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Migration and ageing: *How cultural and linguistic diversity is set to boom among older Australians*

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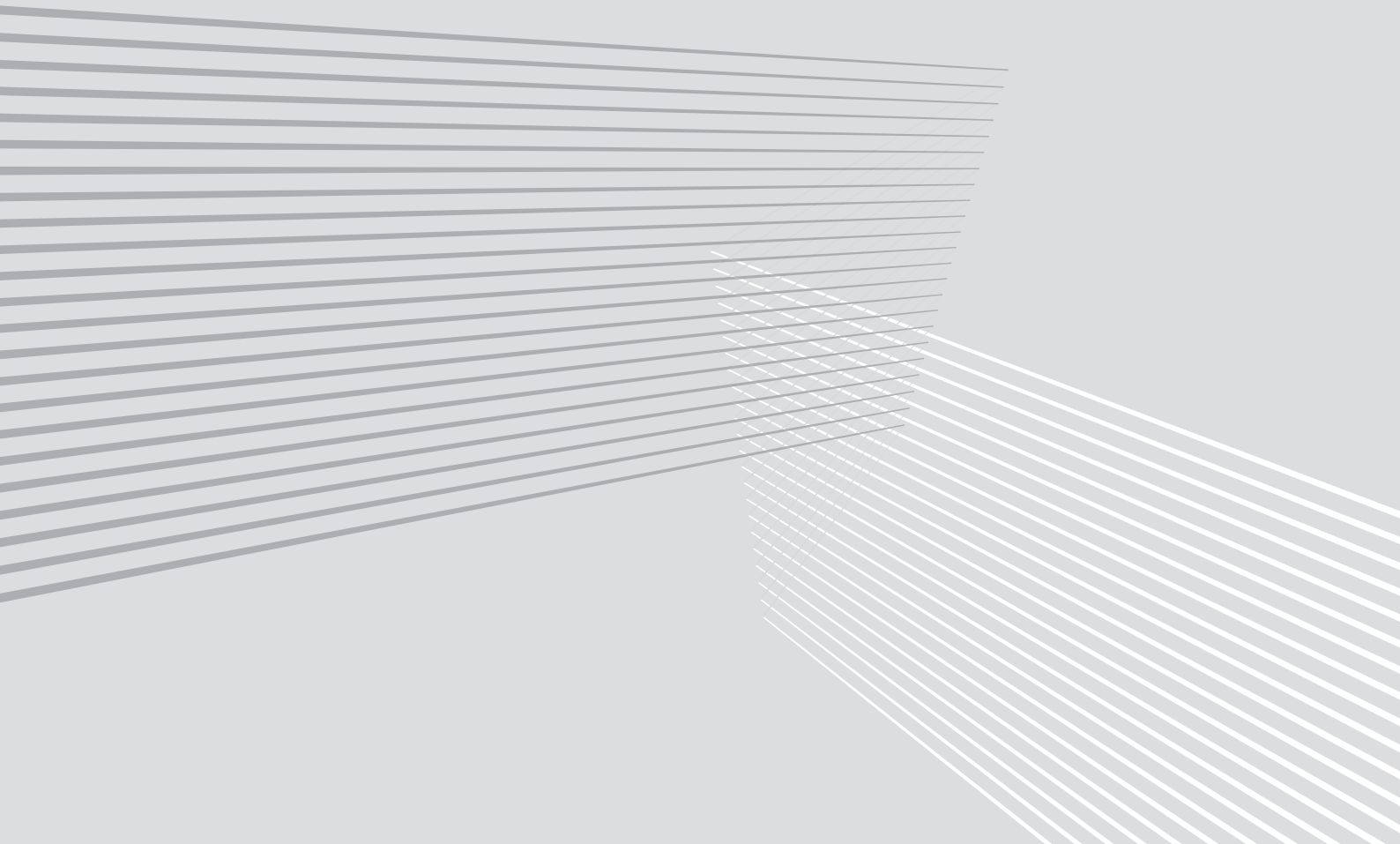
Acknowledgement of Country

The authors acknowledge that the work on this report was undertaken mostly on lands of the Gadigal and Bedegal people. We pay respect to Traditional Custodians and Elders past and present and extend that respect to Aboriginal and Torres Strait Islander peoples throughout all lands, waters, and territories.



Summary of brief

Older and more diverse: Over the last decade, the average Australian has become one year older and three percentage points more likely to have been born overseas. This trend is now feeding into the older population: Among Australians aged 65+, non-European and non-English-speaking backgrounds are set to boom. By 2056, there will be about five times as many older Australians from Asia as there were in 2021, and they will make up a fifth of the older population. By then, a third of the older population will be from non-English-speaking countries (up from about a quarter now). Numbers of those from South Asia will grow the fastest. Although ageing migrants will speak better English than past cohorts, they may risk other socioeconomic, health, and care vulnerabilities. Nuanced, culturally appropriate responses will be needed.

Taking stock and seeking better data: This brief contributes to what we know about the intersection between ageing, migration, and Cultural and Linguistic Diversity (CALD). It assesses socioeconomic, psychosocial, health, and care outcomes by age and time as well as three diversity categories: (1) place of birth, (2) language background, and (3) English proficiency. It also calls for more refined evidence and for better data classification and collection.

Diversity is not just a minority issue: As of 2021, half of Australians were born overseas or had a parent born oversea. Also, the majority of young to middle-aged Australians fit one or more of: (1) having been born overseas; (2) speaking languages other than English at home; (3) not speaking English proficiently; or (4) having parent/s born in a non-English-speaking country. Indeed, an analysis of ancestry shows that Millennials are the least Anglo-European and first minority Anglo-Celtic generation since colonisation. **(Section 1)**

How many migrants do we need to keep Australia young? Projections can help us see our demographic future and also decide on total rates of migration. For example, zero net overseas migration is infeasible and would double the rate of ageing. About 100,000 p.a. would offset declining fertility, stabilise population growth, but still result in ageing and not allow for skilled migrants. About 500,000 p.a., as seen post-pandemic, would halt demographic ageing but cause other pressures. A figure somewhere in between – about 235,000 p.a. – as expected by Australian Treasury, would be enough to offset declines in total labour force participation rate provided that older age groups continue to see participation rate increases. **(Section 2)**

Better education does not mean better employment outcomes: Australia's migration program brings in arrivals who tend to be better educated than the local population. Yet many find the labour market challenging – especially when facing language barriers. Some don't work because they are studying. But employment rates are often lower for non-students (especially women) and some that work also experience skills mismatches. These factors appear to result in lower incomes and higher risks of poverty among some CALD migrants. Rates of full-time work were also low and declined in 2021 among men and women with poor English. **(Sections 3.1–3.3)**

Socioeconomic gaps can result in vulnerabilities in retirement: Employment barriers and lower income can translate into greater retirement risks since CALD migrants typically have lower superannuation savings and are less likely to own a home (e.g. those with poor English are 10 percentage points less likely to own a home in retirement). Many live in more disadvantaged areas though many seek support in somewhat segregated neighbourhoods where speakers of other languages are more likely to co-locate at older ages. Financial literacy is low among migrants, and the gap increases at older ages for those from non-English speaking backgrounds. **(Sections 3.3–3.5)**

Cultural and language barriers can have psychosocial impacts: CALD migrants are more likely to experience ageism and their subjective wellbeing lags behind that of people born in Australia, from English-speaking backgrounds, or who are proficient in English. **(Section 4)**

Better health does not mean better disability outcomes: Most migrants are healthier than the Australian-born or those from English-speaking backgrounds (except with respect to certain diseases, such as diabetes), but this advantage declines over time, rates of health risk factors converge, and CALD migrants' rates of needing support with disability appear to be higher from late-middle age. Differential access to health and care may be the result of cultural barriers. Changes in social norms, technology, and personnel training could improve overall health status and services accessibility but modes of care will also need to change – for example, greater cultural diversity coupled with differential disability rates and preferences among older cohorts will likely accelerate demand for home care. **(Sections 5–6)**

Projections of dementia among migrant groups: Those with poor English are seeing greater rates of mental health conditions and dementia. Rates and migration patterns are expected to result in changes in patterns of people with dementia, including a fivefold increase in the number of people with dementia born in Asia. **(Section 6)**

Summary of featured research

New projections show that demographic ageing coincides with growth in diverse sub-populations: The numbers reveal ageing differences by place of birth, language, Aboriginal & Torres Strait Islander status, remoteness, and sexual minority status. By the mid-2050s, 1.5 million Australians aged 65+ are expected to have been born in Asia – a fifth of the older population. Growth in this group represents a three-fold increase over 20 years and a six-fold increase over 40 years. Those from South Asia will be ten times as numerous in 2056 as in 2016, totalling half a million. **(Boxes 1 and 2)**

Language barriers may be replaced by cultural barriers: Changing migrant profiles mean that the share of older Australians speaking English poorly will decline. Most of the growth in those with poor English is projected to occur among Chinese and Mainland Southeast Asian migrants. While language becomes less of an issue, cultural challenges – including the cultural appropriateness of services – will become more important. **(Box 3)**

Vulnerabilities related to housing: Most migrants rent, often preferring flats, with skilled migrants paying higher rent – buying a home comes with a long lag. There is evidence that housing tenure in old age can affect social support and mental health. So, the coinciding patterns of ageing, growth in CALD communities, and declines in home ownership may expose new vulnerabilities that call for new ways to provide support. **(Boxes 5 and 6)**

Vulnerabilities related to social engagement: In a sample of older men, those born overseas were more likely to say they had family to rely on for support than the Australian-born population, but 34% said they had no friends to rely on locally, compared to 17% among the Australian-born population. This was associated with low satisfaction with social support and in turn more depressive symptoms. Researchers also found a link between English proficiency and broader social participation. Those with good English were more likely to participate in sports groups, professional bodies, and neighbourhood groups. Programs that activate civic participation over the lifecycle could help. **(Box 7)**

Intersectionality in discrimination and the law: Legislation currently focuses on separate and distinct grounds of discrimination, yet people experience discrimination in multiple and overlapping domains. Of those from non-English speaking backgrounds who experienced any discrimination, 82% said it was because of race or ethnicity, but 50% identified more than one reason. (Only 38% of those born in Australia identified multiple reasons.) **(Box 8)**

Migrant diets and nutritional guidelines: Research on an ethnically diverse sample of older Australian men showed that 99% had an inadequate intake of vitamin D and 80% consumed too little calcium. Despite having worse guideline compliance, men with Mediterranean backgrounds did not have worse health outcomes, which indicates that Mediterranean diets may be healthier than existing national guidelines. A new proposed diet scoring tool could help. **(Box 9)**

Differences in healthcare and aged care needs, access, and planning: The main risk factors for subsequent care needs are mild cognitive impairment and disability. But when such factors are controlled for, those from non-English-speaking backgrounds are 70% less likely to end up in residential care, compared to those born in Australia. This may relate either to preferences for home and informal care, or to a lack of culturally appropriate residential care services. Lower access to planned healthcare was also observed for older women from non-English-speaking backgrounds. And, separately, some CALD groups were less likely to plan for the eventualities of ill health: Older Australians born in the Americas, Southern Europe, and Africa were least likely to have advanced care directives and plans in place. **(Boxes 11 and 12)**

How to best support CALD aged care recipients and carers: In navigating aged care, CALD clients encountered challenges related to using social networks as information providers, a lack of base knowledge, complexity, and difficulties using technology. CALD carers were most likely to need financial support (66%), physical assistance (44%), emotional support (44%), respite care (43%), and help with improving own health (39%). **(Boxes 13 and 14)**

Sources of CALD carers: Recent migrants who experienced constraints related to language and unrecognised skills had positive experiences moving into aged care roles, deeming it 'meaningful' and 'accessible' work. Supporting existing and future migrants could help fill gaps in the care workforce. Research also highlights regulatory difficulties faced by grandparents visiting Australia to care for their Australian-born grandchildren. **(Boxes 4 and 15)**

Summary chart: Better education and health, but not economic and disability outcomes

Note: 2021 or closest year. Gap=percentage point difference except super and subjective wellbeing where gap=% difference. For source and definitions see relevant section in brief.

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1. INTRODUCTION

Australia's population is not only ageing; it is also becoming more diverse. Over the decade to 2021, the average Australian has become both one year older and three percentage points (pp) more likely to have been born overseas. This convergence of ageing and migration trends is expected to continue: Projections suggest that not only can Australia expect its older population to grow faster than its younger population, but also that older people from non-European and non-English-speaking backgrounds will continue to see the fastest rates of increase.

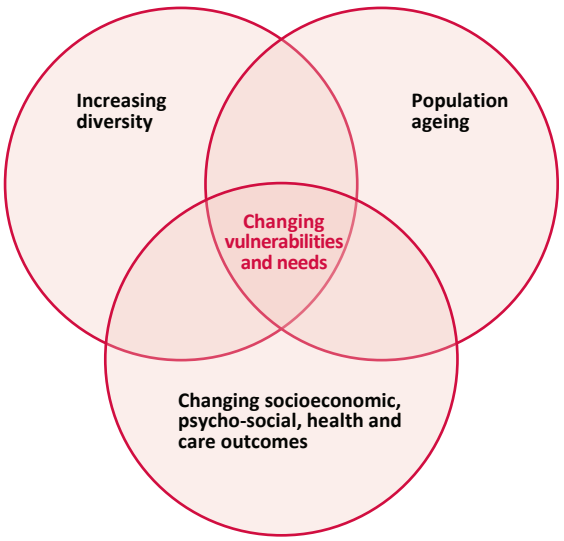
The key driver is Australia's nation-building migration program. It keeps Australia's demography younger, but as migrants age they fuel greater diversity at the top of the age pyramid. They add to the mix of cultures and languages of past waves of migrants and those of Australia's Aboriginal & Torres Strait Islander peoples, who are also seeing significant population growth and rapid rates of ageing, albeit from a smaller population base.

These trends pose new questions. What are the expected characteristics of a more diverse *and* older population? How does this translate to wellbeing in old age and affect needs, demand, and access to public and private goods and services – including the provision of care in residential and community settings? And how does the intersection of ageing and diversity expose strengths and vulnerabilities in some groups?

Several studies have examined characteristics of older people from migrant or Culturally and Linguistically Diverse (CALD) communities (Benham et al., 2000; National Seniors Productive Ageing Centre, 2011; FECCA, 2015; and snapshots by AIHW, 2018a, 2021b). But the picture continues to evolve, with changing social, economic, and health outcomes *by age* and *over time*. Shifting dynamics of ageing, migration, and diversity together demand a nuanced understand of the changing needs and vulnerabilities of Australia's older population (Fig. 1).

The brief presents some of the latest research insights, highlighting CEPAR research in a series of themed boxes from more than a dozen CEPAR researchers. The evidence can aid in understanding the heterogeneity of ageing. However, in presenting mostly descriptive quantitative assessments (in a somewhat chart-book format), the authors do not presume to know the nuanced lived experience of individuals in different communities or to weigh in prescriptively on the solutions to challenges faced. It is hoped that syntheses of evidence can arm those within different communities to seek change on their terms.

1 Diversity and ageing can mean changing needs and new, intersectional vulnerabilities



This brief assesses wellbeing outcomes across the lifecycle (e.g. education, employment, retirement, health) by three high-level migrant and CALD categories: (i) place of birth, (ii) language use at home, and (iii) spoken English proficiency. Despite the limitations of grouping people by just three variables (i.e. mixing all migrants and language groups and ignoring ethnicity or time since arrival), the brief offers a helicopter view of lifecycle outcomes of Australians from migrant and CALD communities. It covers major demographic shifts; highlights potential migrant and CALD groups' vulnerabilities; and illustrates the need for further monitoring and research to inform and develop policy.

Measuring cultural and linguistic diversity

Diversity is itself a multi-faceted concept, defined in biological (e.g. age, sex, physical ability), personal (e.g. religion), or cultural terms (e.g. ethnicity, tradition, behaviour, identity based on norms and/or place of origin of person or ancestors). Unlike in other countries, where data and analysis explicitly consider race and ethnicity (Balestra, 2018), in Australia, the typical practice avoids complex time-place-specific social constructs, instead making use of variables such as place of birth and languages spoken (in addition to the special case of widely and routinely collected data on Aboriginal and Torres Strait Islander status; ABS, 1999, 2022; Morning, 2008; Stevens et al., 2015).

In official data, four *core* culture and language diversity variables (birthplace, language background, English proficiency, and Aboriginal and Torres Strait Islander status) are supplemented with an extended set of variables such as whether country of birth is mainly-English-speaking, parent's country of birth, year of arrival, and self-identified ancestry (ABS, 2022).

It is important to distinguish between *Cultural and Language Diversity variables* (which include Aboriginal and Torres Strait Islander Status) and the term *Culturally and Linguistically Diverse (CALD) communities*, which in social research in Australia does not include people with Aboriginal and Torres Strait Islander backgrounds. Except for some basic population breakdowns in the introduction (Figure 2) and in Box 1, this report focuses on groups defined simply by (1) *place of birth* (i.e. outcomes for people born overseas compared to Australian-born), (2) *language background* (i.e. outcomes for people who are multilingual/speak a non-English language at home or whose first language was not English compared to those who only speak English at home or whose first language was English), and (3) *English language proficiency* (i.e. outcomes for people who do not speak English well or not at all compared to those who speak English well, very well or only speak English).

Diverse cultural and language status: Not a minority issue

Figure 2 presents age-based breakdowns of the Australian population by various diversity categories. Figure 2A includes three of the four core diversity categories plus details on whether parents' place of birth was an overseas mainly-English-speaking country (MESC) or not (NESC). The extra breakdowns are useful. For example, a quarter of the population born in countries where English is not the main language (NESC) currently only speak English at home. In past Censuses they were not asked about their English language proficiency, which could result in undercounts of people with language barriers. Also, where cultural or linguistic diversity status is based only on the 'language spoken at home' question in the Census (as is done in parts of this brief), then this group and its' non-English-speaking *cultural* background may be overlooked.

About a third of the adult population was born overseas, a quarter spoke a language other than English at home, a fifth was born in a non-English speaking country, and 4% spoke English poorly. When including parents' birthplace, half the population was born overseas or had parents born overseas, and the majority of young to middle-aged Australians belonged to one or more of: having been born overseas; speaking another language at home; not speaking English proficiently; or having parents born in a non-English-speaking country. Colour shading in the figure indicates varied CALD classifications, which often relate to NESC background and/or non-English language use (Rahim et al., 2024).

Differences by age: English proficiency lower at older ages

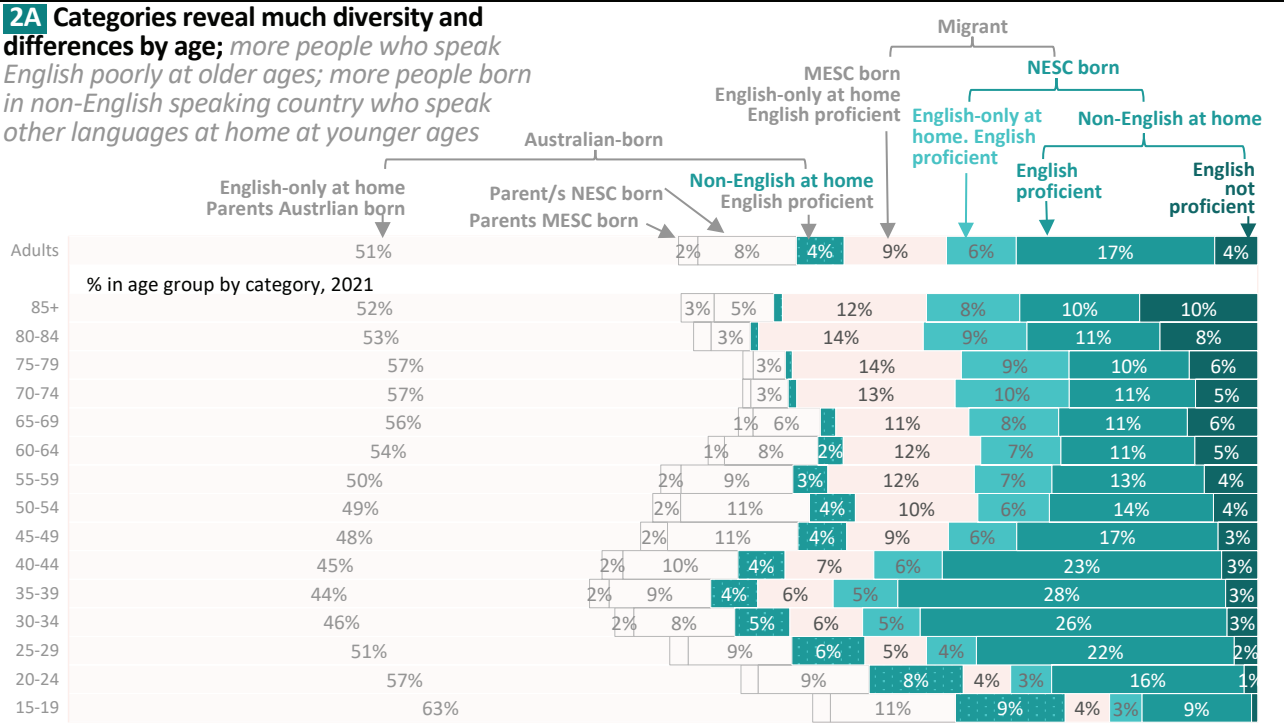
Diversity is a feature across all age groups, but there are also distinct differences by age. For example, the share of people who have difficulty speaking English is higher at older ages. About half of those aged 85+ that speak another language at home, speak English poorly. This is in part a legacy of Australia's migration program, but it may also be because older migrants find it harder to learn English as a second language and/or they are more likely to forget it after retiring from work and not using it at home or with the onset of cognitive decline (whereby more recent languages are lost earlier; Tipping & Whiteside, 2015). There is evidence that the likelihood of transitioning from good to poor English increases with age and that likelihood of improvement declines (Fig. 7A). Nonetheless, the share of the population with language barriers is expected to decline because most of the recent and expected migrants from non-English-speaking countries speak English well (see Box 3 on projections).

In Figure 2A, the bulge of migrants from non-English-speaking country backgrounds is very apparent. Yet, when it comes to thinking about cultural and ethnic backgrounds, country of birth statistics tell only a partial story. One way of delving deeper is to look at self-described *ancestry* (a measure analogous with ethnicity). This measure may overcome complexities like the fact that among older people in the 2021 Census, almost half of those born in South Asia and Southeast Asia had European ancestry or that a large share of people who identify as members of the Pasifika diaspora even though they were born in Australia or New Zealand (Rodriguez 2007).

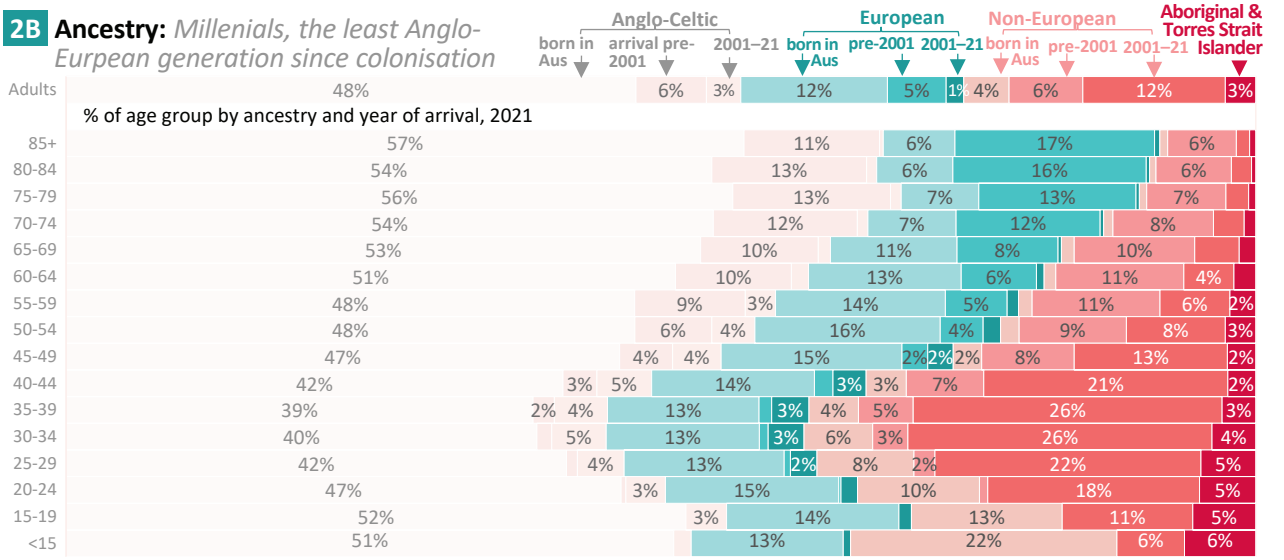
Ancestry: Millennials, the first minority Anglo-Celtic generation since colonisation

Figure 2B presents a classification of ancestries (plus Aboriginal and Torres Strait Islander status) following methodology by the Australian Human Rights Commission (AHRC 2016, 2018a). These are grouped into Anglo-Celtic, European, non-European, and Australian Aboriginal and Torres Strait Islander backgrounds. These do not imply an opinion about the status of such backgrounds, nor that there are only four categories, which would erase vast within-group differences.

