Ageing & Society **35**, 2015, 1011–1031. © Cambridge University Press 2014
doi:10.1017/S0144686X14001226

'Health is their heart, their legs, their back': understanding ageing well in ethnically diverse older men in rural Australia

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ABSTRACT
Older men from ethnic minority communities living in a regional town in Australia were identified by a government-funded peak advocacy body as failing to access local health and support services and, more broadly, being at risk of not ageing well. A qualitative study was undertaken to explore the health and wellbeing of ethnic minority men growing older in a rural community, and to identify the barriers they faced in accessing appropriate services from a range of different perspectives. Individual interviews were conducted with key informants (service providers and community leaders), followed by focus groups with older men from four ethnic minority communities. The men in this study showed signs that they were at risk of poor mental and physical health, and experienced significant barriers to accessing health and support services. Furthermore, environmental, technological, social and economic changes have brought challenges for the older men as they age. Despite these challenges, this study demonstrated how work, family and ethnic identity was integral to the lives of these older men, and was, in many ways, a resource. Key informants' perspectives mostly confirmed the experiences of the older men in this study. The discrepancies in their views about the extent of health-promoting behaviour indicate some key areas for future health intervention, services and research.

KEY WORDS – older men, rural, ethnicity, migration, health, services.

Introduction

Being a man who is growing older in a rural community presents risks to both physical and mental health (Australian Institute of Health and Welfare (AIHW) 2007; Department of Health and Ageing (DOHA) 2008). Coming from an ethnic minority background can exacerbate these risks (Ricciardelli *et al.* 2013). While health-care and service workers are anecdotally aware of

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the unique problems faced by this particular group of men, they have little research-based evidence to draw upon to assist them in designing and delivering culturally responsive services and support. The experiences of older rural men from ethnic minorities are grossly under-reported and under-researched, both in Australia and internationally. The aim of this paper is to present the findings of a study which investigated the health and wellbeing of this group of men as they age in a rural community, both from the perspective of key informants (service providers and ethnic minority community leaders) as well as older men themselves. In drawing on a range of perspectives, and examining any discrepancies between them, we identify some important considerations for innovative policy and practice in order to maintain and promote the health and wellbeing of these older men. These considerations suggest the employment of a collaborative and capacity-building approach, which acknowledges older men's strengths and perspectives and encourages them to be active agents in maintaining their own health and wellbeing.

Growing older as a man in a rural Australian community

The Australian National Men's Health Policy highlighted the neglected needs of a number of groups including men in rural communities (DOHA 2008). Men who live in rural communities are subject to a number of disadvantages. Compared to their urban counterparts, men are more likely to be vulnerable to a range of diseases and premature death, to engage in behaviours that put their health at risk and to have lower levels of health literacy (AIHW 2010). Rural men are also reported to have higher suicide rates and higher incidence of mental health disorders than men in metropolitan regions (DOHA 2008). For rural men, risk factors for poor health may include social isolation, high unemployment, economic hardship and population decline (DOHA 2008). Many older rural men are employed, or have been employed before retirement, in the physically demanding agricultural industry. This work often requires them to deal with the stress of working in socially isolated conditions, extreme environmental changes such as drought and fire, and subsequently under the constant threat of unemployment. Together with poor access to mental and other health services (DOHA 2008), each of these factors has the potential to increase the risk of poor physical and mental health outcomes.

Older men are also likely to experience a threat to their identity and sense of wellbeing as they age, since they tend to encounter greater difficulty in maintaining cultural and social connections to their communities (Constant, Gataullina and Zimmermann 2006). Older men who have

played the 'bread-winner' role are likely to resist retiring from the paid workforce, despite changes to their physical and mental capacity, or may experience a severe disruption to their identity upon retirement since they are likely to lose their connections to significant networks (Constant, Gataullina and Zimmermann 2006). It is the struggle to cope with life changes and transitions that are reported as contributing to high levels of stress, anxiety and increasing suicide rates in older men (Jensen, Munk and Madsen 2010). Older people who have experienced an accumulation of stressful events and daily hassles are at greater risk of poor mental health (Kraaij, Arensman and Spinhoven 2002); and the coping strategies commonly used by older men in stressful situations lead to poor psychological adjustment (Addis and Mahalik 2003; Jensen, Munk and Madsen 2010). Mental health is at further risk due to older rural men being less likely to seek professional assistance for health disorders (Council on the Ageing 2008).

