of new aged care facilities and the expansion or upgrading of existing ones. The State and Territory governments are mainly involved in home care. Local governments provide some residential aged care and home care services in addition to carrying out their regulatory role.

More than one million people are consumers of some form of aged care services each year with over half a million people receiving services at home.¹⁶⁹ On any given night, about one in every 100 Australians receives care either in a residential aged care facility or through a home care package. Every year, about four in every 100 Australians are recipients of home care services. Almost two in every 100 Australian workers are employed in aged care activities¹⁷⁰; the residential care sector by itself is the ninth largest employing industry in the country.¹⁷¹ There is approximately 350,000 aged care staff working in the aged care industry.¹⁷²

All users of aged care services are expected to make a financial contribution to the cost of their care. However, no one will be denied services they need in case of an inability to pay. In order to ensure that aged care is affordable for all, the Australian Government, under the Aged Care Act 1997, regulates the maximum charges that a service provider may ask for.

¹⁶⁹ Department of Social Services, Australian Government, *Ageing and Aged Care—Aged Care Reform* <https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-reform> (Last accessed January 03, 2015)

¹⁷⁰ Aged Care Price Review Taskforce, *Review of Pricing Arrangements in Residential Aged Care: Final Report* (Canberra: Commonwealth of Australia, 2004) p. 1.

¹⁷¹ *ibid.* p. 219.

¹⁷² Department of Social Services, Australian Government, *Ageing and Aged Care—Aged Care Reform*, <http://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-reform> (Last accessed January 03, 2015)

The Australian Government currently spends more than \$14 billion annually on aged care.¹⁷³ The Government contributes 68.4 per cent toward the cost of aged care in the form of subsidies and supplements; individuals contribute 26.2 per cent and State and Territory governments pick up the rest 5.4 per cent of expenses.¹⁷⁴ The Commonwealth funds about 70 per cent of the cost of residential aged care and more than 90 per cent of the cost of home care in its own programs; the balance is met by care recipients. Since July 01, 2012, full responsibility for Commonwealth Home and Community Care (HACC) funding has been transferred to the Commonwealth in all States and Territories, except Western Australia and Victoria. The State and Territory governments continue to fund and administer HACC services for people under the age of 65, or under 50 for Aboriginal and Torres Strait Islander people.

The Government pays approved providers an amount of home care subsidy or an amount of residential care subsidy. The subsidy is only payable for each eligible approved care recipient cared for by the provider during the claim period. It can be paid:

- when the care recipient has been approved by ACAT and
- the care is provided by a Government-approved aged care provider or
- that care is provided in a Government-subsidised aged care place, and
- the care standard in that service meets accreditation requirements.

Religious, charitable, and community-based providers deliver 83 per cent of Australian government funded home care packages with the remaining 17 per cent provided by for-profit organisations, and state, territory, and local governments.¹⁷⁵ For-profit participation in home care is minimal in that 95 per cent of it is provided by private not-for-profit or government providers.¹⁷⁶

In general, residential care in Australia is delivered by providers from the religious and charitable, community, private for-profit, and government sectors with the not-for-profit sector (comprising religious, community-based, and charitable organisations) being the biggest provider. Although residential care is financed and regulated predominantly by the Australian Government, the State and local governments with funding from the Australian Government do operate a small number of aged care homes covering eight per cent of residential care places.¹⁷⁷

¹⁷³ Department of Social Services, Australian Government, *Ageing and Aged Care—Overview* <https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-reform/overview#2> (Last accessed January 03, 2015)

¹⁷⁴ *Review of Pricing Arrangements in Residential Aged Care: Final Report* op. cit. p.107.

¹⁷⁵ Department of Social Services, Australian Government, *2012-13 Report on the Operation of the Aged Care Act 1997* (Canberra: 2013) p. 35.

¹⁷⁶ *A Healthier Future for all Australians: Interim Report*, op. cit. p.163.

¹⁷⁷ Department of Health and Ageing, *Ageing and Aged Care in Australia* (Commonwealth of Australia, 2008) p.9.

The majority of aged care providers remain within one state. Some residential aged care facilities also provide home care services from the same location. A number of aged care homes are run by ethnic community organisations and these homes receive public funding to improve the quality of life and care for older people from CALD backgrounds. In 2012, approximately 25 per cent of residential aged care facilities were catering for a specific ethnic or cultural group.¹⁷⁸

As of June 30, 2013, the total number of operational aged care places across the aged care system was 254,848 which included 189,761 residential care places, 61,087 home care places, and 4,000 transition care places.¹⁷⁹ At 30 June 2013, there were 2,718 residential care facilities across Australia and the occupancy rate on average was 92.7 per cent during 2012-13.¹⁸⁰ Of these facilities, the not-for-profit sector provided nearly 60%; the private sector provided 30% and government-owned (both local and state) organisations provided the rest 10%.¹⁸¹

During 2012-13, 226,042 people received permanent residential care and 48,182 people received residential respite care.^{182 183}

6.5 Care Packages

The Australian Government-subsidised residential aged care is one of the main types of formal aged care for frail or disabled older people. All residential care services must meet a number of national standards. Residential care is discussed in greater detail in Chapter 7.

From July 2013, a new type of care has been introduced that is administered under the Aged Care Act and funded by the Australian Government. This new home care, offered as *Home Care Packages* (so called because it is a package of services tailored to meet an individual's specific care needs) includes care, support, clinical, and other services, is coordinated by a home care provider, and has replaced the existing community care and some flexible care programs, such as Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages, and Extended Aged Care at Home- Dementia (EACH-D) packages.

Home care is aimed at meeting specific care needs of older people who are eligible for residential care but who prefer to remain at home and are safely capable of doing so with the

¹⁷⁸ Debra King et.al. *The Aged Care Workforce, 2012 Final Report* (Department of Health and Ageing, Australian Government, 2013) p. 56.

¹⁷⁹ *2012-13 Report on the Operation of the Aged Care Act 1997*, op. cit. p. 7.

¹⁸⁰ *ibid.* p. 9.

¹⁸¹ AIHW *Aged Care Services and Places*, <http://www.aihw.gov.au/aged-care/residential-and-community-2012-13/services-and-places/> (Last accessed January 03, 2015)

¹⁸² <http://kevinandrews.com.au/latest-news/2014/10/13/launch-south-australian-innovation-hub-trial/>(Last accessed January 03, 2015)

¹⁸³ See Section 7.1.2 for an explanation of these terms.

help and support of family or other informal carers. Under the new reforms, there are four levels of Home Care Packages:

- Home Care Level 1 – assists people with basic care needs
- Home Care Level 2 – for people with low-level care needs
- Home Care Level 3 – supports people with intermediate care needs, and
- Home Care Level 4 – a package to support people with high care needs.

Home Care Levels 1 and 2 packages may include some nursing, allied health or other clinical services but are not intended to provide comprehensive clinical or health services. It is at Home Care Levels 3 and 4 that the packages provide greater emphasis on delivering complex care in the consumer's home, including more clinical care where required. The main difference between the home care levels is the amount of care and services that can be provided rather than the type of care at each package level; consequently, more care and services can be provided under Home Care Level 4, compared to the other levels.

A range of services may be provided under any Home Care level, including:

- personal services – such as help with showering or bathing, dressing and mobility
- clinical care – such as nursing and other health support including physiotherapy, services of a dietician, and hearing and vision services
- support services – such as help with washing and ironing, house cleaning, gardening, basic home maintenance, home modifications related to an individual's care needs, and transport to help with shopping, visit to a doctor, or attending social activities.

Although the Home Care Package is not specifically designed to provide palliative care, consumers are able to receive palliative care services in addition to their package but this need to be arranged by the person's GP or treating hospital.

In addition to the base level of subsidy for a Home Care Package, consumers may be eligible for one or more supplements; these are paid to a provider for any additional costs associated with certain care and service requirements for the consumer. Examples of such supplements are: Dementia and Cognition Supplement, Oxygen Supplement, and Enteral Feeding Supplement.

The care and services in all package levels may also be used to support the use of:

- telehealth, video conferencing, and digital technology to increase access to timely care; and
- assistive technology such as aids, equipment, and devices that assist daily living, mobility, communication, and personal safety.

The *Consumer (or self) Directed Care (CDC)*, an initiative of the Australian Government, is a significant change in the way home care will be delivered in Australia. All new Home Care Packages allocated from 2013 are offered on a CDC basis; from July 2015, all packages will

have to operate on a CDC basis. Under CDC, aged care providers offer care recipients and their carers with greater say and more control. The recipients and carers can make informed choices about the types and delivery of services, including who will deliver and when, and can monitor how much is being spent on the services. The following principles are fundamental to the operation and delivery of packages on a CDC basis:

- Consumer choice and control
- Rights
- Respectful and balanced partnerships
- Participation
- Wellness and re-ablement
- Transparency.

As part of the aged care reforms, a new *Commonwealth Home Support Program* will commence from 1 July 2015. The Home Support Program will incorporate the existing Australian Government-funded *Commonwealth Home and Community Care (HACC) Program*, the *National Respite for Carers Program (NRCP)*, and the *Day Therapy Centres (DTC) Program*. These three programs are briefly described here:

The Home and Community Care (HACC) Program has been revamped as the Commonwealth HACC Program from July 1, 2012. This serves as the mainstay of home care; it aims to provide a range of basic maintenance and support services for older people and people with a disability to prevent premature or inappropriate admission into long-term care so that these people can continue to live independently in their homes and remain part of their local community. The program offers an array of 19 basic services:

1. domestic assistance
2. personal care
3. social support
4. respite care
5. other meal services
6. assessment
7. client care coordination
8. case management
9. carer counselling/support, information and advocacy
10. client counselling/support, information and advocacy
11. nursing care
12. allied health care
13. centre-based day care
14. goods and equipment
15. home modifications
16. home maintenance
17. formal linen services
18. meals, and
19. transport.

Full-time caring can be physically and emotionally demanding and carers need some respite, or time off. The NRCP provides support to family, relatives, and friends caring for those people at home who are unable to care for themselves because of disability or frailty. It offers community-based respite care in a variety of settings, such as:

- day respite in community centres
- respite in the home – both day and overnight
- overnight respite in community cottages
- community outings – either group or individual
- mobile respite
- employed carer respite, and
- day respite in a residential home.

Another type of respite care is the Residential Respite Care and is discussed in Section 7.1.2.

The DTC Program provides a range of therapy and services to frail aged people to help them to maintain or regain their physical and cognitive abilities so as to improve their level of independence.

There are three other types of flexible care included under the *Aged Care Act* -- *Multi-Purpose Services (MPS)*, *Transition Care Program (TCP)*, and *Aged Care Innovative Pool*.

The MPSs are a joint initiative of federal, state and territory governments and provide an integrated mix of health, community, and aged care services that are individually tailored to suit the geography, population, and care needs of rural and remote communities, many of which could not sustain separate services.

The TCP is a program jointly funded by the Australian Government and the State and Territory governments. It provides short-term care to older people at the end of their hospital stay who require more time and support in a non-hospital environment to complete their recovery process and to finalise their longer-term care arrangements. The program offers a package of services that includes low-intensity therapy, care management, nursing support, and personal care. It seeks to enable older people to return home after a hospital stay and minimise the chances of them entering residential care prematurely.

The Aged Care Innovative Pool is a national pool of flexible care places available for allocation to innovative services outside the Aged Care Approvals Round (see Regulatory Framework under section 6.7). The Pool provides subsidy for a limited time to pilot services or projects that may be needed in particular locations or circumstances and also provides opportunity to test new approaches or extend current practices in new directions to provide aged care to specific target groups.

Outside the *Aged Care Act 1997*, flexible places are provided under the *National Aboriginal and Torres Strait Islander Flexible Aged Care Program*. The services funded under this

program provide culturally appropriate residential and home care mainly in rural and remote areas close to Indigenous communities.

The Department of Veterans' Affairs (DVA) administers two programs offering a range of services similar to those delivered through the HACC program. These programs are: the *Veteran's Home Care (VHC)* program serving veterans aged 70 years or older and the *DVA Community Nursing* program that assists veterans of all ages.

The *Community Visitors Scheme (CVS)* is another national program funded by the Australian Government. It offers companionship to people receiving care at home or in an Australian Government-subsidised aged care home who are isolated and lonely whether for social or cultural reasons or because of disability. Through regular visits by community volunteers on a one-to-one basis and the use of innovative technology, the CVS encourages social networking and helps reduce social isolation.

The *National Disability Insurance Scheme (NDIS)* commenced in South Australia and some other states from July 2013; by 2019-20, it is expected to be fully rolled out nationally. Older people can participate in the NDIS to access specialist disability services provided by State and Territory governments but, in general, they cannot have access to both NDIS and Australian Government funded aged care services concurrently. In many cases, choosing aged care services over disability services should enable them to receive care that is more appropriate to their needs.

All the services described in the foregoing paragraphs, whether delivered in the care recipient's home or in a residential care setting, is designed to minimize, restore, or compensate for the loss of independent physical, cognitive, and/or mental functioning of an individual. The Australian aged care recipient more commonly moves between different services and programs as his or her care needs change.

Over the last 20 years, there has been an increasing emphasis on home care. Even as older people become less able to care for themselves, the majority prefer to remain, and be cared for, in their own homes. The fulfilment of their wish to remain home safely is largely determined by the extent to which the home has an aged-friendly design and location, assistive technologies (such as alarm buttons), and support services. As care needs progress and informal carers may not continue to be available, there may come a time when these old people will have to move into residential care.

6.5.1 Eligibility for Aged Care Packages

Nearly 70 per cent of Australians aged 65 years and over live at home without using government-subsidised aged care services. 25 per cent receive care at home and only five per cent live in residential aged care.¹⁸⁴

¹⁸⁴ 2012-13 Report on the Operation of the Aged Care Act 1997, op. cit. p. 17.

In order to access a Home Care Package or a government-subsidised aged care home, a person must be assessed and approved as eligible by the independent and multidisciplinary *Aged Care Assessment Teams (ACATs)*. An ACAT conducts a comprehensive assessment of a person's physical capability, medical condition, cognitive/behavioural aspects, cultural, social, and restorative care needs, physical environmental factors, and personal choice. In order to understand dependency or need for care, a person is appraised across three care domains by the ACAT: *Activities of Daily Living (ADLs)*, *Behaviour (BEH)*, and *Complex Health Care (CHC)*. He or she is appraised as having *Nil* (meaning the person has minimal or no need for assistance in that area), *Low*, *Medium*, or *High* need for assistance in each of the three domains. The ACAT may also refer a person to a medical or health practitioner/service for more specialised assessment of his or her needs and such assessments could be a part of the overall assessment. Except for visitors to Australia or people who may require temporary or short-term care, there are no citizenship or residency restrictions on accessing aged care services. While there are no minimum age requirements for older people to be eligible for aged care, the average age of admission into both home care¹⁸⁵ and permanent residential care¹⁸⁶ is 82 years.

The ACAT assessment requirements for Home Care Packages are "broad-banded"; the two assessment bands for eligibility are:

- Home Care Levels 1 and 2; and
- Home Care Levels 3 and 4.

This broad-banding allows the consumer to move from one package level to another within the broad-banded levels after being approved by the ACAT but without having to be reassessed. This means that the home care provider is able to offer a higher level package when a consumer's needs require a higher level of care – such as from Level 1 to 2, or from Level 3 to 4 – without the need for another ACAT assessment. However, a new ACAT assessment and approval will be required in order for the consumer to move to a package in a higher band – such as when moving from a Level 1 or 2 package to a Level 3 or 4. In any case, a formal re-assessment has to be carried out by the provider at least every 12 months to ascertain if there is a need for updating the care plan or change the services or the level of support the consumer is receiving.

The eligibility criteria for residential, home, and flexible care are quoted below from the Aged Care Act 1997 amendment:¹⁸⁷

Eligibility to receive residential care

A person is eligible to receive **residential care** if:

¹⁸⁵ Department of Social Services, Australian Government, *Home Care Packages Programme Guidelines*, July 2014.

¹⁸⁶ *Ageing and Aged Care in Australia*, op. cit. p.7.

¹⁸⁷ Sections 21-2, 21-3, and 21-4, Australian Government ComLaw *Aged Care Act 1997 No. 112, 1997*, <http://www.comlaw.gov.au/Details/C2014C00698> (Last accessed January 03, 2015)

- (a) the person has physical, medical, social or psychological needs that require the provision of care; and
- (b) those needs cannot be met more appropriately through non-residential care services; and
- (c) the person meets the criteria (if any) specified in the Approval of Care Recipients Principles as the criteria that a person must meet in order to be eligible to be approved as a recipient of residential care.

Eligibility to receive home care

A person is eligible to receive **home care** if:

- (a) the person has physical, social or psychological needs that require the provision of care; and
- (b) those needs can be met appropriately through non-residential care services; and
- (c) the person meets the criteria (if any) specified in the Approval of Care Recipients Principles as the criteria that a person must meet in order to be eligible to be approved as a recipient of home care.

Eligibility to receive flexible care

A person is eligible to receive **flexible care** if:

- (a) the person has physical, social or psychological needs that require the provision of care; and
- (b) those needs can be met appropriately through flexible care services; and
- (c) the person meets the criteria (if any) specified in the Approval of Care Recipients Principles as the criteria that a person must meet in order to be eligible to be approved as a recipient of flexible care.

