Healthcare needs of older Arab migrants: a systematic review

Naser A Al Abed, Patricia M Davidson and Louise D Hickman

Aims and objectives. To explore the healthcare needs of older Arab migrants, focussing on Arab-Australians and their socio-cultural characteristics.

Background. Disparities in accessing healthcare services and addressing healthcare needs are evident among ethnic minorities including Arab migrants, particularly, older people. Racial stereotyping can also affect their ability to use these services. Arabs are a populous and diverse group with a long history of global migration. Australia is one of the most multicultural societies in the world, and Arab-Australians constitute an important ethnic minority group.

Design. Systematic review.

Methods. The electronic databases Academic Search Complete (EBSCO), MEDLINE (Ovid), Ageline, ProQuest, CINAHL, PubMed, PsychINFO and Google Scholar were searched from 1990–October 2012. Search terms included health care needs, aged care, ethnic, cultural, linguistics, social, ethnic groups, culturally and linguistically diverse, nonEnglish speaking, ageing, elderly, Arabs, Arabic-speaking and Australia.

Results. Eight articles reviewing the healthcare issues of Australians from Arabic-speaking background were identified using the search strategy. An additional eight articles were identified through hand searching.

Conclusions. Racial stereotyping can alter health-seeking behaviours and healthcare treatment. Increasing the understanding of specific cultural attributes of Arab-Australians will contribute to improving health outcomes.

Relevance to clinical practice. Healthcare providers and policymakers need to adopt more effective ways of communication with Arab-Australians to provide more culturally competent care and achieve better health outcomes.

Key words: aged care, Arabic, culturally and linguistically diverse, elderly, ethnic groups, healthcare needs, migrants health, nonEnglish speaking, socio-cultural

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Health care needs of elderly Arab migrants

Introduction

Internationally, there has been migration of Arabs to many countries and diasporas exist globally (Aboud 2002). Culturally appropriate care is an important foundation in many countries including the USA, the UK and European countries, and many countries focus on addressing healthcare disparities that are attributed to culture and race (Gunderman 2007, Hunter & Wilson 2012). Ongoing global conflicts mean that Arabs are frequently a focus of prejudice and racism (Mason 2004).

Australia is one of the most diverse migrant populations in the world. From the foundation of an Anglo-Celtic culture, Australian society has evolved to one of cultural pluralism (Davidson et al. 2004). The 2011 census revealed that over a quarter (26%) of Australia’s population was born overseas and one-fifth (20%) had at least one overseas-born parent (ABS 2011). As the population of Australia ages, it is critical that patients, their families, healthcare providers and healthcare systems are equipped to deal with the challenges of cultural diversity and heterogeneity in ageing. Understanding the needs of the older people is central and instrumental in any planning, implementing and evaluating efforts to improve their health care and social life (Boneham et al. 1997). Although this review focuses specifically on Australia, it is likely that these data are relevant to many other countries where Arab migrants have settled.

Although cultural diversity has added to the productivity and richness of contemporary Australian culture, there is emerging data to suggest health disparities, primarily through limited access (Brach & Fraserirector 2000). Beadnell (2006) argues that although the Australian government has undertaken many improvements to the aged care sector, this has not yet addressed the socio-cultural aspects of care. To date, we have limited knowledge of the healthcare needs of older Australians from culturally diverse backgrounds (Davidson et al. 2004, Rao et al. 2006). Orb (2002) argues that the literature is slow and poor in recognising the unpreparedness of the Australian healthcare system to serve the needs of a society with an increasing linguistic and cultural diversity.

Health care for older people from ethnic minorities can be challenging (Susman et al. 2006). These challenges include a higher prevalence of chronic and disabling diseases, the difficulty of treating individuals with multiple comorbidities, limited ability to access services in the community and difficulty in participating in medical decision-making (Susman et al. 2006). Older people from culturally and linguistically diverse (CALD) backgrounds are not a homogenous group, and this heterogeneity has implications and challenges in developing and delivering effective models of services (Radermacher et al. 2009). Understanding the knowledge, attitudes and beliefs of minority groups is critical for developing models of care that are culturally competent and also for improving health outcomes and reducing health disparities (Pamies & Nsiah-Kumi 2009, Meleis 2010).