Men from ethnic minority backgrounds may encounter specific and additional barriers to maintaining their health and wellbeing, which include: lack of English language skills; stigma associated with seeking support; lack of culturally appropriate information about available services; and inequitable access to community aged-care services (Bambling *et al.* 2007; Fuller *et al.* 2000; Kiropoulos, Blashki and Klimidis 2005; Radermacher, Feldman and Browning 2009). For this reason, the needs of people from ethnic minority groups are less likely to be met (Pugh *et al.* 2007), increasing the demand for more effective and culturally responsive management of health problems, particularly in rural locations (Bambling *et al.* 2007; Fuller *et al.* 2000; Sweeney and Kisely 2003). Before describing the details of the study, an historical and cultural profile of Australia will be presented to provide a context in which to understand the experiences of older men from minority ethnic communities.

Multicultural Australia

Australia is one of the most ethnically diverse countries in the world. In 2012, 27 per cent (over five million) of Australia's population was born overseas (Australian Bureau of Statistics 2012). This compares to 13 per cent in the United States of America, 12.3 per cent in the United Kingdom and 1.3 per cent in Japan (Rienzo and Vargas-Silva 2012; Statistics Bureau of Japan 2011; US Census Bureau 2012). In Australia, 36 per cent of people over 65 years were born overseas, with 61 per cent coming from non-English-speaking countries (AIHW 2013). Notably, the proportion of older people from non-English-speaking countries is increasing as compared to those from English-speaking countries (AIHW 2013).

The cultural profile of Australia has been determined by a range of immigration policies and programmes over the years; the most significant of which was the White Australia Policy (abolished in the 1970s) which essentially prevented access to Australia by non-Europeans. The waves of post-war migration began predominantly with Southern Europeans in the 1950s and 1960s (*e.g.* Italians, Greeks, Macedonians). Anglo-Celtic groups, who came in the 1970s, were then followed by people from South-East Asia and the Middle East in the 1970s and 1980s (*e.g.* Chinese, Vietnamese, Turkish and Lebanese) and Africans in the last two decades (*e.g.* Somalis and Ethiopians).

Currently, the older minority ethnic community largely comprise people who came to Australia in their youth and have now turned 65 years, as well as a smaller group of people who have arrived in later life for family reunification or retirement (Ip, Lui and Chui 2007). The former mostly arrived as single, unskilled young men after the Second World War, fleeing conflict, poverty or both, and in response to the Australian post-war economic boom and demand for unskilled labour (Australian Government 2013). They were prepared to work hard often in isolated and remote areas, especially because they believed they would personally reap the rewards – which was often not the case in the countries they left behind.

Dispersal of migrants across Australia is not uniform, with numbers and patterns of settlement varying across and within States, but mainly concentrated in urban areas with 66 per cent of the overseas-born population living in capital cities (Australian Bureau of Statistics 2012). Due to skills shortages (which includes health practitioners), current policies and programmes have the objective of directing increasing numbers of migrants to rural areas.

In Australia, the term multiculturalism has both descriptive and public policy components (Feldman, Petersen and Radermacher 2012). At the descriptive level it is the recognition of the ethnically diverse demographic composition of Australian society. At the public policy level, it represents current Australian government policy aimed at the constructive management of this diversity (AIHW 2007; Radermacher, Feldman and Browning 2009). The policy of multiculturalism (which broadly accepts and celebrates different cultures) has replaced assimilation, which required people from minority (non-Anglo) ethnic backgrounds to adopt the mainstream Anglo-Celtic culture. While multiculturalism has been the favoured policy direction in Australia for several decades (Koleth 2010), whether it has been fully embraced and successfully implemented in practice is open for debate. Within the health-care system, arguably Anglo-Celtic beliefs still prevail, perpetuating an ethnocentric approach which fails to fully acknowledge

the rights and particular circumstances of people from ethnic minority backgrounds. In the context of this study, such an ethnocentric orientation may pose challenges for developing culturally responsive health and support services and thus fall short of adequately meeting the needs of older men from minority ethnic backgrounds.

Talking about ethnic minorities in Australia

To date, talking about and defining ethnic diversity has been a challenge, primarily because it encompasses so many different factors, such as languages spoken, country of birth, ancestry, cultural norms and practices (Feldman, Petersen and Radermacher 2012). Consequently, there is no consensus or universal term to refer to or distinguish people from different ethnic and cultural backgrounds. In Australia, terms are used interchangeably and some States have preferred terms. In Victoria, for example, the preferred term used by Government and policy makers is 'culturally and linguistically diverse' (CALD), which replaced 'Non-English Speaking Background' (NESB) in 1996 to acknowledge that people from English-speaking nations may still have cultural identities distinct from the mainstream population. However, 'CALD' is equally problematic because it still uses Anglo-Celtic culture as the (normal) frame of reference, and does not acknowledge that all citizens (including those from Anglo-Celtic backgrounds) speak a language and have a cultural identity.