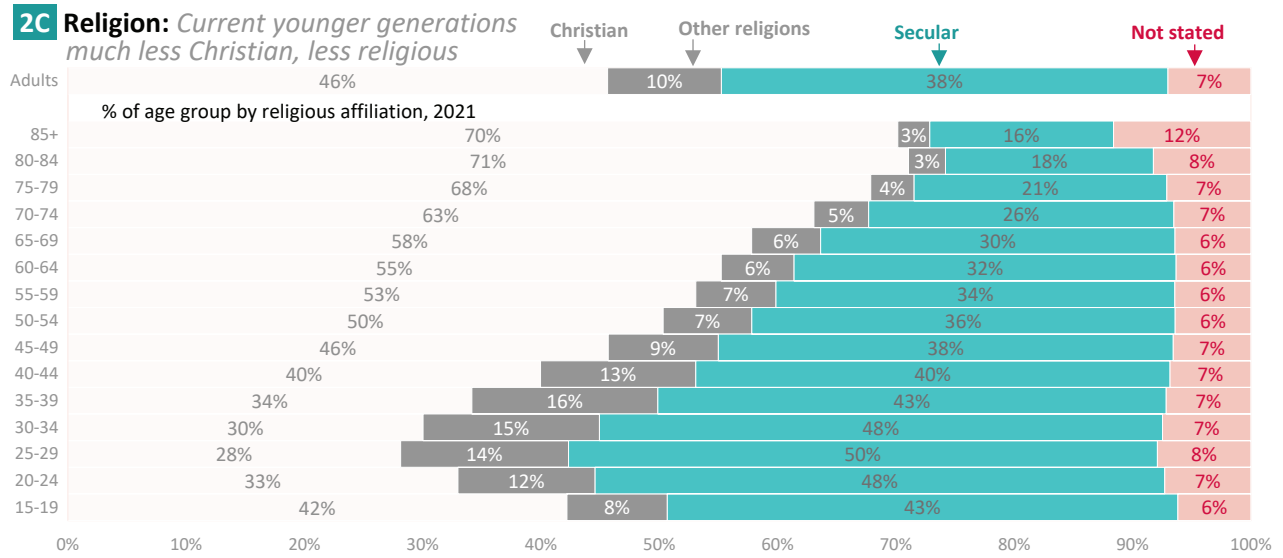
2A Categories reveal much diversity and differences by age; *more people who speak English poorly at older ages; more people born in non-English speaking country who speak other languages at home at younger ages*



2B Ancestry: *Millenials, the least Anglo-European generation since colonisation*



2C Religion: *Current younger generations much less Christian, less religious*



Note: Assumes non-respondents evenly distributed. Fig. 2A: MESC=born overseas in mainly English-speaking country. NESC=non-English-speaking country. Proficient'=self-assessed proficiency in spoken English (i.e. 'speaks English only', 'very well', and 'well' vs 'not well' or 'not at all'). Fig 2B: Follows method in AHRC (2018) with updated data and an age, arrival year split. Based on microdata in 2016 of ~230,000 individuals to estimate pairwise probabilities between ancestry groups and applied to aggregate data from 2021 Census. Cross-group ancestries were categorised in group that is 'more diverse' or as Aboriginal and/or Torres Strait Islander if applicable. In Fig. 2C, 'Secular' includes 'Secular Beliefs', 'Other Spiritual Beliefs', and 'No Religious Affiliation'. Source: Authors' analysis of ABS Census.

Still, broad categories can help us understand and enumerate broad patterns (DCA, 2021; AHRC 2018a), counting approximate population shares of people from non-Anglo-European backgrounds, especially when seeking to ensure fair representation in politics, media, boardrooms, or a regular workplace (Screen Australia, 2023; Remeikis, 2021, 2023).

Figure 2B is a snapshot but shows several patterns: (1) a still large but declining prevalence of people with Anglo-Celtic and European backgrounds at older ages (corresponding roughly to *Boomer* and *Interwar* generations, aged 55+); (2) a bulge of Australian-born people with continental European backgrounds in middle age (*Gen-X,* aged 40–54); (3) large increasing shares of recently-arrived people with non-European ancestry among young adults (*Millennials*, aged 25–39, and some *Gen Z*, aged 15–24); and (4) increasing shares of children with non-European and Aboriginal & Torres Strait Islander ancestry.

The difference between generations is such that although less than 10% of the oldest generation (aged 75+) are from non-Anglo-European backgrounds, among *Millennials*, aged between about 25 and 39 in 2021, the rate is about 40%, making them the most diverse, least Anglo-European generation since colonisation. It is probably also the first time since colonisation that less than half of a generation is Anglo-Celtic. As indicated by year of arrival categories, non-European arrivals (mostly from Asia) arrived in the last 20 years.

The trends are filtering into greater diversity at older ages. As noted in the following section, by about mid-century the Asian-born population aged 65+ is expected to be five to six times larger and the Australian Aboriginal & Torres Strait Islander population aged 65+ is expected to be five times larger (Boxes 1 and 2).

Religion and other measures of diversity: All change

There are other forms of diversity that interact with the ageing experience. For example, Figure 2C presents religious affiliation by age in 2021, showing a sharp contrast between generations. Whereas older Australians, above age 50, are more likely to identify as Christian, less than half of younger cohorts do. Most Millennials hold secular beliefs and, compared to other cohorts, are more likely to identify with other, non-Christian religions.

There are other forms of diversity not included here (e.g. disability, remoteness status, sexual and non-cisgender identity). These also reveal changes by age, time, and/or cohort and differences in ageing patterns. For example, the 2017 Household Income Labour Dynamics in Australia (HILDA) survey shows that whereas about 9% of people aged 75+ identified as non-heterosexual, the rate was more than double that (19%) among those aged 15–24. CEPAR research suggests that Australia's sexual minority population is projected to increase rapidly, rising from 650,000 in 2016 to between 1.25 and 1.57 million by 2041, of which about 200,000 will be aged 65+ (Wilson et al., 2021a; Box 1).

While the focus here is on the three migrant CALD categories, new research is also improving our understanding of ageing across other diverse communities. For example, in a global first, CEPAR research has reported a disparity in dementia risk according to sex and gender identity, revealing a greater prevalence of modifiable risk factors in transgender or gender-diverse participants compared to cisgender adults (Brady et al., 2023).

Data sources for diversity measures: Inconsistent and incomplete

Good evidence-based policy requires good data, yet there is often a lack of consistent and accurate data on diverse communities. The Australian Bureau of Statistics (ABS) Standards for Statistics on Cultural and Language Diversity (1999), were first established over 20 years ago to promote the collection of core and extended culture and language diversity data in administrative and nationally representative surveys.

The Federation of Ethnic Communities' Councils of Australia (FECCA, 2020) suggested that standards require a review (e.g. noting the need for data on ethnicity or preferences for interpreting services). Calls to include collections on ethnicity appear to have been heard but will not, in fact, be collected in the Census (Yussuf and Walden, 2022; Yussuf 2024). Various AIHW datasets, Productivity Commission's Report on Government Services, GP and hospital data, and agencies such as the National Disability Insurance Agency have limited CALD data (FECCA, 2020a; PC, 2022; AIHW, 2014, 2018a; Jakubowicz, 2021). Nor does the government's Multicultural Access and Equity Policy (Australian Government, 2018) mandate specific data requirements. Recent efforts have sought to standardise cultural diversity data collection and reporting in workplace settings, an area in which quality data has been lacking (DCA, 2021).

Such data challenges also affect survey datasets. Figure 3 presents a selection of national household surveys typically used by researchers interested in socioeconomic and health research (including datasets utilised in this research brief). It shows that few of these include the core culture and language diversity data variables, while fewer still contain extended variables. Data is even more limited for some groups, such as older people who identify as LGBTI or otherwise diverse in gender, sex, or sexuality. Linked datasets may help fill some of the gaps in data availability (AIHW 2022a). Even the Census variables used in this report have their own significant flaws. For example, speaking another non-English language at home is not necessarily aligned with CALD status, is subject to averaging across diverse groups, and is weakened by inclusion and exclusion errors.

3 Diversity related variables are collected inconsistently across key national household surveys

		Census	HILDA	LFS/MPHS	SIH/HES	NHS/ NATSIHS	MPHS	SDAC	GSS / NATSISS
Core	Aboriginal & Torres Strait Islander status	✓	✓	✓		✓			✓
	Country of birth	✓	✓	✓	✓	✓	✓	✓	✓
	Language used at home	✓				✓		✓	✓
	Proficiency in English	✓	✓			✓		✓	✓
Extended Standard	Year of arrival in Australia	✓	✓	✓	✓	✓	✓	✓	✓
	Country of birth of Father	✓	✓						
	Country of birth of Mother	✓	✓						
	Languages spoken at home								
	First language spoken/ English as first language		✓						
	Ancestry/Ethnicity	✓							
	Religious affiliation	✓	✓						
Other	Australian citizenship	✓	✓						
	Race								
	Gender diversity/Sexual identity	*	✓					*	✓
	English language ability of household members		✓						

Note: The categories are based on the minimum core standard and extended standard set recommended by the Ministerial Council of Immigration and Multicultural Affairs (MCIMA) for collecting statistics on cultural and linguistic diversity in Australia (Australian Commonwealth Interdepartmental Committee on Multicultural Affairs, 2001). It also includes other additional categories such as Australian citizenship, race/ethnicity, and gender diversity. HILDA=Household, Income and Labour Dynamics in Australia Survey. LFS/MPHS= Labour Multipurpose Household Survey. SIH/HES=Survey of Income & Housing and Household Expenditure Survey. NHS/NATSIHS=National Health Survey and National Aboriginal and Torres Strait Islander Health Survey. MPHS=Multipurpose Household Survey. SDAC= Survey of Disability, Ageing & Carers. GSS / NATSISS=General Social Survey and National Aboriginal & Torres Strait Islander Social Survey. The list is not exhaustive: other relevant national surveys include a new Intergenerational Health and Mental Health Study (IHMHS), running since 2020. *Only same sex couple indicator. Source: Authors' compilation.

Similarly, researchers in social, epidemiological, and clinical research often collect culture and language variables inconsistently, overlook the necessary descriptive data, collect it in culturally inappropriate ways (Walter et al., 2021; Woodland et al., 2021) or design sample collection that inadvertently excludes some communities (e.g. by excluding those with poor English from research questionnaires that are only in English; Hughson et al., 2016; Low et al., 2019).

A recent review of the relevant Australian epidemiological literature suggests that the field is growing but diversity variables are not capturing enough nuance. They found that country of birth was the most commonly used definition (31%), with combinations of two or more components also frequently used (29%; Pham et al., 2021).

Inconsistent collection is matched by inconsistent analysis. One reason may be that, while suggesting culture and language diversity variables, the ABS does not prescribe how these should be combined. It is therefore unsurprising that, for example, the Australian Institute of Health and Welfare uses three different definitions of CALD groups, each of which differs from those used by FECCA or some government departments (Rahim et al., 2024).

Others suggest that rather than broad groupings, greater disaggregation is needed. Stanaway and Campbell (2022) discussed the tension inherent in grouping ethnic sub-populations, which on the one hand improves statistical precision yet on the other dilutes differences among minorities. They suggest that another approach may be to conduct analyses on more granular ethnicity groupings and use meta-analysis to combine multiple study results together to improve precision (the Census collects helpful ancestry information that captures an aspect of ethnicity, but the current approach is difficult to operationalise). Stanaway and Campbell stand with others to call for better classification of CALD groups, as well as better and more consistent data collections.

Although that is a future objective, the high-level analysis in this brief takes stock of key insights by the three core migrant / CALD categories available through the Census, openly noting the inherent limitations of the approach.

2. DEMOGRAPHIC FUTURE OF AGEING AND DIVERSITY

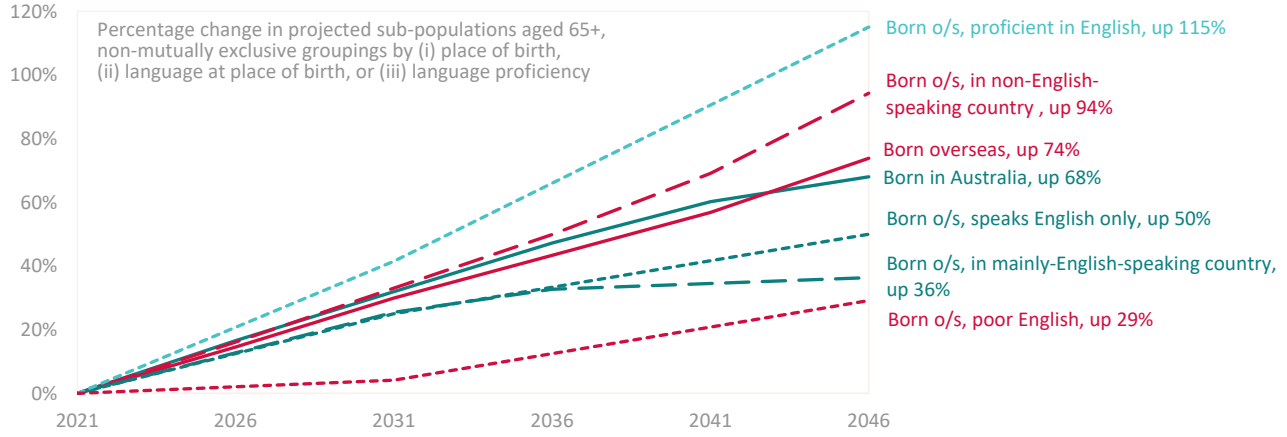
Studies of the demographic composition of culture and language differentiated communities within Australia generally focus on backward-looking, historic trends, or pre-date the dramatic migration flows seen over the last two decades (Gibson et al., 2001). It is only recently that attention has turned to how unfolding trends are likely to shape Australian demography in the future and how these will interact with broader patterns of population ageing (Wilson et al., 2020; ABS, 2019a; Boxes 1-3).

The ageing context is well known, with various projections on offer. Official projections suggest that over the next 40 years, the number of Australians aged 65+ is expected to double (to nearly 9 million), whereas those below age 65 are expected to increase in number by just more than half (ABS, 2017; Treasury, 2021, 2023). Even taking account of several years of lower migration levels due to the pandemic, the number of Australians aged 65+ would be expected to reach 6.7 million by mid-century – a doubling from 2016 (Wilson et al., 2021b).

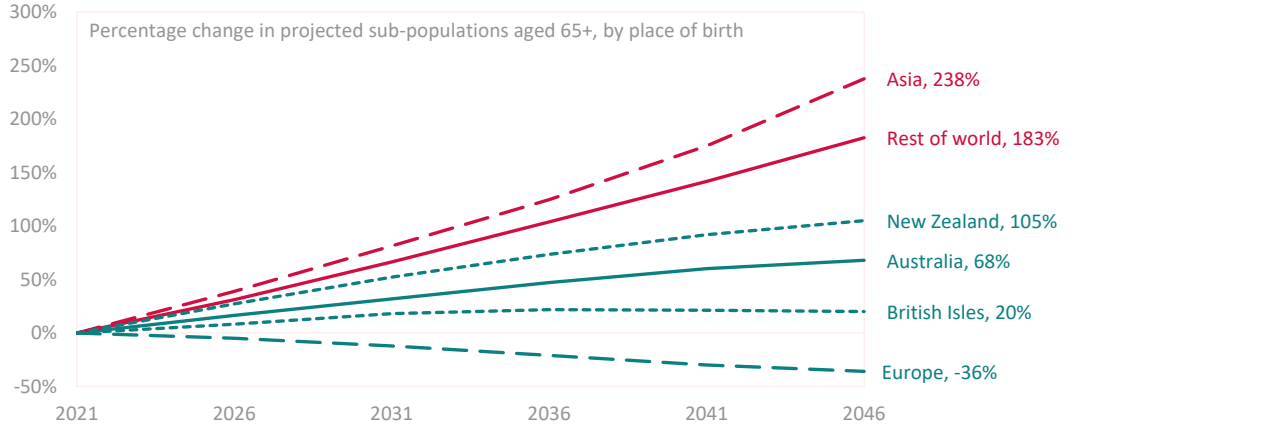
How diversity at older ages is set to boom

The new data is showing that numbers of older Australians with culturally and linguistically diverse backgrounds are growing even faster. This is the case for a range of culture and language diversity categories (see Box 1). As a result, future older Australians will be more diverse than ever. Whereas the European-born population aged 65+ is expected to start declining over the next decade, the Asian born population aged 65+ is projected to be three times larger in 2046 (Fig 4B) and five times larger in 2056 than it was in 2021, reaching about 1.5 million in 2056 or about one fifth of the older population (Box 2). And although the number of older Australians expected to speak English poorly is growing slowly (up 29% by 2046), the number who are NESC-born is growing fast (roughly doubling by 2046; Fig. 4A). Just under a quarter of the 65+ population was NESC-born in 2021, which will increase to 28% by 2046 and about a third in 2056.

4A Faster growth in older people from non-English-speaking backgrounds, yet slower growth in those with poor English



4B Older Australians born in Asia will more than triple in number by 2046



Note: Projections shown stop at 2046 because this is the longest projection for all series. But see boxes for greater disaggregation and projections over longer periods depending on sub-group. Population sub-groups shown are not mutually exclusive (e.g. 'born overseas' include those born overseas regardless of English language skill and whether NESC/MESC born). Source: Authors' analysis of data from CEPAR Population Ageing Futures Data Archive.

Such projections (limited though they are with respect to characteristics like enduring ethnicity and cultural practice) can provide crucial insights for understanding diversity patterns in Australia and designing policies that take better account of the increasingly varied cultures, languages, and backgrounds of older people in Australia.

How migration offsets population ageing

Migration policy decisions have important short- and long-term demographic, social, and economic implications. One economic aspect in the short term is to fill specific gaps in the economy and address unfolding skills shortages in construction, hospitality, logistics, health, and care (ACCI, 2022; NSC, 2022). In the longer term, migration affects Australia's cultural and linguistic diversity (see above) but also the rate of population ageing. Migration intakes must be balanced against community expectations and pressures on infrastructure, housing, and services. But what level of migration might Australia need to deal with population ageing?

As it is, migration is roughly halving the rate of ageing in Australia. The net migration rate is expected to be about 235,000 – or an average of 0.8% of the population over the next 40 years (although post-pandemic rebounds have seen the number at about twice that).

With zero net migration, the dependency ratio (65+/15–64) would increase by 16pp, from 27% now to 43% by 2054 instead of the currently projected increase of 7pp to 34% (Fig 4C(i)). Similarly, zero net migration would see the share of people aged 65+ increase by 7pp, from 18% of the total population now to 25% by 2054, instead of the projected increase of 3pp, to 21% (authors' analysis based on adapted model of Wilson and Rees 2021; long-term total fertility rate, TFR, of 1.62 and net migration of 235,000 as per Commonwealth Government's Intergenerational Report; IGR). A scenario with zero net migration is illustrative but infeasible. So, what are the demographic impacts of other alternatives?

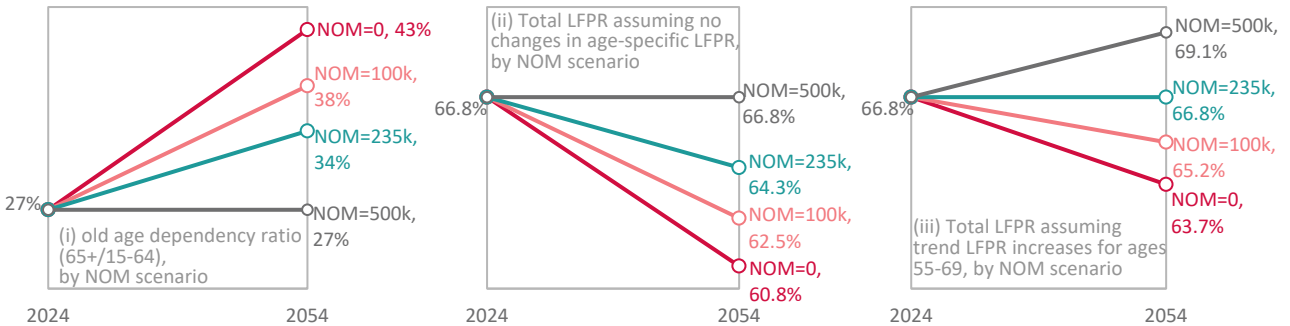
Past analysis has shown that halving expected net migration numbers to 100,000 (or about 0.4% p.a. of the population) would be enough to offset below-replacement fertility (McDonald and Hosseini-Chavoshi, 2022, based on TFR of 1.65). Australia's population would still get older, but the annual number of births would be constant, and the total population would reach 33 million by 2054 and then stabilise below 34 million in the longer term. However, this would see far fewer skilled migrants, because about two-thirds of the 100,000 comprises family and humanitarian migration, which is not easily reduced.

At the other extreme, continuing migration at recent post-pandemic rates, of about 500,000 (or 1.5% p.a.) would be enough to stabilise ageing altogether, keeping dependency and older person population shares constant at 2024 levels – and result in a total 2054 population of 48 million (authors' analysis, as above; Fig 4C(i)).

Yet another yardstick would be to consider impacts on total labour force participation rate (LFPR), which takes better account of economic dependency and age-specific work patterns (Chomik and Khan, 2021). For example, if age-specific labour force participation rates remained constant, then keeping total LFPR constant would indeed require some 500,000 net migrants annually (Fig. 4C(ii)). But if participation rates of older groups continued increasing as they have been – so that by 2060 each older age group between 55 and 69 had the rates of those five years younger – then net migration of about 235,000, as assumed in the IGR, would be enough to stabilise the total LFPR (and result in a 2054 population of 38 million; authors' analysis, as above; Fig 4C(iii)).

The Commonwealth Government is currently formalising its long-awaited migration strategy. The outcome of this process will determine what future Australians will look like in terms of both cultural background and demographics.

4C Pre-pandemic and expected level of net migration of about 235,000 halves ageing rate and can stabilise total LFPR



Source: Authors' analysis based on ada model of Wilson and Rees (2021). Note: NOM=Net overseas migration. LFPR=Labour force participation rate. Increasing LFPR of ages 55-69 assumes each older age group between 55 and 69 ends up with rates of those five years younger by 2060, roughly in line with recent trends.

Box 1 CEPAR research spotlight **The future of ageing across diverse sub-populations**

As noted in this brief, over the past decade there has been a growing gerontological evidence base on the unique ageing experiences of population subgroups. However, the focus and data availability on heterogeneity in *individual ageing* has largely been overlooked at the population level. Yet macro trends in population ageing by group are important, because not all demographic groups are ageing at the same rate – with implications for policy, planning, and service provision.

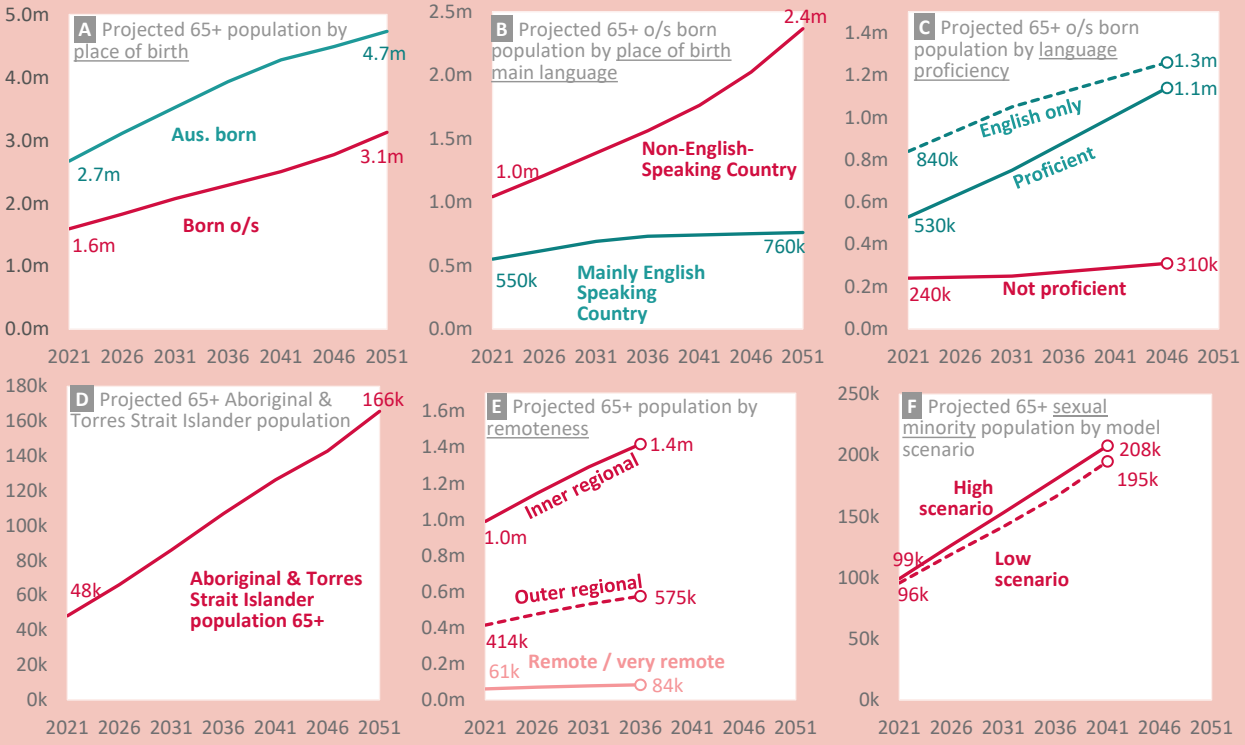
Understanding the diversity of future population change within the older population is also important to comply with the Aged Care Act 1997 as well as a series of policy documents that cement the Australian Commonwealth Government's commitment to ensuring appropriate and safe aged care that recognises the diversity of the Australian population.

To address this urgent data gap, CEPAR's Jeromey Temple and Tom Wilson built a collaboration across multiple universities to provide detailed estimates and projections of various sub-populations, illustrating diversity in population change (Fig. 5; Boxes 2 and 3,).

Projections are now available in the data archive for: (i) migrant populations by country of birth, (ii) English language proficiency population (which are the topic of this brief, as well as for), (iii) the Aboriginal and Torres Strait Islander population, (iv) regional and remote area populations, (v) LGBQ population, (vi) the population with dementia (see Section 5.2), (vii) the oldest old population, and (viii) an analysis of the impact of COVID-19 on population ageing.

The team also launched new population projections for Australia and the States and Territories that show how population ageing is expected to evolve over the next 20 years. Downloadable data of the projections alongside articles for easy interpretation are made available in the Population Ageing Futures Data Archive on the website: https://cepar.edu.au/cepar-population-ageing-projections.

5 New projections show how population ageing coincides with growth in diverse sub-populations



Source: Authors' analysis of data from CEPAR Population Ageing Futures Data Archive and ABS Census 2021. Note: For 5E, projected populations of Statistical Area 3 regions were summed by remoteness shares in 2021.