Currently, an eligible person may need to be on the waiting list for some packages in some locations in Australia; however, the number of care packages will increase significantly across the country over the coming years.

6.5.2 Aged Care Fees

People can be asked to pay a **basic fee** and an **income-tested care fee** for Home Care or a **basic daily fee** and a **means-tested care fee** based on a combined income and assets test for Residential Care.

A basic fee/basic daily fee: a fee which all people receiving care are asked to pay and for some people this is the only fee they are required to pay.

An income-tested/ means-tested care fee: This is an extra contribution towards the cost of care that some people, but not full pensioners, may need to pay. The Department of Human Services (Centrelink) will assess a consumer's assets and income and this assessment will

influence the amount of Australian Government subsidy for that consumer to the provider, the amount a consumer can be asked to pay as an income-tested or means-tested care fee, and also his or her eligibility for government financial assistance in relation to accommodation costs. The government has put in place safeguards for consumers by way of an annual and lifetime limits on the maximum amount of means-tested or income-tested care fees that someone can be asked to pay. Once the applicable annual cap is reached by a person receiving government –subsidised care, he or she will pay no more income or means tested care fees for that particular year. Similarly, once a person reaches the lifetime cap in government- subsidised care, he or she will pay no more income or means tested care fees. In such cases, the Australian Government will pay the full subsidy for that care recipient to the provider. However, the basic fee/ basic daily fee will still need to be paid by the recipient.

For Home Care, the fee depends on the amount of income one has, not the value of one’s home or any other asset. While the Government has strengthened the means testing arrangements for people entering residential care from 1 July 2014 to ensure sustainability, equity, and access, the treatment of the family home has continued to be exempt from the aged care assets test if occupied by a spouse or other protected person.¹⁸⁸

A home care consumer may have their packages “topped up” by purchasing additional care and services-- the “extras” --after negotiation and agreement with the home care provider.

An **accommodation payment** and **fees for extra or additional optional services** may also be included for residential care. The accommodation cost of some people may be met in full or in part by the Australian Government, while others will need to pay this cost to the aged care home. They can choose how they pay for their accommodation: by a refundable accommodation deposit, a daily accommodation payment, or a combination of both. For consumers who want additional services or higher standards of accommodation, additional fees will need to be paid by them to the provider. These fees will vary from provider to provider.

There is provision for financial hardship assistance if a person is not able to contribute to the cost of a care package; in such cases, the value of his or her assets will be taken into account as part of the application process.

The national contact centre (**1800 200 422**) also provides help with estimating the fees and charges for aged care services. There is also a Home Care Fee Estimator and a Residential Care Fee Estimator on the My Aged Care website that one can use to get an indication of the fees and other charges associated with care. It is important to note though that the Fee Estimators are just that—estimators—and are not substitutes for sound financial advice.

¹⁸⁸ For an explanation of ‘protected person’ for aged care purposes, see information booklet of Centrelink, Department of Human Services, p. 6. <http://www.humanservices.gov.au/spw/customer/forms/resources/ci020-1407en.pdf> (Last accessed January 3, 2015)

6.6 Carers

Aged care services are supported by, and are dependent on, the medical personnel and allied health professionals for meeting the nursing care needs of care recipients. Many older people and their carers are also supported by charitable organisations and volunteers, and the market suppliers of services such as house cleaning and private nursing.

The aged care workforce is made up of paid workforce, volunteers, and informal carers.

Although volunteers are used in both residential and home care, they are used more widely in home care programs. Volunteers provide services such as assistance with transport, home maintenance, meal preparation and delivery, companionship, entertainment, and social activities and these complement the kinds of care provided by the informal carers and the formal workforce. There are two broad types of volunteers: formal and informal. A formal volunteer is a person who willingly provides unpaid help in terms of time, service or skills through an organisation or program. By contrast, an informal volunteer offers assistance and support with caring and doing favours for family, friends, neighbours and others, but does not have a direct link to a service provider.

Informal care, provided by a person who has direct relationship with the care recipient, is the dominant form of care throughout the world and is based on kinship, affection, and duty ensuring regular, ongoing, and direct care either with or without formal assistance. According to Carers Australia which represents informal carers, there are 2.7 million unpaid family and friend carers in Australia. Wiener makes a poignant remark about the love and sacrifices of informal carers:

“Caregiving is difficult, but when it is required families almost always do what is necessary to care for their disabled relatives, resorting to institutions mostly when the burden becomes too great. Lack of family and informal care are major predictors to use of nursing home care”.¹⁸⁹

Spouses dominate the carer statistic for recipients in age cohorts from the 50s to the mid-70s. At around age 75, spouses and children are at par. However, for people in the age bracket of 75 to 79 and older, their children fill the predominant carer group, comprising almost three-quarters of the total carer population for packaged care recipients in their 90s and above.¹⁹⁰

Only in the area of health care, formal carers provide a larger proportion of support than informal carers. This increasing reliance on the formal care system is brought about by a change in assistance needs as frailty and morbidity increase with age and because of non-availability or reduced number of informal carers who can provide needed assistance. An interesting contrast can be seen in assistance with cognition or emotion; understandably, older people generally feel more comfortable and, therefore, become more reliant on

¹⁸⁹ Joshua Wiener, “The Role of Informal Support in Long-term Care”, in *Key Policy Issues in Long-term Care*, Ed. J. Brodsky, J. Habib, and M. Hirschfeld (Geneva: World Health organization, 2003) p.4.

¹⁹⁰ Department of Health and Ageing, *The 2008 Community Care Census* (Commonwealth of Australia: 2010) p. 20.

informal carers for assistance with decision making or with sharing emotions and feelings.¹⁹¹ Informal care is largely subject to access to a spouse and other immediate family, living in the same household or in close geographical proximity.

Carers play a vital role not only in assisting older people to remain in their homes and maintain their links with the community but may also act as a 'bridge' to, or facilitator of, formal services.¹⁹² With the ageing of Australia's population, the need for informal support is expected to increase. Unfortunately, demographic trends indicate that there will be a drop in the availability of informal carers relative to the growing older population. Between 2001 and 2031, the demand for informal carers is expected to rise by a staggering 160 per cent; however, the supply is expected to increase by only less than 60 per cent.¹⁹³ The informal carer resources are expected to come under strain as a result of lower marriage rates, smaller families, families with no children, and increased formal labour force participation among women. A weakening sense of obligation and responsibility towards family will further exacerbate the problem of declining number of informal carers. This will result in an increased demand for aged care services as the ability of some older people to receive home-based care may have to be compromised. For better or worse, a growing number of older people may have no other alternative but to rely more on formal sources of care and support.

6.7 Legislative and Regulatory Framework

This section highlights some important parts of the framework regulating aged care in Australia. In 1997, legislation governing residential aged care in Australia was substantially reformed and the Aged Care Act 1997 was established. It is the Act and the accompanying Aged Care Principles 1997 that are the primary regulatory instrument for the aged care industry and these are administered by the Department of Social Services.

Compared to many other industries, the aged care sector is understandably more closely controlled and monitored by the Australian Government and State and Territory governments through tough regulations. These regulatory arrangements exist largely to protect, from exploitation and unsafe practices, the older people who are one of the most vulnerable groups of citizens. The key elements in the aged care regulatory framework are regulations, standards, monitoring, quality, and support.

With respect to residential care, the Act governs all aspects of its provision. Among other things, characteristics and responsibilities of approved providers and charter of residents' rights and responsibilities are set out in the Act. Also included are residential care accreditation and certification, quality, compliance, and sanctions.

¹⁹¹ *Trends in Aged Care Services: Some Implications*, op. cit. p. 15.

¹⁹² *Older Australia at a Glance*, 4th edition, op. cit. p. 104.

¹⁹³ *Trends in Aged Care Services: Some Implications*, op. cit. p. xxiii.

The Commonwealth Government regulates or controls the 'demand' for aged care services through ACATs. ACATs act as the gatekeeper for aged care services as people can only receive access to residential or home care services after a formal assessment by them. ACATs operate throughout Australia as a single point of entry to aged care services, and act as a source of advice and referral about other community services.

Although there are arguments in support of the regulated limit on the supply of aged care places, such a restriction and the consequent low vacancy rate constrain choices for people, more so for older people from CALD communities. The effects of limiting or restricting places are highlighted in a 2008 DoHA report:¹⁹⁴

“Restrictions on the number of aged care places limit choices for older people. They result in an aged care sector with high occupancy; there is little real opportunity for people to move between aged care services; and people often feel they must take the first available place, rather than wait for their preferred facility, especially if they are waiting for aged care in a hospital. There is little incentive for aged care providers to be entrepreneurial and responsive to older people and their families – essentially, they have a ‘captive market’ – and no matter how well they provide care, they cannot increase their market share simply by attracting a larger number of older people, as they cannot simply expand existing facilities or open new ones due to restrictions on places”.

The Commonwealth Government controls the 'supply' of aged care places by specifying a target for the number of places per thousand people aged 70 or over. Each year, new places are formally created and distributed in every State and Territory based upon the identified aged care needs of the community which, in turn, is based upon the national planning benchmark, population projections of the Australian Bureau of Statistics, and the current level of service provision. Community members and groups are consulted; needs of special needs group (please refer to Section 6.8 for classification of special needs group) are particularly considered. Hence, the Muslim community has an important role to play in this regard through canvassing their aged care needs.

To ensure that the number of aged care places aligns with the growth in the aged population, the number of aged care places in terms of types and distribution are determined and new ones made available by the Australian Government each year through the *Aged Care Approval Rounds (ACAR)*. ACAR is an annual open competitive assessment process that allows prospective and existing approved providers of aged care to apply for Australian Government funded aged care places and/ or financial assistance in the form of a capital grant. The allocation of places is the basis on which aged care facilities provide services and on which they are subsidised for those services. The ACAR process aims to ensure an adequate supply of places for people needing different levels of care and also ensure equitable access to services among metropolitan, regional, rural, and remote areas.

¹⁹⁴ *A Healthier Future for all Australians – Interim Report*, op. cit. p.171.

An operational place may be revoked if it has not been used for a continuous period of twelve months for the purpose for which the allocation was made. This would preclude the possibility of having residential aged care facilities for one particular CALD community if the number of prospective clients from that group is too small.

While regulation of aged care, including accreditation and certification of the standard of the facilities, is largely an Australian Government responsibility, the States and Territories also have a regulatory role. Residential aged care facilities are required to comply with regulation on matters such as state and local government planning and building regulations, fire safety of buildings, occupational health and safety, food and drug preparation and storage, drug administration, and consumer protection. It may be mentioned that South Australia has expressly exempted federally funded aged care facilities from state regulations.

The following page displays the Aged Care Regulation and Monitoring Framework.¹⁹⁵

¹⁹⁵ See Department of Health and Ageing, *Aged Care Reform Package-- Regulation Impact Statement*, p. 10. <http://ris.finance.gov.au/files/2012/05/04-Aged-Care-Reform-RIS-Final-20120430.pdf> (Last accessed January 04, 2015)

Regulation	Standards	Monitoring, Quality & Support
Market entry requirements (Accreditation and approval)	Residential Care Four quality standards, comprised of 44 expected outcomes, covering: o management systems, staffing & organisational development; o health and personal care; o resident lifestyle; and o physical environments.	Approved provider obligations
Supply/Availability of places (allocation principles)		o Quality of care
Funding of Aged Provision (Aged Care Funding Instrument and grant/package guidelines)		o Changes to key personnel
Quality of care (<i>Quality of Care Principles 1997</i>)		o Financial management
Protecting resident's funds (<i>User Rights Principles 1997</i>)	Four prudential standards - o Liquidity Standard; o Records Standard (bond register); o Disclosure Standard; and o Governance Standard.	o Police checks
Building certification (1999 Certification Instrument)	Community packaged care Three quality standards, comprised of 18 expected outcomes, covering: o management; o service delivery; and o service user rights.	o Fire safety
<i>Approval of Care Recipients Principles 1997</i>		Reporting assaults
		Reporting missing residents
		Prudential compliance
		Accreditation – residential
		Quality reporting - community
		Aged Care Funding Instrument validation

		Safety Net
		o The Complaints Scheme

		Quality & Support
		o Supporting for developing a skilled workforce
		o Promoting quality practice
		o Information for consumers

6.8 Where Do CALD and Muslim Aged Care Fit in the Aged Care Policy Framework

All aged care providers are expected to pursue policies and practices that would ensure services are accessible to people with special needs. In addition, places are sometimes allocated to a care provider with a specific condition of allocation that priority of access will be given to people who belong to defined special needs groups.

Under the Aged Care Act 1997 and its associated principles, older people from non-English speaking (culturally and linguistically diverse) backgrounds are identified as a special needs group owing to differences that arise from their country of birth, culture, language, race, and religion but is not restricted to these five. People with special needs may belong to one of the following groups:

- people from Aboriginal and Torres Strait Islander communities
- people from non-English speaking (culturally and linguistically diverse) backgrounds
- people who live in rural or remote areas
- people who are financially or socially disadvantaged
- people who are veterans (including spouses, widows, and widowers of veterans)
- people who are homeless or at risk of becoming homeless
- people who are care leavers (a person who was in institutional care or other form of out-of-home care, including foster care, as a child or youth (or both) at some time during the 20th century)
- parents separated from their children by forced adoption or removal, and
- people who are Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI).

Categorizing the above groups in the special needs category means that that their 'different' needs would be included in care planning process by policy planners and service providers and they will have access to appropriate care.

Under the aged care system, diversity of consumers is to be taken into account by the service providers. To illustrate how this is done, reference can be made to the *Home Care Agreement* (previously known as a Care Recipient Agreement). It is a legal requirement to offer it to the consumer before any Home Care Package commences. An important part of the Home Care Agreement is the consumer's care plan determined by the consumer in partnership with the home care provider. The Agreement is to reflect responsiveness to a consumer's individual interests, customs, beliefs, and background, and accommodation of his or her goals and preferences, wherever possible. To do this, the home care provider may need to purchase (sub-contract or broker) services from another service provider in the same way that it may have to work collaboratively with advocacy services and specialist service providers. All these mean that there can no longer be a 'standard' or 'table d'hôte' menu but a wider and innovative selection to meet diverse care needs of consumers. Whatever the arrangements, the responsibility for appropriateness and quality of services and meeting all regulatory requirements, including supporting consumers in an emergency situation, rests with the home care provider.

The Aged Care Act 1997 has clearly defined objectives among which the following two relate directly to older people from CALD backgrounds and certainly could include Muslims:

- Facilitate access to care for people with care needs regardless of race, culture, language, gender, economic circumstance, or geographic location
- Encourage services that are diverse, flexible, and responsive to individual needs.

The *National Strategy for an Ageing Australia* is based on a number of principles, including the following¹⁹⁶:

“All Australians, regardless of age, should have access to... care services that are appropriate to their diverse needs...”

The *Charter of Public Service in a Culturally Diverse Society*¹⁹⁷ aims to ensure that government services are sensitive to the language and cultural needs of all Australians. The federal, state, and territory governments and the Australian Local Government Association have all endorsed the Charter and as such, there is assurance of a consistent approach to government services delivery across the country. The Charter integrates a set of principles into the strategic planning, policy development, budget, and reporting processes of service delivery, irrespective of whether these services are provided by government agencies, community organisations, or commercial enterprises. There are seven Charter principles: access, equity, communication, responsiveness, effectiveness, efficiency, and accountability.

The government had taken initiatives to provide cross-cultural training and information and to encourage ethnic communities to form partnerships with mainstream service providers to establish more culturally appropriate aged care facilities. There are two specific programs in support of this initiative that helps both the care recipients and the aged care industry workers: the *Partners in Culturally Appropriate Care Program* (PICAC) and the *Community Partners Program* (CPP).

PICAC is a 1997 Commonwealth initiative under the Ethnic Aged Care Framework. It funds one organisation in each State and Territory to work in conjunction with aged care homes, ethnic communities, and the government to identify and address the special needs of older people from CALD backgrounds, to support aged care providers to develop culturally appropriate services, and to equip providers to deliver culturally appropriate care by providing training to their staff. PICACs also provide services such as translations, referrals, and information sessions for CALD communities. In South Australia, the Multicultural Aged Care Incorporated functions as the State’s PICAC.

CPP provides grants to community-based CALD organisations to assist older CALD people to access aged care services. CPP also facilitates aged care service providers and CALD

¹⁹⁶ Department of Health and Ageing, *National Strategy for an Ageing Australia: An Older Australia, Challenges and Opportunities for All* (Commonwealth of Australia, 2001) p. 2.

¹⁹⁷ See Department of Immigration and Multicultural Affairs, *2005 Access and Equity Annual Report*, Chapter 2: The Charter of Public Service in a Culturally Diverse Society (Commonwealth of Australia, 2006)

communities to work together to establish and maintain links between people living in aged care homes and their communities.

At the 2009 Multicultural Aged Care Roundtable, it was agreed that DoHA would take action aimed at ensuring that the places in residential aged care facilities that are funded for specific CALD communities are held and provided to members of those CALD communities.¹⁹⁸ This measure would help in mitigating some of the concerns around mainstream care not being appropriate for Muslims in South Australia who do not at present have the critical mass to have separate residential aged care facilities.