Equivalent terminology is 'Black and Minority Ethnic' (BME) in the United Kingdom, and 'Racial and Ethnic Minorities' in the United States of America. In the context of this paper, we will use the term ethnic minority to align with our Western counterparts, which acknowledges that there is a majority ethnic group (in this case, Anglo-Celtic). For the purpose of this study, we defined older people from ethnic minority backgrounds as persons aged 60 and over, and where they or their parents were born overseas in countries where English is not the main language spoken. Ethnicity may include, but is not restricted to, differences arising from a person's country of birth, culture, language, race or religion. Ethnicity is also linked closely with people's social status and their access to opportunities and resources within society. Importantly, it is these differences that need to be acknowledged and considered in any health-related interventions and promotion efforts. Furthermore, it is likely that the context will determine which factors are most salient. For example, in a health-care setting, languages spoken at home and English-language proficiency have been identified as the most useful indicators for identifying the needs of older people from ethnic minority backgrounds because communication is integral for enabling or hindering access to appropriate health care (Howe 2006).

Background to research study

Older men from ethnic minority communities living in a regional town in Victoria, Australia, were identified by a government-funded peak advocacy body as failing to access local health and support services and, more broadly, at risk of not ageing well. This study was undertaken to explore the health and wellbeing of these older men as they age in a rural community, and particularly to identify the barriers they faced accessing appropriate services to support them to age well. The area in which the study was conducted was a regional area a few hundred kilometres north of Melbourne, with a population of about 70,000 people. Situated at the point where two rivers join, it is an area with a rich history of fruit and dairy farming.

Method

Study design

This study employed a qualitative research design comprising face-to-face interviews with key informants (service providers and community leaders; Stage 1) and focus groups with older men (Stage 2). The two-stage design served two main functions. First, recruitment of key informants was expected to assist in the identification and recruitment of older men in Stage 2. Secondly, data from Stage 1 could be used to inform the Stage 2 focus groups, particularly the identification of prompts to be used to elicit further details about issues raised in Stage 1. Furthermore, using focus groups with older men provided the opportunity for the men to discuss both their individual and collective cultural beliefs about health and wellbeing.

Setting, sampling and recruitment

Identification and targeted recruitment of participants was co-ordinated by the advocacy body, with guidance by the researchers. Information about the study was distributed to potential participants in written form or via presentations to groups. All participants were recruited from the regional area. The advocacy body co-ordinated all the practical arrangements for each interview and focus group (*e.g.* venue, timing, booking an interpreter, refreshments, *etc.*). Apart from the provision of refreshments, there was no other incentive for participation.

For Stage 1, we sought to interview general practitioners (GPs), allied health workers, and Home and Community Care workers, with key expertise and relevant knowledge, who represented both large and small health-service providers. We also sought to interview key community leaders from four ethnic groups (Italian, Macedonian, Albanian and Turkish).

For Stage 2, we targeted men aged over 60 from each of the four ethnic groups. These groups were selected due to being populous in the region, as well as being regarded as particularly at risk of poor health. Of 12.5 per cent of the region's population who spoke a language other than English (LOTE) at home in 2011, the top language spoken was Italian (22% of LOTE), closely followed by Turkish (3rd; 8%), Albanian (4th; 7%) and Macedonian (9th; 3%) (State Government of Victoria 2013). Community leaders and community representatives in the area (including participants from Stage 1) were asked to identify potential older men to be interviewed from their community. To our knowledge, no one refused to participate in the study and this was perhaps attributable to our snowball sampling strategy, whereby people approached were asked to inform others about the study. The sample size was primarily determined by the existing networks the advocacy body had with the respective ethnic communities. In one instance, in the Turkish group, a younger male also took part because he was accompanying an older participant. We were reluctant to turn him away due to both of the men's keen interest in our study. Limited study resources also restricted how much time the advocacy body could devote to recruitment, and the capacity of the research team to collect data.

Procedure

Approval for this study was obtained from the Monash University Human Research Ethics Committee. Information letters and informed consent materials were produced and, where appropriate, translated by accredited translators. Written consent was obtained from all participants prior to their participation. All interviews and focus groups were conducted by the authors (one facilitated the process, and the other wrote notes). Interviews took place between June and December 2010. The interviews were generally conducted in local community-based meeting places and centres (*e.g.* residential aged-care centre, local mosque). Each interview or focus group took between 30 and 90 minutes and was audio recorded. Trained bilingual interpreters were present at all of the focus groups, and were briefed by the researchers at the beginning of each focus group. The role of the interpreter was determined by the level of English proficiency within the group; the lower the English proficiency, the greater the role of the interpreter in facilitating the discussion. All the focus group participants were asked to complete a brief demographic information sheet which included questions about their age, marital status, education, when they had arrived in Australia and any health issues.

While interview questions addressed the same key areas, they were tailored to each group of participants as appropriate. Interviews with the service

providers and community leaders were guided by the following questions: What are the key socio-cultural influences that impact on this group of older rural men's health and wellbeing? What are the barriers and facilitators for older rural ethnic minority men seeking assistance or support for health issues? What are the barriers and facilitators to the provision of support and services for this group of older men? What training and information do you need in order to better address the health issues of older men?