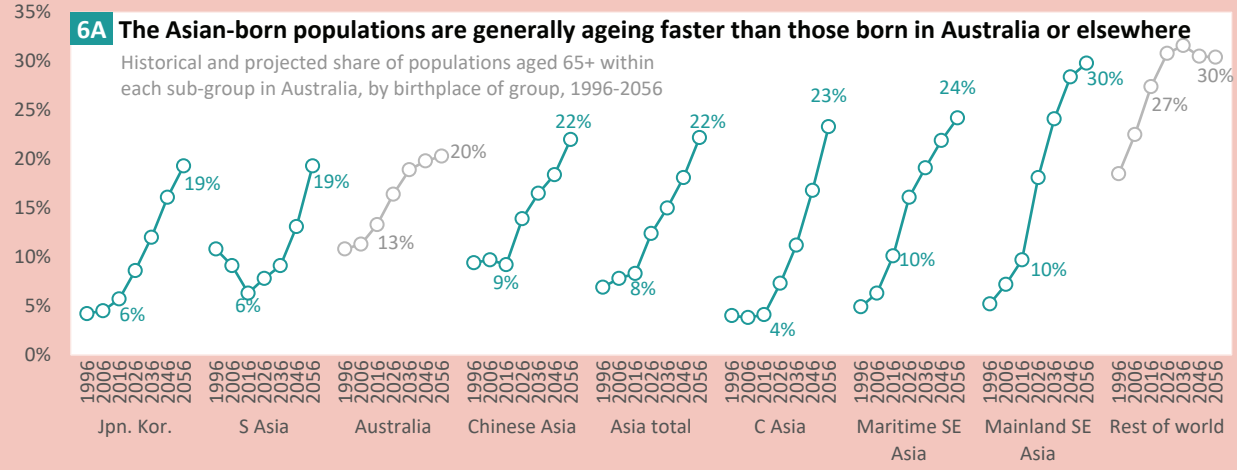
Box 2 **CEPAR research spotlight** **Asian-born older Australians: Increasing shares**

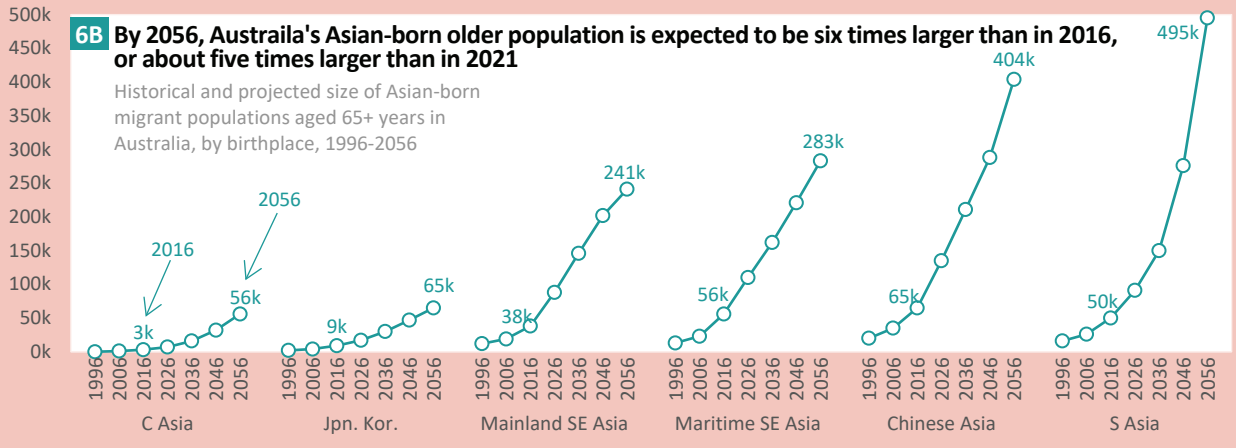
The overall Asian-born population in Australia reached 2.7 million in 2016, yet the number of those aged 65+ remained relatively low, at about 220,000. In Wilson et al., (2021a), CEPAR researchers alongside other colleagues report on projections showing that this will start shifting due to increasingly large cohorts of migrants who arrived in earlier decades reaching older ages, as well as continued immigration, and increasing life expectancy.

The population of older Australians born in places other than Asia (i.e. mostly Europe) will continue ageing, with the proportion aged 65+ increasing from 27% in 2016 to 30% in 2056. However, the age structure of those born in Asia is catching up. The share of Asian-born Australians aged 65+ is expected to increase from 8% in 2016 to about 22% in 2056 (Fig. 6A). Those born in mainland Southeast Asia will see particularly fast rates of ageing because of the historic timing of arrival, with the share of people aged 65+ in this sub-group increasing from 10% in 2016 to 30% in 2056. By contrast, the expected later wave of migrants from South Asia means that the share of older people within this population will only increase from 6% to 19% over the same period.

In absolute numbers, by 2056, about 1.5 million older Australians (aged 65+) are expected to have been born in Asia. This represents a six-fold increase from 2016 (or five-fold increase from 2021), compared to a 52% projected growth in non-Asian migrants of the same age group. In the 2050s, older Australians born in South Asia are expected to overtake the number of older Australians born in China. Their number will be about ten times larger than in 2016 (Fig. 6B). Overall, the projection suggests that the Asian born share of Australia's total 65+ population will increase from 6% in 2016 to about 19% in 2056.

Increases are also expected in the numbers of the 80+ population, who have the greatest health and care needs. The total Asian–born population in this age group is projected to grow from about 50,000 in 2016 to about 470,000 in 2056, an increase of more than 900% (compared to increases of about 135% for people aged 80+ born in other parts of the world). The Asian–born share of Australia's population aged 80+ is therefore expected to rise from 5% to 15% by 2056. The largest absolute increases will be for those born in China, Vietnam, and India.





Source: Wilson et al., (2021a)

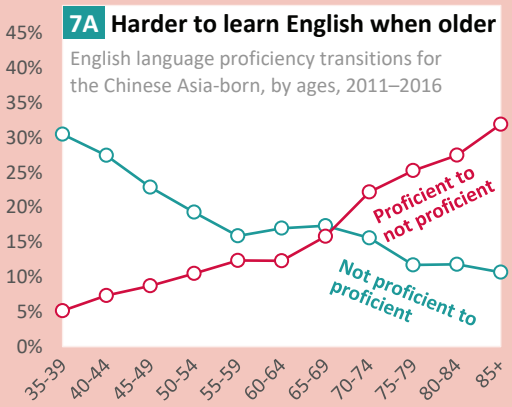
Box 3 CEPAR research spotlight **Older Australians' English proficiency: Shift toward Asian-born**

The number of overseas-born Australians who do not speak English well, or at all has risen from around 500,000 between 1991 and 2006, to more than 800,000 in 2016. At ages 85+, nearly half of the population speaking another language did not speak English well (McDonald et al., 2019).

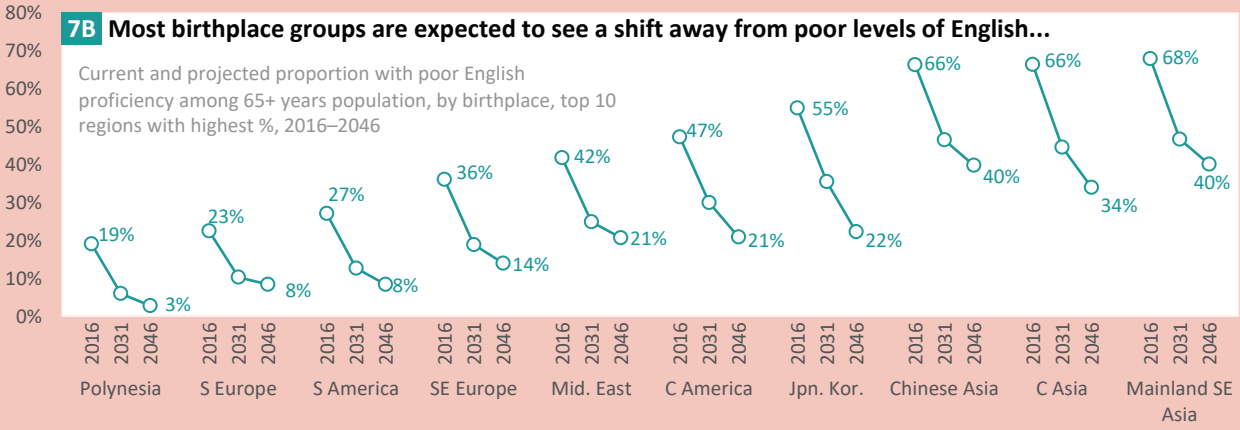
So, how can we expect language barriers to change in an older, more diverse Australia? CEPAR's Peter McDonald, Jeromey Temple, and Tom Wilson, together with other co-authors, have again teamed up to answer this question. Their results have implications for policy areas where culturally appropriate and multilingual services are crucial, such as in aged care and health.

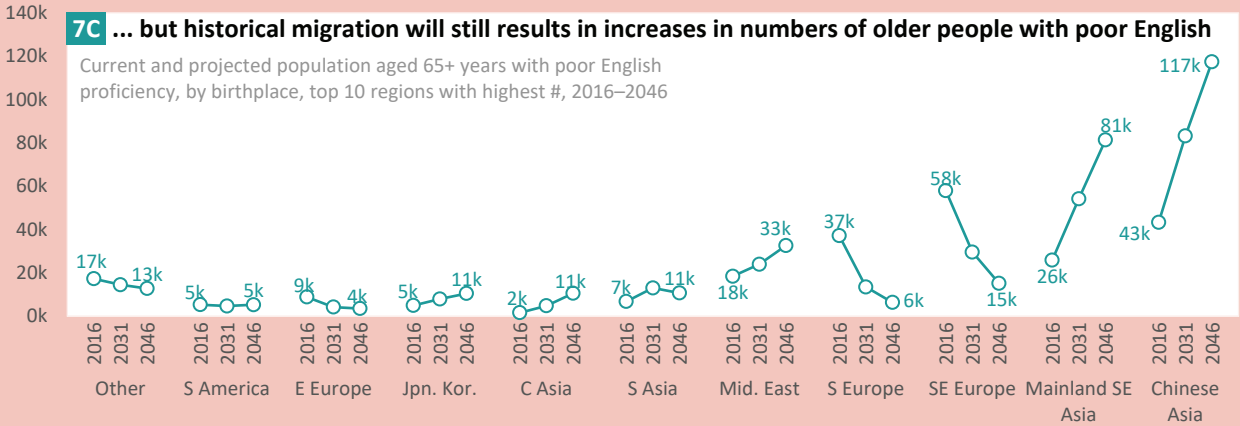
The team extended their projecting models by adding detailed language proficiency transition probabilities by age and birthplace (Temple et al., 2022a; Fig. 7A). There are several findings of note.

First, the results confirm that we are more likely to see English levels drop than improve in older people born overseas (Fig. 7A). *Second,* given the age and profile of future migrants, the shares of each migrant group that ends up speaking English poorly by the time they reach age 65 is expected to decline for almost all migrants (Fig. 7B). *Third,* most of the growth in older migrants with poor English proficiency is projected to occur among Chinese and mainland Southeast Asian migrants. These are offset by declines in numbers of people with poor English skills who were born in Europe (Fig. 7C).



Fourth and finally, the various offsetting patterns mean that overall, the total older migrant population with poor English proficiency increases by only about 80,000 by 2046. This is in contrast with the projected growth of older people who speak English well or as their only language, expected to number more than 720,000 and 500,000 people, respectively. The authors note, however, that culturally appropriate services for a changing migrant population are important even if relative shares of people with language difficulty decline.





Source for all figures: Temple et al., 2022a

3. SOCIOECONOMIC DIMENSION

There is no single definition of what it means to age successfully, age well, age healthily, or age productively. Literature on ageing takes pains to emphasise multiple dimensions that affect an older person's wellbeing, including socioeconomic, psychosocial, and biomedical aspects, even when definitions are based on views and priorities expressed by members of diverse communities (Rowe & Kahn, 1987; Depp & Jeste, 2006; Bowling, 2007; ABS, 2010; Bülow & Söderqvist 2014).

Measurement, in turn, relies on diverse indicators (Chomik & Rodgers, 2018), many of which interact. Increasing evidence suggests that socioeconomic factors are important and drive health-promoting behaviours and health outcomes in old age, with a cumulative effect over the life cycle (CSDH, 2008).

So, what do socioeconomic outcomes look like by age, as well as by each of the three culture and language diversity categories, and are these changing over time? Here we examine indicators of education, employment, income, and housing. In each case a comparison population is offered. Based on 2021 totals, the roughly 7.2m adults born overseas are compared with the 13.6m adults born in Australia; the 5m speakers of another language at home are compared with the 15.7m who speak only English at home; and (of those speaking other languages at home) the 750k adults speaking English poorly is compared to the 4.3m who are proficient in English. Breakdowns by age and time inform lifecycle differences but need careful interpretation. For example, many of those born overseas aged 20-34 are temporary residents that replenish year to year. It's worth also noting that 2021 may have been an unusual year due to pandemic influences, but an analysis of results between 2006-2016 (not shown) revealed patterns similar to those presented here.

Although age and time dimensions are presented, some of the patterns are due to cohort effects that may not be immediately obvious. As noted in Section 2, those at older ages represent migrants with different cultural, skills, and occupational profiles compared to those who are expected to reach older ages in the future. For migrants, time since arrival is often a mediating factor; its absence from the core categories may indicate a weakness of the groupings.

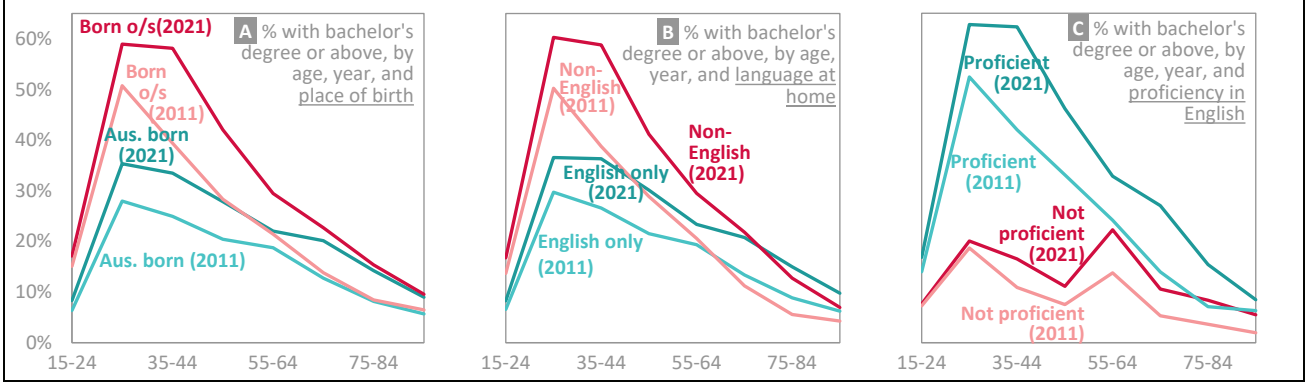
3.1 Education

Education builds human capital and is strongly related to economic, social, and health outcomes, as demonstrated in research that includes culturally and ethnically diverse groups in Australia and elsewhere (Wang et al., 2004; Wu et al., 2009; Montez et al., 2011; Olshansky et al., 2012; Chandola & Jenkins, 2014; Deaton, 2015; Raghupathi & Raghupathi, 2020).

Figure 8 compares educational attainment by group. As is the case with much of the analysis here, the figures tell a story of changing intakes of migrants as well as different stages in the migrant journey. Migrants are more educated than those born in Australia, but this is particularly the case at younger ages, reflecting Australia's growing skilled migration program. In 2021 at ages 25–34, nearly 60% of those born overseas and those from multilingual or non-English-speaking backgrounds (i.e. where a language other than English is spoken at home) held a bachelor's degree or higher. This compares to about a third for the Australian-born population and those born overseas but who speak only English at home.

EDUCATION

8 Education is higher for migrants, particularly those from non-English backgrounds. It is low for those with poor English.



Source: ABS Census. Note: English proficiency chart includes only those who speak a language other than English at home

At older ages, the educational levels converge and are lower for Australians who speak other languages at home. These groups represent a previous cohort of arrivals, largely from Southern and Eastern Europe who were less skilled than new cohorts of migrants. Since the turn of the century, inward migration intake has been increasingly skewed toward skilled migrants. For instance, 59% of permanent migrants from 2000 to 2021 were skilled migrants with an average age of 37 years (ABS, 2021a).

Figure 8C is particularly revealing. It shows the implied educational difference between skilled migrants (who are required to have proof of proficiency in English) and other migrants, such as those coming through the family, temporary visa, and humanitarian programs (who are more likely to have low English language skills).

Consequently, those with lower English language skills also have lower levels of education. In 2021, about 20% had a bachelor's degree and nearly 80% had no qualifications beyond high school. They are, therefore, more likely to experience economic insecurity and require targeted programs (see next section). Parents' English proficiency has also been shown to affect their children's educational outcomes in Australia (Guven & Islam, 2015).

3.2 Employment

Migrants tend to integrate well into the Australian labour market

Employment outcomes differ not only by age and sex, but also by migration and cultural and linguistic background. Figures 9 and 10 reveal that employment rates for Australians born overseas are lower at younger ages, but at older ages the rates broadly converge for those born overseas and Australian-born. This reflects the large numbers of overseas-born students, higher unemployment rates for certain migrants, and better integration of migrant populations from middle to older age.

Indeed, it is documented that Australia is better at integrating migrants than Europe and the US (Jasso & Rosenzweig, 2008; Hartwich, 2011). This is largely attributed to Australia's selective migration program, which has increasingly reserved more places for skilled migrants.

But some continue to struggle

Not all migrants have the same employment outcomes. In 2018, six months after arriving, those arriving on a Skilled Migrant Visa had a substantially higher employment rate, participation rate, and earnings than the general population, with outcomes typically improving further in the year after (DHA, 2020a, 2020b). By contrast, Family Visa-holders have employment rates similar to people born in Australia, with humanitarian migrants tending to fare much worse (Mackey et al., 2022).

Such patterns can be gleaned from Figure 9. Men who speak a language other than English at home have slightly lower employment rates. At middle and older ages, the rate is about 3-6pp less than for those who speak only English at home (Fig. 9B). This pattern is in turn driven by a subgroup of men with low English language proficiency, whose employment rates are substantially lower – more than 20pp lower compared to men who speak another language at home but speak English well (Fig. 9C). At younger ages, this is partly driven by student profiles: for example, students from South Asia who work limited hours to cover costs. At older ages it includes parents born in China living with well off children and not needing to work (McDonald and Moyle, 2020). The gap by proficiency in English is smaller at older ages. For example, it is 7pp at ages 55–64.

Language as a barrier to employment is a longstanding challenge in Australia (Borjas, 1990), alongside lack of recognition of qualifications, mismatched skills, fractured social networks, discrimination in the labour market, and policies that encourage resettlement in rural locations with fewer opportunities (ABS, 2019b, Lee et al., 2020a).

Recent research continues to indicate English language training as the most effective intervention to improve employment prospects for humanitarian migrants (Cheng et al., 2019; 2021; Arendt et al., 2020; Wang et al., 2021). Spoken English is key: Improving the level of spoken English is related to higher self-esteem and a strong predictor of humanitarian migrants' employment outcomes in their first three years in Australia (Cheng et al.,

2021; Blake et al., 2019). In addition, some research also proposes job training, work experience, and help starting up businesses (Delaporte & Piracha, 2018; Atkins et al., 2022).

Australia's well-established *Adult Migrant English Program* has long been providing free English lessons to eligible migrants, but participation was recently made compulsory for awarding permanent residence and opportunities to continue in the program have been expanded. There are occasional calls for further reforms of the program to better target the changing demographic backgrounds of migrants, including focusing on Chinese born populations, humanitarian entrants, and women who may be at greater risk of isolation (Chen et al., 2017; Button, 2019; McDonald et al., 2019; Wu et al., 2021).

The 2023-2024 Budget announced the Government's plans for a new migrant assistance program by 2025. This will provide greater flexibility and support to both teachers and learners to improve employment and settlement outcomes for those enrolled (DHA, 2023). The *Humanitarian Settlement Program* also provides eligible migrants with opportunities to learn English, access education and training, and gain employment (DHA, 2021). But there are many policy improvements beyond language training: to improve employment outcomes FECCA have also called for better capacity building for emerging communities and organisations, training employers and employment service providers, greater flexibility of Skilled Visas, and tackling discrimination, amongst others (FECCA, 2019, 2022).

Women appear to face greater challenges but are increasingly working more

The unequal employment outcomes observed for men are more pronounced for women. The employment gaps between migrant and non-migrant populations are greater for women than for men and widen when cultural and language barriers come into play (Figs. 10A–C). Drivers of these patterns could range from benign – e.g., the group includes female students from China who are financially better off and need to work less (McDonald and Moyle, 2020) – through to more challenging issues – e.g. intersectional labour market and social barriers faced by women from diverse backgrounds (Lee et al., 2020b; Gunawansa, 2021; Due et al., 2021; see Section 4.3).

Yet despite the challenges, the charts suggest that at older ages, women from all backgrounds are increasingly working more in the formal labour market. For example, at age 55–64 employment rates of women with poor English increased 6pp over the decade to 2021 (see Chomik & Khan, 2021 – a research brief summarising CEPAR analysis on mature workers in Australia).

Hours are lowest and declining among younger women with poor English

Hours of work mirror some of the patterns observed for employment rate (Figs. 11-12). For example, at younger ages, men born overseas and those with multilingual or non-English-speaking language backgrounds have lower rates of full-time work (probably because some are temporary migrants, and some are studying). At older ages various migrant and CALD group's employment patterns resemble those of the comparator population. Full-time employment rates are much lower and declining for prime-working-age men with poor English.

As shown in the figures, among middle age and older women, rates of full-time work are higher for most migrants except those with poor English. The latter have also seen a large decline in full-time work between 2011 and 2021, which may reflect a changing profile of migrant women.

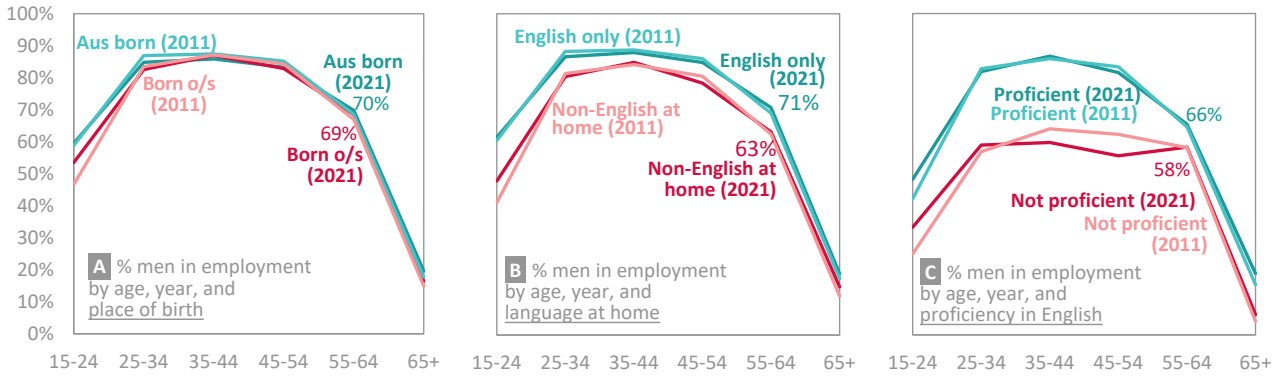
Industry and occupation at older ages

Figures 13A–C depict the extent of industry and occupational segregation by migrant and CALD category. The industrial distributions of workers born overseas and who speak other languages at home are generally similar to those of the majority population. They also have a similar likelihood of being professionals but are more likely to be working as labourers. One major difference is that older Australian-born workers are considerably more likely to work in agriculture than first-generation migrants.

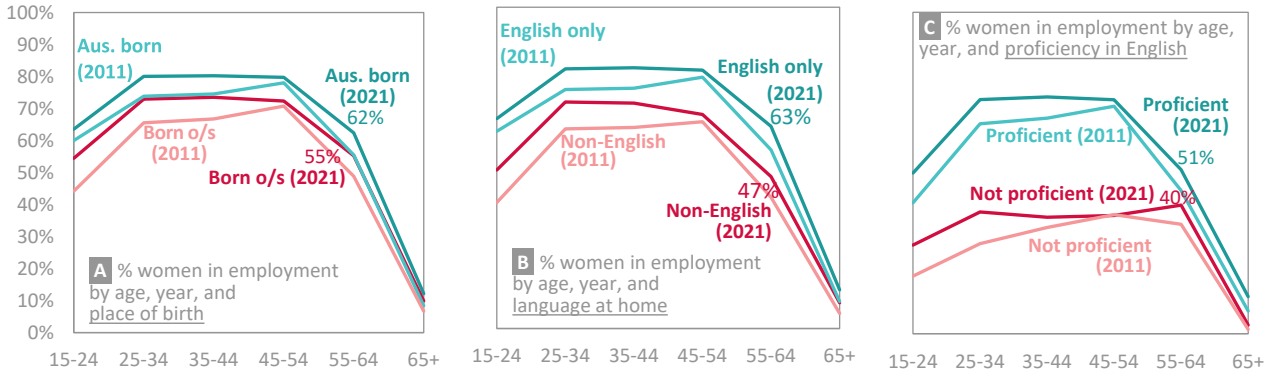
Older people with poor English skills are more likely to be in declining industries such as manufacturing and are considerably more likely to be labourers and in trades. By contrast, the overall older cohort of those born overseas are more likely to be in growing industries, such as health and care services.

EMPLOYMENT RATE

9 Most men born overseas have high employment rates, but a lack of English language skills appears to inhibit employment.

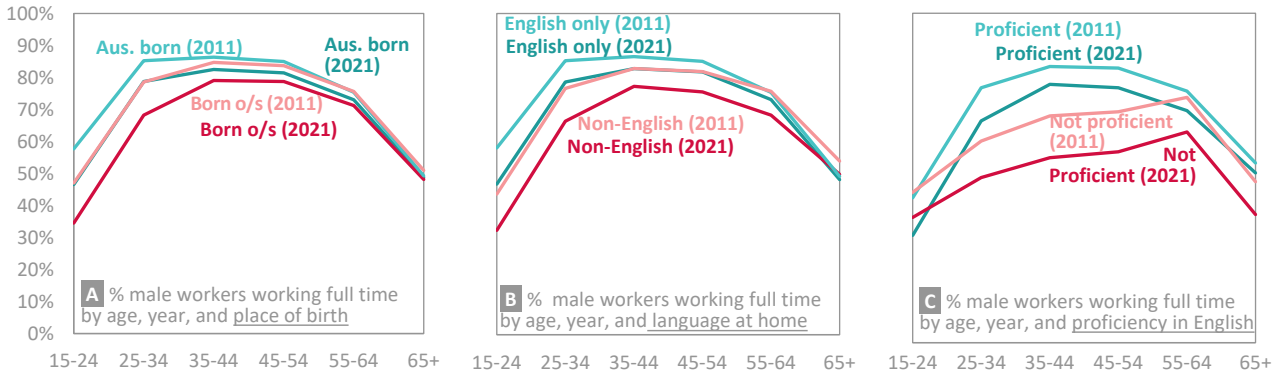


10 Migrant women, especially those with poor English, have low employment rates. But all women are seeing increases.

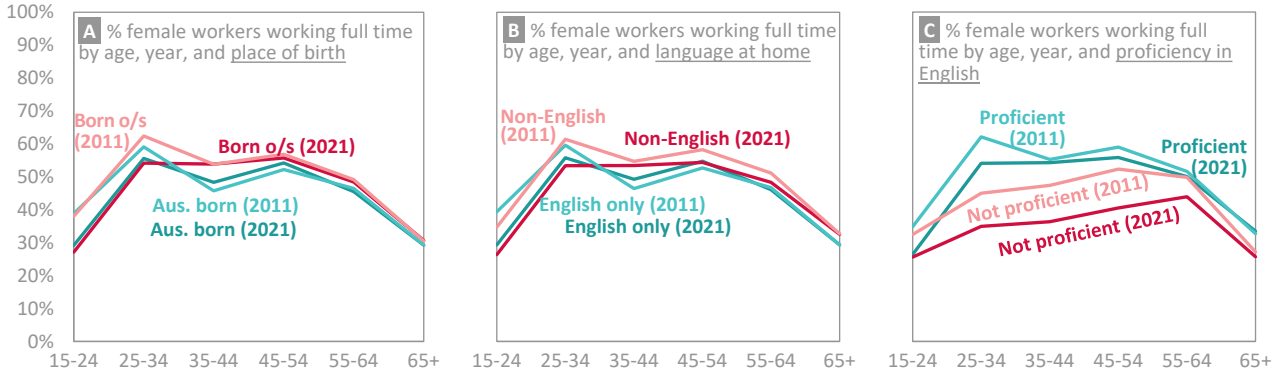


HOURS WORKED

11 Migrant men are slightly less likely to work full-time. Full-time rates are low and declining for men with poor English.