There is a significant impact of cultural factors in influencing the perception of health issues among ethnic migrant groups (Abdulrahim & Ajrouch 2010). Service development and delivery for older migrants need to be responsive to meet their ‘special’ ethno-specific needs (Radermacher et al. 2009). Better understanding of health perceptions among Arab migrants can be helpful in developing more effective communication by healthcare providers (Abdulrahim & Ajrouch 2010). Gerontologists, researchers, healthcare providers and policymakers can improve conditions of migrants from Arab and Middle Eastern origin by incorporating new knowledge of these ethnic groups into research, policy and practice to improve their services and remove negative stereotypes (Salari 2002).

Methods

Aim

This systematic literature review sought to identify relevant peer-reviewed literature focusing that explored the healthcare needs and socio-cultural characteristics of older Arab migrants with a focus on Arab-Australians.

Search strategy

The electronic databases Academic Search Complete (EBSCO), MEDLINE (Ovid), Ageline, ProQuest, CINAHL, PubMed, PsychINFO and Google Scholar were searched from 1990–October 2012. The search strategy was supervised by a health librarian, and search terms included: health care needs, aged care, ethnic, cultural, linguistics, social, ethnic groups, CALD, nonEnglish speaking, ageing, elderly, Arabs, Arabic-speaking and Australia. The search also included the primary and secondary sources of relevant literature, the grey literature and the Internet resources. After consultation with experts in the area and given the paucity of available literature, it was agreed that inclusion criteria for the review would include literature reviews, original research papers and discussion papers in peer-reviewed journals written in English. The retrieved articles were summarised with key issues...
extracted regarding the healthcare needs and the specific socio-cultural characteristics of older Arab-Australians.

Results

Figure 1 below demonstrates the process of paper selection and exclusion. Twenty-nine articles were retrieved for detailed examination against the inclusion criteria, with 16 articles found to be relevant to the focus of this review and classified into general studies on healthcare needs of older people from ethnic groups (Table 1) and studies on healthcare issues of Arab-Australians (Table 2). These studies are discussed thematically below.

Migration and the elderly

Older migrants from ethnic backgrounds are particularly vulnerable to complex health issues that associated with limited literacy and communication skills. They have to face the dilemma of how to combine Western health practices with their traditional health practices with limited support and resources (O’Callaghan & Quine 2007). Racism is one of the major problems that face migrants from ethnic background around the world. Moriarty and Butt (2004) reported that over one-half of older people from ethnic minorities had experienced racism. Osman and Walsemann’s (2013) study suggests that the effect of socio-economic status and traumatic life events may explain the ethnic disparities in disability within the Israeli population. Migration as a result of stressful life events has a significant impact on psychological well-being of migrants, particularly women and older people, resulting in more depressive symptoms. This in turn leads to undermine self-image and sense of mastery and interfere with individual’s capacity to gain and maintain supportive relationships (Bradley & Van Willigen 2010, Brown & Turner 2010). The impact of migration as a result of stressful life event on migrants’ health and well-being is explained in Fig. 2.

Orb (2002) conducted a review of the healthcare needs of older migrants from CALD groups. The main issues emerging from this review were language difficulties, social isolation, access to services and the unpreparedness of the services to meet the needs of these groups. Studies on healthcare needs of older people from ethnic minorities are summarised in Table 1.