Interviews with the older men were guided by the following questions: What affects how well you live your life now as an older man? What life experiences/factors/events impact on your ageing experience/ageing well? With whom do you talk when things are tough? Have you sought assistance for life and health-related issues and from what services? How could current services be improved to be more useful or relevant to you?

Analytic approach

Participant background information was entered into a statistical software package (SPSS) and analysed using descriptive statistics. The audio recording of each interview and focus group was transcribed, and translated as appropriate. Both the authors listened to the audio recordings and read the transcripts several times, both to assure the quality of the transcription as well as familiarise ourselves with the data. The qualitative data were subjected to a systematic thematic analysis to identify major themes and sub-themes (Braun and Clarke 2006). This involved an inductive process whereby each transcript was initially coded by each author, and potential categories identified. As part of the qualitative thematic data analysis, the researchers drew together a list of preliminary themes based on their field notes, impressions and direct observations. A thematic map was created and reviewed by both authors, with continual rechecking of themes against the transcripts and initial field notes. All data were de-identified to retain anonymity and confidentiality of all participants and their organisations. A range of opinions were offered by participants, demonstrating the heterogeneous perspectives within and across the groups of key informants and older men, as well as within and across different ethnic groups. This diversity and commonality is described as appropriate in the findings.

Profile of participants

Service providers/community leaders (Stage 1)

We conducted eight individual or small group interviews with 12 participants (seven men, five women). Participants included seven service providers/practitioners from a range of organisations (including community health

TABLE 1. *Characteristics of the older male participants*

	Italian	Macedonian	Albanian	Turkish	Overall
N	6	8	4	8	26
Age (range)	66–85	63–82	57–77	39–70	39–85
Years in Australia (range)	50–72	49–65	7–69	7–69	7–72
Number in paid employment	0	2[1]	3[3]	2[2]	7
Marital status:					
Married	5	7	4	8	24
Living with a partner	1	0	0	0	1
Widowed	0	1	0	0	1
Education:					
Never went to school	0	1	0	0	1
School	6	7	3	7	23
University	0	0	0	0	0
Unknown	0	0	1	1	2
Children:					
No	0	0	0	0	0
Yes	6	8	4	8	26

Notes: 1. Part-time employment. 2. Full-time employment.

services and centres, residential aged-care services, community support and advocacy services) with a range of roles (including generalist counsellor, cultural diversity worker, nurse practitioner and programme co-ordinator). Four community leaders (one Albanian, two Italians and one Macedonian), one agricultural industry employer and one men's group volunteer leader were also interviewed.

Older men (Stage 2)

We conducted four focus groups comprising 26 older men from four different ethnic backgrounds (Turkish, Albanian, Italian and Macedonian; *see* Table 1 for participant characteristics). Participants had an average age of 67 (ranging from 39 to 85 years); the majority of whom were married (N=24), did not have post-school qualifications and all had children. They had a range of health conditions (including heart disease, diabetes, musculoskeletal conditions, high blood pressure and Parkinson's disease), and their current/previous occupations included orchardist, labourer and farmer. On average, the Italians and the Macedonians had been living in the area for the longest time, followed by the Albanians and the Turks.

Findings

In talking to key informants and older men, several key issues emerged and will be discussed in turn. Participants' perspectives both converged

https://doi.org/10.1017/S0144686X14001226 Published online by Cambridge University Press

and diverged, depending on the issue. For each issue, we first present data revealing the key informants' perceptions in relation to the older men and their situation. Then we present data illustrating the older men's own views and experiences. This is then followed by a comparison of how the men's own experiences differ from how the service providers perceive of them. The key issues identified, as well as any discrepancies between the key informants and the older men's perspectives, are then drawn on in the discussion to highlight the implications for service delivery and health promotion amongst older ethnic minority men in rural communities.

Older ethnic men have complex health issues

Key informants spoke generally about a range of health issues experienced by older men from minority ethnic communities in the regional area, which included diabetes, musculoskeletal conditions, cardiovascular disease, arthritis, hepatitis B (particularly the Albanians), dementia and depression. Furthermore, the majority of key informants identified the high stress associated with long working hours well into their old age, which often involved hard physical labour.

The older men themselves reported having a range of these health conditions, but also spoke specifically about their work-related illnesses and injuries, including back and breathing-related problems, due to working with heavy machinery and dangerous chemicals. Of note too was their high cholesterol levels and blood pressure; all eight participants in the Macedonian group reported being on medication for high blood pressure.