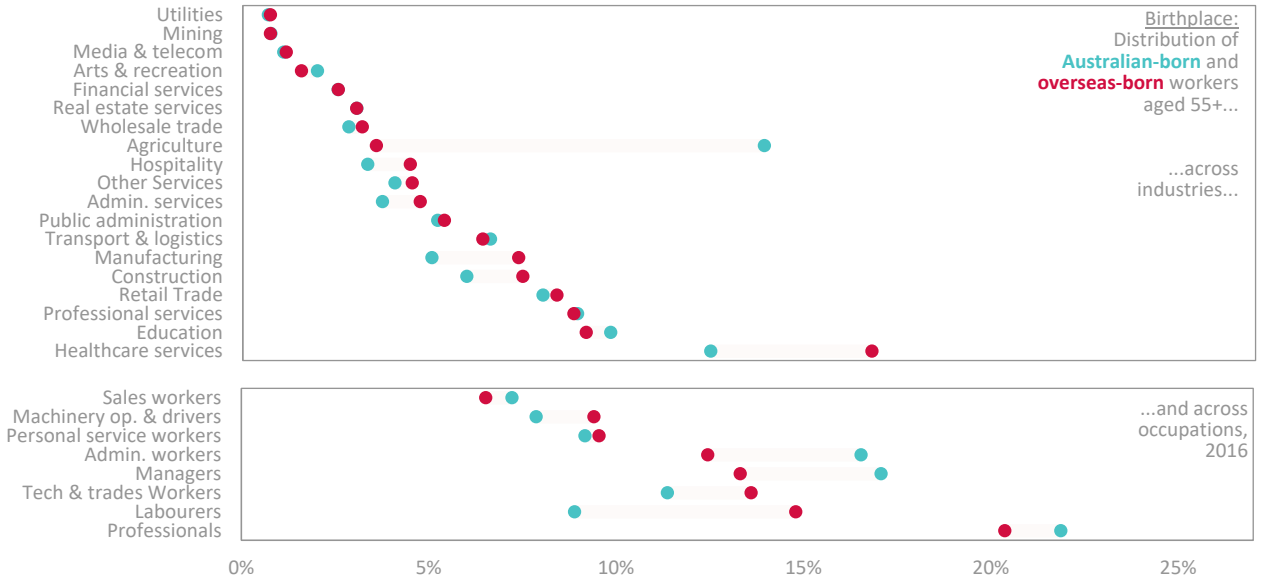


12 Full-time work rates are similar for women born locally and overseas, but low & declining for those with poor English

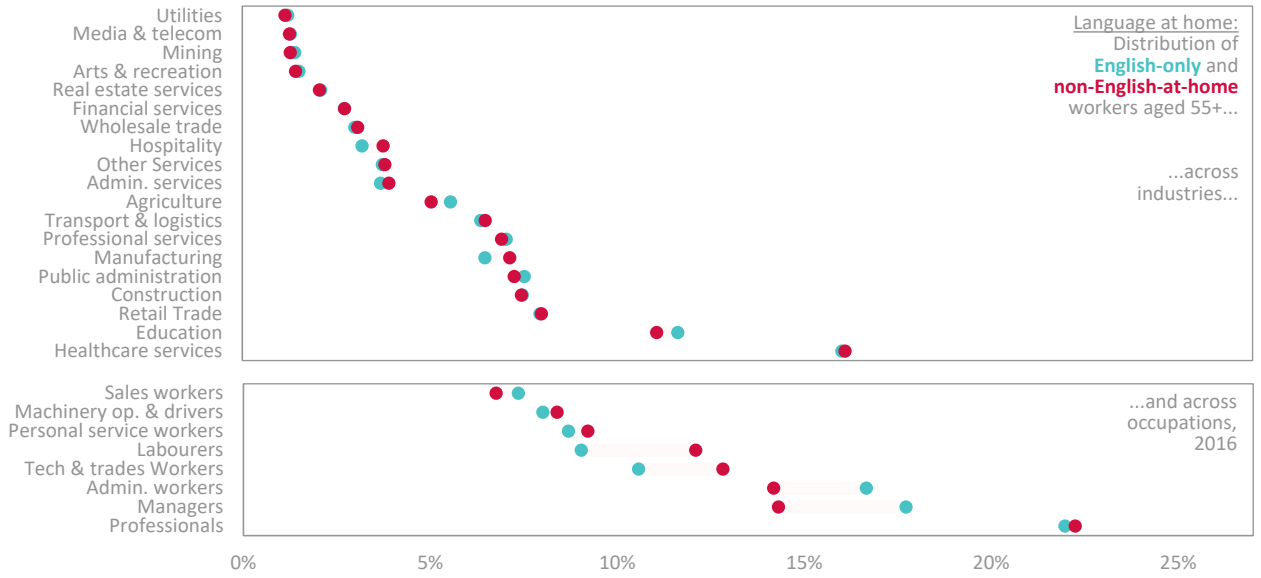


Source: Authors' analysis of ABS Census. Note: English proficiency chart includes only those who speak a language other than English at home. Full-time defined as work of 35hours+. Note that the form of wording that asked about employment in the Census sought to overcome the distorting effect of pandemic-related lockdowns (see details of 'LFPS' in the 2021 Census dictionary at https://www.abs.gov.au).

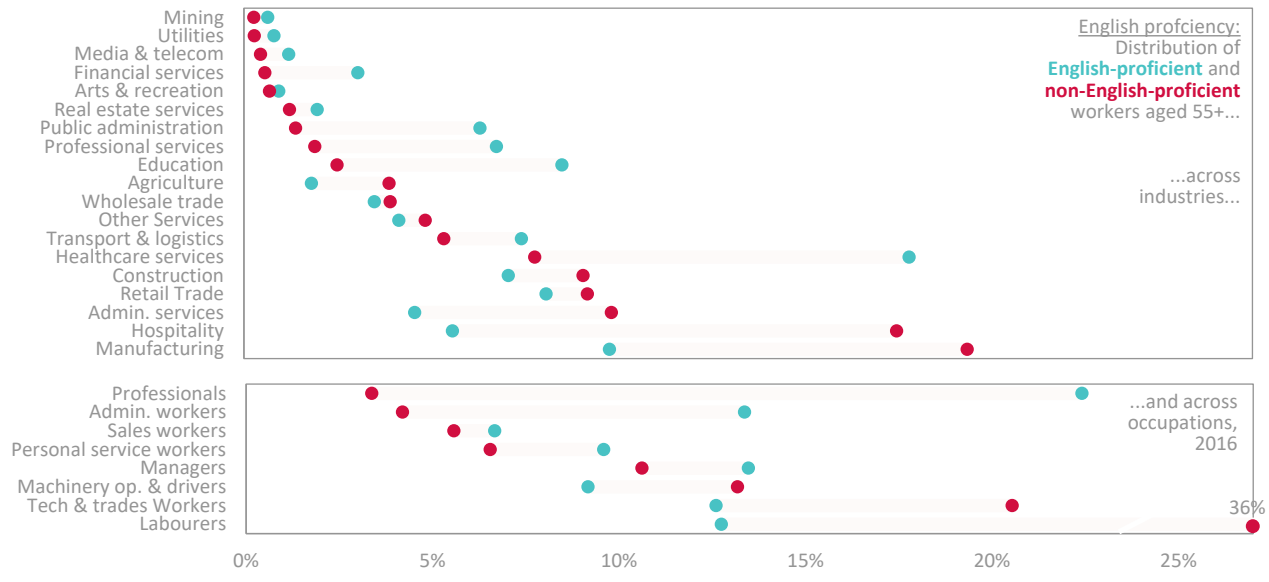
13A **Older Australians born overseas are less likely to work in agriculture and more likely to work in health.**



13B **Industrial distribution is similar by language status, but those who speak other languages are less likely to be managers**



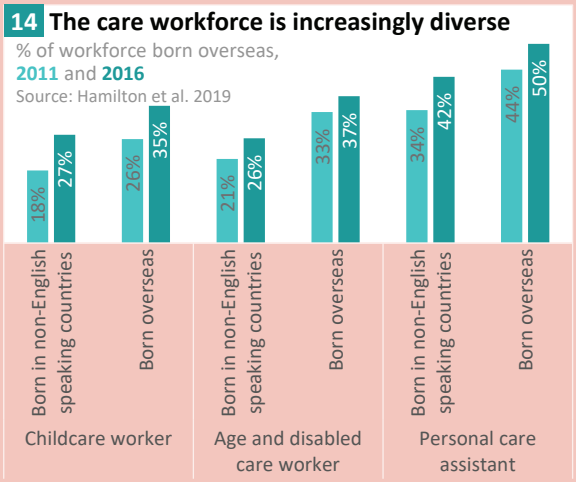
13C **Older workers with poor English less likely in not-for-profit ind. They are substantially more likely to be labourers.**



Source: Census 2016. Note: English proficiency chart includes only those who speak a language other than English at home

Box 4 CEPAR research spotlight Employment pathways for migrant carers

Population ageing will continue to put upward pressure on the demand for health and aged care workers. To meet this demand in the short term, Australian politicians have raised the possibility of international recruitment programs for migrant care workers.



But another source of workers could include recent and future migrants that arrive through other migration streams, particularly those with language barriers who are often underemployed. Some have already made their way into the sector. For example, half of personal care assistants in 2016 were born overseas (Fig. 14).

Recent work by CEPAR's Myra Hamilton (with other colleagues) delved into how recent migrants to Australia find their way into the care sector. She found that after first arriving, participants typically experienced a constrained sense of agency because of language barriers and the fact that their skills were unrecognised.

Over time, participants mobilised existing and new resources to regain a sense of agency and pursue a more active 'career shift' into employment in formal care settings. Increased agency allowed them to deliberate on their career choice as one shaped by what they perceived as '*meaningful*' and '*accessible*' work and by social expectations around gender and migrant status.

> *"So I was thinking what I wanted to do and the ideas from friends were coming from different places and I remember one of my friends told me that you are a caring person and would you like to do something related to the healthcare and she told me nursing would be a great opportunity for me to look at but then of course I did not have the qualification and anything." – Study participant*

For example, an important driver of change in personal agency was permanent residency status. Participants reported that permanency gave them the security and time to consider what type of work they wanted. Unlike the initial step of the migrant journey where participants often need to take on fragmented, low paid work to 'survive', a job in frontline care was seen as a more conscious and calculated career choice. As their horizons for action and planning expanded, participants' also chose to pursue further study, or a change in the type of care work performed.

For many, language was also less of a barrier in accessing work in frontline care sectors, partly because of the demand for workers – but also because, according to participants, some employers saw bilingual workers as desirable.

The authors note that even though a frontline care career may involve an active choice, the nature of the work may still leave many who pursue it vulnerable to economic insecurity. And a shift toward more internationally recruited care workers may exacerbate this if programs limit the agency of future care workers by restricting their mobility and tying them closely to employers. It means that *decent work* in the care sector will remain an ongoing policy challenge with implications for migrant worker wellbeing and security.

3.3 Income

Income affects quality of life, wellbeing, and health. Figures 15A–C show median incomes across populations groups in 2010 and 2020 (adjusted for inflation). There are several patterns of note when comparing by group, time, and age.

Incomes are lower for CALD groups

First pattern to notice is that incomes are similar between overseas-born and Australian-born people, but gaps appear for some sub-populations. For example, middle-aged migrants who speak English as a second language as well as those who speak English poorly, experience higher respective gaps in income relative to native English speakers and those who speak English well.

As a result, people from non-English speaking backgrounds with some of the highest average educational attainments (see above) do not necessarily have higher average incomes. One reason could relate to lower rates of employment and full-time work (Section 3.2).

Another reason could relate to skills mismatches. As shown in Figure 13 above, people in this group are more likely to work in less skilled jobs. For example, about 15% of migrants and 12% of those from multilingual or non-English-speaking backgrounds are labourers, compared to 9% of those born in Australia and 9% of those who speak only English at home. Migrant working in jobs beneath their skill level not only affects household incomes but is also thought to reduce Australia's overall productivity (Barker and Tofts-Len 2024). Exploitation could be a related factor. Migrants are twice as likely as long-term residents to be underpaid (Berg & Bassina, 2018; Coates et al., 2023).

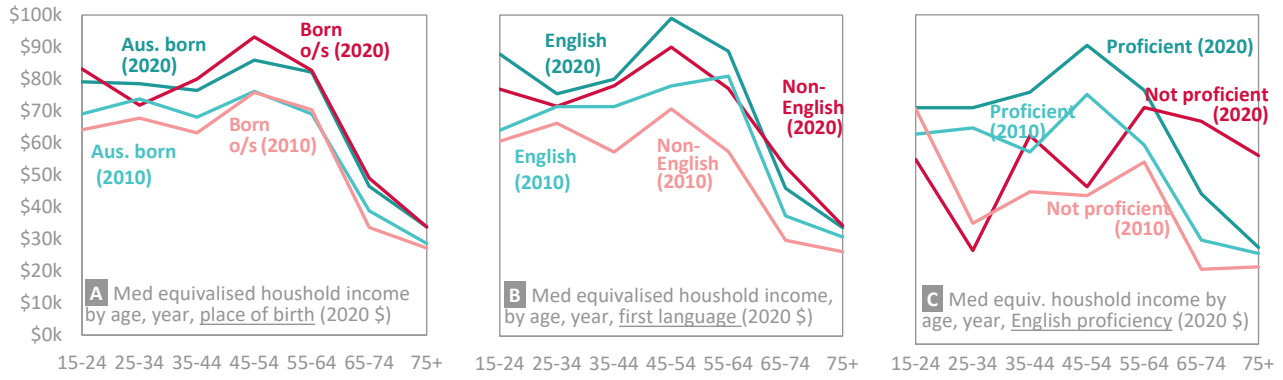
Yet another explanation is that median income is adjusted here for household size, and those who speak other languages at home tend to have more household members. For example, in 2021, 25- to 34-year-olds from multilingual or non-English-speaking backgrounds lived with 0.5 more people than people of the same age in English-only households.

Most have seen incomes rise, but not uniformly

The second pattern to note is that on average, all groups saw a rise in their standard of living. But the increase was largest for prime-working-age people from non-English-speaking backgrounds. For example, in the decade to 2021, those from non-English-speaking backgrounds saw an increase of almost $10,000 in median incomes. Similarly large increases in income were seen among those who were not proficient in English.

MEDIAN INCOME

15 Incomes of overseas- and Australian-born are similar, but differ by language background and English proficiency



Source: Authors' analysis of HILDA data. Note: English proficiency chart includes only those for whom English was not the first language they learnt to speak. Income is gross equivalised household income by person characteristics. Results for chart C should be interpreted with caution given small sample sizes.

Incomes converge in old age due to the means tested Age Pension

The third notable pattern is that for each comparison, the gaps between different groups narrow, and incomes converge with age, albeit at a lower level. These reached a range of about $25,000–$35,000 at ages 75+ in 2020.

The pattern may relate to cohort effects, but a key explanation is the design of Australia's retirement income system (Chomik et al., 2018). The Age Pension is means tested, so those who have more income in retirement (or assessable assets) receive less pension, which acts to compress the income distribution in old age.

Low income before and after taxes and transfers: Poverty gaps disappear by old age

The Age Pension is just one policy that offsets income inequalities over the lifecycle. Figures 16-17 demonstrate the effect of public benefits and taxes on poverty outcomes by migrant and CALD status. They depict shares of the population with incomes below 50% of the national median before and after taxes and transfers.

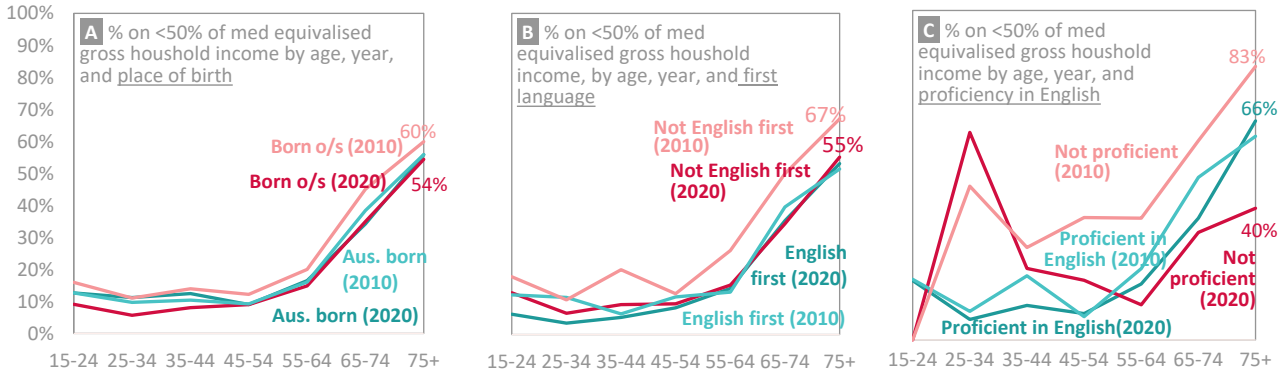
Proportions earning low *market* income are similar for migrants and those born in Australia (Fig. 16A). Indeed, the likelihood of having a low market income is lower among young migrants than among the Australian-born population (e.g. 6% at ages 25–34 for migrants versus 11% for Australian-born). Shares with low market income are higher among older people (over 50% in most cases, which is to be expected since most have retired) and young people with poor English (63% at age 25–34 in 2020; Fig. 16C).

By comparing these patterns with shares of people with low *net* income after taxes and transfers, a common measure of poverty (Fig. 17), we see poverty rates decline dramatically once taxes and transfers are included. Poverty gaps with the comparison population are reduced at younger ages and in some cases disappear or are negative at older ages. For example, older people with poor English have the same or lower poverty rates than those with proficient English.

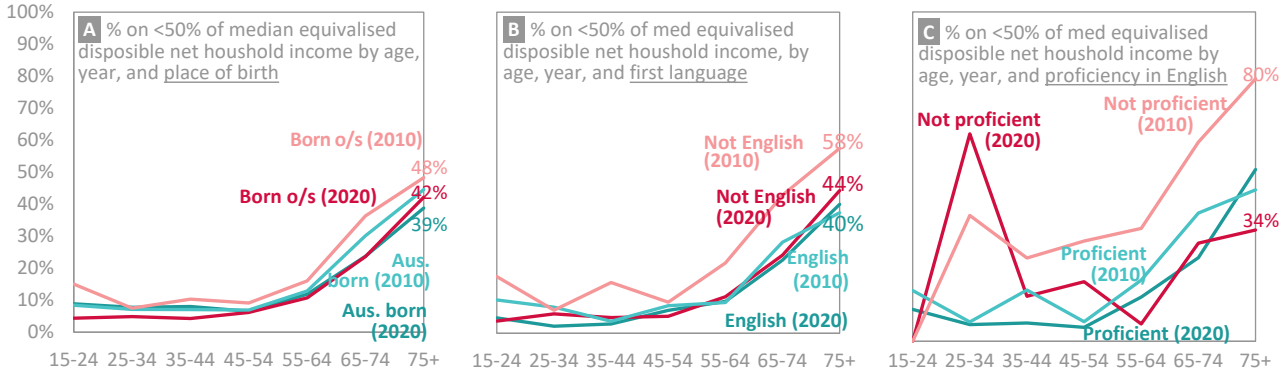
One exception to this pattern is younger migrants with poor English, who are more likely to be temporary visa holders with limited access to public transfers. This is not simply related to the pandemic, because a similar result is also apparent in previous years (including in 2018; not shown).

INCOME POVERTY BEFORE AND AFTER TRANSFERS

16 Before transfers: Minor differences in low-income shares. Poor English relates to low income for younger, not older.



17 After transfers: Poverty rates are reduced for most groups, particularly older people.



Source: Authors' analysis of HILDA data. Note: In each case, the median is for total population. English proficiency chart includes only those for whom English was not the first language they learnt to speak. Results for chart C should be interpreted with caution given small sample sizes.

Superannuation: Savings gap

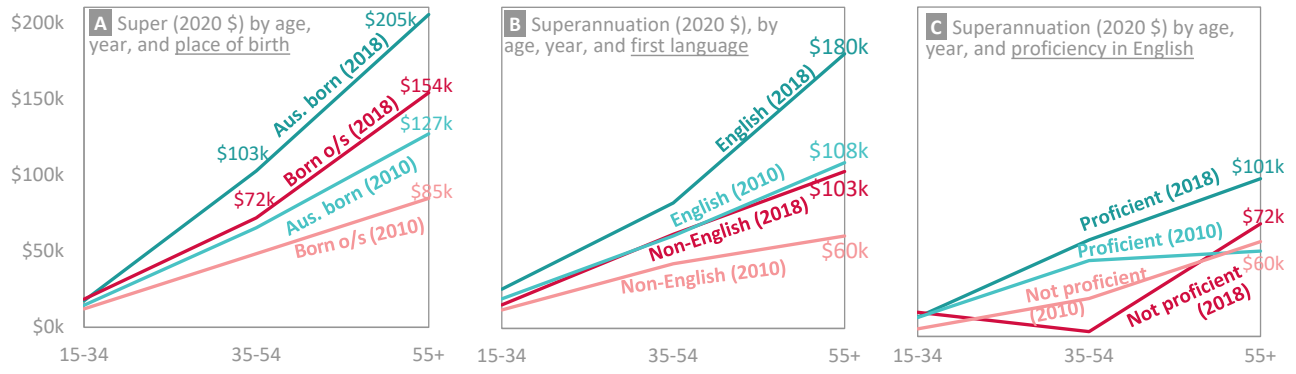
Figures 18A–C show superannuation accumulations in 2010 and 2018 (adjusted for inflation to 2020 dollars). It reveals large gaps in retirement savings between the Australian-born cohort and those born overseas, particularly in non-English-speaking countries. Such gaps reflect each group's labour market experiences in Australia and their recency of arrival. The breakdown doesn't allow for split by sex, but we know that accumulations are typically much lower for women and likely lowest for migrant women (Chomik et al., 2018).

Such gaps often widen in absolute dollar terms but narrow in relative terms by age and over time. For example, in 2018, migrants aged 35–54 had about $30,000 (or 30% less) in super than the Australian-born population. But at ages 55+ the gap was about $50,000 (or 25% less; Fig. 18A).

Those from non-English-speaking backgrounds appear not to have had the same opportunity to catch up by old age. At ages 55+ the gap with English speaking migrants was about $70,000 or 40% (Fig. 18B). Accumulations are generally lowest among those with poor English (Fig. 18C).

SUPERANNUATION SAVINGS

18 Superannuation savings are unsurprisingly lower for migrants and those from non-English speaking backgrounds.



Source: Authors' analysis of HILDA data. Note: English proficiency chart includes only those for whom English was not the first language they learnt to speak. Results for chart C should be interpreted with caution given small sample sizes.

Persistent gap in financial literacy

Savings behaviour and engagement with retirement savings may relate to financial literacy, which is commonly lower in migrant and CALD communities (Gerrans et al., 2009; Mercer, 2013; PC, 2015a; Wilkins, 2018; Preston, 2020). Strategies to improve financial literacy need to be sensitive to cultural and linguistic contexts.

Financial literacy can be measured with a simple set of five questions that test subjects' understanding of concepts and their ability to make calculations about interest, inflation, diversification, and risk (Lusardi & Mitchell, 2011). Figure 19 presents the share of people who answered all five questions correctly, by group.

The charts show three important aspects of financial literacy across the population. First, financial literacy is low. Less than half the population were able to answer all five questions correctly.

Second, the age-based pattern resembles an inverse U-shape, which also leads to a convergence between groups at older ages. That is, financial literacy is low for the young, peaks in middle age, and declines in old age (even when tracking cohorts in longitudinal data). This pattern is not new and has been observed elsewhere (Lusardi & Mitchell, 2014; OECD, 2020).

Third, financial literacy is lower among migrant and CALD groups, and the gap persists in cross-sections of time. For example, compared to those with proficient English, those with poor English see a gap of about 25–35% (see Chomik et al., 2022: a research brief summarising CEPAR research on financial literacy and financial decision making for and in old age).

Compounding effect on women from migrant and CALD backgrounds

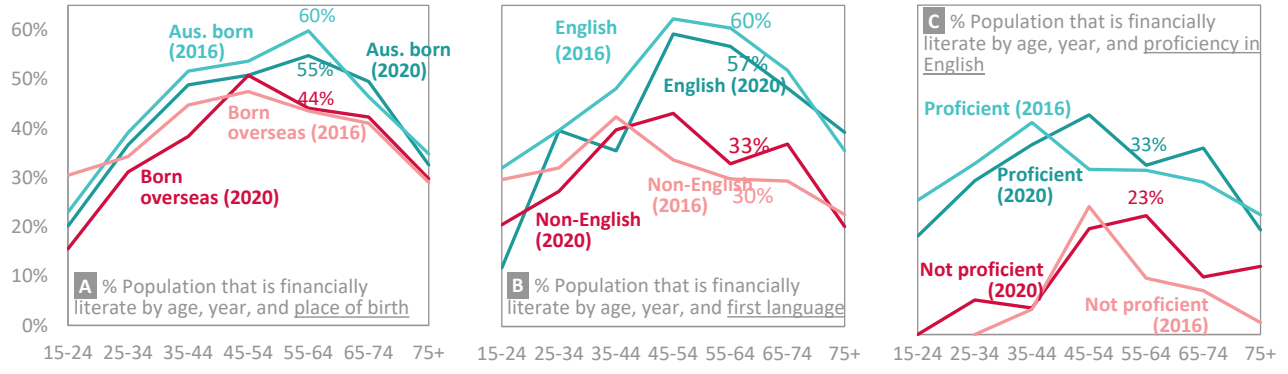
For some, this is compounded with English literacy and digital literacy, especially in remote communities (FSRC, 2018; AIST & ACFS, 2018; ASIC, 2018; PM&C, 2018; PC, 2018).

