Exploring the Social and Health Needs of Chinese Baby Boomer Migrants in Brisbane, Australia

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Abstract

Australia’s population is ageing rapidly with growing demands for health and aged care services. Providing these ageing populations with adequate, affordable and sustainable healthcare poses significant challenges for the government. It is even more challenging to plan for the upcoming large number of ageing and retiring baby boomers born between 1946 to 1964, who are the first generation to face the new ‘third’ age: a decade or two of longer life after retirement. Current aged care planning is largely based on data collected from previous generations with little focus on this bulging baby boomer generation, whose experiences and expectations greatly differ from those of the previous generations.

Among the Australian baby boomer cohort are the growing culturally and linguistically diverse (CALD) populations. Previous studies demonstrate that Australia’s CALD migrants’ social circumstances, language and cultural issues result in programs delivered failing to meet their needs. But few examine what these needs are and the factors underpinning them. This is the case for Chinese migrants, the fastest growing and largest subgroup of the CALD baby boomer population. Information about their experiences and social and health needs is very limited, making it difficult for health planners to provide them with timely and appropriate information, supportive resources, and culturally-sensitive services. Thus, this study investigates the social and health needs of Chinese baby boomer migrants in Brisbane, Australia so as to inform the future development of policies and programs that promote their health and wellbeing.

This research adopts WHO’s concept of the ‘healthy ageing’ approach as the theoretical base for the methodological design. Healthy ageing is about planning health programs that promote active and healthy life stages in order to achieve healthy life expectancy. To this end, this study applies a comprehensive needs assessment framework to identify issues of concern, the various determinants of health and potential solutions from different perspectives, from the users to experts and beyond.

This study uses multiple qualitative data collection methods: literature review, in-depth interviews, expert consultations, existing secondary data collection, and focus group discussions. As a resource limited PHD project, this study is exploratory by nature. It had a small sample of thirty-two participants (Chinese baby boomer migrants living in Brisbane),
and twenty-five informants (workers with the Chinese communities). The study was conducted from November 2013 to March 2016 in Brisbane, Australia.

The study has resulted in rich insights about the participants’ experiences, social and health needs from various perspective. There are two key findings: 1) participants’ experience of having to cope with “changes”, and 2) issues and gaps in service-provision and programs. Participants have to deal with many physical, financial and social changes including relationships, children leaving home, or relatives’ death or illnesses, and, importantly their housing needs. In addition, participants long for ageing-in-family, but there are challenges to this in Australia. This study also found many issues relating to programs delivery. For example, health professionals need to ensure that their programs are delivered in not only appropriate languages, but also dialects to ensure program success. Finally, the majority of participants wish for more affordable traditional Chinese medical services and culturally sensitive information.

There are four major recommendations from this study;
1) Develop social and health service policies and plans that target baby boomers in Australia; 2.) Conduct a more extensive comprehensive needs assessment incorporating relevant stakeholders’ perspectives to inform the development of useful, culturally appropriate programs to meet baby boomers’ needs; 3.) Provide relevant information, networks, resources and support measures to help Chinese baby boomer migrants cope with the social and health changes that they face; and 4.) Facilitate the provision of affordable traditional Chinese health services.

This study’s findings have filled existing knowledge gaps Chinese baby boomer migrants’ issues and needs in Australia, and informs future program developments to address their needs. Hopefully future policies and social and health services programs will promote healthy ageing and quality of life for Chinese baby boomer migrants in Australia. This study’s methodological framework and findings may have implications for social services and health planning for other CALD groups beyond the Chinese migrant population in Australia.
Declaration of Originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Signed

Date: 29 June 2019

Christiana Chau-Yang
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<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>CALD</td>
<td>Culturally and linguistically diverse</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<td>ASGS</td>
<td>State suburbs based on the Australian Statistical Geography Standard</td>
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Publications

2 papers have been developed from this thesis. Paper arising from Chapter 7 and Chapter 8:
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Chinese baby boomer migrants in Brisbane, Australia

A paper developed from Chapter 8:
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When published, full copyright of the article is with the Journal of the Australian Traditional
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Acupuncture and Chinese Medicine Annual Conference (AACMAC) at the Brisbane &
Exhibition Convention Centre, Brisbane, Australia.

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South Australia.

2016 Conference, Perth Australia.

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and Exhibition Centre, Australasian Acupuncture & Chinese Medicine Annual Conference,
Brisbane, Australia.

Chapter 1
Introduction

1.1 Introduction

Australia’s rapidly ageing population is one of its most challenging demographic changes, with significant social and health services implications. In Australia, there has been much government attention and policy discussions regarding planning for the growing demand of health and aged care of the elderly population. But, few foci on the upcoming large cohort of baby boomers, the 5.5 million people born between 1946-1964, whose life experiences and expectations are described as “profoundly different from those of previous generations” (NSPAC 2012). Among the baby boomers is a growing number of culturally and linguistically diverse populations (CALD). While studies show evidence that Australia’s CALD migrants’ social circumstances, language and cultural issues result in many challenges to meeting their health needs (Chu & Leasure, 2010; Tan et al., 2010; Khoo, 2012), few examine in detail what these health needs are.

This is particularly the case for the Chinese, the fastest growing and largest subgroup of CALD baby boomer migrant population. The paucity of information about their needs and concerns, making planning social and health services to support their healthy ageing challenging. In order to fill the knowledge gap, this study investigates the social and health needs of Chinese baby boomer migrants so as to inform future development of policies and programs that promote their health and wellbeing.

This chapter provides an overview of the study. It begins with discussing the background to this research followed by explaining the rationale and the aim of this research. It then provides a brief description of the methodology and the scope of this study. The final part of this chapter will present the structure of this thesis.

1.2 Background and rationale

Australia is facing an unprecedented demographic change; a rapidly ageing population, which poses significant challenges for its policy makers (Christensen et al., 2009; Aldrich, 2010). The increasing proportion of aged and retired Australians will challenge Australia’s social security, health and aged care systems and economic growth (AIHW, 2007). The growing
demand for social and health care provisions of the ageing of populations will challenge the government's capacity to provide sustainable and equitable healthcare and aged care services (AIHW, 2011).

Australia's ageing population is the result of rising life expectancies and falling mortality rates (ABS 2017). More and more people are living longer hence the proportion of people aged 85 years and over has doubled since 1990 to 2010 (AIHW, 2016). As a result of the rise of life expectancy and the fall of the fertility rate after the Second World War, there is a large number of upcoming retiring and ageing baby boomer population, who will live long after their retirement.

The Australian baby boomers are described as the first generation “to face the new ‘third’ age”- a decade or two of longer life after retirement (NSPAC, 2012). Current aged care planning is largely based on data collected from previous generations (AIHW, 2016). There is little focus on this bulging baby boomer cohort who are fast approaching or entering retirement age who have different experience and expectations from previous generations (Franklin, 2012).

Moreover, the ageing baby boomers will be the main drivers of healthcare expenditure, with further implications for Australia’s social security, healthcare and aged care resources. Studies have already found that Australians are living longer with rising life expectancy, but not a healthy life expectancy (AIHW, 2010). There is an increasing prevalence of chronic diseases and comorbidities as the population ages. In order to provide sustainable and equitable healthcare services for this rapidly increasing number in the ageing population, the Australian government has adopted the “healthy ageing” approach, a concept initiate by the World Health Organisation to encourage countries to provide health promotion programs to support health development of the ageing populations. In essence, healthy ageing is about planning for health programs to promote an active and healthy life stages in order to achieve healthy life expectancy. However, planning for the upcoming ageing baby boomer population toward healthy ageing is challenging for various reasons.

Firstly, there is limited information about the baby boomers' health needs. All the current data collected from the previous generations have different characteristics and expectations from those of the baby boomer generation. Planning for this large ageing cohort based on mostly
information collected from the previous generation is inappropriate, and thus require more information about the current cohort of baby boomers. Secondly, the Australian baby boomer cohort has diverse backgrounds, because Australia has been recruiting workers from a wider range of countries to maintain its economic growth. As a result, Australia has a significant number of immigrants from non-English speaking and cultural and linguistically diverse backgrounds (CALD). For example, the 2011 census has shown that over a quarter of the Brisbane residents were born overseas. At 30 June 2016, 28.5% of the estimated resident population (ERP) was born overseas (6.9 million persons). This was an increase from 30 June 2015, when 28.2% of the population was born overseas (6.7 million persons). In 2006, ten years earlier, 24.6% of the population was born overseas (5.0 million persons).

Studies have shown that the current Australian healthcare system has failed consumers in the CALD group, because of the lack of information about their health needs (Chu & Leasure, 2010; Tan et al., 2010; Khoo, 2012). Among them, the largest and faster growing CALD sub-group of baby boomers is the Chinese migrants. But planning for the Australian Chinese baby boomer migrants' health needs is difficult as they came from many different places and countries of origin, settled in different locations, under different immigration programs with different socioeconomic and linguistic background. More importantly, there is very limited data on their health needs.

1.3 Aim, scope and objectives of the research

The overall aim of this study is to promote Chinese baby boomer migrants' health and wellbeing. The goal of this study is to understand the many factors that influence their healthy ageing process, with a focus on the socio-cultural determinants of health. The objectives of this study are to explore and identify Chinese baby boomer migrants' social and health needs, in order to provide information to health care providers for future development of social and health services to support the healthy ageing of the Chinese baby boomer migrants in Australia.

For this PHD study, the scope is limited to a small-scale qualitative exploratory study, applying a comprehensive community needs assessment framework (see further information from 1.4) to gather information from four sources: the literature, the experts and health care professionals, the community organisation program managers, and the participants.
The overall research question is: What are the social and health needs of Chinese baby boomers in Brisbane, Australia? To answer the research question, there are four focus questions (FQ):

FQ1 What are the health needs of Chinese baby boomer migrants according to the Australian Chinese baby boomer migrants themselves (felt needs)?

FQ2 What are the health needs of Chinese baby boomer migrants according to statistics and/or census and/or surveys (expressed needs)?

FQ3 What are the health needs of Chinese baby boomer migrants according to experts and professionals (normative needs)?

FQ4 How do other developed countries in similar circumstances meet their Chinese baby boomer migrants’ health needs (comparative needs)?

FQ5 What are the key recommendations based on the needs assessment about potential policies and programs to meet the social and health needs of the Chinese baby boomer migrants in Australia?

1.4 Theoretical base, methodology and data collection methods

WHO defines health promotion as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health"(WHO, 1986). This definition highlights the importance of addressing multi-determinants of health (multiple factors affecting health). In order to assess and mitigate the determinants of health, it is necessary to identify issues and support needs from multiple perspectives: from the community themselves, the providers and relevant stakeholders, and experience from other communities with similar circumstances.

Thus, to guide the design of data collection, and in line with the theories and concepts of health promotion, this study has adopted the comprehensive Community Needs Assessment methodological framework developed by Chu for health promotion programs development (2005). The methodological framework is based on Bradshaw’s concepts of four types of needs (comparative needs, expressed needs, normative needs, and felt needs) (1972), representing the inputs from literature and secondary data, policy makers, experts, practitioners, and community members, in order to identify issues, concerns and potential strategies for health-promotion (See Chapter 5 page 60 for further details).
1.4.1 Methodology
This study is a qualitative study using multiple data collection methods: in-depth interviews, expert consultations, existing secondary data collection, participant observation of program activities, and focus group discussions. The stakeholders – the participants and informants, residing in Brisbane (Ip, 2007), were recruited by purposive, convenience and snow-ball sampling. The research participants consist of thirty-two Australian Chinese baby boomer migrants, born overseas between 1946 - 1965, are now residing in Brisbane area. They speak Chinese as their first language. There were also twenty-five informants who are professionals and experts who work with the Chinese community. The study’s field work was conducted from 2013 to December 2016. Primary data were collected from semi-structured in-depth interviews, focus group discussions and participant observation. Literature reviewed provided secondary data.

1.5 The structure of the thesis
Apart from this Introduction chapter, the thesis will be presented in two parts. Part One provides an extensive literature reviews to explain background and rational of the study. There are three chapters in total (Chapter Two, Three and Four). Part Two presents the Methodology and reports study findings. There are Five chapters from Chapters Five to Nine.

Chapter 2 focuses on Australia’s ageing population. It discusses the factors that contributed to Australia’s ageing population and its implications. It also examines the polices that the Australian government uses to deal with the issues arise from an ageing population. Chapter 3 reviews the literature about the Australian baby boomers’ characteristics, profiles and the challenges they face. Chapter 4 discusses the literature on non-English speaking and overseas born culturally and linguistically diverse groups in Australia, especially the Australian Chinese migrants. It focuses especially on the Australian Chinese migrants’ migration history, their settlement experiences in Australia, and their characteristics. There is plenty of studies about Chinese migrants’ cultural background, but a lack of information about the Australian Chinese baby boomer migrants’ health needs.

Part Two focuses on the methodology and findings from the field study. Chapter 5 discusses the research methodology. It begins by laying out the theoretical base and explains the research questions and focus questions. It then presents the conceptual framework of this study, describing the research design: research methods of data collection and analysis, and
their validity and reliability. Chapter 6 gives a snapshot of the socioeconomic and demographic profile of the participants residing in Brisbane (Australia) and the services provided by the Australian government and the Chinese community. Chapter 7 presents the normative and comparative needs: findings collected from the experts and professionals working within the Chinese community in Brisbane. It also includes secondary data on comparative needs. Chapter 8 reports the felt needs from the participants concerning their settlement experiences, their physical, social and spiritual needs, and their health beliefs and health practices. Chapter 9 summarises key findings of the study, and conclusion of the whole thesis. It provides recommendations to support the health needs of the participants and includes a discussion of the implication of the findings to future research into this area.

1.6 Conclusion

This chapter provides a synopsis of this thesis. It presents the background and rationale of this research, methodology and the scope of the study. It also describes the structure of the thesis. The following chapter discusses the factors that brought about Australia’s ageing population and its challenges.
Part 1: Literature reviews

Chapter 2

Australia’s ageing population

2.1 Introduction

Australia’s population is facing one of its most significant demographic changes – ageing of the population. Ageing of the population is increasingly important because it brings about social, economic, and policy changes, which impacts on Australia’s provision for health care, aged care and housing needs of the population (Bloom et al., 2010; Bloom et al., 2015). There are numerous studies about Australia’s ageing population, but there is a lack of information about policies that promote population ageing successfully, especially as a multicultural society with a growing number of people from culturally and linguistically diverse backgrounds.

This chapter begins by presenting Australia’s demographic profile and outlines the underlying factors that have contributed to changes in Australia’s demographic profile: falling fertility and mortality rates, rising life expectancy and immigration. That is followed by a discussion of the issues of Australia’s ageing population associated with demography, economy, social security and its health and aged care resources. Then the chapter discusses the Australian policies used to deal with the effects of the population ageing. Finally, it identifies the diversity of this ageing population, especially the next generation of ageing baby boomers.

2.2 Australia’s changing demographic profile (Figure 1 and 2)

Australia’s population is ageing because there are proportionally fewer children (under 15 years of age) in the population and a proportionally larger number of those aged 65 and over. The median age (the age at which half the population is older, and half is younger) of the Australian population has increased from 34 years in 1997 to 37 years in 2017 (ABS, 2017).

Between 1997 and 2017, the proportion of people aged 65 years and over increased from 12.1% to 15.4% of the population, and the proportion of people aged 85 years and over increased from 1.2% of the total population in 1997 to 2.0% in 2017. In contrast, the proportion aged under 15 years decreased from 21.2% to 18.8% in the same period.
In the past century, the population aged under 25 has declined from 54 percent of the total population in 1901 to 3% in 2010 (AIHW, 2018). In contrast, in 1901, people aged 65 or over comprised 4% of the population, compared with 13% in 2010 (AIHW, 2018), and 15 percent in 2016 (AIHW 2018). In 2016, approximately 3.7 million people (15% of Australia’s total population of 24.3 million) were older Australians i.e. people aged over 65. Just over half of them (57%, or 2.1 million) were aged 65–74, one-third (30%, or 1.1 million), were aged 74–84 and 13% (487,000) were aged 85 and over (Figure 1 and Figure 2). By 2046, it is projected that there will be about 7.3 million older people; more than 3.3 million people aged 65–74 (about 45% of over-65s), 2.6 million people aged 75–84 (35% of over-65s) and 1.4 million aged 85 and over (19% of over-65s) (AIHW, 2018).

Figure 1: Population growth indices by age group
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Figure 2: Percentage of the Australian population aged 65 and over, at 30 June, over time
Sources: AIHW, 2018b
By 2031, it is projected that the proportion of people aged 65 and over in the total population will increase from 13.8% to 18.7% (AIHW 2018b). This means that there will be fewer people of traditional working age compared with the very young and the elderly. The number of people aged between 15 and 64 (the working age) for every person aged 65 and over has fallen from 7.3 in 1974-75 to an estimated 4.5 people today. By 2054-55, this is projected to nearly halve again to 2.7 people. (IGR, 2015)

2.3 Factors that contributed to the ageing of the population

There are mainly two factors that contributed to the ageing of the Australian population: the decline in Australian’s fertility rate and the rise in Australians’ life expectancy.

2.3.1 Decline in fertility rate

Australians are, on average, having fewer children. Almost all the women in Australia, whether they are categorised by age, marital status, occupation or education, are having fewer children. The fertility rate in Australia has gradually fallen since the peak fertility rate of 3.55 was recorded in 1961, followed by a steady decline till 2001, when the lowest fertility rate of 1.74 was recorded. There has been a gradual increase in birth rate since Australian policy makers introduced a federal tax rebate payment of $4,000 per child to first time mothers in 2002. The birth rate rose again until 2008, then it slowly declined to 1.79 in 2016 (ABS, 2016). Consequently, the total fertility rate for Australia has been below replacement level, causing a decline in the proportion of younger people in the population, as shown in Figure 3.

Figure 3 shows the projected fertility rates, suggesting that the fertility rate may not reach the replacement rate in the future. (Replacement level is the total fertility rate that will bring about a stable population from generation to generation). Several factors that could have contributed to the decline of Australia’s fertility rate are discussed further in Chapter 3.
2.3.2 Other contributing factors

Life expectancy in Australia has improved dramatically for both sexes in the last century. Life expectancy is commonly used to measure how long, on average, a person is expected to live based on current age and sex-specific death rates. The increase in life expectancy at birth is a product of declining death rates for most age groups.

<table>
<thead>
<tr>
<th>Year</th>
<th>Life expectancy in years</th>
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<tr>
<td>1993</td>
<td>77.88</td>
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<tr>
<td>2000</td>
<td>79.23</td>
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<td>2013</td>
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<td>2014</td>
<td>80.3</td>
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<td>2016</td>
<td>91.5</td>
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Table 1: Life expectancy in years in specific years.

AIHW, 2018
In 1901-1910, male and female Australians at 75 years old would live for another 6.6 and 7.6 years respectively. In contrast, in 1993, male and female Australians aged 75 could expect to live another 9.5 years and 12.0 years respectively, as shown in Table 1 (AIHW, 2018). Male life expectancy has improved more than female life expectancy in recent years. In the past 10 years, life expectancy has increased by 1.7 years for males and 1.1 years for females. In 1971, life expectancy at birth in Australia was 68.3 years for males and 74.8 years for females, a gap of 6.5 years. This gap has now narrowed to 4.1 years in 2014-2016 (AIHW, 2018), as shown in Figure 4.

![Life expectancy at birth (years)](chart)

**Figure 4: Life expectancy (years) at birth by sex, 1881-1890 to 2013-2015**

AIHW, 2018

These improvements in life expectancy are the results of medical and technological advancement, and safer working environments. The rising life expectancy is also related to falling mortality rates. In 2016, the standardised death rate (SDR) decreased slightly to 5.4 deaths per 1,000 standard population, following an SDR of 5.5 in both 2014 and 2015. Increased life expectancy at all ages since the latter half of the 20th century is largely the result of the decline in the age-standardised death rate from various conditions (AIHW, 2018).

Studies credit this phenomenon to a combination of factors: such as ongoing medical advances, leading to improvement in prevention and treatment of diseases; continued improvements in living standards and work environment; healthier lifestyles, improved nutrition levels, better sanitation, water and sewerage control. Early diagnosis of various
chronic diseases such as cancer and cardiovascular diseases and improved treatments have also contributed to the decrease in the death rate (Figure 5).

![Figure 5: Standardised death rates: 1976 - 2016](image)

AIHW, 2018a

2.4 Implications of the ageing of Australia’s population

There are many issues associated with the ageing Australia’s population: the impact on Australia’s economy; the shrinking labour market; the increase demand on its healthcare and aged care services; together with the rising health cost.

2.4.1 Impact on Australia’s economy

There is a looming budget and economic crisis if Australia’s policy makers do not undertake pre-emptive social and fiscal reforms now (2015, IGR Intergenerational report). Policy makers are concerned about the effect of the shrinking labour supply, which will lead to a fall in government income from tax revenue (Drabsch, 2004). Some economists project that the shrinking tax revenue will not be able to sustain the increasing number of elderlies relying on
the already stretched social security, healthcare and aged care systems (Drabsch, 2004; National Seniors, 2011; Tamiya et al., 2011).

Spending by the Australian Government is projected to exceed the amount it raises in taxes by around 5% of GDP by 2041-42, which means that instead of a surplus of $4.6 billion, Australia will have a deficit of around $40 billion (IGR, 2015). Demand for long-term care, health insurance and management of the funding will continue to rise as the demand from an ageing population escalates (Tamiya et al., 2011). Australia’s healthcare expenditure has escalated at such an alarming rate, by about 70% in the past decade, that it may reduce Australia's ability to care for the ageing population (Aldrich, 2010; Howse, 2010). Studies suggested that costs in the health sector have grown quicker than the Australian economy as a whole over the past 10 years (Banks, 2008). Projections shown in Figure 6 indicate that the Australian Government’s spending on health, aged care and aged pension will escalate disproportionately compared with other government expenses over the next four decades (IGR, 2015). Thus, the impact on the nation’s economy is likely to be dramatic.

Figure 6: Projections of Australian Government spending
Source: Treasury.
2.4.2 Shrinking labour market

While Australia's fertility is falling, its workforce is shrinking (Lu et al., 2011). One of the problems for the next generation is that the ratio of the number of people of traditional working age (between 15 and 65) to retirees (above 65) will be halved. In 1970, there were an average of 7.5 people in the workforce relative to those retired. This has shrunk to 4.5 today. By 2042, it is projected that there will only be 2.5 people of working age supporting each retiree (IGR 2015).

Some authors have suggested that Australia’s shrinking workforce and labour shortage will jeopardise productivity at work and slow down Australia’s economic growth over the next 40 years (Draper & Anderson, 2010; Graham & Duffield, 2010). More significantly about 50% of men and 20% of women retire early because of ill health, indicating that poor health is potentially a limiting factor for economic growth (Schofield et al., 2007). Hence, promotion of health may allow more people to remain in the workforce, however, there is a lack of information available to older workers to maintain their health.

2.4.3 Greater demand for health services

Overall the use of health services is increasing faster than population growth in Australia (AIHW 2012). Total health expenditure has risen from $72.2 billion (7.9% of GDP) in 1991, to $121.4 billion (9.4% of GDP) in 2010 (AIHW 2012). Australian Government real health expenditure per person is projected to more than double over the next 40 years. Over recent years, total health expenditure has grown continuously, from $95 billion in 2003–04 to $155 billion in 2013–14, with an average annual real growth of 5.0%, 2.2% points higher than the 2.8% growth in GDP. Overall, Australia’s health cost has risen higher than its gross domestic product (GDP). Health economists such as Banks (2008) projected that Australia’s healthcare cost will rise to more than 10% of Australian's GDP by 2044–2045, however, Table 2 shows that it has already reached 10% in 2014-2015. This rising cost of healthcare resources is undermining Australia's economic growth (Fry, 2010; Huber et al., 2011). With an ageing population, studies have shown that the growth in the costs of many services, especially in health, will put pressure on the budget and threaten the sustainability of those services. Each day Australians’ spending exceeds Government revenue by more than $100 million, which must be borrowed and eventually becomes a threat to our social security and stability (IGR, 2015).
There are several factors that contribute to rising health cost, such as the increasing cost of the new biomedical technological advancements in health, and the demand for higher quality health services by people of all ages and Australians' health beliefs and health concepts (AIHW, 2016). The Commonwealth Treasury also recognised that non-demographic growth, such as the growth of inflation and technology, has been a key factor of the increasing healthcare expenditure. There are two significant factors that contribute to rise in health cost: the rise of life expectancy and age-associated health conditions and the change of disease pattern from infectious diseases to chronic diseases (AIHW, 2009; AIHW, 2010).

### 2.4.3.1 Rise of life expectancy

The rise of life expectancy means a rise in associated health conditions. One thing that most researchers agreed on is that health and aged care costs increase with age (Harris and Sharma 2018; King & Guralnik, 2010). The societal expenditure per person over the age of 60 years continues to grow with age, so that the amount spent per person 75 years and over is more than double the amount spent on a person 60-64 year old (Banks, 2008).
In general, it is easy to attribute the rise in healthcare costs to an ageing population because health usually deteriorates with age as shown in Figure 7 (The Health of Queensland 2012). In 2000-2001, 12.5% of the population were aged 65 and over, yet they accounted for almost 40% of the health expenditure (Drabsch, 2004). Average healthcare expenditure on those older than 65 was around $5200 per person (2002–2003), which was three times greater than for those aged under 65 (Banks, 2008). Studies have found that people aged 65 and over consult more often with their doctors and allied health professionals, are hospitalised more frequently and for longer periods. They also tend to consume more medication (Banks, 2008).

![Figure 7: Disability rates by age group and sex in 2009](https://example.com/figure7)

ABS, 2009

Studies have shown that a high proportion of older Australians have various long-term health conditions (AIHW, 2014). For example, the prevalence of long-term circulatory conditions increases with age, hence the cardiovascular disease burden increases markedly with age. Almost 19% of those aged 45 to 54 years had a current long term circulatory condition, rising progressively to 62% of those aged 75 years and over (ABS, 2009). For example, in 2012, a person aged 80 years or over was seven times more likely to have dementia or Alzheimer's disease (7.6%) as compared with someone aged 65 to 79 years (1.0%) (AIHW, 2016). Ageing is associated with increasing incidences of multi-morbidity (Jowsey et al., 2013), as shown in Figure 7. Nearly half of the Australians aged 65–74 have five or more long-term physical health conditions (AIHW, 2012a).

Some researchers predict that the societal costs of this ageing population will continue to rise because of age related disabilities and chronic diseases (Singh & Hubbard, 2011). There is an escalating prevalence of the age-associated chronic diseases, which rely on long term treatments and are highly dependent on medication, therefore pharmaceutical costs continue...
to inflate the healthcare costs in Australia at twice the rate of the Consumer Price Index (AIHW 2011).

2.4.3.2 Change of disease pattern

Most researchers have agreed that one of the factors that contributed to the rising cost of healthcare is the change in disease pattern in recent years. There is a shift from acute infectious disease to complex non-communicable chronic conditions. Almost 80% of the total burden of disease in Australia is covered by chronic diseases (Aldrich, 2010; Howse, 2010; Humpel et al., 2010; King & Guralnik, 2010). Research has shown that non-communicable disease is one of the leading causes of death, killing more people each year than all other causes combined. Chronic disease has become the principal cause of disability and the use of health services (Hall et al., 2012; AIHW 2016a).

Even though between 1983 and 2013 the death rates from chronic diseases fell, there is a rise in the prevalence of chronic diseases. In 2014 -15, more than 11 million Australians (50%) had at least one of these chronic conditions: arthritis, asthma, muscular skeletal pain, cancer, chronic obstructive pulmonary disease, cardiovascular disease, diabetes mellitus, or a mental or behavioural condition. Out of these 11 million people, 5.3 million had two or more of the eight chronic conditions. The number of new cancer cases diagnosed has more than doubled, from 47,400 to 130,500, between 1982 and 2016 (AIHW, 2016a).

Studies have found that life expectancy has risen as mortality from non-communicable diseases, such as cancer, cardiovascular disease, elevated blood pressure or cholesterol levels, chronic obstructive pulmonary disease/asthma and arthritis or other musculoskeletal problems, has fallen (AIHW 2012). In other words, more people are living longer with multiple non-communicable disease and co-morbidities. 49% of Australians aged 65–74 have five or more chronic diseases, increasing to 70% of those aged 85 and over. 35% of Australians, or around 7 million people, experience multiple chronic conditions (AIHW, 2012).

Most of the medical spending on healthcare services is for acute situations, which are often the by-product of chronic diseases, such as cardiovascular disorder, cancer, arthritis, osteoporosis, type 2 diabetes, hypertension, kidney and Alzheimer's disease (Graves et al., 2006; Shoham et al., 2008). More than half of all potentially preventable hospitalisations are
from certain chronic conditions, as a result, the prevention, management and treatment of chronic diseases impose a considerable burden on the health system (Humpel et al., 2010; Leskinen et al., 2012). Since 1999, the Australian government has encouraged Australians to be covered by private health insurance to ease the burden to the public health system (Van Doorslaer et al., 2008).

2.4.4 Growing demand for aged care services
As the Australian population ages, there is a growing demand for aged care services. Australian Government expenditure on aged care has nearly quadrupled since 1975. This expenditure is projected to nearly double again by 2055, as a result of the increase in the number of people aged over 70 (IGR, 2015). Australian government spending on aged care has increased 19% over the past 5 years from approximately $14 billion in 2011–12 to $17 billion in 2015–16. As the number of Australians aged 85 years and older quadruples over the next 40 years, the spending on residential aged care (e.g. nursing homes and hostels) is expected to escalate accordingly (AIHW, 2017 a).

Australian government provide many levels of care of the aged. In 2017, about four in five older Australians received some sort of government benefit. More than two thirds (70%) of government funding on aged care was spent on residential aged care, which is specialised accommodation for older people who are unable to live independently in their own homes. Home care for those living at home accounted for 26% of government funding (AIHW, 2017b). This includes help with personal care, services for transport, installation of things like handrails or ramps, meals, nursing, or walking frames. Flexible care (flexible places receiving short-term care after dealing with a setback like an illness or a fall) and service improvement, and assessment and information services accounted for just 5% of total spending as shown in Figure 8 (AIHW, 2018b). Even though AIHW (2016) reported that 67%, or 2 in 3 older Australians (2.4 million) did not use aged care services, yet between 2011–12 and 2015–16 there was an increase in spending on residential care, home care and support, and assessment and information services, as shown in Figure 9. (AIHW 2017a).

According to the ABS (2015) most Australians over age 65 were living in households (94.8%), while 5.2% of the population lived in care accommodation such as nursing homes. Despite the amount of funding being provided in aged care, almost one in three older people still living at home reported that their needs were not fully met, and this figure was even higher among those with a profound or severe disability (AIHW, 2017).
2.4.5 Contrasting arguments of the sustainability of Australia’s social and health care needs

Nevertheless, some researchers believe that Australia's ageing workforce will have negligible effect on its economy (Johnstone & Kanitsaki, 2009; Harvey & Thurnwald, 2009; Marszalek, 2012), as demonstrated by those countries that have rapidly adopted automation technologies (Acemoglu & Restrepo 2017). Some authors argue that in view of medical advances and health awareness, people are ageing differently from previous generations (Marshall, 2015). Better health as they age will lessen the need for healthcare services from the upcoming ageing baby boomers. Therefore, the prediction that Australia cannot sustain the future health
and social care needs of older Australians may be misleading (Johnstone & Kanitsaki, 2009; Jones & Higgs, 2010).

Surprisingly, while the proportion of older Australians has increased, the prevalence of disability amongst them has decreased. In 2015, 50.7% of people over 65 were living with a disability, down from 52.7% in 2012. Studies have shown that older Australians living in households are more active, with the proportion who participate in physical activities for exercise or recreation increasing from 44.5% in 2012 to 49.2% in 2015 (AIHW, 2016). If older people have less disability, there is a higher probability for them to stay at home instead of staying in aged-care facilities (nursing homes) (Roy et al., 2018). Unfortunately, there is a lack of information about maintaining their health and mobility.

2.5 Issues with the management of retirement villages
Nevertheless, while some authors in Australia have suggested that with aged population retirement villages or age-segregated ‘Active Adult Lifestyle Communities’ could be a viable accommodation option (Bosman, 2012) there are questions about these facilities. Many authors have explored the management of the retirement village industry and residents’ satisfaction in Australia (Hu et al., 2017). There are recent media reports about the issue of mismanagement of retirement villages in Australia. For example: residents of retirement villages have accused one of Australia’s largest property developers of raising fees and downgrading services since taking over management of some facilities (National Reporting), and staff at a private Melbourne retirement village were reported to have stopped work because they had not been paid in months (ABC News). In another instance, there were reports of retirement village operators owing staff their wages and owing residents the proceeds from the sale of their units (ABC News 2). These incidents suggest that there are serious problems with retirement villages or ‘Active Adult Lifestyle Communities’.
Therefore, Burgess (2010) suggests that older people need appropriate and timely information to help them make decisions about housing.

2.6 Government policies to deal with the effects of population ageing
Australian governments have used various strategies to ease the burden of social security for this ageing population. Australian government have implemented several changes in policies in order to deal with the issues of Australia’s ageing population, such as the changes of the superannuation tax and the change in retirement age.
With the increasing life expectancy, the baby boomers could live for another 20 years or more (Van Solinge and Henkens, 2018), they may be able to contribute more to the labour market, either on a paid or unpaid basis, therefore, the Australian government is raising the retirement and pension age to 67 years incrementally over the coming years starting with people whose birthdays are from 1 July 1952 – 31 December 1953 who will now be eligible to retire and claim an age pension (if they meet the eligibility requirements) at age 65 years and 6 months. The increments increase by six months every two years until it reaches people born in 1957 who will only be able to claim an age pension and retire when they are 67 in 2023 (https://www.dss.gov.au/seniors/benefits-payments/age-pension). If further changes are accepted by government the age at which one may claim the age pension and therefore retire on a government age pension will be at age 70 years in 2035 (ABS, 2009a). Couple with that, the federal government has legislated compulsory superannuation contributions by employers and provided incentives for Australians to save for their retirement.

However, older workers need to maintain their health in order to be part of the workforce. In 2009, 40% of Australians aged 65-69 years old had a disability. If this trend persists, then the number of Australians with a disability appears likely to increase considerably, which will, instead of contributing to the workforce, add to the healthcare cost and become a burden on social security. Therefore, to maximize the future labour participation, more investigation of the association between health and employment is critical (Buckley, Tucker & Hugo, 2013). In 2018, the Australian government came up with a new policy that allow retirees to sell the family home and downsize, to boost their superannuation & retirement fund. There is a lack of information about the impact of this new policy on the ageing population.

2.6.1 Immigration of skilled workers
As Australia’s fertility rate kept falling, Australia had to attract migrants to lift the three "Ps" of economic growth - population (fertility rate), participation (workforce and society) and productivity (The Australian Government the Treasury and the Department of Home Affairs, 2018). Myers (2008) has suggested that immigration offers a partial solution to the problem of a shrinking workforce by bringing in new workers to replace the retiring baby boomers. Net overseas migration is mainly comprised of permanent migration of skilled workers and families; and temporary migration which includes temporary skilled workers and students (IGR, 2015). In fact, Australia has been importing workers from overseas for many years to mitigate the impact of a shrinking labour market and to maintain the country's economic
growth (Calahorrano & Lorz, 2011). In 2015-16, net overseas migration (NOM) was 3.0% more than in 2014-15. According to the Australian Bureau of statistics, at 30 June 2016, 28.5% of Australia's population (6.9 million people) was born overseas.

Howse (2006) suggested that since most of the overseas workers came as adults, they have contributed to Australia's population ageing, especially the baby boomer cohort. Therefore, some people believe that immigration provides temporary relief from ageing but requires ever more immigration in the future, this will have negative impacts on Australia’s economic and social infrastructure, congestion, housing affordability, and the environment (van Onselen Leith https://www.skynews.com.au/details/_6011062129001). However, their alarm may not be well founded. According to the 2015 Intergeneration report, about 88% of migrants are aged under 40 years, as compared to only 54% of local born Australians; almost half of new migrants are aged 20-34 years as opposed to only one in five local born Australians (Australian government treasury, 2017). In 1981, 25% of people aged 65 and over came from different cultural and linguistic backgrounds. This increased to over 36% of people aged 65 and over who were born overseas in 2011. As a result of this growing migrant population, from non-English speaking and culturally and linguistically diverse backgrounds (Calahorrano & Lorz, 2011), Australia has become a nation of heterogenous multicultural population (Giampaolo 2013). This population is considered by the Australian Institute of Health and Welfare (AIHW) as a priority population (ABS, 2013a) because of the various issues this cohort faced. These issues are further discussed in Chapter 4.

2.7 Planning for Australia’s ageing population
Studies of older people in Australia, Europe, Italy, the USA, New Zealand and China have shown that their socioeconomic background could affect their potential to recover and to maintain their wellbeing. Socioeconomic status underlies several determinants of health: such as income levels, level of education and employment, housing security, mobility, social contact, health care, environmental exposure, and health behaviors (Barrett, 2006; Gaymu, 2010 and Sun et al., 2011).

Current Australian Government policies are based on the previous generations’ experience of ageing. The upcoming huge group of baby boomers is fast ageing and retiring, which will have significant impact on Australia’s economic growth and health resources. Studies have found that the baby boomers have different life experiences, expectations and needs
compared with the previous generation (Van Solinge and Henkens, 2018). Appropriate planning for their needs is essential and urgent, which is discussed in Chapter 3. To complicate things further, Australia’s baby boomer population is an ethnically, culturally and linguistically diverse and heterogeneous cohort, which makes planning for this population even more challenging. Furthermore, little is known about their diverse and specific health needs as they age. The characteristics and issues faced by this group are further discussed in Chapter 4.

2.9 Conclusion
This chapter has explored the drastically changing demographic phenomenon of Australia’s ageing population. It has discussed the contributing factors of low fertility and increasing life expectancy, and their implications. It has highlighted pressures on the sustainability of the Australian government's budget that population ageing will cause by contributing to labour shortages, limiting economic growth and diminishing taxation revenue, coupled with the demand for increasing aged care and healthcare services. It has summarised how Australia’s policy makers have, over the years, applied various relevant strategies to address Australia’s population’s rapidly ageing phenomenon. However, planning for the upcoming ageing baby boomer population is more challenging because of various factors, which are discussed in the following chapter.
Chapter 3
Profile and characteristics of Australian baby boomers

3.1 Introduction

Australia is at a critical demographic turning point because the baby boom cohort is now turning 65 years of age, currently representing approximately 26% of the population (AIHW, 2018a). The upcoming ageing baby boomer generation has a significant impact on Australia’s demography, economy, and resources, because of their huge number, and the diversity within this group. According to the 'life course' theory the baby boomer generation has different experiences from the previous Silent Generation, hence, they have different experiences, expectation and needs compared with the latter, yet there is a lack of information about the Australian baby boomers’ healthy ageing. Moreover, the ageing Australian baby boomers who came from non-English speaking and culturally and linguistically diverse background have different and diverse needs and expectations, which makes planning even more challenging.

This chapter begins by defining this group of baby boomers, followed by describing the demography and characteristics of the baby boomers. it then discusses the changes that have significant health impacts on the baby boomers. Subsequently, it discusses the challenges policymakers face in planning for Australian baby boomers’ health needs.