Having good physical health was regarded as the most important factor for ageing well, as reported by the older men themselves. Mental health was an issue that was not talked about so readily or explicitly. However, high levels of stress and anxiety were evident among all the groups, but not all groups expressed their concerns in the same manner:

> Everyone, they have stress . . . if they say 'I haven't got stress, I haven't got that' they're just telling a lie. (Macedonian man)

While tough working conditions were also discussed by the older men, additional sources of stress and worry related to coping with changes in the agricultural industry (both government policies as well as rising expenses), and the increasing reliance on technology. The men also talked about their experiences of migration, the strained relationships with their children (often related to conflicting priorities and values, as well as children moving away), and dealing with the loss or illness of their wives. For the men who had retired, or were thinking about their post-retirement years, they were

worried about losing their social connections, becoming less active and having nothing to do, particularly in their rural town:

> But in the town you have nothing to do. Finish the job, sit, drink, lay down on the carpet and the couch. (Macedonian man)

Discussions with the older men confirmed what the key informants said about the complexity of issues faced by older men, and specifically that they often have to manage a variety of health conditions in unison. However, it was only in talking with the older men themselves that the intimate struggles and worries of the men were revealed, and the likely reasons for the presentation of such complex health issues.

Health literacy and health-promoting behaviour

Key informants indicated that in their experience many older men from ethnic minority backgrounds had low levels of education and high illiteracy. This was perceived to affect their capacity to understand their health, as well as how to improve it and make recommended lifestyle changes:

> They're not aware [older ethnic minority men] because they've never been in the sphere, no one has ever told them about . . . their health is their heart, their legs, their back. (Service provider)

There was also a perception by the key informants of high levels of smoking, drinking alcohol and eating traditional unhealthy food by people from ethnic minority backgrounds, and in particular the Italians. In addition, some of the key informants perceived that older ethnic minority men do not take care of their health (*e.g.* via regular health check-ups, health-promoting behaviours, *etc.*):

> A lot of them still smoke heavily because that's part of the culture and we've tried many times to provide services information to them. We've trained professionals at the club and they won't pick up . . . Because they don't want to. They just say no. I'm not going there. Why should I? I've been smoking for 30 or 40 years. I don't care. (Italian community leader)

Another service provider, with Italian parents, stated that service providers had a tendency to over-estimate the men's level of comprehension of the service system, especially if the community was well established and had been in Australia a long time:

> I think a couple of things the service providers really lack is that they assume that the older generations, that the cultural groups that have been here for a long period of time, have a level of understanding, they assume that. Okay my mum and dad know how to get to a doctor, my mum and dad know how to get to the hospital but they don't know anything about community health, they don't know anything about dieticians or anything like that. (Service provider)

On speaking to the men, it appeared there was a greater range of healthy behaviours and understanding about health promotion than that described by some of the key informants. In the Albanian group, for example, the men appeared to be up to date with health-promotion information and messages, were fit, healthy and engaged in regular exercise, and in addition were not drinking alcohol or smoking either at all or excessively. One Albanian participant compared his generation to the generation that came before:

> . . . they [Albanian men] never looked after themselves the way we are. They used to smoke right until they passed away. They drank alcohol, not excessively but they did, we don't do that anymore . . . We do regular [medical] check-ups. A lot more regularly than our parents did. What else? I think food, we eat healthier food. (Albanian man)

However, there have been two main waves of migration from Albania (the old wave in the 1920s and the new wave in the 1990s). For the Albanians who were born in Australia, children of migrants of the old wave (two participants), they said:

> We have grown up here so we have experienced what you have experienced. Things have changed a lot in the last 20 to 30 years. And it has been drummed into us by the TV, the media, that we should be changing food we should be eating healthier. Not eating much. All that. (Albanian man)

There were men in all the groups that engaged in hard physical labour, and this activity was viewed as a reason for not engaging in additional physical activity. Some men, however, who had retired from the paid workforce, did speak of engaging in regular walking, exercise routines and social activities: 'I'm involved in sport. Not as much as I used to. I still go to play lawn balls with the senior citizens' (Italian man).

So while there was one discourse that constructed ethnic minority men as illiterate, uneducated and non-English-speaking, there was talk of a simultaneous assumption that these men were able to navigate a complex and sophisticated health-care system. Importantly, there was evidence of a discrepancy regarding some of the key informants' perceptions of older ethnic minority men's health-promoting behaviours and what the older men said about themselves. However, it was also evident that there was some diversity in the men's experiences, which was influenced by their current employment status and when they migrated.

Accessing the service system

Some of the service providers perceived that older ethnic minority men have complex health needs but regardless do not seek services until they face a critical health episode:

> The only time you'll see one of these guys do something about their health is at the stage where it is an acute issue . . . they have to fall over . . . they have to be in significant

pain before they will [go to a doctor] . . . I'm talking about they've got to go to hospital in pain, they're not going to stop because it hurts they're going to stop because they've actually collapsed. (Service provider)

In addition, key informants described the older men, for example the Italians, as 'hard-headed', in denial of their health issues and not able to readily talk about their health, which was attributed to both pride and fear. Furthermore, key informants noted that older men are confused and do not understand how the health system works, this is particularly so with regard to the availability and use of interpreters.