The *Quality of Care Principles 2014*¹⁹⁹ specifies Accreditation Standards for residential care providers and Home Care Standards for home care providers. There are four Standards and each Standard consists of a principle and a number of expected outcomes. Standard 3 recognises cultural and spiritual life as an important element; it follows that the application of this Standard would lead to understanding and valuing an individual's background. The principle for Standard 3 is:

“Care recipients retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.”

One of the expected outcomes under this Standard is:

“Cultural and spiritual life: Individual interests, customs, beliefs and cultural and ethnical backgrounds are valued and fostered.”

Therefore, when an aged care facility is assessed for accreditation, it has to demonstrate that in managing and delivering services, it fulfils its responsibilities to residents in relation to, among other things stated in Standard 3, cultural and spiritual life. Pringle stresses three key terms in the outcome stated above: individual, valued, and fostered. She explains:

“The word *individual* recognises that cultural and spiritual aspects are highly individualised, and hence homes have to cater for the needs of individuals, not groups. The word *valued* reflects the way in which the home must show respect and honour in regard to each resident's culture and spirituality. The third key word, *fostered*, indicates that homes are not only to recognise and value the culture and spirituality of residents, but also to demonstrate how they encourage further growth and development.”²⁰⁰

¹⁹⁸ Government of South Australia, *Multicultural Aged Care Roundtable Report* (Adelaide: Multicultural SA, 2009) p. 1.

¹⁹⁹ Australian Government ComLaw, *Quality of Care Principles 2014*- F2014L00830 <http://www.comlaw.gov.au/Details/F2014L00830> (last accessed January 04, 2015)

²⁰⁰ Elizabeth Pringle, “Promoting High Quality Care”, in *Ageing and Spirituality across Faiths and Cultures*, Ed. Elizabeth MacKinlay (London: Jessica Kingsley Publishers, 2010) p.234.

The Australian Government is a signatory to the *Political Declaration and Action Plan*, also known as the *Madrid Plan*,²⁰¹ agreed in 2002 by the Second World Assembly on Ageing held in Madrid, Spain. The Declaration stresses the responsibility of governments in promoting, providing, and ensuring access to basic social services with particular emphasis on specific needs of older persons. The Madrid Plan provides an international policy framework through its three priority directions:

- Priority Direction I - Older persons and development
- Priority Direction II - Advancing health and well-being into old age, and
- Priority Direction III - Ensuring enabling and supportive environments.

The third priority direction could be related to extending aged care services to include the care needs of older Muslims in Australia.

6.9 Improving Access

Getting access to residential and home care services that meet their needs can be difficult for many people, particularly the CALD communities. Compared to other older Australians, people from CALD backgrounds have special needs due to the following factors:²⁰²

- Being separated from country of birth
- Severing of family ties
- Migration process and subsequent isolation
- Lack of proficiency in English
- Low income
- Low occupational status
- Needing to adapt to a new socio-cultural system which is different from their own, and having their own culture not appreciated or acknowledged by others
- Having to cope with intolerant or racist attitudes, or cultural stereotyping; and
- Difficulties experienced in accessing health and aged care services due to these and other factors.

Improving the access of people from non-English speaking countries to aged care has been a key policy objective of the Australian Government for the last decade. According to the Productivity Commission:

“There is strong empirical evidence that consumer choice improves wellbeing, including higher life satisfaction, greater life expectancy, independence and better continuity of care”.²⁰³

²⁰¹ See United Nations, *Political Declaration and Madrid International Plan of Action on Ageing*, Second World Assembly on Ageing, Madrid, Spain (New York: 2002)

²⁰² Kate Barnett, *“Aged Care Policy for a Multicultural Society”*, op. cit. pp. 3-21.

²⁰³ *Caring for Older Australians*, op. cit. p. XXIX.

To this end, the Government has focussed on providing aged care services for specific groups and promoting cultural sensitivity in service delivery. One significant result of such focussed attention has been the *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds* launched in December, 2012. It was developed by DoHA in partnership with FECCA and with inputs from consultations with the public and the stakeholders throughout Australia. This Strategy is designed to facilitate all aged care policies and government-related aged care activities to be appropriate and sensitive to the needs of older people from CALD backgrounds. While acknowledging the increasing diversity of Australians, the Strategy underscores the importance of spirituality along with culture and language in designing aged care services to make such services appropriate to the needs of older CALD people.

Among the five principles contained in the Strategy, the principle of *Access and Equity* states, “All ageing and aged care services have the responsibility to provide culturally, linguistically and spiritually appropriate and flexible aged care (across generalist, multicultural and ethno-specific service types) to facilitate maximum choice for CALD aged care recipients.”²⁰⁴ The principle also states, “It is important to have an appropriate understanding of each individual’s background, culture, beliefs and needs”.²⁰⁵ The Strategy’s *Capacity building* principle emphasises the need to strengthen the CALD community capacity in order to train and develop a workforce with the skills and knowledge to deliver culturally, linguistically and faith-appropriate aged care services. Implementation of the five principles of this Strategy would help reduce, hopefully even offset, some of the feelings of ‘cultural exclusion’, which otherwise could become a major impediment to building a vibrant, cohesive, and strong multicultural society.

Aged care was identified by CALD communities as one of the high priority areas and where significant barriers in accessing and utilising Commonwealth Government services exist.²⁰⁶ The Government announced plans to conduct an inquiry into the responsiveness of Australian Government services to clients who face cultural or linguistic barriers. The outcome of this inquiry would help the Government to assess how existing services are performing and to formulate strategies to improve them.

6.10 Aged Care Department and Agencies in Federal Government

The responsibility for aged care and ageing has moved from the Department of Health to the Department of Social Services.²⁰⁷ The Department has the following areas of responsibilities:

- Aged Care Quality & Compliance

²⁰⁴ *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*, p.10.

²⁰⁵ *ibid.*

²⁰⁶ *The Bigger Picture: Joining Up Solutions to Achieve Access and Equity*, op. cit. p. 12.

²⁰⁷ The Department of Social Services is the former Department of Families, Housing, Community Services and Indigenous Affairs.

- Aged Care Policy & Reform , and
- Ageing & Aged Care Services

These obligations are carried out through policy advising, program management, research, regulation, and partnerships with other government agencies, consumers, and stakeholders.

- There is an Office of the Aged Care Commissioner (the Office), a statutory body that supports the Aged Care Commissioner (the Commissioner) who is a statutory officer appointed under the *Aged Care Act 1997*. The Office seeks to promote good complaint handling and “aims to encourage continuous improvement in the quality of aged care services for older Australians and provide for greater confidence in aged care”. The Commissioner’s primary function is to address complaints lodged against the Australian Aged Care Quality Agency and the Aged Care Complaints Scheme.
- The Australian Aged Care Quality Agency, also known by its short title, the Quality Agency, is an independent statutory agency which performs the following functions:
 - accredit and supervise Australian Government- funded aged care facilities
 - conduct quality review of home care services
 - register quality assessors
 - advise the Secretary of the Department about aged care services that do not meet the Standards
 - promote high quality care, innovation in quality management and continuous improvement, and
 - provide information, education, and training.

The Quality Agency has replaced the Aged Care Standards and Accreditation Agency Ltd.

- The Aged Care Complaints Scheme (the Scheme), part of the Department of Social Services, provides free service for anyone to raise their concerns about the quality of care or services being delivered to people receiving Australian Government-subsidised residential care or Home Care packages. The Scheme works with service providers to identify quality improvements and helps people to resolve their concerns. The Complaints Scheme can be contacted on **1800 550 552**. Complaints can also be made to the Scheme in writing and via the Scheme’s website.
- The Australian Institute of Health and Welfare (AIHW), an independent statutory authority, is the national agency for health and welfare statistics and information.

6.11 Key Organisations

Some key organisations that are linked to aged care in Australia are: the National Aged Care Alliance, Federation of Ethnic Communities' Councils of Australia, Aged and Community Services Australia, Aged Care Association Australia, Aged Care Advocacy Agencies, Council on the Ageing, and Carers Australia.

- National Aged Care Alliance (NACA) is a representative body of peak national organisations in aged care, including consumer groups, providers, unions, and health professionals.
- Federation of Ethnic Communities' Councils of Australia (FECCA) is the national peak body representing Australians from CALD backgrounds, and seeks for them equal access to all aspects of life, including culturally appropriate aged care. The Multicultural Communities Council of SA (MCCSA) is the only FECCA member in South Australia.
- Aged and Community Services Australia (ACSA) is the national peak body that represents church and charitable and community-based organisations providing residential and home care. Aged & Community Services SA & NT Inc. (ACS SA & NT) is the State association for South Australia and Northern Territory.
- Aged Care Association Australia (ACAA) is the peak body that represents care providers from the private and voluntary sectors nationwide. There is a chapter of ACAA in South Australia.
- National Aged Care Advocacy Program (NACAP) is funded by the Australian Government to provide free and confidential advocacy services to consumers of aged care. The National Aged Care Advocacy line is **1800 700 600** (free call). Should the consumer not have an advocate, one may be made available through the NACAP. Under the NACAP, there are independent community-based Aged Care Advocacy Agencies in each State and Territory to promote and protect the rights and wellbeing of older people through advocacy support. The advocacy agency in South Australia is the Aged Rights Advocacy Service (ARAS).
- Council on the Ageing (COTA) is Australia's leading seniors' organisation, with a COTA chapter in every State and Territory. COTA is an independent consumer organisation that protects and promotes the well-being of all seniors. COTA SA is the South Australian branch of COTA.
- Carers Australia is the national peak body representing and advocating for unpaid carers to influence care programs and services at a national level. Carers SA represents and supports family carers across South Australia.

This chapter makes clear that given the tightly regulated aged care sector, the government has to play the leading role in facilitating an attitudinal shift to aged care provision that takes into account not only one's language and culture, but also one's faith requirements.

7. Residential Care

This chapter discusses accommodation choices for older people with particular focus on residential care and why it is important to continue to make provisions for such care even though, to many, it may be a 'refuge of last resort'. It also includes a section on retirement village as it may be helpful to many older people and their families to understand the differences between residential care and retirement village. The chapter ends with a glimpse into aged care issues in regional areas of Australia.

7.1 Accommodation Choices

As one approaches retirement or old age, one must ponder where one can live. Arrangements may need to be put in place for accessing services that assist the elderly in daily living if he or she wishes to continue to remain at home. Depending on one's family and financial situations and physical and mental health conditions, there may be a need to modify one's present home to better meet one's needs or even to move from a current home or the local community into a new environment that offers greater comfort. As care needs progress, one may need to move into a serviced unit in a retirement village, or even into residential care to access needed services or facilities. The final choice of accommodation is usually made by the aged person, his or her family, and the service provider.

7.1.1 Retirement Villages

Independent older people aged over 55 who do not require the level of care offered at aged care homes but need more security, support, or company and yet want to maintain their independence may choose to live in retirement villages. A *retirement village*²⁰⁸ provides people with independent accommodation but may include shared facilities, such as meeting rooms, a library, or pool. Services in retirement villages generally do not include health care. Although these are regulated by State and Territory governments, some villages operate without organised services. Services are delivered through a service contract between the village operator and the resident. However, there is no fixed or agreed list of services provided in self-care or serviced units as is in aged care homes.

Retirement villages are usually run by commercial operators for profit, or by community organisations such as religious or ethnic associations. Unlike residential care, payments made by residents in a retirement village are not set by the government but by an agreement between the resident and the operator of the village.

The most common terms that are used to describe the level of care provided in a village are *independent living units* and *assisted living units*. Independent living units or self-care units are offered to people who can look after themselves and, thus, these provide the lowest level of care, although a range of personal services known as *flexi-care* may be available at an

²⁰⁸ For more on retirement village and other options, see Department of Families, Housing, Community Services and Indigenous Affairs, *Accommodation Choices for Older Australians and their Families: what older Australians and their families need to know* (Canberra: 2010)

additional cost that the user pays for. Assisted living units or serviced apartments provide the highest level of care, usually including the regular provision of a range of personal care and/or domestic services such as, meals, house-cleaning, and laundry, for an additional fee. Only people assessed by an ACAT as requiring residential aged care are allowed to move into serviced units that receive government funding .

In August 2013 there were 519 retirement villages with approximately 24,800 residents in different locations all over South Australia, except for the far north.²⁰⁹

7.1.2 Residential Aged Care

When people are no longer able to maintain themselves or be maintained by others in their own homes because they require intensive and continued support, they move into a residential care setting which is the only place where such support is available and possible. A move into residential aged care can be triggered by a range of factors including not only a serious health incidence but also, inappropriate living arrangements or unavailability of, or lack of support from, an informal carer.

Residential aged care was first started in Australia in the late nineteenth century by friendly societies, churches, and charitable organisations. In the 1950s, the Commonwealth Government stepped in as a major player by providing grants to this voluntary sector.

Although across cultures, community-based arrangements are clearly preferable to older people who are still functioning, some will find that because of their increasing impairment, they will have to move to a residential care setting. Older people prefer to live in a residential aged care facility which accommodates their culture and language.²¹⁰ On average, they also end up spending more time in permanent residential care than on home care packages.²¹¹

According to the Australian Productivity Commission, the main users of formal aged care services tend to be those who are over 85 years old.²¹² As mentioned in Section 3.5, the average age of entry into residential care is 82 for both men and women. Younger residents aged under 65 years are not usually admitted to residential aged care unless no other suitable disability services are available. Most residents in Australian aged care facilities are women; this may be attributed to the fact that females comprise a larger proportion of the older population;²¹³ they are more likely to live alone as they live longer than men and, consequently, more likely to be widowed than men.

²⁰⁹ Office for the Ageing, *Prosperity through longevity: South Australia's Ageing Plan, Our vision 2014-2019* (Government of South Australia, 2013) op. cit. p. 46.

²¹⁰ Ethnic Communities' Council of Victoria Inc., *Ageing and Cultural Diversity Strategy* (Melbourne: 2011) p.11.

²¹¹ *Caring for Older Australians*, op. cit. p.26.

²¹² *Trends in Aged Care Services: Some Implications*, op. cit. p. 33.

²¹³ Australian Institute of Health and Welfare, *Residential Aged Care in Australia 2010–11: A Statistical Overview*. Aged care statistics series no. 36. Cat. no. AGE 68. (Canberra: 2012), p.22.

Although only a small proportion of older persons live in aged care facilities at a given point in time,²¹⁴ as the population grows older, the demand for residential aged care will also increase along with an increase in demand for quality care.²¹⁵ The Government's acknowledgement of this is reflected in its aged care reform measures. One of its Fact Sheets on the reform measures says, "At the conversations on ageing held across Australia, it was acknowledged that there is a need for quality residential care when home care is no longer an option".²¹⁶ Not only that the likelihood of a person entering permanent residential aged care at some point during their lifetime is increasing,²¹⁷ permanent resident population has also been growing steadily every year.²¹⁸ A 2008 Government report estimated that at any one time, about one in 13 people over the age of 70 have entered into a residential aged care facility in Australia. The same report also estimates that a third of all men and half of all women who have reached 65 will go into permanent residential care at some time in their lives.²¹⁹

The residential aged care program is provided on a *permanent* or *respite* basis. Until recently, the two main types of permanent residential aged care were *high care* (formerly nursing home) and *low care* (formerly hostel). From 1 July 2014, this distinction has been obliterated; under the new aged care reform measures, there is now a single level of residential aged care that will give residents the right to stay indefinitely in the same home even when their care needs change so that there is continuity of care in familiar environs with less disruption. This is called *ageing in place*, a concept enthusiastically embraced by both the government and the aged care industry.

Residential respite care is short-term care in aged care facilities given on a planned or emergency basis to frail older people who need temporary care, but intend to return to their own homes. It supports elderly people for reasons such as relieving carers or the unavailability of a carer. Residential respite care occupies an important place in the aged care system. In 2010-11, over half of all admissions into residential aged care were for respite care and 35% of respite care recipients eventually moved into permanent residential care within the year.²²⁰ Respite care recipients continue to receive low-level and high-level care approvals and resident classifications as this distinction still determines residential respite care subsidies.

²¹⁴ *Older Australia at a Glance*, 4th edition, op. cit. p.137.

²¹⁵ *The Australian Longitudinal Study of Ageing: 15 years of Ageing in South Australia*, op. cit. p. 83.

²¹⁶ Department of Health and Ageing, FACT SHEET *Living Longer Living Better – Strengthening Residential Aged Care*, April 2012.

²¹⁷ See Department of Health and Ageing, Technical paper on the changing dynamics of residential aged care prepared to assist the Productivity Commission Inquiry *Caring for Older Australians* (Canberra: 2011) p.15.

²¹⁸ *ibid.* p.19.

²¹⁹ *Ageing and Aged Care in Australia*, op. cit. p.7.

²²⁰ Australian Institute of Health and Welfare, *Residential Aged Care in Australia 2010–11: A Statistical Overview*. Aged care statistics series no. 36. Cat. no. AGE 68 (Canberra: 2012) p. 63.