3.2 Definition of Australia’s baby boomer

For the purposes of the present study, Australian baby boomers will be defined as those 5.5 million Australians born in the 20-year period between 1946 and 1965. Baby boomers is a term used to describe a demographic cohort following the end of World War II. There was a massive increase in births following World War II. The post-war baby boom happened because many people had postponed marriage and childbirth during the 16 years of the Great Depression and World War II (Van Bavel and Reher, 2013).

There are no precise dates for when this cohort begins or ends because the term baby boomer is used in a cultural context, therefore, it is difficult to achieve broad consensus of a precise date definition. It is generally agreed that the term “baby boomers” covers those who were born after the Second World War, from 1945 or 1946 to around 1964 or 1965 (Wilson, 2012). The Australian Bureau of Statistics (ABS) defines baby boomers as those Australian residents
born within the 20-year period between 1946 and 1965, including those who were born overseas (ABS 2005). Individuals, scholars, and organisations may define baby boomer differently according to their cultural or/and professional background (Gridley et al., 2000). Some authors classify the baby boomer generation further into two broadly defined cohorts – First Wave boomers and Late boomers. These two baby boomer cohorts possess different characteristics because of their significantly different experiences. The First Wave boomers were born from post-war (WWII) to around 1955. Many of them are now entering retirement. The Late boomers were born between 1956 and 1964. However, Reisenwitz & Iyer (2007) suggest that except for the cognitive age, there are no significant differences between younger and older baby boomers. Hence, caution should apply when using a segmentation strategy of splitting baby boomers into younger and older boomers. According to the age stratification theory, Australian baby boomers have distinctive experiences that set them apart from previous generations, because they have a variety of different health needs and make a variety of demands on health resources (Buckley et al., 2013).

3.3 **Demographic profile of the Australian Baby Boomer**

Baby boomers differ in various ways from the previous generation of older people, because each cohort lives through quite different economic, social and cultural conditions, and have different sets of education, and world experience, etc. (Hugo 2014). Australian baby boomers have been shaped by the interaction between the global and Australian historical, social, economic and political factors of the time (Leach et al., 2008). Studies have found that Australian baby boomers have different values, attitudes, needs and expectations compared to the Frugal and Silent generations before them or the X and Y generations after them (Landau, 2010; Stram, 2011). Most of the studies concentrated on the ageing of the previous generations, that is over 70 years old (Quine & Carter, 2006). There are studies about priority groups such as the pregnant, the young and the very old, Indigenous Australians, people with disability, pregnant and postnatal women, those living in prisons, and those in the rural and remote area (AIHW, 2016a), but the baby boomers were not considered as a priority population even though they require urgent attention. Even though Australian baby boomers have higher rates of chronic disease than previous estimates (Black et al., 2015). More significantly the Australian baby boomer generation went through a lot of changes (MacKinlay & Burns, 2013). To further complicate things, there is a large group of immigrants from culturally and linguistically diverse (CALD) non-English speaking
population within the baby boomer cohort (Kendig et al., 2016). They have diverse and
different health needs compared with the Australian born and the immigrants from European
and English-speaking countries, such as England and New Zealand, yet there is not much
information about their health needs.

3.4 Changes that Australian baby boomers face
There seems to have been a significant social and cultural change in Australia after WWII.
The Australian baby boomers are perceived as the most privileged generation, affluent and
consumerist (ABS, 2006). McCallum et al. (2018) have identified one of the most significant
characteristics that Australian baby boomers are expected to save for a longer life than
expected, which was not previously required of their parents and grandparents. The impact of
the huge number of baby boomers retiring and ageing will affect Australia's economy, social
security and workforce. Most of the Australian baby boomers are expected to live a decade or
two after retirement, therefore, with the growth in demand of healthcare and formal aged care
services. However, with the retirement of the baby boomers, there is a fall in the formal care
workforce. At the same time, the low fertility rate also means a large fall in the potential pool
of informal carers. This informal care cannot be easily replaced by the less flexible and much
more expensive formal care, who are currently diminishing (Deloitte Access Economics,
2015).

Australian baby boomers have also enjoyed the fruit of technological advances such as mass
communication and witnessed the first human walking on the moon and globalisation.
Therefore, baby boomers are better informed about the wider world than previous
generations; they question decisions made by those in power and are more prepared to use
alternative options (Ozanne, 2009). They also possess a strong sense of individualism and are
more liberal and demanding citizens (Court et al., 2007). Studies have found that baby
boombers are less communicative and engaging with their communities and neighbourhoods
(McLeod, 2009; Ozanne, 2009; Landau, 2010), which may impact on their demands for
formal care. They are politically influential and vocal advocates, rejecting, changing or
redefining traditional values with issues like abortion and homosexuality (Court et al., 2000;
Dickerson, 2010). They are prosperous. Baby boomers currently comprise 25% of the
population yet they own 55% of the nation’s private wealth. The first-wave baby boomers
have enjoyed a period of economic prosperity and experienced major social and political
changes with civil/human rights movement, the environmental movement, women's movement and sexual freedom with LSD and other hallucinogenic drugs. However, the Late baby boomers experience is dominated by the recession and the advent of AIDS (Ozanne, 2009).

There are many changes that may have an impact on baby boomers' health: climate changes (Ozanne, 2009; McMichael & Lindgren, 2011); the Global Financial Crisis (GFC) (Humpel et al., 2010; O'Loughlin et al., 2010); the collapse of the housing bubble and the resulting plunge in the stock market, which destroyed an enormous amount of the baby boomers' household wealth and their retirement fund (Harvey & Thurnwald, 2009). The social changes which suggest that baby boomers have lower levels of bonding social capital than their parents, which may increase their social isolation, leading to greater mortality and higher levels of depression, and a lower likelihood of tangible assistance and care, placing a higher demand for formal services, at greater cost to the welfare system (McCallum et al., 2018). The baby boomers who are immigrants from the CALD population face far more changes compared to immigrants from English speaking and European countries, which is discussed in Chapter 4

3.4.1 Changes of Australian baby boomers’ education level
Australia’s baby boomers are much better educated than the previous generations. One of the reasons could be that the Australian government subsidised the baby boomers in their tertiary education (ABS, 2006). 43% percent of them have completed secondary school compared to only 6% of the previous generation. Almost a fifth of them (20%) gained a Bachelor or higher degree qualification, compared to only three percent of the previous generation.

3.4.2 Changes of Australians’ marital life
People are getting married later in life. The median age of both men and women at first marriage has increased steadily from 1990. The median age at first marriage in 2010 was 29.6 years for males and 27.9 years for females. The median age at marriage for men in 2016 (ABS) was 31.9 years. The median age at marriage for women in 2016 was 29.9 years.

Australia’s baby boomers are the first generation of Australians to experience high rates of divorce and separation so that a third of them are entering their older years without a spouse
compared with less than a fifth among the previous generation. Over the last 20 years, the proportion of divorces granted has been increasing since the 1970s (ABS, 2006). Over the last twenty years cohabitation prior to registered marriage has increased, from just over half of all registered marriages in the 1990s, (56% in 1992) to almost eight in ten (79%) by 2010. There is also a significant proportion of the population who have never married. Among older people, 4.6% of older people in the 2011 census had never married. Of those who had been married, on average 34% entered later life without a spouse, 38% of older women being widowed or divorced compared with 11% of men in the same age group (ABS, 2011). This reflects the different life expectancy for women and men in Australia.

3.4.3 Changes of Australian baby boomers’ fertility rate

Urbanisation, higher levels of educational attainment and socioeconomic position are associated with lower fertility rates. The cost of bringing up children is high. More women are working outside the home and choosing career over children. Fewer people are getting married, and are getting married at an older age, and fewer married couples are having children (McDonald, 2007). Coupled with these factors, there were other related social changes that have impacted the fertility rate, which has contributed to the falling population. Australia’s fertility has fallen. A higher proportion of baby boomer women have never had children (14%) than the previous generation (9%). Even when people have children, they have fewer children than previous generations, as shown in Figures 5 and 6. People have also delayed parenthood. The average age of childbearing has been increasing over the past 30 years. however, ex-nuptial births have increased considerably since the 1970s. In 2012 34.5% of births were ex-nuptial, compared to only 7.4% in1971 (McDonald, 2007).

3.4.4 Changes of Australian baby boomers’ homeownership and housing needs

Australian baby boomers have high homeownership rates because they were met with a robust and thriving economy, and an affordable housing market that allowed many of the baby boomers to buy their first home (Cigdem et al., 2015), hence, they were able to get into the market before the property boom of the last two decades. However, the ABS reports that the rates of home ownership, as a financial asset on retirement, by older Australians has decreased in recent years. In 2003–04, 8 in 10 (79%) aged 65 and over owned their homes without a mortgage; this had declined to 76% in 2013-14 (ABS, 2015).
Studies have shown that Australian baby boomers are facing multiple changes in their lives (Quine & Carter 2006): declining health and disability; retirement; changing financial circumstances; children leaving home; relationship change; inability to maintain house and garden (Granbom et al., 2014; Judd et al., 2014; Yu & Lee, 2017), which will affect their housing needs and will ultimately impact on their health.

There are many studies about baby boomers’ plan for their changing housing needs and lifestyle changes (Adair, Williams, and Menyen, 2014; McCallum et al., 2018; Rees and McCallum, 2017; Lamont and Sargent-Cox, 2017). Currently, studies of housing needs have targeted mostly those over 70 years old’s housing needs (Quine and Carter 2006; Morley, 2012; Byles et al., 2014; Granbom et al., 2014). Many of the studies about baby boomers’ housing needs were conducted overseas, and very little is known about Australia’s ageing baby boomers’ changing housing needs (Quine and Carter 2006).

Currently, a large body of literature studied the housing bubble created by the baby boomer generation and the financial planning to diffuse the housing crisis ahead (Rosnick and Baker, 2010; Painter and Yu 2014; Saita et al., 2016). Currently, Australian government encourages Australia’s baby boomers to downsize from their large family homes, occupied by only singles or couples, that no longer meet their needs, to invest the proceeds of selling their home into their superannuation. In the 2017 Federal Budget, aged 65 or over can make a non-concessional contribution, of up to $300,000 from the proceeds of selling their home, into their superannuation (Australian Taxation Office). Hence, allowing more effective use by young growing families.

Judd (2014) have found that 46% of Australians aged 55-64 cited accessibility as a key consideration in moving. The most common factor contributing to downsizing for older Australians was a desire for a change in lifestyle. The second most important factor contributing to downsizing was an inability to maintain the home and/or garden, followed by the children leaving home and retirement were also important factors. Other factors such as relationship breakdown, health, and disability were important only for a smaller percentage of older people. Financial gain was a more common motivation than a financial difficulty in downsizing (Judd, 2014). Painter & Lee (2009) suggested that baby boomers only chose to relocate when they have experienced a combination of changes.
The proportion of Australia’s baby boomers living alone is twice as high (Hugo et al., 2009; Hugo, 2014), which means that the ageing baby boomers will need more formal care. On the other hand, some authors have found that older Australians are choosing to live together (Vella Lara, 2017).

Myers & Ryu (2008) have found that the retirement of the baby boomers could lead to less demand for low-density housing, and an end of a generational housing bubble, with a new emphasis on compact development. Studies have suggested that baby boomers have rejected the traditional definition of the retirement of leading a vacation lifestyle (Winston & Barnes, 2007). Some authors anticipate that baby boomers may choose not to move to seniors-only retirement communities, but prefer to move to specially designed retirement communities, inner city apartments, or smart houses which can be technologically designed to cater for the needs of the elderly (Banks, 2008; Myers & Ryu, 2008; Williamson, 2008; Ozanne, 2009; Landau, 2010; Finkelstein et al., 2012). Authors in the United Kingdom identified the complexity of the retirement community model (Bernard et al., 2007). However, very little is known about Australia’s ageing baby boomers’ changing housing needs, especially for those from culturally and linguistically diverse population (Laidlaw et al., 2010; Smith & Hung 2012), which is discussed in Chapter 4.

### 3.4.5 Changes in the workforce

There are changes in the proportion of men and women in the workforce. While the rate of employment for men has stayed almost the same for thirty years, the rate that women participated at work has risen as shown in Figure 10. Men are no longer perceived as the only breadwinner of the family. There is a lack of information about how this change affects the baby boomers’ health.

![Figure 10: Female employment Categories, all of Australia 2008–2018](https://thesector.com.au/2018/12/20/the-number-of-women-participating-in-the-workforce-continues-to-rise/)
There is change in the baby boomers’ employment status. In 2015, 3.8% of the workforce aged 55 and over was unemployed (ABS 2015a). One-quarter (26%) of those aged 65 and over who were available for work had been unemployed for 52 weeks or more (ABS 2016). Currently, the Australian government is cracking down on a growing number of baby boomers who are desperately seeking employment but are thought to “effectively retire” on unemployment benefits (Chang, 2014). Rates of unemployment are generally higher among people in ethnic minority groups (AIHW 2015b).

The baby boomers will form a large cohort of retirees. The first Australian boomers reached retirement age in 2011. Probably half of the cohort have not reached retirement age, and the rest are approaching retirement age. The ratio of retirees to workers will increase by 67% over the next two decades. Researchers suggest that the baby boomers approaching retirement are more anxious, frustrated, and concerned about their future than were the previous generations because of the unprecedented changes they are facing (Court et al., 2007). Nevertheless, Insler (2014) suggests that baby boomers’ retirement has a significant beneficial effect on their health because many retirees practice healthier habits such as exercise with additional leisure time.

In view of the labour shortage and the heavy financial load on the working population, the traditional retirement age at 65 years old is disappearing, as a result of a changing economy and the shortage of labour (Harvey and Thurnwald, 2009). Jackson and Walter (2010) debated the pros and cons of baby boomers’ delayed retirement. Australian government now encourages those who are approaching retirement to stay at work longer (Schofield et al., 2007; Harvey and Thurnwald, 2009; Schofield et al., 2009; Stram, 2011). As a result of a changing economy and the shortage of labour (Harvey and Thurnwald, 2009), a large number of Australian baby boomers would reject the traditional definition of retirement (Winston and Barnes, 2007), and be happy to work part-time or never retire (Taylor et al., 2014) in jobs that provide them with high personal satisfaction (Williamson, 2008; Landau, 2010; Hoffmann and Burns, 2011; Shacklock and Brunetto, 2012).

Unfortunately, the baby boomers face many unexpected changes and barriers to their planning of retirement, because of the many changes arise in their lives, such as the global financial crisis of 2007 (O'Loughlin et al., 2010; Noone et al., 2013; Kendig, 2013; Johnson
et al., 2015), the change in retirement age and the raising of the pension age, (Australian government human services) and age discrimination in the workforce. Some baby boomers faced redundancy because of the global financial crisis and were forced to retire early (Moody, 2009). Some baby boomers may not be able to afford to retire and may need to look for second careers (Landau, 2010). Some baby boomers may have to depend on social security payments (Rosnick and Baker, 2010; Snoke, 2011).

Chen et al. (2014) have ranked finance, a necessity for survival, the second most important component for quality of life (QoL). Hence, older people who did not work before or did not continue to work after retirement may have a relatively disadvantaged financial situation with less social interaction, which can negatively affect their QoL (Chen et al., 2014). Currently, 10 percent of those over 65 years old are working. The IGR forecasts that about 20 percent of all people aged over 65 will still be participating in the workforce by 2055, many of them because they will not be able to afford to retire.

Many studies have examined baby boomers' expectations and plans for their retirement and policies of retirement (Quine & Carter, 2006; Humpel et al., 2009; Humpel et al., 2010a; Landau, 2010; Légaré and Boucher, 2012; Sargent-Cox et al., 2012). Noone et al. (2010) suggested that it is critical that baby boomers, especially women, plan for their retirement. Lusardi and Mitchell (2007) recommended that baby boomer in USA should be planning for their retirement security financially, which coincide with the same experiences in Australia. Studies from the USA reported that decisions of when and how to retire from the labour force are often based on financial background (Pruchno, 2012).

Apart from financial reason, Noone et al. (2013) suggest that retirement policy and planning initiatives should aim to facilitate a holistic approach to retirement planning for future retirees, particularly those facing an early and unexpected retirement, because declines in health commonly compel workers to retire (McGarry, 2004; Insler, 2014). The baby boomers’ participation in the workforce depends highly on their health status. Instead of complete withdrawal from the labour force, policies that make the workplace a safe, flexible and welcoming environment, to encourage older workers to participate, is required (Taylor et al., 2014). However, there have been few substantial attempts to encourage such a work environment that would welcome older workers.
Some authors suggested that self-rated health has deteriorated in recent decades with increased prevalence of obesity and diabetes, which may impact on workforce participation of older working-age Australians (Cai & Ong Changxin 2009). Hence, it is essential that baby boomers maintain their health so that they could remain in the workforce (McCallum, Maccora, and Rees, 2018). Therefore, it is crucial to understand their health needs.

3.4.6 Changing demand and ability to care

There is an increasing demand for formal care, even though more and more baby boomers assume roles of being carers of their spouse, elderly parents, their children and/or grandchildren (Finkelstein et al., 2012). Some of the baby boomers are caring for family members who are both a generation above and a generation below them simultaneously, are known as the “sandwich generation” (Caro Jane, 2017).

Findings have implied that one in five baby boomers will be alone, as a result of the breakdown of family ties because more people stayed single, divorced and never had children (Court et al., 2007), will need, apart from traditional informal support, new sources of community assistance and formal care (Court et al., 2007). Consequently, there is expected a rise of the demand for formal carers because of the diminishing number of informal carers (Banks, 2008; Ozanne, 2009; Cangelosi, 2011; Snoke et al., 2011; Finkelstein et al., 2012). Many baby boomers are in denial about what it might mean to live 20-30 years beyond retirement. As such, they are postponing planning for long-term care needs in their old age (Knickmen and Snell, 2002; Sörensen et al., 2015).

Australia’s shrinking workforce results in a shortage of healthcare and aged care professionals and reduces its ability to care for the ageing population, as shown in Figure . The medical professionals such as general practitioner, specialist, and nursing workforce has aged since 1986. In 2001, more than half the doctor and the nursing workforce were from the baby boomer generation. Currently, retirements of the baby boomers in the medical profession could place unprecedented pressure on the medical workforce. However, one study has found that a large proportion of general practitioners continued to work beyond the traditional retirement age of 65 years, with nurses retiring at a younger age than doctors (Schofield & Beard 2005; Draper, 2017).
At the same time, the large cohort of frail elderly baby boomers will have a major impact on the Australian healthcare system, (Cangelosi, 2011; Dychtwald, K 2011). Some experts have projected that visits by baby boomers will soon strain emergency departments and healthcare budget (Hampton, 2008). Consumers' major concern is that they cannot get care when they need it because of the lack of health practitioners who could provide adequate services for chronic diseases (Blosser et al., 2010; Harahan, 2010; Sorrell, 2010; Ebuehi and Campbell, 2011; Haber et al., 2011; Laranjeira, 2012).

3.5 The unpaid workforce
The unpaid workforce is funded by the volunteers. In 2014, 5.8 million (31%) of the Australian population aged 15 years and over participated in voluntary work. One study has found that volunteering has contributed more than $290 billion to the GDP per year in Australia (Volunteers Worth More to Australia Than Mining), a volunteer was defined as someone who willingly offered free service through an organisation or group (Pietsch & Archer 2013). There is an increase in the number of volunteers as shown by the data in Table 1.

As more baby boomers retire, Einolf (2009) predicted that the number of elderly volunteers would probably increase in the next decade. Studies have found that there is an emerging group known as the ‘sandwich generation’, who are those mid-life adults who are simultaneously raising dependent children and caring for frail elderly parents (Miller, 1981; Wiemers and Bianchi, 2015). Wassel and Cutler (2016) report that this sandwich generation has less time to prepare for their own retirement and older years.

The percentage of the population aged 65 to 74 who volunteer is 35%, third highest after the 15-17-year-old and 35-44 year-old age groups. Comparing the sexes, women were more likely (at 34%) to volunteer than men (29%). Figure 9 shows that women who work part-time have a higher volunteering rate than men.

In 2010, there were higher proportions of women than men across most age groups who volunteered, except in the 55-64 year age group and 65-74 year age group. Men aged 55-64 years in 2010 were more likely than other men to volunteer (46%), perhaps a result of the increased number of men entering retirement (ABS, 2014).
Volunteering increased with household income as shown in Figure 8. People with a higher level of education have a higher rate of volunteering (ABS, 2014). Curiously, in 2010 unemployed people had the lowest volunteering rates (15% and 24% respectively) (ABS, 2014).

There are several reasons that volunteers offer free work. It allows them to do something useful and meaningful in life and gives them a sense of personal achievement, satisfaction, and enjoyment as shown in Figure 11 (ABS, 2014). It is therefore not surprising that studies have found that volunteering or participation in productive activities is beneficial for older people’s well-being (Hank and Erlinghagen, 2010; Mojza et al., 2010; Wahrendorf and Siegrist, 2010).

Studies have shown that age, education, health, and involvement in other social activities strongly influence an individual's propensity to engage in volunteer work. 15% of the people suggested that their health restricted their capacity to volunteer. There is a negative association between health and volunteering rate. In other words, people with excellent health have a higher rate of volunteering (Erlinghagen and Hank, 2006).

Many of the baby boomers are truly unpaid workers because they look after their elderly parents, some of them also look after their own children at the same time. As a result of the increase in life expectancy, many of the baby boomers have elderly parents. Some describe the baby boomers a sandwich generation because, they are sandwiched in between two generations (Lundholm, and Malmberg, 2009; Do, Cohen and Brown, 2014).

3.6 Intergenerational relationship at work and at home

Numerous studies have explored the intergenerational relationship and the dynamics between the generations of employees in the workplace (Kupperschmidt, 2006; Carver & Candela, 2008; Farr-Wharton et al., 2012) and the differences between the baby boomers and another generation, in order to improve the efficiency and productivity at workplace (Dodd et al., 2009; Bettendorf et al., 2011). Many studies have focused on age discrimination, which jeopardises older workers’ employment opportunities (Thornton and Luker, 2010; Vodopivec and Arunatilake, 2011). There is a lack of information on improving intergenerational relationship at work with the extending retirement age. Many baby boomer women relish the
later stage of their life — enjoying grandparenthood, extra leisure time and a newfound sense of self-assurance. (Arbera and Cooper, 1999). However, there is no investigation about the intergenerational relationship between family members, especially when the life expectancy is increasing.

3.7 Australian baby boomers’ health status

Aging baby boomers are living longer but have higher rates of chronic disease, more disability, and lower self-rated health compared with the previous generation (Humpel et al., 2010). There is rising age-related morbidity and mortality from chronic diseases (Buckley et al., 2013; Badley et al. 2015; Case and Deaton 2015). Similarly, King et al. (2013) identified that in the USA, the baby boomers have a longer life expectancy over previous generations. However, they also have poorer health status with higher rates of chronic disease and more disability, which increase the likelihood of support from health and aged care resources as the baby boomers age (LeRouge et al., 2014). This coincides with the current trend in Australia.

The Australian baby boom generation is more obese and became so at younger ages than their predecessors. (Hoffman, Lee, and Mendez-Luck, 2012; Black et al, 2015). In 2009, 40% of Australians aged 65-69 years old had a disability. If this trend persists, then the number of Australians with a disability appears likely to increase considerably, which, instead of contributing to the workforce, would add to the healthcare costs and become a burden on the society. Therefore, investing in older people's health by maintaining their independence and productivity, lessens the disease burden and broadens the benefits for society (Drabsch, 2004; Lemelin et al., 2009; Stanner and Denny, 2009; Räsänen et al., 2010; Stram, 2011; Doyle et al., 2012).

Some literature has suggested that baby boomers' later life may be healthier than their parents because most of the baby boomers are better informed about disease prevention and have had improved health services throughout their lives (Banks, 2008; Humpel et al., 2010; Wulfman, 2010). They may be more focused on their general health, self-care and using non-prescriptive medicines (Wulfman, 2010). In 2001, the majority (82%) of Queensland baby boomers self-reported that they enjoy good or excellent health (ABS, 2005).
3.7.1 Age-associated health conditions

Humpel et al. (2010) suggest that even though better healthcare has given the baby boomers a higher life expectancy, evidence has shown that the health of Australians has declined over the years, which may impact on workforce participation and health care utilization in the future (Pilkington et al., 2014). One study suggested that baby boomer will face about the same age-associated chronic conditions with physical, psychological and mental disabilities, depression, cognitive and functional loss as the previous generations. But they are eight times more likely than the older generation to have three or more health problems. (Fitzpatrick & McCabe, 2008). An increasing number of ageing baby boomers will become frail and inflicted with multiple morbidities (Humpel et al., 2010; Yeoh & Furler, 2011; Finkelstein et al., 2012), which include decreased vision, hearing loss, cognitive impairment, such as Alzheimer’s disease, decreased mobility and slower reaction time (Fitzpatrick & McCabe, 2008; Yeoh & Furler, 2011; Wakeman & Grundy, 2001). Thus, though they have a longer life expectancy, their longer old age is likely to be marked by more ill health, especially chronic conditions.

3.7.2 Australian baby boomers’ lifestyle and health risk factors

Government census has suggested that many baby boomers are leading inappropriate lifestyles which have contributed to higher risks of chronic disease (Haugh, 2004; Leveille et al., 2005; Drabsch, 2004; Vaupel and Kistowski, 2005; Fineberg, 2008; Lay et al., 2008; Humpel et al., 2010; Duncan et al., 2010; Cangelosi, 2011). In 2001, 54% of the baby boomers were considered to be overweight or obese as compared with 46% of the total population (ABS, 2005). The incidence of obesity and overweight is two and a half times that of the previous generation. They are also less active. Only 29% of the baby boomers undertook moderate to high levels of exercise, while the remainder exercised at a lower level, or were mainly sedentary. Over 28% of the baby boomers were smokers and over 60% had risky alcohol consumption (Martin et al., 2009; Humpel et al., 2010; Duncan et al., 2010; Cangelosi, 2011). These risk factors suggest that there is an increased risk of various chronic disease for baby boomers.

Studies have linked alcohol and other substance abuse with a rise in the rate of divorce and marital separation. The baby boomers experience of a rise in the rate of divorce and marital separation coincides with the trend of rising in alcohol and substance abuse by the baby boomer generation (Colliver et al., 2006; Lay et al., 2008). Reports suggest that Australians
over 50 have higher rates of binge drinking and illicit drug use than younger people (Scott and Armitage, 2017). Researcher have also found that the largest percentage increase in drug misuse of prescription drugs between 2013 and 2016 was among people aged 60 and over.

Against this background, some experts have projected that visits by baby boomers will soon strain emergency departments and the healthcare budget (Huelskamp, 2002; Hampton, 2008). Demographers and social policy analysts have predicted that the large cohort of frail elderly baby boomers will have a major impact on the Australian healthcare system, (Knickm and Snell, 2002; Cangelosi, 2011; Dychtwald, K 2011). Many authors have promoted lifelong learning, to adapt and adjust to changes in roles and lifestyle of ageing baby boomers (Grundy, 2006; Andonian and MacRae, 2011). Hence, there is a substantial need for improvement of the baby boomers’ healthy ageing.

3.8 Diversity within Australia’s baby boomer cohort

Another change that Australians are facing is that the Australian baby boomer generation is financial, socially, culturally and geographically more diverse, with diverse needs and expectations, which are different from the previous generations. Age stratification assumes that baby boomers are a homogenous group; however, researchers have cautioned policy makers and planners to keep in mind that there is considerable diversity among the ageing baby boomer population (Ozanne, 2009).

Australia’s multicultural society is a major factor in diversity. Among the Australian baby boomers, 31 percent are overseas born, with a fifth from the culturally and linguistically diverse (CALD) countries (Ozanne, 2009; Cangelosi, 2011; Snoke et al., 2011; Hugo, 2014). The Australian government and AIHW consider the overseas born, especially the non-English speaking migrants, as priority populations (Singh & de Looper, 2002; Carter-Pokras et al., 2012).

Their diversity means that they adopt different perspectives in response to the different social and political environments which they have experienced. Thus, each individual deals differently with ageing and adapting to the process of ageing (Mein et al., 1998; Knickm and Snell, 2002; Savic et al., 2010; Stram, 2011). This contributed to one of the changes Australian baby boomers must face.
The cultural diversity within Australian baby boomer cohort makes planning for them more difficult and challenging, especially in aged care provision because until relatively recently the population aged 85 and over was overwhelmingly Anglo Celtic in origin. Little is known about health practices and inequalities between the culturally diverse groups (Leveille, Wee, and Iezzoni 2003; Humpel et al., 2010a; Seeleman et al., 2015).

One would think that the factors shaping aging processes are mostly similar across populations. Migrants experience similar morbidity and mortality causes as compared with the general populations, but the severity and age of onset may be different within and between migrant groups, as a result of migrant-specific risk factors which include exposure to health risks before and during migration, for example, Blackwell, Hayward, and Crimmins (2001) reported that poor childhood health increases morbidity in later life. This association was found in cancer, lung disease, cardiovascular conditions, and arthritis/rheumatism. Other factors that affect migrants’ health are: language and cultural barriers influencing health-seeking behaviours and low health literacy; a more disadvantaged socioeconomic position with psychosocial vulnerability and discrimination could affect health and quality of life (Hahn et al, 2008; Macfarlane et al., 2009; Kulla et al., 2010; Ding & Hargraves, 2009; Ding et al., 2011; Kim et al., 2010; Kim et al., 2011; Kim et al., 2013; Ng and Newbold, 2011; Carter-Pokras et al., 2012; Vasey and Manderson, 2012; Kristiansen et al., 2016).

3.9 Conclusion
Australian government and policymakers are challenged by the planning needed for the ageing baby boomer population for multiple reasons: its huge number, its distinct characteristics, its diversity and their changing experiences and expectation as compared with previous generations. Hence the following chapter discusses the characteristics of the overseas-born Chinese, a subgroup of the non-English speaking culturally and linguistically diverse population, in order to understand their healthy ageing needs.
Chapter 4

Sociodemographic profile and characteristics of the Chinese migrants in Australia

4.1 Introduction

Australia is a multicultural country, a land of migrants, with 28% of Australians, 6.6 million people born overseas (ABS 2015f). Colonial Australia has always been a country of migrants because it has always relied on immigration to increase its population (Haralambous et al., 2014). This population growth has traditionally come from other English-speaking countries but more lately from culturally and linguistically diverse countries.

Australian policy makers have classified the culturally and linguistically diverse population as a priority group with special needs (Ozanne, 2009; AIHW, 2010a; Villa et al., 2012), because of their different culture and language compared to the local born Australians (Kim & Keefe, 2010; Gushulak et al., 2011; White & Kliner 2012), yet little is known about their unique health needs (Kim and Keefe, 2010; Gushulak et al., 2011; White and Kliner 2012). Of those born overseas, 36% of them are aged 65 and over, and 61% of these older people were born in non-English speaking countries (AIHW, 2011a), making their needs particularly important for health policies and services. There is a lack of information whether the culturally and linguistically diverse population's diverse ageing health needs are being met (Huber et al., 2011). Planning for the baby boomer migrants from the "non-English speaking" and culturally and linguistically diverse cohort has multiple challenges (Andrulis et al., 2011; Khoo, 2011; Szmagalski, 2011; Selvarajah et al., 2012). One of the challenges is their heterogeneity, both between and within groups.

Studies have suggested that generalisation about culturally and linguistically diverse people from overseas born non-English speaking countries is inappropriate because of their heterogeneity (Rao, Warburton and Bartlett, 2006; Rechel et al., 2011). Therefore, a comprehensive study of a sub-group from the culturally and linguistically diverse population is more fitting.

The Chinese migrants are chosen for this study because of many reasons: Chinese migrants form one of the largest overseas born non-English speaking and culturally and linguistically
diverse population in Australia and the third largest immigrant group, following those from United Kingdom and New Zealand. Currently, Chinese migrants are also one of the fastest growing culturally and linguistically diverse migrant populations in Australia (Daly et al., 2002). Studies have shown that the Chinese migrants have different language and culture both compared to the Australian local born and within itself (Kwok and White, 2011). Very little is known about any of their needs, especially those relating to the Chinese baby boomer migrants’ social and health needs.

This chapter begins by summarising the historical background of Chinese migration to Australia. It then highlights the challenges of planning for the Chinese migrants in Australia. It is important to understand their background in order to plan for their social and health needs; therefore, it discusses the factors affecting the Chinese migrants’ social and health needs.

4.2 Historical background of immigration of Chinese in Australia

Many developed countries such as Australia and New Zealand have similar stories of the immigration of the Chinese (Chiou, 2017). Chinese immigration to Australia began during the gold rush era in the 1850s when a large number of Chinese fled from civil disorder, famine, and floods in southern China. They were attracted by opportunities to strike it rich in Australia. The newly formed Australian Parliament passed the Immigration Restriction Act 1901, in order to restrict entry of Chinese migrants to Australia. This formed the basis of the ‘White Australia policy’ that excluded all non-Europeans from Australia. People who were predominantly from English, Scotch, Irish and Welsh backgrounds were encouraged to migrate, in order to preserve the social and cultural homogeneity in Australia. After the first world war (1914-1918), the Australian Parliament passed the Empire Settlement Act 1922, which aimed to attract migrants from England (Klapdor et al., 2009). After the Second World War, immigrants in Australia mainly came from European countries such as Italy and Greece, Estonia, Latvia, Lithuania, and Poland. The level of overseas migration and migration patterns changed after 1975 with successive governments at federal and state levels abandoning the ‘White Australia policy’. The census of 2016 showed that for the first time in Australia’s history, the majority of people born abroad are from Asia, and not from Europe.

There are several reasons why Chinese migration has risen notably government programs and policies to increase the skilled workforce and to provide safety to refugees in Australia
A large number of ethnic Chinese migrated to Australia following PNG’s independence on 16th September 1975, the fall of East Timor to Indonesian's troops in 1975, the Vietnam war, the Cultural revolution and civil conflict such as the Chinese Tiananmen Square massacre in June 1989, the hand-over of Hong Kong back to China in 1997, and the Jakarta riots of May 1998.

The migration status of the Chinese migrants also varies greatly depending on the different type of visa they were under such as student, business and skilled migrants, refugee or as spouse and family reunion. Ip, (2001), has suggested that the Chinese migrated to Australia in three stages; from mainland China, then Hong Kong and mainland China and now Taiwan and mainland China. Many Taiwanese migrants entered Australia as business migrants while those from Hong Kong migrated under the skilled migration category. Most of these migrants were born between 1945 and 1964 and so belong to the baby boomer generation (Schoorl et al., 2000).

4.3 Challenges of planning for the Chinese migrants in Australia

There are many challenges in planning for the Australian Chinese migrants. Foremost, Chinese migrants have different language and culture compared with the mainstream Australians. Secondly, this is not a homogeneous cohort with uniform needs, lastly, there is a lack of information about the Chinese baby boomer migrants’ expressed health needs, documents examined were listed in Appendix 16.

4.3.1 Heterogeneity of the Chinese migrants in Australia

The heterogeneity of the Chinese migrants contributes to the complexity in meeting their social and health needs. Studies have reported that the Chinese migrant community in Australia is a heterogeneous ethnic group, because of their different countries of origin (Chau, 2008; Kwok and White, 2011). Many overseas born Chinese migrants were born in Mainland China, Taiwan, Hong Kong, Macau, Indonesia, Malaysia, Singapore and the Philippines. There were 1,213,903 (5.6%) Australian residents identifying themselves as having Chinese ancestry in the 2016 census, of these Chinese, two in five (41%) were born in China, ahead of Malaysia (8.0 per cent) and Hong Kong (6.5%) (ABS, 2016). Similarly, Chiang & Hsu (2005) have found that the Chinese migrants have different experiences and expectations because they come from different places of origin, have different political
orientations and different language proficiencies and socioeconomic backgrounds. Therefore, it is argued, in this study, that they have different social and health needs.

4.3.2 Australian Chinese migrants have different social and health needs

Chinese migrants have different health needs compared with the mainstream Australians and the English-speaking Anglo-Celtic immigrants from the United Kingdom and New Zealand. Because Chinese culture and language is very different from the Australian language (English) and culture (Matwijiw, 2011), it is self-evident that their social and health needs will be very different from that of the mainstream Australians (Leung et al., 2014). For example, studies comparing cross-cultural issues of ageing between the Anglo-Australians and the Chinese in Australia have found differences in their ageing experiences and expectations (Merriam and Associates 2002; Chu and Leasure, 2010; Tan et al., 2010; Khoo, 2012). According to Tan et al. (2010), both Chinese baby boomers and Australian born baby boomers agreed that an important part of being successful in ageing is to have and maintain health. However, the Anglo-Australians define important aspects of successful ageing as to ‘grow old gracefully’ and to have ‘acceptance’, to accept life’s limitations and to have a positive outlook. The Chinese in Australia on the other hand valued financial security and an active lifestyle. This difference between them highlights that their needs are different in maintaining their healthy ageing. Chinese migrants in Australia hold health beliefs that do not coincide with Australians’ biomedical approach (Singh and de Looper, 2002; Kwok et al., 2012; Leung et al., 2014). For example, they placed more emphasis on promoting everyday health and well-being, rather than looking for early diagnosis and treatments (Kwok and Sullivan, 2006; Liu et al., 2011), and their prevention behaviour is not consistent with scientific evidence (Singh and de Looper, 2002; Tong and Sentell, 2017). Therefore, Australian-Chinese migrants’ lower participation rate in health screening might be a result of them managing their own health with self-remedies and self-care (Kwok and Sullivan, 2007; Lam et al., 2010; Tan et al., 2010; Blignault et al., 2008; Wong et al., 2010).

4.3.3 A lack of information about Chinese migrants’ social and health needs

Studies have found that the information about the Australian Chinese migrants’ health status and their use of health services is either lacking or incongruent (Ward, 2009; Fry, 2010; Perry and Wolburg 2011). For instance, Shen et al. (2011) have found that Chinese migrants have a higher prevalence of diabetes and hypertension and more likely to have haemorrhage and stroke, whereas Daly et al (2001) and Li et al (2001) have found that Chinese migrants have
significantly less mortality rate from cardiovascular diseases than that of the Australian born. Then again, Cheung et al (2011) have found little difference in the incidence of hypertension and hyperlipoidaemia in Chinese Australians compared with the mainstream Australians. There is a lack of information about the prevalence of osteoporosis of Australian-Chinese baby boomer migrants compared with Chinese baby boomers living in China. Similarly, there is a lack of information on the differences between the dietary practices between the Australian Chinese baby boomer migrants and their counterparts living in China. Unfortunately, there is also an absence of evidence-based health assessment tools and guidelines based on Chinese or ethnic people. All the current research studies that explored the health needs of Australian-Chinese migrants focused on the biomedical approach of pharmacotherapy and health screening (Kwok et al., 2011; Kwok et al., 2011; White and Kliner, 2012; Kwok et al., 2012). Hence, planning for Australian-Chinese can become very challenging (Sundararajan et al., 2007; Yu, 2009; Rechel et al., 2011).