In talking about their experiences, key informants proposed a number of approaches that might go some way to improving older ethnic minority men's understanding and access to health-care services. Fundamental to these suggestions was the importance of trust, which was perceived to influence greatly older men's decision making about whether to talk about their health needs and using health services. The role of pharmacists or a trusted GP were considered effective and successful models for older men's access to information and support. Moreover, some key informants emphasised the important role of a (trained) trusted lay person to act as a mediator or to assist referral, who speaks their language and is local. Targeting men at work, or their meeting places, was also suggested as a useful strategy and integral to success: 'You've got to take it to them [older ethnic minority men], I think that's probably the best model' (Service provider).

While many of the men reported having a range of health issues, not seeking help until a crisis was a commonly shared behaviour and confirmed by some of the older men in all four groups. They also expressed reluctance to discuss their problems with family, friends or professionals. The dominant attitude of these men was 'I'll be alright'. What reinforced this attitude was (a) the perceived expense of the health system, and it was not necessarily because they could not afford it; (b) lack of information and knowledge about the health and service system; (c) the lack of trust or understanding of the advice and treatment provided by doctors (mostly reported by the Italians and Macedonians).

The men also varied in their use of health services, with some more willing than others to seek assistance. However, if and when the men talked about using health services (*e.g.* GPs, hospitals, *etc.*), they said that they were generally happy with the quality of the support they received, and this was especially the case when they compared the services to those in their home countries. However, the lack of interpreters and information available in their own languages was reported as a problem for those older men whose English proficiency was limited. These men commonly described taking family members to medical appointments to act as interpreters, but that this was not always a desirable or appropriate strategy, as illustrated in the

following comment: 'There are some personal issues that he can't explain to his daughter and have his daughter hearing it' (Interpreter translation of Turkish man).

The key informants and older men in this study shared similar perspectives about the barriers to accessing health and support services, namely knowledge of the system, language and communication, as well as pride and fear.

The role of work, family and ethnicity

Work, employment and retirement experience. Employment and retirement were reported by key informants to be critical considerations for understanding the health and wellbeing of these older men. Employment, they said, was intricately associated with older men's identity, sense of worth and role in the family, with retirement posing a significant risk for social isolation. They talked of their experiences that these men will work until they drop, often maintaining heavy workloads.

While only seven (27%) of the men reported still being in part- or full-time paid employment, through discussions with the men it was clear that many of the men were still involved in ongoing unpaid employment (*e.g.* the Macedonians worked to assist their children on family farms). For the Turks, paid employment constituted hard physical labour in factories or on orchards. Regarding work, an Albanian participant noted: 'It keeps your mind occupied. If I didn't work I think I don't know what I would do. You have got to be doing something'. In all instances, paid or unpaid employment appeared to dominate these men's lives.

For those associated with family businesses (particularly the farm-owning Macedonians), there was little intention or thoughts of retirement. Particularly in current hard times (*e.g.* the increasing price of water), the men saw it as their ongoing duty to keep the family business going for the next generation. The introduction of new technology in agricultural practices was perceived as a burden for the men – as was having a farm as an asset, which deemed them ineligible for a pension, which they strongly felt they deserved, having worked so hard and paid taxes all their lives.

While the Macedonians tended to convey that there was a lack of activities to keep them occupied in later life, in contrast, the Italian group reported to be generally enjoying retirement, and participating in family and social activities.

The role of family. For the key informants, family was identified as critical for not only understanding and promoting the health and wellbeing of these older men, but also for thinking about ways in which to engage these men

in actively managing their health and wellbeing. The family unit was reported to be central in their lives but family members were also noted to act as gate-keepers in their role as carers. Families were often noted to refuse assistance (sometimes due to cultural values), commonly leading to a burden on the children and a reliance on them to be used as interpreters within the service system. Women and daughters in particular were identified as carrying a substantial load in this regard. Cultural beliefs and attitudes about the expectation that family members will support one another have led to hesitations and lack of willingness of families to accept and use formal support services, particularly nursing homes.

A high proportion (92%) of the men in this study were married and spoke about the important role their wives played in ensuring they ate regular and healthy home-cooked meals, as well as encouraging them to seek medical attention when needed. Men from all groups emphasised that the family unit was integral to their cultural traditions. For the Italians especially, personal matters were reported not to be talked about outside the family unit, primarily due to not trusting others with personal details, particularly due to the rate at which gossip spreads, and they appeared afraid of being the subject of social judgement and bringing their family name into disrepute. Whilst the success and ongoing interaction with their children was important, the men's relationships with their wives were deemed central.