![Flow chart of literature search](image)
<table>
<thead>
<tr>
<th>Authors</th>
<th>Design/ Intervention</th>
<th>Study sample</th>
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<tbody>
<tr>
<td>Low et al.</td>
<td>Survey</td>
<td>350 Italian, 414 Greek, 437 Chinese and 500 third-generation Australians</td>
<td>Ethnic minorities have more negative attitudes towards persons with dementia than third-generation Australians. Differences were identified between ethnic groups on markers of acculturation in relation to knowledge and beliefs of these groups. Dementia education is needed for these minority groups</td>
</tr>
<tr>
<td>Low et al.</td>
<td>Literature review</td>
<td>A review of Australian literature on dementia published between 2005–2007</td>
<td>The article describes challenges to conduct dementia research in culturally and linguistically diverse (CALD) communities such as sampling, having valid instruments and costs. Future CALD research on dementia has been identified in areas of (1) epidemiology, (2) community knowledge, (3) carers, (4) service delivery, (5) screening and assessment, (6) medical management, (7) residential aged care, (8) staff and training and (9) minority CALD providing guidance for future research endeavours.</td>
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<tr>
<td>Radermacher et al.</td>
<td>Literature review</td>
<td>Relevant literature in English from 1980–2008</td>
<td>No single model of delivering community aged care service can meet the needs of all older people from CALD backgrounds. The role of ethno-specific, multicultural and mainstream services working together or independently is widely supported. Heterogeneity of older people from CALD backgrounds has significant implications and challenges for developing and planning effective service delivery models.</td>
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<tr>
<td>Rao et al. (2006)</td>
<td>Literature review</td>
<td>Australian literature from 1995–2006</td>
<td>It is difficult to generalise the issues and challenges associated with CALD groups. CALD groups' health and social needs can be particularly acute as a result of cultural and language difficulties, geographical location and circumstances of migration, which impacted on their socio-economic status and psychosocial health.</td>
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<tr>
<td>Runci et al. (2005)</td>
<td>Survey</td>
<td>189 registered aged care facilities in Melbourne</td>
<td>19% of residents either preferred or needed to speak one of 40 different non-English languages. Almost one-quarter of the facilities did not provide any language-relevant services.</td>
</tr>
<tr>
<td>Orb (2002)</td>
<td>Literature review</td>
<td>Australian literature from 1979–2002</td>
<td>Health issues of older migrants from CALD backgrounds in Australia is scarce. Major issues are language barriers, social isolation, access to services and unpreparedness of the services to meet the needs of CALD communities.</td>
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<tr>
<td>Rowland (1999)</td>
<td>Census data analysis</td>
<td>1996 Australian census data on people aged 65 years and older from non-English-speaking backgrounds</td>
<td>One-third of ethnic older people will need ethno-specific support in their care. The majority of ethnic elders are well integrated into the Australian society.</td>
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</table>
Older migrants are divided into two main groups: first group is migrants who came during their youth and became old in the new country, second is those who migrated during their old age. Old age is often seen as a time of life review and a search for meaning. Those who migrated at an older age are noted to be less flexible and motivated to make adjustments to the culture of the new country (Thomas 2003). In addition, many older migrants in Australia have extended families spread over two or more countries, and this in turn has a significant impact on their psychosocial well-being (Thomas 2003).

Rowland (1999) argues that despite decades of residence in Australia, many older migrants learnt little English, resulting in their limited ability to integrate into mainstream society and in their later years reinforces the need for maintaining ethnic lifestyle. Garrett et al. (2008) have identified that language barriers decrease equity in health care by excluding people who do not speak the common mainstream language from institutional interaction. This in turn leads to disempowering them and affects their ability to access primary healthcare services including emergency departments and also reduces their understanding and involvement in decision-making regarding their treatment options (Garrett et al. 2008). Thomas (2003) indicates that poor English language skills among older migrants affect their ability to communicate with others and make new friends, contributing to their social isolation. Furthermore, the lack of English language skills seems to affect all aspects of the quality of life among older migrants from diverse ethnic backgrounds. Fluency in English and good education, income and home ownership in Australia are key players in enhancing better integration and creating greater freedom of choice among ethnic older migrants (Rowland 1999).