One of the reasons for the lack of information about Chinese migrants’ health status and health practices is because of their under-participation in the health system and underreporting of their cases. Studies have found that Chinese migrants have a lower rate of participation in health services because of their cultural background. For example, they only seek help when their conditions were critical (Kwok and Sullivan 2007; Cheung et al., 2011). People from culturally and linguistically diverse background are much less likely to report ever having a mental disorder than those born in Australia and other English-speaking countries. They also have a culturally different interpretation of depression (Goh et al 2010). Parker et al. (2007) have suggested that Chinese have a lower reported rate of depression and were less likely to seek professional help or take antidepressant medication which could point to either a greater resilience in the Chinese, or it could be explained by a general response bias (e.g. denial), differential resistance to psychological illness (e.g. stoicism) or differential coping (e.g. minimizing psychological distress). Overall, Chinese migrants tend to avoid stigma and discrimination (Liu et al., 2009; Haralambous et al., 2014), in order to protect family honour by not disclosing their health conditions (Vu, 2012; Kwok, 2011; Kwok and Sullivan, 2006; Wong et al., 2010; Chui et al., 2005; Ho et al., 2008; Bryant and Lim 2013).

Some authors argue that the Chinese migrants have a lower rate of participation in health services because they are healthier than the local born Australians when they first arrived in the host country – the “healthy migrant effect” (Fennelly, 2007; Gushulak et al., 2011;
Moullan and Jusot, 2014; Hamilton, 2015; Vang et al., 2017). Research has found that most migrants enjoy health that is at least as good as, if not better than that of the Australian-born population and that they often have lower mortality rates and hospitalization rates, as well as lower rates of disability and lifestyle-related risk factors (Kennedy et al. 2014; Jatrana et al. 2017).

The healthy migrant effect is believed to result from two main factors. First, a self-selection process including those who are willing and economically able to migrate, excluding those who are sick or disabled. Immigrants having higher health and wealth status are more able to physically and financially migrate to another country (Kennedy et al. 2014). Secondly, the result of a government selection process of screenings which involves certain eligibility criteria based on health, education, language and job skills (Omeri and Raymond, 2009). However, some studies suggested that this healthy migrant effect may persist even after about two decades and then diminishes over time as migrants undergo acculturation (Cheung et al 2011; Corlin et al., 2014).

Cerin et al. (2015) have reported that the health of Chinese migrants deteriorated after they adopted Western dietary habits and reduced their levels of physical activity. Zhang et al (2002) have suggested that Chinese migrants have changed from traditional soybean-pork diet to a wheat-red meat diet. There is evidence that Chinese immigrants experience an increased risk of coronary heart disease after the change in cultural habits and acculturation in the host country, whereas Chinese older adults living in their country of origin are more active and followed a healthy diet compared to their Western counterparts. (Kai et al., 2015). Studies conducted about the Chinese community tend to be based on a preconceived concept of what the Chinese migrants need. Many authors suggested that, in order to plan culturally sensitive health programs for Chinese migrants, an important initial step is to gain a good understanding of their cultural, social, historical, and environmental background (Lui and Ip, 2009; Blignault et al., 2008).

4.4 Factors affecting the Chinese migrants’ social and health needs

There are a few factors that could impact on the Chinese migrants’ health negatively. As they are part of the culturally and linguistically diverse population, the Australian Chinese migrants face language and cultural barriers, but foremost, their migration experiences impact critically on their health. Migration is a stressful experience for the Australian Chinese
migrants. Haralambous et al. (2014) have found multiple barriers to Asian migrants accessing health services in a foreign land; the cultural barrier is one of the most recognised factors that affect Chinese migrants’ health (Chu, 2005; Kwok et al., 2011). Other major factors affecting the ability to maintain a healthy lifestyle by older Chinese immigrants are language barriers, accessibility, and affordability of relevant services, and public transport (Cerin et al. 2015).

### 4.4.1 Impact of migration on the Chinese migrants’ health

Studies have shown that migration impacts on Australian migrants’ health (Lassetter and Callister; 2009). The stress of migration arises from three main areas: racism, the migration experience itself, and employment. People from culturally and linguistically diverse background may experience prejudice, isolation, discrimination, or antagonism and stigmatization, directed against them based on the belief that a race is inferior or superior to another race (Ip et al., 1998; Ip, 2008; Ip et al., 2008; White and Kliner, 2012; Forresta and Dunn, 2013). A longitudinal study found that when immigrant groups from non-English speaking countries had been in Australia for more than 10 years, their mental health and self-assessed health were worse than that for Australian-born individuals (Jatrana et al. 2017). Evidence has shown that the migrants’, especially the women, health deteriorated after migrating to the host countries, because of their vulnerability to social changes and stress of postmigration settlement (Shen et al., 2011; Kim et al., 2013; Jatrana et al. 2017).

Kwok and Ho (2011) have reported that some Chinese migrants have found it stressful to live in Australia because of multiple stressors. Their traumatic experiences include the loss of cultural norms, religious customs, and social support systems, adjustment to a new culture and changes in identity and self-concept, resulting in social isolation and loneliness (Bhugrai and Becker, 2005; Ip, 2207; Ip et al., 2008; Sternthal et al., 2011). Some of the Chinese migrants had to manage two households – one in the place of origin and one in the host country (Ip et al., 2006; Ip and Dunn, 2008).

The Chinese migrants experience similar cases of prejudice and discrimination as the other migrants. For example, Chinese traditionally place an extremely high value on education, as a means of enhancing a person's worth and career (Chen and Uttal, 1988; Francis and Archer, 2005; Wong et al., 2012). In 2006, 31.9% of Chinese migrants attained a bachelor's degree compared to just 14.8% for the general Australian population. Even though the Chinese migrants held higher education attainment yet the median weekly earnings for Chinese
migrants are relatively lower than the population average (ABS, 2006). Furthermore, Chinese migrants and those Chinese from Hong-Kong also have an unemployment rate of 11.2% and 6.6% respectively. Both figures were higher than the national average of 4.9% (available at https://en.wikipedia.org/wiki/Chinese_Australians). Studies have found that people in employment are healthier (Faragher et al., 2005; Goodman, 2015). Furthermore, there is a lack of study into the impact of a higher unemployment rate of the Chinese migrants on their health.

Evidence has suggested that higher education associates with better health (Winkleby et al., 1992), low education levels are linked with poor health, more stress and lower self-confidence, however, this is only true when their education was not fully utilised at work as suggested by Leeves and Soyiri (2015). There is a lack of information about whether Chinese migrants were working in the fields they were trained in.

4.4.2 Impact of Chinese migrants’ traditional core values on their health

It has been well documented that Chinese philosophies and religions strongly influence the Chinese migrants’ core beliefs, values, cultural practice, way of living and health practices (Fung, 2011; Wong et al., 2011). The three most prominent belief systems that have left a collective and lasting impression on Chinese culture and tradition are: Confucianism (Lam, 2006; Kwok and Ho, 2011; Daly et al., 2001; Haralambous et al., 2014), Taoism (Kwok and Ho, 2011; Koo, 2011) and Buddhism.

The Chinese traditionally have a patriarchal culture which may result in gender inequality and a resulting health disparity between men and women (Yu and Sarri, 1997; Li, 2004; Aattane, 2012; Giuliano, 2017). Gender inequality in the Chinese is built into the culture. Rong & Shi (2001) and Bauer et al. (1992) have found that there is inequality in gender when it comes to education and that males are more likely to be enrolled than females at every age group in formal education (Chu, 2005; Ip, 2007). The society has a son-preference, the male household head owns the land, and only sons inherit, women take on the primary housework role, and daughters-in-laws are the primary care providers. The Chinese also has residence patterns that are multi-generational and co-residence (Cheng and Chan, 2006; Hsu and Barker, 2013; Yu, 2013).

Ho (2006) also suggested that male and female Chinese migrants have different migration experiences, where female migrants experience predominantly is downward occupation
mobility compared with their male counterparts. There is also a major barrier to achieving gender equality and women’s sexual autonomy in marriage (Stevi et al., 2008). Kwok & White (2011) has suggested that Chinese female migrants experienced isolation, compounded by the lack of culturally sensitive resources and information.

Authors have found that Chinese female migrants tend to adopt different gender identity and body images compared with local born Australian women, which may also affect their participation in health services (Chu, 2005; Kwok et al., 2012). For example, some authors have suggested that Chinese female breast cancer patients did not worry about their body image of femininity and beauty as much as their Australian counterparts, but rather they were worried about their capacity to look after their family (Kwok and Ho, 2011; Kwok & White, 2011). They have also found that Chinese female breast cancer patients were more concerned about their family and children’s welfare than about themselves, that is they place a higher value on the role of being a mother and homemaker. The Chinese patients never thought of breast reconstruction surgery. The Australian patients however were more concerned with self-worth, their body image, sexuality and feminicity as a result of a loss of their breasts.

Evidence has shown that family support and the older person’s living arrangement could influence their physical and psychological health (Lam, 2006; Ugargol et al., 2016). Studies have suggested that older people, particularly among immigrants, who are alone (never married, widowed, divorced or separated) may experience a feeling of loss of intimacy, a high level of loneliness, and have higher psychological distress, which all have a negative impact upon their psychological well-being (Sun et al., 2011; Kikuchi, 2014; Bélanger et al., 2016).

Studies have shown that the Chinese have a family-centred culture, therefore, Chinese migrants have more structured, controlling family environments than the mainstream Australian culture (Bryant & Lim, 2013; Haralambous et al., 2014; Zhang, 2014). Chinese immigrant communities tend to maintain close contact with their families and friends at their places of origin (Ho, 2007).

Many authors reported that Chinese hold traditional Chinese values of ‘filial piety’ (Li et al., 2010; Haralambous et al., 2014; Ip-Winfield et al., 2014; Zhang, 2014). They rely heavily on family and close members of their informal network for support, which includes physical,
financial, information or emotional support and decision making (Wong, 2010; Kwok & White 2011; Low et al., 2011; Shen, 2011; White & Kliner, 2012; Zhang, 2014; Bryant & Lim, 2013; Poon et al., 2013; Kwok & White, 2014). There are more Australian-Chinese migrants who live with their extended families compared to the mainstream Australians (Shen et al., 2011; Wong et al., 2010; Poon et al., 2013), because of their traditional beliefs based on the concepts of collectivism and filial piety (Lui et al., 2009). The Chinese immigrants’ living arrangements depend on various factors, such as their cultural preferences, physical, psychological, social and financial support they needed, family dynamics, financial status, English proficiency, education, gender and age (Lai, 2005; Chen, Hicks and While, 2013; Zhang, 2015).

Studies have found many differences between the traditional Chinese health beliefs and the western biomedical approach. For example, Chinese migrants considered Western medicine as an active and aggressive approach to combat disease (Tang, 2009) therefore the former were more concerned about the harmfulness of certain treatment strategies (pharmacotherapy and surgery) than the Australian population (Lam et al., 2012). Heiniger et al. (2015) have found that Caucasians are more frequently screened for illness than Chinese migrants. For example, the rate of Chinese female migrants who used breast cancer screening services were 50% less than Australian-born women (Kwok & White, 2011; Kwok, et al., 2012; Cheung et al., 2011). Some authors have investigated the sociocultural factors associated with health screening in Chinese and ethnic communities (Armstrong and Eborall, 2012; Lee-Lin et al., 2012; Ma et al., 2012; Patel et al., 2012). Evidence has shown that screening disagreed with Chinese migrants’ health beliefs and practices, therefore, they seldom participated in regular health screening programs (Kwok et al., 2011). However, studies from NSW have found that written invitations for Breast Screening and organised transport with interpreters was helpful and appreciated by the Chinese migrants (Kwok et al 2005). According to Kwok et al. (2012) health screening is a strategy for early detection and early treatment, which may reduce mortality and extend life expectancy, but may not improve healthy life expectancy. Chinese migrants however predominantly did not believe in the benefits according to the Western medical model and preferred a restorative approach to protect and maintain health, by using traditional Chinese medicine, dietary therapy, and practising qi gong and Tai Chi (Chu, 2005; Kwok & Sullivan, 2006; Kwok & Sullivan, 2007; Ho et al., 2008).
Chinese migrants consulted both western and traditional Chinese medical practitioners (Daly et al. 2001; Chui et al., 2005; Chu 2005; Ahn et al., 2006; Chao et al., 2006; Kronenberg et al., 2006; Roth and Kobayashi, 2008; Ho et al. 2008; Tanaka et al., 2008; Wong et al. 2009, Lui et al. 2009, Lai and Surood, 2009; Wong et al. 2010; Lai and Surood, 2009; Yeoh and Furler, 2011; Henderson and Kendall, 2011). Henderson & Kendall (2011) have suggested that most culturally and linguistically diverse people feel respected for their beliefs when their doctors use their traditional healing methods alongside orthodox/allopathic medicine. Unfortunately, there is prejudice, discrimination, and intolerance against traditional Chinese medicine by some sectors of the orthodox medical establishment (AIHW 2014). Many of the Chinese migrants' health beliefs that are experienced as proper and functionally positive in their native cultures are considered unscientific, negative and of questionable value by some health professionals (Priebe et al., 2011; Mangrio and Forss, 2017).

4.4.3 Impact of sociocultural issues on health

Chinese migrants’ health seeking behaviour is based on who they are and what they believe. Daly et al. (2002) have suggested that health and illness are culturally constructed experiences. Health then, is the product of the dynamic interaction between social factors and the individual's socio-economic and cultural characteristics (Choi, 2009; Lo and Tan, 2014). Studies have found that the different cultural background of migrants is reflected in different perceptions and behaviours which affects their health (Davidson et al., 2007; Graham et al., 2011; Jamil and Dutta, 2012).

Cultural barriers can affect Chinese migrant physical, mental and social well-being, leading to further exclusion and isolation, with long-term negative implications for their health (Ip, 2007; Ding and Hargraves, 2009; Yoo et al., 2009; Kulla et al., 2010; Han et al., 2011; Teixeira and Vaz, 2011; Lebrun, 2012). An individual's health beliefs and health-seeking behaviour may be hampered by a number of different factors: social structure, cultural and language barriers to accessing appropriate services; administrative problems in delivery; and by circumstantial challenges (Okafor, 2009; Lai and Surood, 2010; Fung, 2011). Other factors found to be significant are personal attitudes, and education and occupational status. Religious beliefs, cultural and lifestyle practices, and lack of access to culturally specific care are also factors that affect an individual’s health (Radermacher et al., 2009; Jacob, 2010; Lai and Surood, 2010; Prus et al., 2010; Ta et al., 2011; Lebrun, 2012). Poverty, and domestic violence too are factors affecting Chinese migrant health. Domestic violence can be
particularly significant because it tends to increase social disorganization and inhibit personal adjustment, hence, creating social problems and equity issues among the culturally and linguistically diverse population (Lang and Rayner, 2012). Evidence has shown that those who experienced more cultural barriers and a higher level of association with Chinese cultural values resulted in a higher probability of being depressive and that almost 25% of the elderly Chinese immigrants have at least a mild level of depression (Lai, 2004; Lai, 2004a). Chinese migrants may also defer or delay seeking help from health professionals because of cultural beliefs such as fatalism, denial and avoidance of stigma attached to diseases such as cancer or mental health issues. (Lui et al., 2009; Lam et al., 2010; Wong, 2010; Poon et al., 2013).

Many Australian-Chinese migrants follow traditional health beliefs which provide an important basis for diet and lifestyle habits (Ahn et al., 2006; Chao et al., 2006; Kronenberg et al., 2006; Tanaka et al., 2008; Lai and Surood, 2009). Shen (2011) has found that Chinese migrants are less likely to smoke and drink regularly. Chui et al. (2005) and Kwok (2011) have reported that Chinese migrants used food for health maintenance, or in some cases for managing the side effects of cancer treatments or to prevent cancer reoccurring. Li et al. (2001) have suggested that the dietary pattern of the immigrants’ higher intake of vegetables, and lower saturated fat might have contributed to lower mortality from cardiovascular diseases. Chinese migrants also take Chinese nutritional foods and supplements to correct and maintain their health (Ahn et al., 2006; Chao et al., 2006; Kronenberg et al., 2006; Roth and Kobayashi, 2008; Tanaka et al., 2008; Lai and Surood, 2009; Henderson and Kendall, 2011).

Chinese migrants’ lower participation in health services could be the result of the lack of culturally and linguistically appropriate health information and health programs. Australia's universal health care system provides accessible and affordable services to all Australians; however, it does not mean that everyone wants the allopathic medical care services offered (Walter & Gameau, 1993), simply because allopathic medicine would not work with traditional medicine (Nemutandani et al., 2016). Authors have suggested that Chinese migrants under-participated in health services because the services have inadequate access and poor-quality culturally appropriate health care for migrants (Derose et al. 2009; Mangrio and Forss, 2017). Literature has suggested that the Chinese traditional beliefs might have contributed to their underreporting and underutilisation of health services in Australia (Chu, 2005; Ip et al. 2007; Tan et al., 2010; Kwok, 2011). Wilson (2008) and Chalmers et al. (2014)
stressed that culturally appropriate health service is one that includes Chinese migrants' cultural beliefs and practices into intervention plans.

Some authors have investigated the sociocultural factors associated with health screening in Chinese and ethnic communities (Armstrong and Eborall, 2012; Lee-Lin et al., 2012; Ma et al., 2012; Patel et al., 2012). Evidence has shown that screening disagreed with Chinese migrants’ health beliefs and practices, therefore, they seldom participated in regular health screening programs (Kwok et al., 2011). Studies have found that Caucasians are more frequently screened for illness than Chinese migrants. For example, the rate of Chinese female migrants who used breast cancer screening services were 50% less than Australian born women (Kwok & White, 2011; Kwok, et al., 2012; Cheung et al., 2011). A study with larger number of participants may be able to decide if this is true with the Chinese baby boomer migrants. However, studies from NSW have found that written invitations for breast screening and organised transport with interpreters was helpful and appreciated by the Chinese migrants (Kwok et al 2007). According to Kwok et al. (2012) health screening is a strategy for early detection and early treatment, which may reduce mortality and extend life expectancy, but may not improve healthy life expectancy.

Studies have found many differences between the traditional Chinese health beliefs and the western biomedical approach (Rochelle and Marks, 2011; van Rooyen et al., 2015; Ibeneme et al., 2017). Chinese migrants considered Western medicine as an active and aggressive approach to combat disease therefore the participants were more unsure about the harmfulness of certain treatment strategies (pharmacotherapy and surgery) than the Australian population (Tang et al., 2009). Chinese migrants predominantly did not believe in the benefits according to the Western medical model and preferred a restorative approach to protect and maintain health, by using traditional Chinese medicine, dietary therapy, and practising qi gong and Tai Chi (Chu, 2005; Kwok & Sullivan, 2006; Kwok & Sullivan, 2006a; Kwok & Sullivan, 2007; Ho et al., 2008).

Studies have found that Chinese migrants consulted both western and traditional Chinese medical practitioners (Daly et al 2001; Chui et al., 2005; Chu 2005; Ahn et al., 2006; Chao et al., 2006; Kronenberg et al., 2006; Roth and Kobayashi, 2008; Ho et al 2008; Tanaka et al., 2008; Wong et al. 2009, Lui et al 2009, Lai and Surood, 2009; Wong et al 2010; Yeoh and Furler, 2011; Henderson and Kendall, 2011). Henderson and Kendall (2011) suggested that
most culturally and linguistically diverse people feel respected for their beliefs when their doctors use their traditional healing methods alongside orthodox/allopathic medicine. Unfortunately, there is prejudice, discrimination, and intolerance against traditional Chinese medicine by some sectors of the orthodox medical establishment. Many of the Chinese migrants’ health beliefs that are experienced as proper and functionally positive in their native cultures are considered unscientific, negative and of questionable value by some health professionals (van Rooyen et al., 2015).

Countless authors have suggested that there is a need for culturally appropriate and sensitive health promotion programs targeted and tailored for Chinese migrants, in order to encourage them to participate in the mainstream health programs (Vu et al. 2012, Wong et al., 2010a.; Wong et al. 2010b., Hua, 2002). However, there are several barriers to providing culturally appropriate health practices. One of the major issues in offering culturally appropriate health practices is a lack of consensus on the definition of culturally appropriate health practices.

The lack of linguistically and culturally appropriate health information may also contribute to Chinese migrants’ lower rate of participation in health services and under-reporting of health conditions (Greig & Crossman, 2005; Blignault, 2008; Cheung, 2011; Kwok, 2011), leading to late diagnosis and delayed help-seeking (Shen 2011; Vu 2011; Kwok & Klinner 2012; Kwok & Sullivan 2006; Kwok et al 2011, Daly et al 2001, Haralambous et al, 2014, Ho et al 2008; Poon et al 2012), which ultimately contributes to the lower prevalence of health conditions (Cheung et al 2011; Wong et al 2010).

Therefore, some authors stress the significance of cultural inclusiveness (Lamm, 2005; López-Acuña, 2008). However, Chinese migrants could not always integrate both approaches successfully (Chui et al., 2005). Heidenreich et al. (2014) suggested providing culturally appropriate services sensitive to the diverse socio-cultural backgrounds and the individual Chinese migrant’s needs. Unfortunately, there is a lack of Australian research studies within the Chinese cultural framework (Koo et al., 2012). There is also a lack of knowledge and support for Australian Chinese migrants in integrating the traditional Chinese medicine and western biomedical medicine approach. Evidence have found that traditional Chinese medicine is not just a resource for illness management, but when incorporated in their daily health practices it provides an important basis for their diet and lifestyle habits, therefore it is their cultural heritage. It allows them to
perform and reaffirm cultural identity by using their existing health knowledge (Ahn et al., 2006; Chao et al., 2006; Kronenberg et al., 2006; Roth and Kobayashi, 2008; Tanaka et al., 2008; Lai and Surood, 2009). The same finding was consistent with an USA study by Kong and Hsieh (2012) and Liu et al. (2011) which suggested that the American Chinese migrants used traditional Chinese medicine to reaffirm their cultural identity, maintain their moral status and fulfil their social roles.

Health professionals’ relationship with Chinese migrants may also influence the latter’s help-seeking behaviour (Rochelle and Marks, 2011). Chinese migrants prefer doctors who speak the same language. Because the doctors are more sensitive to their health needs, it is easier to express their concerns and understand the medical talk (Kwok and Sullivan, 2007; Chui et al., 2009; White and Klinner, 2012; Kwok et al., 2011; Kwok and Ho, 2011). Evidence has shown that general practitioners were considered by Chinese migrants as the first point of contact when they seek health services (Tang, 2009). However, studies have found that most health care providers did not meet Australian migrants’ needs (Chui, 2005; Chu, 2005; White and Klinner, 2010). Evidence has shown that Chinese migrants do not confront health providers, neither do they seek clarification of information from their doctors (Kwok 2011; Liu et al. 2009). The Chinese migrants still respected the medical professionals and were reluctant to offend them. Even though the general practitioners do not understand traditional Chinese health concepts and practices, the Chinese born migrants were sceptical of the doctor’s treatments and unsure of western treatments’ efficacy (White and Klinner, 2012). Furthermore, doctors had no time to explain things to Australian-Chinese migrants when the latter were confused with dosage information about the western medicine they were taking and with concerns about the medicines’ side-effects (White and Klinner, 2012). Studies should explore if these experiences occur with Chinese migrants in Australia. Wong et al. (2010) suggested that technical and medical terms should be avoided, and plain and ordinary language used instead. Chinese migrants might be deterred from seeking health services if doctors talked in technical terms, which their patients could not understand, and if they had to wait for consultation and treatment, and also have to bear the cost of consultation/treatments (Cheung et al., 2011; Wong et al., 2012).

Chu (2005, p. 48) identified many needs of the Australian migrants:

“Access to information regarding: health in general ........ Improved quality and appropriateness of services: less waiting time, availability of bilingual health staff or interpreters, and more friendly services. ............... General social needs of
individuals: such as transport; help to improve English language skills; and, recognition of their professional or education qualifications so they could seek employment relevant to their background.”

4.4.4 Impact of language proficiency on health

Studies have unanimously agreed that language is one of the most significant factors that affect the Chinese migrants’ health. Studies have found that immigrants from English-speaking countries were found to have advantages related to physical health, mental health, and self-assessed health. English proficiency had an effect on the difference in health between populations, as a language barrier could hinder an individual’s access to health services. Language barriers can lead to an under-representation of Chinese people when English is used in surveys or is required for self-reported information. It can also have an impact on employment, which has broader socioeconomic implications (Hua, 2002; Cheung, 2011; White and Klinner, 2012; Kwok and White, 2014; Zhang, 2014; Cerin et al., 2015; Biehl and Kahn, 2016; Rains, 2016; De Choudhury and Kiciman, 2017).

A communication breakdown because of a lack of language proficiency could also contribute to the Chinese migrants’ underreporting of health conditions. Literature reviewed has shown that Chinese migrants’ low English proficiency can have deleterious effects (Hua 2002; Kwok 2011; Cheung 2011; White and Klinner 2012; Kwok et al 2011; Zhang 2014; Kwok and White 2014; Shaw et al 2015; Fernández-Gutiérrez et al., 2018). Some of these effects were that the individuals were unaware of health services (Ho et al., 2008; Daly et al., 2001; Oei and Raylu, 2009; Lam et al., 2010; Poon et al., 2012; Blignault et al., 2014). Another effect was that it discouraged their participation in the health services, in the workforce, and in the community (Greig & Crossman, 2005; Chu, 2005; Tang et al 2009). Kwok and White (2014) and Shaw et al. (2016) reported that low English proficiency resulted in higher unmet supportive care needs, higher sense of isolation and psychosocial issues, more treatment side-effects, with lower health screening and survival rate, lower QoL, and a lack of knowledge of health systems, tests and protocols. Lack of English proficiency also impedes their understanding of health information, which ultimately undermined their safety, independence and health (Kwok, 2011).

Some authors have suggested bilingual therapists and different languages to be offered in health programs to ameliorate some of these issues of language proficiency (Kowk and Ho,
2011; Lam et al, 2010). However, Kowk et al. (2006) have stated that health promotion material even though in Chinese is not effective because it does not coincide with Chinese beliefs (Leung et al., 2014). Furthermore, Kowk and Ho (2011) reported that there is a lack of culturally and linguistically appropriate information and resources for Chinese migrants. Lui et al. (2009) and Blignault et al. (2008) have suggested that cross-cultural communication was not just a matter of hearing individual words but also incorporating the Australian migrants’ cultural, social, historical, environmental, and psychological forces that influenced them.

4.5 Conclusion

Australia has a very diverse population, including descendants of its original inhabitants and the largely British people of the colonial period to many of these who have come from different parts of the world at different times. Since the 1970’s increasing migrants came from the culturally and linguistically diverse background. Within this group the largest and fastest growing is the Chinese migrants. Their health and social needs may be particularly critical as a result of their migration experiences, and their cultural and language barriers; and which impact on their financial circumstances and their psycho-social health, however, little is known about their health needs, especially their baby boomers. Therefore, it is critical to understand the Chinese baby boomer migrants’ social and health needs. Therefore, this study uses a holistic and comprehensive methodology and methods to explore their social and health needs as discussed in Chapter 5.
Chapter 5
Methodology

5.1 Introduction
This chapter presents the methodology used for this study. It begins by introducing the theoretical base drawn from the field of health promotion and the needs-based program planning approach to health promotion. It then explains the rationale aims, objectives, and the reasoning behind adopting the Community Needs Assessment approach. This is followed by presenting the research question and focus questions of this study and the corresponding methods of data collection and data analysis. Finally, it describes the procedures adopted to ensure ethical practice and the strategies that ensure this study’s rigor.

5.2 Theoretical base for this study
The theoretical framework based on the health promotion and the community needs assessment framework.

5.2.1 The health promotion approach
This study adopts a holistic multi-determinants approach of health promotion. According to the World Health Organization's Ottawa Charter for Health Promotion in a Globalized World (WHO, 1986), health promotion is defined as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health". Health promotion is a comprehensive social and political process directed toward changing social, environmental and economic conditions or determinants of health. More significantly, it improves the skills and capabilities of individuals, thus enabling people to increase control over the determinants of health and thereby improve their health (WHO, 1986), by nature it is an empowerment process. Frieden (2010) suggested that there are different types of public health interventions that provides a framework to improve health. Interventions focusing on lower levels of the pyramid tend to be more effective because they reach broader spectrum of the society and can achieve the maximum possible sustained public health benefit. Evidence has shown that interventions that would give the greatest potential impact are those efforts that address the socio-economic determinants of health, as shown in Figure 10.
Health promotion also aims to reduce inequity by ensuring equal opportunities and resources to enable people to achieve their fullest health potential. Health promotion enables them to take control of the things that determine their health, such as: access to information, resources and network, and opportunities to make decisions that could promote a healthy life, including their healthy ageing.

Haveman-Nies, de Groot and van Staveren (2003) and Pham et al., (2019) suggested that health promotion at older ages can contribute to healthy ageing. The academic focus more on physical and mental health and social functioning in later life, whereas older lay people’ definitions of healthy ageing included independency, family, adaptation, financial security, personal growth, and spirituality. Hence, a more holistic perspectives of older lay people and culturally diverse is added into the classical ‘physical–mental–social’ healthy ageing concept (Hung et al., 2010).

Evidence has shown the healthy ageing is a multi-dimensional and complex concept, and that there are substantial differences in different cultures. There are also pronounced differences in conceptualisation of healthy ageing between academic and older lay people (Hung et al., 2010).

Based on the Socio-Ecological approach, WHO (1986) suggested a list of basic prerequisites that could improve a person’s health: peace, shelter, education, diet, income, a stable ecosystem, sustainable resources, social justice, and equity. Evidence has shown that interventions that would give the greatest potential impact are the efforts that address the
socioeconomic determinants of health. Thus, to influence health outcomes, health promotion efforts should prioritise the assessing and mitigating of the social determinants of health.

Ageing is a life-long process. WHO uses the life course approach of health promotion throughout life to plan for people’s health and wellbeing. Both the Life Course theory and the Social Ecological model share a multidisciplinary paradigm in analysing people's lives and health within their structural, social, and cultural contexts, except that the Life Course approach uses a longitudinal timeline (Figure: 11). Moreover, the Health promotion and Social Ecological approaches are fully in line with the Life Course theory which asserts that people’s experience of their social and economic circumstances at different life stages can affect their health in years to come. (Burton-Jeangros, et al., 2015).

![Diagram of life course perspective for maintenance of the highest possible level of functional capacity](WHO 2000. The implications for training of embracing a Life Course approach to health)

As explained above, health promotion is about addressing physical, social and environmental determinants of people’s health as such, identifying their social and health needs is the first step of empowering them in this process. To identify needs and the complex multi-determinants of health, it is necessary to use a comprehensive needs assessment model to collect data and views from multiple perspectives by relevant stakeholders involved in the process. This is the theoretical base for this study, to conduct a comprehensive needs assessment in order to understand the social and health needs of the Chinese baby boomers in Australia aiming to promote their healthy ageing process. To this end, Chu’s comprehensive
Community needs assessment (CNA) framework (1994) will be applied here to guide the research process and data collection methods. This is further supported by Liberato et al. (2011); Ahari et al. (2012), Pieh-Holder (2012); Altschuld et al., (2014). Engle and Altschuld (2014). Dwipayanti et al. (2017).

5.2.2 Community Needs Assessment Framework

This CNA framework was originally developed by Chu to identify reproductive health needs for health promotion program planning. It has been used by researchers in many health projects from Australia, China, Indonesia, Taiwan and Vietnam to develop policy and practices to meet the users’ needs (Chu & Ma 2005a; Pieh-Holder et al., 2012; Phung et al 2013; Lin LY 2014; Xia et al 2015;). It consists of a methodological framework based on Bradshaw’s concepts of four types of needs (comparative needs, expressed needs, normative needs, and felt needs) (1972), representing the inputs from literature and secondary data, policy makers, experts, practitioners, and community members in order to identify issues, concerns and potential strategies for health promotion. This strategy allows the triangulation of perspectives (Stefaniak et al., 2015).

The needs assessment uses multiple qualitative data collection methods: in-depth interviews, expert consultations, existing secondary data collection, and focus group discussions. A literature review from studies of similar experience found elsewhere, local histories and quantitative secondary data will be used to identify comparative needs, in which the comparison of the needs and intervention measures in other similar settings globally will be considered to inform the potential policy and practices for the study. Secondary data will be collected to assess express needs, such as statistic about demographic, mortality and morbidity, health, injury, housing, and health facility utility trends. In-depth interviews with relevant authorities and experts, health service providers will be conducted to identify the normative needs; Focus group discussion and interviews of community members will be used to identify the felt needs.
5.3 Research rationale, aims and objectives (Figure 12)

Previous studies have identified the gap in current policy and planning in promoting healthy ageing targeting the baby boomer generations, particularly for those from the culturally and linguistically diverse background. Literature also points out that planning for these diverse non-English speaking background populations is challenging. First, there is a lack of up-to-date information about their health needs. Current aged planning is based on data collected from previous generations (AIHW 2016) but this large number of baby boomers who are ageing and fast approaching retirement age have different expectations from previous generations (Franklin, 2012). Second, Australians’ life expectancies have increased steadily over the years, this longer life expectancy has been accompanied by increased chronic illnesses. Therefore, it is crucial to promote healthy ageing to the upcoming ageing baby boomers. Third, there appears to be a health disparity between the local born Australian and the overseas born non-English speaking background migrants (Kulla et al., 2010; Manthorpe, J. 2010; Prus et al., 2010; Haghshenas et al 2011; Henderson et al., 2011; López et al., 2011; Ng and Newbold, 2011; Warner and Brown, 2011; Dilworth-Anderson et al., 2012). The overseas born Chinese make up one of the largest groups of non-English speaking migrant population in Australia. There is a large number of Chinese workers, who have migrated to Australia since 1970, who are baby boomers now fast approaching retirement. In a time of tightened resources, the main concern is that when the health resources are constrained, the equity of the distribution of health resources may be affected (Gupta et al., 2007). The most vulnerable groups negatively impacted may be migrants from culturally and linguistically diverse background such as the Chinese.
The Chinese baby boomer migrants have different culture, social and health needs from that of the local born Australians. However, there is little information about their needs and concerns, making planning social and health services for them challenging. In order to fill the knowledge gap, this study investigates the social and health needs of the Chinese baby boomer migrants to inform future policy or program development towards promoting their health and wellbeing.

5.3.1 Aim of research study

The long-term aim of this study is to promote and improve the health and wellbeing of the Australian Chinese baby boomer migrants. The goal is to better understand their experience and needs to provide recommendations to address them.

The objectives of this study are to gather information that will help identify and understand the Chinese baby boomers’ social support and health needs. These include the following:

- The socio-demographic characteristics, housing situation and migration history of the Chinese baby boomer migrants underpinning their social circumstances, health and lifestyle choices.
- The community organisation, network and support systems available to the Chinese baby boomer migrants.
- The Chinese baby boomer migrants’ views and concerns about their health needs and experience of available services.
- Views and experience of relevant stakeholders including experts and service providers regarding the needs of the Chinese baby boomers. Information collected from different stakeholders are useful to policy makers and professionals to develop appropriate programs and support measures to meet the needs of the Chinese baby boomer migrants. Lee et al. (2007) have identified that involving various stakeholders is important in obtaining the full perspective of the community needs.
5.4 Research question and focus questions

The overall research question for this study is:

“What are the social and health Needs of Chinese Baby Boomer Migrants in Brisbane, Australia?”

The focus questions (FQ) are as follow (Table 3):

FQ1 What are the social and health needs of the Chinese baby boomer migrants in Australia according to the Chinese baby boomer migrants themselves (felt needs)?

Felt needs were how the Chinese baby boomer migrants in Australian perceived their social and health needs and services. This included individual the Chinese baby boomer migrants’ awareness, and the accessibility and acceptability of services which promote their health and wellbeing (Royse et al., 2009). The self-disclosed social and health needs contributed to the information that could help policy makers to understand individual's health concepts and plan for their services. In order to empower the Chinese baby boomer migrants, involving them would allow them to claim ownership and responsibilities of their own needs; moreover, it was essential to draw on their experiences, expertise and knowledge (Robinson & Elkan, 1996). This data was collected by semi-structured interviews, focus groups and participant observation.

FQ2 What are the health needs of the Chinese baby boomer migrants in Australia according to experts and professionals (normative needs)?

Normative needs are those needs seen from the perspectives of stakeholders (professional, political and public views), and defined by different experts and professionals who work with and provide services to the Chinese baby boomer migrants. There may be a discrepancy between the needs perceived by these professionals and those perceived by the Chinese baby boomer migrants. The experts may not see the needs from the same perspective as the Chinese baby boomer migrants. The perspectives may vary between experts, over time and in different places. The experts perceive the Chinese baby boomer migrants' awareness of, and the accessibility and acceptability of services which promote the Chinese baby boomer migrants' health and wellbeing differently according to their own perspectives and criteria. They may not be aware of the Chinese baby boomer migrants’ dissatisfaction with services or what their priorities are. However, professionals from different sectors and agencies may be
more committed to putting a health plan into action if they are involved in the process and development of the plan for health promotion. This data was collected by semi-structured interviews.

**FQ3** What are the health needs of the Chinese baby boomer migrants in Australia according to statistics and/or census or literature review (expressed needs)?

Expressed needs could be described as what services the Chinese baby boomer migrants were observed to use or are felt needs turned into action. This information about the Chinese baby boomer migrants' help seeking behaviour will display the community's awareness of, and its response to the availability, accessibility, and acceptability of services which promote the Chinese baby boomer migrants' healthy ageing process. This data was collected by literature review and observation by the researcher.

**FQ4** How does another developed country in similar circumstances meet the Chinese baby boomer migrants’ health needs (comparative needs)?

Successful planning for the health needs of the Chinese baby boomer migrants from Greater Brisbane region may be improved by observing how a community from another developed country/region meets the health needs of the Chinese baby boomer migrants with similar characteristics. This data was collected by literature review.

<table>
<thead>
<tr>
<th>Aim</th>
<th>Research question</th>
<th>Focus question</th>
<th>Data collection techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>To promote and improve the health and wellbeing of the Chinese baby boomer migrants and prevent their health disparity.</td>
<td>Exploring the Social and Health Needs of Chinese Baby Boomer Migrants in Brisbane, Australia</td>
<td>What are the felt needs?</td>
<td>Interviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What are the normative needs?</td>
<td>Focus group discussion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What are the expressed needs?</td>
<td>Interviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What are the comparative needs</td>
<td>Literature reviews</td>
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<td></td>
<td></td>
<td></td>
<td>Participant observations</td>
</tr>
</tbody>
</table>

Table 3: Summary of research aim, research question, focus questions, and data collection methods
5.5  Research design

This research seeks to explore social relationships, social processes, phenomena, meaning, values and experiences of a broad group of stakeholders. Almost all the studies reviewed of the culturally and linguistically diverse populations including that of the Chinese migrants have used qualitative methods, such as interviews, and focus group discussions. Since the qualitative research method answers a wide variety of questions related to human responses to actual or potential issues related to the Chinese baby boomer migrants’ health needs and because the purpose of qualitative research is to describe, explore and explain the health-related phenomena being studied, therefore, the qualitative approach is the most appropriate method to investigate the health needs of the Chinese baby boomer migrants. Therefore, this study has adopted the most appropriate exploratory approach, using semi-structured in-depth interviews, focus groups discussions and participant observations, to gather preliminary information, which will help to define and identify issues, and extrapolate explanatory relationships and suggest hypotheses (Liamputtong 2013, and Liamputtong 2017).

5.5.1  Research location and setting (Figure 13, 14)

This research ideally should be conducted nationally. However, studies have suggested that health promotion strategies and programmes should be adapted to the local needs and characteristics, considering differing social, cultural and economic systems. according to studies the highest settlement of Chinese overseas born migrants concentrate in Brisbane, capital of Queensland (Ip et al., 2007). this research was conducted in the geographical setting of the Greater Brisbane area which comprises the greater Brisbane metropolitan area (city of Brisbane), the Logan, Redland, Moreton Bay and Ipswich local government areas, because most of the overseas born migrants residing in Queensland have settled in this region, and because of the time and financial constraints. The researcher has been living in Brisbane since 1976, and therefore, is familiar with the local society.