Among permanent residents, death is the predominant reason for separation,²²¹ accounting for over 90% of cases. During 2010-11, only 4% returned to the community and just 2% moved to a different residential aged care setting.²²²

There is provision for care recipients to opt for a variety of *Extra Services* care which provides a higher standard of accommodation, food, and services for additional fees paid by the resident, but regulated under the Aged Care Act. It is important to mention that 'Extra Service' does not mean residents are provided with a higher standard of care, since all aged care facilities are legally obliged to provide the same care standards to their residents. A residential aged care home can have Extra Service status for the whole home or for a part of the home. Although small in number, the 'Extra Service' places have broadened service choice for residents.

The Australian Government is encouraging residential aged care providers to build new facilities or make considerable improvements to existing ones. The government will support this investment via a higher accommodation supplement paid per resident per day.

7.2 Issues in Regional Australia

Approximately 11.3% of Australians aged 70 and over live in outer regional, remote and very remote areas.²²³ Australia's coastal areas have experienced a surge in population growth while population in inland areas has either remained stable or declined. Australia's regional population is older and growing faster than that of the capital cities. According to Graeme et.al., the greater concentration of the 'young' aged (65-74) in regional areas can be explained by the migration inflow of retirees and the 'ageing in place' of baby boomers in those areas. There is also a strong migration outflow of the 'older' aged (75 and over) from regional to capital cities. This is often necessitated upon the death of a spouse or by the loss of personal mobility through disability or losing driver's licence, and by the need to be closer to medical services or informal carers.²²⁴

Residential aged care facilities in outer regional, remote, and very remote areas are generally small in size and lack the economies of scale and economies of scope. Extra funding in the form of viability supplement is provided to some facilities in rural and remote areas to assist in providing quality aged care to the residents. However, aged care in regional Australia costs more per consumer and the viability supplement is often not enough to cover the higher costs. Compared to the urban localities, home care as well as palliative care is less available in regional areas and waiting period to get into residential care is higher. It is difficult to

²²¹ A separation occurs when a resident leaves residential aged care and does not re-enter the same or another service within two days.

²²² *Residential Aged Care in Australia 2010-11: A Statistical Overview* op. cit. p. 38.

²²³ Richard Baldwin, Marguerita Stephens, Daniel Sharp and John Kelly, *Issues Facing Aged Care Services in Rural and Remote Australia*, Aged and Community Services Australia (December 2013) p. 1

²²⁴ For more on this, see Graeme Hugo, Helen Feist and George Tan, *Population Change in Regional Australia, 2006-11*, Australian Population & Migration Research Centre Policy Brief Vol. 1, No. 3, March, 2013

attract and retain aged care staff and the threat of closure looms large as small providers struggle to attain financial viability.

The discussion in this chapter calls attention to the critical place residential care occupies in the aged care system. The fact that, on an average, older people end up spending more time in residential care than on home care packages, underscores the need for making residential care a viable alternative for people who eventually have to enter such care. For Muslims, this would mean aged care facilities that support their faith-based lifestyle.

8. Aged Care in South Australia

This chapter briefly discusses the demographics and aged care in the state of South Australia.

8.1 Demographics of South Australia

The South Australian population is predominantly urban. It is predicted that right through 2021, Adelaide will continue to be the dominant population centre in South Australia.²²⁵ According to the 2011 Census, there were 1,596,572 people (roughly 1.6 million) in South Australia; the percentage of male population was 49.3 and that of female was 50.7.²²⁶ At June, 2013, the sex ratio (the number of males per hundred females) in Greater Adelaide was the lowest sex ratio (96.8) of all capital cities.²²⁷

One in five South Australians was born overseas and one in ten was born in non-English speaking majority countries.²²⁸ South Australia reflects a truly multicultural society with its people coming from about 200 countries, speaking more than 200 languages (including Aboriginal languages) and believing in about 100 religions.²²⁹ People born in Australia made up 73.3% of the State's population; for the rest, the top five countries of birth were England, Italy, India, China (excludes SARs and Taiwan), and Scotland. Also, 56.8% of people had both parents born in Australia and 31.1% of people had both born overseas.²³⁰ Migrants and children of migrants from non-English speaking backgrounds make up nearly 25 per cent of South Australia's population. The top ancestries of its residents are English, Australian, Scottish, German, Irish, Italian, Greek, Chinese, Dutch, Indian, Polish, Vietnamese, Filipino and Welsh.²³¹ The overwhelming majority of people in the State-- 81.6%-- speak only English at home. Other common languages spoken at home included Italian, Greek, Mandarin, Vietnamese, and Cantonese.²³²

²²⁵ Government of South Australia, *South Australia: Our Health and Health Services* (Adelaide: SA Health, 2008) p.12.

²²⁶ Australian Bureau of Statistics, 2011 Census QuickStats, South Australia
http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011/quickstat/4?opendocument&navpos=95#demographics (Last accessed January 05, 2015)

²²⁷ Australian Bureau of Statistics, 3235.0 - Population by Age and Sex, Regions of Australia, 2013
<http://www.abs.gov.au/Ausstats/abs@.nsf/mf/3235.0#PARALINK2> (Last accessed January 05, 2015)

²²⁸ *Prosperity through Longevity: South Australia's Ageing Plan, Our Vision 2014-2019*, p. 21.

²²⁹ South Australia's Diversity, 2011 Census Data Summary, Multicultural SA, Government of South Australia, <http://www.multicultural.sa.gov.au/communities-in-sa/statistics> (Last accessed January 05, 2015)

²³⁰ Australian Bureau of Statistics, 2011 Census QuickStats, South Australia, op. cit.

²³¹ South Australia's Diversity, 2011 Census Data Summary, op. cit.

²³² Australian Bureau of Statistics, 2011 Census QuickStats, South Australia, op. cit.

For older South Australians from CALD backgrounds, Italy is the most common country of birth; Greece is the second most common country of origin, followed by Germany.²³³ Approximately, one in five people in 2006 aged 65 years and over in South Australia were born overseas in a mainly non- English speaking country.²³⁴ At 30 June 2013, the number of care recipients from CALD backgrounds totalled 2,614 in residential care and 924 in home care across South Australia.²³⁵ However, no information is available with regard to the number of Muslim care recipients.

In 2013, the median age of South Australians was 39.8 years. According to the 2011 Census, the proportion of South Australians aged 65 years and over (16.7%) was slightly smaller than in Tasmania (17.3%), making South Australia home to the second oldest population of all the States and Territories. Older people from CALD backgrounds live in geographically dispersed areas in Adelaide and country areas across South Australia. Within the State, Victor Harbour (37%) and Goolwa - Port Elliot (35%), on the Fleurieu Peninsula, had the highest proportions of people aged 65 and over, and were among the highest in Australia.²³⁶

Where the Aged Are: Proportion of Population Aged 65 Years and Over Top 5 Areas in SA, 2013		
	Area	% population aged 65 years and over
1	Victor Harbour	36.8
2	Goolwa - Pt. Elliot	34.8
3	Yorke Peninsula - South	30.9
4	Moonta	29.9
5	Yorke Peninsula - North	28.6

Source: Australian Bureau of Statistics, 3235.0 - *Population by Age and Sex, Regions of Australia, 2013*.

The State's Ageing Plan (2014-2019) recognises the diversity among its older population. This recognition, along with respect for, and valuing, our seniors and protecting their rights underpin the Ageing Plan.²³⁷ An ageing population and increased life expectancy bring their

²³³ Multicultural SA, http://www.multicultural.sa.gov.au/__data/assets/pdf_file/0004/2011/south-australian-diversity-in-2012.pdf (Last accessed January 05, 2015)

²³⁴ Office for the Ageing, Department for Families and Communities *Cultural and Linguistic Diversity Amongst Older People in SA: A Demographic Overview* (Government of South Australia, 2009) p. 6.

²³⁵ *2012-13 Report on the Operation of the Aged Care Act 1997*, op. cit. p. 60.

²³⁶ Australian Bureau of Statistics, 3235.0 - *Population by Age and Sex, Regions of Australia, 2013*, <http://www.abs.gov.au/ausstats/abs@.nsf/products/72D4A8F0C7957E85CA257A6A0012F5A0?OpenDocument> (Last accessed January 05, 2015)

²³⁷ *Prosperity through Longevity: South Australia's Ageing Plan, Our Vision 2014-2019*, op. cit.

own opportunities and challenges. Among the challenges that are emphasised in the plan are: ageism, increased uptake of health services and other support, and increased cost associated with frequency and complexity of health care. Religion and spirituality has been recognised in the Plan as an important factor in care issues of older people.

8.2 Home Care

The number of allocated and operational home care places in South Australia per 1,000 people aged 70 years or over at 30 June 2013 was 27.3 and 24.9 respectively.²³⁸

During 2011-12, there were 104,918 clients who received a HACC service in South Australia. Although the HACC program is changing from 2015 as mentioned in Section 6.5, a quick look at a few statistics²³⁹ on HACC clients would help to know the profile of consumers of home care in the State:

Age and sex:

- Almost 78% clients were aged 65 years and over.
- Women comprised 62 % and men 38% of total clients.

Languages spoken at home:

- About 88% of clients spoke English.
- The top languages other than English were Italian, Greek, Polish, Croatian German, and Vietnamese.

Living arrangements:

- 40.8% of HACC clients lived alone.
- 54.7% lived with family.

Carer availability:

- A staggering 72.8% of HACC clients had no carer. (If a client has a paid or formal volunteer carer, the carer status is recorded as "has no carer" as the term 'carer' is used for the purpose of this data set to indicate informal carers among family members, friends and neighbours.)

Services most frequently used by HACC clients:

- Home modification
- Meals (home)
- Centre-based day care
- Domestic assistance
- Social support
- Transport

²³⁸ 2012-13 Report on the Operation of the Aged Care Act 1997, op. cit. p.20.

²³⁹ Department of Health and Ageing, Australian Government, *Home and Community Care Program Minimum Data Set 2011-12 Annual Bulletin*, Australian Government Department of Social Services (Canberra:2012)

- Personal Care
- Respite care
- Nursing care
- Meals (centre).

8.3 Residential Care

Data suggest that South Australia had the highest occupancy rate²⁴⁰ and provision ratio²⁴¹ in residential care compared to other States and Territories. In South Australia, the average occupancy rate of residential care places has been consistently higher than the national average; at 30 June 2013, it was 94.7%.²⁴² Also, the State had the second highest residential aged care provision ratio of 91.8 at June 30, 2011.²⁴³ Compared with other States and Territories, at June 30, 2011, South Australia had a greater proportion of permanent residents who were appraised as *High* in BEH and CHC domains.²⁴⁴ From 2007-08 to 2010-11, South Australia also had the highest hospital patient days used by patients waiting for residential aged care.²⁴⁵

Residential Care Statistics of SA reveals that as of June 30, 2011:²⁴⁶

- South Australia had 16,499 residential places operated by 181 organisations in 256 facilities.
- Majority (78%) of the residential care places were located in the Adelaide Metropolitan Region.
 - The highest (3654) number of operational places were located in the Metro South Area (Holdfast Bay, Marion, Mitcham, and Onkaparinga Councils).

²⁴⁰ An aged care home's occupancy rate is the proportion of operational places that are occupied by care recipients.

²⁴¹ The provision ratio compares the number of places available to a specific population at a point in time, usually a 30 June date. Currently, aged care planning calculates the number of aged care places available per 1,000 people aged 70 and over. Thus, an aged care provision ratio of 10 would mean that there are 10 places available for every 1,000 people 70 years and over.

²⁴² *2012-13 Report on the Operation of the Aged Care Act 1997*, op. cit. p. 40.

²⁴³ *Residential Aged Care in Australia 2010-11: A Statistical Overview* op. cit. p.16.

²⁴⁴ *ibid.* p. 54.

²⁴⁵ SCRGSP (Steering Committee for the Review of Government Service Provision) 2013, *Report on Government Services 2013*, Productivity Commission, p. 13.61.

²⁴⁶ See Aged & Community Services SA & NT Inc., *Residential Care in South Australia*, <https://www.agedcommunity.asn.au/aged-and-community-care-information/residential-care-information> (Last accessed April 06, 2012)

- The lowest (2545) number of operational places was in Metro West (Charles Sturt, Port Adelaide-Enfield, and West Torrens Council).
- Outside Adelaide Metropolitan Region, the Hills, Mallee and Southern area had the highest number of operational places (1118) while the Eyre Peninsula had the lowest (142).

The number of allocated and operational residential care places in South Australia per 1,000 people aged 70 years or over at 30 June 2013 was 98.9 and 92.9 respectively. The number for both allocated and operational transition care places was 1.8.²⁴⁷ Each year, the Department of Health publishes an exhaustive list of aged care service providers by State and Territory.²⁴⁸ The 2014 Aged Care Service List of South Australia shows that religious and charitable organisations account for almost half of provider types. At 30 June 2013, South Australia had the second highest proportion of government-owned residential care facilities (12%) among all States and Territories.²⁴⁹

8.4 Highlights of Aged Care in South Australia

In October 2014, the Aged Care Innovation Hub was launched in South Australia. The trial project, if successful, will be rolled out across other States and Territories. The concept of the Hub was born out of the need to cut unnecessary and stifling regulatory obligations and free up more time and resources of the providers to better enable them to continue to improve the quality of service delivery; in other words, to “allow providers greater independence in governance and quality assurance as a reward for sustained high performance in relation to regulatory obligations”.²⁵⁰

South Australia has had a low rate of complaints received by the Aged Care Complaints Scheme about the quality of care or services received in both community and residential care and also had a high proportion of complaints resolved without the need for a direction.²⁵¹

The Ethnic Link Services (ELS), a state-wide program funded by the Department of Human Services, was established in South Australia in the late 1980s. It has proved very effective in reaching out to older CALD people and linking them to a range of mainstream services, thus overcoming diversity barriers to ensure that CALD people have access to care support. Some

²⁴⁷ *2012-13 Report on the Operation of the Aged Care Act 1997*, op. cit. p.20.

²⁴⁸ See Department of Social Services, *Aged Care Service List - SA - as at 30 June 2014*.

²⁴⁹ Australian Institute of Health and Welfare, <http://www.aihw.gov.au/aged-care/residential-and-community-2012-13/services-and-places/> (Last accessed January 07, 2015)

²⁵⁰ Speech by Kevin Andrews, Federal Minister for Social Services (Adelaide:2014), <http://kevinandrews.com.au/latest-news/2014/10/13/launch-south-australian-innovation-hub-trial/> (Last accessed January 03, 2015)

²⁵¹ *Report on Government Services 2013*, op. cit. pp. 13.69-13.70.

have no English language proficiency and there are not enough interpreters. ELS provides language assistance, cultural expertise, information, and advocacy services to older people in the metropolitan, Riverland, and Whyalla areas representing over 50 different cultures. Since 1992, ELS has been a part of Uniting Care Wesley Port Adelaide (UCWPA).

8.5 Relevant Government Departments and Agencies²⁵²

The South Australian State Government provides a range of specific aged care services that are funded by the Commonwealth government. Included are: packaged home care services, administration of the Aged Care Assessment Program, and managing residential aged care facilities and beds in many regional hospitals.

- The Department for Health and Ageing provides leadership to South Australia's health reform, policy development, and planning. Under this Department, the Office for the Ageing is responsible for policy advice and, development and implementation of programs and services for older people, as well as raising awareness about issues that affect them.
- The Department for Communities and Social Inclusion works with other agencies and provides direct services in areas such as disability, ageing, and community services.
- The Office for Carers works with the government to advocate for issues concerning carers.
- Multicultural SA is the agency responsible for advising the government on all matters concerning multicultural and ethnic issues in South Australia. Multicultural SA includes the statutory body, the South Australian Multicultural and Ethnic Affairs Commission (SAMEAC). SAMEAC is the State's peak advisory body on multicultural and ethnic issues and its members come from various ethnic backgrounds.

Although the size of the Muslim population in South Australia is not very significant, Muslim older people have the right to aged care services that meet their needs. Government affirmative policies with regard to expanding and delivering culturally appropriate services to CALD communities hold out assurances that older Muslims in South Australia, too, would have such services available to them.

²⁵² Information last accessed November, 2014 from SA government website.

9. Aged Care Services Delivery Models

Aged care services model broadly defines the way aged care services are delivered. It outlines best practice care and services to ensure people get the right care, at the right time, by the right team, and in the right place. The models describe, among other things, types of aged care services to be provided by an organisation.

9.1 Types of Models

In attempts to address the specific linguistic, cultural, and spiritual needs of an ageing CALD population, a number of *aged care models* have been developed and applied over the past three decades. Currently, there are three predominant models of culturally responsive aged care service delivery; these are:

1. Ethno-specific service provision (focusing on a specific CALD community)
2. Multicultural service provision (responsive to a range of CALD communities), and
3. Partnership service provision (between CALD communities and 'mainstream' or generic service providers).