Arab-Australians

Arab-Australians constitute a relatively small minority group in Australia. However, their contribution to the cultural and social life of Australia is worthy of study. In Australia, Arabic language is the third top spoken ethnic language at home by 1.4% of the total population (ABS 2011). Arab-Australians can be defined as those who migrated or descended from Arabic-speaking countries to Australia. The majority of Arab-Australian population are from Lebanon, Egypt, Iraq, Syria and Palestine (Aboud 2002). Other countries include Jordan, Morocco, Sudan, Somalia, Tunisia, Libya, Algeria, Yemen, Saudi Arabia, Kuwait, United Arab Emirates (UAE), Qatar, Bahrain and Oman (DIAC 2011).
<table>
<thead>
<tr>
<th>Authors (year)</th>
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<tbody>
<tr>
<td>Boughtwood <em>et al.</em> (2012)</td>
<td>Focus groups and interviews</td>
<td>121 Carers for persons with dementia from four culturally and linguistically diverse (CALD) communities (19 Arabic, 37 Chinese, 40 Italians and 25 Spanish-speaking carers), and 16 bilingual GPs (4 Arabic, 3 Chinese, 4 Italian and 5 Spanish speaking)</td>
<td>Dementia information for CALD communities is often scattered and difficult to find. Primary focus should be directed towards understanding and overcoming problems associated with dissemination of dementia information rather than producing more information.</td>
<td>Need to improve policies and practices in relation to dementia information for CALD communities. Increased focus on dissemination structure and process; interpersonal aspects of information provision; greater range of information; and information to meet the needs of the CALD communities.</td>
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<tr>
<td>Saleh <em>et al.</em> (2012)</td>
<td>Ethnographic study</td>
<td>38 Arabic-speaking adults who are cancer patients or community members</td>
<td>Terminologies about cancer and cancer diagnosis were believed to have more impact and greater fear in Arab-Australians than terms used in diagnosis of other illnesses.</td>
<td>Communication and clinical practices with Arab-Australians should be culturally competent by incorporating their social and cultural beliefs. Stereotyping must be avoided.</td>
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<tr>
<td>Boughtwood <em>et al.</em> (2011)</td>
<td>Focus groups</td>
<td>121 Carers for persons with dementia from four CALD communities (19 Arabic, 37 Chinese, 40 Italians and 25 Spanish-speaking carers)</td>
<td>Many similarities exist among the carers of the four CALD communities in their perceptions and experiences towards people with dementia. However, some differences also exist between the different groups.</td>
<td>It is pivotal for caregivers and healthcare professionals to understand the specific cultural context and the barriers and challenges of caring for people with dementia from CALD communities to provide sensitive and supportive care for them.</td>
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<td>Sneesby <em>et al.</em> (2011)</td>
<td>Interpretive methodology</td>
<td>15 Adults from Sudanese community</td>
<td>Participants had no experience of palliative care. Death and dying is not discussed openly within the community.</td>
<td>Incorporating Sudanese people’s ethnic and religious beliefs will contribute to improving palliative care services and outcomes for them.</td>
</tr>
<tr>
<td>Youssef and Deane (2006)</td>
<td>Interviews and Literature review</td>
<td>35 Key informants from Arabic-speaking community</td>
<td>Shame and stigma affect services accessing strong cultural prohibitions on exposing personal or family matters to outsiders.</td>
<td>Working closely with religious leaders, Arabic-speaking GPs, families and carers can facilitate accessing mental health services and overcoming issues of trust, stigma and privacy with Arabic patients.</td>
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Table 2 (Continued)