Despite high expectations on family for support, there was some acknowledgement that given the increasing pressures on their children (particularly bringing up their own children) that the men's attitudes and expectations are changing. There was an understanding that their children are more 'Australianised', and that they did not necessarily want to take on the family business, marry within the community and live in the same town. The expectation that each generation must provide for the next was closely associated to the role they played in their families, as head of their own home, and of being respected. Despite this predominant attitude, the desire to live with their children was not always apparent, as was the case for one Italian participant and his wife who declined an offer to live with their children in Melbourne.

All participants (whether service providers, community leaders or older men) emphasised the central role that family, and the community at large, played in older men's overall wellbeing and sense of belonging and worth. However, key informants were more likely to conceptualise the central role of family as being somewhat problematic in relation to accessing appropriate services to support health and wellbeing.

Cultural diversity and identity. All key informants reported that people from different ethnic groups have different health and wellbeing experiences

and issues based on many different factors (*e.g.* migrant experience, reason for migration, home country politics and values, level of education, religion, health service system in home country, attitudes, *etc.*). They acknowledged that these differences need to be considered in any health-related interventions and promotion.

The older men in all the groups confirmed the perspectives held by the key informants, identifying the important role of their home country's traditions and culture. Importantly, they emphasised that their cultural background was integral to their identity and wellbeing. Maintaining cultural traditions, such as eating traditional foods, living close to family and adhering to religious practices, was a key factor in the older men's sense of wellbeing. One Italian participant said that 'as you get older you go back to your roots' and that 'with Italian people you do feel better', which illustrated the importance for him of his past and where he came from, and that by surrounding himself with Italians it made him feel good perhaps because he could connect with his past and his identity.

For the Albanians and Turkish men, the role of community was also particularly significant, and this was associated to their religious beliefs (being Muslim). They upheld a strong belief that the strongest members of the community looked after the most vulnerable.

There were no significant discrepancies found between the perspectives of the key informants and the older men, with all participants highlighting and confirming the great importance of work, family and ethnic identity in the lives of older ethnic men.

Discussion

Many of the men in this study migrated to Australia with very little, particularly in terms of financial resources or schooling. They were largely young and single, and were willing to work hard to build a new life. Many established farms in regional areas, met their wives and raised a family. Now, in their later years, and with less physical capacity, their children are growing up as first-born Australians, often with a different set of values and priorities. The changes impacting the agricultural industry (*e.g.* drought, flooding and technology) along with changing family values and structures are presenting some challenges for these men. These challenges are resulting in adverse health consequences (*e.g.* high blood pressure, anxiety and stress) which the men may be ill-equipped to manage. Combined with the generally low levels of education, as well as poor English proficiency and health literacy, the concerns of service providers and community leaders in this study about the health and wellbeing of these older men appear to be mostly well founded.

Findings from this study indicate that service providers, ethnic minority community leaders and older men themselves acknowledged the complex health issues and challenges faced by ethnic minority older men as they age in a rural community. Moreover, all participants were aware of the barriers faced by men, particularly older men from ethnic minority backgrounds, to access appropriate health and support services (*e.g.* language and communication, denial of health problems, health risk behaviours, health literacy), and these issues are well supported by existing literature (Bambling *et al.* 2007; Fuller *et al.* 2000; Kiropoulos, Blashki and Klimidis 2005; Radermacher, Feldman and Browning 2009; Ricciardelli, Mellor and McCabe 2012).

Of significance to the men in this study, which was acknowledged by all participants, was the role of work and their ongoing responsibilities and identity as heads of their families. There was also a prevalent assumption held by many of the older men that family will be available to provide support and assistance as they age. However, increasing levels of stress were evident amongst the men, particularly related to coming to terms with their decreasing levels of capacity to sustain a workload, and the decreasing capacity and willingness from families (particularly children) to provide support.

Importantly, the study did not paint an entirely bleak picture, confirming the necessity of seeking out the perspectives of older men themselves. Service providers, with a health perspective, had a tendency to frame older ethnic minority men as problematic, particularly in relation to their health, and lack of health-promotion and help-seeking behaviours. This was also evidenced by the initial approach to the research team and questions asked by the funding body, particularly about barriers to accessing services. Rather, this study served to challenge some of the stereotypes about older men being immovable in their beliefs and behaviours. From the men's perspective, there was evidence of a greater understanding and awareness about healthy living than often they were given credit for (*e.g.* awareness about diet, exercise, smoking, *etc.*). There was also evidence of a shift in the attitudes (*e.g.* expectations of family support) and behaviours (*e.g.* exercise, healthy eating) of the men, via the comparisons they made to the generations that came before them. Furthermore, the men talked about their experiences of migration and working extremely hard, demonstrating evidence of great resilience and resourcefulness. Their ethnic identities and values were clearly integral to their sense of who they were and how they lived their lives. While participants in this study appeared to acknowledge the importance of ethnic identity and its associated factors for the effective delivery of services, this is perhaps an issue that is overlooked (and constructed as a problem rather than a resource) by mainstream service providers. This not only risks the development of culturally inappropriate and unresponsive services

(that often will not be used), but also fails to build on the strengths and existing resources available to these older men.