9.1.1 Ethno-Specific Model

The 2010 FECCA Consultations showed that there is a high demand for ethno-specific residential care. It was felt that many of the mainstream services were not able to provide care that is appropriate to the needs of CALD communities and that there is a heavy reliance on brokerage of ethno-specific services by mainstream agencies.²⁵³

The *ethno-specific model* of aged care works best with larger and longer established CALD communities who have the critical mass to attract experienced bicultural and bilingual staff. Under this model, the ethno-specific service is usually operated by mainstream providers in partnership with ethnic communities or by the ethnic community organisations themselves. However, the ethno-specific model is considered too challenging for most small size communities although there are examples of several small communities collaborating to achieve the economies of scale and critical mass they would otherwise lack. A South Australian example is the Croatian, Ukrainian, and Belarusian communities forging an alliance, the Croatian Ukrainian and Belarusian Aged Care Association of SA Incorporated, to offer multicultural home support and residential aged care for their community members.

9.1.2 Multicultural Model

Taking advantage of decades of experience with ethnic communities, many ethno-specific aged care providers have become highly skilled and flexible in designing and delivering care that can meet the needs of multiple communities, not just the community they were originally targeting. In other words, they take on the characteristics of a *multicultural model*.

²⁵³ *The Bigger Picture: Joining Up Solutions to Achieve Access and Equity*, op. cit. pp. 51-52.

The multicultural model of aged care is designed to work with a range of communities by targeting a variety of cultural and linguistic groups and has been welcomed by ethnic communities. Citing Doyle, a review of literature on service delivery to ethnic groups points out, "... 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".²⁵⁴

9.1.3 Partnership Model

The *partnership model* or 'joint ventures' is a long standing feature of aged care in Australia. Two national CALD partnership programs-- the Community Partners Program (CPP) and the Partners in Culturally Appropriate Care (PICAC) program --have been discussed in section 6.8. Partnerships drive participants to think outside their proverbial boxes and enhance their abilities to create systems that are adaptable, flexible, and responsive to diverse needs. The partnership model of aged care service delivery makes possible cost-effective use of resources, and effectively links older CALD people to the wider community; many older Australians from CALD backgrounds do access aged care services through the mainstream system. However, it has been alleged that in too many instances, unequal status and power may make partnerships unbalanced and prone to domination by the mainstream agency partner.²⁵⁵ This is why the success of the partnership model of care is essentially based on the commitment of the aged care provider to forge strong partnerships with local communities.

Barnett supports the partnership model for ethnic communities when the ultimate objective is "the promotion of an integrated care system, rather than a dual system involving a central and a peripheral system of aged care".²⁵⁶ According to Barnett, a balance between ethno-specific and generalist approaches to aged care seems to be the most appropriate mechanism to providing aged care services to ethnic communities. Barnett makes a case for accommodating the specific needs of the ethnic aged people by the mainstream non-profit service providers since this type of provider, she maintains, appears to be more responsive to the needs of ethnic communities. Collaborative initiatives between government and service providers are critical to the success and sustainability of an expanded general service to include specific services. Barnett argues that although such efforts are not costly at all, the for-profit sector may not be very keen to invest the additional time needed for such an expansion.²⁵⁷

²⁵⁴ Harriet Radermacher, Susan Feldman, Colette Browning, *Review of Literature Concerning the Delivery of Community Aged Care Services to Ethnic Groups- Mainstream versus ethno-specific services: It's not an 'either or'* (Melbourne: Healthy Ageing Research Unit, Faculty of Medicine, Nursing and Health Sciences, Monash University, 2008) p. 19.

²⁵⁵ FECCA Pre-Conference Forum: *Culturally Responsive Aged Care Reform* op. cit. p. 6.

²⁵⁶ Kate Barnett, "Aged Care Policy for a Multicultural Society", op. cit. p.21.

²⁵⁷ Kate Barnett, "Aged Care Policy for a Multicultural Society", op. cit.

9.1.4 Clustering Model

One model initiated in the early 1990's offers a wider choice to CALD communities. The *clustering model* is a means of providing culturally appropriate care by bringing together people who share similar cultural, language, or religious backgrounds within one mainstream aged care facility thus maximising the facility's capacity to provide culturally appropriate care. This provides even smaller communities an opportunity to live in a mainstream facility and yet have access to ethno-specific benefits.

MacKinlay recommends:

“It would be desirable to arrange for numbers of older people of a particular cultural and religious group to live together in the same complex, where they may share common rituals and cultural practices may be more readily upheld. Where this is not possible, staff should do all they can to facilitate the meeting of religious practices”.²⁵⁸

Although the Government had endorsed the clustering model and provided funding to expand 'ethnic clusters', there has been criticisms that it has not offered adequate resources and funding to encourage service providers to invest in executing the model.²⁵⁹ The clustering model is likely to meet the preference of the Hogan Review (a federal Government initiated major review named after Professor Warren Hogan) to provide residential aged care within a large residential service, rather than in a facility committed to any one ethnic or cultural group.²⁶⁰

9.2 Is There a Right Model?

The provision of culturally appropriate aged care by service providers lends an opportunity to older people to enhance the quality of life by enabling them to continue with life patterns established years ago. Such service provision also recognises that different cultural backgrounds and circumstances can shape attitudes and expectations that may not always be met by mainstream service providers.²⁶¹

Mr Pino Migliorino, Chair of FECCA and Managing Director of Cultural Perspectives, notes:

“The diversity represented by the CALD ageing group poses a significant challenge to aged care service delivery. As a consequence there is a need to

²⁵⁸ Elizabeth MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life*, op. cit. p. 137.

²⁵⁹ Reply to Productivity Commission's Public Inquiry into Caring for Older Australians (Perth: Independent Living Centre of WA, 2010), p.2. http://www.pc.gov.au/__data/assets/pdf_file/0015/102309/sub139.pdf. (Last accessed April 06, 2013)

²⁶⁰ *Review of Pricing Arrangements in Residential Aged Care: Final Report*, op. cit. p. 200.

²⁶¹ *Trends in Aged Care Services: Some Implications*, op. cit. p.47.

increase the capacity of all aged care service providers to deal with the diversity of clients. This would apply equally to generalist, multicultural and ethno-specific service types and organisations.

Rather than operating a demarked system between ethnic specific and mainstream the fundamental principle in service delivery should be supporting choice in aged care settings and between aged care providers for CALD older people and their families.

CALD older people and their families need flexibility in their choice of services, with some needs met by ethno-specific or multicultural agencies, and others by generalist organisations”.²⁶²

There is no one best-practice model for delivering aged care services as different individuals and communities have vastly different needs. A review of Australian and international literature indicates that no single aged care service delivery model is equipped to meet the needs of all CALD older people.²⁶³

Nevertheless, it is important to ensure that care that is provided is culturally and religiously sensitive. Voula Messimeri-Kianidis observes:

“One size can never fit all. For this reason, mainstream services provision alone cannot meet the diversity of needs within our community. We need a mosaic of culturally appropriate responses for Australian culturally and linguistically diverse background elderly people. ‘Mainstreaming’, whereby generalist services receive funding to provide appropriate care to people from CLDB [culturally and linguistically diverse background] is not currently the only effective solution to meeting the needs of our diverse population”.²⁶⁴

Many a time, improving and extending Australia’s aged care services design and delivery has been aided by experimentation and trialling. Innovation in services delivery has been widely recommended by Australian Government- initiated review reports on aged care. Barnett strongly endorses innovation and experimentation in finding alternative approaches to caring for the ethnic aged.²⁶⁵ Overseas experience also affirms the usefulness of experimentation

²⁶² Pino Migliorino, *CALD Aged Care – Who Cares?* Speech at the Cultural Diversity in Ageing Conference, Melbourne, 2012, <http://www.fecca.org.au/images/stories/cald-aged-care/stories-to-inspire-pino-migliorino-address-june-7-2012.pdf> (Last accessed January 07, 2015)

²⁶³ See *Review of Literature Concerning the Delivery of Community Aged Care Services to Ethnic Groups- Mainstream versus ethno-specific services: It’s not an ‘either or’*, op. cit.

²⁶⁴ Voula Messimeri-Kianidis, *A Mosaic of Culturally Appropriate Responses for Australian Culturally and Linguistically Diverse Background Elderly People*. Keynote Address to the Cultural Diversity in Ageing 2007 National Conference, Victoria.

²⁶⁵ Kate Barnett, *“Aged Care Policy for a Multicultural Society”*, op. cit.

and trialling in encouraging and developing new services and improving delivery. Such a move may facilitate services delivery for Muslims as well.

The literature review contained in an empirical research on Australian Muslim families, and the empirical study itself have identified a series of interventions that service providers could employ in order to facilitate care access for Muslims as well as other CALD communities and stressed upon increasing the quality and appropriateness of services, enhancing the cultural competency of staff, and strengthening and developing real collaboration and partnerships with communities and other services.²⁶⁶

Faith-based organizations or what are sometimes described as religious organizations (such as in the Aged Care Service List of the Department of Health) and charitable organizations have significant competence and knowledge to contribute, born of a tradition of providing services and support. Their experience and support could be valuable for planning aged care services for Muslims. In this context, it may be pertinent to mention the coverage in *The New York Times*²⁶⁷ of Muslim students enrolling in American Catholic colleges and universities in greater numbers than in the past decade. These students, in particular the Muslim women students who wear head coverings, said that they chose Catholic institutions over secular ones as they felt welcomed, accepted, and comfortable in such places. These institutions respected their faith and shared many similar values which greatly aided them in continuing with their lifestyle. Another example is the University of Dayton, a Roman Catholic institution that has accommodated the needs of its Muslim students by setting aside prayer rooms, providing ablution facilities, and offering *halal* (the meaning of '*halal*' is explained in Section 12.2 under FOOD) meat for special events.

An example closer to home is Our Lady of the Sacred Heart, a Catholic girls' school in South Australia, with a significant enrolment of Muslim students.²⁶⁸ At Tenison Woods College, a regional Catholic school in Mt. Gambier, South Australia, Muslim students and their families have been offered the use of a room in the Church Hall for their prayers.²⁶⁹

9.3 Person-Centred Approach to Aged Care

Person-centred care is part of today's lingo or mantra in health care that adopts a holistic perspective of patient care and is responsive to individual differences, cultural diversity, and the preferences of care recipients. It is partly achieved through providing choices in care, one of which may be through consumer-directed care.

²⁶⁶ *Meeting the Needs of Australian Muslim Families: Exploring Marginalization, Family Issues and 'Best Practice' in Service Provision*, op. cit. p. 116.

²⁶⁷ Richard Pérez-Peña, "Muslims from Abroad Are Thriving in Catholic Colleges", *The New York Times*, September 2, 2012

²⁶⁸ Independent Education Union (South Australia), *Public Submission to Review of School Funding*, March 31, 2011, p. 88.

²⁶⁹ *ibid.* p. 15.

It is important to note the difference between person-centred care and *consumer-directed care*. The term consumer-directed care or CDC²⁷⁰ describes an arrangement whereby consumers have direct control over their allocated funds and they can use the funds flexibly to meet their needs. In addition to allowing services and equipment to be purchased from provider, the funds can also be used for options outside the formal service system. Thus, the person needing care is given direct control over the resources provided for their care.

In contrast, following the definition of person-centred practice by the Victorian Government Department of Human Services,²⁷¹ person-centred aged care may be explained as care that places the older persons at the centre of their own care and considers the needs of the older persons' carers. Person-centred care is variously known as patient-centred care in health settings as well as client-centred care in aged care and health settings. Person-centred practice is treating patients/clients as they want to be treated, a practice that could be understood as including concepts such as dignity and respect toward the person and his or her background.

The principles of person-centred practice as outlined by the Victorian Department of Human Services are:²⁷²

- Getting to know the patient or client as a person
- Sharing of power and responsibility (focussing on respecting preferences)
- Accessibility and flexibility (in terms of meeting individual's needs)
- Coordination and integration of care by the service provider
- Having an environment that is conducive to person-centred care both for the service providers and service users (physical, organisational, and cultural environments).

Addressing spirituality and religious beliefs is an important consideration for a truly person-centred care.²⁷³ In the context of aged care, the person-centred approach would mean focussing on the older person's spiritual as well as physical needs and preferences collectively.

The Productivity Commission's report, *Caring for Older Australians*, had recommended both person-centred services and consumer-directed approach to improve choices and quality of life of older Australians. There is limited information available on person-centred care for people of CALD backgrounds, particularly older CALD people. As for the effectiveness of CDC,

²⁷⁰ In Section 6.5 of this Report, the CDC packaged care initiative under the aged care reform measures has been discussed.

²⁷¹ Department of Health, Government of Victoria, *Person-Centred Practice: Guide to Implementing Person-centred Practice in Your Health Service*, 2008, p. 1.

²⁷² *ibid.* p. 2.

²⁷³ Jo Galloway, "Dignity, Values, Attitudes, and Person-centred care", in *Nursing Care of Older People, A Textbook for Students and Nurses*, Ed. Andrew Hindle and Alison Coates (Oxford: Oxford University Press, 2011) p. 10.

international experience offers the suggestion that in addressing diversity in care needs, it is better suited than the 'one size fits all' approach of many service providers.²⁷⁴

The discussion in this chapter summarises the discourse related to aged care services delivery model. Whereas it is important to examine the various models, what is also needed is, perhaps, a bold move to experiment with a model that would offer wider choice to the Muslim community taking into consideration the immense diversity of their backgrounds and the small size of many ethnic groups within.

²⁷⁴ Carmel Laragy and Gerry Naughtin, *Increasing Consumer Choice in Aged Care Services: A Position Paper* (Brotherhood of St Laurence, 2009) pp. 13-14.

10. Ethnic Aged Care at Home and Abroad

In countries with ever increasing cultural diversity, government policies and services need to be relevant to all people. Some countries have made commendable progress in improving equity and access of services through targeted programs for ethnic communities. However, there are countries where a lack of goodwill and commitment has resulted in some of the most vulnerable sections of the society, such as the minority ethnic aged, being left on the sidelines. From Europe and the US to Australia, there is growing awareness of the need for appropriate care for diverse communities and a growing sense of acknowledgement that more needs to be done to provide for, and increase the utilisation of, aged care services that are sensitive to the specific needs of older people from diverse backgrounds. The following paragraphs give a very brief summary of ethnic aged care in Europe and the US; this chapter also describes the progress made in Australia in terms of providing aged care services to the Muslims.

10.1 The European Experience

In its Summary Report launched at the European Parliament in 2004, the Minority Elderly Care (MEC) Project supported by the European Commission provided information on aged care of minority population in ten countries: the United Kingdom, France, Germany, Netherlands, Spain, Finland, Hungary, Bosnia-Herzegovina, Croatia, and Switzerland.²⁷⁵ The extensive research finds that the users of aged care services across all the ten countries expressed a strong desire for culturally sensitive care and for service providers to understand their needs and preferences. It also found that ethnic voluntary organisations in all these countries were proactive in representing the interests of the ethnic aged as well as providing services in many instances. As for the reasons of under-utilisation of services by the older ethnic minority, a pattern emerged to the responses from the Western European countries: language barriers, lack of information about the system and services, lack of multicultural competence of service staff, and lack of understanding of the complex services structure by the users.

10.2 The US Scenario

Laura Katz Olson says about the United States:

“The diversity of the nation continues to increase....Although policy makers, gerontologists, and practitioners alike often give short shrift to the specific elder-care needs of various, racial, ethnic and socio-religious groups, they will be forced increasingly to confront these concerns as we advance through the twenty-first century”.²⁷⁶

²⁷⁵ For more details, see Policy Research Institute on Ageing and Ethnicity (PRIAE), *Summary Findings of the Minority Elderly Care (MEC) Project*, PRIAE Research Briefing (Brussels, 2004)

²⁷⁶ Laura Katz Olson, *Multiculturalism and Long-term Care: The Aged and their Caregivers*, in *Age through Ethnic Lenses: Caring for the Elderly in a Multicultural Society*, Ed., Laura Katz Olson (Lanham, MD: Rowman & Littlefield Publishers, 2001) p.2.

“Inadequate resources and cultural and religious barriers, along with exclusionary and discriminatory practices, have limited their [the low-income minority ethnic elderly] access to private and public sources of assistance. Many needed services... are not sensitive to particular food preferences, distinctive lifestyles, or the traditions and beliefs of the elders they are supposed to serve”.²⁷⁷

In their research paper on Muslim nursing homes in the US,²⁷⁸ Alfarah et. al. express their firm belief that although there were no Muslim nursing home in the United States, the need to establish one would become stronger as the Muslim population ages and their families become more integrated with American culture and society. Among the probable factors they list as limiting the possibility of Muslim nursing homes are the small (albeit growing) and uneven distribution of elderly Muslims in the US and the absence of cultural sensitivity towards Muslims in the American long-term care institutions. Although providing aged care services to Muslims by the mainstream providers is yet to gain momentum, ethnic and community organizations have stepped forward to provide some services that are consistent with cultural plurality.

10.3 The Australian Story

In the absence of a truly culturally sensitive environment, only a small portion, and not the full range, of needs of people can be met. The under-representation of older CALD people in the aged care services usage profile in Australia can be attributed largely to the insufficient culturally appropriate services on offer.

However, there has been some progress that is encouraging. In some places in Australia, appropriate home care packages are being offered to Muslims by their own ethnic or religious community organisations. These organisations have partnered with some mainstream aged care service providers to enhance the access of older Muslims to services appropriate to their needs. However, it is the Arabic-speaking Muslims who seem to have benefited more from this development as the Arab organizations have been aggressively seeking out ways to serve their older community members through collaborative arrangements or even on their own. Perhaps their homogeneity in terms of language, culture, and religion has helped the Arab Muslims to forge ahead in having some of their aged care needs met, albeit largely in terms of home care covering limited geographical areas. By contrast, the non-Arab Muslims still have a long way to go.