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<tr>
<td>Quine (1999)</td>
<td>Focus groups:</td>
<td>12 Focus group sessions with older Australians (60+) (4 Anglo, 3 Italian,</td>
<td>Older ethnic Australians differ from Anglo participants in their use herbal remedies, language, relationship with pharmacist and doctor and awareness of health rights. Differences also exist between ethnic groups in their health concerns and expectations.</td>
<td>Increased awareness of healthcare providers in relation to the concerns, expectations and preferences of older ethnic Australians can improve communication and quality of health care for them (avoiding the use of a blanket approach with them).</td>
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<td></td>
<td>Comparative approach</td>
<td>2 Chinese, 2 Arabic and 1 Greek)</td>
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<tr>
<td>Rissel (1997)</td>
<td>Survey</td>
<td>851 Arabic-speaking adults attending 20 Arabic-speaking general practitioners in Canterbury, Sydney</td>
<td>A significant inverse association were found between acculturation and preferences for patient involvement in medical decision-making process.</td>
<td>The mechanisms for how acculturation affects healthcare needs of Arab-Australians require further exploration.</td>
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<tr>
<td>Legge and Westbrook (1994)</td>
<td>Survey</td>
<td>371 Healthcare workers from Anglo, Chinese, German, Greek, Italian and Arabic communities in Australia</td>
<td>Ethnic communities differ significantly in their evaluation of health services for aged people. Arabic and Chinese people were the most satisfied with ethno-specific services for aged people, while German and Italian were the least satisfied with these services.</td>
<td>No clear guidelines for the government or healthcare providers whether to fully develop ethno-specific aged care services or to provide more culturally sensitive services within the mainstream facilities.</td>
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Although Arab-Australians are populous and diverse group, Mason (2004) mentioned that the event of 11 September 2001 and the subsequent events of the wars in Iraq and Afghanistan and the Bali bombings have a significant impact on Arab-Australians as they found themselves under attack. These events raised questioning of the compatibility of Arabs and Muslims within the Australian society and increased the level of prejudice and discrimination against them (Mason 2004). Stereotyping of Arab-Australians in the media and within the community may affect all aspects of their quality of life including accessing healthcare services.

Studies on the healthcare needs of older Arabs are scarce, particularly in the context of the Australian healthcare system. Saleh et al. (2012) indicated that Arab-Australians are an important group of the Australian community with unique culture-specific attributes. Saleh et al. (2012) argued that if healthcare professionals become more familiar with the patient and family’s cultural beliefs of Arab-Australians, then the communication process and provision of the services for this group will be improved. In this article, studies on healthcare needs of Arab-Australians are summarised in Table 2. These studies may give an insight about the healthcare needs of Arab community in Australia including the older people in the community.

Gibson (2001) estimated that by 2026, the Arabic-speaking older population will be among the top five ethnic older populations counting for around 38,600 people (4.1% of ethnic older people) behind the Italian (82,200), Greek (68,300), Cantonese (59,500) and Vietnamese (42,100) populations. In 2026, the majority of older Arab-Australians will be living in New South Wales and Victoria counting for about 7.2% (third position) and 2.9% (seventh
position) of older Australians, respectively, in these states (Gibson 2001).

**Arabs in health context**

A number of studies have explored the characteristics of Arabs in the context of health. Table 3 below summarises key findings. Awad (2010) identified that the most important values were the role of family in Arab-American life and the respect for parents and older people. Religion also played a significant role in shaping Arab-Americans’ way of life.

Ypinazar and Margolis (2006) identified that older Arabian Gulf Arabs’ perception on health and illness is strongly influenced by their religious convictions and traditional culture. UAE older Arabs view good health as the absence of visible disease. Therefore, they will only seek medical treatment when having visible disease rather than seeking preventive health care, especially for subtle conditions such as hypertension, diabetes and hyperlipidaemia (Ypinazar & Margolis 2006).