Women are also more severely impacted (not shown in charts). For example, low financial literacy can exacerbate spousal financial abuse (Farooqi, 2020). In 2020, among the total population, 34% of women answered all five financial literacy questions correctly compared to about 50% of men. Among women from non-English-speaking backgrounds and those with poor English proficiency, the rate was even lower at about 12%.

Financial literacy programs, including the Australian Government's '*National Financial Capability Strategy*', should target and be sensitive to various CALD communities including disadvantaged migrant women and older people (Farooqi, 2020; Uddin, 2021).

FINANCIAL LITERACY

19 Financial literacy is low among migrants, and gap increases with age for those from non-English speaking backgrounds.



Source: Authors' analysis of HILDA data. Note: English proficiency chart includes only those for whom English was not the first language they learnt to speak. Financially literate persons are defined as persons who responded correctly to all five HILDA questions on financial literacy. These questions are based on Lusardi & Mitchell (2011) as discussed in Preston (2020). Results for chart C should be interpreted with caution given small sample sizes.

3.4 Housing

Housing can serve multiple purposes over the lifecycle. It not only provides shelter and a place of social interaction, but for homeowners it is also a store of wealth, guaranteeing greater financial security in retirement. Not owning a home can be indicative of the cumulative effect of disadvantage over the life cycle.

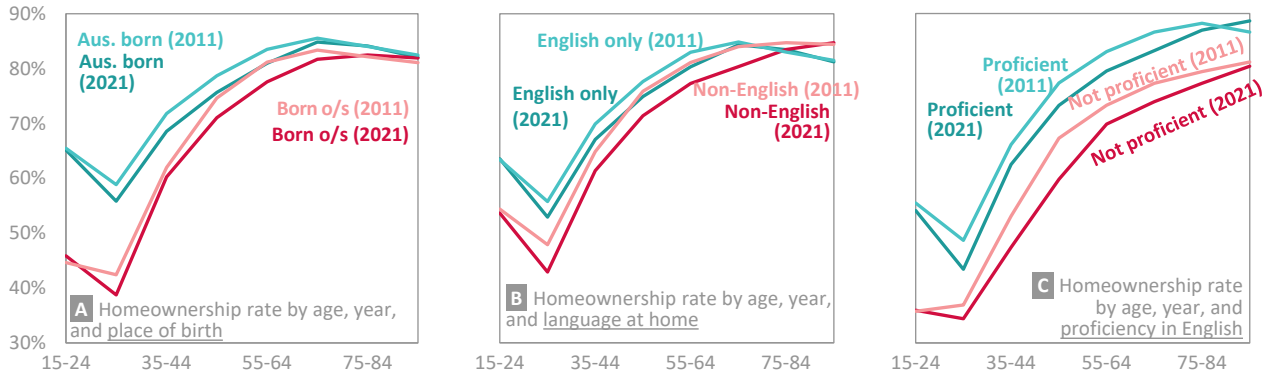
Homeownership has declined among most groups

Homeownership rates have declined for most groups over the decade to 2021 (Fig. 21; note that declines may be underestimated due to the Census measure of homeownership; Chomik & Yan, 2019). But the decline is more pronounced for younger migrants. For example, the homeownership rate for 45-to-54-year-olds from multilingual or non-English-speaking backgrounds and/or those not proficient in English has declined by 5–7pp to about 60–71%, compared to the declines for the Australian-born population of 4pp to about 75%.

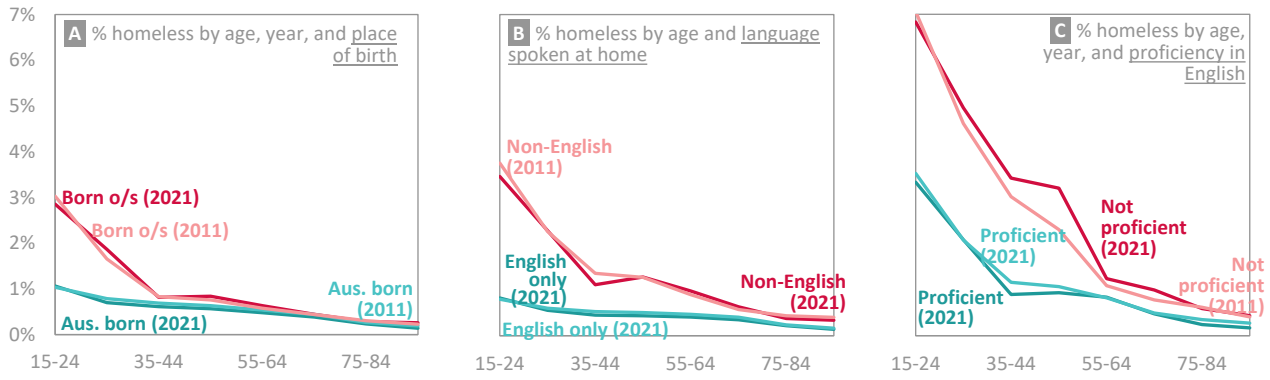
The trends reflect challenges related to affordability but are also the result of demographic patterns where people delay various life events, including home ownership (Chomik & Yan, 2019), and the influx of new temporary and permanent migrants who are less likely to buy in the short to medium term (see Box 5).

Many families from migrant and CALD communities continue to rent, either by choice or necessity, and many are likely to need to rent at older ages too. In a related research brief, Chomik and Yan (2019) documented both the changes in home ownership in Australia in recent decades and the broad poverty, financial stress, and homelessness impacts of reaching retirement without owning a home. The combination of rapid ageing in migrant communities and increasing difficulties in attaining homeownership may thus open up new vulnerabilities in the future.

20 Homeownership is lower for migrants, with greatest gap for those with poor English. It has declined for all groups.



21 Homelessness risk is greater in youth and for migrants. Risk is higher and increasing with language barriers.



Source: Authors' analysis of ABS Census. Note: English proficiency chart includes only those who speak a language other than English at home. Homelessness defined as living in improvised dwellings, sleeping out, in supported accommodation for the homeless, temporarily with other households, in boarding houses, other temporary lodgings, in severely crowded or other crowded dwellings, and those marginally housed in caravan parks. See Chomik & Yan 2019 on how census measure of ownership may overstate numbers.

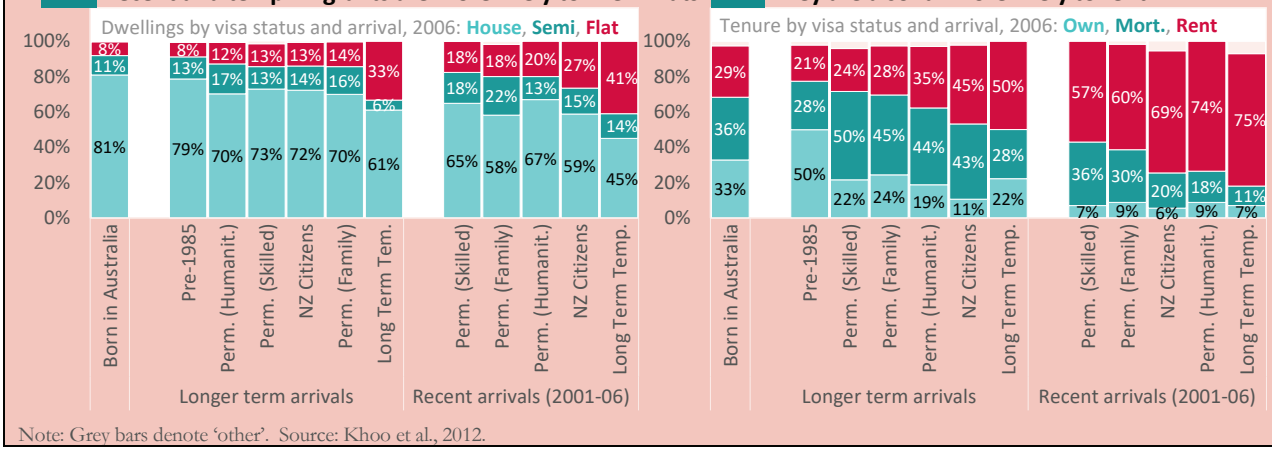
Box 5 CEPAR research spotlight What are the housing needs of migrants?

A common assumption in debates about housing is that migrants put upward pressure on house prices. But research from CEPAR's Peter McDonald and Jeromey Temple suggests that the effect has a lag (McDonald & Temple, 2013).

Their research on migrant housing needs found that migrants are more likely to live in larger, often multiple-family households, whereas temporary migrants are more likely to live in flats and be renters (which could overstate declines in home ownership at times of high migration; Khoo et al., 2012; Figs. 22A–B). Instead, it was permanent migrants with longer duration of residency who were more likely to be homeowners.

Among recent arrivals, those from New Zealand as well as skilled migrants, were more likely to pay higher rents than family and humanitarian permanent migrants. Yet, perhaps unsurprisingly, skilled migrants were less likely to report affordability stress. Migrants were also more likely to move to a new house (usually for work), creating greater churn in the housing market than might otherwise occur.

22A Recent and temp. migrants are more likely to live in flats **22B They are also far more likely to rent**



Note: Grey bars denote 'other'. Source: Khoo et al., 2012.

Housing challenges compounded for migrant and CALD communities

People from migrant and CALD backgrounds who come to Australia later in life may reach retirement without having bought a house, which leaves them at an increased risk of homelessness particularly in a market with increasing rents (Schetzer, 2017; Freilich et al., 2014). Such groups are most in need of advice, information, and advocacy (White, 2018). A good example of a targeted intervention comes from Victoria, where a project targeting older, recently arrived migrants from communities least likely to access services, has sought to improve the group's access to services and affordable housing options (HAAG, 2015).

Historical and contemporary disadvantages can compound to affect ageing CALD Australians' ability to own property, which in extreme cases can lead to homelessness (Flatau et al., 2005; White, 2018; Waters, 2018; Perkins & Boseley, 2018).

Box 6 CEPAR research spotlight New vulnerabilities in housing tenure, mental health, and social support

Although housing tenure and health outcomes are likely jointly determined by other vulnerabilities, such as low income, there may be a direct link too. For example, rental properties are less likely to allow necessary modifications (e.g. insulation, air conditioning, or grab-bars) and may thus constitute housing that is ill-fitted to the health needs of occupants. Another channel could be low levels of social support and greater psychological distress caused by lack of control of, and access to, space for social relations that come from insecure housing.

In a project led by Saman Khalatbari-Soltani, CEPAR researchers studied the association between different indicators of socioeconomic status and mortality, as well as investigating the potential mediating impact of psychosocial conditions. In Khalatbari-Soltani et al., (2021a), the authors report on the relationships between housing tenure, social support, and depressive symptoms in a culturally diverse community of older Australians. One result was that relative to owner-occupiers, those in rented housing were more likely to be unmarried, to live alone, to have limited family and non-family member support, to have lower social interactions and life satisfaction scores, and to have elevated depressive symptoms. They suggest that the role of housing tenure plays an important role on the psychosocial conditions of older people.

The research suggests that rapid population ageing of CALD communities, alongside declining ownership rates, may result in new vulnerabilities of increasing concern. Finding ways to increase social interactions and support for those with less secure housing may bring benefits.

Homelessness rates converge at older ages

Homelessness is one of the most extreme outcomes of disadvantage. Data on the topic is informed by the idea that homelessness is about the absence of a home rather than absence of a roof. A homeless person is defined as someone who (1) lives in an inadequate dwelling; (2) has no control of nor access to space for social relations; or (3) has short and not extendable or no tenure; and in addition, (4) has no financial, physical, psychological, and personal means necessary to provide access to alternatives. The latter condition ensures that the definition excludes people choosing to live in circumstances similar to someone who is homeless (e.g. couch-surfing while travelling). Definitions of home and homelessness may differ between cultural groups, but the indicator is a good predictor of other outcomes of health and wellbeing (Mallett, 2004) and deserves attention.

By 2021, about 8,000 Australians were 'sleeping rough' and, based on the broader definition, about 120,000 were homeless (Census, 2021). Figures 21A–C show that younger groups are most likely to be homeless, that rates are indeed higher for CALD groups (and men – not shown), but that rates decline and converge between groups in old age.

There is no quick fix to either homelessness or housing affordability. The *National Housing and Homelessness Agreement*, renewed in 2018, involves funding to states, including for homelessness and social housing services. But it comes against a historic decline in the relative supply of social housing – the safety net for the most vulnerable. Announcements of increased social and affordable housing should therefore be welcomed, as should increases to the rent assistance, which has not always kept pace with rent inflation. In the broadest sense, without better and more affordable housing supply, the politics of migration will continue to plague Australian policymakers.

3.5 Location

Segregation: Highest among older migrants with poor English

Where people live can affect their access to economic resources, social connections, public services, and political influence. Spatial segregation and over- or under-represented in poor areas, outer suburbs, or remote locations is therefore worth monitoring.

Ethnic concentration can relate to kinship preferences, socio-economic and community resources, the availability of housing and amenities, or historical patterns of settlement and dispossession (Crowder, 2000; McCrea, 2009; Atkinson et al., 2010; Dewilde & Lancee, 2013; Biddle, 2013).

Segregation can be measured in different ways (Meister & Niebuhr, 2021). Here we use the dissimilarity index at Statistical Area 3 (SA3) level. It represents the proportion of the population that would have to move to make group shares in each SA3 area reflect the group shares for the overall population. In this case, the analysis is within each age group (which also controls for differences in age structures between groups). A larger number indicates greater segregation in the group compared to the overall population of the same age.

Figure 23A suggests that for migrants in general, segregation is lower at later ages, a pattern that has changed little over time. This may reflect a slow, longer-term process of assimilation that is more advanced once people are in their later years. But the pattern differs for some CALD categories (Figs. 23B–C). Segregation is higher for older people speaking other languages, especially among older people with poor English (the index indicates that more than 60% would hypothetically 'need to move' to even out the distribution). Overall, the analysis suggests that linguistically diverse communities are more likely to co-locate at older ages.

Disadvantage: CALD communities more likely to live in poorer areas

One driver of segregation is likely to be economic: Poorer households may live in poorer, cheaper neighbourhoods by necessity. The literature suggests that Australian cities do not display the extreme socioeconomic polarisation of neighbourhoods seen in some other countries, and the relative employability of skilled migrants in Australia means that socioeconomic and ethnic segregation does not overlap as much as elsewhere (Sydes & Wickes, 2021).

Figure 24 confirms that being a migrant has little relationship with area socioeconomic status: A similar share of Australian-born and overseas-born residents live in the bottom quintile of disadvantaged areas (14–18%, depending on age). By contrast, those from multilingual non-English-speaking backgrounds are significantly more likely to live in disadvantaged areas, as are middle-aged migrants with language barriers (e.g. 37% at ages 50–54).

Distance to the city: Migrants live closer to the centre

Australians born overseas live close to the city centre of Australia's capital cities. Again, this is affected by large contingent of young international students. On average, migrants in their 20s live about 19km from the centre, compared to 24km for those born in Australia. The gap is narrower at older ages. Migrants in their 70s live on average 24km from the city, 3km closer than those born in Australia.

On average, Australians from multilingual or non-English-speaking backgrounds live even closer: about 21km for those in their 70s in 2021. Many live in the middle and outer bands 15–20km or 30–40km from the capital city centre, respectively. Those from English-speaking backgrounds appear more evenly distributed, with higher relative proportions in both the inner city, <5km, and the city-fringe, more than 50km away (see Daley et al., 2017 for a postcode-based analysis).

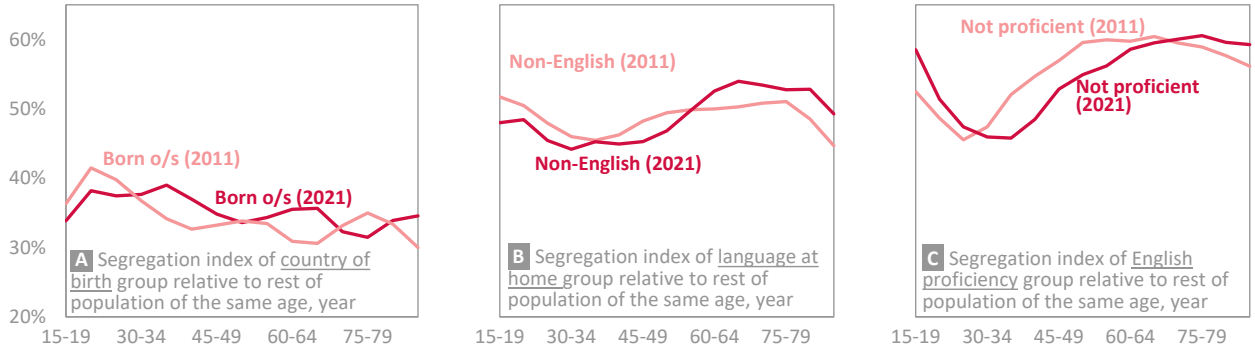
City vs country: Most migrant and CALD communities are urban

Finally, Figure 25 shows the extent that CALD communities live outside major cities, in regional and remote areas. Overall, older people born in Australian are the group most likely to live outside a major city: about 43% of 70-year-olds, compared to 27% of Australian-born 20-year-olds and 20% of 70-year-olds born overseas.

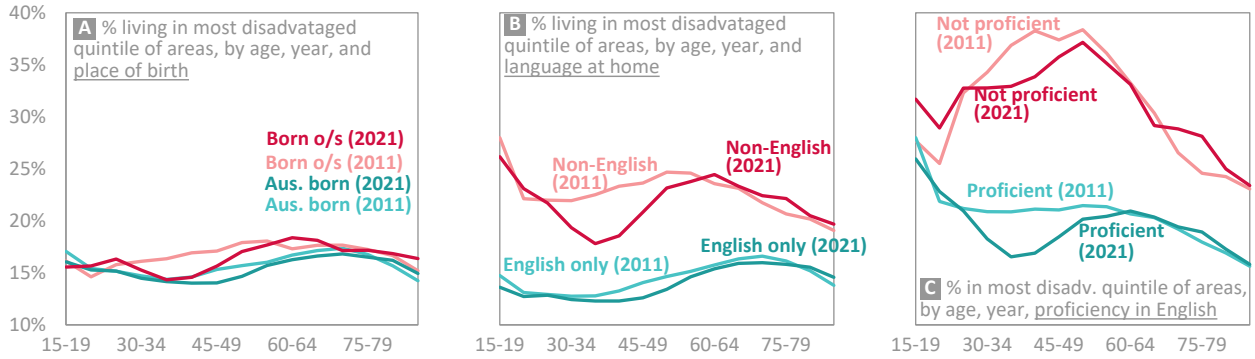
People from multilingual or non-English-speaking backgrounds have a low likelihood of living rurally (about 10%), regardless of age. English barriers in accessing services in old age may inhibit living in rural areas, with very few doing so (<5% past age 60).

GEOGRAPHY

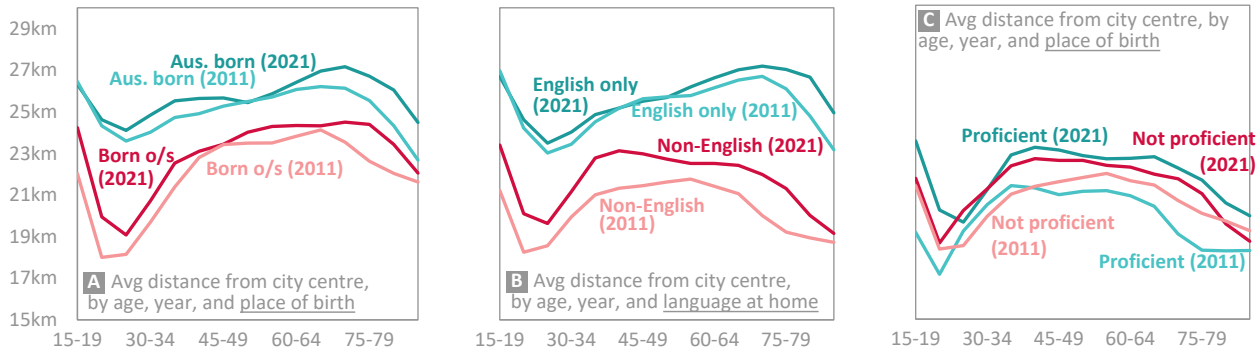
23 NEIGHBOURHOOD SEGREGATION: For those from non-English speaking backgrounds, segregation increases with age.



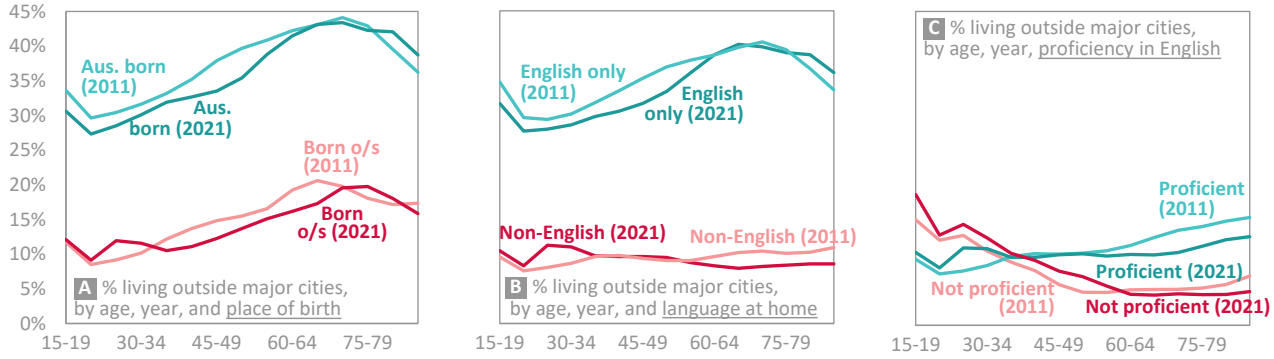
24 DISADVANTAGED AREAS: Those from non-English speaking backgrounds are most likely to live in the poorest areas.



25 WITHIN THE CITY: Migrants typically live closer to the CBD, especially the young and those from non-Eng. backgrounds.



26 BEYOND THE CITY: Older, Aus-born most likely to be living rurally. Few from non-English-speaking backgrounds do so.



Source: Authors' analysis of ABS Census. Note: Segregation index is the percentage of a group's population within a given age bracket that would have to move for each SA3 area to have the same percentage of that group as the total population for that age bracket. The comparison to the total population is unlike that for most other charts (i.e. where the comparator for people with multilingual/non-English-speaking backgrounds is other migrants from English-speaking backgrounds, and for those with poor English are those with multilingual/non-English-speaking backgrounds who speak English well). Disadvantage is based on bottom quintile of Statistical Area 3's Index of Relative Socioeconomic Disadvantage in 2016, corresponded to boundaries in 2011 and 2021. Poorer areas tend to be less populated so their population share can be below a quintile of the population. The English proficiency chart includes only those who speak a language other than English at home. City distances based on populations within greater capital regions only and centroids based on SA3 level, which is an approximation because population within each area may not be distributed equally. CBD=central business district. Living outside cities is based on Accessibility/Remoteness Index of Australia (ARIA) 2011 and ARIA 2016 applied to population distribution in 2021.

4. PSYCHOSOCIAL DIMENSION

One school of thought on human wellbeing is that although good economic outcomes may be enablers of a good life, life is pursued in the social domain (Sen, 1999; Stone & Hughes, 2002; Nussbaum, 2011). Indeed, the quality of social interactions can affect behaviour and mental and physical health (Laslett, 1989; Kalache & Gatti, 2002; Rowland, 2003; Warburton et al., 2007; Khoo, 2012).

Here we look at three indicators of social interaction – living alone, volunteering, and perceived age discrimination – acting as proxies for quality/quantity of social interactions at the household, local community, and broad societal levels. The section concludes by touching on an indicator of life satisfaction.

4.1 Social interactions at household level: Living alone

Marriage and cohabitation have long been associated with better health and wellbeing outcomes (Gopinath et al., 2013; Perelli-Harris et al., 2018). This may relate to partnership being protective of health and/or because healthier people are more likely to form family households (Waldron et al., 1996; Perelli-Harris et al., 2018). By contrast, living alone may be associated with greater health and care risks in later life. For example, older Australian women living alone required more hours of care and assistance with medication management and were more likely to be discharged into an acute hospital than those living with others (Joe et al., 2020).

Patterns showing lone person household rates are presented in Figures 27A–C. Unsurprisingly, the rate of living alone increases with age, yet people from migrant and CALD backgrounds are less likely to live alone at almost all ages, with the gap growing to 10-25pp by ages 85+.

The broad pattern is consistent with findings that, compared to the Australian-born population, migrants rely more on family for social interactions rather than friends (see Box 7). Reasons for declines in living alone may relate to socioeconomic constraints, differences in marriage and divorce, and cultural practices related to filial piety and multigenerational households (Himes et al., 1996; Liu & Easthope, 2017; Han et al., 2019).

4.2 Social interactions at community level: Volunteering

An indicator of social engagement beyond the household is presented in Figures 28A–C, which show the volunteering rates by group (including volunteering for sporting teams, youth groups, schools, and religious organisations; see Box 7 on other forms of civic engagement).