With a \$10 million funding from the former federal Labour government, together with a promise of a matching grant from the Liberal-Nationals Coalition, the Lebanese Muslim Association is now poised to be the first Muslim community organisation in Australia to

²⁷⁷ *ibid.* p. 6.

²⁷⁸ For more, see Ziad Alfarah, Fadi H. Ramadan, Emily Cury and Gary H. Brandeis, “Muslim Nursing Homes in the United States: Barriers and Prospects” in *JAMDA (Journal of the American Medical Directors Association)* 13/2 (2012) pp.176-179.

provide an 80- to 100-bed aged care facility for Muslims. The Australian Multicultural Aged Nursing (AMAN) Home will be situated near Lakemba mosque which will further enhance and enrich the social and cultural lives of AMAN's residents.

The Tripoli and Mena Association Limited, an Arabic community organisation, offers home care packages including centre-based day care to Arab Muslims in Sydney. Muslim Care in Sydney provides social support opportunities to elderly Muslims.

The Sydney-based South Asian Muslim Association of Australia (SAMAA) aims to cater to the aged care needs of Muslims from South Asia. It has arrangements with Wallgrove Aged Care Facility, a mainstream residential care service provider, to bring culturally and religiously appropriate care to the Muslims in NSW.²⁷⁹ SAMAA has drawn up a \$20 million project and is awaiting government support to develop it.²⁸⁰

In Victoria, the Ottoman Village Aged Care offers residential and respite care services for the aged and the disabled. Its target group is people from Turkish speaking background. It is a non-profit organization and is part of the Broadmeadows Turkish Islamic and Cultural Centre Incorporated.

Situated at Lysterfield, Victoria, the ISOMER Retirement Home or IRH was set up to care for ageing Muslims and is owned by the Islamic Society of Melbourne Eastern Region (ISOMER). It offers 50 individual bedsit units and has received Commonwealth government funding.²⁸¹

The Madina Village Community Services Limited (MVCS) has been engaging with the government and other stakeholders to start providing aged care service for Muslims in Western Australia. It has signed agreements with the Bethanie Group and the Southern Cross Care (WA) Inc. to facilitate appropriate home care to Muslims and has also completed a need assessment that would inform MVCS's offer of services.

The Iranian Muslim Association of Western Australia Inc. offers aged care through the Takreem Home and Community Care by running the following two aged care programs:

- Out and About Support Service (for individuals who need assistance accessing the community)
- Comforts of Home Support Service (for individuals requiring personal/medical care at home).

The Islamic Women's Association of Queensland (IWAQ) offers personalized home care and respite care to Muslims.

²⁷⁹ South Asian Muslim Association of Australia, <http://samaa.org.au/home/services/nursing-homes/> (Last accessed January 06, 2015)

²⁸⁰ Parliament of New South Wales
<http://www.parliament.nsw.gov.au/prod/parlament/hansart.nsf/V3Key/LC20130911045> (Last accessed January 07, 2015)

²⁸¹ Isomer Retirement Home, <http://www.isomer.com.au/> (Last accessed January 07, 2015)

Although South Australia may not have any residential aged care services targeting its Muslims, a promising development has taken place in home care. The Aged Care and Housing (ACH) Group, in partnership with the Muslim community, had applied for and were granted home care packages allocation in the 2014 ACAR Round. This signals a positive crucial step toward designing and delivering services appropriate for the Muslims in South Australia. Bene, the renamed aged care services of the Italian Benevolent Foundation SA Inc. (IBF), partnered with the Tatar Bashkurt Community of SA under the HACC program to provide culturally and linguistically appropriate home care such as domestic assistance, social support, and home maintenance to the elderly Tatar Bashkurts residing in the Northern - Eastern Metropolitan Region of Adelaide. The majority of Tatar Bashkurts are Muslims. The Muslim Women's Association of South Australia (MWASA) refers Muslims who need home care to Bene. MWASA itself has received funding to assist older Muslims who are cared for at home; this assistance is in the form of activities aimed at reducing feelings of isolation among clients and engaging them with the rest of the community.

Some state governments and departments have developed materials which, though focusing on Muslim patients in hospitals, would certainly help aged care providers and staff to develop awareness and understanding about the Muslim faith and aid them in taking better care of Muslim older people through a greater understanding of the care recipients' needs.

The Madina Village Community Services Ltd. has launched the *Western Australian Health Care Providers' Handbook on Muslim Patients* that provides guidelines on not just physical but also mental health issues in the context of a Muslim patient. In 2012, the Office of Multicultural Interests of the Government of Western Australia brought out a fact sheet, *Culture and Religion Information Sheet—Islam*, with the support of the Islamic Council of Western Australia. Queensland Health, in partnership with the Islamic Council of Queensland, has published the second edition of *Healthcare Providers' Handbook on Muslim Patients*. This handbook covers some details on how to care for a Muslim patient and issues surrounding death and dying. The Islamic Council of Victoria has developed *Caring for Muslim Patients: A Guide for Health Care Professionals and Pastoral Carers*.

ADF Health, the journal of the Australian Defence Health Service, has also published an article which provides advice to healthcare professionals on how to provide appropriate and effective care to their Muslim patients.²⁸²

The *Care of Muslim Patients* app is the world's first Muslim health-care app developed by the Elsevier Health Sciences and vetted by the Federation of Islamic Medical Associations (FIMA). Designed for both iPhone and iPad, the app contains 26 chapters and can be downloaded from the Apple iTunes store. This app is designed to help health care professionals care for Muslim patients more effectively through cultural understanding of health issues.

It is pertinent to mention here that residential aged care facilities for Jews were established in the 19th and 20th centuries in Australia. The Sir Moses Montefiore Jewish Home in Sydney is

²⁸² Hyder Gulam, "Care of the Muslim Patient", *ADF Health*, 4/2 (2003) pp.81-83.

an example. This is an ethno- specific aged care provider that offers a wide range of services, including residential aged care facilities that cater for the Jewish community. Although it does not exclude other religious groups, the Home offers care in a Jewish environment in that Jewish customs, traditions and observances are followed. In 1994, the Jews set up their own organization in South Australia, the Jewish Community Services Inc. (JCS), a non-profit community organisation, to provide culturally appropriate services to the State's Jewish community. The JCS receives government funding under the HACC program. According to the 2011 Census, Jews are 0.5% of Australia's population.

Compared to many other countries in the West, Australia can truly take pride in having embraced multiculturalism and having done it successfully. This is evident in efforts to reach out to people with diverse backgrounds and in policies and strategies that have been developed to accommodate the needs of these people. While a majority of Muslims in Australia are not from the Middle East, they are, nonetheless, viewed from the prism of the West's relationship with the Middle East. This distorted view has not helped Muslims here. Not only have they to continually experience vilification of their faith, but much also remains to be done for them so that they can have a viable option when it comes to care issues.

11. The Case for Muslim Aged Care

For many people, the residential aged care environment can be disempowering, particularly when a resident's culture and spiritual beliefs differ from those of the dominant population. Culturally competent aged care would help to extend individualised quality care through supporting cultural, linguistic, and spiritual needs and preferences. This chapter begins with an exposition of the peripheral place given to religion in aged care planning and draws on the earlier chapters to make a case for Muslim aged care that support their spiritual needs. As many Muslims are part of the larger CALD community, relevant issues relating to people of CALD backgrounds have been included in this chapter.

11.1 Whither Religion in Aged Care?

Chapter 4 cited the many studies that have shown that as people age, spirituality deepens for many of them; in other words, their faith journey becomes more important than ever before. Is the aged care system accommodating people of all faiths to make this all-important journey? In other words, are religion and spirituality part of aged care planning and delivery? The following discussion throws some light on this issue.

The ABS has developed *Standards for Statistics on Cultural and Language Diversity* (the Standards), a set of statistical standards which are designed to collect and disseminate all the cultural and language information necessary for an accurate and nationally consistent measurement of cultural diversity in Australia. The Standards is a reference document which defines the standards and outlines methods for their use in statistical, administrative, and services provision settings. It recognises religious affiliation as one of the diversity indicators.

The Standards is based on the following four core variables:

1. Country of Birth of Person
2. Main Language Other Than English Spoken at Home
3. Proficiency in Spoken English, and
4. Indigenous Status (for those data collections which are not specifically focussed on migrants to Australia).

The full Standards set also includes:

- Ancestry
- Country of Birth of Father
- Country of Birth of Mother
- First Language Spoken
- Languages Spoken at Home
- Main Language Spoken at Home
- Religious Affiliation, and
- Year of Arrival in Australia.

Three main indicators of cultural and linguistic diversity were highlighted in a 2009 report²⁸³ published by the Government of South Australia on diversity amongst older people in the State. The indicators are:

1. Country of birth of person
2. Language spoken at home, and
3. Religious affiliation.

The importance of having services designed around linguistic and cultural diversity as a means to provide appropriate services to older CALD people feature prominently in discourses and debates surrounding aged care reforms. However, despite governments being increasingly aware of the needs of older people coming from CALD backgrounds, it seems that the importance and role of religion in aged care services provision is yet to be fully recognised. Language and culture play vital roles in all aspects of care and treatment of older people; clearly, the spiritual needs must be addressed as well.

In both practice and research in the field of ageing and spirituality, there seems to be a general idea that spiritual care is the province of palliative care and physical care has to be at the heart of aged care. MacKinlay's observations²⁸⁴ reaffirm one of the points of departure of this Report. Noting that the first developments in spiritual care sprung from within palliative care and mental health, she maintains that both the dimensions of care, physical and spiritual, need to be part of a holistic care regime for aged care. There needs to be greater understanding among government and the aged care industry about the importance of religion and spirituality to the health and well-being of many older people, not just to those in palliative care.

The NSW Transcultural Aged Care Service (TACS) and the Community Partners Program (CPP) projects of NSW highlighted the importance of culture and religion for CALD communities in response to the Productivity Commission draft report *Caring for Older Australians*. The distinct possibility of not appreciating how central religion and culture is to the CALD communities and, therefore, treating these as peripherals is highlighted in the TACS and CPP Response:

“In discussing the cultural and religious ‘preferences’ of some groups the Report [*Caring for Older Australians*] risks making light of the significance of such views held by CALD individuals. For those who don't understand the weight of cultural, religious and other values these may seem to be a matter of individual choice. But for the majority of CALD individuals, service issues related to their cultural and religious values are of the utmost importance and are considered to be ‘needs’ and not ‘preferences’“.²⁸⁵

²⁸³ *Cultural and Linguistic Diversity Amongst Older People in SA: A Demographic Overview*, op. cit. p. 6.

²⁸⁴ See Elizabeth MacKinlay, “Practice Development in Aged Care Nursing of Older People: the Perspective of Ageing and Spiritual Care”, op. cit. pp. 151-158.

²⁸⁵ NSW Transcultural Aged Care Service, *Response to Productivity Commission Draft Report*, p. 2. http://www.pc.gov.au/__data/assets/pdf_file/0004/109147/subdr713.pdf (Last accessed January 10, 2015)

In 2006, the Multicultural Council of Tasmania launched an investigation into the experiences of older CALD people with regards to aged care facilities in Tasmania. Not surprisingly, the inquiry found that language, food and culture, spirituality, and isolation were the greatest issues of concern for the CALD respondents.²⁸⁶ The report was largely based on community consultations with targeted and ethnic groups and their feedback. Of particular relevance to Muslims is the observation in the report that:

“Spirituality and religious practice was high on the list of what was considered important to nearly all groups. It is important to involve religious groups and churches in the life of the residents and to a large extent this is the case. However, there are other issues that need to be considered with regards to spiritual or religious practice and these mostly revolve around personal religious observances, e.g. those related to diet, fasting, prayer; in some instances, the importance of dress or other everyday practices; the need for seclusion and meditation”.²⁸⁷

11.2 CALD Aged and their Needs

It may be a difficult experience to be an ethnic aged; it has been suggested that they face the ‘double jeopardy’ of being aged and ethnic. The consequences of their ageing experiences can, therefore, be doubly negative. The double jeopardy hypothesis describes apparent racial inequities in the use of institutional care; the hypothesis grew from concerns regarding the disadvantages of older African-Americans.

It is important to note that since people from non-English-speaking countries are a diverse group, generalisations or assumptions covering the whole group are often not appropriate. As Aged and Community Services, Australia observes:²⁸⁸

“The best quality care is designed around the unique and complete needs of the individual. People from any particular ethnic or cultural group are different from one another”.

Mitchell put the problem of double jeopardy into proper perspective when he said:

“The experience of ageing in mainstream society is now very positive with dramatic increases in recent years in health and well-being. However for older people in CALD communities there remain a number of societal, economic, and health consequences of ageing and significant service gaps with intrinsic cultural isolation, disadvantage and marginalisation. Mainstream community attitudes

²⁸⁶ Multicultural Council of Tasmania, *Power and Powerlessness: A Project Investigating Matters Affecting Residents from Culturally and Linguistically Diverse Backgrounds in Aged Care Facilities* (Multicultural Council of Tasmania, Hobart: 2006) p.13.

²⁸⁷ *ibid.* p. 27.

²⁸⁸ Aged and Community Services Australia, *Strength through Diversity, Culturally & Linguistically Diverse Aged and Community Care*, National Policy Position (2006) p. 2.

in Australia in effect are barriers to the provision of culturally sensitive aged care”.²⁸⁹

The Foreword of the report *Power and Powerlessness* states:²⁹⁰

“Among those in residential aged care, particularly those from culturally and linguistically diverse (CALD) backgrounds, there is an obvious issue of powerlessness. These residents do not want to offend the care providers on whom they rely for their care and are often afraid to speak up with their problems and needs.... Formal methods of involvement and consultation do not take into account the feelings of powerlessness and resulting low self-esteem of many CALD aged and, in many cases, their fear of residential care, especially those who do not speak English”.

For much of the CALD population, residential care, commonly known as nursing home or old people’s home in their home countries, has the negativity associated with institutionalisation- -almost like an abandonment of one’s family member. Further exacerbating the issue is the fact that an unfamiliar physical and cultural environment makes residential aged care facilities a terrifying place for many. Older CALD people, just like their Australian-born counterparts prefer to continue to live at home with support from carers and the community for as long as they can; sometimes the delay is too long. Increasingly, those going into aged care facilities are of the ‘high care’ category.²⁹¹ Their urgency not only puts greater demands on the aged care system but for those older people and their families who are not at all familiar with the Australian aged care system, the difficulty in accessing the right services or to have their particular needs met is multiplied.

In 1986, the Australian Institute of Multicultural Affairs published the findings of its extensive research into migrant population. The report suggests that ethnic communities have limited access to services such as aged care because these do not provide for a wide range of needs that can be met in a culturally sensitive environment. The Key Findings section states:

“... Many immigrants lack confidence in service providers and have reservations about their sensitivity in administering appropriate services. As the survey has indicated, there is a very real desire by immigrants to preserve their identity”.²⁹²

Similarly, DoHA reports that older people from CALD communities are under-represented in the use of residential aged care services. This clearly points to the fact they are not accessing

²⁸⁹ Ron Mitchell, *The Spiritual Imperative in Multicultural Aged Care – Multiculturalism, Mainstreaming and Marginalism*, op. cit.

²⁹⁰ *Power and Powerlessness: A Project Investigating Matters Affecting Residents from Culturally and Linguistically Diverse Backgrounds in Aged Care Facilities*, op. cit. p. 3.

²⁹¹ Voula Messimeri-Kianidis, *A Mosaic of Culturally Appropriate Responses for Australian Culturally and Linguistically Diverse Background Elderly People*, op. cit.

²⁹² Australian Institute of Multicultural Affairs, *Community and Institutional Care for Aged Migrants in Australia: Research Findings* (Australian Institute of Multicultural Affairs, Melbourne: 1986) p.265.

aged care services in proportion to their numbers among Australia's older population.²⁹³ Such issues with access raises serious concerns about cultural exclusion, as difficulty in accessing public services by minorities may be an indication of people not being treated equally.²⁹⁴

Submissions made to the Inquiry Panel during the government inquiry into access and equity issues had identified two major barriers, among others, in achieving access and equity for CALD people. These were: (1) lack of cultural capability within government agencies and deficiency in cultural competency on the part of their staff and service providers, and (2) 'one size fits all' approach by Australian government agencies in development of policies, programs, and services.²⁹⁵

In its 2007 *Ageing Policy Statement*,²⁹⁶ FECCA draws attention to the lack of access experienced by older CALD people to timely and appropriate care and support and the subsequent impact on quality of their life, such as:

- Poorer health
- Increased isolation, withdrawal and depression
- Increased stress and physical demands as carers
- Increased use of prescribed medication
- Diminished exercising of rights and responsibilities.

In order to attempt to reduce the above negative consequences, Migliorino stressed the importance of consultative mechanisms involving CALD older people and ethno-specific and multicultural services providers.²⁹⁷ He noted that although it is critical to access these consumers and allow for their voices to influence policies and programs, there have been only inadequate efforts in this regard.