The city of Brisbane, capital of the state of Queensland, is in the south-east of the state of Queensland. Brisbane is a river port situated on the Brisbane River, 100 km from the New South Wales border. The city centre is on the north side of the river and 15 km in a straight line from the river mouth on Moreton Bay. It is the state's main commercial and administrative centre and contains the state's largest domestic and international airport.
5.5.2 Stakeholders (Appendix 2)

This community health needs assessment process began by conducting a stakeholder analysis, which may be defined as a process that identifies all persons, stakeholder groups and organisations in the Chinese community. It centred upon “the stake” or the issue: "healthy ageing" of the Australian Chinese baby boomer migrants in Brisbane. Two types of stakeholders were recruited as informants.

There were two different types of informants. Informants A (participants) were stakeholders, Chinese baby boomer migrants residing in Brisbane (Australia), that gave information to answer focus question 1 and 3 (felt and expressed needs). Informants B were stakeholders that gave information which answered focus question 2 (normative needs). There were no stakeholders for comparative needs. Information to answer focus question 3 for expressed needs came from literature reviews and observations. Information to answer focus question 4 for comparative needs came from literature reviews, as reported in the Chapters 2, 3 and 4 of literature reviews and part of Chapter 7.

Selection of stakeholders were based on availability and accessibility. Some of the stakeholders were not accessible and available, such as those working in government departments (both state and local governments). Only some of the private organisations were willing to provide information to the researcher.
Figure 16: Stakeholder analysis 1

Informants

<table>
<thead>
<tr>
<th>Organizations</th>
<th>Characteristics</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeta Gardens</td>
<td>Aged care facilities</td>
<td>Managers</td>
</tr>
<tr>
<td>St Paul’s de Charters</td>
<td>Non-profitable aged-care facility</td>
<td>Healthcare service providers</td>
</tr>
<tr>
<td>Blue care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diversicare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cathy community Association</td>
<td>Community associations</td>
<td>Managers</td>
</tr>
<tr>
<td>Chinese Fraternity Association</td>
<td></td>
<td>Workers/carers</td>
</tr>
<tr>
<td>Anglicare</td>
<td></td>
<td>Service providers</td>
</tr>
<tr>
<td>Meals on Wheels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious groups – Buddhism, Catholic/Christian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australian Department of Health &amp; Ageing</td>
<td>Government agencies</td>
<td>Service providers</td>
</tr>
<tr>
<td>Centrelink</td>
<td></td>
<td>Financial support</td>
</tr>
<tr>
<td>Medicare</td>
<td>Financial services</td>
<td>Provider of financial support</td>
</tr>
<tr>
<td>Health insurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Participants

Chinese baby boomer migrants in Brisbane

Figure 17: Stakeholder analysis 2
5.5.3 Sampling strategy

This study’s target population was Chinese, definition of Chinese is the Chinese ethnicity and those who consider themselves as Chinese (Shen et al., 2011). The Australian Chinese baby boomer migrants were invited by advertisement sent to members of Chinese social and religious groups. In addition, the researcher recruited informant A (the Australian Chinese baby boomer migrants) and informants B by purposive, convenience and snow-ball or chain referral sampling technique, that is when the Chinese baby boomer migrants or informants made use of their social networks to refer the researcher to other people who might participate in or contribute to this study. Ideally, a randomly selected sample of informants A would be representative of the Chinese baby boomer migrants in Brisbane, Australia. Unfortunately, the Chinese baby boomer migrants residing in Brisbane were a minority hidden population, which is difficult to access, because of its ethnicity and age range. Therefore, random selection was out of the question because access was limited. Coupled with that, a conscious decision was made to choose some Informants B purposefully, because of their occupation. Furthermore, only a handful of individuals and organisations were willing to participate in this study.

5.5.4 Sampling process and criteria

The rationale for selection of informants and recruiting the sample was based on the following criteria: the type of information they could provide, the number of people needed in this sample, the ease of access to the informants, and their willingness to participate. The participation of multiple stakeholders would help in identifying and interpreting the health and social needs of the Australian Chinese migrants (Lee et. Al., 2007).

Recruitment of informants A was based on criteria that this sample would provide the type of information researcher needed to answer the research question and focus question 1 and 3 (felt and expressed needs). Informants A include the participants who are Chinese baby boomer migrants residing in Brisbane, both genders, born between 1946 and1965, who considered themselves as Chinese ethnicity, can speak either English or Chinese (Cantonese or/and Mandarin). Their place of nativity and origin, and the length of their stay in Australia was not included as part of the recruiting criteria.

Recruitment of Informants B was based on criteria that this sample would provide the type of information researcher needed to answer the research question and focus question 2 (Normative needs). Informants B were experts or people who have been working in the community associated with the well-being of baby boomers and/or Chinese baby boomer
migrants and the Chinese community in Brisbane. Informants were selected according to their roles, activities and organisations they belonged to. For example, some informants were chosen purposely because of their occupation as researchers from Ethnic Communities Council Queensland or because they worked as aged carers in the Chinese community. The backgrounds of these informants are listed in Appendix 3.

5.5.5 Sample size
An appropriate number of participants and informants was considered for the purposes of this qualitative study. This study used a relatively small sample size: 32 informants A (participants) and 25 Informants B, which was determined by resources, time available and based on data saturation occurred when less data generated and optimal quality data have efficiently and effectively emerged (Kwok & Sullivan, 2007; Tan et al., 2010; Gallegos & Nasim, 2011).

5.6 Data collection process
The process of data collection (Figure 17) began after the researcher gained ethical clearance from November 2013 till March 2016. Data collection was cyclical, with several follow-up interviews with some Informants A (participants).

![Figure 18: Phase 1 and Phase 2 of data collection process](image)

Initially first meeting was to introduce the researcher and to get to know informants’ background. The first cycle of the qualitative data collection was in-depth semi-structured interviews, conducting focus group discussions and participant observation. After interviewing many informants, the researcher reviewed data collected. Then researcher
proceeded with further data collection (2015-2016), by follow-up interviews and participant observation. Subsequently, follow-up meetings were sometimes in more relaxed and casual environment such as birthday parties, or lunch meetings etc., which extracted new information and clarified issues picked up from the first interviews and focus groups. Lot of times informants became more relaxed and open to engage in subsequent meetings. Prolonged fieldwork helps to reduce bias such as the likelihood of informants lying or withholding information (Liamputtong, 2009).

Based on a literature review, this study adopted several methods of collecting data: semi-structured in-depth interviews, focus groups discussion and participant observation. Primary data were those collected from participants who were the Informant A – the Chinese baby boomer migrants and the informants B, using semi-structured in-depth interviews, focus group discussions and participant observation. Secondary data was collected from the literature review of the statistics and census and government and/or professional documents, books, newspapers, magazines, journals and online articles.

The study used a systematic process of contacting and collecting data from the informants. Initially the participants and the informants were contacted by either phone or emails. After the participants and the informants accepted the invitation to be interviewed. The first meeting was to introduce the researcher and to get to know informants’ background.

Formal and accurate data collection was essential to maintain the integrity of this research, to ensure that data gathered were defined (precise), accurate (reliable) and appropriate (valid). Therefore, researcher designed appropriate data collection instruments, carefully planned data collection procedure and followed a systematic procedure to collect data, that answered the research question and satisfy the objectives of this study.

5.6.1 Interviews
This study used a systematic approach in collecting data from interviews. Semi-structured in-depth face to face interviews of 32 informants A (participants) and 25 informants B (Informants) were conducted. Two sets of interview questions were designed (Appendixes 5 and 6): one for the Informant A – the participants, who are the Chinese baby boomer migrants and the other for the informants B who are working with the baby boomers and the
Chinese community. Interview questions were revised and modified, according to the individual’s circumstances and as the research evolved.

5.6.1.1 Preparation before semi-structured in-depth interviews

This research seeks to understand social processes or social structures as well as illuminating ACBBMs’ experiences and their health needs. Semi-structured in-depth interviewing, which is very flexible and engaging in collecting large amounts of information, was considered the most appropriate method because it allowed informants and participants to tell their lived experiences in greater detail. Semi-structured in-depth interviews provided feedback and answers to focus questions 1 and 2.

Themes and examples of questions from literature reviewed formed the basis for open-ended questions used during the interviews. The interview protocol is not only designing a set of questions, but a guide to direct the researcher through the interview process (Jacob & Furgerson, 2012). Researcher designed interview tools to answer focus questions 1 and 2 (Chapter 5), keeping in mind the multi-determinants.

The researcher directly approached informants-A (participants) and informants-B by phone or email, then provided informants with information (Appendixes 6 and 7) about the study and the interview before the meeting, to allow them to prepare beforehand and to give them sufficient time to decide if they wanted to participate.

The researcher checked all the tools, such as tape recorder, batteries, pens, etc. to avoid any interruptions during the interview. Before commencing the interview, the researcher provided informants with background information to the study, made sure that they had read the information about the study, understood that they had to give information about themselves, the purpose of the study and how their information would be used, how they would participate in the study, and how it might directly or indirectly affect them, and finally ascertained their willingness to participate and asked them to sign an informed consent form (Appendixes 8 and 9).

5.6.1.2 Location of interviews

Evidence has shown that better quality information will be forthcoming if the interviewee is in a familiar setting (Moriarty, 2011). Therefore, researcher conducted all the semi-structured
interviews at a relaxed environment suggested by the informants, such as at their offices, their homes, their favourite restaurants, and local Brisbane City Council Libraries.

5.6.1.3 During Interview
The researcher ensured uninterrupted time for at least one hour. Data collected during the semi-structured interviews of the Australian Chinese baby boomer migrants began with more structured questions, to collect general and personal information such as their name, age, gender, marital status etc. followed by largely unstructured questioning that guided interviewees to talk about their background and experiences.

During the interviews, the researcher was mindful of being sensitive to and aware of interviewees’ needs, tone, body language and sentiments etc.. The researcher listened actively, engaged with them according to the individual informant’s personalities and styles, and used “probes” to encourage them to elaborate on their answers. One of the best ways of developing an understanding of any aspect of the culture of the OBCBBs is to listen to them talking about their lives (Jack & Gill, 2012).

Throughout the interview the researcher also took notes. After conclusion of interviews, the researcher requested permission to follow up issues, if necessary, by telephone/face to face/e-mail.

5.6.1.4 After Interview
In order to enhance the quality of the data collected, data collection and analysis were carried out simultaneously, to ensure a cyclical process, which allowed the researcher to identify issues that needed further clarification, and to modify interview techniques.

The researcher transcribed the interviews and entered interview-notes into a database as soon as possible after the interviews, while nuances, body language and sentiments were still fresh in her memory.

5.6.2 Focus group discussions (Table 15)
The researcher conducted three informal focus group discussions among individuals of the Chinese baby boomer migrants, aged care workers and carers and families of the aged people, who had shared experiences. The meeting was held in a pleasant environment, and refreshments were served to create a relaxed atmosphere. Participants of the focus groups were not comfortable to have their conversation taped, either for personal reasons (probably confidentiality issues) or because it was their company policy (Brisbane City Council). The researcher recorded the data by hand during and after the group discussions.
The researcher conducted three informal focus group discussions among individuals of Australian Chinese baby boomer migrants, aged care workers and carers and families of the aged people, who had shared experiences. A similar procedure was followed as with the semi-structured in-depth interviews, except this was carried out in a group situation. The meeting was held in a pleasant environment, and refreshments were served to create a relaxed atmosphere. All the focus groups were conducted during mealtime, because it saves a lot of time for the participants, and researcher could observe as a participant.

Total number of participants in focus groups were 16. Total of number of participants who only attended the focus group were 7, the rest were also interviewed.

There are certain problems with the use of focus groups and interviews. One of these is that the participants during the focus group discussion were not openly engaging when all of them were strangers to each other. On the other hand, focus group members who were members of the same family also were not engaging. Only the ones that were co-workers from the same Chinese aged care agency were open and engaging during the focus group discussion.

A focus group discussion between three workers from Brisbane City Council was organised. Before the interview began, the informants from a local government department declined answering any questions until all the interview questions were assessed by their legal team beforehand. Studies should investigate the barriers to collecting data for research studies.

<table>
<thead>
<tr>
<th>No. of people</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Chinese baby boomer migrants celebrating birthday</td>
<td>5</td>
</tr>
<tr>
<td>Australian Chinese community aged carers</td>
<td>5</td>
</tr>
</tbody>
</table>
who are working as aged carers. They talked about their concern about their work, their clients’ needs, and how the changes in government policies in aged care has affected them financially and psychologically.

Australian Chinese baby boomer migrants who attended the free Chinese language program at TAFE

6

The purpose was to understand the challenges that the Australian Chinese baby boomer migrants who have language barriers. They did not reveal much about their personal details, especially the male participant (who happens to be the only male participant), sitting next to his wife, was silent the whole time. They treated each other cordially and reservedly.

Table 15 Focus groups

5.6.3 Participant observation

Participant observation can yield information which is normally inaccessible because people might be unwilling or unable to provide any information during interviews. In order to strive for an in-depth understanding of the Chinese baby boomer migrants’ population, the researcher conducted unstructured participant observation. The researcher gained access and became a member of several social groups, and actively participated in the groups that were being studied, fully embracing the skills and customs of the group under observation, for the sake of complete comprehension. The stages of participant observation were similar with other methods: establishing rapport or getting to know the participants being observed and immersing oneself in the field (Ambert et al., 1995; Richardson, 2000). Consent forms were not signed, and audio-recorders were not used during the participant observations. The researcher was mindful in maintaining a balance between "insider" and "outsider" roles, which allowed a fair degree of involvement while maintaining the necessary detachment to remain objective. After the field experience, the researcher recorded her personal reflexions about each event and her experience.

5.7 Process of data analysis
Qualitative analysis was a circular and non-linear, iterative, progressive and very personal process (Figure 18). The researcher was the only one responsible for analysing the data, using a less structured and informal immersion method. All the data collected were transcribed by hand and manually coded, even though this was time consuming, but the researcher found this method more intuitive and creative.

This study uses the thematic analysis, a process of coding to create and establish meaningful patterns.

The process of analysis consists of 3 stages: deconstruction, interpretation, and reconstruction. Researcher read and reread transcripts and then breaking down data into categories that describe the content. It began with familiarization of the data by listening to and transcribing (and translating where relevant) the recordings of the interviews, translating the information collected about the community (Chinese baby boomer migrants) into rich data. The researcher then read and re-read the notes, the transcribed interviews, and observation etc., followed by comparing and contrasting the data to establish similarities and differences between the data groups, coding the data into categories and sub-categories according to patterns and themes identified, looking for interrelationships between different categories and sub-categories of the data, identifying the main themes, reviewing themes, defining and naming the themes and finally reporting new knowledge about the world and health determinants, from the perspective of the informants in the study. Hence, this method of analysis was an inductive process - developing theories from the data the researcher had gathered.

This is followed by comparing data codes and categories within and across transcripts, while purposefully looking for similarities and differences among themes, comparing findings with those of other studies, exploring theories which might explain relationships among themes, and exploring negative results (those that do not confirm the dominant themes) in more detail.

Finally, repackaging the prominent and prioritised themes in order to show the relationships and insights. There are many different means to set priorities (Salihu et al., 2015). In this study, researcher used criteria based on ‘relevance condition’, that is decisions were made on the basis of reasons (i.e., evidence from literature reviewed and data collected from the Chinese baby boomer migrants) that "fair-minded" people can agree are relevant under the
circumstances. This criterion relates to seriousness of the issue, proportion of population affected, urgency and benefits.

Figure 19: Data collection and analysis process

Researcher is well aware of the researcher’s role, which could contaminate the result of the study. Researcher’s role is to collect data from the various sources, followed by reflection, interpretation and analysis. The researcher was aware that while listening to the participants during interviews and making observations, the researcher was allowing words and images filtering through her own paradigm, reading her own autobiography into other's lives. The only way to ensure more credible result was to engage more analysts and data collectors.

Unfortunately, the researcher was the only one responsible for data collection and data analysis. She did not use a computer but used a less structured and informal immersion method. All the data collected were transcribed by hand and manually coded, even though this was time consuming, but the researcher found this method more intuitive and creative.

This process began with familiarization of the data by listening to and transcribing (and translating where relevant) the recordings of the interviews, translating the information collected about the community into rich data. The researcher then read and re-read the notes, the transcribed interviews, and observation etc., followed by comparing and contrasting the
data to establish similarities and differences between the data groups, coding the data into categories and sub-categories according to patterns and themes identified, looking for interrelationships between different categories and sub-categories of the data, identifying the main themes, reviewing themes, defining and naming the themes and finally reporting new knowledge about the world and health determinants, from the perspective of the informants in the study. Hence, this method of analysis was an inductive process - developing theories from the data the researcher had gathered.

5.8 **Criteria and techniques that ensure rigor**

The researcher used a series of strategies and techniques (Lincoln and Guba, 1985) that ensured the rigor, credibility and confirmability of this qualitative research study.

To begin with, the researcher identified the gap in knowledge that led to the research question, based on a literature review of all the appropriate contextual backgrounds (ageing, baby boomers, culturally and linguistically diverse and Chinese, changing social and health needs). The researcher used the most relevant theoretical approach of ‘health promotion’ in developing the research question. The proposed research question was valid in achieving the aim of preventing health disparity among the Chinese baby boomer migrants by promoting and improving their health and wellbeing.

The researcher then chose the most appropriate data collection methods of the need’s assessment, to gather rich information to answer the proposed research question. The alignment of focus questions and research methods improved the study’s internal validity. The researcher applied the appropriate and comprehensive research process to meet the aims of the investigation. The chosen research methods maximized the chance of identifying the full range of phenomenon and issues faced by the Chinese baby boomer migrants in Brisbane.

Researcher’s role is to collect data from the various sources, followed by reflection, interpretation and analysis. During the whole process, the researcher was mindful of maintaining neutrality and endeavoured to rise above her own preconceptions. The researcher was aware that while listening to the participants during interviews and making observations, the researcher was allowing words and images filtering through her own paradigm, reading her own autobiography into other's lives.
The researcher used two main strategies to promote the rigor, credibility and confirmability of this qualitative research study: ensuring authenticity” (the quality of the data) and “trustworthiness” (the quality of the analysis). During the whole process, the researcher was mindful of maintaining neutrality and endeavoured to rise above her own preconceptions. The researcher described every aspect of this study and what she did in detail with clear and simple language, and to ensure that the findings of the study is shaped by the participants and informants, and not by the researcher’s bias, motivation, or self-interest.

The most commonly used strategy to establish trustworthiness in qualitative studies is the triangulation of methods (Denzin, 1978 and Patton, 2001). Therefore, this study used several methods of triangulation to provide a more complete picture, to improve the consistency and accuracy of data, to ensure the credibility, reliability and dependability of qualitative methods (Denzin, 1978 and Patton, 2001). The triangulation methods available are theory triangulation, methodological triangulation, data triangulation, theoretical or perspective triangulation, triangulation of sources, data triangulation, space triangulation, person triangulation and investigator and analyst triangulation.

This study used space triangulation, which means collecting data from different sources/locations, such as different nursing homes - the Jeta Gardens, Villa Maria residential care and St Paul de Chartres Residential Aged Care from different suburbs, and agencies that serve senior Australians - Cathay Community Association, Evergreen Community and Chinese Fraternity Association, which are located at different areas in Brisbane.

This study used methodological triangulation, which involved using more than one method to gather data: semi-structured in-depth interviews, focus discussions, participant observations, and literature reviews. The use of multiple data sources to cross-check and validate findings increased the depth and quality of the study.

This study used data and person (perspective) triangulation, that is using multiple data sources of data from different stakeholders, with different backgrounds and viewpoints could improve its reliability, and ensures that an account is rich, robust, comprehensive and well-developed to improve quality of the data. In this case, the Chinese baby boomer migrants came from various social groups, and different professionals such as doctors, nurses, managers and workers from aged-care facilities and members of Chinese community associations.
Furthermore, the essence of reliability for qualitative research depends on consistency, therefore, the same procedure and the same questions were used for each in-depth interview in order to increase the reliability of the data collected. Furthermore, this study examined the consistency of different data sources from within the same method, when the researcher collected data both from the Chinese baby boomer migrants and their family members at different times. The researcher also collected data from a variety of sources: primary and secondary (data triangulation). This was coupled with prolonged engagement in the field to collect data, that is when the researcher spent extended period in the field. This enabled the researcher to become more oriented to the situation so that the context is appreciated and understood, developing relationships and rapport with members of the culture, to learn or understand informants in their native culture and their every day’s world, in order to gain a better understanding of their behaviour, values, and relationships in a social context, and hence, establishing credibility. The researcher also conducted follow-up interviews with the same informants.

All the findings of this study were extracted from recorded interviews to ensure that results were supported by the data. The data collected produce information that is appropriate for the level of precision required in the analysis and to address the research question. Data analysis ensured identification of the full range of relevant themes and salient relationships among themes. After deep immersion into the data, an extensive range of themes were identified to bring more rigor to qualitative research. The researcher also used theory triangulation, by interpreting the results, from multiple perspectives based on several approaches – Health Promotion advocacy, Social Ecological approach, Life Course approach and Empowerment theory.

5.9 Research ethics (Appendix 1)

The researcher was fully aware of her duty of care, and placed the welfare, rights and beliefs of informants ahead of the study objectives. The researcher gave prospective participants information written in English and Chinese detailing: their purpose of this study, their roles, all the implications, risks and benefits of this research study. They were also told that participation was voluntary and that they could withdraw at any time. They were assured that results obtained in this study would be published in journals and conferences; however, this information would not include any information identifying any
participant. The researcher assured informants of their confidentiality and privacy. Even though the informants knew that information they gave would be kept anonymous, they might still feel uncomfortable or anxious. Thus, informants had a run-in (cooling) phase to decide whether they wanted to be involved in this study. A couple of times, informants agreed to participate initially, but changed their minds later.

The well-being of the participants and associates was considered during the whole process of the study. For example, the researcher halted the interview when an informant broke down during the process. The researcher was aware of the sensitive nature of seeking information from informants. Thus, the researcher did not seek clarification when informants could not or did not want to answer some questions or seemed to be concealing the truth.

Being an Australian Chinese baby boomer migrant herself, the researcher shared the same language (Cantonese) and cultural heritage with informants and had appropriate knowledge of the Australian Chinese baby boomer migrants’ beliefs and cultural protocols. This helped build rapport between the researcher and informants, which proved to be very helpful because talking about one’s health and family background could be perceived as a very personal and sensitive topic in Chinese culture.

The design of this research is respectful of the cultural beliefs and protocols, when greeting each other and during meetings, of the Chinese baby boomer migrant informants. This respect is also extended to potential informants, third parties who might be affected by the study, and those who worked with the researcher.

The Social Sciences Human Research Ethics Committee of the Griffith University approved this research study in 2013 (Ref No: 2013/529). This research was bound ethically by giving informants written information about the aim of this study, its procedure and contact details of the researcher and the Human Ethics Committee. The participants gave their informed consent to participate in this research, and the researcher guaranteed that their details and responses would be kept confidential. All details of the ethical commitments are given in.

5.10 Conclusion

This chapter presents this study’s theoretical base, methodology and design. It explains the rationale of this study and its conceptual framework for the community needs assessment design, the research process and details regarding sampling and data collection. The community needs assessment data collected and analysed from the community consultations
are used to build the community profile and the findings of the four needs (normative needs, comparative needs, expressed needs and felt needs will be presented in the following Chapters 6, 7 and 8.

Chapter 6

The socioeconomic and demographic profile of the study sample

6.1 Introduction

This chapter gives a snapshot of the demographics and socioeconomic profile of the study sample, who belong within the cohort of Chinese baby boomer migrants residing in Brisbane. Understanding the study samples’ socioeconomic profile and background will provide a deeper appreciation of their health needs because it is argued that these socioeconomic factors impact on the participants’ health.

The data for the study sample’s demographic and socioeconomic profile were collected from semi-structured in-depth interviews, focus groups and participant observations. The findings answer the focus question: “What are the expressed needs of the Chinese baby boomer migrants?”

This chapter begins by describing the study sample’s migration experience and their settlement patterns in Brisbane. A demographic profile follows, providing details about socioeconomic backgrounds, marital status, language proficiency, level of education, and other factors by which individuals can be described. The final section covers the health services provided to ageing Chinese migrants by the Australian government and by the Chinese community in Brisbane.

6.2 The participants’ migration experiences (Table 4)

The 32 participants, 7 men and 25 women, had different migration experiences. They came from different socioeconomic backgrounds and had different expectations. The participants came to Australia for study, employment, family reunion and as refugees. One participant came as visitor but remained as an illegal immigrant (Figure 6.1). Even though most of the participants have stayed in Australia since the 1970s’ - 1980s’, some of them are still homesick and experienced a sense of loss, dislocation, alienation, and isolation living in Australia. This is a factor that is identified in the literature review. Most of the participants
maintained close contact with their family and friends back in their original countries of origin, also identified by studies of migrants in the literature review.

Of all the participants in the study some have regretted migrating while others are very satisfied with their decision to migrate. Some of the participants who regretted coming to Australia have achieved financial success outside of their professional fields. Even though they were highly qualified professionals prior to migration, they could not find employment in their profession after settling in Australia and have had to work in other areas in order to support themselves and their families. They miss the jobs and responsibilities and status they had at work in their countries of origin. The use of the English language has not been a limiting factor in their working lives. However, they do miss the lifestyle of their places of origin, and most of all they miss their family, friends and colleagues.

Other participants who are financially dependent on Australian social security are happy with their choice to stay in Australia. Those participants who are not proficient in English and rely on Australia’s social security have reported that their lives are more secure in Australia than if they were to stay in their places of origin, such as Hong Kong or China. They are very happy with the health care services and social security available to them in Australia. The male participants seemed to enjoy life in Australia, especially if they liked outdoor sports such as fishing, camping, or golf.

The only participants who would prefer to be back in their places of origin are the females who are married and comparatively well off. They miss their families and friends overseas, or they miss the lifestyle and culture of the country of origin, or they would rather live with their children who are working overseas.

<table>
<thead>
<tr>
<th>Migration status</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study</td>
<td>3</td>
</tr>
<tr>
<td>Work</td>
<td>12</td>
</tr>
<tr>
<td>Visitor</td>
<td>1</td>
</tr>
<tr>
<td>Family reunion</td>
<td>14</td>
</tr>
<tr>
<td>Refugee</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 4: The participants migration status
6.3 Settlement areas of the participants in Brisbane

All the participants settled in areas that they have chosen carefully. Major factors that affect the participants’ choice of areas to settle were the affordability of the property; and the security of the area. Most of the participants were attracted by the amenities available to them. These were things such as public transport, major shopping centres with products and services that cater to the Chinese culture and a vibrant Chinese community. Many of them also chose to live near their family members and friends. A majority of the participants are living in suburbs on the south side of Brisbane: Mt. Gravatt, Sunnybank, Sunnybank Hill, Wishart, Streeton, Robertson, Calamvale, Macgregor, Eight Mile Plains, and Runcorn, as shown in Figure 19 and Figure 20.

According to Chiang & Hsu (2005), the Chinese migrants preferred to reside in the ethnic enclaves with a high concentration of Chinese people. These suburbs are Sunnybank, Sunnybank Hills, Eight Miles Plains, Calamvale, Macgregor and Runcorn. (Table 5) The suburb of Sunnybank is considered the social and commercial hub for the Chinese community in Brisbane, offers almost everything that the overseas-born Chinese need. It has supermarkets, butchers and bakeries that offer specialised Asian produce, products, and services. All the shop assistants are Chinese, who speak Chinese. Even some of the signage of the shops are in Chinese. Hence, many Australian-Chinese migrants who do not speak English can find employment and social support around this area, hence, thereby, promote self-sufficiency and economic prosperity.

![Figure 19: Ratio of settlement areas within the study sample](image-url)
The property prices in Sunnybank and the surrounding areas, are higher than the average property prices in Brisbane (Figure 10). Currently, the median price of a unit in Sunnybank ($452,500) is higher than Queensland’s median unit price ($381,000). The median unit rental price per week in Sunnybank is $405, which is more expensive than Queensland's average of $360. In 2017 the median price for houses in Sunnybank was $810,000 compared to the median price of houses in Brisbane of $517,539.

(http://www.yourinvestmentpropertymag.com.au/top-suburbs/qld-4109-sunnybank.aspx). Obviously, residents in this area have an above average socioeconomic status compared with those living in other areas of Brisbane. There is a lack of information about the Chinese-Australian migrants’ settlement pattern’s effect on their health.

<table>
<thead>
<tr>
<th></th>
<th>Total population</th>
<th>No. of Chinese</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Macgregor</td>
<td>5,844</td>
<td>2,229</td>
</tr>
<tr>
<td>2</td>
<td>Sunnybank</td>
<td>8,697</td>
<td>2,939</td>
</tr>
<tr>
<td>3</td>
<td>Calamvale</td>
<td>17,124</td>
<td>5,463</td>
</tr>
<tr>
<td>4</td>
<td>Runcorn</td>
<td>14,592</td>
<td>3,678</td>
</tr>
<tr>
<td>5</td>
<td>Sunnybank Hill</td>
<td>18,085</td>
<td>5,647</td>
</tr>
<tr>
<td>6</td>
<td>Eight Miles Plains</td>
<td>15,322</td>
<td>4,269</td>
</tr>
</tbody>
</table>

Table 5: Number of the Chinese migrants living in Brisbane suburbs

Source: ABS, 2016 Census of Population and Housing

Figure 20: Map of Brisbane suburbs
6.4 **Heterogeneity of the participants** (Table 6)

The participants in this study sample of the Australian Chinese baby boomer migrants have some common characteristics – their ethnicity (Chinese), being overseas-born, are migrants, and reside in Brisbane (Australia). However, within this commonality there are diverse socioeconomic backgrounds, different belief systems, different attitudes and other differences that are significant for their ageing health needs. Studies in the literature review have suggested that within each seemingly homogenous group lies even greater heterogeneity which is true of the study sample as well.

One of the differences among the participants in this study sample stems from the fact that they came from several different countries. Fifteen of the participants came from Hong Kong; four came from Macau; six came from China, and four came from Vietnam. One came from Taiwan; Singapore and Papua New Guinea respectively (Figure 6.4).

The year that the participants migrated to Australia and the place of origin where the participants came from are highly associated with their migration status. Some of the participants migrated to Australia because of political unrest and war in their countries. For example, those participants who came from Vietnam during the seventies were refugees because they fled from the Vietnam War. Some of the participants who came from Hong Kong around 1997 because of security and political concerns during the handover of Hong Kong to Mainland China. In 2011 the census recorded 74,955 Hong Kong-born Chinese in Australia. (Lui et al., 2009).

<table>
<thead>
<tr>
<th>Place of origin</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>People Republic of China</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Taiwan</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Hong Kong</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Macau</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Vietnam</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Singapore</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Table 6: Places of origin of the participants

Participants who came from the People’s Republic of China were born after the second world war and the Second Sino-Japanese War and lived through the Chinese Communist
Revolution (1945-1950), during which time there was the Great Chinese Famine between the years 1959 and 1961. Hence, food was very scarce while some of the participants were growing up in China. Some of the participants from the People’s Republic of China were also brought up by their grandparents because their parents were sent away during the Cultural Revolution (1966-1976). Some of the participants went through traumatic experiences of war and political unrest while growing up. Previous life experiences ranging from abandonment and war shaped their worldviews and underpins their health, thus contributing to the diversity in the type of health needs they require.

Some of the participants’ ancestors migrated from China to other countries, such as Taiwan, Vietnam, Singapore, Malaysia, and Papua New Guinea generations before. These participants are themselves migrants from other non-Chinese countries to Australia. They have acculturated to their adopted countries. Hence, even though their ethnicity is Chinese, they can speak other languages as well as Chinese. Furthermore, all the participants migrated to Australia for various reasons: as investors, as skilled migrants or professionals, as students, as refugees; for political stability or for family reunion.

6.5 Socioeconomic profile of the participants
A knowledge of the participants’ socioeconomic profiles will help to situate the participants in the study and assist in better understanding their very different health and ageing needs. The study sample’s socioeconomic profile includes their language proficiency, education level, employment and retirement status, their financial status, marital status, family background, housing styles, living arrangements and the sources of information.

6.5.1 The study sample’s language proficiency (Table 7)
Almost half of the study sample were proficient in English. None of the participants have used the interpreter services, because they did not need it or because of privacy issues. Participants who do not speak English proficiently sought help from their family members, friends and associates from the community to translate information. However, many of the participants have been working with Chinese people, which means that they do not need English proficiency. Curiously, some of the participants who do not speak English proficiently, have married to Australians and Britons.
Many of the participants’ level of English proficiency is related to the level of their education. Generally, people who finished a higher level of education have higher English proficiency. However, this is not the case for one participant (14), who does not have a high English proficiency even though he had finished tertiary education in Taiwan, because all his tuition had been in Mandarin and he had never learned English.

All the participants, except one, speak Chinese – either Mandarin and/or Cantonese. One of the participants who came from Papua New Guinea speaks English only. Those participants from Mainland China and Taiwan mainly speak Mandarin, whereas the participants from the south of China (Hong Kong Macau and Vietnam) mainly speak Cantonese.

Surprisingly, participants with limited-English proficiency are not worse off than those English speaking in accessing care, which is contrary to findings from the literature review. In fact, the ability to speak Chinese proficiently help the participant to get employment among the Chinese community. For instance, several participants are working as aged carers or home help for Chinese families. Some of the participants who do not speak English proficiently (P3; P5; P9; P10) have married spouses who are English speaking Caucasians and they say that they still communicate effectively with their spouses.

<table>
<thead>
<tr>
<th>Places of origin</th>
<th>Language spoken</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Republic of China - North</td>
<td>Mandarin</td>
<td>2</td>
</tr>
<tr>
<td>Republic of China – Canton</td>
<td>Cantonese</td>
<td>3</td>
</tr>
<tr>
<td>Taiwan</td>
<td>Mandarin</td>
<td>1</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>Cantonese</td>
<td>16</td>
</tr>
<tr>
<td>Macau</td>
<td>Cantonese</td>
<td>4</td>
</tr>
<tr>
<td>Vietnam</td>
<td>Vietnamese Cantonese</td>
<td>4</td>
</tr>
<tr>
<td>Singapore</td>
<td>Cantonese</td>
<td>1</td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>English, Cantonese</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 7: Places of origin related to the language the participants speak
6.5.2 The participants education level (Table 8)

Traditionally Chinese place extremely high value on education, regardless of social class, therefore, 14/32 (43.75%) of the participants finished tertiary studies, which is higher than the 20% of the Australian baby boomers who finished tertiary education.

According to the ABS, there are more Australian females achieving a higher education than the Australian men, in May 2017, 35% of the Australian women and 28% of the Australian men attained a bachelor’s degree or higher education (http://www.abs.gov.au/ausstats%5Cabs@.nsf/mediareleasesbyCatalogue/D422D0160CA8AE8CA25750C00117DD1). More female participants did not finish proper schooling compared with the male participants. A couple of the female participants left school when they were around 13 years old to work and support their families. 8/25 (32%) of the female participants had tertiary education, whereas 5/7 (71.4%) of the male participants had tertiary education.

Education seems to be associated with the place of origin, as identified by James (2001), which coincide with a profile of the participants. Many of those participants who have completed tertiary education came from Hong Kong, two of whom had postgraduate degrees (PhD). Some of the participants missed out on formal schooling because they grew up in Vietnam during the Vietnam War (1955-1975) or in Mainland China during the Chinese Cultural Revolution (1966-1976) in China.

Evidence from the health literature has shown that higher education is associated with better health and low education levels are linked to poor health, more stress and lower self-confidence. However, this general finding did not appear to apply to the participants in the study. This is because the research is a case study and is not dealing with a large data set which is required for generalised, statistical findings.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not finish high school</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Finish high school</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Finished tertiary education</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Finished post-graduate</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 8: The study samples’ level of education
6.5.3 Participants employment (Table 9)
At the time of interview, of the 32 participants 7 were employed full-time. Of these, 3 were either self-employed or employed in family businesses. Apart from 2 of the female participants who were full-time homemakers. All the 23 female participants had to manage their homes as well as work outside their homes.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never worked</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Retired</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Part time work</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Full time work</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 9: Employment status of the participants

All the participants, except 1 male and couple of the female participants, volunteered in various non—charitable organisations such as Meals on Wheels, or Chinese community agencies and religious groups.

6.5.4 Participants’ retirement (Table 10)
Of the 32 participants 17 are retired. 7 retired early (before age 65) because of ill health or personal reasons. 15 of the participants volunteer in various organisations. Some participants volunteer at churches, temples (Buddhist and Taoist), Meals on Wheels, the Lions’ Club, professional associations, Chinese business Forum, Brisbane Multicultural Radio Stations, ‘Environment and Health group’ and Chinese community associations (Cathay Community Association, Chinese Fraternity Association of Queensland, Evergreen Community etc.) etc.. Some participants volunteered to deliver traditional Chinese soup to the Chinese residing in aged care facility. Volunteering provides participants the social support and meanings in life.

<table>
<thead>
<tr>
<th>Reason of retirement</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being bullied</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Ill health</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Redundancy</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cannot find employment</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Reached legal retirement</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 10: Reasons for the retirement of some of the study sample
6.5.5 Participant’s financial status

Data of the participants’ financial status was not collected because of its sensitive nature; unsure number of the participants who are on social security, because this is a sensitive topic; 3 participants travel overseas regularly and are planning to build a new home in the future. Out of all the participants, only four of them do not own their homes. 10 of the participants have found that the maintenance of their homes put extra strain on their financial situation. Couple of the female participants would like to downsize to ease their physical burdens. However, they have found it difficult to do so for various reasons, as discussed in Chapter 8.

6.5.6 The participant’s marital status, family and relationships (Table 11)

The marital status of the participants and their family relationships are important because children traditionally have looked after parents as they age. All the male participants were married except one divorced, whereas five of the female participants had never married (5/25). Three female participants divorced; two female participants are widows.

The participants’ family size affects the type of care they will need. Twenty-two of the married participants have only one or two children, while only two participants have three or more children. Ten of the participants do not have children and of these only three were married without children. The number of children born to the participants is lower than replacement ratio.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never married</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Married</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Widowed</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants that are married to each other</th>
</tr>
</thead>
<tbody>
<tr>
<td>P11</td>
</tr>
<tr>
<td>P14</td>
</tr>
<tr>
<td>P17</td>
</tr>
<tr>
<td>P18</td>
</tr>
</tbody>
</table>

Table 11: Marital status of the study sample
Regardless of whether they have children or not it is likely that all the participants will have to rely on formal care at some time or another as they age, because the participants’ children may reside overseas or interstate. Furthermore, the participants’ intergenerational relationships depend on their ability to communicate effectively with their children and grandchildren.

The communication problem is different to that of the participants and their parents because the culture and language spoken between them were similar. The culture and language problem have resulted in some of the participants unable to communicate effectively with their extended family. Even though participants rely on family members for information, some of the participants have found it difficult to talk to their significant others – spouse and/or children, as discussed in Chapter 8.

6.5.7 The participant’s housing styles (Table 12)
The type of dwelling the participants reside in, and who lives with them in the dwelling, has implications for their future health needs because of poor accessibility and problems with maintenance as possible mobility issues increase with age.