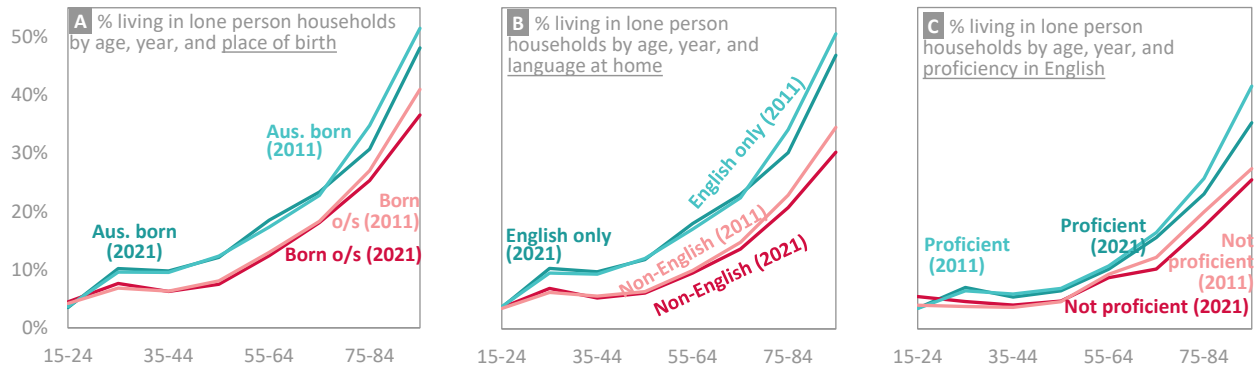
Volunteering is lowest at youngest and older ages and highest between ages 45 and 74. But rates across age groups are typically lower among migrant and CALD groups compared to non-migrant and non-CALD groups. A common explanation relates to access and English proficiency (AIHW, 2021; Fung & Macreadie, 2018).

The gaps appear greatest around ages 65–74. One reason for this is the apparent increase in volunteering among people from Australian-born and English-speaking backgrounds as they retire from the workforce. Around that age, migrant and CALD groups' participation rates were 5–14% in 2021, whereas comparator group rates were about twice that, peaking at about 11–22%.

The time trend suggests that volunteering declined between 2011 and 2021 across all ages and groups. However, declines relate to the COVID-19 pandemic, which reduced opportunities for such activities. Census data from 2006, 2011, and 2016 show that volunteering has in fact seen a slow upward trend over time (not shown).

LIVING ALONE

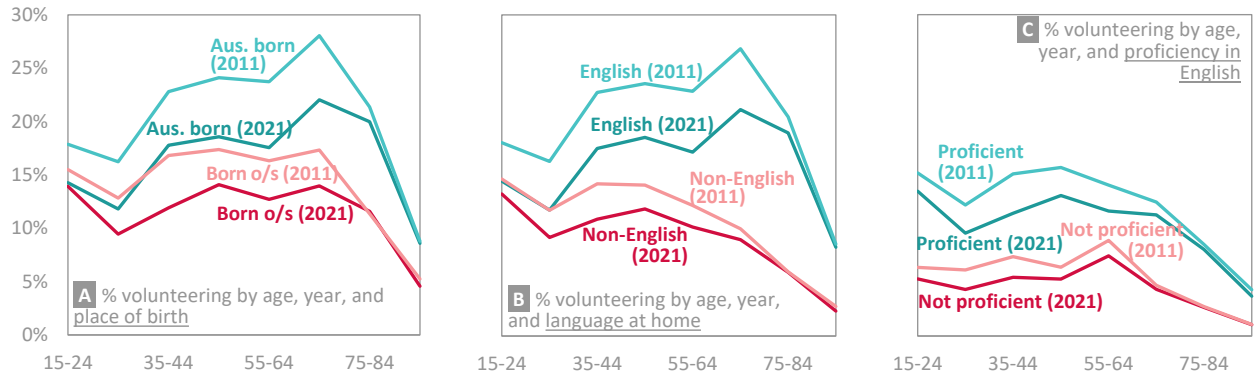
27 Migrants are less likely to live alone than those born in Australia. Differences between groups increase with age.



Source: Authors' analysis of ABS Census. Note: English proficiency chart includes only those who speak a language other than English at home.

VOLUNTEERING

28 Volunteering is lower among the oldest old, migrants, and especially among those with poor English.



Source: Authors' analysis of ABS Census. Note: English proficiency chart includes only those who speak a language other than English at home.

4.3 Social interactions at society level: Age discrimination

Prejudice and discrimination, whether in formal or informal settings, can have profound psychosocial and economic effects over the lifecycle and impact overall social cohesion. For example, older workers often experience discrimination in the workplace based on flawed stereotypes, which can affect employment outcomes (O'Loughlin, et al., 2017; Petery et al., 2020; Chomik & Khan, 2021). It can also lead to worse mental health outcomes (Ziersch et al., 2020). Discrimination may reinforce social exclusion by reducing trust and self-efficacy in familial and community contexts (Temple et al., 2020a).

Of interest here is the *intersection* between age and other forms of discrimination. Because people embody different characteristics and identities, discrimination can occur simultaneously across multiple dimensions including age, gender, race, ethnicity, faith, disability, and sexuality (Marcus & Fritzche, 2014; Holman & Walker, 2021; Ramirez et al., 2022; see Box 8). For example, women from CALD backgrounds experience more setbacks with regards to leadership roles than CALD men or non-CALD women (Hunt et al., 2018). Such intersectional challenges can compound and result in worse outcomes across social, economic, and health outcomes, as is apparent in this report (Bastos et al., 2017; AHRC 2018b). Potential pathways through which discrimination in turn affects health include its strong association with delaying healthcare access (Temple et al., 2020c; Temple et al., 2021a; Box 11), as well as deleterious mental health outcomes (Temple et al., 2019).

Ageism is experienced differently among different groups. Figure 29 shows the percentage of workers who reported experiencing age discrimination from employers by age and migrant/CALD status. In 2018, older people born in Australia and who speak English as a first language reported slightly higher rates of ageism at work compared to those born overseas and who speak English as a second language.

Box 7 **CEPAR research spotlight** **Social support and social interactions among migrants**

Social settings differ by age and background, but they may have real effects on mental and physical health. A team led by CEPAR's Robert Cumming, Fiona Stanaway, Fiona Blyth, and Saman Khalatbari-Soltani studied actual and perceived levels of social support by ethnicity and place of birth.

More family support, but less satisfaction

The team compared older men born in Australia with migrant men from Italy. The latter were much more likely to rely on family for support than on friends (Stanaway et al., 2010, 2011). Only about 4% of the Italian-born men had no local family but 34% had no local friends they could rely on, compared to 13% and 17%, respectively, for the Australian-born population. This makes some sense because the migrants had higher rates of marriage and lower rates of living alone.

Yet for Italian migrants, having family around did not translate to feeling more emotionally supported, even after controlling for other factors such as health. This could be because they had greater culturally based expectations of support (e.g. expectation of filial piety).

Lack of social support may be related to worse health

Social conditions may be an added stressor affecting health. Italian born older men had more self-reported depressive symptoms than their Australian-born counterparts. About 18% of Italian born men over the age of 70 displayed depressive symptoms compared to just 10% among the Australian-born. Lower satisfaction with social support was implicated as a contributing factor; the other important driver was needing to rely on the Age Pension for income (Stanaway et al., 2010).

The interaction of social support and socioeconomic condition are turning out to be very important for health. Although we know that poorer men have shorter lives, the team found that up to a third of such mortality differences could be explained by the fact that poorer men have weaker social relationships and greater rates of depression (Khalatbari-Soltani et al., 2020). That is, strong relationships may partly offset the health impacts of having a low income.

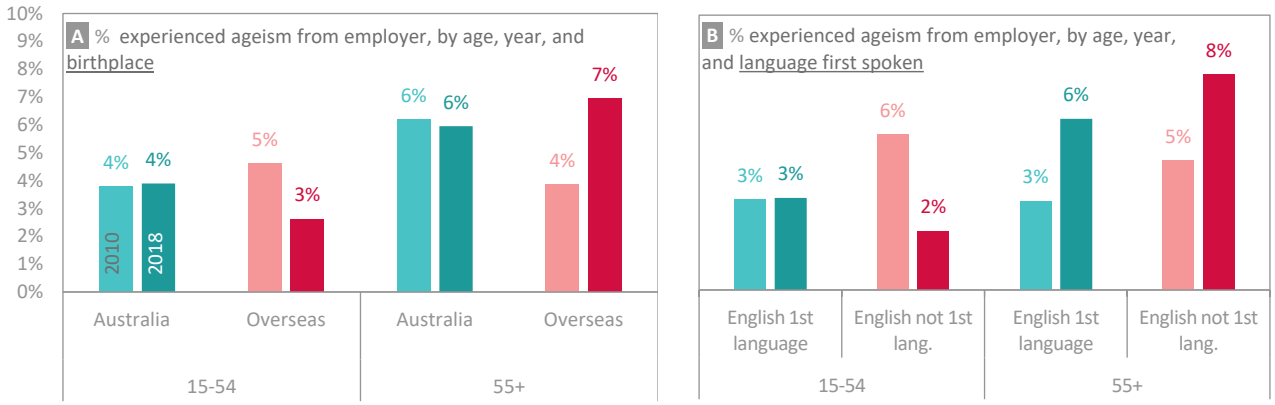
Less participation in civic activities, with language as a key driver

CEPAR's Jeromey Temple studied migrants' participation across a broad range of social and community activities in Australia. The research found that people who spoke English well were not only more likely to participate in sports and recreational groups, but also that they were more likely to be involved in trade unions, professional organisation activities, body corporates or tenant groups, and other neighbourhood groups (Khoo & Temple 2008).

Because participation in cultural activities is thought to be associated with improved health and wellbeing, Temple and co-author Lena Gan also looked at cultural engagement habits by studying museum visitation (Temple & Gan, 2020). Their findings suggest that those who were aged 80+, born in non-English-speaking countries, and self-reported poor or fair health were less likely to visit museums. They often stated that there was 'no need' or that they were 'not interested' in museums. One implication of the study is that there is potential for habit forming in early life to encourage engagement in cultural activities in later life. The authors also suggest promoting intergenerational programs that activate new audiences and visitors or reactivate those who have disengaged.

AGE DISCRIMINATION

29 Older migrants and those with non-English-speaking backgrounds experience more instances of workplace ageism.



Source: Authors' analysis of HILDA. Note: Experience of ageism based on answers to: Has your employer discriminated against you due to age?.

Interventions to reduce discrimination

Australia's first federal anti-discrimination law came into force in 1975, making discrimination in aspects of public life illegal. The law was extended over subsequent years also outlawing public acts of racial hatred and adding other protected characteristics. Despite such protections, some groups continue to face discrimination, prejudice, and unfair treatment, including at older ages.

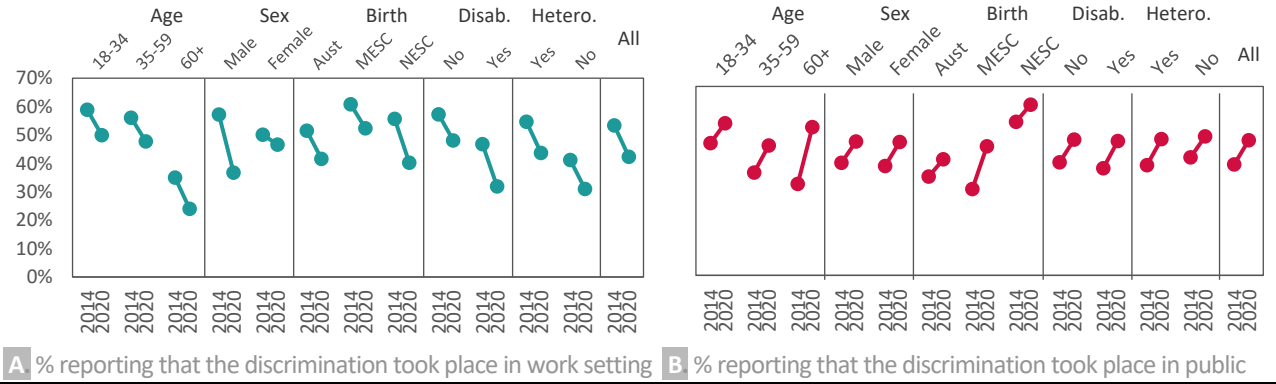
Most employers may take diversity seriously, but an impediment to measuring progress for CALD communities is poor data (AHRC, 2017). Collecting data on cultural and linguistic diversity is not a legal obligation for companies (unlike data on gender diversity which federal legislation compels companies to collect it). In some cases, diversity and inclusion strategies can help actively address such challenges (Soutphommasane et al., 2018). As far as age discrimination goes, reviews of the evidence found that education and intergenerational contact reduced ageist attitudes, and that age diversity workshops in workplaces were so far backed by better evidence (Burnes et al., 2019; Sinclair et al. 2024).

Less discrimination at work, more in public

Most interventions tackling discrimination have been in formal work settings. Such measures may have contributed to declines in the share of Australians, including recent migrants, who reported experiences of any discrimination between 2014 and 2020, from 19% to 13% and 24% to 18%, respectively (ABS, 2014, 2020). Discrimination also frequently occurs in public (e.g. when purchasing goods and services or on public transport) – and this is particularly the case for older Australians living with a disability (Temple et al., 2020b). Of those who experienced discrimination in the previous year, fewer people are saying that it occurred at work: a decline from 53% to 42% between 2014 and 2020. At the same time, the share occurring in public has increased from 41% to 50%. The trend is similar across personal characteristics (Fig. 30). Among those born in non-English-speaking countries who experienced discrimination, the share reporting that this occurred in public was the highest, increasing from 57% to 63%. The AHRC is currently driving a major effort to tackle race discrimination in all settings through a National Anti-Racism Framework (AHRC, 2022).

PLACE OF DISCRIMINATION

30 Those facing discrimination are increasingly more likely to experience it public rather than at work



Source: Temple et al., 2020 and custom table from ABS. Note: Results for both dates are based on General Social Survey. A factor affecting the results in 2020 (which represents the period of June to September) may be due to pandemic-related reasons.

Box 8 **CEPAR research spotlight** **Intersectionality in discrimination and the law**

To achieve systemic change, Australian law still largely depends on individual enforcement in a society where discrimination is complex and culturally embedded. CEPAR's Rafal Chomik, Alison Williams, and Marian Baird summarised the different protections against discrimination available to older workers (Chomik et al., 2019).

Legislation currently focuses on separate and distinct grounds of discrimination, yet people experience discrimination in multiple and overlapping domains, which compounds disadvantage when intersectional discrimination is experienced. CEPAR's Jeromey Temple, along with co-author, Alysia Blackham, conducted an empirical critique of the legal framework focusing on this issue (Blackham & Temple, 2020).

The Federal Discrimination Law in Australia is contained in five statutes, four of which are based on protected grounds of sex, race, age, and disability. The only concession for intersectional discrimination is in certain causation provisions. For example, the Age Discrimination Act 2004 notes that if discrimination relates to 'two or more reasons; and one of the reasons (whether or not it is the dominant or a substantial reason) is [age]', then it 'is taken to be done because of the age of the person'.

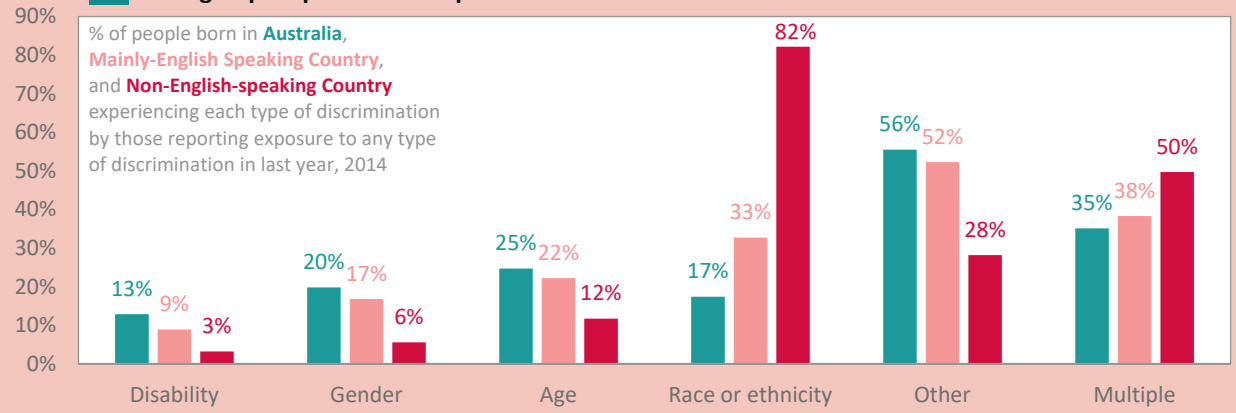
The authors suggest that this provision implies that claims of intersectional discrimination are not prohibited, although there is a lack of explicit recognition of the intersectionality and compounding of discrimination across protected characteristics. Unified anti-discrimination statutes, with all protected grounds covered by one piece of legislation, have been adopted in all Australian States and Territories. Explicit recognition of multiple discrimination is present only in the jurisdiction of the Australian Capital Territory.

To further examine the extent of intersectionality in discrimination, the authors analysed a 2014 survey that asked questions on discrimination. They found that an individual's demographic characteristics are highly associated with the grounds of discrimination. The groups reporting the highest rate of discrimination were middle-age female non-heterosexuals (50%), young carers (37–39%), young male non-heterosexuals (37%), and young and middle-aged people with disabilities. In contrast, reported discrimination was lower among older Australians.

But focusing only on single forms of discrimination underestimates not only the prevalence but also the range of discrimination experienced by people from diverse backgrounds. About 40% of those who experienced any discrimination, reported experiencing it in multiple forms; this rate is higher for people from non-English-speaking backgrounds. In addition to what they perceived as racial discrimination, half were also the target of other discrimination forms, including those related to age (12%) and gender (6%).

These results suggest that as Australia becomes older and more diverse, we will need legal frameworks to better accommodate and reflect intersectional experiences of discrimination.

31 **Some groups experience multiple forms of discrimination**



Source: Temple et al., 2020b. Note: Not adjusted for different age distribution of groups

4.4 Life satisfaction

Economic, social, and health aspects influence people's subjective wellbeing. This can also be coloured by beliefs (Ji et al., 2001; Lu & Gilmour, 2006; Joshanloo, 2013; Oishi et al., 2013; Suh & Choi, 2018), emotional patterns (Kitayama & Markus, 2000; Kitayama & Park, 2007; Ford et al., 2015), and focus on social standing across cultures (Bonn & Tafarodi, 2013; Pflug, 2009; Uchida & Kitayama, 2009). Conversely, there are common factors that transcend national and cultural differences, including relationship quality, employment, and purpose (Tay & Diener, 2011; Tegegne & Glanville, 2019; Jebb et al., 2020).

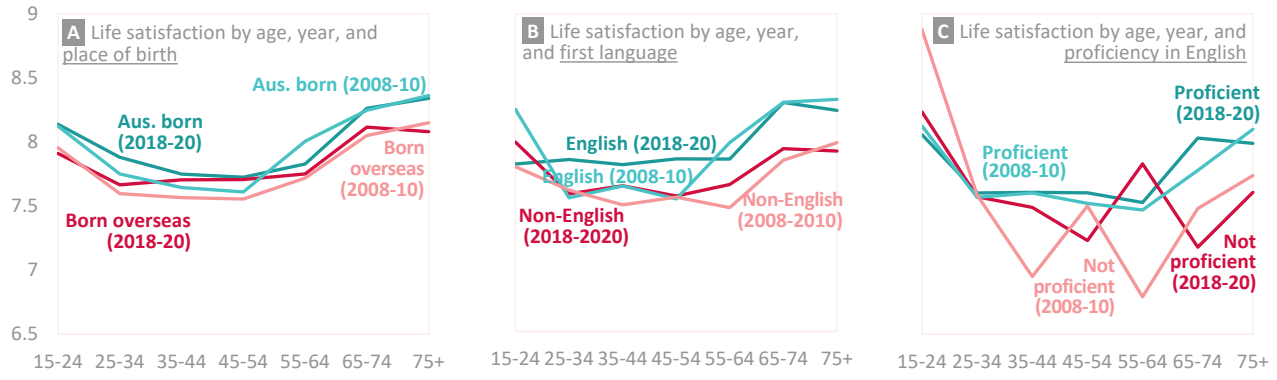
For migrants, disruption in social networks, coupled with linguistic and cultural barriers to integration can explain much of the gap in subjective wellbeing (Tegegne & Glanville, 2019). Indeed, poor English skills are a common source of stress and anxiety for migrants living in Australia (Maneze et al., 2016; Lee et al., 2022).

Figures 32A–C examine self-reported life satisfaction, showing that satisfaction is higher at younger ages, decreases in middle age, and increases in old age. This age pattern is well observed worldwide and relates to the greater levels of stress experienced in midlife (Rauch, 2018; Blanchflower & Graham, 2022).

Life satisfaction is slightly lower for migrants and those from non-English-speaking backgrounds compared to the Australian-born and English-speaking-background populations – and lower still for those with poor English.

LIFE SATISFACTION

32 Life satisfaction at older ages is lower among migrants, and such gaps are greater for non-English-speaking backgrounds



Source: Authors' analysis of HILDA data. Note: English proficiency chart includes only those for whom English was not the first language they learnt to speak. Life satisfaction based on answers to: How satisfied are you with your life?. Although the data have been grouped over three years, results for chart C should still be interpreted with caution given small sample sizes.

5. HEALTH

Health outcomes can depend on traits, behaviours, resources, and the physical and institutional environment in which we live. These factors can act cumulatively over the lifecycle (Deaton & Paxton, 1998) and result in similarities in health outcomes within groups that share certain characteristics (CSDH, 2008; Tran et al., 2012; Quinn et al., 2014; Bambra & Thomson, 2019). This includes various markers of cultural and linguistic diversity, which have been associated with common health outcomes and common patterns of health disparity of some groups (Renzaho et al., 2015a, 2015b). However, the supporting research on healthy ageing among migrant and CALD communities remains patchy, not least because the epidemiological literature is incomplete, struggles with consistent definitions, and its data collection methods under-sample or exclude ethnic minorities (Anstey et al., 2011; Correa-Velez et al., 2015; FECCA, 2016; Pham et al., 2021).

Healthy migrant effect

Evidence from Australia and elsewhere suggests that, at the time of arrival, migrants tend to be healthier than the local population (Kennedy et al., 2015; Jatrana et al., 2014; AIHW, 2018b). This is mostly down to self-selection (better-off, healthier people are more likely to be able to migrate) and selection by the host country (e.g. directly, via health screening, or indirectly, by selecting for higher skills, associated with better health; Burgess, 2023). It is known as the 'healthy migrant effect'.

This effect is weaker for refugees, however, who have worse health outcomes on average, especially with respect to mental health (Chiswick et al., 2008; Johnson et al., 2012; Lu & Ng, 2019; Ziersch et al., 2020). Initial interventions for this group include health assessments and linking arrivals with resettlement agencies that assist in navigating the health system (Au et al., 2019).

But the healthy migrant effect does not last

Migrants' health advantage disappears over time, and some migrant groups even end up falling behind the local population as they age. For example, after 20 years, Asian migrants to Australia lost their health advantage with respect to respiratory conditions and became more likely than the Australian-born population to report diabetes (Pasupuleti et al., 2016; Jatrana et al., 2014; Jatrana et al., 2018).

Worse health trajectories for migrants may relate to (1) acculturation (e.g. adopting a poorer diet), (2) difficulties with health care access (e.g. via a lack of language skills, health system knowledge, and trust), and (3) the emergence of multiple vulnerabilities, discrimination, and other social barriers (e.g. difficulties with employment, housing, and social connections; Gimeno 2016; Clarke & Isphording, 2017; Feliu et al., 2017; Alidu & Grunfeld, 2018; Markides & Rote, 2019; Salami et al., 2019; Stanaway et al., 2021; Hossin, 2020; Lee et al., 2022).

The dynamic nature of the phenomenon suggests that migrant and CALD communities can benefit from preventative health interventions. Emerging research highlights several measures for changing migrant health behaviour in culturally appropriate ways, including by appropriate instruction, demonstration, and examples to imitate (Jagroep et al., 2022; Renzaho et al., 2015a). Culturally appropriate strategies include those that are: (1) peripheral (e.g. packaging materials using certain colours, images, fonts); (2) evidential (e.g. stating what research has found about the specific group – for which research must first exist); (3) linguistic; (4) constituent-involving (e.g. where members of the target group are involved in designing and implementing the program; Brijnath et al., 2022); and (5) sociocultural (e.g. where health issues are discussed and adapted to respect social values; Kreuter et al., 2003; Lood et al., 2015; Chu & Leino, 2017).

Here we examine indicators related to health risk factors, chronic diseases, self-assessed health, and disability to gain a better understanding of health outcomes by age and migrant/CALD status, as well as whether these patterns change over time.

5.1 Health risk factors

Modifiable behaviours as proximate causes of health outcomes

Health risk factors are exposures that increase the likelihood of a person developing a health disorder (AIHW, 2017). Many are modifiable. More than a third of the disease burden imposed by chronic illnesses (see Section 5.2) may be eliminated by reducing or preventing smoking (which contributes to 9% of the population-wide disease burden), being overweight (8%), and drinking alcohol (5%) (AIHW, 2019).

Among migrants, the decline in health advantage with more time spent living in Australia is partly attributed to changes in lifestyle risk factors (Dassanayake et al., 2009; Jasso, 2004; ABS, 2013). For example, acculturation is associated with weight gain among adult migrants (Alidu & Grunfeld, 2018). It takes migrants from non-English-speaking backgrounds about 20 years to lose their BMI advantage over the Australian-born population, with proficiency in English mediating these results (Jatrana et al., 2018; Menigoz et al., 2018).

But socioeconomic factors are often the underlying causes of the causes

Some may blame disadvantaged communities for poor health behaviours. Yet health behaviours are not necessarily conscious choices. They are often driven by socioeconomic and environmental factors (Marmot, 2018; Addo et al., 2019). These include greater cognitive load due to stress, longer and more structured working hours leave less time for meal preparation, high cost of traditional foods, and easily accessible processed foods. Similarly, lower physical activity may result from a lack of time, expensive gym memberships, and changes in transport options. Perceived discrimination faced by migrants may also play a role (Bilal et al., 2020). But the exact pathways in which differences in ethnicity affect health outcomes are likely to be varied and not well understood (Katikireddi et al. 2021).