The following observation made in a report initiated by the South Australian government stressed the necessity of encouraging and supporting CALD communities to have their needs determined and expressed:

"Twenty-three residential aged care facilities were identified as catering for ethnic groups in South Australia. ... Unfortunately, there is little data available on the need for such accommodation, although there is likely to be an unmet need for culturally and linguistically appropriate residential aged care services. Additional

²⁹³ *Trends in Aged Care Services: Some Implications*, op. cit. p. 47.

²⁹⁴ UNDP, *Human Development Report 2004*, op. cit.

²⁹⁵ *Access and Equity for a Multicultural Australia*, op. cit. p. 45.

²⁹⁶ Federation of Ethnic Communities' Councils of Australia, *Caring for older Australians from Culturally and Linguistically Diverse Backgrounds (CLDB), Ageing Policy Statement 2007* (2007) pp.1-2.

²⁹⁷ Pino Migliorino, *CALD Aged Care – Who Cares?* op. cit.

research into this issue is strongly recommended, and research with a focus on future needs for planning would be particularly useful”.²⁹⁸

A FECCA 2011-12 Report²⁹⁹ reaffirms earlier findings that a lack of cultural competency on the part of service providers and carers can cause distress and isolation to elderly CALD people who are put in long-term care. Although all older people regardless of their backgrounds have largely similar needs and experiences with regard to the ageing process, CALD communities experience additional needs that must be addressed. To this end, training aged care staff to be sensitive to the needs of diverse groups has become a major undertaking of the aged care reform measures initiated by the government.

Olson says:³⁰⁰

“Culturally sensitive care contributes to the well-being of older people, enhancing both their self-respect and the quality of their lives. For nursing home residents, in particular, it provides a sense of continuity, allowing them to keep a piece of their identity intact. When we ignore their racial/ ethnic/ socio-religious backgrounds, we treat our vulnerable elders as objects. ...if we want to meet the needs of our minority/ethnic eldersstaff should be trained in the culturally appropriate values and customs of the people they serve”.

It is not right to expect the aged care industry, particularly the mainstream service providers, to offer culturally appropriate services without the active participation and involvement of the communities that need such services. Proactive measures on the part of the ethnic communities would go a long way in redressing some of the deficiencies with regard to planning and delivering appropriate services.

11.3 Appropriate Aged Care Services for Muslims-Issue of Creating or Accessing?

Muslims make up 2.6 per cent of CALD population in the 65+ age group and 1.4 per cent in the 80+ cohort.³⁰¹

Although there is no specific data available on aged care services usage pattern and usage rate for Muslims, there is ample documented evidence in government reports and reviews that testifies to the under-representation of older CALD people in residential care services and over-representation in community services package. This can largely be explained by the expressed preference of CALD communities for home care and by their perception of

²⁹⁸ Graeme Hugo et al., *State of Ageing in South Australia*, op. cit. p.302.

²⁹⁹ Federation of Ethnic Communities' Councils of Australia, *Opening the Door to Access and Equity: FECCA Access and Equity Report 2011-2012* (2012) p. 51.

³⁰⁰ Laura Katz Olson, *Multiculturalism and Long-term Care: The Aged and their Caregivers*, op. cit. p. 16.

³⁰¹ ABS 2011 Census.

community-based services as being more culturally appropriate and responsive to their cultural needs as compared to residential care.

The ability of older Muslims to exercise their choice of an aged care service is limited in Australia because Muslims have needs that require services that differ from, or are additional to, the 'mainstream' services offered by operational providers. True choice can only be exercised in a system that offers and supports a variety of preferences to people and is not limited in its offerings. One would acknowledge that appropriate aged care is an equal right of all Australians but one would struggle to assert that this right is being equally realised by all Australians. Certainly, the current approach to aged care does not adequately address the needs of practicing Muslims.

A fundamental point to ponder is whether aged care for Muslims is an issue of creating appropriate services or accessing available services. This Report suggests that although the factors limiting the accessibility of available services by CALD communities largely apply to Muslims, the concern in regards to Muslims is essentially driven primarily by lack of appropriate aged care services that support their faith.

Babacan found that there was an element of fear among some Muslim communities towards residential aged care and that all her respondents "did not want to see it as an option for them. There was a clear preference for wishing to remain at home and to be with families".³⁰² While the latter part of her observation is true across cultures, the former part may be partially explained by the fact that the expression of need for aged care services and wanting to access such services are shaped by the experiences, attitudes and beliefs of older people and their families. These, in turn, can be affected by what is known to be available or by the perceived suitability or accessibility of available services.³⁰³

The research report *Meeting the Needs of Australian Muslim Families: Exploring Marginalisation, Family Issues and 'Best Practice' in Service Provision* cited earlier, mentions other studies where it was found that Australian Muslims are among the most deprived groups.³⁰⁴ The report identified a number of barriers and difficulties in accessing formal services by Muslim families including language and communication problems, distrust or negative perceptions of services, and unfamiliarity with the system. Participants believed that there was a lack of culturally and religiously appropriate aged care services to meet the needs of Muslims and mentioned that this made the services even more unacceptable. This contributed to a trying time for families in deciding aged care options for the elderly member. Many families associate putting their older family members into formal aged care with neglecting their duties toward them at a time when the elderly member is frail and vulnerable. As a result of this stigma associated with 'outsourcing' of one's responsibilities toward one's

³⁰² Hurriyet Babacan, *Care Needs of Muslim Older Adults* (Woodridge, Qld: Islamic Women's Association of Queensland Inc., 1998) p.6.

³⁰³ *Older Australia at a Glance*, 4th edition, op. cit. p. 102.

³⁰⁴ *Meeting the Needs of Australian Muslim Families: Exploring Marginalisation, Family Issues and 'Best Practice' in Service Provision*, op. cit. p.23.

loved one to formal care service, the collectivistic values were upheld even when taking care would stretch the family finances or when there would be a shortage or lack of carer in the family.

The above report observes that even well-established Muslim families had only partial knowledge of the range of available services and it identified lack of knowledge or understanding of the system as a major barrier in finding out about needed services and how they worked. Participants opined that there was a need to create understanding in the Muslim community about the aged care system and available support and also to address cultural and other barriers of utilizing such services. The study also discovered that there was a significant reliance on religious and community leaders who are often approached by Muslim families either for direct assistance, or for linking them to the appropriate service/s or source/s of help.

In 2007, the Department of Families, Community Services and Indigenous Affairs (FaCSIA) had led a whole-of-government project titled *Sharing Our Achievements: Symposiums on Australian Muslims* under its *Bringing Communities Together Strategic Framework*. Under this project, symposiums and expos were organised throughout Australia to highlight the positive contributions of Australian Muslims to Australian society, as well as to provide opportunities for the wider Muslim community to identify gaps in service delivery by government and non-government agencies. One of the key recommendations of this project was that information on community services provided by governments, community groups, and the not-for-profit sector needs to be shared, and constructive dialogue between service providers and recipients needed to be established.

There may be unsatisfied demand among Muslims in terms of a lack of greater choice in consuming aged care services. Unsatisfied demand focuses on the extent to which consumers are not able to choose from a range of differentiated services offerings. This may arise out of services gaps when some services for which there is a need in the community may not be available under current arrangements. A small community such as the Muslims, and the even smaller number from this community who will enter aged care, makes it more likely that their special needs would either be passed over or would seem as too problematic. The consequences of the resultant culturally inappropriate care could include psychological distress for the care recipients and their families as well as for the carers. This may give reason to dwell upon the 'triple jeopardy' of being ethnic, old, and Muslim.

Data is not available on the number of Muslims who would like or who cannot receive these services. Nonetheless, there is an undercurrent of concern about the unavailability of culturally appropriate services and a 'pressing need' for services such as aged care as reported in a newspaper article.³⁰⁵

An Emerging Needs Scoping Study (ENSS) was undertaken covering five communities in Australia who have or will have a significant ageing population in two or three decades. The

³⁰⁵ Sally Neighbour, "Our High-Profile Muslim Minority", *The Australian*, February 18, 2011.

ENSS Middle Eastern and North African Report found that there are Muslims who want to use a faith based service.³⁰⁶ In the ENSS South-East Asian Report, it is interesting to note the differences between options that Australian Muslims who migrated from relatively affluent Muslim countries, such as Indonesia and Malaysia, have and those who come from so many other impoverished and /or violence-torn Muslim countries. As the South-East Asian Report says:

"At present elderly Indonesians prefer to go back to Indonesia for care, but this may change over time should appropriate services be made available".³⁰⁷

With regard to Malaysians, the Report says:

"Some community members stated that they would also be happy to return back home for support if necessary....The majority of respondents currently have no unmet needs. This may be a reflection of the community affluence and ability to purchase services."³⁰⁸

As for Muslims from less developed countries, they may not have the purchasing power in Australia to access needed services and, to make matters worse, the health care and institutional aged care support in their home countries may be inadequate or poor, thus constraining their option of going back for needed support and care.

In aged care facilities, culturally appropriate care takes on greater significance for Muslims as they may feel isolated and marginalised among large non-CALD and non- Muslim resident groups. Amidst the large number of studies and reports on service planning for CALD people, it seems that the needs of older Muslims often get subsumed within those of other CALD people as within issues of language, culture, and diversity. It does not serve to address the needs of the Muslim older people if their needs are conflated with the concept of cultural diversity in isolation of religion. Of critical importance to Muslims are having the government and the aged care industry realise that their efforts to meet the cultural and linguistic needs of the CALD population do not necessarily and always coincide with satisfying the faith requirements of practicing Muslims. In this context, it is relevant to quote from a study on social service providers in Canada who work with Muslim clients: "Service providers, educators, and social work agencies all have a role to play in ensuring that Muslims receive effective social services."³⁰⁹

³⁰⁶ Kristin Johansson & Helena Kyriazopoulos, *Emerging Needs Scoping Study: Middle Eastern and North African Report* (Adelaide: HOKJOK, 2011) p.15.

³⁰⁷ Kristin Johansson & Helena Kyriazopoulos, *Emerging Needs Scoping Study: South East Asian Report* (Adelaide: HOKJOK, 2011) p.22.

³⁰⁸ *ibid.* pp. 24-25.

³⁰⁹ John R. Graham, Cathryn Bradshaw, and Jennifer L. Trew, "Adapting Social Work in Working with Muslim Clients" *op. cit.* p. 545.

It is very important for the Muslim community to understand that a dedicated facility for them may not be a reality as the passage of the Human Rights and Anti-Discrimination Bill 2012 ensures that no provider of aged care services that receives Commonwealth funding, including religious organizations providing aged care, can discriminate people although such religious organisations can continue to prefer people of their faith. In this context, it is interesting to note that Jews could set up their own residential aged care facility in Australia under the ethno-specific service provision arrangements as they are considered to be an ethnic group. As has been noted in section 5.2, Australia is yet to determine how to classify Muslims.

It is pertinent to mention here that in September 2012, the authors had submitted the draft of this Report to IICSA and sent copies to the South Australian state government as well as to relevant federal government departments and agencies and the aged care industry, among others. In addition, the authors had made a submission and provided comments to FECCA on the draft *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds* (developed by DoHA in partnership with FECCA). FECCA acknowledged that the draft report together with the comments and the submission on the draft Strategy were important to considerations around the CALD Aged Care Strategy and the key points of the draft report about the importance of faith and spirituality considerations in providing culturally appropriate aged care was included in FECCA's suggested redraft of the Strategy. In a move to bring the aged care service providers and the wider Muslim community together, the authors had organised an information session under the auspices of IICSA on February 15, 2013. This session marked a significant step in efforts to provide appropriate aged care for Muslims in that, perhaps for the first time in Adelaide, both parties had the opportunity to exchange views and the Muslim community could obtain first-hand information on aged care. The authors had also organised a dementia information session for Muslims on August 09, 2014 with support from Alzheimer's Australia SA and the Islamic Students Society of the University of Adelaide.

11.4 Need for Attitudinal Shift of Muslims toward Aged Care

Islam puts a premium on filial piety; it is a religious edict that requires children not only to love and respect their parents but also to assume duty toward their parents, particularly when they are old and infirm. Muslims share a culture of strong tradition of family members caring for the elderly; such caring is regarded as a central value. Most Muslims often see their role as a carer to be a natural extension of family duty that they would have done normally as a spouse, parent, offspring, or sibling. In addition, there is also an expectation on the part of Muslim parents that their children would look after them in their old age. Consequently, there may be a stigma and a sense of shame or failure to do one's duty that is associated with utilising formal aged care services. This largely explains why care among Muslim community is often provided by family members within the home and with little outside support.

A corollary to such expectation and practice on the part of the Muslims is that older Muslims and their families may be reluctant to seek assistance, unlikely to search for and access available services, or to identify additional services that may be needed. They may not even

know about services that exist. Because of the cultural practice, religious values, and negative stereotypes of residential care among Muslims, they may be reluctant to put their loved ones in aged care facilities. However, as family structures change and care needs progress, caring for the aged at home may become increasingly difficult without proper support.

An important study has been done by Zokaei and Phillips on altruism and community relations among Muslims in UK.³¹⁰ Their research shows that clashes between individualistic values (regarded as western) and collectivistic values (such as encouraged in Islam) were proving to be potentially disruptive to family unity and solidarity within British Muslim families. Among the major findings of the study were the presence of strong family ties and respect for parents among Muslim families. However, many respondent parents lamented the fact that their children did not share their values and adopted a lifestyle that was reflective of “too much freedom” that is enjoyed by children in a western, secular society. Parents agonised over the possibility that such an individualistic attitude could change the concept of duties and obligations toward one’s family resulting in, perhaps, parents or other older family members being left to care for by outsiders. This apprehension is likely to resonate with Muslim families in other Western countries as well.

Barnett criticises two inaccurate and widely held assumptions among people both inside and outside the aged care industry: (1) extended family support is available among ethnic communities, and, therefore, (2) institutional aged care is not a priority for these communities. Among the factors that she lists as making the assumptions untrue are the following.³¹¹

- Migration involves the severing of family ties, particularly with siblings and extended family members.
- The ability to care for older relatives is affected as much by economic and social factors as by the willingness of individual family members.

Needless to say, factors that affect the availability of informal carers could exacerbate the situation even more for an aged person from CALD community.

As is evident from the above discussion, placing culture and/or language at the centre of services planning for CALD elderly people does not necessarily constitute appropriate CALD care. In the current approach to aged care, there is a vacuum in terms of an overarching perspective on diversity that would also include religion. This could force the Muslims from a ‘double jeopardy’ situation to a ‘triple jeopardy’ one.

³¹⁰ See Saeed Zokaei and David Phillips, “Altruism and Intergenerational Relations among Muslims in Britain”, *Current Sociology*, 48/4 (2000) pp. 45-58.

³¹¹ Kate Barnett, “Aged Care Policy for a Multicultural Society”, *op. cit.* p. 6.

12. Planning For Muslim Aged Care

This Report calls for a new approach to providing aged care to Muslims. In planning and delivering aged care, not enough emphasis is given to religion compared to that given to language and culture. It is felt that too often, the issues of religion in particular and spirituality in general, has been an after-thought or an add-on in aged care. This chapter emphasises on building religion and spirituality considerations into strategic planning of the entire aged care continuum.

12.1 Planning Issues

Any proposition or plan needs to be made on the basis of careful study to ensure a high degree of success. On the one hand, the Muslim community needs to have a good understanding of the choices provided under current aged care arrangements as well as under aged care reform measures that have been announced. On the other hand, service providers need to have an appreciation of what Muslims want in terms of enhanced choice.

Many Muslims, like many older people from CALD communities, may not be familiar with the aged care system in Australia. For long, the Muslim community has been on the sidelines of aged care services planning and delivery. Consequently, their needs as dictated by their religious values may not have been on the agenda of most service providers. Instead of remaining passive recipients, Muslims must become proactive in seeking greater diversity of, and more appropriateness in, services.

Although a myriad of multicultural and ethno-specific services are available in Australia, there is a serious dearth of services appropriate for the Muslim community who want to maintain their faith practices. Their needs must be understood in a more favourable cultural context and, that is why, a minimum level of cultural awareness is a necessary prerequisite for delivery of care that is culturally sensitive and that pays due respect to the beliefs of care recipients. There may be a gap in the current knowledge and understanding of Muslim culture and religious values among service providers. Muslims, therefore, have an obligation to contribute to the cultural competence (the ability to understand and respond effectively in cross-cultural situations) of the aged care industry. They can do this by articulating and advocating their needs in order to make those 'visible' and helping the industry understand their religious values so that appropriate services can be planned, designed, and delivered.

If an operational service plans to offer care to the Muslims, it has to start with proper planning, incorporating the requirements for privacy, arrangements to meet washing requirements according to Islamic teachings, ablution facilities, prayer space, diet, and dealing with intimate functions to name just a few. Absence of these features would make it difficult for practicing Muslim residents to fully carry on their religious observances. Services may need to be modified or expanded depending on consumer preferences and existing services repertoire to enable older Muslims to maintain continuity with life patterns established by way of their religious beliefs. As mentioned earlier in Section 7.1.2, the building of new and refurbishment of existing aged care facilities by service providers is being

rewarded through higher government subsidies. This will be a shot in the arm in planning for Muslim aged care as construction activity is expected to lead not only to an increase in the number of aged care homes but also additional capacity in terms of places and, of particular significance to Muslims, hope for enhanced choice and appropriate amenities.