Three-quarter of the participants have enjoyed living in large two-storey and three-storey houses with sizable gardens since the 1980s. Similar to findings from the ABS, free-standing houses were by far the most popular style of accommodation for the participants, especially for the married couples. Many of the houses have more than three bedrooms, some are palatial. A couple of the participants are living in townhouses. Some participants are living in apartments and units. One participant is living in shared accommodation with several total strangers and is faced with a lack of privacy and security. Almost all the houses were large, with 3 or more bedrooms. These dwellings usually have the living area downstairs, with the bedrooms upstairs and, have a large garden. These houses have internal and/or external stairs. As a result, many participants, who have mobility issues, are struggling with climbing up and down the stairs in their homes. Three of the participants have to climb stairs to gain access to their units.
The participants’ living arrangements and family values (Table 13)

The variety of participants’ relationships with their family members are displayed by their diverse living arrangements: empty nest, living alone, living with a spouse or living intergenerationally. Female participants are more likely than the male participants to live alone, and this together with the fact that female participants have higher life expectancy implies that more female participants will probably need formal care in the future. Four participants are living with extended families, but 6 of the participants who, are living with their spouses, are also expecting their children and extended families will live with them, not to mention those who are living with their spouses and adult children now, seven participants, are also hoping that the children and their extended families will also live with them. All the participants are hopeful that their extended families will live them so that they will age while living with their family. Therefore, hence, they are not planning to downsize – still hanging onto their huge family homes, waiting for their children and extended families to come back to live with them.

<table>
<thead>
<tr>
<th>Living arrangement</th>
<th>Men</th>
<th>Women</th>
</tr>
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<tbody>
<tr>
<td>Alone</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>With parent</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>With sibling</td>
<td></td>
<td>2</td>
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<tr>
<td>With spouse</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>(do not have children)</td>
<td></td>
<td>(3 do not have children)</td>
</tr>
<tr>
<td>With spouse and child/ren</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>With spouse, children and extended families</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>With children</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Table 13: Living arrangement of the participants
The participants not only prefer ageing-in-place, but also because of their attachment to their families they also desire ageing-in-family according to their traditional values, that is to live with their families and be looked after by their extended families as they age-in-place. Most of the participants, whether they are living alone or with their spouse, regardless of their socioeconomic background prefer to live with their children.

Many participants adhere to their traditional Chinese family values. More than half of the participants have looked after their parents and/or parents-in-law in the past. A couple of them are still looking after their elderly mothers. The participants demonstrate a high filial expectation of themselves and of their children and expect that their families will live with them in the future. Twelve participants are already living with their spouses, their children, and the latter’s family, all under one roof.

The participants who have never married or widowed do not feel lonely or depressed as suggested by literature review, instead, all the participants who were divorced felt lonely and looking for partners. Interestingly, those participants who are depressed are those living with their family members.

6.5.9 Sources of information on health and ageing for the participants
There are many sources that the participants can access for information. The participants already have access to the internet, many local and overseas Chinese newspapers and social media. There are half a dozen local Chinese newspapers, a Chinese radio station 4 EB. RadioDroid is a free software app that allows people to stream thousands of radio stations. Almost all of participants regularly read the Chinese newspapers. Ten participants also access social media and listen to the Chinese radio. Seven participants access internet health reports and keep themselves informed about services available to them. Participants are also constantly informed by their family and friends, who live locally and overseas, about services available to them to help cope with ageing and health. Many participants receive information from overseas family, some visit overseas families constantly (Ip and Richards, 2006; Ip et al., 2006; Ip and Dunn, 2008).

6.6 Government and community support for the participants
The Australian government provides various kinds of services and assistance to the participants, such as interpreting services, language appropriate websites and free language
tuition programs, financial assistance, health care services and aged care services. The participants only access those services and assistance that are directly relevant to them when seeking information about improving their health while ageing.

6.6.1 Language assistance for the participants

According to Australia’s policy on language, its national language is English. The Australian government realises that the most limiting factor for the migrants’ participation in Australian society is their lack of English proficiency, therefore, the Australian government (Department of Home Affairs) provides ‘Translating and Interpreting Service’ and 510 hours of free English classes for newly arrived migrants or refugees with low English levels through the Adult Migrant English Program, at the institutes of Technical and Further Education. The aim of the Adult Migrant English Program is to help migrants learn practical English skills for day-to-day activities such as banking, shopping, filling out forms, making and attending medical appointments and participating in their new community. Advanced students focus on preparation for work or further education. Increase in the participants’ English proficiency may increase their employment probabilities, which is similar to findings from the literature review.

There are many other less formal free English language classes offered by the local government such as the Brisbane City Council (Appendix 13), the religious groups, Chinese Community Associations and University of Third Age.

All the language programs differ in their aims and standards of achievement of English proficiency. Brisbane City Council provides English conversation groups which encourage people to socialise and practise English with all the other participants facilitated by native speakers of English. Language classes offered by the Chinese Community Associations are taught by Chinese who are not qualified teachers, and some of whom are not too proficient in English themselves.

6.6.2 Interpreting services and translations for the participants (Appendix 18)

The Australian Department of Home Affairs provides a free translating and interpreting service for people who do not speak English and for agencies and businesses that need to communicate with their non-English speaking clients.
Free interpreting services are provided to anyone in Australia who has a Medicare card. However, none of the participants used the interpretation services, partly because they rely on their family and community, and partly also because of privacy issues. The Australian government translates a lot of information into ethnic languages to communicate with the non-English-speaking culturally and linguistically diverse population. For example, during the 2016 Federal election, one of the political parties used different languages in their election campaign to inform population from the multicultural background.

6.6.3 Language appropriate websites
Some Australian government websites offer ‘other languages’ as shown in Appendix 15. Unfortunately, users need to be English proficient and internet savvy in order to navigate the webpage. Hence, language proficiency is definitely a barrier to the access of health information and health services if the participants use this approach.

6.6.4 Community services and aged care services available to the participants
The Aged Care Act 1997 identified that culturally and linguistically diverse groups as being special needs groups, therefore, this population has been given special consideration in the planning and delivery of linguistically and culturally sensitive aged care services. For example, the Australian government funded body - Partners in Culturally Appropriate Care - assists the aged care agencies that service the multicultural community to apply for grants from the Australian government.

There are many aged (home and residential) care service providers in Brisbane, among them there are several agencies that provide aged home-care services exclusively for the Chinese community – the Cathay Community Association, Chinese Fraternity Association of Queensland and Evergreen Community. They are relatively small agencies compared with organisations such as Diversicare and Anglicare.

None of the participants are members of organisations that represent and catered for the older Australians, such as Council on the Ageing (COTA), National Senior Australia, University of the Third Age and 60’s and Better. All these organisations cater for the English-speaking Australian seniors.
6.6.5 Financial assistance to participants
The Australian government has provided some form of financial support to the participants. All the participants receive concessions for public transport and Aged Pension (asset tested) once they reach the legal retirement age of 65 years old. Some of the participants are entitled to receive a Disability Support Pension; Payment and Allowance for carers; Crisis Payment for the victim of domestic violence; Government subsidised housing; health care cards and concession of utility fees.

6.6.6 Australian health care services provided for the participants
The Department of Human Services of the Australian government fund and operate Medicare, the universal health care system, which provides access to a range of primary health care services, medical prescriptions and free care for Australians as public patients in a public hospital.

There are three hospitals located close to the areas in which most Brisbane Chinese live. There are the government run QEII Jubilee Hospital, the Princess Alexandra Hospital as well as a private hospital, Sunnybank Private Hospital. Only a couple of the participants have used the services of the hospitals, one went in for an acute condition, the other had chronic kidney condition, and hence she went in regularly for dialysis and monitoring.

Studies have identified that the current Australian universal healthcare system is not tailored to promote health or cater for effective management of chronic conditions. Increased and poorly targeted service use is resulting in significant financial impacts across the entire health system. Medicare funded consultations, designed as a public insurance mechanism, to treat and manage episodic, or one-off illnesses, such as an infection, may extend life expectancies. Medicare is not designed for doctors to spend time to discuss and provide appropriate information on prevention and management of chronic conditions. Whereas the chronic and complex health conditions need ongoing, comprehensive and coordinated care to manage (Blendon et al., 2001; Bajramovic et al., 2004; Cutler, 2006; Andrews, 2007).

Since 1999, the Australian government has encouraged Australians to be covered by private health insurance to ease the burden to the public health system (Van Doorslaer et al., 2008).
6.6.7 Health promotion programs provided to the participants

The Australian government provides health promotion programs available to all Australians. For example, everyone aged 65 years and older are offered free flu immunisation. Currently, the National Bowel Cancer Screening Program is offered to people turning 50, 54, 58, 60, 64, 68, 70, 72 or 74 years of age in 2018. By 2020, this will extend to all Australians aged 50 – 74. Women aged 40 to over 74 are provided free mammogram through BreastScreen Australia by the Australian Government. The Australian government also provides 70 years old people free vaccine for shingles and a free catch up is available for 71 to 79 years old. Medicare also covers the cost of eye tests. The Australian government sends reminder letters and encourages all eligible people to attend health screening as a preventive measure. Many of the female participants receive mammography and colonoscopy tests, Pap smear test, bone density test and blood tests.

There are a handful of health promotion programs offered to the Australian-Chinese by the Chinese Community Associations, in collaboration with other agencies. Many non-government organisations such as the Ethnic Communities Council of Queensland and Diversicare conduct culturally and linguistically appropriate health promotion programs for people from CALD backgrounds. The Ethnic Community Council of Queensland, in partnership with Brisbane City Council, delivers health promotion workshops to empower and support women from Arabic, Spanish, and Vietnamese speaking communities. For example, the ‘Culturally and Linguistically Diverse Women Get Out, Get Active’ project is funded by the Department of National Parks, Recreation, Sport and Racing to assist women from culturally and linguistically diverse backgrounds to make healthy lifestyle choices. The health promotion programs include healthy eating, physical activity, and chronic disease education but also smoking cessation, alcohol consumption and understanding the Australian Health Care System. Currently there are not many health promotion programs catered specifically to the Chinese migrant participants.

6.7 The social support and network provided to the participants

Resilience among the participants was driven by their social networks as is suggested from the literature review. Many Chinese community groups provide networking opportunities for the participants. Most of the participants only associate with Chinese speaking people from the community, regardless of whether they speak English proficiently or work with English speaking Australians.
All the Chinese Community Associations also provide transport and daily programs for their members. These programs include classes to learn English, computers, iPad and mobile phones, exercises, social events that offer traditional foods and entertainments, games and health promotion. Members also surf the internet, read Chinese newspapers, and correspond with their relatives overseas on the computers.

There are also groups that are organised informally by the Australian-Chinese themselves, to enjoy their special interests and satisfy their social needs, such as: Yum-Cha (Chinese lunch), exercises, Tai Chi, dancing (friendship dance, folk dance, healthy dance), singing, Chinese opera, Chinese literature, Environmental & Health, art & craft, mah-jong, chess games, variety shows, language and computer classes, day trips and prayer groups.
Many participants volunteer at the community agencies and religious groups.

Many of the participants use these social events to gain information, share experiences they face in their daily lives and gain psychological support. For example, during these social gatherings, they talked about the issues they face in their daily lives, as discussed in Chapter 8.

There are several factors that promote the social gathering of the participants. These are location, transport, and parking. Some of the Chinese community agencies conduct their social events at their own premises, while others lease from church halls. Some of the social gatherings use public areas such as the local council libraries or school halls.

There are several characteristics among the social gatherings. One of the common denominators of all the social groups is language. All the members of the same social event or group speak the same dialect: Cantonese or Mandarin. For example, more than half-a-dozen Australian Chinese baby boomer migrants, who speak Cantonese, share lunch (Yum-Cha) together at different restaurants each Wednesday. Similarly, all the 4 players during the game of mah-jong had to speak the same dialect – either Mandarin or Cantonese. Another characteristic of most of the social events includes food sharing, usually cooked in Chinese style. They have birthday cakes and traditional festive foods during special occasions.
The religious centres offer a place not only for worship and spiritual support, but also provide social and cultural support for the Chinese community. For example, they offer language classes, computer classes and social events. The more prominent religious groups – Christians (Protestant and Catholic) and Buddhists built their places of worship themselves and brought their own ministers, pastors, priests and monks from overseas because they can speak their own language and relate to their culture.

There are many Chinese Protestant churches and half a dozen Buddhist temples and a Taoist temple in Brisbane. There is only one Chinese Catholic church. Chinese Catholics church, which was chosen to conduct participant observations because the researcher is a practicing Catholic, therefore, making it is easier for the researcher to gain access to this religious group.

The Chinese Catholic church is situated at Runcorn (a suburb next to Sunnybank, on the south side of Brisbane). Services are offered in different languages - Cantonese, Mandarin, and English. The Chinese Catholic congregation, almost all the members are overseas-born migrants and their families. The church hall is also used for social functions such as seniors’ group social events, social dance and special festival celebrations. Behind the hall, there is a domestic house, built for the caretaker.

One of their church events, the Chinese Catholic Prayer group, meet at the caretaker’s house to pray, read and discuss passages from the bible. It is in this group that the researcher has conducted her participant observation. The prayer group has more than a dozen members, all of them are overseas born Chinese baby boomers who originally came from Hong Kong and Macau. They speak the same language (Cantonese) and have similar social and cultural backgrounds. Most of the members live around the Runcorn area (south of Brisbane). However, a couple of them drive across Brisbane from suburbs at Aspley and Nudgee (over 30 Km north of Brisbane). There are approximately 6-8 women and 3-4 men who attend regularly and who have developed close relationships with each other. Some of the group members treat each other as their extended family. Most of the members have family members overseas. All of them have shared experiences; such as being migrants, baby boomers, married and possess the same faith, therefore, they understand each other’s needs. They receive physical and emotional support from each other. They celebrate each other’s birthday together. They confide in each other and pray for each other’s concerns, they share
their own story with the group, they compare and exchange recipes, and they discuss news here and back home. They turn to each other in time of crisis and seek help from other members. After each meeting they would share dinner together. Every member would bring a plate, usually home cooked, prepared in the traditional manner, and with traditional ingredients.

6.8 Conclusion
This chapter is a snapshot that summarises the profile of the study sample of the participants in Brisbane. It reports their demographic and socioeconomic background and the services that the Australian government and the community offer them. The findings summarised in the chapter identifies some of the expressed needs of the study sample. The following chapter discusses the findings associated with the study sample’s normative needs.
Chapter 7
Normative and comparative needs of the participants in the study sample

7.1 Introduction
This chapter discusses the health needs of the participants as defined by different experts and professionals, from their own perspectives and criteria. It identifies some of the challenges that the professionals face in providing the services to the participants. The data collected addresses the focus question: “What are the normative needs of the Chinese baby boomers?” All the data was collected from in-depth semi-structured interviews of informants who work in the community that service the Chinese baby boomers in Brisbane. It also discusses studies about the experiences of Chinese migrants from other countries and the issues they faced. This answers the focus question: “What are the comparative needs of the Chinese baby boomers?”. All the data was collected from a literature review.

This chapter begins by reporting the experiences of ethnic enclaves. It follows with the difficulties of planning for the Australian baby boomers and the Chinese migrants, the under-participation of Chinese migrants, the significance of language proficiency and policy makers’ aims in promoting English proficiency, the significance of Chinese proficiency, challenges and issues that the promoters of linguistically and culturally appropriate health programs face and health practices of the Chinese migrants.

7.2 Ethnic enclaves of Chinese migrants in Australia and developed countries
Lansley et al. (2015) identified that one of the major traits of ethnic populations in England and Wales is that the same ethnic group clusters and lives near people and businesses from the same ethnic or cultural backgrounds. This common characteristic is displayed by the Chinese immigrants in the developed countries because they feel socially inclusive and supportive of one another. The same is reflected in the study sample, which has shown that ethnic enclaves allows the non-English speaking Chinese migrants to gain access to employment and social support easily. This aligns with the participants’ experience. There are conflicting arguments about the effects of the settlement of the migrants in the host country. Abigail et al., (2011) provided three reasons for ethnic clustering in Chicago and other US cities: the homogeneous groups allowed greater self-control and self-policing, hence minimising conflict between different groups; and to maximise political voice. However,
some authors suggested that, in England, the ethnic enclave has a negative effect on health and economic outcomes (Pickett and Wilkinson, 2008; Xie and Gough, 2011). This finding is contrary to the experiences of those participants in the study sample.

7.3 Planning for the Australian baby boomers

There is consensus among the experts working within the aged care industry that acknowledges the lack of planning for ageing of the baby boomer cohort. According to informant 8 (Appendix 3), an executive manager of an aged care facility:

*Baby boomers [in Australia] do not start thinking about their [own] future till they are well over the seventies.*

He suggested that the Australian baby boomers, regardless of whether they were baby boomer migrants or Australian born baby boomers, are not prepared to plan for their ageing needs, since they expect to have a much longer life expectancy than previous generations. His observation is supported in part by the statement from one of the presenters during a Partners in Culturally Appropriate Care workshop:

*We [policy makers] are only looking at servicing the aged (over 70 years old) population. We are not interested in [planning for] the baby boomers.*

This statement corresponds to the findings from the literature review which found that currently there is not much information about planning for baby boomers. All the studies concentrated on services for older people, who were aged 65 years and over.

Currently, the Australian government is concerned about the housing situation: the younger Australian cannot get into the property market, while the older Australian are hanging onto their homes. At the same time, the older Australians are finding it difficult to maintain their homes and gardens. Hence, the Queensland Government Department of Housing and Public Works partnered with the Associated Residential Parks Queensland, National Seniors Australia, Tenants Queensland, and Caxton Legal Centre in hosting the ‘Retirement Living Options’ – a community education event, to assist current, former and future retirement village residents and manufactured homeowners to better understand and exercise their living arrangement rights. The main message of the event suggested that, those who are going to downsizing or moving into a retirement home, they should consult their legal advisers, because there is no fixed contract between the parties, hence, everyone has to negotiate with the owner of the retirement homes individually. This sounds like uncharted water with a lot of uncertainties ahead for the participants and the Chinese baby boomer migrants.
The same is happening in other developed countries. According to Humphries et al. (2016) baby boomers in the UK are unprepared for their ageing. They will experience an unpleasant surprise when they need to find and pay for aged care in the future.

The literature review has identified that Australian baby boomers have different expectations from previous generations. This coincides with findings from the experts working in the aged care industry. Informant 10 who manages a boutique nursing home catering for a minority group said:

"Those committee members on the board of this aged care facility are all baby boomers. They said that they would want more space in the residential accommodation if they were to enter this nursing home."

Developed countries such as Australia, UK and USA are experiencing similar challenges. According to some authors Governments in these developed countries are struggling to meet the needs of their older people (Humphries et al. 2016). There is a widening gap between aged care needs and the resources available. For example, there is a diminishing workforce with shortages of nurses and care workers for the aged, which is threatening to undermine policies to support people at home, as discussed in the literature review. Similarly, literature suggested that the UK government will be struggling to meet the widening gap between the funding available and the health and aged care needs of the ageing population (Humphries et al. 2016). Correspondingly, Eskildsen and Price (2009) suggested that the USA is also struggling with financing aged care and maintaining its quality. Hence, policy makers in UK are encouraging older people to reduce dependence on support from the state, instead, to be independent financially, or draw on the resources of their families and communities (Humphries et al. 2016).

Studies in Australia concur with that from the USA about the major factor influencing the decision to retire. Pruchno (2012) reported that decisions of when and how to retire from the American labour force are often based on financial considerations. Lusardi and Mitchell (2007) suggested that baby boomer in the USA should be planning for their retirement security financially, Howe and Healy (2005) discussed whether housing assets of the elderly in UK and Australia could be a resource for aged care, which coincides with the same experiences in Australia, with the Australian government encouraging older Australian people to sell their homes and downsize.
The trend of poor health in the older population in Australia coincide with the current trend in USA. King et al. (2013) identified that in USA, the baby boomers have a longer life expectancy than previous generations. However, they also have poorer health status with higher rates of chronic disease and more disability, which increases the likelihood of the need for support from health and aged care resources as the baby boomers age. Hence, the authors suggested that there is a need for policies that promote healthy lifestyles and disease prevention for the baby boomer generation.

Another experience that is common to the developed countries is multiculturalism. Studies in the USA suggested that a multicultural approach is necessary to understand and to accommodate the various needs of the baby boomer generation because of the USA’s diversified society, with different socioeconomic backgrounds, beliefs, cultures and family structures among the different groups with unique healthcare needs (Cravey and Mitra, 2011; Wassel and Cutler, 2016). Therefore, this study focuses on one of the culturally and linguistically diverse groups – Chinese migrants. However, even though Chinese migrants are one of the largest groups within the culturally and linguistically diverse population, it is not included in the list of the culturally and linguistically diverse communities by ECCQ (Ethnic Community Council Queensland):

*In 2017, we delivered program cycles for the following culturally and linguistically diverse communities across the state: Afghan, Arabic Speaking [nations], Bhutanese, Myanmar, Pacific and South Sea Islander, Somali, Sri-Lankan, Sudanese and Vietnamese.* (Informant 4)

This is echoed by one of the executives from the Chinese Community Association:

*At first funding from the Australian government in 1981 helped migrants from Vietnamese Chinese. Then, government reckons that the Chinese were doing well and pretty OK, so they cut off the funding to us guys, and gave it to the refugees from Africa.* (Informant 22)

This highlight the fact that the Australian Chinese baby boomers are not considered as priority population that requires support from the Australian government. Informant 3 works for an organisation (National Senior Australia) that services and advocates specifically for those Australians who are over 50 years. When questioned about the reason that his organisation did not seem to encourage culturally and linguistically diverse people, such as the Chinese to join them, the response from an informant was illuminating:
This informant demonstrated how the local born Australians perceived the participants and the Chinese migrants in Australia. How the participants perceive themselves and their situation is discussed further in Chapter 8.

7.4 Challenges of planning for the Chinese migrants

Authors unanimously agreed that planning for the Chinese migrant community, in developed countries such as Australia, UK, Canada and USA, is challenging. One of the reasons is that the Chinese migrant is a heterogeneous group because they came from different countries of origin (Kim & Keefe, 2010; Kwok and White, 2011; Gushulak et al., 2011; White & Klinner 2012), hence, they have diverse needs. Another reason that planning for the Chinese migrants is difficult is because there is a lack of information or inconsistent information about them. The majority of Australian research does not adequately include immigrant samples, for example, in the field of mental health where there is little attention paid to migrant mental health (Minas et al. 2013). The consequence of the lack of information about the Chinese migrant population is that they are not considered as a priority target group:

*The lack of data means these people (Chinese migrants) would not be considered as a priority, which translated into a lack of health programs catered for them.* (Informant 4)

There is another reason that determined why the Chinese migrants were not getting help from the Australian government.

*Government supports refugees, not migrants. [There is a] a small number of migrants, hence no advocacy.* (Informant 4)

Funding from the Australian government is directed to the recent refugees; hence, Chinese migrants are not considered as disadvantaged, thus, there is a lack of funding from the government for the Chinese migrants in Australia.

This is echoed by others working within the Chinese community:

*Even though the Chinese migrants have some money and can speak English, but they still faced the same issues as Australians, problems with their children, [all the children] getting all these bad habits. There was a lack of social support, hence, one of our social workers has joined the Police Liaison Officers. Nowadays, there are
four or five Chinese Police Liaison Officers who speak Cantonese or Mandarin. If there is a real problem that the Police Liaison Officers could not handle, then they have to go to the mainstream social worker who is an Australian. (Informant 22 – the director of a Chinese Community Association)

This informant and many others who work with the Chinese community do not believe that lack of English proficiency is a barrier to their health needs. In fact, they perceived that English proficiency associated with some issues of the Australian’s youth culture, which have created more issues for the participants and their families.

7.4.1 The lack of information and inconsistent information

There is a lack of information or inconsistent information about Chinese migrant’s health needs. It is challenging to provide appropriate health promotion programs to participants based on limited evidence or conflicting and confusing evidence about the Chinese migrants’ health conditions. There are many factors contributing to the lack of information and the incongruences. For example: some authors in the USA have suggested that lower cardiovascular diseases and asthma prevalence among the Chinese immigrants in USA, may be partially attributed to healthier diets, more physical activity, lower Body Mass Index, and less cigarette smoking (Corlin et al., 2014; Gong and Zhao, 2015; Jin et al., 2015). However, other authors suggested that Chinese migrants in the USA were more likely to have a haemorrhagic stroke (Fang et al., 2004).

There is also limited data on the Chinese migrants in Australia for various reasons. When people end up in hospitals, there is data on ethnicity, but no data on Chinese background. Very little research on the Chinese population, hence no data to show that they have high risk. (Informant 4)

According to the literature review in Chapter 4, evidence has shown that the Chinese migrant population in various developed countries appeared to have the lowest participation rate of health services among all the ethnic groups. This was reported in Australia and Canada (Lai and Chau, 2007; Lai and Chau, 2007a; Lai and Surood, 2010; Lu et al., 2014), similarly in the UK (Lauderdale et al. 2003; Lee et al., 2017), in New Zealand (Zhang et al., 2014) and in the USA (Aroian et al., 2005). The reason attributed to:

There is the ‘Healthy Migrant effect’. (Informant 4)
Chinese migrants in Australia may under participate in health services because of the healthy migrant effect, which is discussed in Chapter 4. Initially all the Chinese migrants were health screened before they migrated to Australia, therefore, they were healthier than the local Australian born. Similarly, Lai (2004) and Wu et al. (2005) reported that overall, older Chinese migrants in Canada have better health profiles than non-migrants, including fewer chronic conditions, and long-term disabilities. Unfortunately, there is a lack of information comparing the health status of the Australian Chinese migrants with the mainstream Australians or comparing the health status of the Chinese migrants with the Chinese residing in other countries.

A program manager of the Ethnic Community Council Queensland explained the implication of the lack of information about the Australian Chinese migrant population:

> It is difficult to get data from the Chinese population because Chinese do not participate in surveys or research studies, hence, there is a lack of information about the Chinese community, (Informant 4)

Blaming the lack of information about the Chinese population on their lack of participants seems a bit lame. Interestingly, there is a lack of information of the reasons that the Chinese migrants do not participate in studies.

### 7.4.2 Under participation or under reporting

Chinese migrants in Australia under participate in services and under reporting may also contribute to the lack of information. For example, one of the officers from the Australian Bureau of Statistics:

> Among all the ethnic migrant population, Chinese migrants have the lowest participation rate in the national surveys.

The reason that Chinese migrants may not want to participate in surveys or studies is because they were unsure how they would benefit from their participation. Gambino et al. (2014) have found that in the USA, one of the main purposes of collecting information on languages spoken at home and English proficiency is to determine bilingual election requirements under the Voting Rights Act. In other words, policy makers’ aim of collecting data on language proficiency from migrants did not coincide with the aim of the migrants’ need for English proficiency. Obviously, the data collected was not intended to benefit the target population.
Some Chinese baby boomer migrants were concerned about confidentiality issues, hence, many of them do not want to provide information for interviews, one of the prospectus interviewees, when asked to participate in this study asked:

*Is the information kept secret?*

Studies have found that language and cultural barriers have contributed to the Chinese migrants’ underutilization of health services in Australia and Canada (Lai and Chau, 2007; Lai and Surood, 2010; Lu et al., 2014) and USA (Aroian et al., 2005). One of the reasons that the Chinese migrants seldom volunteer information is because of its cultural background. Example that demonstrates this cultural trait was displayed during a first aid refresher training session of the Chinese community aged carers: no one from the audience asked any questions or made comments during a first aid training session for the Chinese community aged carers. When the presenter asked questions related to the subject matter, no one answered either. One of the participants indicated softly that she knew the answer, yet she refused to respond. The instructor commented that this was not the first time these aged carers have attended this course, insinuating that they should know the answers. Obviously, the lack of engagement is based on cultural conditioning, which needs further investigation. This phenomenon coincides with Chau (2008) suggesting that the Chinese migrants in England are conservative and introverted in nature and keep a low profile, and that they do not lobby on behalf of their community at the local government or national level.

Chinese migrants’ traditional health beliefs and practices influences their health seeking behaviours. Evidence has shown that Chinese migrants in the United Kingdom tend to under-participate in services because of their cultural background (Cross and Sing 2012; Lai and Surood, 2010). Ou et al. (2017) suggested that cultural factors such as strong family ties and the practice of traditional Chinese medicine influenced the Canadian Chinese migrants’ health behaviours and healthcare access patterns.

*Culturally [Chinese] people do not see doctors when they do not feel sick. If they feel well, why would they need to see a doctor?* (Informant 4)

Aroian et al. (2005) also reported that Chinese migrants in the USA underutilize services because of fear and distrust of western biomedicine, which is also experienced by some participants. Studies have shown that the mixed-use of traditional Chinese medicine and biomedical medicine is common among elderly Chinese immigrants in Canada (Pang et al., 2003; Lai & Chappell, 2007; Lai and Surood, 2009), and British Chinese migrants (Rochelle...
and Marks, 2011), which coincide with the participants’ health practices. This may have contributed to their lower participation rate in health services.

Another reason that the Chinese in Australia under participate in health services is because Chinese tend to affiliate with and rely on their family members and other Chinese. Chau (2008) suggested that Chinese migrants in the United Kingdom are mainly family oriented. A similar finding is that Chinese migrants in Canada also seek health information from their friends and family (Woodall et al., 2009), which coincides with the participants’ experiences and information seeking behaviour.

Furthermore, Chinese migrants who do not speak English proficiently tend to consult Chinese speaking health professionals. For example, a Chinese Cantonese speaking doctor (Informant 20):

*I have a lot of Chinese speaking patients [who do not speak English proficiently].*

Many of these Chinese migrants also rely on their families for transport and access to other social services. Hence, there is unanimous consensus that language proficiency contributes to migrants’ under-participation of health and social services. Many professionals have found that language proficiency is a significant health determinant for the participants as discussed in Chapter 4. Many of the participants consult Chinese doctors who can speak Chinese and understand their culture.

7.5 Impact of language proficiency on health

Studies have suggested that the lack of English proficiency affects the Chinese migrants in many ways. Dustmann and Fabbri (2003) identified that migrants’ language proficiency increases the probabilities of employment in the United Kingdom, which is similar to findings from studies in Australia. Ponce et al. (2006) in the USA and Gulati et al. (2011) in Canada reported that limited-English proficient people were significantly worse off than English speaking in access to care and had poorer physical and emotional health. Similarly, Liu, (2014) has found that the majority of older Chinese immigrants, in the United Kingdom, who have limited English proficiency also have low service use rate, lack of social support, and poor mental health. Ding and Hargraves (2009) have found that in the USA migrants who have an English language barrier were generally more stressed, especially at the beginning of their migration, which could lead to their poorer health. Similar experiences were reported by Bernard et al. (2006) in the United Kingdom.
One of the health program coordinators acknowledged the significance of language proficiency in delivering the programs:

*We [a non-government organisation that advocates for ethnic communities] believe that language is the key. [We] cannot force the English language on people, instead, we educate people, train people from their own community – to go back to their own community. Chinese for Chinese, Vietnamese for Vietnamese. Through interpretations, [we] lost a lot of information, not effective, therefore our program caters only for people who speak the same language.* (Informant 4)

### 7.5.1 Significance of language barriers

Surprisingly, Chinese dialect proficiency is more significant for the Chinese migrants because it is a necessity for the participants to network and socialise with fellow Chinese migrants (as discussed in Chapter 6), and especially for those who work in the Chinese community, for example the Chinese aged carers who service the elderly in the community.

English proficiency did not seem significant to the experts who are working among the Chinese community. All the managers, the aged care workers of the Chinese Community agencies and their elderly clients are Chinese, and many of them have limited English proficiency. For example, there were spelling mistakes (in English) found in some of the aged care and health promotion materials that were distributed by the Chinese community aged care agency to the public.

Informant 19, an aged care nurse who is an Australian Caucasian complained:

*They (the Chinese aged carers studying for the aged care certificate course) have plagiarised their assignments for their aged care certificate courses.*

The Chinese aged carers may not need English proficiency; however, they need to be Chinese dialect proficient in order to communicate with the aged clients they cared for because all the elderly Chinese clients prefer their carers to speak in their native dialect - Mandarin or Cantonese. Hence, English proficiency became of secondary importance to their Chinese dialect proficiency. Unfortunately, all the Chinese aged carers must pass the Queensland Government funded aged care certificate courses, therefore, they needed help in gaining the certificate.

A case manager of the Chinese aged care agency openly admitted:
I have been translating the case reports for my colleagues (the Chinese aged carers), because some of them wrote the report in Chinese. (Informant 16)

The truth is that aged care carers have a very low wage. If these Chinese aged carers had a higher English proficiency, they would probably have worked in other higher paid professions.

One of the most significant issue with Chinese language proficiency is the different dialects spoken among the participant and within the Chinese community. For instance, one of the health program presenters said:

I [can only] speak Cantonese, I deliver the health education programs in Cantonese to the Cantonese speaking Chinese audiences. (Informant 5)

Hence, Cantonese speaking presenters talk to Cantonese speaking audiences, and Mandarin speaking presenters talk to Mandarin speaking audiences. Alternatively, during a health promotion program, the interpreters had to translate English into Cantonese and Mandarin, one after the other, which distracted the audience from the meaning of the content. Furthermore, it takes twice the time to finish the presentation.

7.5.2 Ways to resolve language barriers
All the authors agreed that language proficiency affects the Chinese migrants’ health. However, not all the authors agreed on the same solutions in resolving the language barrier issue. Different authors from different countries have different findings. Chaves et al., (2017) suggested that translated and cross-culturally adapted version of health assessment instruments to resolve the Brazilian’s Portuguese language barrier. Ngo-Metzger et al. (2003) suggested that migrants preferred using professional interpreters rather than their family members, and gender-concordant interpreters in the USA. Therefore, they suggested that providing interpreter services and training providers in cultural competence could reduce linguistic barriers, improve access to health care, and ultimately improve health status for the migrant populations in the USA. On the contrary, Chau (2008) has found that even though many in the United Kingdom have regarded interpretation as a key measure to break down language barriers, Chinese people in the United Kingdom however had negative experiences with interpretation services, which included their lack of awareness of service availability, the unavailability of the service and poor quality of interpretation, resulting in misdiagnoses and inadequate explanations of treatment. Similarly, Zendedel et al. (2018) suggested that
migrants are more comfortable with informal interpreters rather than professional interpreters in The Netherlands.

Currently, all the PowerPoint presentations provided by the Australian government and the Chinese community agencies are in English, which is meaningless to those Chinese migrants who do not read English, unless the presenter translate the contents verbally, either to Mandarin or Cantonese. Unfortunately, there are not many health workers who could speak both Mandarin and Cantonese to the audiences. Hence, the solution is to present the PowerPoint in Chinese characters, since all the Chinese migrants can read Chinese characters.

7.5.3 Language proficiency and communication

Language proficiency may not translate to effective communication. For example, Ngo-Metzger et al. (2003) suggested that Chinese with limited English proficiency in the USA have encountered significant barriers when they wanted to discuss the use of traditional Chinese health practices with their doctors, which coincided with the participants’ experience, as discussed in Chapter 8.

Some female participants have also reported difficulties in communicating with health professionals, because the latter may not have the same understanding of their illness in their cultural context. Evidence has shown that most culturally and linguistically diverse people feel respected for their beliefs when their doctors use their traditional healing methods alongside orthodox/allopathic medicine (Henderson & Kendall, 2011).

Kong and Hsieh (2012) and Liu et al. (2011) suggested that the Chinese migrants in America used traditional Chinese medicine to reaffirm their cultural identity, maintain their moral status and fulfil their social roles. Unfortunately, there is a lack of investigation about the effects of integrating of the use of traditional Chinese medicine and western biomedical medicine.

7.6 Issues with the health programs provided by government and others

There are multiple challenges and issues with the health programs currently offered to the participants. Some of these are the health promoters’ ill-defined role, their linguistic and cultural competency, management of the programs and the aim and evaluation of the programs. The success of a health program begins from conceptualising the needs of the
audiences, followed by marketing, sourcing the appropriate venue and the style of presentation. Some of the health promotion programs did not project professionalism or competency delivering the health programs. For example, a presenter was twenty minutes late for a health promotion program.

7.6.1 **Health programs are structured according to government policy**

Identifying the needs of the audience or the community would be the foremost significant step. Unfortunately, all the presentation materials were provided by the government and are structured according to Australian government policies, not according to the audiences’ needs. One of the main issues that the health promoters face is that all the health programs are funded by the Australian government:

> [It] takes courage to work in this area [of] HIV prevention, very difficult, not many organisations seek funding for this topic, whereas numerous organisations seek funding for chronic diseases. Chronic disease is much easier to study with BMI, blood test and blood sugar etc. (Informant 4)

This informant has identified couple of the issues about the current health programs. Firstly, the health programs are disease-oriented, it is about the management of chronic disease, not about preventing the chronic diseases. There is a lack of information and health programs about the prevention of chronic diseases.

There is a lack of information about the social and health needs of the Chinese baby boomer migrants, hence, the Australian government do not have any health program designed to cater for the former’s needs.

> The health programs and the set of information [approved and prescribed by Queensland Health] are provided by the Australian government; therefore, we just present the [prescribed] material to the audience. (Informant 5)

These government-controlled health programs are designed for Australians who are Anglo-Saxon and Australian born, hence, the materials presented during these health programs are evidence-based on the Anglo-Saxon and Australian born population. However, the audiences who attended these health programs were the participants and the Chinese baby boomer migrants, who have different cultural background compared to the local born Australians. Furthermore:

> The health programs available are about chronic diseases. The set of information given by Queensland Health to me is very general. (Informant 5)
During the health programs we suggest more vegetables and fruits, [and] less meat. (Informant 4)

The health promoters are hampered by their limited control over the materials that they are delivering to the audience, because it is provided by the Queensland Health Department. The information provided during these health promotion programs was standardised and common knowledge to the participants. Even the participants and those non-English speaking Chinese people would be able to access this kind of general health information from the media – Chinese radio, Chinese newspapers and Chinese television. This sounds like a waste of time and resources for the program presenters and the audiences, since there is no added information from these health programs, as demonstrated by the participants’ interviews in Chapter 8.

7.6.2 Roles of the health promoters

The strategies and design of the health programs are highly dependent on how the health promoters and presenters perceive the aim of their programs and their roles. There are several issues that the health promoters face with the aim of their programs and their roles.

[We health promoters] only can [only] do limited work, you (that is herself) are not in there, cannot contact leaders, cannot organise the ongoing workshop. [this is] not a mainstream thing. (Informant 4)

This health promoter stressed the limitations she faced in her role. Another limitation is that the health promotion programs are perceived as health information programs that educate the community:

I think this [health program that I offer] would provide information which benefits the [Chinese] community. My job is to provide health information. Within 2 hours, I can only deliver general information. (Informant 4)

This clearly identifies the role of the health promoter as one who delivers health information. Furthermore, the health promoters place the responsibility on the audience and community to cooperate with their programs:

Do you (the participants of the health programs) want to become healthier, if you do not want to change, it is up to you. (Informant 4)

There is no mention if the health programs meet the needs of their audience and the Chinese community.
7.6.3 **Strategies in marketing the health programs**

Targeting the appropriate audience is a crucial step in health promotion, therefore, identifying and recruiting the target audiences is critical, followed by using the appropriate marketing strategies.