This study did not specifically seek to examine and compare mainstream service provider perspectives with those of ethnic minority older men, but this area does warrant further investigation; particularly, given that this study has highlighted inconsistent perspectives about older ethnic minority men's health literacy and their comprehension of service systems. Addressing these discrepancies in understanding may be important for developing more appropriate health-promotion strategies, including how information is disseminated and the availability of interpreters. Managing a range of health conditions requires quite sophisticated knowledge and access to information about the Australian health system, which older men do not necessarily have. Coming from a minority ethnic background can exacerbate the problems that men face as they grow older, and it cannot be assumed that because men have grown up in Australia that they understand the complex health and support systems.

Older people, and particularly those from ethnic minority backgrounds, are often constructed as a homogenous group both in policy and planning documents as well as in the popular press. This approach can be problematic, especially when people from ethnic minority backgrounds are labelled as being at risk, or illiterate, because the whole group tends to get labelled accordingly. However, this study, and many other studies, reinforces our understanding that people from different ethnic backgrounds are as diverse within as they are across groups due to a whole range of factors (LaVeist 2000).

Implications for health and service delivery

A policy of multiculturalism necessitates a culturally responsive service system that is equitable and inclusive of all different cultures. The lower rate of service usage by people from ethnic minority backgrounds indicates that the current service system is not commensurate with Australia's espoused multicultural policy. Furthermore, it is indicative of a service system that still operates according to the previous policy of assimilation whereby people from ethnic minority backgrounds are expected to fit into existing service delivery frameworks.

There are important implications of this study for health-service delivery, not only for nations that espouse a multicultural policy but for all nations in a world with increasing numbers of migrants. In particular, it may be important to focus on the migration experience and everything migration entails, in addition to ethnic identity *per se*. Furthermore, in developing

and delivering services, it may be helpful to consider both the strengths and challenges of a whole range of factors, such as English-language proficiency, age, gender, rurality, literacy, education, religion and cultural traditions.

The suggestions by key informants in this study demonstrate growing acknowledgement and consideration of the diversity of migrants, particularly in thinking about person-centred care and ways in which to talk about health on their terms. Innovative culturally and linguistically responsive community-based models that engage with older men from ethnic minority backgrounds, which acknowledge the integral role of work, family and ethnic identity are required. Importantly, these models also require comprehensive consideration for how to develop and deliver appropriate and responsive health-promotion materials and information for older ethnic minority men who do not necessarily have literacy or English-language skills. In highlighting such suggestions, we are not necessarily implying that the men do not benefit and appreciate current support and access to services, but alternative more exploratory approaches, services, strategies and policies may be more effective. This study has identified that service providers may not be fully aware of the diverse experiences and behaviours of older ethnic minority men, and as such engaging older men themselves may serve to foster greater mutual understanding and subsequently the development of more effective services.

Conclusion

In this paper, we drew on data from a study which explored ageing well in older men from four minority ethnic communities (Albanian, Macedonian, Italian and Turkish) in regional Victoria, Australia. We have considered how the lives of older men who participated in this study are influenced by a whole range of factors beyond that of ethnic identity alone. Namely their lives are inextricably influenced by their migration experience, ageing in a foreign land, their gender, where they live, the language they speak, spirituality, educational background, their family and occupation. For this reason, we continue to advocate that in thinking about and addressing the welfare of people from ethnic minority backgrounds, ethnic identity is only part of a complex tapestry for policy makers, practitioners and researchers alike to consider as people age.

In this study, ethnicity was integral to the men's identity, and having the opportunity to enact and express their ethnic identity was important for maintaining their health and wellbeing. However, their ethnic identity was not who defines them. These older men were not homogenous, but diverse on many levels. Their identity and experiences were dynamic, fluid and socially constructed, and most importantly, a resource.

Migration and ageing are, and continue to be, both an inevitable and valuable part of the Australian and global landscape. Therefore, innovative, flexible and responsive policy and practices and ongoing work and commitment are required to ensure the optimal quality of life for people from all cultural backgrounds as they age, and for the future generations of people who will continue to make Australia their home.

Acknowledgements

We acknowledge the generosity of the participants who took part in this study, as well as the Regional Information and Advocacy Council which was integral to its implementation. We thank Tiasha De Soysa for her assistance in an earlier version of this paper.

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Accepted 26 September 2014; first published online 17 November 2014

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