Health risk behaviours converge at older ages

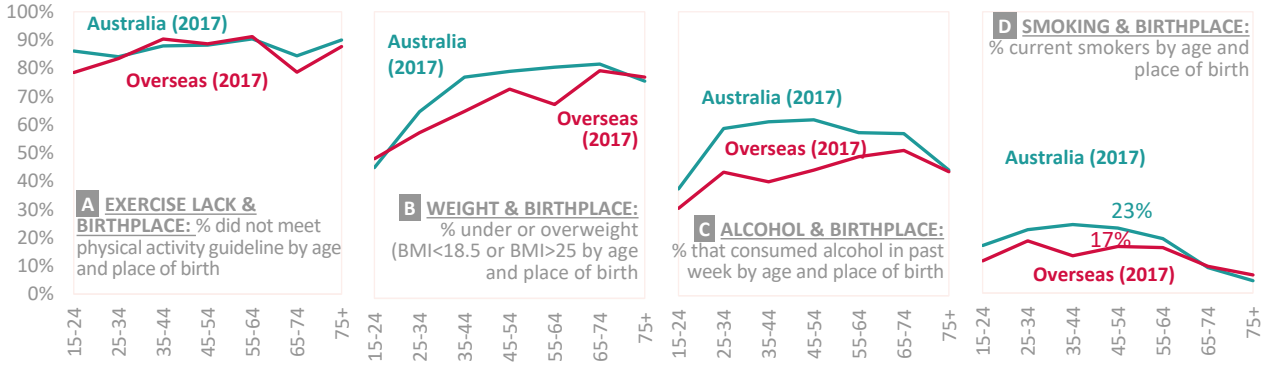
Figures 33–34 depict the prevalence of four risk factors related to exercise, weight, alcohol, and smoking, by group. Not meeting physical exercise guidelines is the most common factor. The shares of migrants who do not exercise enough (about 80-90%) is similar to the share of those born in Australia but is slightly higher among people from multilingual or non-English-speaking backgrounds (see also Joshi et al., 2017).

In general, migrants and those from multilingual or non-English-speaking backgrounds tend to have a healthier weight, are less likely to smoke, and drink less alcohol than the Australian-born or English-speaking-background populations. The health risk gaps are most advantageous in middle age but converge with comparator populations at older ages.

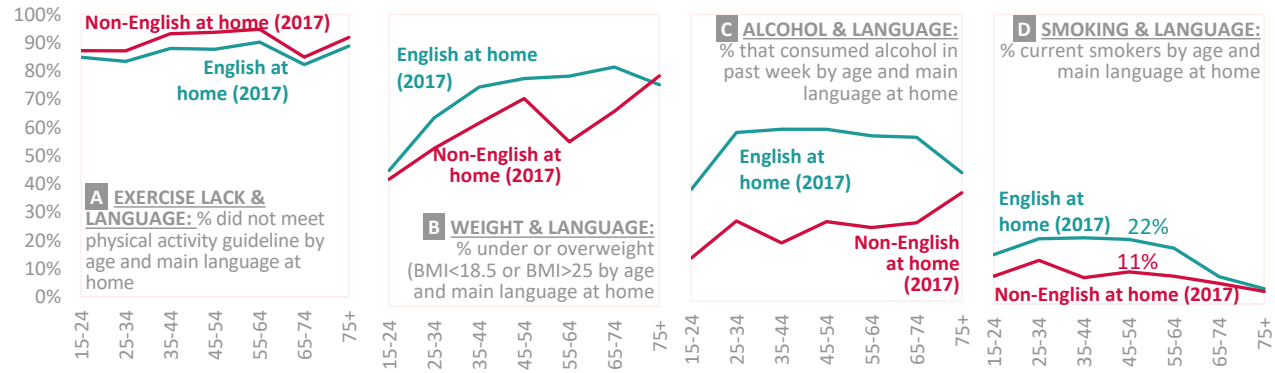
Diet (not shown here) has a considerable impact on health. For adults, two servings of fruit and five servings of vegetables daily are recommended for a healthy lifestyle, yet most adults in Australia do not eat enough of these (NHMRC, 2013). See Box 9 on diet related research within a culturally diverse population of older Australian men.

There is growing evidence on how to promote culturally appropriate behavioural change (Marmott et al., 2007; Vaughn et al., 2009; Bhupathiraju & Tucker, 2011; Rahati et al., 2014; Kuiper et al., 2015; Minagawa & Saito, 2015; Roh et al., 2015; Zhang et al., 2015; FECCA, 2016; Jagroep et al., 2022). For example, social comparisons and behavioural practices or rehearsals were effective in improving older migrants' health and wellbeing.

33 More Aus born are under or overweight, consume alcohol or smoke, but the percentages converge at older ages.



34 Those from non-English-speaking backgrounds are more likely to not meet physical activity guidelines.



Source: Authors' analysis of NHS data. Note: The physical activity guidelines recommend that people aged 18–64 years undertake either 150–300 minutes of moderate intensity physical activity, or 75–150 minutes of vigorous intensity physical activity (or an equivalent combination of both) per week. The guidelines also recommend that people aged 18–64 years include strength or toning on at least two days per week. For adults aged 65+ the guidelines recommend at least 30 minutes of physical activity on most, preferably all, days (interpreted as completing 30 minutes or more of physical activity five days per week and having completed any physical activity on seven days in this survey).

Falls: A major risk factor in old age

About 5% of falls among older people lead to fractures, but even falls without obvious injury can lead to loss of confidence and eventual institutionalisation (Chomik & MacLennan, 2014).

Fall prevention programs aimed at CALD communities have had limited sustained success (Haas et al., 2014). Although participants did report some improvements in joint flexibility, mobility, and balance, they often failed to continue recommended exercises or to recall what they had learned a year earlier. Recent migrants were also less familiar with *allied health services* like physiotherapists (Yang et al., 2008), which indicates a persistent need for education on risk factors and prevention strategies. For a start, such programs must be available in the appropriate languages (Yang et al., 2008).

Box 9 **CEPAR research spotlight** **Nutritional guidelines may need further refinement**

CEPAR researchers led by Robert Cumming and Fiona Blyth examined nutrition and health in an ethnically diverse population of older Australian men, including a large share from southern Europe (for a summary, see Chomik et al., 2021). The data showed that although the majority of older men were getting enough protein, iron, zinc, and vitamin B2, as many as 99% and 80% were consuming inadequate amounts of vitamin D and calcium, respectively (Waern et al., 2015). This is perhaps unsurprising since most older men in the sample didn't consume enough dairy (or alternatives). The majority also did not eat enough fruit and vegetables and 99% consumed less than the recommended 2.6 litres of fluid per day. All the while, most consumed more than the recommended amount of unsaturated fat and sugar (Ribeiro et al., 2017).

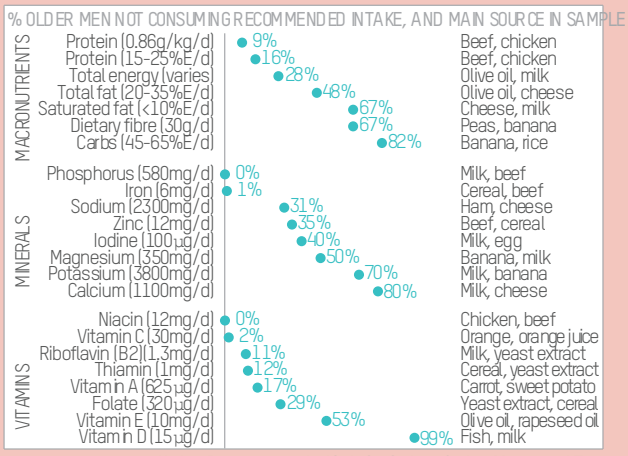
Those straying further from dietary guidelines were more likely to have lower education, income, and physical activity. They were also more likely to be smokers, have higher waist-hip ratios, and experience frailty symptoms.

Interestingly, despite having worse guideline compliance, men with Mediterranean backgrounds did not have worse health outcomes, which indicates that Mediterranean diets may be healthier than existing national guidelines and that such guidelines may need further refinement (Das et al., 2021a). The divergence between Mediterranean and guideline diets may also explain why ethnic background is related to apparent 'declines' in diet quality over time (Fig. 35B, left panel). Of interest to aged care home support providers is the fact that worsening diets are also associated with receiving meal services (although causality is not clear).

This was followed up by a study led by CEPAR's Fiona Stanway, who found that the Pyramid-based Mediterranean Diet Score (pyrMDS) was a better estimator of diet quality in older Italian and Greek men compared to the Australian Dietary Guideline Index (DGI-2013) (Stanaway et al., 2021). The pyrMDS score was significantly higher among Italian and Greek men compared to those born in Australia. It was also a better predictor of incident cardiovascular disease and all-cause mortality.

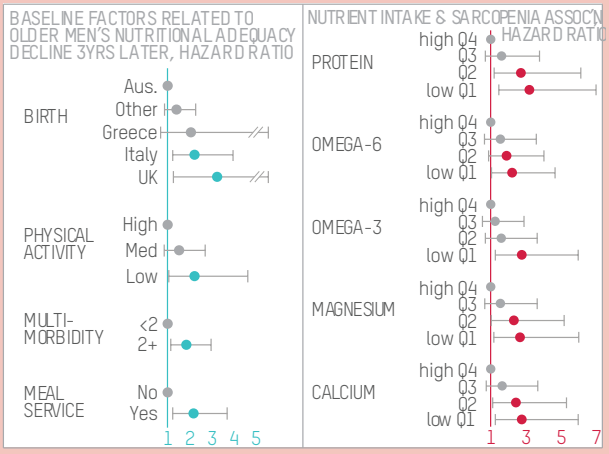
The researchers also looked at diet and declining muscle mass (Das et al., 2021a). They found that poor diets, as scored against each of these benchmarks, were related to a greater likelihood of age-related loss of strength and muscle mass (sarcopenia). For example, men in the bottom quartile of intake of protein, magnesium, calcium, and omega-6 and omega-3 were two to three times more likely to have sarcopenia (Fig. 35B, right panel). Notably, the association applied to only one of three different definitions of the disease, which attests to ongoing debates about its precise diagnosis.

35A Nutritional lack: Not enough calcium and vitamin D



Note: Recommended intake in brackets. Men aged 75+
Source: Waern et al. 2015

35B Nutritional decline and the likely effects



Note: Men aged 75+ at baseline. Both panels show multivariate-adjusted results. Sarcopenia as per Foundation for National Institutes of Health definition. No association based on EWG definitions. Source: Das et al., 2021a, 2021b

Box 10 **CEPAR research spotlight** **Burden of cancer attributable to smoking**

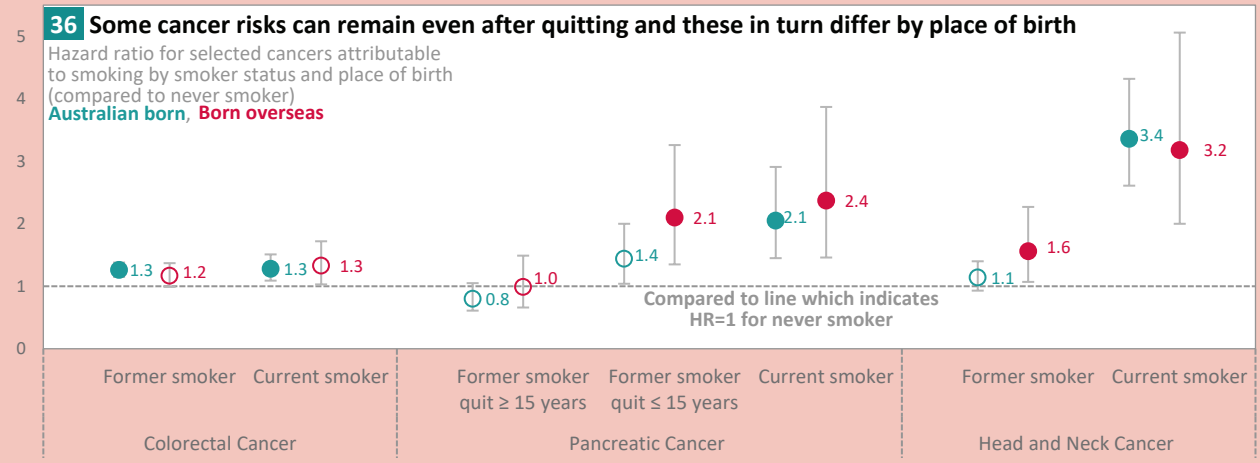
Data on smoking by outcomes by birth or background are scarce. But research from CEPAR's Robert Cumming, Vasant Hirani, and Julie Byles, along with other co-authors has been a valuable resource to study differences among population subgroups of older men (as part of the Concord Health and Ageing in Men Project).

The work has contributed to various insights, where the data is pooled with other sources. Sometimes the samples for migrant groups are still too low to show significant differences between Australian and overseas born populations. For example, this is the case for colorectal (Vajdic et al., 2018) and pancreatic cancers (Arriaga et al., 2019; see Figure 36).

Still, both Australian and overseas born populations who smoke, or who have only recently quit, see significantly higher hazard ratios of pancreatic cancer than those who have never smoked. For those who have quit within the last 15 years, migrants have more than twice the pancreatic cancer rate of never-smokers, whereas recent quitters Australian-born recent quitters have a rate only about 40% higher than that of never-smokers.

Similarly, differences in head and neck cancer rates by place of birth are subtle. The hazard ratio confidence intervals for such cancers overlap for Australian-born and overseas born ex-smokers. The former see no statistical difference compared to never-smokers, whereas the latter see ratios that are 50% higher than never-smokers (Fig. 36; Laaksonen et al., 2021).

Finally, even though there are only small differences in hazard rates for various cancers between Australian-born and overseas born smokers, once incidence is taken into account, the fraction of lung cancer attributable to having ever smoked is higher among older Australian-born men than for those born overseas (Laaksonen et al., 2018).



Source: Laaksonen et al., (2018; 2021) and Vajdic et al., (2018)

Another study by CEPAR Associate Investigator Fiona Stanaway and co-authors on Italian born men in Australia found a paradox between risk factors and health outcomes (Stanaway et al., 2020). Although migrants from Italy were more likely to smoke and be overweight as well as have lower socio-economic status, higher morbidity from diabetes, chronic pain, dementia, and depressive symptoms, they appeared to have similar rates of age-adjusted mortality. Indeed, after controlling for their lower socioeconomic status, as well as lifestyle and morbidity differences, Italian-born men in Australia had a 25% lower mortality rate than those born in Australia.

5.2 Chronic illness

Population ageing means a shift in the disease burden towards chronic illnesses. But a more diverse population may also see changes in disease patterns (Quinn et al., 2014).

Figures 37A–C show prevalence rates of key chronic illnesses by migrant/CALD status. In line with the healthy migrant effect, the prevalence of many such conditions is lower among Australians born overseas. Indeed, the data suggests that Australians born overseas are less likely to suffer from arthritis, cancer, mental health conditions, lung conditions and asthma with a larger gap for those from multilingual/non-English-speaking backgrounds. While cross-sectional, the findings are consistent with those of other analyses (AIHW, 2022b, 2023).

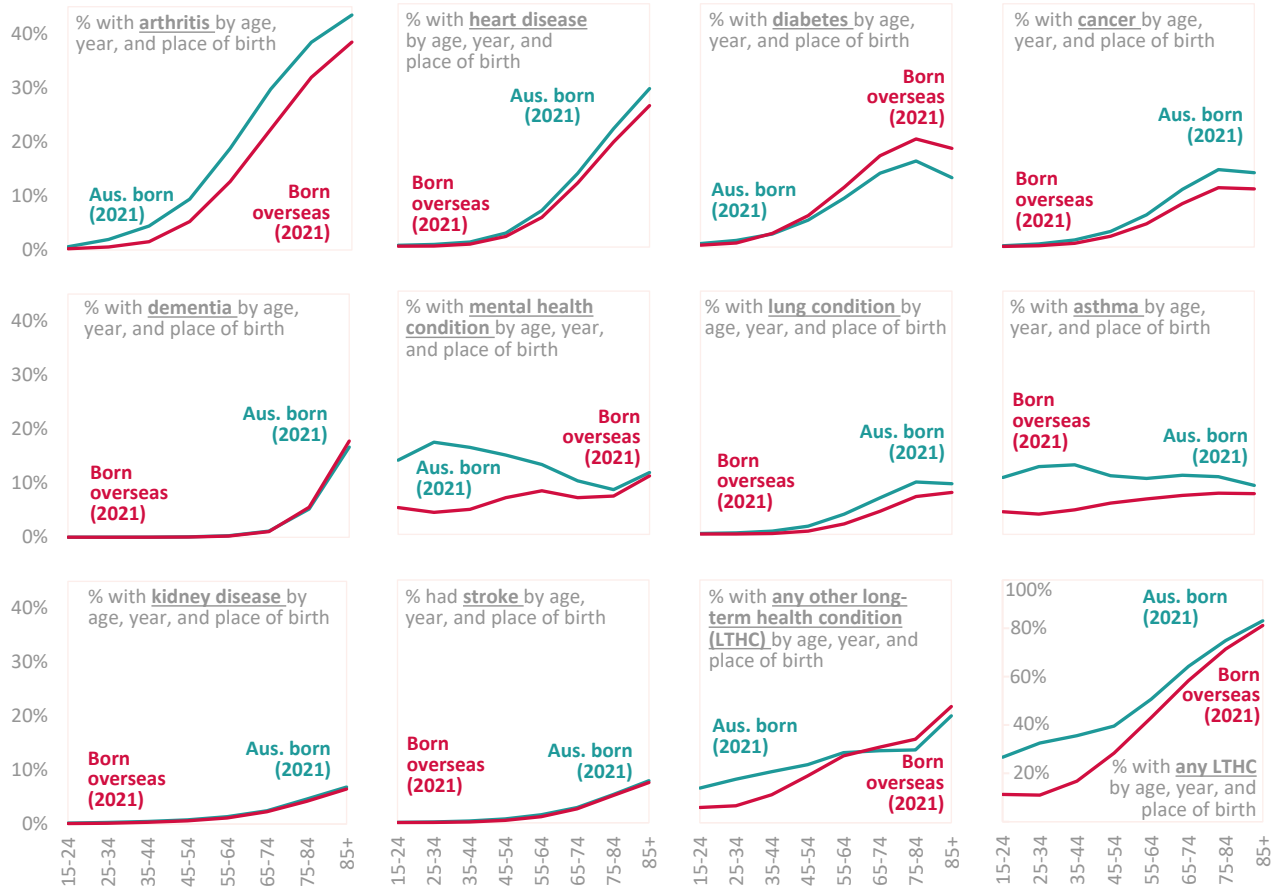
But not all are in the same situation. Those who speak other languages at home or who have poor English proficiency are at greater risk of diabetes and dementia in old age and mental health conditions at younger ages.

The overall rates of chronic illness are telling (bottom right panel). In 2021, at ages 55–64, 51% of the Australian-born population had some chronic condition, compared to 43% of those born overseas and 41% of those from multilingual/non-English-speaking backgrounds. Then, along with the dissipating healthy migrant effect, disease prevalence converges at older ages for many conditions (though migrants retain lower rates of cancers). For some conditions (e.g. diabetes), Australians born overseas end up seeing worse outcomes relative to the comparator population.

Although mental health rates appear lower among people from CALD backgrounds, they may be more reluctant and less likely to seek help (Brijnath & Antoniades, 2016). Research on mental health often fails to capture these differences (Minas et al., 2013; Carta et al., 2005). Various measures have been proposed with some progress (Minas et al., 2013; DoH, 2020a) and mounting research is looking at the links between cultural background, language barriers, and migration experiences and mental health (Watkins et al., 2012; Bojic et al., 2015; FECCA, 2016; Silove, 2017; National Mental Health Commission, 2017; Shawyer et al., 2017).

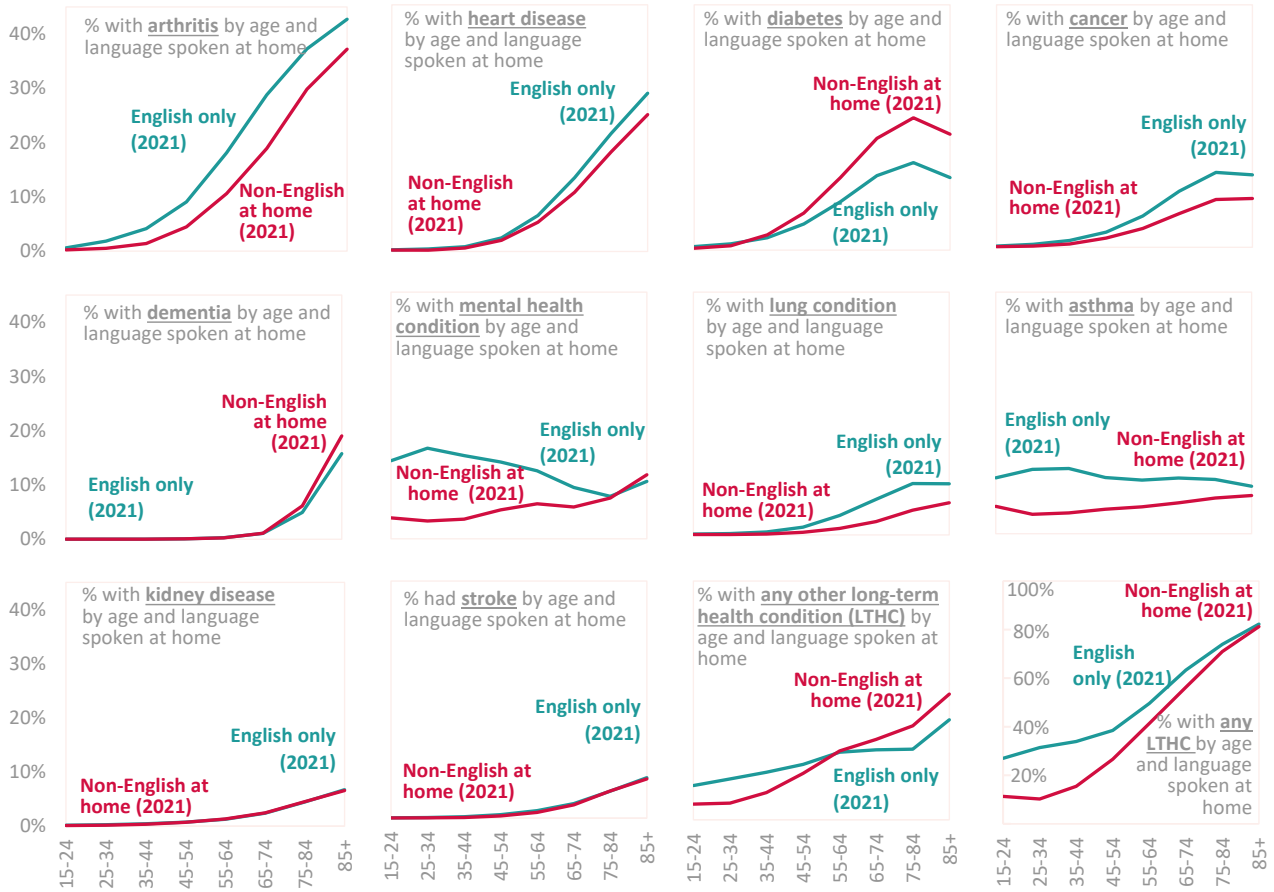
CHRONIC ILLNESS BY PLACE OF BIRTH

37A Older Aus-born people are more likely to have long-term health conditions, including arthritis, cancer, and asthma.



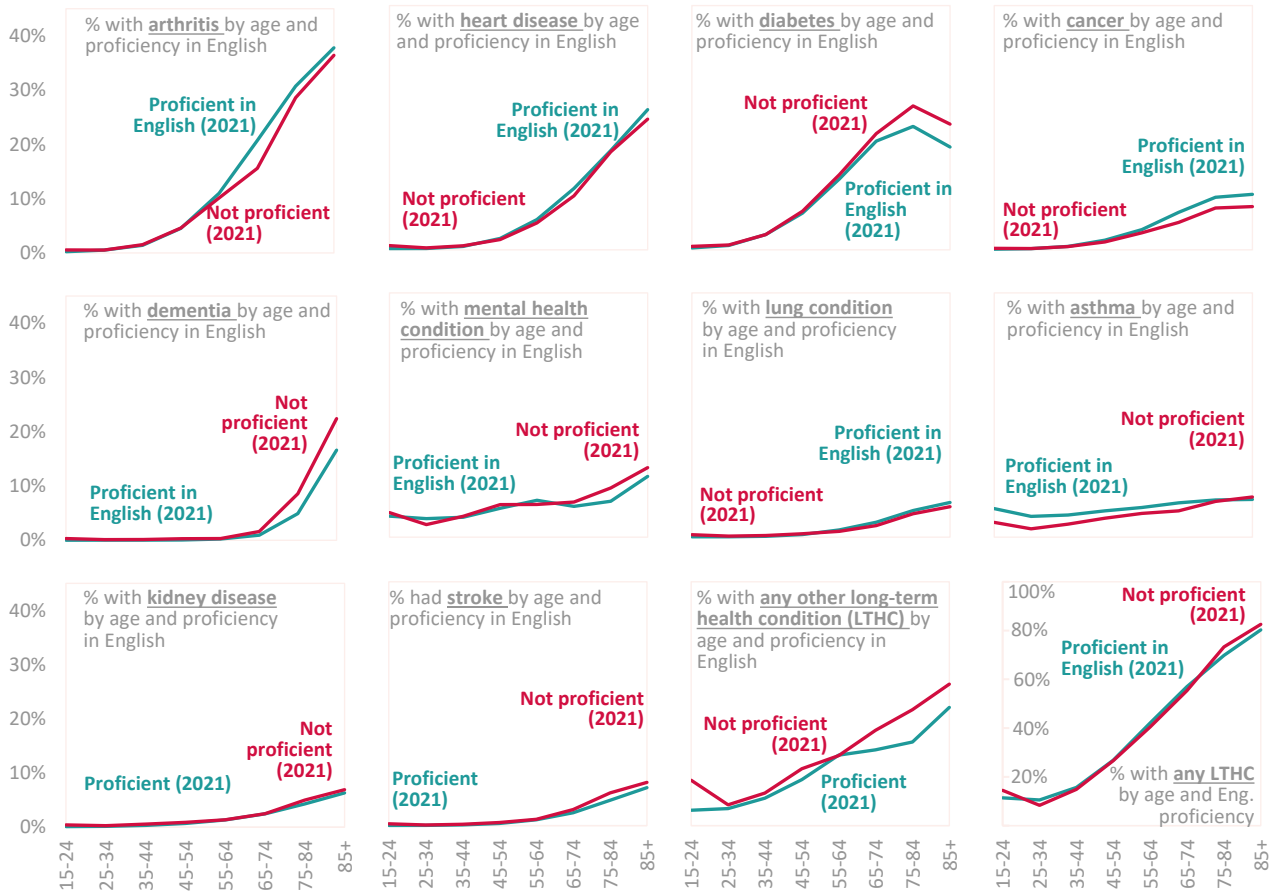
CHRONIC ILLNESS BY LANGUAGE BACKGROUND

37B Those from non-English-speaking backgrounds have more diabetes, dementia, and other long-term health conditions.