For example, a health promoter recruited audiences and participants for her health program from her own network of friends at her church:

> All the participants were my friends from our church. (Informant 5)

It is puzzling that Informant 5 did not advertise in the Chinese newspaper or collaborate with the Chinese community agencies, which has a far wider reach to the Chinese community.

Language must be expressed and understood in its appropriate cultural and age context in communicating the title of the health program. Some of the titles and the topics of the promotion programs were misleading. For example, the title of one of the health promotion programs – “Health Needs of the Ageing”, gave the impression that it was about health maintenance needs of the ageing baby boomers. It turned out to be a talk about marketing the assisted aged care packages and equipment to help elderly people to live at home independently. However, none of the audiences needed these products because they were not aged carers and they are still relatively healthy and mobile.

Sometimes the health program provider failed to recognise the culture needs of the audiences. For example, Australian Chinese migrants attached stigma to many mental health issues such as depression, therefore, it is seldom discussed or disclosed. However, this particular health program’s topic is ‘Depression’. Health programs could be more culturally appropriate if the program designers identify the audiences’ cultural background and need first. Somehow, the audiences’ needs, and cultural background were ignored by the health programmers. As a result, the audiences were not engaging with the presentation.

To compound with the lack of cultural sensitivity, the health program provider had all the audiences seated facing each other on opposite sides of the two rows of tables, instead of facing the front and the presenter. Those audiences seated at the end of the rows could hardly see the presenter, let alone engage with the presenter. This seating arrangement encouraged the audiences to talk to each other instead of listening to the presentation. During the presentation, Chinese tea and snacks were offered, which could be very distracting.

After this presentation, when asked about the purpose of this seating arrangement, the coordinator (informant 23) insisted:
I feel positive about this session. It does not matter [to me] if they (the audience) do not listen to the presentation, at least they are out of their homes and socialising. It is better than people from the community came [to attend the health programs] than to stay at home. Besides, learning is accidental: people learn by being exposed to knowledge and information.

Obviously, there is confusion about the aim of this health promotion programs, alternatively, this health promoter had several goals in mind: to promote networking among the people from the Chinese community and to convey health information at the same time.

7.6.4  Confused aim and goal of health programs

Who is responsible of the aims and goals of the health programs? The health promoters blamed the government and politicians for the confusion of the health programs aims and goals:

Sometimes, government and politicians waste money on programs when they rush into things without looking at long-term impacts that does not help the community.

(Informant 4)

The aims and goals of the health programs seemed confusing because of a mismatch between the aims of the stakeholders – the Australian government, the program promoters and the audiences. One of the reasons that the programs and services catered for the Chinese migrants were unsuccessful because of the mismatch between the aim of the programs or services and the Chinese migrants’ changing social and health needs. The aims of improving English proficiency may differ between the providers and the learners (in this case the learners are the participants). A retired qualified teacher, teaching English to the culturally and linguistically diverse migrants at University of Third Age (a non-profit organisation catering for the over 50 years) explained her aim in teaching English language to the migrants:

I believe that learning English is not just about being able to speak the language.

When I teach the migrants English, I am actually giving them a voice, hence, building their self-confidence and self-esteem. (Informant 7)

Here the informant assumed that the Chinese baby boomer migrants want to voice their opinion. However, study has suggested that the Chinese migrants are conservative and non-assertive (Chau, 2008). Hence, the informant’s aim in teaching English does not match the participants’ cultural background and conditioning, therefore, it does not satisfy the participants’ needs.
7.6.5 Issues with the culturally appropriate health programs and services

Health program organisers are aware of the challenges they face with providing programs to the culturally and linguistically diverse population:

_We [Multicultural-health workers] know that culturally and linguistically diverse population has language and cultural barriers that limit their access to information._ (Informant 4)

_The different community has a different definition of health, education level, and health beliefs._ (Informant 4)

Program managers are faced with the challenges of reconciling the diverse needs from a population with disparate cultural needs.

There is a lack of culturally appropriate health information for the participants. Bearing in mind that all the health information provided by the Australian Government are evidence-based on western biomedical approaches, which does not align with the diverse cultural background of the audiences who were attending these health programs. The health programs offered to the participants did not seem to be based on their cultural practices and needs. For example, a Chinese general practitioner, commented on her observation of the Chinese diet:

_Traditional Chinese people do not have a healthy diet. My Chinese patients eat quite a salty diet; preserved salty fish, Chinese sausages, Yum Cha, [and they] add a lot of soy sauce in their cooking, etc. They also eat too much jasmine rice which is high Glycaemic Index, and I suspect this may be contributing to the high incidence of diabetes._ (Informant 26)

Unfortunately, this kind of information is not included in the health promotion programs designed for the participants and the Australian Chinese migrants.

Another reason that health information presented to the participants and Australian Chinese migrants may not be helpful is because there is confusing information about the Chinese migrants’ health needs.

_Certain food [have] negative impact on health. Dairy products [are] recommended, but it is up to them (the audiences to do what they want)._ (Informant 4)

In this context, this informant identified and acknowledged the negative effect of lactose intolerance, but unfortunately, did not provide more culturally appropriate strategies.

Furthermore, there is a lack of investigation about the dietary pattern of the participants or Australian Chinese migrants, which matches with their cultural background.
Chow (2010) identified that there is a need to provide culturally sensitive and linguistically appropriate healthcare, social, and medical services for the growing older Canadian Chinese population. This is echoed by the coordinator of one of the health promotion programs:

*Our program uses trained Multicultural Health Workers to support culturally and linguistically diverse communities, including refugees, to increase their knowledge of nutrition and exercise, make positive lifestyle changes and to self-manage chronic diseases through education.* (Informant 4)

These health promotion programs focused on the individual’s lifestyle choices and knowledge which are based on the evidence-based biomedical model to manage chronic diseases. None of the traditional health beliefs and culture of the culturally and linguistically diverse population were included in these health promotion programs.

One of the difficulties in providing culturally appropriate health programs is the definition of being culturally appropriate and the interpretation of culturally appropriate approach:

*We work with people on foods [that] they are familiar with rather than things [that] they do not want.* (Informant 4)

*All I have to do is to adapt the content of the programs to suit the Chinese culture – such as replacing the recommended vegetables with Chinese vegetables in the diet and suggest Tai Chi as an exercise strategy. This is considered a culturally appropriate format.* (Informant 5)

According to this health program presenter, culturally appropriate means replacing the dietary ingredients, but stick to the biomedical approach, which the health program is based on. Studies have shown that the Chinese migrants adhere to their traditional Chinese diets. According to a study reported by Kwok et al. (2009) the dietary habits and health beliefs of Canadian Chinese are similar to those practised by the participants. In other words, health-seeking behaviours and dietary habits are part of the Chinese culture, which the Chinese migrants retained no matter where they migrated to.

### 7.6.6 Challenges in the evaluation of the effectiveness of the health promotion programs

Conducting impact evaluations, process evaluations, and outcome evaluations could help to improve health programs.
It is possible to evaluate after each activity. For example, during a workshop, have a pre-test and post-test to assess their knowledge. The health promotion programs are independently evaluated by the Queensland University of Technology which worked with a wide range of local and national stakeholders. (Informant 4)

However, this informant did not clarify if the stakeholders included the Australian Chinese migrants. The researcher is unsure if there was feedback from the audience attending these programs. This strategy would not help improve the effectiveness of the health programs if the audiences (Australian Chinese migrants) were not included in the program evaluation. Furthermore, there are other challenges in evaluating the health programs:

*It is difficult to evaluate the success of the program; we need a baseline. We need a fixed population, with interventions, then (look at their) behaviour change, infections etc., but this is a transient population, impossible to collect data. Furthermore, this is sensitive; we cannot follow up to ask them any questions.* (Informant 4)

Informant 4 was proud to say that:

*Queensland Health has acknowledged the success of our program in achieving better health outcomes in the communities we work with and ensuring [that] they have access to health information and services that are culturally appropriate to their needs.*

Finally, evidence has shown that imparting information may not be the most effective strategy in promoting health, because:

*Knowledge does not (automatically) translate into action.* (Informant 4)

There is a lack of studies on effective strategies in promoting health. More studies are needed to explore the effective design and management of health programs, otherwise there is a waste of time, energy and resources for everyone.

### 7.7 Significance of the traditional Chinese family unit

The traditional Chinese family unit is important factor that underpins the interdependence between the members of the family, their living arrangements and their changing social and health needs.

Chinese are more attached to their families. Studies have shown that the older Chinese migrants in New Zealand maintain their transnational connectedness with their families and ethnic communities both in New Zealand and overseas (Hodgetts et al., 2010). Their happiness depends on the people around them – their family, which affect their own health.
There is co-dependency between the Chinese parents and their children. Whereas compared with Australians are more let go of their families. They have their own lives, not so attached. Children tend to control their parents who do not speak English and rely on them, hence the parents become depressed, as reported by Informant 20.

A general practitioner (Informant 20), who is a Chinese migrant herself, reported her observation about her Chinese patients:

*My Chinese speaking patients rely on their families [because they lack English proficiency]. The family members control their elderly.*

Many of the participants are attached to their children and families (who are residing locally and overseas), as discussed in Chapter 8. However, evidence has shown that this phenomenon applies not only to Australian Chinese baby boomers but also apply to baby boomers in other developed countries. Evidence has shown that the collectivist cultures from Asian, Southern European, African and Middle Eastern people adopt similar beliefs in filial duties and family responsibilities. The parents expect respect, support, and obedience from their children. They also expect their children to live with them and involve the son/daughter-in-law in providing care (Trang 2003; Chau, 2008). Conversely, the baby boomers in the USA are looking after their adult children and the grandchildren (Wassel and Cutler, 2016), which coincides with many of the participant's current situation. The participants’ living arrangements are similar to that as classified by Zhang (2014) in New Zealand, which is independently, with or without a spouse, with children, relatives, and non-relatives, which is similar to the study sample.

However, Pang et al. (2003) and Lin et al. (2015), reported that Chinese traditional family values in the USA are changing. Similarly, Chappell and Kusch (2007) in Canada suggested that there is a blending of Chinese and Canadian patterns of care. Things may be changing for the traditional Chinese because evidence has shown that majority of the elderly Chinese migrants in New Zealand moved out and lived independently after cohabitating with their children initially when they arrived (Zhang, 2014). This finding coincides with Participant 6’s experience. Participant 6 and her husband do not speak English proficiently, initially they lived with their son, but moved out. However, they still manage their son’s household, cook for him and dine with him daily. Studies have shown that different living arrangements have different impacts on the elderly in different cultures. For example, Kikuchi (2014) reported
that Japanese older adults living alone have higher psychological distress. Whereas both Gaymu (2010) in Europe and Sun (2011) in China have found that highly educated older people have an increased life satisfaction when they can live alone independently, with no limitations in daily activities and participation in leisure activities.

7.8 **Challenges that the Chinese community aged care facilities are facing**

There is fierce competition between the Chinese aged care agencies to get more clients. Informant 16, a manager from a Chinese aged care agency, complained that informant 21, a manager from another aged care agency had interfered in her program:

*She ‘poached’ one of my clients, by promising her (the clients) the world.*

Smaller organisers have found it difficult to acquire a suitable site to hold social events. For example, one of the premises, where members of the Chinese Community Association meet weekly for their social event, has no commercial kitchen, which means that they cannot prepare food onsite. Hence, they either have to purchase the food for the participants/members, or they have to prepare food there illegally.

All the Chinese aged care agencies are small, both in size and resources, in comparison to the Australian aged care agencies, therefore, the officer from the Partners in Culturally Appropriate Care recommended:

*All the Chinese Community Associations should combine effort and resources to work under one organisation, such as the one in Sydney, which is more accessible to the Australian government.*

It means that the Australian government would find it easier to communicate and work with one organisation instead of several small agencies. It is logical that they should combine forces to enable a more powerful voice.

Unfortunately, there are language and cultural barriers for the Chinese community agencies to work together, for example, the founder of the Cathay Community Association came from Papua New Guinea; that of the Chinese Fraternity Association came from Vietnam and that of the Evergreen Community came from Mainland China. Even though they are all ethnically Chinese, they speak a different language and adopt different sub-cultures. It is quite inconceivable that they could work together under one body.
There are waiting lists for entering nursing homes and requests for home services. For example, Bluecare home care services reported that they have a 6 to 12 months waiting list because of the shortage of volunteers and vacancies. Some of the aged care facilities acknowledge the Chinese people, living in the aged care facilities, have special needs, but they cannot cater only for the Chinese residents’ needs, because there is not enough Chinese to support the residential aged care facilities.

7.8.1 Challenges and issues the Chinese aged carers face

The roles of an aged carer vary from domestic work to driving clients to doctors meetings or shopping. Most of these Chinese aged carers are Australian Chinese baby boomer migrants who came from China, Hong Kong, Macau, Malaysia or Vietnam. These Chinese aged carers face unique challenges for various reasons.

The job of the Chinese aged carers is a labour of love; the average wage for an aged care worker is around AU$22 per hour. Many of the Chinese aged carers, for example informant 18 had to get another part-time job to subsidise her income:

*Our company is too small, I only get 15 hours work each week, not enough to support myself financially.*

The Chinese aged-carer who needs a reasonable income would not have stayed in the job because they only get several hours of work per week. People who want to make a decent income would rather take on other jobs. Informant 17 would like to take on more hours, unfortunately, the agency could only give her couple of hours a week:

*Lucky that I cook for the client, he has to eat during public holidays. I get double time during the holiday. I travel from Carindale (return 40 km) to client’s home. There is no petrol allowance, I am paid only from job to job.*

Many aged carers admitted that their vocation is to serve the Chinese community, it is not a career or money-making profession. Many of the aged carers, such as informant 15 and 16, felt good about serving the Chinese elderly who do not speak English, for example, helping them to access the services they need. Sometimes, they even help their clients after hours. Informant 15:

*It is not the amount of time needed [by the client] but the diverse needs [that they have].*

Informant 13 has a certificate III in aged care training, but she prefers to work as a kitchen hand in a nursing home:
I receive the same wage as a kitchen hand, but with fewer responsibilities compared with that of an aged carer.

All the aged care workers (both Chinese and Australian) agreed that one needs dedication and passion to be an aged-care carer.

The Chinese aged carers’ job also carries a fair amount of emotional turmoil. Some of the aged carers were in shock when their elderly clients died suddenly. Informant 18:

I saw her (the elderly client) only yesterday [now she is dead]!

Many carers, such as informant 19, grieved over their clients’ death for a long time. Participant 24 wanted to be an aged carer but had to give up after 2 weeks, because:

[It is] too stressful – clients are too controlling and demanding.

Informant 18, an aged carer, who showers and feeds her elderly client (from 3:30 - 6 pm) daily, felt helpless observing:

I am stressed when I watched my client’s children fighting between them, over the sharing of responsibilities looking after their parent.

On the other hand:

I have seen the elderly very demanding and creating conflicts between siblings.  
(Informant 18)

There are many seniors being abused [by their family members] in the Chinese community.  (Informant 17)

Unfortunately, none of these cases were reported to the authorities.

7.9 Conclusion

This chapter highlighted some of the insights from the experts who work with the Chinese community in Brisbane. These are the insights from the experts who work for and with the Australian Chinese migrants, hence they provide their experiences of the participants’ health needs, which provide answer the question about the Australian Chinese migrants’ normative needs. However, none of the findings are the experiences of the Australian Chinese baby boomer migrants’ health needs. Hence, Chapter 8 discusses findings collected directly from the participants who are Australian Chinese baby boomer migrants.
Chapter 8
Participants’ experiences of ageing in a foreign land

8.1 Introduction
This chapter reports the health needs as perceived and experienced by the participants. The data collected addresses the focus questions: “What are the felt needs of the Australian Chinese baby boomer migrants?” and “What are the expressed needs of the Australian Chinese baby boomer migrants?” However, the participants did not actually express their needs or wants specifically, but they did identify some of the challenges and issues they face that may undermine their quality of life and health. The participants in the study sample are one of the major stakeholders in this study, because their health needs are the foci of this study. The participants’ comments expressing their feelings, perceptions, and expectations contribute to the holistic view of their health needs. The participants discussed their health beliefs and practices, and their relationships with their significant others at home and at work. The data collected by in-depth semi-structured interviews, focus group discussion and participant observations captured the participants in the study samples’ experiences and opinions. The semi-structured questions asked during interviews and procedures of collecting the data are discussed in Chapter 5.

This chapter begins with describing the study sample’s migration experiences, their experience of language proficiency; their relationship with their family members; experiences of communication within the Chinese community gender inequality and their social and spiritual needs, followed by a summary of their health-seeking behaviours and their traditional beliefs.

8.2 The experience of being migrants in the foreign land
The participants had diverse experiences of migration because of their migration status, life experiences and expectations. Even though participants came from different countries, yet they experience some similar challenges of ageing in the foreign land. Surprisingly, most of the participants still adhere to the core Chinese traditional culture in their customs, dietary and health beliefs. The only difference is that they speak different dialects – Cantonese or/and Mandarin.
Unfortunately, one of the most common experience that that some participants faced was discrimination on multiple levels – racism and sexism when they first arrived here. This reality is well described by Participant 20 where she expresses issues of racism, sexism and ageism in her new migrant experience:

*In the past I dared not talk to the Australians for many years, because they laughed when I spoke. It was difficult for me being a Chinese woman working with a Caucasian male partner [compared with the Caucasian male working with Caucasian female]. He [being a younger man] could not also tolerate an older woman [as myself]. If I was a man, he might have treated me differently. Also, because I was a migrant, [I] did not go to the pub with him, [we had] nothing in common. (Participant 20)*

Participant 25 was particularly eloquent about the stripping away of her sense of identity as a competent Chinese woman, which similar experience was also repeated by other participants in the study:

*I was a public health and safety officer working for the Hong Kong government prosecutors, but when I came here, I could not get a job. (Participant 25 was only 40 years old at the time). I have been volunteering in translating religious materials.*

For those female participants who gave up their jobs when they migrated to Australia, they lost their network, career, and the roles they played.

Some participants mentioned that they are living in safer and healthier physical environments, because the quality of air, water and food are much higher compared to that from the places that they originally came from.

*I think I am much better off living in Australia than if I stayed in Hong Kong [where I was originally from]. I am financially more secure. (Participant 32, widowed with 3 children)*

This is echoed by some other participants, especially those who do not speak English proficiency (11/32 participants). The participants acknowledged that the social security and health care services provided by the Australian government are far better than that offered at the origin countries they came from. The participants mentioned that they are living in healthier physical environments, because the quality of air, water and food in Australia are much better compared to the places they originally came from.

However, some participants crave the cultural and social support they were accustomed to in their place of origin. Most of all, the participants miss their culture, as expressed by this
participant, who would travel thousands of miles back to get in touch with her familiar culture.

*I travelled to Hong Kong to watch my favourite singer perform.* (Participant 7)

A third of the female participants admitted that:

*I miss the lifestyle (or their family, friends and previous co-workers) in Hong Kong (or the place of origin).*

The participants have experienced ageism, racism and sexism different times in their lives. For example, Participant 9 receiving aged pension, living alone in government subsidised housing:

*I cannot find a job, because of my age.*

Participant 20, is single and living with her mother, working as a kitchen hand in a nursing home:

*I once had an Australian young man working for me, it was difficult, we had nothing in common, because I did not go to the pub with him, and because I was older than him.*

Participant 17, a maintenance man at a nursing home, retired early because he felt he was bullied by the fellow Australian workers. All the above examples demonstrated that the participants have experienced various kinds of discrimination in the Australian workplace.

### 8.3 The changes that are experienced

Apart from the changes in language and culture that they are experiencing, the participants are facing many other changes in their lives: deteriorating health, social circumstances such as death of spouses, divorces and children leaving home; and changes with Australian policies.

Health deteriorating is one of the most common changes that every participant or baby boomer is facing. All the participants were considered healthy when they first migrated to Australia because of the health screening carried out by the immigration department. However, over the years, the participants’ health has deteriorated. Currently many of them have chronic health conditions, with some of them having multiple chronic diseases. Many participants reported that they have high cholesterol, hypertension, joint and muscular pain, digestive disorder, and thyroid dysfunction etc. One participant had knees and hip replacements, another participant had kidney failure and kidney transplant. Several participants had breast cancer. A couple of the participants were taking anti-depressants.
These health conditions experienced by the participants are also common to all ageing populations.

Even though they are taking prescribed medication that helps to maintain their physiological functions, they still consider themselves healthy, because they are living independently. Unfortunately, there is a lack of information that would allow the researcher to compare the health status of those in the study sample with the local born Australians.

As a result of their changing health status the participants have found it difficult to maintain their huge houses and gardens, physically and financially:

- *I cannot cope with cleaning my house. It is too big for me to manage.* (Participant 4)
- *I can only clean one room at a time and finish cleaning the whole house after a week.* (Participant 16)
- *We have to close the doors to some of the rooms because then we do not need to clean them.* (Participant 18)

Some participants are facing desperate situations:

- *I have to move to the ground floor because I have found it difficult to climb those stairs.* (Participant 9)
- *My husband passed away recently; I have to sell our home soon when my money runs out.* (Participant 2)
- *My wife divorced me and kept all the proceeds from the sale of our home. I am broke and staying at shared accommodation [in a room,] with other strangers. I must look for a place in the nursing home.* (Participant 5)

Other participants are presented with the dilemma of making decisions about their changing housing needs:

- *My children left home and left all their things here in our family home. I do not know what to do with these things. Some of these things are full of memories. I have 10 mattresses, which I will need when my children and their families come visiting from overseas.* (Participant 4)
- *The apartment I am living in [for the past 25 years] is in disrepair. I do not know whether to sell and relocate or remodel. In either case I will be stressed with many decisions that I have to make.* (Participant 21)
To make things more challenging for Participant 21 she is single and lives alone, her parents have passed away, so she has no one to discuss things with. It would help if she could discuss things with her family and have support from her family.

Interestingly, participants such as Participants 1, 7, 19 and 21 never married, have plenty of friends and associates, seemed contented to be on their own. Whereas participants like Participant 5 and Participant 16 who are now divorced and alone, have expressed their loneliness.

8.4 The views and plans
Some participants know exactly what they want and are planning accordingly, for example Participant 18, used work for the Brisbane City Council as a health promotion officer, is living with his wife. They do not have children:

*I will install a chairlift when I cannot climb those stairs [in my home]. I am not moving or downsizing. We cannot find another house like this. We specially choose this location and built this house according to our specification. We have all the furniture on rollers so that we can move them around easily.*

Sounds like this participant has plans put in for their ageing-in-place already.

Participant 11 is living with her husband. Their daughter goes to work and leaves the grandchildren for her and her husband to look after:

*I am going to build a two-storey house for our family. My daughter and her family (son-in-law and granddaughters) will live on the second level, while I and my husband will live on the ground floor.*

This participant is already planning to age-in-place and age-in-family, which is an ideal situation. Obviously, they have the foresight, the knowledge, resources and network to do so. Unfortunately, not all the participants have a clear self-knowledge. Almost all the participants’ comments have shown that they do not know what they need. They (14/32) could not explain their thoughts or how they feel. For example: when Participant 17 complained that his son did not talk to him, he was asked if he knew how he felt about this situation. He answered:

*I sometimes know how I feel.* (Participant 17)

It is difficult for the participants to voice their concerns and issues in their lives if they are unaware of their own thoughts and feelings:
I do not know what to do. I do not want to think about it (planning for the future). How do I know what will happen? How can I plan for things in the future? (Participants 3, 7, 14, 19 and 22)

I do not want to plan. Whatever happens; happens (Que Sera, Sera). (P32)

These participants may not have the awareness, resources, energy and network to plan for their future. Some participants seem to know exactly what they wanted, whereas other participants do not have any idea what they need.

8.5 The experiences of the relationship with their families

As discussed in Chapter 5 (literature review) and Chapter 7 (study’s findings), Chinese traditionally value their families. The participants gave support (physically, financially, mentally, emotionally and spiritually) to each other in the family. Some participants were sponsored to come to Australia with the help from their family members and relatives.

Our brother sponsored us to come here to work in his factory as seamstress. (Participant 7, Participant 19)

I came here to help with my sister’s business. (Participant 32)

I work in my uncle’s restaurant when I first arrived here. (Participant 17)

Many of them sponsored other members of their families to come over to Australia after they settled down here. They brought their parents over to retire in Australia or sponsored their nieces and nephews to study here.

Participants still attached to their roots back where they came from – China, Taiwan, Vietnam, Malaysia, Papua New Guinea, Hong Kong or Macau. They learn about the latest news of their family members overseas and their places of origin.

I chat regularly with my overseas family members on my phone (with an app). (Participant 9)

All the participants visit their families overseas, or alternatively their families visit them regularly:

I visit my father each year because he is elderly and unwell. (Participant 1)

I should visit my father more often [he is alone], especially when my brother passed away recently. (Participant 32)

The participants’ attachment to their parents and ancestors extend beyond their death, as demonstrated by many of the participants, who still practice their Taoist or Buddhist faiths.
Each year I went back to China to perform ancestral worship during Qingming or Ching Ming festival (Tomb-Sweeping Day) for my parents. (Participant 5)

Even though Participant 32 is a Catholic, she still follows the Taoist ritual of ancestral worship of offering incense every year on her husband’s date of death. Hence, regardless of their religious faith these participants still adhere to traditional Chinese cultural modes of respecting their dead.

There are other ways in which some of the participants rely on their family or look after their family.

*We drove from our home [at Bracken Ridge] down to Gold Coast (100Km., 1½ hours journey) to visit our dentist [who is our niece].* (Participant 7 and Participant 19)

Some participants (15/32) have suggested that the support from the family is crucial to the success of their financial security and family business.

*I am very grateful for my father for starting our family business forty years ago.* (Participant 21)

*My sister and I both worked in our brothers’ garment factory as seamstress. This gave us the finance to buy our own home that we live in now.* (Participant 7 and Participant 19)

Many of the participants have built successful hospitality businesses and Chinese grocery retail outlets in Brisbane, even though they do not have proficient English language. The success of their businesses depends on the kind of business they operate, and the support they have from their family and family contacts.

Eleven participants have demonstrated that the support from their family is crucial in their everyday lives. 11/32 participants looked after their elderly parents till their death, a couple of the participant are still looking after their elderly mothers. Those who have elderly parents overseas visit the latter regularly. A couple of the siblings are living with each other and looking after each other – one is wheelchair bound while the other has chronic depression. 5 participants rely on their family for translation in professional interactions and 8 participants need help with transport because of their lack of English proficiency or they do not own a car. Participants always use their family members as interpreters during medical consultations. Almost all except a couple of the participants consulted Chinese speaking doctors, however, there are not many Chinese specialists, therefore, they had to rely on their family during consultations with non-Chinese specialists.
I do not speak English, so I need my son [or daughter] to come with me when I visit a specialist. (Participants 6, 23, 27 and 28)

Those participants (16/32) living with their families (parent, siblings, children, in-laws and grandchildren) prefer to age-in-place, because they feel secure in their own homes, when their siblings, children and extended families are helping them to manage their household, as well as supporting them financially and psychologically. Therefore, participants may react negatively when their children and extended families leave home.

I cried for weeks and needed treatments for my insomnia and pain after my daughter left our family home. She used to listen and talk to me, gave me massages and helped me physically and financially. I really miss her. (Participant 3)

Conversely, some participants are supporting their children and their families by looking after their grandchildren and managing their children’s household.

I cook for my son [over 30 years old and single] every day and do his laundry. Both my husband and I clean my son’s place weekly. (Participant 6 and her husband do not speak English)

We [I and my spouse] look after our grandchildren while their parents go to work. (Participants 10, 11, 12 and 26)

Some participants do not live with their children and grandchildren but look after their grandchildren in the daytime, but they are planning to live together in the future.

We [I and my husband] will build a new house so that we can live with our daughter and her family [son-in-law and grandchildren]. (Participant 11)

As has been demonstrated by the expressed needs of the participants this far, many of the participants are very attached to their families, and not just their family homes. Almost all the participants who have children (22/32), would like their children and extended families to live with them. Many of the participants expect to age-in-place, and they also prefer to age-in-family with their extended families, that is to stay with their families as they age in the future. According to traditional Chinese beliefs, as discussed in Chapter 4, their expectation coincides with the Chinese culture of familial obligation. However, many of the participants’ children were born and brought up here in Australia, and they may not have the same cultural beliefs as their parents, and hence, may not meet the participants’ expectations.

I have asked my son and his family to move in with me, but they never came back with a reply. (Participant 16)
I am waiting for my son to come back from overseas to live with us (me and my husband). (Participant 4)

Both Participant 4 and Participant 16 are still waiting for their children to respond to their requests. The desire to age-in-family is stronger among the female participants. Female participants seem to bond to their children more than their husbands. There is a lack of information about the future of the participants’ living arrangement and its impact on their health.

Even though participants rely on family members for information, some of the participants have found it difficult to talk to their significant others – spouse and/or children.

My daughter is a dietician, she does not believe our Chinese traditional diet. After all, we had brought up our children on our traditional diet. (Participant 26)

Participant 6, a retired qualified teacher in China, migrated from New Zealand to Australia just to be with her only child:

I regret coming to Australia. I and my husband are on our own. We do not speak English and have no families here, apart from our son (only child), but he does not want to live with us.

Obviously, she is less than happy with her life in Australia because her relationships with her only child is unsatisfactory. Another participant also has difficulties talking to his child:

I seldom talk, because I left home early as a teen. [I do not know how to communicate and talk to my son]. Now my son does not talk to me. (Participant 17)

Many of the participants are relying on their children psychologically, financially or physically (help in maintain the home or for language support). These participants’ children used to rely on the participants, now the participants are relying on their children instead.

Other participants’ experiences reflect this difficulty in communicating with members of their families. This is often not a case of a language barrier, but a difference of culture between the participant’s baby boomer generation and their children who were educated and brought up in the Australian culture.

I do not communicate with my family (husband and sons). Planning is difficult because I have to include them (husband and sons). (Participant 4 and Participant 16)

My wife does not talk to me. I do not know what she’s thinking or what’s going on. (Participant 14)

I do not tell him (husband) anything. He is crazy, he talks nonsense. (Participant 22)
We (my husband and I) never sat down and had a meal together. I cooked for my husband (an Australian) separately, because he eats different foods from mine. He eats whenever it pleases him, whereas I have to eat at a regular time. (Participant 3)

These participants do not have difficulty communicating because of a language barrier with their family members, but because of other interpersonal factors where they do not talk to each other. This shows that language proficiency does not automatically translate into effective communication.

Another reason that communication becomes difficult within a family is when the spouses do not agree on certain decisions, because of their different gender, hence, they have life experiences and expectations.

I do not mind going into a nursing home when the time comes, because I do not want to burden my children. (Participant 29):

Whereas her husband (Participant 17):

I have looked after my invalid brother and my elderly mother for more than 10 years; therefore, my children will look after us [myself, my wife, my unmarried sister and my married sister with her husband]. I will extend our current house to accommodate all of us.

He neglected to mention that he did not actually provide the care for his mother and brother – his mother and brother had four female carers – his wife and his three sisters, who gave his mother and his brother round-the-clock care. His wife also had to manage her household (with 2 children) and work beside him in their family business (Chinese take away restaurant) as well.

Another female participant expressed her dissatisfaction with her current situation:

We [my husband and I] have a big two-storey house with 4 bedrooms. My husband left his plates and mugs all over the place after he finished with them, whereas I had to pick them up after him. I feel exhausted after I clean after his mess and the house every day. My husband cannot understand the reason that I need to downsize. He is comfortable with this big house. (Participant 4)

Both Participant 29 and Participant 4’s situation reflects a common problem of mis-communication and non-communication among family members. This lack of effective communication makes it difficult to plan and make decisions.
A similar situation applies to Participants 3, 4, 8, 23 and 25. For example, a married couple (Participant 14 and Participant 22) are living in a six-bedroom two-storey house, with one kitchen and one bathroom on each level. No one lives upstairs unless family members occasionally visit from overseas or interstate. They have been living only on the ground level because of their ill health. Participant 22 had a kidney transplant and heart attack.

_I would like to downsize – either remodel the house into two self-contained flats, so that we (I and my husband) could live downstairs and lease upstairs to gain some income. Alternatively, we could move to a smaller place._ (Participant 22)

However, Participant 14 refused to change, even though he injured his back falling from a ladder while he was pruning a shrub:

_I like the space [that we are living in now]. I can somersault in my house._ (P14)

This couple is stuck in deciding about their different housing needs. There is a lack of information about how to resolve this dilemma of dealing with their different housing needs.

This demonstrated that married couples have different experiences and expectations of their housing needs. Many of the couples are unable to agree on making the decision about their changing housing needs. They are waiting till things are critical, by which time they may not be able to make the decision and it will be made for them by their children or other family members.

Some female participants miss the lifestyle and family back at their place of origin. Participant 10, a homemaker who does not speak English experiences this quite accurately:

_I play mah-jong several days each week, then I have lunch and dinner out several times a week, I play squash once a week, apart from that what could I do? If I go window shopping, there are not many places to go, besides, things are so expensive compared to Hong Kong. Whereas if I go back to Hong Kong, my siblings and friends are all there. We go out every day – to lunch, dinner, high-tea and massages etc. There are so much to do and so many places to go in Hong Kong._

She misses the lifestyle and her family and associates in Hong Kong. Other participants (Participant 4, 8, and 25) echoed similar experiences:

_If it is not because my husband who wants to stay here in Australia, I would have gone back home [to Hong Kong]._
It seems that these wives have given the power of making the decision to stay in Australia to their husbands. There is an imbalance of power between the husbands and wives when it comes to deciding where to settle or live.

The male and female participants have experienced different life experiences when they were growing up, as a result they have different expectations in life. Most of the female participants have lower levels of education, hence, some have never worked outside their homes, while others who do work outside the home receive lower wages than the male participants. Currently, many of the female participants are dependent on their spouse physically (such as transport) and financially. One of the ladies at the table during a ladies’ Yum-Cha meeting self-disclosed:

- I only drive to the local shopping centre on my own. I do not drive too far from home; [I do not have the confidence to drive further] therefore, my husband drives us across town (30 km.) to the prayer group. (Participant 8)
- My husband [who is retired] manages our finances, I give him all my wage each week. (Participant 29 working part time as an aged carer)

These female participants seemed to lack confidence in some skills, hence, they depend and rely on their husbands with certain roles. The gender roles could develop into gender inequality. Gender inequality is part of the Chinese culture. As mentioned in Chapter 4, the female participants have experienced culturally related gender issues with less opportunities provided in education, employment and socioeconomic status.

- During the Cultural Revolution, we girls [in our family] were not allowed to eat meat (which was very scarce), only my brother had meat. (Participant 28)
- We girls in the family do not inherit any land. The girls had to help with the housework as well as working outside the home. (Participant 23)
- Our father helped our brother (only son in the family) set up his garment factory here in Brisbane, [we did not get any inheritance from our father because we are girls]. (Participant 7, Participant 19)
- I [regret that I] missed out on a good education because I am a girl, therefore, I make sure that all my children [boys and girls] had a proper education. (Participant 9)

This gender inequality does not appear to exist in the participants’ families, because their children, regardless of their gender, are given the same opportunities in education and choices. However, gender inequality persists between married couples among the participants.
Chinese have close knit families, which is based on either dependency or co-dependency between the members of the family. There is an imbalance of power between the members of the same family. For example, this imbalance of power was displayed between the spouses of some of the married couples; and between the parents and their children.

8.6 The experiences of the relationship with the community

Many of the participants felt isolated and lonely when they first arrived in Australia, especially when they did not have any family here. Support (physical, financial, social and psychological) from the community is essential in these cases.

*When I first arrived here, I was not working, and I could not speak English fluently. I felt I was no body, I thought people were only nice to me because of my husband (an Australian engineer). Since then I have been working as a volunteer at the Meals on Wheels. When I had surgery on my knee replacement, all the workers from Meals on Wheels came to visit me. I was very thrilled. I felt so touched that they treated me like a friend.* (Participant 3)

This participant demonstrated the significance of being accepted and supported by people from the community.

The participants who came here alone have found it more difficult because they do not have any family support. For example, Participant 9 migrated to Australia after marrying an Australian (Caucasian) in Hong Kong. She sustained physically and emotional abuse at home. She did not say anything about her domestic violence to anyone because she was a foreigner who did not speak English and was unfamiliar with the system here. She landed in hospital one night because of the abuse but luckily, she was treated by a Chinese speaking doctor.

*The doctor in the hospital reported my domestic violence case after he examined me. I have left my husband and living alone in a Government subsidised housing.*

(Participant 9)

As discussed in Chapter 6, English proficiency is perceived as one of the most significant barriers for the Chinese migrants. It has affected some of the participants’ opportunities to stay in Australia. For example, Participant 23 and her husband owned a home-renovation business in Hong Kong:
My husband and I brought our two sons to Brisbane twenty years ago. We could not run the same business successfully here, because we lacked English proficiency and had no business contacts. We had to go back to our business in Hong Kong. We left our children here to board and study. Now we sold our business in Hong Kong and retire here in Brisbane.

Again, this demonstrated the significance of family support and network for migrants living in the foreign land. This also echoed the findings from previous studies as discussed in Chapter 4.

Participant 20, who has never married, had owned her business and been working with local Australian for many years, yet she felt isolated and alienated because of her lack of language proficiency:

*I built a wall around myself (to protect myself). Now in hindsight, I realise that I was lacking in maturity and self-confidence, I could have handled it differently.*

This further demonstrated that the participants’ success in running a business or living in the foreign land needed more than language proficiency, but personal development and support from the family and others.

Language proficiency, especially Chinese language is important for the participants. All the participants maintained their Chinese language because they associated mostly with Chinese speaking people daily, they speak Chinese at home and kept contact with their family and friends in their countries of origin. The participants are all Chinese proficient, however, they may not be able to talk to each other, as Participant 4 explained:

*I can only speak Cantonese. I had to give up volunteering in teaching English to Taiwanese Chinese who can only speak Mandarin.*

The challenge with Chinese proficiency is that there are Cantonese and Mandarin speaking Chinese. These are totally different dialects that cannot communicate with each other. Therefore, participants from difference dialect groups often have difficulty communicating with each other; and this could affect their social life just as much if not more than their English proficiency. This coincide with findings of Yan et al. (2019), that subethnicity also exists within the study group because of their different dialects.

There is a lack of Catholic priests and nuns who are Chinese and speaks Chinese language (Cantonese and Mandarin) and can relate to Chinese culture.
We need Chinese [Cantonese and Mandarin speaking] priests to celebrate Mass and hear confession from our Chinese community. (Participant 1)

Chinese language proficiency is more significant in networking and social situations. For example: all the players, in the same team in sport (golf, tennis), card games ‘bridge’ or mah-jong, must speak the same language. Similarly, participants at a social group and religious group usually speak the same language (Cantonese or Mandarin).

The participants seek support from fellow Australian-Chinese because all of them have left their family and friends overseas, therefore, some of them have found themselves isolated, hence, many of them join religious groups. The participants felt comfortable to share their concerns and vulnerability with each other and sought help from each other in these religious groups.

The participants practice a mixture of religious practices – Buddhism, Taoism and Christianity. They usually associate with others who have similar faith.