Institutionalisation of older family members is discouraged in Islamic values that focus on respecting, honouring and caring for older family members (Salari 2002). Ypinazar and Margolis’ study (2006) indicated that aged care services in the UAE are extremely limited. According to Boggatz et al. (2010), the majority of older Egyptians tend to reject home care and nursing home care due to feelings of shame when receiving care from a nonfamily member and to the belief that care is a duty of the family. They believe that both factors are rooted in the Egyptian culture and that cultural values affect the attitudes towards receiving care from nonfamily source (Boggatz et al. 2010). Sibai et al. (2004) mentioned that although the older population in Lebanon is a respected group in the society, they appear to be marginalised in the health policy-making process and health intervention programmes to meet their increasing health, social and economic needs.

People from Arab-Muslim culture view health status including illness and cure as a matter of God’s control of destiny. However, this belief is not contradicted with their responsibility to maintain personal health (Ypinazar & Margolis 2006, Abdulrahim & Ajrouch 2010). These beliefs were also confirmed by the study of Saleh et al. (2012) who mentioned that Arab-Australians believe in God control in bringing cancer or not. They also mentioned that individuals still have the responsibility to do their best in fighting the disease and get the proper treatment.

Salari (2002) identifies that it might not be appropriate for a male health professional to examine a female Muslim patient, and this may warrant the need for a female medical examiner. Furthermore, it is normative for family members to accompany an older person during medical appointments. Muslim families usually do not comply with rules and limits on hospital visitation as they consider visiting a hospitalised relative as a family requirement in Islam (Salari 2002).

In a study on different family groups in Jordan and Morocco, Dalky (2012) mentioned that Arab families perceived the experience of caring for a family member with mental illness with fear, loss, embarrassment and disgrace of family reputation. She argued that despite recent social changes regarding perceptions and attitudes towards mental illness, most Arab families are still influenced by restrictive cultural norms and social beliefs that shape family members’ perception of coping and their ability to manage caring for a relative with mental illness. Similarly, Saleh et al. (2012) emphasise that communication about cancer in Arab-Australian community is associated with fear and stigma. Fear feelings towards cancer may be a reason why some people of Arab-Australians do not access screening or diagnostic oncology services (Saleh et al. 2012).

Sneesby et al. (2011) studied the perception of death and dying in Australia among the Sudanese community in Australia. Findings of this study showed that the Sudanese people in Australia tend not to openly discuss issues of death and dying even with terminally ill and older people. Saleh et al. (2012) supported these views among members of Arab-Australian community who are resistant to openly

<table>
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<th>Table 3 Some factors that influenced the shape of Arabs in health context</th>
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<td>The role of family is central to health and care (Awad 2010)</td>
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<td>Respect and authority for parents and older people (Salari 2002)</td>
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<tr>
<td>Institutionalisation of older people is considered inappropriate and shame/stigma (Salari 2002)</td>
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<tr>
<td>Religion plays important role in health beliefs and practices (Ypinazar &amp; Margolis 2006)</td>
</tr>
<tr>
<td>Control of God on health and illness (Ypinazar &amp; Margolis 2006, Abdulrahim &amp; Ajrouch 2010)</td>
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<tr>
<td>Feelings of shame when receiving care from a nonfamily member (Boggatz et al. 2010)</td>
</tr>
<tr>
<td>Gender sensitivity/preferences and modesty (Salari 2002)</td>
</tr>
<tr>
<td>Shame and stigma affect services accessing (Youssef &amp; Deane 2006)</td>
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<tr>
<td>Strong cultural prohibitions on exposing personal or family matters to outsiders (Youssef &amp; Deane 2006)</td>
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<tr>
<td>Stigma and stereotyping, especially with mental illness (Dalky 2012)</td>
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<tr>
<td>Avoidance of open discussions on critical health issues (Rissel 1997, Sneesby et al. 2011, Saleh et al. 2012)</td>
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<tr>
<td>Noncompliance with hospital visitation rules and limits (Salari 2002)</td>
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Arab immigrants in USA are less likely to report activity limitations and do not differ from American-born White people in their self-rated health. They argued that Arab immigrants are diverse and not uniformly disadvantaged in their health as documented in previous studies. Osman and Walsemann (2013) have found that the rate of functional limitations (disability) in activities of daily living (ADLs) was similar among older Arabs and veteran Jews contrary to previous studies which showed that Arab Israelis have greater rates of limitations in ADLs than Jews. This can be explained by the fact that Arab people vary considerably according to the countries, socio-economic, racial and religious backgrounds that they come from (Nydell 2006). Aboul-Enein and Aboul-Enein (2010) argued that although people from the Middle East and Arabic background can be racially different, most American healthcare professionals see people from the Middle East and Arabic background as similar, probably because they have shared values and behaviour.