CHRONIC ILLNESS BY ENGLISH PROFICIENCY

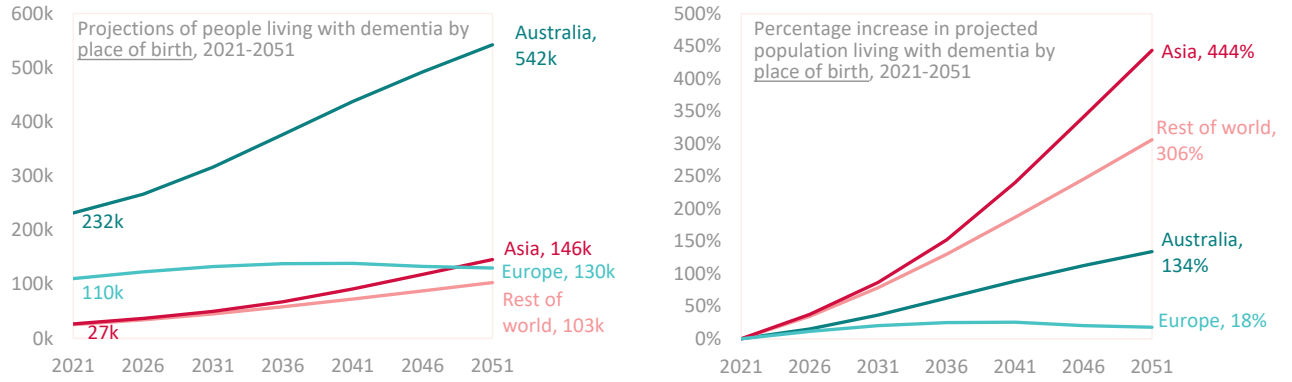
37C Poor English proficiency is associated with greater prevalence of mental health conditions, dementia, and diabetes.



Source: Authors' analysis of ABS Census data. Note: English proficiency chart includes only those who speak a language other than English at home.

DEMENTIA PROJECTIONS

38 Migration and ageing will likely see large increases in numbers of people with dementia from diverse backgrounds.



Source: Authors' analysis of CEPAR Population Ageing Futures Data Archive

New projections are shedding light on the demographically driven future of age-related diseases in Australia (Fig. 38; Temple et al., 2022b). For example, population ageing, combined with historic and expected migration patterns, suggests that between 2021 and 2051, the largest absolute increase in the population with dementia will consist of people born in Australia (over 300,000). But the largest relative increase will consist of people born in Asia. By 2051, Asian-born Australians with dementia are expected to increase by over 400% (or more than five times as many as now). High growth in the number of people living with dementia poses implications for culturally appropriate care, health care access, and support for migrant CALD communities.

Box 11 CEPAR research spotlight Mild cognitive impairment & disability as early indicators of care need

Many people want to avoid or delay moving into a care home. But what are some of the risk factors associated with institutionalisation? CEPAR's Robert Cumming, Fiona Blyth, and Fiona Stanaway examined the precursors of institutionalisation among a sample of older men from a culturally diverse community (Gnjidic et al., 2012).

They found that the main risk factors for moving into a care home were mild cognitive impairment and disability. But they also found a strong association between the risk of institutionalisation and country of birth. Those from non-English-speaking backgrounds were approximately 70% less likely to be institutionalised during the study period compared to their Australian-born counterparts. It's unclear whether these lower rates of institutionalisation are a result of cultural preferences (e.g. whereby older people from non-English-speaking backgrounds prefer to be cared for by family members) or whether it is the result of a lack of culturally and linguistically appropriate residential aged care services.

What about hospitalisations and other healthcare use? CEPAR's Julie Byles, along with co-authors, examined planned and unplanned hospitalisation incidents among Australian women aged 75 and above (Shebeshi et al., 2020a. 2020b). While various factors were associated with more or fewer incidents of planned and unplanned hospitalisation, planned healthcare use was lower among older women whose first language was not English.

Using the Taiwan Longitudinal Study on Ageing, CEPAR Partner Investigator Professor Carol Jagger, with co-authors, examined the relationship between total and disability free life expectancy and different dimensions of religiosity (Zimmer et al., 2019). She found that engaging in public and private religious practices is associated with living longer and more disability-free years, but also that there were no differences across levels of religiosity.

5.3 Disability

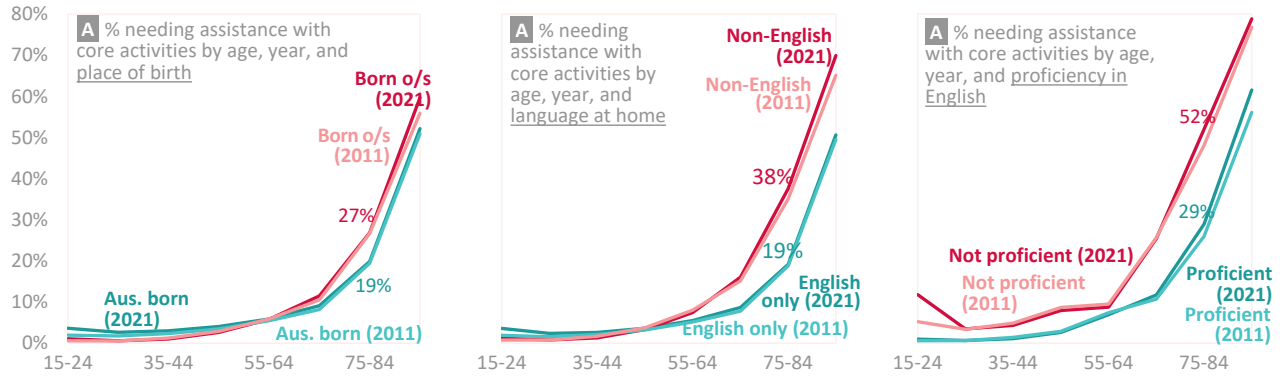
Chronic health conditions can often lead to functional disability, which affects a person's quality of life, their experience of ageing (Megari 2013), and exposure to discrimination and exclusion in later life (Temple et al., 2020b). Disability is commonly defined as a limitation, restriction, or impairment related to performing everyday activities that has lasted, or is expected to last, for more than six months (WHO 2001).

Figures 39A–C show the percentage of population who need assistance with daily activities – a definition consistent with a *severe* or *profound* level of disability (ABS 2021b). Overall, the older you are the greater the risk of disability. But

after middle age, disability risk is greater for people from migrant/CALD communities. At ages 75–84, about 19% of people born in Australia report this level of disability. By contrast, the rate is 27% for migrants, 38% for those from non-English-speaking backgrounds, and 52% for those with poor English. Despite these needs, evidence suggests that CALD communities experience cultural barriers in healthcare and are less likely to access the relevant services (Box 11). The charts suggest that there has been limited change to disability profiles over time and even some increases in disability risk among Australians from non-English-speaking backgrounds. An important implication is that disabling effects of health risk factors and chronic diseases (sections 5.1 and 5.2) are greater for people from migrant and CALD backgrounds than for those from Australian-born and non-CALD backgrounds.

DISABILITY

39 Older migrants have higher rates of severe/profound disability. Rates are especially high for those with poor English



Source: Authors' analysis of ABS Census. Note: English proficiency chart includes only those who speak a language other than English at home

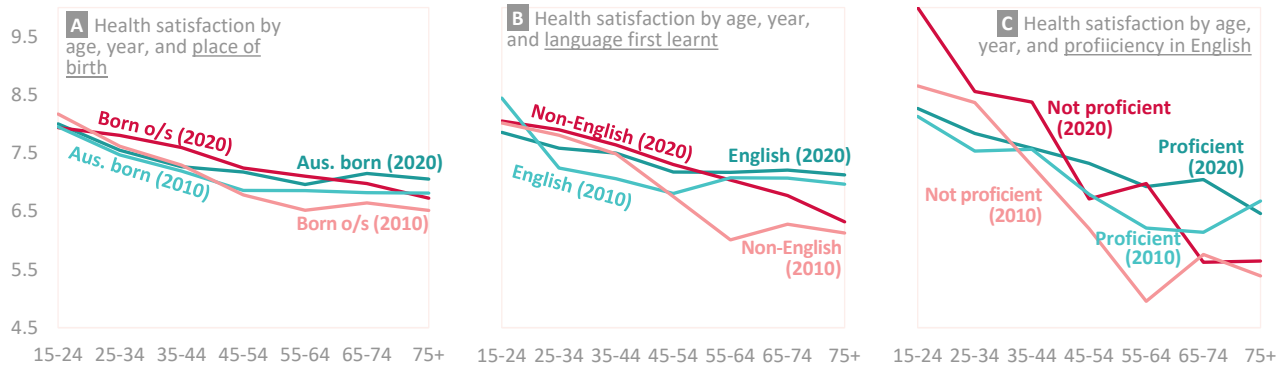
5.4 Self-reported health

Quite aside from clinical measures of health, what people think of their health matters as well. Such measures can differ based on cultural background. For example, in 2017–18, the age-adjusted proportion of Australians who said their health was 'excellent' or 'very good' ranged from 49% for those born in North Africa and the Middle East to 56% for those born in Australia, and 67% for those born in Sub-Saharan Africa (AIHW, 2022a; based on the National Health Survey). Some differences may correlate with clinical measures but can also be affected by cultural differences in reporting and perceived ideas of health (Zola, 1966; Jürges, 2007; Mackenbach, 2014).

Figures 40A–C present self-reported satisfaction with own health by migrant and CALD status, using HILDA data. Unsurprisingly, health satisfaction decreases with age, but declines appear to differ by group. For example, health satisfaction in old age tends to be lower for those from non-English-speaking backgrounds, and appears to have a more rapid decline among those not proficient in English.

SATISFACTION WITH HEALTH

40 Satisfaction with health decreases with age. The decline appears greater among those with poor English



Source: Authors' analysis of HILDA data. Note: English proficiency chart includes only those for whom English was not the first language they learnt to speak. Life satisfaction based on answers to: "How satisfied are you with your health?". Results for chart C should be interpreted with caution given small sample sizes.

The patterns are consistent with the literature that suggests greater English proficiency improves self-reported mental health and overall life satisfaction (Lee et al., 2022). These improvements are significantly greater among highly educated, as well as older immigrants who have been in Australia for a long time.

For those not proficient in English, the gap is largest in mid-life, with health satisfaction converging slightly at older ages. These could represent differences between cohorts or an age-selection effect, whereby lower average life expectancies of disadvantaged groups may mean that people within these groups who survive did so because they have better health.

6. CARE

As the Australian population ages and becomes more diverse, care settings and services must adapt. Now is the time to understand and address the nature of evolving culturally appropriate care needs and wants against the existing provision and barriers to access.

6.1 Aged care

Cultural barriers to and preferences for aged care services

The Aged Care Act identifies nine categories of people who require special considerations. These include Aboriginal and Torres Strait Islander people, people from CALD backgrounds, and people living in rural or remote areas. But as reported in a Royal Commission on aged care, people from diverse backgrounds continue to experience challenges despite legislative requirements (Pagone & Briggs, 2021). This may derive from a lack of knowledge about services, limited information in one's native language, low confidence in the system, lack of belonging and/or culturally inappropriate or alienating services (e.g. dietary, religious observances, end of life care; Georgeou et al., 2023).

As a start, assessments to determine need for care may not always be culturally safe. And once care is approved, although specialist services exist, waiting lists tend to be longer (Burgess & Ozdemir, 2022). Once in care, staff may be poorly trained and practices not culturally appropriate (Pagone & Briggs, 2021; Kaspiew et al., 2016).

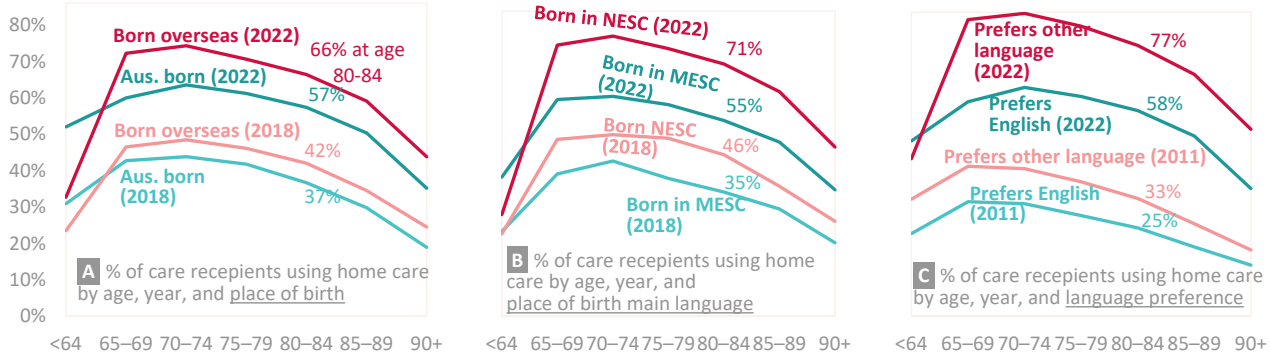
Such challenges are exacerbated by language reversion, particularly with residents who suffer from dementia (Tipping & Whiteside, 2015). For instance, among the aged care residents who spoke a language other than English, 16% were the only person in their facility to speak their language (FECCA, 2016). Older CALD Australians, particularly those living in rural areas, may experience further isolation due to limited mobility and distance to health and care services.

These challenges translate to differential care use: More home care

The result is that home care is more popular among people from migrant and CALD backgrounds, while residential care is strongly resisted (Khadka et al., 2019; Rees & McCallum, 2018)). Figures 41A–C show the share of home care use by those receiving any of home, residential, or transition aged care services.

USE AND ACCESS TO HOME CARE V RESIDENTIAL CARE

41 Home care use is highest among migrants and speakers of other languages. It is increasing in importance for all.



Source: Authors' analysis of GEN data. MESC=Mainly English-Speaking Country. NESC=Non English-Speaking Country. Note: Shares of those using either home or residential. Does not include Home Support services.

Overall, home care – as opposed to residential and transition care – is accessed more at younger ages (65–79), and its importance as a mode of care is increasing over time. For most age groups, more than half of those receiving care received it at home in 2022 – the opposite was true just four years earlier. Typically, relative reliance on residential care increases with age, as level and complexity of care increases.

The data also underscores the apparent strong preference for home care among migrant and CALD groups, which may in turn reflect a lack of appropriate care in residential settings. In 2022, at ages 80–84, 57% of Australian-born care users received care at home, compared to 66% of migrants. The rate was even higher (77% at the same age) among those who preferred communicating in another language. Thus, high shares of migrants and greater cultural diversity in Australia can be expected to accelerate the demand for home care.

6.2 Informal care

Family may often need to pick up the slack

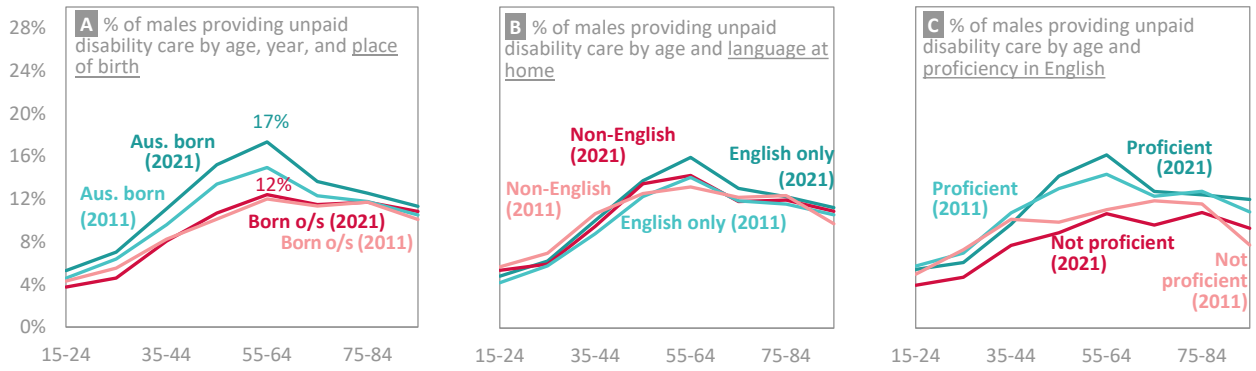
Existing care options and preferences can lead to reliance on family or members of the kinship group to coordinate formal and provide informal care, while also bearing the associated stress and potential loss of income (Vecchio, 2008; FECCA, 2015; PC, 2017; Funk et al., 2019; Dalmer, 2020; Kiraly et al., 2020; Gilbert et al., 2020), while oftentimes reporting considerable unmet support needs (Temple and Dow 2018).

Figures 42–43 present the share of Australian men and women providing unpaid disability care. Unsurprisingly, women are more likely to be informal carers. In 2021, between about 5–15% of males provided unpaid disability care, compared to about 25% of females, with caring responsibility peaking around age 55–64 years.

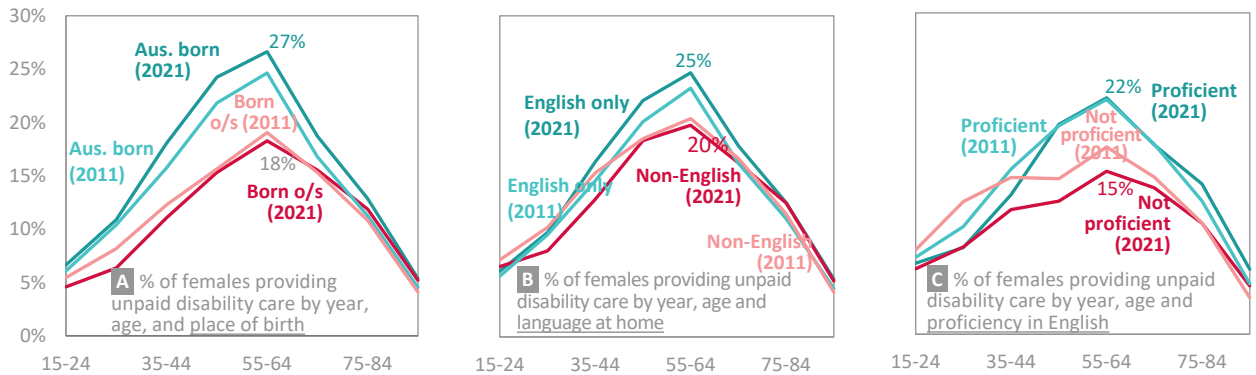
But perhaps unintuitively, members of migrant communities are less likely to report disability caring responsibilities compared to those born in Australia, especially at younger ages. The likely reason may be that many migrants are first generation Australians (the pattern is also confirmed by HILDA data).

UNPAID CARING

42 Generally, migrants, particularly those with poor English, are less likely to provide unpaid disability care.



43 Women provide more unpaid care than men but differences by migrant/CALD status disappear in old age.



Source: Authors' analysis of ABS Census. Note: English proficiency chart includes only those who speak a language other than English at home.

The system is slowly changing

Various aged care measures have been introduced to address the challenge of a more diverse older Australia. These include translation services through the aged care information gateway, cultural competency training for aged care staff, and a new verification process that allows providers to advertise their specialisation in services for CALD communities. The Australian government also funds a flexible aged care program to provide culturally appropriate aged care services within or close to recipients' own communities. And, alongside changes in the diversity of the overall population, there is also an increasing pool of CALD care and healthcare workers who are more likely to work in settings with higher shares of CALD care recipients (DoH, 2020b, 2024). A current review of the Aged Care Act is a further opportunity to improve the framework in which a more diverse set of older Australians get the care they need.

Box 12 CEPAR research spotlight **Advance care planning less common for CALD Australians**

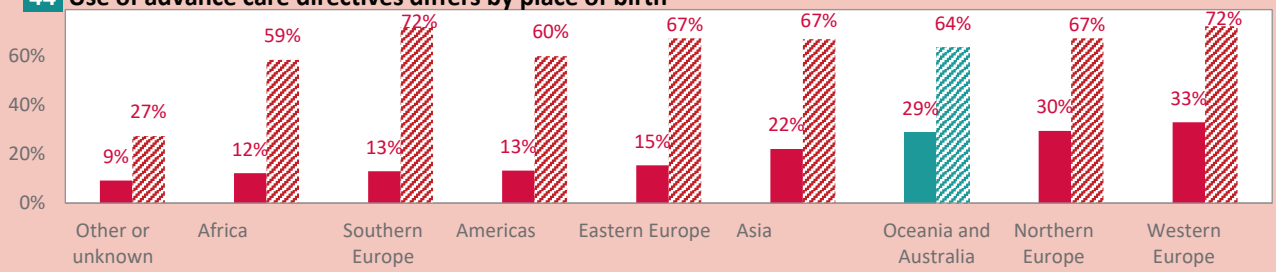
Advance care directives (completed by oneself) and advance care plans (completed by someone else) can result in greater agency in health and care decisions in case of serious illness. CEPAR's Craig Sinclair, with co-authors, examined how this is practiced in Australia.

First, the team found that knowledge about advance care directives and planning is lacking (Sellars et al., 2021). About 62% of participants had never heard of the programs. Knowledge regarding medical substitute decision making is also limited resulting in participants accessing minimal support in times of challenging medical decisions.

Second, the quality of advance care directives among older Australians is poor for both migrants and those born in Australia (Buck et al., 2021). Documentation was often completed by people other than the patient.

Third, the uptake of advance care directives and plans differed by region of birth (Sinclair et al., 2021). The researchers found that about a quarter of Australians aged 65+ who accessed GP clinics, hospitals, or aged care had a completed a directive. Those born in Western Europe had the highest rate of self-completed directives at 33%, followed by 30% for those born in Northern Europe, and 29% for those born in Australia. The rates were lowest for those from the Americas, Southern Europe, and Africa (12–13%; Figure 44). These results suggest that enduring differences in normative practices in relation to healthcare decision making exist in CALD communities.

44 Use of advance care directives differs by place of birth



Source: Sinclair et al., 2021

Box 13 CEPAR research spotlight **What support are carers from CALD backgrounds asking for?**

Cultural considerations are important in the provision of care, but they also matter when supporting carers from diverse backgrounds. CEPAR's Jeromey Temple let a team to find out more about this group. The authors found that about half of carers from non-English-speaking backgrounds reported needing additional support, compared to 37% for those from main-English-speaking and Australian-born backgrounds (Temple et al., 2021b). CALD carers were most likely to need support in the forms of financial assistance (66%), physical assistance (44%), emotional support (44%), respite care (43%), and help with improving own health (39%).

Indeed, carers face various barriers to resolving their own health challenges (Temple et al., 2021c). About a third of carers reported one or more barriers to healthcare. These included barriers to accessing dental care (28%), GP (18%), and medical services (15%). Cost was a common impediment and so were time constraints. About 16% of those from non-English-speaking backgrounds reported a barrier to accessing GP services, compared to 10% for those from English-speaking backgrounds.

Box 14 CEPAR research spotlight Navigating aged care

Aged care services in Australia are shifting towards a more consumer-directed approach, which generates a host of new problems and policy implications. The topic was considered by CEPAR's Yuchen Xie, Myra Hamilton, and Kaarin Anstey in a scoping review about navigating community-based aged care services (Xie et al., 2023).

Some of the problems in aged care navigation included using social networks as information providers, lack of base knowledge, complexity, difficulties using technology, waiting, and structural burden associated with informal carers. According to the authors, to allow for successful navigation of the aged care system, individual circumstances must be assessed, and there must be a focus on reducing the complexity and improving the coordination of aged care.

Box 15 CEPAR research spotlight Older migrant and CALD carers

When first-generation migrants have children, grandparental childcare is less of an option – yet some make it work. CEPAR's Myra Hamilton, studied the role of transnational grandparenting among migrants in Australia (Hamilton et al., 2021a, 2021b). The research found examples of 'flying grannies' who regularly visit, as well as grandparents who permanently relocate to provide care to grandchildren. Study participants typically felt a strong obligation to fulfil care responsibilities, supporting the employment of adult children. But regulations (e.g. short-term visas) in Australia often hamper these opportunities and undermine the continuity and security of care as well as limiting the ability of grandparents to secure their own health.

Similarly, arrangements for *migrant nannies* (au pairs) are also fraught. Migrant care givers offer an affordable, flexible, and culturally appropriate solution for childcare but become vulnerable without appropriate labour or social rights, increasing their vulnerability to exploitation (Hamilton et al., 2021b).

Compared to other countries, Australian regulations can also result in early childhood education and care headaches for parents who are initially temporary migrants (Naldini et al., 2021). Pathways to permanent residency are more complex, so migrant families may be temporary residents for longer, hindering their children's and their own prospects.

7. CONCLUSION

Australia is growing older and more diverse. Among younger Australians, cultural and linguistic diversity is not a minority issue when family background or ancestry is considered. Millennials are the first minority Anglo-Celtic generation since colonisation. Past and future migration is now beginning to dramatically transform the profile of older Australians.

Australia needs migration to offset demographic ageing. But migrants also age and the rise in cultural and linguistic diversity among older Australians may reveal new vulnerabilities across socioeconomic, psychosocial, health, and care domains. Indeed, with declining language barriers, cultural barriers may become more significant.

Four key examples noted in this brief relate to the labour market, savings, social engagement, and health: (1) better education does not necessarily translate to better employment and income outcomes, indicating the presence of skills mismatches and barriers in the labour market; (2) lower superannuation and financial literacy, as well as a lag in home purchase may spell challenges in retirement for some migrants / CALD communities; (3) lower social participation of people in migrant and CALD communities is associated with isolation and worse mental health; and (4) migrants' advantages in health and health risk factors converge with the rest of the population, resulting in delayed and lower access to health care and aged care as well as higher disability rates.

Each area would benefit from a myriad of policy interventions, from targeting financial literacy and English language training, to improving recognition of international qualifications, requiring employers and service providers to collect CALD data, and tailoring delivery services and educating staff to ensure access across an ageing and more diverse community.

This brief lays out the demographic future while flag-posting potential challenges that may result. It also calls for continued monitoring as well as better, more nuanced data and research.

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About CEPAR

The ARC Centre of Excellence in Population Ageing Research (CEPAR) is a unique collaboration between academia, government and industry, committed to delivering solutions to one of the major economic and social challenges of the 21st century.

Funded primarily by an initial seven-year grant from the Australian Research Council (ARC), with generous support from the collaborating universities and partner organisations, the Centre was established in March 2011 to undertake high impact independent multidisciplinary research and build research capacity in the field of population ageing.

Renewed funding awarded for an additional seven-year term from 2017-2023 supports an exciting new research program which will deliver comprehensive outcomes with the potential to secure Australia's future as a well-informed nation with world-best policy and practice for an ageing demographic.

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