I drive from my home Nudgee to Runcorn (32 Km, 30 minutes’ drive) every week to attend mass at the Chinese Catholic church. (Participant 1)

We drive from Aspley to Runcorn (30 Km, 30 minutes’ drive every week to attend Mass (a religious ceremony) at the Chinese Catholic church). (Participant 8)

These participants need the spiritual support, but also the psychological support from their associates and friends with the same faith. For example, in the Chinese Catholic Prayer group (Cantonese speaking), the members turn to each other in time of crisis. Once during the meeting, one couple rang and said that the husband who normally drove, was having a dizzy turn, one of the members immediately drove and fetched them over to the gathering. In another instance, a 90-year-old, who is living with her daughter in Brisbane was unable to attend because her daughter who usually drove her was in Hong Kong and asked for assistance. Members of this group treat each other as extended family, which is typical of the experiences of many of the participants. The members recited and reminisced on Chinese idioms and poetry that have cultural themes, which was comforting and reassuring for them, and they felt connected.
Another thing that connects the participants as migrants are their traditional diets. Home cooked traditional meals (normally not available in restaurants) and home grown vegetables are highly appreciated among the Chinese community:

I have grown these traditional Chinese vegetables in my garden, I share them with my family and close [Chinese] friends. (Participant 17, Participant 29)

Only Chinese would appreciate the organic and home grown traditional Chinese vegetables.

For those participants who are Buddhists (Participant 14, 22 and 25), they have found it limiting with their diet for various reasons. Chinese vegetarians do not normally include dairy products in their diet. Traditional Chinese vegetarian products are not readily available from supermarkets, and some of these products can only be found in specialised Chinese grocery stores.

I fast on vegetarian foods on certain days of the month (according to Buddhism). (Participant 22)

There is a limited variety of traditional Chinese vegetarian ingredients [gluten and soy products, as well as many Chinese vegetables] available. (Participant 18)

There are not many Chinese vegetarian restaurants [in Brisbane that] I can go to. (Participant 25)

Not to mention that it also limits their opportunities in socialising and networking, because usually there were very few vegetarian dishes available during social functions. Furthermore, participants such as Participant 25 find the smell and presentation of the meat very offensive.

Many participants volunteer in the community:

I volunteer at the Meals on Wheels. (Participant 3)

I volunteer at the Chinese radio station. (Participant 12)

I volunteer at the Rotary Club and was president at my professional association. (Participant 12 and Participant 13)

I volunteer at the Chinese Buddhist temple. (Participant 14)

I volunteer to translate the religious books from English into Chinese. (Participant 25)

We cook traditional Chinese soups and deliver to the Chinese residents living in nursing homes (Participant 8 and Participant 32)

Many other participants volunteer at the Chinese community agencies, churches and nursing homes.
8.7 The experiences of the services and programs available

Even though the Australian government and the community offer many free programs to support migrants and help them to gain employment or enter higher education, yet not many of the participants were able to benefit from them. For example, the Australian government offers all migrants free English tuition, however, there are many reasons why the participants have difficulties in learning English. Some of the participants would like to attend English classes but could not for various reasons:

*I had to work; therefore, I could not attend the free English classes.* (Participant 5)

*I have found the program too academic and difficult to master. I was so stressed and worried that I got sick over my homework and ended up in the hospital’s emergency department.* (Participant 9)

*I cannot go to the language classes because I had to look after my three children.* (Participant 27)

All of the participants who attended these classes were baby boomers over 50 years old, with no intention to enter higher education and start a new career. Some of them would like to work, however, they have found it difficult to be employed because of their age.

One of the reasons that the participants have difficulties in learning English is that most of the class members they associated with were also Chinese speakers:

*I only speak to the Chinese who attended the same English class.* (Participant 27)

The participants tend to associate and make friends with the Chinese who speak the same language and have similar culture; therefore, they lacked the opportunities to practice English.

There are other reasons that some of the participants have found it difficult to learn English. For example, some of the participants were working with Chinese people, which meant that they did not need to use English at work. English is difficult to learn when the learners do not associate or work in environments that make them practice the language. The participants need to associate with people who speak English and work in an English-speaking environment in order to learn the language effectively. However, it is a dilemma because they cannot find employment in an English-speaking environment if they do not have English proficiency.
The participants are attached to their countries of origin; hence, they tend to read and listen to Chinese news.

*I used to buy the Chinese newspaper from Hong Kong. Now I do not buy it anymore, I could read it online.* (Participant 17)

Another reason that the participants have found it difficult to learn English is that they are attached to their Chinese culture:

*I listened to the famous Chinese singer [from Hong Kong] perform in Gold Coast.* (Participant 22)

*I join a [singing] group to sing Chinese opera each week.* *(Participant 11)*

*I play Mah-jong each week with a group of friends (Chinese speaking), then we had dinner together afterwards.* (Participant 10)

These participants have demonstrated that they not only speak Chinese, but they are also immersed in the Chinese culture and associate with people who appreciate the same culture. Hence, not learning English is not just about language proficiency, but is also an expression of their cultural identities.

Many of the participants do not trust the government, they have issues with confidentiality, and therefore, they do not want to volunteer information. Hence, there is a lack of information about the Australian Chinese migrants. However, the Australian government also failed to take data from the Australian Chinese migrants at various public agencies, such as health care and aged care facilities, such as hospitals and nursing homes or educational facilities, such as schools and universities etc.

8.8 **The experiences of the relationships with health professionals**

The participants’ relationships with the health professionals and their health seeking behaviours depend on their health beliefs, life experiences and expectations. These include their language proficiency, religious and cultural influence, their gender preference, and concept of health.

Many female participants chose health professionals based on gender. Typically, many female participants, such as Participant 4 and Participant 23, would prefer a female doctor, especially when they needed gynaecological procedures such as a cervical examination:

*If I need a Pap smear test, I would go to the female doctor who works in the same clinic as my regular general practitioner.* (Participant 3)
Participant 24 looks for doctors who are sensitive to her emotional needs:

*I am looking for a female general practitioner. I had a gay general practitioner whom I thought could be sensitive to my emotions, unfortunately, he did not seem to understand women. Last time when I got upset and cried, he distanced himself. He could not handle my emotions. Unsure if female doctors would be better.*

Hence, the participants have gender-specific needs in accessing health services.

One of the significant reasons that the participant chose their health practitioners is their language proficiency. There are not many health practitioners who can speak Cantonese and Mandarin.

*I (speak Cantonese only) could not communicate with my Traditional Chinese Medicine therapist. He spoke in Mandarin. I could not understand him.* (Participant 32)

That means people, who are both Chinese, have to speak the same dialect in order to communicate with each other. She was referred to consult this therapist; hence, she would rather stay with him than to consult someone else who spoke the same dialect.

Almost all the participants prefer Chinese speaking doctors. Interestingly, none of the participants who do not speak English proficiently asked for an interpreter when they consulted an English-speaking doctor. Participants either consult a Chinese speaking doctor or they brought their own family members along to interpret for the medical consultation as it is more confidential to hold this information within the family.

As mentioned previously, English proficiency could affect the participants’ access to health professionals.

*I can speak Cantonese with my psychiatrist, I do not know what to do when he retires [soon].* (Participant 19)

Even those participants who can speak English proficiently also consult Chinese speaking doctors.

*I look for doctors who are Chinese because I think they can understand me better (since we belong to the same culture).* (Participant 6)

It is not just the Chinese language that the participants seek, but they prefer doctors whom they consult with also share the same culture as theirs.
It appears that many participants do not consult medical practitioners just to seek health advice but do so to maintain supportive and comfortable relationships. Many of them visit general practitioners who were their neighbours or friends they made over the years they have been in Brisbane.

*I visited the Chinese General practitioner in Runcorn, [30.7 Km away from my home] because he is my friend [whom I met in our university days].* (Participant 8)

*I consulted a physiotherapist whom I met in Lion’s club.* (Participant 13)

The participants usually consult people whom they have built rapport with. The participants consult the medical professionals not only because the latter are linguistically and culturally competent, but because the participants felt that they were acknowledged, heard, understood, respected, and supported.

This is not always the case though. Participant 6 and her doctor speak the same language and share the same culture, but she complained about her Chinese general practitioner because:

*My doctor is not interested in me, [she does not care about me]. She never asked me any question [about me].*

There was no rapport or communication in this case.

Linguistic appropriateness may not be the most important issue in servicing the participants, as Participant 5, who only speaks Cantonese, identified what the participants need from a health professional irrespective of their language competencies:

*I have consulted at least five General Practitioners since I came to Brisbane last year. Initially, I visited two Chinese [speaking] doctors, then two Australian doctors. Then I met this doctor who could only speak Mandarin. She bulk-billed me and explained the side-effects of the gout medication that I have been taking. She did a lot of investigations and gave me a thorough health screening [before she made any diagnosis]. She put me on the multidisciplinary chronic disease management plan, and she arranged for me to go to the sports centre and the allied health practitioners for my chronic pain. Whereas all the previous doctors only prescribed me painkillers and anti-inflammatory medicines. I am sticking to this doctor.*

Participant 5 has shown that language proficiency does not necessarily promote health and that the most important thing is that he felt heard and supported. He has shown that linguistic appropriateness was not an issue when it comes to diagnosing, identifying and satisfying his needs. The fact that effective communication needs more than linguistic appropriateness is
further demonstrated by Participant 17, who has no problem communicating with his general practitioner in Chinese but was unhappy with the service he received:

*I am taking cholesterol medication [prescribed by my doctor]. My doctor did not explain about my cholesterol medication, cholesterol control [and its physiology] to me and never discussed lifestyle changes with me.*

Obviously, the participants wanted more than just receiving treatment (a medication), they also want to know how to improve their health condition by self-care. Hence, several participants went online to seek health information.

As a result, some of the participants are very wary of health professionals. They do not trust the health professionals:

*I always seek several second opinions.* (Participant 26)

*Best is not to visit your family doctor. Only visit them socially, because doctors are bound to find something wrong with you.* (Participant 26)

However, Participant 8 was bewildered:

*When I want to discuss with my doctor about the information that I learnt online, he asked me if this information was evidence based.*

Obviously, this participant was confused and frustrated. This situation is common during consultations because Medicare system is not designed for discussions, but rather for treatment of critical conditions, as discussed in Chapter 6.

The participants’ health beliefs could be influenced by their religious or cultural background. Some participants perceived certain illness or health conditions as a stigma, for example: according to the participants, depression is a taboo topic that they did not normally discuss openly. Participants 17, 19 and 29 did not want to admit that they were on anti-depressant medication when they were interviewed.

*My sister does not want others to know that she has depression. Very few people know about her mental health issues.* (Participant 7)

Some of the participants who were on anti-depressants did not want anyone to know that they were depressed or on an anti-depressant. Sometimes participants do not want to disclose that they had consulted traditional health professionals, for example; one participant denied that he had used Chinese medicine when he was asked about his health seeking practices, however, his wife reminded him that he had sought Chinese medicine many times in the past. The reasons behind this behaviour is uncertain, which may need further investigation.
Chinese religious beliefs – Buddhism and Taoism play an important role influencing the participants’ health. Several of the participants expressed this belief:

\[ I \text{ believe in Buddhism, which teaches that one needs to use wisdom to control one's own destiny. Sickness is the result of one's karma. (Participant 14)} \]

\[ A \text{ Buddhist monk once suggested that I should get onto a vegetarian diet, which is better for health. I do feel lighter ever since I changed my diet. (Participant 25)} \]

These participants’ religious beliefs have affected their health beliefs, diet and lifestyle choices.

According to literature review Chinese women migrants are less likely to participate in breast examinations than Australian-born women, which is not reflected by the participants’ experiences.

\[ I \text{ have booked for a free breast screening next week. (Participant 1)} \]

This could be explained by the fact that the Australian government sends health screening reminders regularly to the participants. Many of the participants have exploratory tests and health screenings regularly. Some of the participants want to maintain their health by various preventive strategies. For example, Participant 8’s father had bowel cancer, therefore, she had operations to remove cysts in her stomach:

\[ I \text{ am observing it (the cysts) with technology – I have X-ray, colonoscopy, and biopsy regularly to monitor regularly.} \]

Participant 17 seeks stomach and large intestine investigation annually; Participant 21 has regularly check-ups of her uterus and breasts, which is a strategy for early detection and early treatment.

Participant 22 developed hypertension at 30 years old, which developed into kidney failure when she was 50 years old. Since then she has had dialysis, kidney transplant, heart attack and consequently a stroke. She has health checks and blood tests every 3 months. She maintained that her specialists had never referred her to a dietician or to lifestyle counselling. None of the participants were encouraged to explore their health needs beyond regular health screening and treatments.

On the other hand, many participants do not want to know about health promotion strategies.

\[ I \text{ do not want health screening or anything else done. I only visit my doctor to get repeat prescriptions of my medication. (Participant 3)} \]
Participant 3 has hypertension and hyperlipidaemia, arthritis and insomnia, she also has had hip and knee replacements. She is not interested in changing her diet or getting help from allied health practitioners. Participants 26 concurs with Participant 3’s assessment of health promotion strategies when she says:

*The health assessment report does not prevent disease, only leads to more tests.*

(Participant 26)

There are other participants who know they have health issues, which could improve with changes they can make in their lives, but they refuse to do so. For example, Participant 21 who has gout says:

*Why do I need to change (cut down on diet that feeds to gout, such as the consumption of meat) unless something goes wrong? I would not change for the sake of changing.*

Typically, many participants do not want to change their health practices, such as their diet or lifestyle in order to maintain their health, even though their body is showing certain signs and symptoms of chronic diseases. Some comments from the participants that reflect this are:

*I never thought about what to do now, only if and when I will need help [in sickness].* (Participant 13)

*You cannot help the aged like my mother – [she has] emotional issues.* (Participant 20 lives with her elderly mother)

These participants do not want to deal with their health conditions or seek help from health professionals until they are critical. This coincides with the expert’s observations reported in Chapter 7.

All the participants use a mixed treatments approach, which is they have consulted their general practitioners, but they also use traditional Chinese medicine which coincides with findings from the literature review. These traditional Chinese health treatments include Chinese herbalism, acupuncture, moxibustion, cupping, tuina and qigong.

The participants’ traditional health belief is part of their culture. Some of the participants have a strong connection with this traditional culture, for example, Participant 23 thought that all the herbs that she had taken when she was young had helped her current health condition:

*I am relatively healthy even though I worked very hard because when I was young; my mother used to cook herbs for herself, she would drink the soup stock while I ate the remaining ingredients.* (Participant 23)
Ten women strongly believed in using a traditional Chinese medicine approach in after birth:

_{I had doing-the-month (Chinese postnatal confinement) 坐月 after birth._}

This is a form of postpartum care that was documented in ancient literature Taiping Guangji (太平廣記) and in contemporary studies (Chu, 2005). Participant 16 strongly believes that her health has been compromised because she did not follow the Chinese traditional belief:

_{I was alone here in Australia when I gave birth to my son. I never had doing-the-month. I also had cold jelly and caught a cold during a shower in the hospital [against traditional Chinese health beliefs]. [Therefore,] I had a high fever and no breast milk afterward._}

Participant 18 identified the differences between biomedical and traditional Chinese medicine. From his perspective:

_{Western medicine is better used for acute illnesses because it acts faster, but TCM is used to eliminate root causes._}

All the participants have used traditional Chinese medicine and western biomedical medicine. Typically, this approach is explained by Participant 23:

_{I used western medicine for my hot flush and irregular period and took traditional Chinese medicine for minor things such as flu._}

This was repeated by Participant 23:

_{I am waiting for my specialist to stabilise my diabetes and properly regulate it first before I seek help from traditional Chinese medicine._}

There are also cases where participants are using western medicine and traditional Chinese medicine simultaneously, as indicated by Participant 22, who had a kidney transplant:

_{I need traditional Chinese medicine treatments to ease the side effects of all the medications I am taking for my high blood pressure and anti-rejection of my new kidney. My specialist and my traditional Chinese medicine practitioner are unaware of the kind of treatments I am having from both of them._}

There is a danger of interactions brought about by taking the traditional Chinese medicine and biomedical medications concurrently without any medical supervision. All the participants do not inform their health practitioners that they are using other treatments. Participant 8 is an anomaly in that she says she does not want to use the two modalities at the same time, when she is in fact using biomedical medicine and Chinese medicine at the same time:
I do not want to use traditional Chinese medicine and biomedicine at the same time, because I am concerned about interactions between the two. (However, Participant 8 had acupuncture to relieve her pain in the legs).

The participants are aware of the risk of interactions from the mixed treatments approach (both traditional Chinese medicine and western biomedical medicine). However, there is lack of investigation about the integration of the use of Traditional Chinese Medicine and Western Biomedical Medicine.

Even though all the participants prefer to use the mixed, traditional Chinese and western biomedical, approaches in treating their health conditions, yet many of the participants are deterred from using traditional medicine because they cannot afford it or that traditional Chinese medicine is not available.

My medication prescribed by my doctor does not cost me anything. Whereas traditional Chinese medicine cost me $18 a fortnight. I cannot afford it. (Participant 5)

Each TCM treatment cost me $90 a session. I only get a portion of that money back from my private health fund. (Participant 2 and Participant 3)

I had to take painkillers for 2 weeks while I was hospitalised after I had a back injury. I wish I could have some Traditional Chinese Medicine sooner. I had to wait until I was discharged before I could get some Traditional Chinese Medicine treatments. (Participant 14)

I do not know where to find a reputable traditional Chinese medicine practitioner. (Participant 32)

Even if the traditional Chinese medicine practitioner is allowed to treat the participants in the hospitals, the charge for the hospital visit to treat one patient is unfeasible.

Many participants do not have health insurance because they have found the health insurance too expensive or not affordable.

I do not subscribe to private health fund. It is more expensive than my mortgage. (Participant 26)

Hence, the participants have experiences with affordability, accessibility and availability issues when in need of the traditional Chinese treatments.

Alternatively, three of the participants (8, 10 and 26) would rather seek health services overseas, which they consider much more affordable. Six participants (7, 8, 19, 25, 26 and
29) sought health services when they returned to their countries of origin. Some participants return to Hong Kong to obtain physiotherapy and dental treatment, because of the difficulty of communication and the cost of treatments in Australia.

    *I used to work in Hong Kong as a teacher, therefore, I can get free treatments when I go to Hong Kong. I like the way they organised my treatments.* (Participant 8)

Curiously, Participant 12 (a scientist) denied that he had ever used traditional Chinese medicine until his wife overheard and reminded him:

    *Every time you had a cough, nothing helped except Chinese medicine.* (Participant 11)

This participant was probably embarrassed that he sought help from an ‘unscientific based’ treatment, nonetheless, he could not dispute that the Chinese treatments helped him.

Some of the participants are very knowledgeable about health issues and adopt various self-care strategies. Participant 27 expressed her commitment to remaining healthy well:

    *What we can do is to eat fresh or natural food. Another thing is rest, have good rest as well as good sleep ... We should keep balance and peace. Ageing and diseases always come hand in hand. There seems no way to stop it. Doing exercise is always important. When I feel uncomfortable, such as dizzy. I guess maybe because of my blood pressure, then I will adjust my diet - eating lighter foods.* (Participant 27)

Participant 27 also relies on diet and exercises to regulate her health condition but denies her emotional stress at home, which has probably contributed to her mental health condition (depression).

    *I do not take any medication or vitamin. They all give side effects.* (Participant 26)

Participant 16 also uses exercise to keep herself healthy but can overdo the exercise at times and injure herself:

    *I like powerwalking and sweating because it pushes all the toxin out of my body, I have deeper sleep afterward* (Participant 16).

Conversely, there are those participants who are willing to try anything, without knowing what their body needs:

    *My friend (or family member) told me that she felt much better after she took this supplement, therefore I am taking it as well.* (Participant 29 has menopausal symptoms and depression)
My wife gives me vitamins every day, personally, I do not know what they are and do not think much about these vitamins. (Participant 13 has hyperlipidaemia)

All the participants were relatively active and engage in many physical activities, except for a couple, one who was wheelchair bound and the other was critically ill. Many of the participants practice extra activities, apart from their daily activities doing housework or other home maintenance activities. These comments from a number of participants illustrate their physical activities to promote their health:

*I work in my vegetable garden every day. We get to eat the produce I have grown.* (Participant 17)

*We practise Qi Kun every morning* (Participant 18 and Participant 25)

*I walked from work to university (2 Km 30 minutes’ walk) every week to give lectures* (Participant 13)

*I walk at Mt Cootha to the top, then I enjoy a cup of coffee there.* (Participant 13)

*I walk at the local shopping centre car park every Saturday morning* (Participant 4)

*I power walk every evening for couple of kilometres* (Participant 16)

*I play squash and my husband plays golf every week.* (Participant 9)

Participants also practice meditation, yoga, tai chi, qi qung, they play badminton and squash, bicycle, swim, and line-dance. They also engage in other activities: weightlifting (plastic bottles filled with water), stretch exercises, gardening and sit up.

According to the literature review, there is a rise in Australian baby boomers consuming alcohol and drugs, however, none of the participants, except one, drinks alcohol regularly. None of the participants smoke cigarettes either. Overall, the participants made healthy lifestyle choices in this regard.

There is a diverse dietary habit among the participants, however, they are all familiar with traditional Chinese foods for special occasions, such as Chinese New Year, Moon Festival, Lantern festival, Qingming festival, Dragon Boat Festival, and Winter Solstice festival. All the participants followed a combination of Chinese and Australian culture in their eating habits. The participants do eat standard supermarket foods such as bread, biscuits, ham, and bacon and bought roasted chickens for convenience.
All the female participants cook according to Chinese styles - stir-fry, soup, stew/simmer and steam. None of them bake, roast or grill when cooking. Some of the participants cook soups for health reasons, for example, cooling soup with watercress and Chinese dates. Two of the participants are vegetarians and they have found it difficult to get a variety of vegetarian ingredients in Brisbane that they can obtain easily in Hong Kong and China. The following comments give some idea of the female participants’ attitude towards food and eating:

*I cook traditional Chinese meals: rice, vegetable and soup daily.* (Participant 29)
*I sometimes have ham sandwich for lunch and buy a roast chicken from the shop.* (Participant 16)
*We (I and my husband) have takeaway every day. We have no time to cook because both of us work full time.* (Participant 31)

Sometimes they integrate the Chinese with the Australian way of cooking, for example,
*I made soup with the leftover of the roast chicken.* (Participant 16)

None of the participants are aware of the Australian dietary recommendations of the core foods. However, many of the participants are taking alternative health supplements such as glucosamine; pollen; grape seeds; fish oil; multi-vitamins B12, D, and E; and calcium supplements; and Sustagen, even though these were not prescribed by health professionals.

Even though many the participants mentioned that they are exercising regularly and searching for disease prevention strategies, they are also taking prescribed medications for their chronic diseases. When asked about how the participants perceive their diet:

*I would like to cook the traditional Chinese way [therapeutic diet], but I do not know how. [Where can I learn?]* (Participant 11)

Obviously, they need support to promote their health and not just maintaining their chronic conditions. However, there seems to be a lack of information about disease prevention or health promotion programs that the participants can relate to and rely on.

**8.9 The experiences of access to health information**

Many of the participants gain health information from family members, friends, associates, community agencies and Chinese media (newspaper, internet, television). Only those participants who are English proficient would access the information from Australian government online resources, as discussed in Chapter 7. For those participants who do not speak English proficiently, all the information presented in PowerPoint during health
programs should be written in Chinese; and the provision of earphones and pre-recorded translations of the information. These health programs could be made available online or as apps.

Many participants, of which Participants 8 and 26 are typical examples complained about their health professional not encouraging them to access their own information and denigrating the information that they do bring to the consultation:

*I often surf online for health information. When I asked my doctor about some health information I read online. My doctor did not discuss this information, instead, he scolded me and asked me if the information I gathered online was evidence-based.*

Participant 26 argued:

*Scientific based evidence is not absolute. Medical professionals use only trial and error on patients.*

One participant has a clear approach to evidence-based medicine.

*I am not taking a full dose of the medication that my doctor prescribed, because they were evidence-based on Caucasians. Have you seen the size of them? (Participant 22).*

This participant represents some others who think that since the medication were trialled on Caucasians, therefore, the medications would be too strong for the Chinese people who are smaller in size.

### 8.9.1 The experiences of health promotion/education programs

Participant 11 complained that there was a lack of culturally appropriate health information about traditional Chinese medicine approach in diet and maintaining health:

*I would like to cook the traditional Chinese way [diet that maintains health], but I am not familiar with it (I need more information about traditional Chinese diet).*

The participants’ experience of health promotion and education programs was mixed. Participants were confused about adopting health information based on ‘evidence-based practices’, especially when there is a lack of evidence-based information on health practices that support the participants’ traditional cultural beliefs. This is most notable in relation to Australian government dietary guidelines. For example, one of the recommended core food groups is dairy products, which is not a core food in the traditional Chinese diet.
Then there are those who knew they have health problems, such as Participant 9, and would like to change for the better, but do not know how to change:

*I believe the anti-depressant that I have been taking for more than 10 years is contributing to my health deterioration. I do not want to take it anymore; I tried to stop but I could not do it on my own. I do not know what to do and where to seek help.*

Unfortunately, many of the participants who are dependent on medication to keep them functional initially are now finding the side effects impacting on their health. They feel trapped and helpless, hence, some of the participants turn to traditional Chinese medicine for help; or they went online to seek help.

There are participants who are keen to gain more information on how to maintain their health.

*If the information given [in the health programs] was too generalised, I am not interested, I do not want to waste my time just to socialise.* (Participant 6)

However, some participants may attend health promotion programs for social support, as suggested by the informant in Chapter 7.

Sometimes a participant would find the health programs did not meet their information seeking needs. For example, a Chinese community agency promoted a health information program titled ‘Health Needs of the Ageing People’. Hence, it attracted the Chinese baby boomers. Unfortunately, it should have been marketed as ‘Healthcare Needs for the elderly’, which would have attracted a different kind of audiences. The health program organisers were unaware that health care needs and health needs are two totally different things. During the presentation, the speaker from a private enterprise that sells services and products that support aged and disabled people to live independently talked about assisted aged care packages and equipment to help aged people to live at home. The speaker passed around aged care products such as aged care nappies, pill boxes, alarm clocks, and personal home assistance alarms. Some of the audience looked despondent and did not engage during the presentation but left very quietly and quickly after the talk. One of the attendees who is also Participant 10, was disturbed and perplexed as she walked out of the room and said:

*This is terrible. I am very disappointed with the talk. I was expecting to gain some health information to improve my health, but instead, this is marketing health care and aged care products, which was very disturbing and confronting for me to listen. I am scared now that I heard about all these products – that I may need one day!*
Another attendee who is also Participant 18 in the research study found the talk very useful but too late for his purposes:

I wish I knew about all this information years ago when I was nursing my ailing mother, I could have helped her with all these products. I was desperate looking for things to help her then, [now she has passed away].

This also showed that the programs did not fulfil the participants’ health needs.

Interestingly, there were different reactions from the audience members, even though the participants were all Australian Chinese baby boomer migrants. This demonstrates that the participants do not constitute a homogeneous group when it comes to their health or healthcare needs.

8.10 Conclusion

This chapter presents the relationships between the study sample participants with their family and their community and studies their health beliefs and health practices from their personal experiences. The results in this chapter indicate that they prefer ageing-in-place and ageing-in-family, however, there is a lack of information as to whether their desires will be satisfied. Many of the participants’ health seeking behaviours and health practices coincide with literature review (Chapter 4). The challenges that the participants are facing in meeting their health needs are discussed in Chapter 9.
Chapter 9
Discussion, recommendations and conclusion

9.1 Introduction
This chapter discusses the main points from the study findings based on a community needs assessment, makes recommendations according to the implications of the findings and concludes the thesis. The integrative community needs assessment methodological framework, developed by Chu, based on Bradshaw’s concept of the four types of needs collected experience and views from four perspectives: 1) the professionals, experts and program managers providing the services, 2) the Chinese baby boomer participants themselves, 3) the existing secondary data and literature about the social circumstances and historical background of the study population, and 4) relevant information and strategies drawn from literature and policy documents concerning other Chinese migrant communities in similar circumstances from other countries. This has resulted in some significant insights about the participants’ experience, social and health needs.

This chapter begins by summing up the social, physical and health changes experienced by the Chinese baby boomers in Australia, some of which are common to baby boomers regardless of race or ethnicity, and some of which are more unique to the Chinese baby boomers because of their traditional values. This is followed by identifying some of the issues and gaps in the social and health services on offer to Chinese ageing migrants, as well as recommendations to address them. Finally, this chapter provides a conclusion to the overall study.

9.2 Summary of key findings
In summary, using a community needs assessment approach has resulted in two key findings that can directly and indirectly impact on the participants’ health and wellbeing. The most prominent finding this study have identified is that some Australian baby boomers are facing multiple changes on different levels – physically, financially, socially and psychologically. An experience common to all participants is their need to cope with changes to their social, physical, financial and housing arrangement, and to identify the support they need. Second, current health and educational programs do not address their needs.
9.2.1 The changes experienced by the participants

Some changes are experienced by all the Australian baby boomers, whereas some of the Chinese baby boomer migrants may experience experiences different to those of the Australian born baby boomers because the former have different cultural background.

9.2.1.1 Changes common to the Australian baby boomers

The study’s participants and the Australian baby boomers share some common experiences regardless of their race or ethnicity. As examined in Chapters 3 and 4, the literature review has shown that all Australian baby boomers, including the Australian Chinese baby boomer migrants, face similar changes in their lives (Fingerman et al., 2012). Some are global and societal changes, while others are personal changes, such as health deterioration; death and severe illness among close relatives; retirement; divorce and children leaving home, as discussed in Chapter 8. Sometimes the changes are overwhelming, because of their speed, magnitude or complexity.

One of the changes experienced by every Australian baby boomer regardless of whether s/he is locally born, or an immigrant is health deterioration and issues relating to health degeneration. Evidence has shown that Australian baby boomers are experiencing changes to their disease patterns and a growing prevalence of chronic diseases (Chapters 2 and 3). This coincides with the participants’ experiences. Thus, as discussed in Chapter 8, the participants need health-promotion programs to help them manage their health conditions and to prevent further deterioration.

9.2.1.2 Changes to the Chinese baby boomer migrants

Some changes that participants are facing, such as their health and relationship changes, lead to and interact with other changes, such as those to their changing housing, financial and social needs. Unfortunately, some participants are reluctant to make attempts to adapt to these changes because they feel comfortable with things as they are. Other participants cannot make decisions for themselves because they have lost autonomy and are dependent on family members to deal with the changes they face. Alternatively, they are unable to access crucial information, resources, and professional help to make these decisions. One of the most significant challenges that this study’s participants face is to make complex planning decisions to deal with their changing housing needs.
Changing housing needs is one of the key issues confronting Australian Chinese baby boomer migrants. As their health conditions change, and family members move in and out of their home, they need to consider whether to move from or stay in their current homes. There are challenges to making these decisions. For example, some participants cannot come to a decision because family members, such as the husband and wife, cannot agree on what to do. This becomes more complicated when the participant is unable to communicate effectively with their families and children; therefore, no decision is made.

Some of the participants are reluctant to plan because they enjoy the status-quo. Many participants have stated that they not only prefer ageing-in-place, but, unlike Australian baby boomers (Judd et al 2014), or that is, to ‘age-in-family’, as a couple of participants are doing. There are several explanations as to why participants prefer to age-in-family. Lai (2005) has suggested that participants who prefer to live with children are less educated or have non-western religions. However, this has not been found in this study. Instead, one of the major reasons is that participants hold traditional Chinese values of ‘filial piety’ (Li et al., 2010; Haralambous et al., 2014; Zhang, 2014) as discussed in Chapter 3. Furthermore, older Chinese people feel that elderly people who enter nursing homes are stigmatised, (Luo et al., 2018) since, traditionally, only those who lacked family support would end up in nursing homes. Hence, the participants have little desire to downsize or relocate. Some participants also resist downsizing in the hope that their children and extended families will move back to their family homes. Others are waiting for their families to make decisions for them about their living arrangements.

This study’s findings also coincide with the literature that Chinese rely heavily on family and close members of their informal network for support, which includes physical, financial and emotional support, as well as for information and decision-making (White and Kliner, 2012; Bryant & Lim, 2013; Poon et al., 2013; Kwok and White, 2014; Zhang, 2014). In turn, older people, such as the participants, can provide informal childcare to their grandchildren (Horsfall & Dempsey, 2011), hence, contributing to the family’s well-being. Shin and Sok (2012) have found that older people living with their families and extended families have better health statuses and self-esteem compared to older people living alone (McDonald, 1992; Chappell and Kusch, 2007; Robinson et al., 2008; Klocker and Gibson, 2013; Cerin et al., 2015). In view of the shortage of aged care providers and a growing demand for formal care, the participants’ desire to age-in-family and receive informal care from their families
could provide relief to the government-funded formal aged-care system, as well as being more in line with their needs and desires. It could, therefore, be encouraged.

However, it is not always possible for participants to age-in-family because many of their children and extended families live interstate or overseas. Furthermore, Lo and Russell (2007) have suggested that conflict between generations can mean that living with family does not guarantee that they will enjoy better care and communication, more understanding or closer intimacy between the generations. Since all the participants’ children were brought up in the Australia, the different generations’ traditional Chinese or more Australian values may make it difficult for them to cohabit. Studies report that some older Chinese Australians have been better off from leading separate lives. In addition, many Chinese Australians reported that they do not want to burden their children with their care (Lo & Russell 2007; Kwok & White, 2014). Even for the participants, typically traditional Chinese filial values are transforming into more western values (Ip et al., 2001; Lam, 2006). Future studies might explore the effect of this change in cultural beliefs on the dynamics between the participants’ family members, and how this affects their health.

Another source of reluctance for participants in planning for their changing housing needs is that they cannot afford to make a wrong decision because of the possible physical, financial, mental and psychological consequences. The participants have demonstrated that planning and decision-making are mental and emotional challenges that consume time and energy. They also feel that they lack the networks of trustworthy professionals, such as real estate agents or builders, who could help them to make and carry out their decisions.

Whatever the participants decide, there will likely be positive and negative implications to their decisions. However, there is an urgent need for participants to make timely decisions about their housing, because these decisions are best made by choice, not under duress. Failing to plan carefully and make appropriate decisions can create a stressful situation, not just for the participants, but for their families and the community, and may result in the participants’ loss of autonomy and diminished quality of life. Hence, government support is important, as a failure to address both the participants’ and the baby boomers’ changing housing needs will result in unnecessary and higher costs for health and social care (Donald 2009).

**9.2.1.3 Changes to government policies**
As discussed in Chapter 2, there are couple of recent changes to Australian government policies that may affect Australian baby boomer and Australian Chinese baby boomer migrants’ health. The first is a change to superannuation tax law aimed at encouraging and supporting Australian baby boomers to downsize and gain more financial security as they head toward retirement. However, there is a lack of information about the implications of this change, especially if the participants and baby boomers are receiving pensions or social security payments from the Australian government.

Another change to the Australian policy is the raising of the retirement age (also discussed in Chapter 2). Again, there is a lack of information about the implications of this change on the participants and the Australian baby boomer’s health and wellbeing (though those who have already retired will not be affected by the change).

9.2.2 Issues with language proficiency

As discussed in Chapter 4, the literature review has suggested that due to low English proficiency, Chinese migrants have low rates of accessing social and health services, such as health screenings, and that they under-report their health conditions. As such, policy makers and program designers have suggested various strategies to overcome these barriers, such as designing linguistically and culturally appropriate and sensitive programs, such as English classes or health programs delivered with language translation. However, there are various issues with these programs that prevent them from obtaining their goals in relation to Australian Chinese baby boomer migrants’ needs.

First, this study has found that some participants do not participate in health screenings even though they are proficient in English. Hence, some studies’ suggestions, discussed in Chapter 4, that there be bilingual therapists may not encourage the participants to participate more in health services, nor is English proficiency necessarily a barrier to accessing services.

Second, the Australian government has a strategy of offering free English tuition classes, which could help Australian Chinese migrants with education or employment opportunities. However, this study has found that English proficiency is not a priority for baby boomers because they are no longer seeking employment, nor opportunities to meet new English-speaking friends. This is especially the case for this study’s participants who speak exclusively Chinese at home and prefer to socialise with Chinese-speakers (as discussed in
Chapter 6). The primary benefit of this program, then, is to provide a forum for meeting fellow Chinese students to network with.

The government and other organisations have also attempted to provide Chinese (and other) migrants with health programs that are delivered in English with translations, for example, to Chinese. While participants reported that they felt there were gaps in the program content, language delivery, and that sometimes there were overly long presentations, there is a larger issue here. This study echoes the points found by experts and informants (discussed in Chapter 7) that language translations may not be sufficient to allow Chinese migrants to participate in these programs because of the variety of Chinese dialects and culture. There are five main dialects of Chinese spoken among the participants: Mandarin, Yue (which includes Cantonese), Min, Wu and Hakka (of the more than 200 individual Chinese dialects) (Lewis, 2009). While the written language is the same in all dialects, when spoken, most Chinese dialects, including those mentioned, are not mutually intelligible. Thus, Chinese who speak one dialect cannot speak to someone with a different dialect. This means that Chinese dialect can be a strong determinant of a Chinese migrant’s social support as well as their ability to network or participate in their community, or social programs.

As such it is important that health programs deliverers not only consider whether participants are proficient in English but should be sensitive to participant’s needs for programs in dialects that they can understand, or that materials provided are simple enough to be understood by linguistically and literacy-diverse audiences.

9.2.3 The Participants’ desire for traditional Chinese health services and culturally sensitive information

As discussed in Chapter 4, traditional Chinese medicine is part of the participants’ cultural heritage. Many Chinese migrants tend to use traditional Chinese medicine when they experience non-acute illnesses (Aung et al., 2013; Ali and Katz, 2015) (not for preventative measure or health promotion). However, participants described barriers to safely and easily having access to this kind of medicine. First, Chinese medicine-related services are not covered by Medicare, so for those who cannot afford private insurance, which offers partial coverage, Chinese traditional medicine are too costly. Second, many participants use both Western and Chinese medicines, but there is a lack of information about how these medicines might interact, thus they would like more information about this. Hence, culturally
appropriate health services and programs that includes Australian-Chinese migrants' cultural beliefs and practices in the intervention plans are more appropriate (Wilson, 2008; Chalmers et al., 2014).

Participants also report that some health information is not helpful within the context of Chinese culture. For example, the ‘Recommended Food Intake’ is based on evidence collected from the population from European and recommends that dairy products be a core part of a balanced diet (NHMRC. Australian Dietary Guidelines. Commonwealth of Australia. Publication reference: N55 2013). However, most of Chinese are lactose intolerant and therefore are unlikely to eat any dairy-based foods (Bolin & Davis 1970; Yang et al., 2000; Zhang et al., 2001). It would be helpful and a more effective use of resources if health information was inclusive to accommodate this kind of cultural diversity, as identified by Shim (2016).

9.3 Recommendations

Based on the key findings of this study, the recommendations are as follows:

9.3.1 Develop social and health service policies and plans that target baby boomers in Australia

While there are a few programs on offer for the Australian elderly, there is a gap in the planning for the upcoming baby boomer generations who have different levels of education and expectations compared with the previous generations. It is necessary to better understand the baby boomers’ social and health needs, so that they can be incorporated into government planning to create appropriate health and social services that not only promote their general health and well-being, but better prepare them to manage their social and health needs as they age.