Studies on healthcare needs of older people from cultural and ethnic backgrounds internationally are limited in spite of the importance of this issue (Abdurahim & Ajrouch 2010). Particularly, studies on health issues and healthcare needs of Arab-Australians are very limited. Interestingly, no single study was found to be directly investigating the healthcare needs of older Arab-Australians. Similarly, Salari (2002) examined the titles of studies on specific race or ethnic groups residing in the USA presented in the 54th Annual Scientific Meeting of The Gerontological Society of America in 2001. She noted that among 117 titles on specific race or ethnic groups, there was absence of any study on Arab-Americans or other Middle Eastern immigrants in the USA. The study of Orb (2002) has reviewed the healthcare needs of migrants from CALD background in literature in general. However, there is a need to address the specific needs of each group of these communities. This article aims to explore the literature evidence and studies about healthcare needs of older Arab-Australians. Very few studies were found on healthcare issues of Arab-Australians, particularly older people of this community.

Orb (2002) argued that although the ethnic older population of Australia is a heterogeneous group with different cultures, languages, nationalities, religions and educational backgrounds and socio-economic status, they were portrayed in literature as disadvantaged, lonely, isolated and poor. However, Rowland (1999) argued that the majority of the ethnic aged population are well integrated into the Australian society, and therefore, they may never need long-term support from aged care services or nursing home accommodation. Similarly, Gaugler et al. argued that residents of long-term aged care facilities from diverse ethnic
and racial backgrounds are more likely to report positive affect and greater psychosocial adaptation possibly due to feelings of survivorship (Gaugler et al. 2004). Therefore, Rowland (1999) argued that planning future aged care services for ethnic groups should be based on the projections of their levels of needs and disability.

Legge and Westbrook (1994) found that there were no clear guidelines for the government or healthcare providers to fully develop ethno-specific aged care services or to provide more culturally sensitive services within the mainstream facilities. These findings emerged from the divergent positions of ethnic communities towards ethno-specific aged care services. These findings support the fact that ethnic groups are not a homogenous group, and this necessitates the need to explore the specific needs of each ethnic group and investigate the similarities and differences between them. Arabs and Chinese are the most satisfied communities with ethno-specific services, while German and Italian communities were the least satisfied with such services (Legge & Westbrook 1994). Similar findings were supported in Quine (1999) who studied the health concerns and expectations of older people of four ethnic groups (Italian, Chinese, Arabic and Greek) and the Anglo group in Australia. She found that all these ethnic groups, particularly Arabic and Chinese, were more likely than the Anglo counterpart to believe in the efficacy of traditional and home remedies over the modern medicine. Interestingly, Arabic elders were found to be the most deviated in their attitudes from those of the Anglo group.

Thomas (2003) mentioned that studies on attitudes of different cultural groups in Australia have shown that people from Asia, South Europe and Middle East usually place a greater emphasis on family responsibilities and obligation than those from Western Europe and Anglo backgrounds. Legge and Westbrook (1994) studied the attitudes of healthcare workers of five Australian ethnic communities and the Anglo-Australians towards aged care services. Interestingly, Arabic-speaking respondents reported the highest rating and most value for the helpfulness of health interpreters (74%, mean 54%), availability of doctors speaking ethnic languages (61%, mean 41), availability of health interpreter services (47%, mean 35%), information leaflets regarding health entitlement and benefits (47%, mean 30%) and availability of ethnic health workers (40%, mean 20%).