While religion contributes to shaping a Muslim's beliefs, values, and attitudes, not all Muslims would share the same needs or preferences in aged care. Just like any other religion, Islam has varying degrees of observance and influence among its followers. It is, of course, prudent to always consult the care recipient about their personal level of religious observance. It is also important to remember that the spiritual needs of people may change over time with some becoming more aware of, and interested in, spiritual and religious matters as they confront mortality and uncertainty.

Because of personal and cultural variations in the way any religion, including Islam, is practiced, the following section explains some of the essential requirements for any Muslim wanting to abide by the teachings of the Qur'an and Sunnah. As has been discussed in chapter 2, Islam requires strict adherence to its core beliefs and rituals and these ought to influence all aspects of a Muslim's daily life. In spite of the immense diversity in language, ethnicity, and culture of millions of Muslims around the world, there is one point of reference and unity—their religion Islam.

It is essential, nonetheless, to acknowledge the importance of culture and language issues when planning for Muslim aged care. The lack of accessible information in relevant languages is a major contributing factor to the isolation of older individuals from smaller ethnic communities, aggravated in case of a wide geographical dispersion. Language takes on importance of immense proportions when the care recipient suffers from dementia as it is a well-accepted fact based on research that people with dementia often revert to their first language and, thus, require language-specific care. An issue for aged care providers will be the strong correlation between the inability of some older Muslims to communicate proficiently in English and, their understanding of the aged care system and opportunities to access services. There is thus a strong argument for attracting aged care workers from the major Muslim linguistic groups.

When designing a facility which will be providing accommodation for residents of diverse cultural backgrounds, certain cultural considerations need to be thought of, such as, creating areas for smaller sub-groups, decor and interior design, orientation of rooms, and food preparation.³¹² In this context, Kopec and Han point to an important but easily overlooked aspect in planning a facility, that of designing rooms. They opine:³¹³

“The complex and interwoven nature of culture and religion as they relate to one's identity is an important consideration when designing the physical environment of a

³¹² Department of Human Services, Government of Victoria *Aged Care Residential Services Generic Brief* (Melbourne: 2000) p. 18.

³¹³ D.A.K Kopec, and Li Han, “*Islam and the Healthcare Environment: Designing Patient Rooms*”, op. cit. p. 111.

healthcare setting. However, consideration of culturally appropriate visual, auditory, and tactile opportunities as part of the overall healthcare plan is often neglected in the design of patient rooms”.

A responsible healthcare facility designer, according to Kopec and Han, is placed “...in the unenviable position of balancing the unique needs of a single patient with those of subsequent patients who will occupy that patient room in the future. The answer to this conundrum is flexible design solutions that allow for the adaptation of patient rooms to meet the various cultural and religious beliefs and practices of each user”.³¹⁴ While strongly advocating the importance of accommodating relevant aspects of religion in physical infrastructure, they go on to say, “Given the profound effects of culture and spirituality on one’s identity and subsequent behaviours, it stands to reason that a physical environment that supports cultural and spiritual beliefs would contribute positively to one’s health and recovery”.³¹⁵ These comments are equally relevant for designing rooms in an aged care facility that wishes to cater to residents from diverse backgrounds.

12.2 Aspects of Care for Muslims

In her study of Queensland Muslims from different ethnic backgrounds, Babacan found that *halal* food, appropriate prayer facilities, and respect for religion and culture were among the important things that Muslims wanted in aged care facilities.³¹⁶

A sensitive approach to cultural and religious practices of care recipients would involve taking steps that help them to perform their rituals with relative ease. In light of such an approach, the following section sketches the important aspects of care pertaining to a practicing Muslim. Most of these aspects of care are equally pertinent for home care. The following outline is by no means exhaustive but rather serves as a pointer to aid in developing a comprehensive plan for Muslim aged care.

PHYSICAL FACILITIES:

- If the residential aged care facility has a mosque in the same neighbourhood, it would greatly facilitate offering of congregational prayers. A prayer room for such prayers inside the facility would help if there is a number of male residents who may be too frail to go to the mosque.
- It is helpful if there is a mark or an indication in each room as to the direction of Qibla (Makkah).
- Beds should be placed so that the feet do not face the Kaaba.

The layout of a room is illustrated on the following page showing inscriptions from the Qur’an on the wall above the bed and a prayer mat on the floor.

³¹⁴ *ibid.* p. 112.

³¹⁵ *ibid.* p.116.

³¹⁶ Hurriyet Babacan, *Care Needs of Muslim Older Adults*, *op. cit.* p.62.



Photo credit: D.A.K Kopec, and Li Han, Islam and the Healthcare Environment: Designing Patient Rooms, *Health Environments Research & Design Journal*, 1/4 (2008) p. 117.

TOILETS:

- It is essential for purification to cleanse every time after using the toilet. Use of toilet paper is acceptable, but washing with water is still needed for purity. Therefore, toilets should have adequate washing arrangements. If a bidet is not available, at least a small water container or beaker to assist with washing should be provided. Whenever possible, a bedbound Muslim would need to have his or her private parts wiped with water after using a bed pan.
- Bathrooms must have ablution facilities, specifically, a hand shower to wash one's feet.
- Toilets must not face the Kaaba. One should neither face nor have one's back toward the Kaaba whilst relieving oneself.

HYGIENE AND PERSONAL CARE:

Cleanliness is an important part of Islam and, therefore, Islam has always placed strong emphasis on personal hygiene. In addition to the ritual purification before prayers, there are strict rules regarding cleanliness. Cleanliness in Islam stresses upon the following:

- Purification from impurity by taking a bath (ghusl) or performing ablution (wudhu) in states in which a bath or ablution is necessary or desirable according to Islamic teachings. A Muslim cannot say prayers or handle the Qur'an or be involved in various religious activities unless ritually purified
- Cleansing one's body, dress, bed, or place from any impurity or filth
- Cleansing teeth and nostrils, trimming nails, and removing armpit and pubic hair.

If washing with water or having a bath is not medically advisable or possible, an alternative method of purification called *tayammum* can be performed.

THE QUR'AN:

- There must be a clean place where religious objects/items such as the Qur'an, the prayer beads, and the prayer rug can be kept as these items are treated with due respect.
- The Qur'an must be kept high above the ground or bed.
- The Qur'an should not be touched by anyone who is ritually unclean.
- Nothing can be placed on top of the Qur'an.
- While the Qur'an is recited, it is important to observe silence and refrain from distracting since reciting the Qur'an is a form of worship.
- The care recipient may receive great comfort in reading, reciting, or listening to tape recordings of the Qur'an.
- It is desirable to recite the Qur'an to a dying Muslim.

PRAYER:

A person performing the Salaah must not be disturbed. No-one should talk to one who is praying or cross in front of him or her during prayer. Prayers are often performed in a quiet and clean place on a special prayer mat which all practising Muslims possess; in case of unavailability, a clean sheet or towel will suffice. A Muslim who is too sick or weak to get up and perform the usual prayer movements is exempted from these movements and may perform prayers while seated or even while lying down.

FASTING:

Just like the followers of many other religions, Muslims observe fasting. Diabetes Australia with the assistance of the Australian Federation of Islamic Councils Inc. (AFIC) -- Australia's peak national Islamic organisation -- has developed a comprehensive guide on fasting and diabetes titled *Diabetes and Fasting for Muslims: A Resource for Health Professionals*. For those who are ill or are taking medications, it would be advisable to consult a doctor about fasting safely.

FOOD:

Food is an important part of religious observance and beliefs for Muslims. They follow a dietary code called *halal* meaning permitted or lawful, that is, foods that can be consumed according to Islamic law. The main prohibited foods are alcohol, pork and all of its by-products, and all animals that have not been slaughtered according to Islamic rites. It is also important to remember that there are some foods which although usually *halal* may contain ingredients and additives, such as animal gelatine, that can make them *haram* (unlawful). For Muslims, the issue with food has more to do with meeting religious requirements than a way of connecting with their cultural backgrounds and identities. Muslims have special dishes prepared for religious festivals that reflect the culture and tradition of a particular ethnic group.

A healing practice many Muslims believe in is the use of 'holy water' or *Zamzam* water obtained from a well in Makkah. Other traditional medicines are honey and black cumin (nigella seeds).

DRESS:

Modesty is very important for both sexes, especially for women. Even after death, modesty should be maintained as if the person were alive. Muslim men usually prefer keeping the area between the navel and the knees covered, and for Muslim women, only the face and hands are usually left exposed. Although this standard may not be followed by all Muslims, it is important to most to screen themselves from view when dressing or being dressed or examined.

HEALTH ISSUES:

Muslims believe in both medical cure and spiritual healing. The latter is based on the recognition of the positive effects of spiritual health on the physical body and is manifest in the well-established tradition of Muslims seeking healing through prayers, supplications, and fasting.

Administration of medicines: As far as possible, medications must meet the *halal* requirement. Where choice exists, medicines containing alcohol/pork derivatives should NOT be used. The left hand is considered unclean and health care professionals must use their right hand when administering medications and carers should do the same when feeding.

Medical examination: It is very important to address the gender segregation issues as prescribed in Islam. Unnecessary touch between non-related people of the opposite sex should be avoided. Same-sex doctors, nurses, and carers should be assigned as far as possible. As much as possible, the modesty concern of the patient must be respected even during physical examination as indicated earlier.

VISITATION OF THE SICK:

It is a social or communal obligation of the Muslims to visit the sick and offer words of comfort. Therefore, it is not unusual to have many visitors.

CHAPLAINCY:

In line with the various roles of Imams discussed in section 4.5, Muslim residents in aged care settings and their families may seek chaplaincy services that may involve an Imam praying or reciting the Qur'an, especially when someone is dying; offering the sick and the dying and their family members words of comfort drawn from Islamic theology; giving spiritual direction; playing the 'adjudicator' role on issues surrounding medical decisions that may run contrary to Islamic teachings ; and providing pastoral counselling in the context of illness, suffering, death, and so on.

END OF LIFE ISSUES:

- There are no formal last rites.
- The conscious, dying patient may wish to have some form of religious comfort for which assistance can be sought from the local Imam if family members are not available.
- There are certain customs concerning the handling and washing of the dead body.

GOOD DEATH PERSPECTIVE OF MUSLIMS:

A list based on an empirical study³¹⁷ on Muslims concerning what constitutes 'good death' is provided below:

- Aspects related to faith and relationship with Allah
- Aspects related to self-esteem and the person's image in the eyes of relatives
- Aspects related to concerns about family security
- To be afforded dignity and privacy
- To have access to any spiritual or emotional support required
- To have access to hospice care in any location, not only in hospital
- To be able to have control over pain relief and other symptom control
- To be able to issue advance directives, which ensure wishes are respected
- To have time to say goodbye and control over other aspects of timing
- To be able to leave when it is time to go, and not to have life prolonged pointlessly
- To be able to retain control over what happens.

However, it is critical to note that there are clear guidelines in Islam that must be followed on issues concerning resuscitation, life-support, and other complex medical decisions.

12.3 Planning for Old Age

There is much wisdom in the old adage that "ageing happens naturally, but aging well takes careful planning". One needs to take steps to ensure that one's spiritual, financial, medical, and other needs will be met in old age. That is why planning for old age is best done early in life when one can make informed and wise decisions and have time to implement them. Some of the issues that must be addressed are:

- power of attorney/guardianship
- estate planning
- an advanced care plan or directive
- choosing an appropriate aged care provider

³¹⁷ Mohamad A Tayeb, Ersan Al-Zamel, Muhammed M Fareed, and Hesham A Abouellail, "A 'Good Death': Perspectives of Muslim Patients and Health Care Providers", *Annals of Saudi Medicine*, 30/3 (2010) pp.215-221.

- how fees and other charges will be paid if there is a need for formal aged care services, and
- funeral arrangements.

Since July 01, 2014, a new decision-making framework has come into force under the *Advance Care Directives Act 2013*. Essentially, this is the Advance Care Directive Form that replaces Medical Power of Attorney, Anticipatory Direction, and Enduring Power of Guardianship (however, any of these existing forms will continue to have legal effect post 1 July 2014).

The Advance Care Directive Form allows individuals to appoint substitute decision-makers and/or to clearly document their wishes and instructions regarding their future health care, end of life, living arrangements, and other personal matters. If and when an individual loses the ability to make decisions, such as when due to cognitive impairment, who has the legal authority to make decisions will be a crucial part of the care planning process and the care provider will need to know this.

Further information about the Advance Care Directives is available at :

<http://www.advancecaredirectives.sa.gov.au/>

It is advisable that Muslims consult an Imam or Islamic scholar as well as a Muslim lawyer to help them with Advance Care Directives and, importantly, to ensure that the Directives do not include anything that may contradict Islamic beliefs and customs.

A 2010 publication of the Australian Government titled *Information on Accommodation Choices for Older Australians and Their Families: what older Australians and their families need to know*, (no updated version is currently available) provides detailed information on living options including managing finances for older Australians.

Another publication that would be a useful guide is the *Australian Government Directory of Services for Older People 2012-13* (no updated version is currently available). This guide includes information on Australian Government programs and services for older people in areas such as health and aged care, as well as practical information on finances and individual's rights.

As mentioned earlier in Section 6.3, a single, national information line has been set up to make it easier for older Australians, their families, and carers to access information about aged care over telephone. The number is **1800 200 422**. There is also a national aged care website: **www.agedcareaustralia.gov.au**

The key to delivering high quality services is developing an understanding of the community for which a service is planned or will be provided. Offering Muslim consumers enhanced choice will need to take into account the nature and extent of the changes required. The foregoing discussion seeks to make service providers aware of the particular needs of a Muslim aged care recipient. It also reminds the Muslims to be proactive in planning for their old-age lifestyle and living arrangements.

13. Recommendations

As a key component of appropriate aged care, facilitation of faith observance must be integrated into service planning and delivery.

The Muslim community in Australia has to become active participants and not remain passive consumers so as to be able to overcome the challenges of an aged care system that caters largely to the mainstream in terms of services planning and delivery. A common and unified approach towards community issues such as aged care is vital for moving forward and delivering benefits. In order to become change agents, Muslims need, first and foremost, the right information about the aged care system and how it works. The system is undoubtedly complex and, hence, difficult to navigate for many.

While Muslims must begin to articulate their own needs, Muslim community organisations have a key role to play as 'cultural brokers', given their strong connections to and understanding of their communities. The aged care industry could engage with Muslim community leaders and organisations to receive direct input about the nature of services the community wishes to receive. Not only consultation but participation must be encouraged and facilitated by the service providers to ensure that planning and delivery of aged care services are in congruence with the needs of the target community. Muslim community organisations could serve as bridges between the community and the service providers in facilitating provision of care that is attuned to Islamic beliefs. They can provide their community with information on available services and link it to services as well as receive feedback on barriers to receiving support.

Collaborative ventures between mainstream non-profit service providers and the Muslim community organisations could pave the way for incorporating the special needs of Muslims into care planning and delivery. Coming from a wide variety of ethnic backgrounds but bound by strong religious beliefs and practices, the Muslims would also likely to benefit from the clustering model. Clustering would help ensure that Muslims are not precluded from receiving appropriate services in that, in addition to linguistic and cultural aspects, their religious needs also would inform services strategies. The Innovative Care Pool may also be utilised to start aged care services directed at the Muslim population.

Owing to the small number of older Muslims, the aged care market in South Australia for this group is 'thin' with relatively few consumers; therefore, setting up a separate facility or a separate wing in an existing facility may not be a viable option. However, their relatively small number cannot be an excuse for not meeting the needs of older Muslims. To the extent possible, every effort must be expended to incorporate faith requirements into services planning and delivery; in order to facilitate this, service providers need to have the flexibility to meet the preferences of smaller communities. Adoption of a person-centred approach to care by service providers would increase the possibility of having the needs of Muslims addressed.

Care for Muslims could be implemented in the short-term through extensions to existing programs or incremental refinements to the existing programs or services. More fundamental changes, such as care workers being trained to become more culturally competent and modifying or changing certain aspects of the physical facilities in aged care homes to accommodate Islamic considerations, would be required if real enhancement of choice for this community is to be realised.

As spiritual care is a critical component of quality care regime, there is an important role for Muslim chaplains. A formal chaplaincy training program would, in addition to supplying Muslim chaplains, offer professional standing and recognition of competence.

Undoubtedly, with the aging of the Muslim population, the need for appropriate aged care services will increase. But since the current demographic of older Muslims in South Australia is unlikely to influence the level of demand for residential care services that would appeal to the service providers, a need assessment would be an important starting point for planning for Muslim aged care. The assessment can be based on prospective (rather than current) need especially for those at the low end of the care spectrum whose needs are expected to accelerate with time. This would then need to be pursued and the support and cooperation of relevant departments and agencies enlisted so that the aged care industry can start to plan and deliver appropriate care for Muslims.

This Report is the first in-depth inquiry into making a case for Muslim aged care in South Australia and it is hoped that this Report will generate new ideas and give directions for the future. Further research and analysis is required to determine the current and anticipated demands, user preferences of services, and the scope of services to be included in enhancing choice for Muslims.