9.3.2 Conduct a community needs assessment that meet Chinese baby boomer migrants’ needs

Conduct a more extensive and comprehensive community needs assessment, incorporating relevant stakeholders’ perspectives, to inform the development of useful policy and culturally appropriate programs, to meet the Chinese baby boomer migrants’ social and health needs. This chapter has discussed issues with and gaps in programs on offer for older Chinese and highlighted the importance of culturally appropriate and sensitive policies to enhance community participation. To this end, a community needs assessment is useful to develop tailored strategies relevant to their needs. The community needs assessment process could
begin with the Chinese community’s self-help groups and agencies conducting surveys and forums via Chinese newspaper, radio, internet and posters, to collect information about the participants’ needs. This could engage the participants and the Chinese community to voice their concerns and discuss the challenges they face in relation to the decisions they have to make to cope with their changing needs, especially those relating to housing. In addition to identifying people’s social and health needs, this needs assessment and program planning process could provide opportunities for participants to network with each other during group discussions and forums. Importantly, this creates networks that Chinese non-government organisations and service providers can use to provide needed information for the future planning.

9.3.3 Empower the Chinese baby boomer migrants

This chapter has highlighted that the key issue confronting the Chinese baby boomer migrants is the changes to their social and health needs. To help them to cope with these changes, it is important for policy makers and community agencies to provide them with information, resources and support measures relevant to their changing social and health needs.

There are many strategies to empower the Chinese baby boomer migrants. For example, to address their changing housing needs, service providers such as health program coordinators and Chinese non-government organisations could form a network taskforce to compile a list of credible tradesman, gardeners, financial consultants and real estate agencies, along with their associated cost and predicted time-frames for community members; local Chinese newspapers could publish awareness-promoting news articles to encourage readers to make prompt decisions about their housing needs; ethnic radio programs could offer a question and answer program relating to choices and types of housing available, etc. These networks could also facilitate coalition-forming to advocate for more culturally appropriate and sensitive policies. For example, the participants have expressed their desire to age-in-family. The responses generated from the community needs assessment from the participants’ children and extended family, and the intergenerational dynamics regarding ageing-in-family could be included in policy discussions. Thus, a comprehensive community needs assessment may lead to culturally appropriate information, resources and policies that are supportive of ageing-in-family.
Other accommodations to Chinese migrants might include health programs with Chinese
translations, and the provision of earphones and pre-recorded translations of the information.
Programs could be available online or as apps.

9.3.4 Facilitate the provision of affordable traditional Chinese health services
Many participants of this study reported their desire for the provision of more affordable
traditional Chinese medical treatment from traditional Chinese doctors, particularly for their
non-acute chronic health issues. Chinese medicine-related services are not covered by
Medicare, so for those who cannot afford private insurance, which offers partial coverage,
Chinese traditional medicine is considered to be too costly. Some Chinese non-government
organisations might consider developing a non-profit partnership arrangement with retired
Chinese medical practitioners, to offer a low cost traditional Chinese medicine clinic
providing their venue as a means to cut costs.

<table>
<thead>
<tr>
<th>Issues</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 A lack of data and studies that identify the ACBBMs’ health and social needs</td>
<td>Conduct a comprehensive community needs assessment that meet ACBBMs’ needs</td>
</tr>
<tr>
<td>2 Changes in the study sample’s physical being</td>
<td>Provide information and health promotion programs to help the ACBBMs to prepare for the changes in their health deterioration</td>
</tr>
<tr>
<td>3 Changes in the study sample’s housing needs</td>
<td>Provide information to help the ACBBMs to prepare for the changes in their housing needs</td>
</tr>
<tr>
<td>4 Changes in the study sample’s relationships</td>
<td>Provide information to help the ACBBMs to prepare for the changes in loss and changes of relationships</td>
</tr>
<tr>
<td>5 Changes in the study sample’s financial needs</td>
<td>Provide information to help the ACBBMs to prepare for the changes in their financial needs</td>
</tr>
<tr>
<td>6 Changes in the study sample’s social needs</td>
<td>Provide information and health promotion programs to help the ACBBMs to prepare for the changes in their social needs</td>
</tr>
<tr>
<td>7 Changes in government policies</td>
<td>Provide information to help the ACBBMs to prepare for the changes in government policies</td>
</tr>
<tr>
<td>8 Various physical, mental and psychological changes</td>
<td>Provide directories of lists of professionals who could help the ACBBMs to prepare for the changes</td>
</tr>
<tr>
<td>9 A lack of participation in health screening</td>
<td>Coupled with invitation and reminder to health screenings, health promotion programs with culturally and linguistically appropriate strategies should be offered to promote disease prevention, not only early disease detection and diagnosis.</td>
</tr>
<tr>
<td>10 Language barrier – different dialects spoken among the ACBBMs</td>
<td>Chinese community provide free language classes and develop a program that translates different dialects.</td>
</tr>
<tr>
<td></td>
<td>The study sample’s desire for traditional Chinese health and culturally sensitive information</td>
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<tr>
<td>---</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>12</td>
<td>The study sample’s desire for traditional Chinese health services</td>
</tr>
</tbody>
</table>

Table 14 List of recommendations to satisfy the study sample’s social and health needs

9.4 Thesis Conclusion

This study has explored the Australian Chinese baby boomer migrants’ social and health needs. The study’s participants are significant because they belong to the growing number of Australian’s culturally and linguistically diverse ageing baby boomers. It used a comprehensive needs assessment approach investigating four needs: normative, comparative, express and felt needs, from experts and service providers, literature, existing secondary data and the participants. In these categories it has collected information about socioeconomic characteristics, health beliefs and practices, health services accessed, the structure of the community and its resources and the relevant socio-demographic features that affect health.

9.4.1 Summary of the thesis chapters

There are two sections to this thesis. The first section consists of the literature review of the background to this study, which is discussed in Chapters 2, 3 and 4. Chapter 2 discusses one of Australia's demographic challenges: its rapidly ageing population. This has significant implications for Australia's economy and healthcare resources. Population ageing has social and economic consequences that affects the demand for services (both welfare and health) and creates rising health and welfare costs as well as a shrinking workforce. As such, planning for the ageing population is essential. Furthermore, there is a large number of baby boomers who have retired since 2011 and more are retiring each year. According to a Life Course approach, each generation is distinguished by its own unique set of values, ideas, ethics, and shared experiences. Currently, much government attention and planning has focused on priority age groups, which include mothers and babies, children, young people and older people.

Chapter 3 discusses the characteristics of Australian baby boomers. The government does not consider the baby boomer cohort to be a priority group even though it is an emerging ageing
population. Most of its policies and planning are based on data collected from the past
generations with little attention paid to baby boomers’ health needs. This creates issues
because baby boomers may not age the same way as previous generations because of their
different life experiences and expectations. To complicate things further, Australia has been
importing workers to boost its shrinking labour force and to maintain economic growth. As a
result, in 2016, more than a third of Australian residents were born overseas. Among them is
a growing number of culturally and linguistically diverse people in the population, with the
Chinese migrant group being one of the largest.

Chapter 4 discusses the various factors affecting Australian Chinese baby boomer migrants’
health. Planning for the large number of upcoming ageing Australian Chinese baby boomers
is difficult because information about their health status and their use of health services is
either lacking or incongruent. Policy makers have suggested that is caused by Australian
Chinese baby boomers’ underutilisation of health and community services due to their
cultural and language barriers.

The second section of this thesis consists of the methodology, the findings and discussion of
the findings. The study methods are based on a health-promotion concept described in
Chapter 5. According to the WHO and the Ottawa Charter, health-promotion needs to adopt a
holistic approach and empower individuals and communities to take action for their health,
foster leadership for public health, and encourage intersectoral collaboration to build public
policy in all sectors for health-promotion. Evidence has shown that health is determined by
many factors outside the health system. Therefore, this study takes a holistic approach,
incorporating a multidimensional model of health that incorporates multiple determinants,
such as cultural, socioeconomic and environmental factors, as well as the provision of and
access to health care services by Australian Chinese baby boomer migrants.

The major findings in Chapters 6, 7 and 8 identify the type of information that policy makers
and professionals need to develop Australian Chinese baby boomer migrants’ ageing
policies/programs. Chapter 6 provides a snapshot of the participants’ socioeconomic profile
and demographic characteristics, including their age, sex, settlement area, marital status,
employment and retirement status, living arrangement and housing styles and the services
available to them in Brisbane. This chapter also identifies the community structures and
socio-demographic features that affect Australian Chinese baby boomer migrants’ health.
Chapter 7 provides findings about how well current services and programs provided by the Australian government and the community have met the participants’ health needs, according to the experts’ perspectives and the literature review. Chapter 8 presents the Australian Chinese baby boomer migrant participants’ self-disclosed experiences of the issues relating to the health programs or services available to them. Chapter 8 presented the “felt needs” of the participants based on interviews, focus group discussions and participant observations. It provides information about their socioeconomic characteristics, their health beliefs and practices, and the health services that they access. Chapter 9 discusses the key findings, recommendations and overall conclusions of the thesis. It also discusses the strength and limitations of this study.

9.4.2 Summary of the major findings and recommendations

This study has found that the participants, who are Australian Chinese baby boomer migrants, under-participate in health and community services because they do not feel that the health programs and services meet their needs. While the Australian government has funded programs to servicing Australian Chinese older migrants, there is little effort in creating programs aimed at the aging baby boomer generations. Hence, this study recommends that a comprehensive needs assessment be conducted when designing policy and programs that incorporates relevant stakeholders, so that it can better meet stakeholders’, including baby boomers’ needs. It further suggests that Australian Chinese baby boomers be more involved in program conception, design, and implementation, and be empowered to identify and take better control over their health determinants. Improved communication and stronger partnerships between stakeholders could help in designing versatile and flexible strategies to meet diverse health needs.

Given that Chinese baby boomer migrants face not only social and health changes common to Australian baby boomers, but some that are more specific, this study recommends that rather than creating ‘one-size-fits-all’ programs, Chinese baby boomer migrants’ inclusion in health programs be furthered by providing them with relevant information, networks, resources and support measures.

These programs and policies should not only be aimed at improving or maintaining baby boomer health in a narrow sense, but also matters that can help with their overall well-being by better enabling them to plan for their retirement, and to age and retire according to their
preferred cultural norms, for example, by aging-in-family, or by having better and more affordable access to traditional Chinese medicines for non-acute chronic illnesses.

9.5 Strength, limitations, significance and contributions of the study

This study has both strengths and limitations. This study’s results should be interpreted in the context of several limitations. The study is a PHD project with limited resource and scope. It had a small sample of thirty-two participants who are Australian Chinese baby boomer migrants living in Brisbane, as well as twenty-five informants who work with the Chinese community. There is also a gender imbalance among the participants, which consisted of twenty-five women and seven men. Furthermore, using a convenient snowball sampling technique may also limit the scope of the generalisability of this study’s findings. Future studies using a larger sample would be useful in order to verify and generalise findings from this study to Chinese community at large.

In terms of strength, this study has used a community needs assessment process to collect data from different stakeholders, gaining from them a richer understanding of their experiences and concerns from multiple perspectives. It makes a significant contribution to understanding the process of researching the Chinese baby boomer migrant population in Australia, as well as enhancing knowledge and understandings of the methodological issues involved in doing a health needs assessment of this population. Through this approach, it has identified issues and insights about social and health needs that are particularly timely and relevant to the Chinese migrants and the baby boomer generation.

This study is the first to create a profile of Chinese baby boomer migrants in the Greater Brisbane Area, as well as to identify and investigate their social and health needs, particularly as an ageing population in Australia. It thus enriches the literature on Chinese baby boomer migrants in Brisbane. The findings have supported the health promotion approach. This study has shown the process of enabling people to increase control over the determinants of their health and thereby improve their health. It provides evidence-based data and information that can be used by policymakers and professionals; for future planning and to develop policies/programs that support and promote the Chinese baby boomer migrants’ health and wellbeing.
From a bottom-up level, this research process has empowered members of the Chinese community to engage in identifying their health needs and strengthen the OBCBB community action by encouraging them to involve in identifying, prioritising and voicing their own social and health needs.

This study has encouraged communication and partnership between stakeholders; reorient health services if necessary, to remove any existing health inequity affecting the Chinese baby boomer migrants’ health and wellbeing. It also identifies and prioritises areas of unmet need or if the current services are responding appropriately to Chinese baby boomer migrants’ social and health needs.

This study’s findings have filled gaps in the existing knowledge and practices surrounding the understandings of Chinese baby boomer migrants in Australia and can inform future program developments to address their needs. Hopefully future policies and social and health services programs will contribute to the promotion of health and the quality of life of Chinese baby boomer migrants in Australia. The needs assessment used, and the findings of this study may have implications for social services and health planning for other culturally and linguistically diverse groups beyond the Chinese migrant population in Australia.
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Appendix 1

Research ethics

The researcher gave prospective participants information written in English and Chinese detailing: the purpose of this study, their roles, all the implications, risks and benefits of this research study. They were also told that participation was voluntary and that they could withdraw at any time. They were assured that results obtained in this study would be published in journals and conferences; however, this information would not include any information identifying any participant. She assured informants of their confidentiality and privacy. Even though the informants knew that information they gave would be kept anonymous, they might still feel uncomfortable or anxious. Thus, informants had a run-in (cooling) phase to decide whether or not they wanted to be involved in this study. A couple of times, informants agreed to participate initially, but changed their minds later.

The well-being of the participants and associates was considered during the whole process of the study. For example, the researcher halted the interview when an informant broke down during the process. The researcher was aware of the sensitive nature of seeking information from informants. Thus, she did not seek clarification when informants could not or did not want to answer some questions or seemed to be concealing the truth.

Being an Australian Chinese baby boomer migrant herself, the researcher shared the same language (Cantonese) and cultural heritage with the participants and had appropriate knowledge of the Australian Chinese baby boomer migrants' beliefs and cultural protocols. This helped build rapport between the researcher and participants, which proved to be very helpful because talking about one’s health and family background could be perceived as a very personal and sensitive topic in Chinese culture.

The design of this research is respectful of the cultural beliefs and protocols, when greeting each other and during meetings, of the Australian Chinese baby boomer migrants who are participants of this study. This respect is also extended to potential informants, third parties who might be affected by the study, and those who worked with the researcher.

The Social Sciences Human Research Ethics Committee of the Griffith University approved this research study in 2013 (Ref No: 2013/529). This research was bound ethically by giving informants written information about the aim of this study, its procedure and contact details.
of the researcher and the Human Ethics Committee. The participants gave their informed consent to participate in this research, and the researcher guaranteed that their details and responses would be kept confidential.
Appendix 2

**Stakeholder analysis**

Stakeholder analysis may be defined as a process that identify all persons, stakeholder groups and organisations in Chinese community that might have some form of stake or an interest in affecting or promoting Australian Chinese baby boomer migrants’ healthy ageing.

Stakeholder analysis centres upon “the stake” or the issue: "healthy ageing" of the Australian Chinese baby boomer migrants in Greater Brisbane.

Stakeholder analysis is particularly useful with large population such as Australian Chinese baby boomer migrants in Greater Brisbane region when contact with each individual is impossible. Identifying key stakeholder representatives of major interest groups involved, allowing the researcher to engage in the community health needs assessment process.

Information collected from stakeholders who had different perspectives, roles, expectations and interests, with different kind of challenges or barriers they faced could provide rich insight into Australian Chinese baby boomer migrants’ health needs.

**What is a stakeholder?**

A stakeholder was defined as any interested party of Australian Chinese baby boomer migrants, who had an impact on Australian Chinese baby boomer migrants’ healthy ageing, or who was affected by Australian Chinese baby boomer migrants’ healthy ageing. In other words, stakeholders were those who had a direct or indirect stake in identifying the Australian Chinese baby boomer migrants’ health needs.

Stakeholders or research informants and participants were carefully selected to obtain the best, most relevant information for addressing the research problem. Information collected from these samples would allow the researcher to make accurate estimates and draw conclusions about the thoughts and behaviour of the target population (Australian Chinese baby boomer migrants).

Stakeholders can be either direct or indirect. Direct stakeholders were those people (Australian Chinese baby boomer migrants’ family members, carers, friends and community) whose actions can directly impact on Australian Chinese baby boomer migrants’ healthy ageing, or vice versa.
Indirect Stakeholders were those who have some political power to influence Australian Chinese baby boomer migrants’ healthy ageing (Australian government policy makers, non-government organisations who catered for Australian baby boomers, Chinese community associations).

Identifying stakeholders

Identification and analysis of stakeholder began with brainstorming techniques, by listing all parties which were likely to be concerned in any way with Australian Chinese baby boomer migrants healthy ageing, hold an influential position that could affect or be affected by Australian Chinese baby boomer migrants healthy ageing, be affected by Australian Chinese baby boomer migrants healthy ageing, both positively or negatively, directly or indirectly.
Appendix 3
Informants (B) of the research study

Table: Key informants & experts – their roles and organisations they belong to

<table>
<thead>
<tr>
<th>Role</th>
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<tbody>
<tr>
<td>1 Community Development Coordinator Connected Communities Lifestyle and Community Services</td>
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<tr>
<td>2 Language coordinator</td>
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<tr>
<td>3 Manager</td>
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<tr>
<td>4 Health program coordinator</td>
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<tr>
<td>5 Health program presenter</td>
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<tr>
<td>6 Ex-President of U3A</td>
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<tr>
<td>7 One of the tutors (English) of U3A</td>
</tr>
<tr>
<td>8 Director of an aged care facility</td>
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<tr>
<td>9 Manager of an aged care facility</td>
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<tr>
<td>10 Manager of an aged care facility</td>
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<tr>
<td>11 Manager of an aged care facility</td>
</tr>
<tr>
<td>12 Aged carer of an aged care facility</td>
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<tr>
<td>13 Kitchen hand of an aged care facility</td>
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<tr>
<td>14 Co-ordinator of a Catholic prayers group</td>
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<tr>
<td>15 Co-ordinator of a Chinese information program</td>
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<td>16 Manager of a Chinese aged care agency</td>
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<td>17 Aged care carer of a Chinese aged care agency</td>
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<td>18 Aged care carer of a Chinese aged care agency</td>
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<td>19 Aged care nurse of a Chinese aged care agency</td>
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<td>20 Medical consultant</td>
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<td>21 Manager of a Chinese aged care agency</td>
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<td>22 Director of a Chinese aged care agency</td>
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<td>23 Administrator of a Chinese aged care agency</td>
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<td>24 Health program co-ordinator of an aged care agency</td>
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<tr>
<td>25 Case manager of an aged care agency</td>
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</table>
Appendix 4

Information from informant A (participants)

Your Personal Details & records remain strictly confidential Date:
Title: Ms, Miss, Mrs, Mr, Dr Last Name: First Name:
Address: Post code:
D.O.B.: Place of birth:
Occupation: Employer:
Marital status: Married / de-facto / separated / widow(er) / single
Spouse name: Occupation:
Number of pregnancies you had (including miscarriages and abortions): Ages of children?
Phone: Home: Work: Mobile: Email:
Height: Weight: Ideal weight: BMI: Waist circumference:
Favorite foods: Favorite drinks:
Number of cigarettes each day: Smoked for years
Are you allergic to anything? Yes No Details:
Alcohol consumption
Thyroid Liver Blood glucose (HbA1c) Cholesterol (HDL/LDL) Blood counts
Coeliac disease Virus (Glandular fever, Ross River, etc) Other Blood tests:
Health screening: X-rays (areas) Bone Mineral Density Endoscopy Colonoscopy
Laparoscopy CT scans): Heart/Cardiovascular (ECG, etc) Mammogram Pap smear
Do you have a pacemaker? Vaccination (last 5 years): Tetanus Hepatitis Others
Family illnesses (please state relationships)
Past illnesses, accidents/injuries, operations, and hospitalization:
Present Medications or Treatments
Health supplements (herbs, vitamins, minerals, and contraceptive pills etc.):
Where did you come from? When did you arrive in Australia?
How do you look after your health? Whom did you seek help from?
Whom did you seek information from? How and where did you seek information?
Is there any kind of help you need to maintain their health?
What is the barrier that hinders you from seeking help?
What happens in 20-30 years’ time, will you anticipate going into a nursing home?
What is your plan in the future as you age?
Appendix 5
Information from informant B

Name of informant: ___________________________ Organisation: ___________________________ Date: ___________________________

Education background:

Work experiences:

Years worked in this organisation:

Why do you work in this organisation?

What is/are your role/s?

How do you achieve your role/s?

Contribution: What were you trying to accomplish?

What have you achieved/accomplished?

What didn’t work? Why?

Insights: What significant insights and experiences have you gained or learnt from your work/organisation about the Australian Chinese baby boomer migrants?

How did you come to this understanding? Why?

Data collected from the 25 informants will focus on their perception based on their professional experiences working with the Australian Chinese migrants. Information gathered from the informants will begin with their name, their role as a stakeholder, followed by their mission, vision and their definition and concept of health and healthy ageing and finally their opinion on the health needs of the Australian Chinese baby boomer migrants' healthy ageing process.
Appendix 6
Participant's Information

Research Title: Coping with changes and health needs of the Australian Chinese Baby Boomer migrants in Brisbane (Australia): A community health assessment approach

Chief supervisor:
Prof. Cordia Chu
Principle supervisor
Director, Centre for Environment and Population Health, School of Environment, Griffith University
Contact phone: 3735 7458

Associate supervisors:
Dr Sarah Rickson
B.A.,M.A.PhD
Contact phone: 37353722
School of Humanities and the Social Sciences, Griffith University

Student researcher:
Ms. Christiana Chau
PhD student
Centre for Environment and Population Health, School of Environment, Griffith University
Contact Phone: 31616888
Contact Email: christianayang@optusnet.com.au

Background
Studies have shown that planning to meet the health needs of the overseas born Chinese baby boomers is challenging. There is a lack of information about this cohort. Therefore, this research study explores your opinion about their health needs and the barriers that prevent their health needs being met.

Purpose
This research project is part of the researcher's PhD study aiming to promote a healthier life expectancy of Australian Chinese baby boomer migrants residing in the Greater Brisbane region. The goal is to contribute to the promotion of healthy ageing programs that will meet their health needs.
Your knowledge, experiences and insights of the needs of the ageing population will contribute to the planning of health programs that will promote this cohort's healthy ageing process.

**Inclusion criteria**
You are included because you are an overseas born Chinese baby boomers residing in Brisbane (Australia).

**Procedures**
The interview will last more than an hour.
The interview will be tape recorded. If the conversation is in Chinese then the contents of the interview will be transcribed and translated into English. Any identifying information such as individual and your names will be removed, and the taped recorded conversation will be deleted.

**Potential benefits**
You will indirectly benefit from this research by exploring and identifying the needs of the ageing overseas born migrants.
This research study will give us an insight into the issues and the barriers that hinder the needs of the overseas born migrants from being met.
The findings of this research study will contribute to developing policies and programs that will promote not just an increased life expectancy, but also a healthy ageing process of the overseas born migrants.

**Potential risks**
There is no risk involved in this research. The only investment is your time and energy.

**Informant's rights**
Informant has the right to understand all the implications, risks and benefits of this research study.
Informant's confidentiality and privacy will be assured and only the researcher listed on this form and the supervisors will have access to informant's securely stored data.
The results obtained in this study will be published in journals and conferences; however this information will not include any information identifying you.
Please understand that while your cooperation would be sincerely appreciated, you are under no obligation to participate in the study.
A run-in (cooling) phase prior to consent would give the informant the time to decide whether or not the participant wants to be involved in this study.

**Voluntary Participation**
You are free to choose to participate in the research.

Confidentiality and Privacy statement
Your anonymity will be safeguarded at all times. Your name and identity will not be disclosed at any time.

Your confidentiality and privacy will be assured and only the researcher listed on this form and the supervisors will have access to participant's securely stored data.

The information provided by you will remain confidential and will not be disclosed to third parties without your consent, except to meet government, or other regulatory authorities or legal authorities if necessary.

Nobody except principal investigator and the supervisors will have access to the information. A de-identified copy of the information collected will be used for the research purposes, that is non-identifiable data and results obtained in this study will be published in thesis, journals and conferences.

All records will be stored in a secured area with restricted access for a minimum of five years. All computer records will be password protected.

For further information consult the University’s privacy Plan at University’s Privacy Plan to http://www.griffith.edu.au/privacy-plan or telephone 0061 7 3735 4375.

Feedback
The investigator/researcher will inform you the summary of the findings.

Contacting the investigators
You are welcome to contact the chief investigator Prof. Cordia Chu at phone: 3735 7458 for any concern, queries or further information.

Complaints Mechanism
This study has been approved by the Griffith University Human Research Ethics Committee in accordance with the National statement on Ethical Conduct in Human Research (2007). If you have any concerns or complaints or reservations about the ethical conduct of this research study, then you should contact the Manager, Research Ethics at Griffith University Human Research Ethics Committee on 0061 7 373 54375 or research-ethics@griffith.edu.au).

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix 7
Informant's Information

Research Title: Coping with changes and health needs of the Australian Chinese Baby Boomer migrants in Brisbane (Australia): A community health assessment approach

Chief supervisor:
Prof. Cordia Chu
Principle supervisor
Director, Centre for Environment and Population Health, School of Environment, Griffith University
Contact phone: 3735 7458

Associate supervisors:
Dr Sarah Rickson
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School of Humanities and the Social Sciences, Griffith University

Student researcher:
Ms. Christiana Chau
PhD student
Centre for Environment and Population Health, School of Environment, Griffith University
Contact Phone: 31616888
Contact Email: christianayang@optusnet.com.au

Background
Studies have shown that planning to meet the health needs of the Australian Chinese baby boomer migrants is challenging. There is a lack of information about this cohort. Therefore, this research study explores your opinion about their health needs and the barriers that prevent their health needs being met.

Purpose
This research project is part of the researcher's PhD study aiming to promote a healthier life expectancy of Australian Chinese baby boomer migrants residing in the Greater Brisbane region. The goal is to contribute to the promotion of healthy ageing programs that will meet their health needs.
Your knowledge, experiences and insights of the needs of the ageing population will contribute to the planning of health programs that will promote this cohort's healthy ageing process.

**Inclusion criteria**
You are included because you have knowledge, experiences and insights of Australia's ageing population.

**Procedures**
The interview will last more than an hour.
The interview will be tape recorded. If the conversation is in Chinese then the contents of the interview will be transcribed and translated into English. Any identifying information such as individual and your names will be removed and the taped recorded conversation will be deleted.

**Potential benefits**
You will indirectly benefit from this research by exploring and identifying the needs of the ageing overseas born migrants.
This research study will give us an insight into the issues and the barriers that hinder the needs of the overseas born migrants from being met.
The findings of this research study will contribute to developing policies and programs that will promote not just an increased life expectancy, but also a healthy ageing process of the overseas born migrants.

**Potential risks**
There is no risk involved in this research. The only investment is your time and energy.

**Informant's rights**
Informant has the right to understand all the implications, risks and benefits of this research study.
Informant's confidentiality and privacy will be assured and only the researcher listed on this form and the supervisors will have access to informant's securely stored data.
The results obtained in this study will be published in journals and conferences; however this information will not include any information identifying you.
Please understand that while your cooperation would be sincerely appreciated, you are under no obligation to participate in the study.
A run-in (cooling) phase prior to consent would give the informant the time to decide whether or not the participant wants to be involved in this study.

**Voluntary Participation**
You are free to choose to participate in the research.

**Confidentiality and Privacy statement**
Your anonymity will be safeguarded at all times. Your name and identity will not be disclosed at any time.

Your confidentiality and privacy will be assured and only the researcher listed on this form and the supervisors will have access to participant's securely stored data.

The information provided by you will remain confidential and will not be disclosed to third parties without your consent, except to meet government, or other regulatory authorities or legal authorities if necessary.

Nobody except principal investigator and the supervisors will have access to the information. A de-identified copy of the information collected will be used for the research purposes, that is non-identifiable data and results obtained in this study will be published in thesis, journals and conferences.

All records will be stored in a secured area with restricted access for a minimum of five years. All computer records will be password protected.

For further information consult the University’s privacy Plan at University’s Privacy Plan to [http://www.griffith.edu.au/privacy-plan](http://www.griffith.edu.au/privacy-plan) or telephone 0061 7 3735 4375.

**Feedback**
The investigator/researcher will inform you the summary of the findings.

**Contacting the investigators**
You are welcome to contact the chief investigator Prof. Cordia Chu at phone: 3735 7458 for any concern, quires or further information.

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Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix 8
Informed consent form
Participants

Research Title
Health needs of the Australian Chinese baby boomer migrants (ACBBMs) in Greater Brisbane region (Australia)

Chief Investigators:
Prof. Cordia Chu
Principle supervisor
Director, Centre for Environment and Population Health, School of Environment, Griffith University
Contact Phone: 0061 7 3735 7458
Contact Email: c.chu@griffith.edu.au

Associate supervisors:
Dr Sarah Rickson
Dr Sarah Rickson
B.A.,M.A.PhD
Contact phone: 37353722
School of Humanities and the Social Sciences, Griffith University

Student researcher:
Ms. Christiana Chau
PhD student
Centre for Environment and Population Health, School of Environment, Griffith University
Contact Phone: 31616888
Contact Email: christianayang@optusnet.com.au

I agree to participate as a subject in the study to explore if the health needs of the Chinese baby boomers (BB) in Greater Brisbane (Australia) being met.
I acknowledge that I have read the Participant Information Sheet, which explains in detail the reasons for my selection, the aims and method of the study and any risk and benefit that are associated, and describes what my participation in the study will require.

My decision to participate will not prejudice my relationship with Griffith University.

I understand that I am free to withdraw from the discussion at any time.

I agree that research data collected from the results of the study may be published, and that my involvement will remain confidential.

I can contact the chief investigator Prof. Cordia Chu at contact phone: 3735 7458 for any concern, queries or further information.

I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.

NOTE: This study has been approved by the Griffith University Human Research Ethics Committee. If I have any complaints or reservations about the ethical conduct of this research, I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on 3735 5585 (or research-ethics@griffith.edu.au).

Any issues I raise will be treated in confidence and investigated fully, and I will be informed of the outcome.

Signature    Name    Contact    Role    Orgnisation

Date    Signature of investigator
Appendix 9
Informed Consent Form
Informant

Research Title: Coping with changes and health needs of the Australian Chinese Baby Boomer migrants in Brisbane (Australia): A community health assessment approach

Chief Investigators:
Prof. Cordia Chu
Principle supervisor
Director, Centre for Environment and Population Health, School of Environment, Griffith University
Contact Phone: 0061 7 3735 7458
Contact Email: c.chu@griffith.edu.au

Associate supervisors:
Dr Sarah Rickson
B.A.,M.A.PhD
Contact phone: 37353722
School of Humanities and the Social Sciences, Griffith University

Student researcher:
Ms. Christiana Chau
PhD student
Centre for Environment and Population Health, School of Environment, Griffith University
Contact Phone: 31616888
Contact Email: christianayang@optusnet.com.au
I agree to participate as a subject in the study to explore if the health needs of the Chinese baby boomers (BB) in Greater Brisbane (Australia) being met.

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My decision to participate will not prejudice my relationship with Griffith University.

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I agree that research data collected from the results of the study may be published, and that my involvement will remain confidential.

I can contact the chief investigator Prof. Cordia Chu at contact phone: 3735 7458 for any concern, quiries or further information.

I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.

NOTE: This study has been approved by the Griffith University Human Research Ethics Committee. If I have any complaints or reservations about the ethical conduct of this research, I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on 3735 5585 (or research-ethics@griffith.edu.au).

Any issues I raise will be treated in confidence and investigated fully, and I will be informed of the outcome.

Signature Name Contact Role Orgnisation

Date Signature of investigator
Appendix 10

Reply from coordinator for the English Conversation groups at Brisbane City Council Library

After persistent correspondences and numerous phone calls, coordinator for the English Conversation group replied to researcher’s questions:

**What exactly does your program offer to community?**

*Access to informal English conversation groups in a local, safe, free and comfortable environment.*

**Whom does your program target or cater for?**

*Adults from CALD backgrounds who want to build confidence in speaking and understanding English and connecting with other members of the local community.*

**Who are qualified to join your program?**

*There are no qualifications required to attend the conversation groups. Library staff who facilitate the groups have attended internal English as a Second Language facilitation training and training from the Ethnic Communities Council of QLD.*

**How does one enrol or join your program?**

*There is no enrolment or bookings required. The library promotes the times and dates of the groups in the What’s on in Libraries publication, on the online events calendar, posters in the library and local community and through word of mouth.*
## Appendix 11

### Resources available to the participants and service providers

<table>
<thead>
<tr>
<th>Services &amp; structures</th>
<th>Resources and service providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Existing structures</strong></td>
<td>Community halls; Places of worship (church, temple); School hall; Shopping complex/centres at Sunnybank and Sunnybank Hills*; Library</td>
</tr>
<tr>
<td><strong>Transport</strong></td>
<td>BCC; Community associations &amp; agencies* (Cathay association, Chinese Fraternity, Evergreen)</td>
</tr>
<tr>
<td><strong>Support for multicultural aged care agencies &amp; community</strong></td>
<td>PICAC; ECCQ</td>
</tr>
<tr>
<td><strong>Social events and classes: English language, computing, history and literature, Environment &amp; health, Opera, dancing, singing, art and crafts, mah-jong, cooking, Taichi, walking,</strong></td>
<td>Community associations &amp; agencies; BCC; U3A; Chinese community associations &amp; agencies*; 60 &amp; Better; National Senior Australia</td>
</tr>
<tr>
<td><strong>Home care services</strong></td>
<td>Community associations &amp; agencies* (Cathay association, Chinese Fraternity, Evergreen); Meals on Wheels</td>
</tr>
<tr>
<td><strong>Aged residential care</strong></td>
<td>Villa Maria, St Paul's de Charte, Jeta gardens; Finncare (ethnic specific)</td>
</tr>
<tr>
<td><strong>Health promotion programs</strong></td>
<td>Community associations &amp; agencies* (Cathay association; Chinese Fraternity, Evergreen)</td>
</tr>
<tr>
<td><strong>Research and advocates</strong></td>
<td>National Senior Australia, COTA, ECCQ</td>
</tr>
<tr>
<td><strong>Health insurance</strong></td>
<td>National Senior Australia, COTA</td>
</tr>
<tr>
<td><strong>Travel agency</strong></td>
<td>National Senior Australia, COTA</td>
</tr>
<tr>
<td><strong>Health system</strong></td>
<td>Medicare; Private health insurance</td>
</tr>
<tr>
<td><strong>Healthcare services</strong></td>
<td>Hospitals (private, public); Primary care (biomedical) Traditional Chinese Medicine*</td>
</tr>
</tbody>
</table>

*Chinese specific
Appendix 12
Website on Brisbane City Council and Queensland health on ‘Queensland’ health system’
Appendix 13
A lack of information about
the study samples’ participation in health care services

There is a lack of evidence about the Australian Chinese baby boomer migrants’ expressed needs, documents examined were:

1. Australian Bureau of Statistics (ABS) Census and Census-derived data on demographics, including the Socio Economic Indices for Areas (SEIFA) and profiles of health including the National Health Survey, the National Nutrition and Physical Activity Survey and the National Health Measures Survey.

2. A range of Australian Institute of Health and Welfare (AIHW) and National Health Performance Authority (NHPA) datasets and publications, including the METeOR metadata registry.

3. Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) and Practice Incentives Programme (PIP) data.

4. Aged care data (both residential and community based) such as Commonwealth Home Support Programme, or Department of Veterans Affairs (DVA) data.

5. Mental health data such as the Access to Allied Psychological Services (ATAPS) data collection

6. The National Notifiable Diseases Surveillance System

7. Resources from the Royal Australian College of General Practitioners (RACGP) data from practices through clinical audit tools, and the Bettering the Evaluation and Care of Health (BEACH) data

8. Health workforce data

9. State and Territory Health Department data

10. Data from Local Hospital Networks or equivalents (including individual acute and community care services)

11. Local Government data

12. Information on the PHCRIS website

13. Information on the PHIDU website, such as the Social Health Atlas of Australia

14. National Health Services Directory (NHSD) and Healthdirect
None of the above have records of OBCBBs’ participation in the health care services, hence, there is only data collected from participant observation to support their expressed needs. Similarly, the ABS do not have statistic record of migrants’ socioeconomic background.
Appendix 14
Issues that the study sample face according to Bradshaw’s framework of needs

<table>
<thead>
<tr>
<th>Issues that the OBCBBs face</th>
<th>Felt needs</th>
<th>Expressed needs</th>
<th>Normative needs</th>
<th>Comparative needs</th>
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<td>House maintenance &amp; safety</td>
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<td>Traditional health beliefs</td>
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<td>✔</td>
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</tr>
</tbody>
</table>

✔ degree of urgency and intensity
Appendix 15

Free Interpreting Service


The Free Interpreting Service aims to provide equitable access to key services, that are not government funded, for people with limited or no English language proficiency. The Free Interpreting Service is delivered by TIS National, on behalf of the Department of Social Services. Using the Free Interpreting Service is easy and convenient. It is quick and simple for service providers to register and they can be connected to a phone interpreter within a few minutes.

Eligible groups

The following groups can access the Free Interpreting Service to provide services to anyone in Australia who has a Medicare card: Photo of a mother hugging her young son.

Private medical practitioners
Pharmacies
Non-government organisations
Real estate agencies
Local government authorities
Trade unions
Parliamentarians

Interpreting services


Non-government organisations can access the Free Interpreting Service to provide approved casework and emergency services, where the organisation does not receive substantial government funding to provide these services.

Non-government organisations provide a range of casework and emergency services and can use credentialed interpreters to communicate with people who have limited or no English language proficiency. This is particularly important when communicating complex or
technical information and can help to establish a relationship and communicate effectively with these clients.

**Eligibility**

Non-government organisations are eligible to access the Free Interpreting Service if they are:

- An incorporated, not for profit, non-government and community based organisation
- Delivering services to anyone in Australia who has a Medicare card
- Providing approved casework or emergency services
- Not receiving substantial government funding for the delivery of the service (organisations delivering government funded services should discuss access to interpreters with their government funding body).

The Free Interpreting Service can be used by non-government organisations to provide approved casework or emergency services that are essential to economic or social participation (provided they are not listed as an ineligible activity, as per the below). This includes services that manage issues arising from health conditions, housing, employment, personal or family safety, and financial crisis.

**Eligible services may include but are not limited to:**

Information, referral, support and advice for people with:

- Chronic disease
- Acute health conditions
- A disability

Services that facilitate community engagement, including:

- Referral services to third party agencies (such as those providing services for; health, housing, legal, employment, or education services)
- Mentoring programs
- Respite care

**Crisis intervention services, including for:**

- Domestic violence
- Homelessness
- Unemployment
- Severe financial difficulties
- Legal matters.

**The Free Interpreting Service cannot be used by non-government organisations for:**
Government funded services (organisations delivering government funded services should discuss access to interpreters with their government funding body)
Clinical medical services (see 'private medical practitioners category')
Recreational activities or programs
Political and media advocacy or lobbying
Vocational training
Immigration advice
Child care services.
Appendix 16
Profile of participants of the study

<table>
<thead>
<tr>
<th>Year Born</th>
<th>Gender</th>
<th>Employment</th>
<th>Language</th>
<th>Place of origin</th>
<th>Marital status</th>
<th>Education level</th>
<th>Housing style</th>
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M male; F female; P/T part time; F/T full time; E English; C Cantonese; M Mandarin; V Vietnamese
HK Hong Kong; M married; D divorced; W widowed; S single never married; T tertiary education
TH townhouse; H2 2 level house; H3 3 level house; U unit
Si sister; S spouse; C children; F family -spouse and children; SE spouse and extended family; P parent