Among these communities, Arabic community was the most satisfied with ethno-specific services, followed by the Chinese, Greek, Italian and German communities (Legge & Westbrook 1994). Thomas (2003) argued that people from Asia, South Europe, Middle East and Africa have cultural values in common towards their older parents that demand almost absolute obedience and support from children and children’s respect for their dignity.

Many older migrants came to Australia from countries where residential aged care facilities (nursing homes) either do not exist or are of very poor quality. Furthermore, older migrant parents often expect services from their children that can be better performed by professionals such as nursing and personal care. They also expect their families to look after them instead of being looked after in nursing homes (Thomas 2003). Indeed, residential aged care is not a preferred choice even for many of native-born older Australians (Thomas 2003). Many studies showed that placing older people in formal care facilities is considered as one of the most stressors that face families (Marquis et al. 2004). Gaugler et al. indicated that feelings of guilt and attenuated self-esteem may arise following this placement and shifting in relationship between spouses. They added that the role of family and the resident’s psychosocial well-being have not received much attention in literature (Gaugler et al. 2004).

Older people living in nursing facilities have extensive psychosocial needs; however, addressing these needs by care providers are often unmet (Bonifas 2008). The psychosocial status of older residents is significantly correlated to the type of facility, resident’s health condition, resident’s race and facility family orientation (Gaugler et al. 2004). Older people in acute hospitals and residential aged care facilities who experience a limited social network with low social connectedness may feel isolated and are more likely to become psychosocially distressed (Haesler et al. 2010). Therefore, care providers should employ strategies to increase their social connectedness such as encouraging family involvement in care, providing homelike areas for residents and developing activities that promote interaction between residents (Buckley & McCarthy 2009).

Majerovitz et al. (2009) emphasised that good communication between families and nursing home staff was essential to engage the residents actively in the decision-making process regarding their care. They recommended that communication should focus on the psychological, social and medical needs of the residents and family members. Garrett et al. (2008) argued that there is a paucity of evidence available in Australia on the best ways in which to facilitate communication with people from CALD backgrounds. Saleh et al. (2012) argued that exploring barriers to communication with ethnic minority groups in health context could improve the healthcare needs of these population groups through better understanding of the different health beliefs. This will enhance more culturally competent
clinical practices as well as remove stereotyping of these ethnic minority groups.

Studying healthcare needs of ethnic minorities although important for healthcare planning and delivery is challenging. Low et al. (2009) described the challenges in conducting dementia research in CALD communities. These challenges include lack of reliable and valid assessment instruments for most of CALD groups, difficulties in recruiting skilled bi- or multilingual interviewers, longer interview time and bias resulted from using interpreters, and higher costs of CALD research compared with the mainstream research (Low et al. 2009).

Conclusion and relevance to clinical practice
Health care for older people from ethnic minorities can be challenging due to a range of knowledge, attitudes, beliefs and health-seeking behaviours. Disparities in accessing healthcare services are evident internationally among ethnic minorities including Arab-Australians. The Arab-Australian community is an important minority group with unique culture-specific attributes. Arab-Australians are often stereotyped in the media and within the community, and this may influence health-seeking behaviours and health care delivery. Healthcare providers and policymakers need to adopt more effective ways of communication with Arab-Australians to achieve better health outcomes. Better understanding of specific cultural attributes of Arab-Australians will contribute to improving their quality of life and remove stereotyping. Providing culturally appropriate care is pivotal to improve their health services. More research is required to explore the gaps, barriers and facilitators to achieving culturally competent aged care services in acute, community and residential aged care settings for older Arab-Australians. Although these data pertain specifically to Arab-Australians, it is likely that these findings have relevance and salience to other communities internationally.

Disclosure
The authors have confirmed that all authors meet the ICMJE criteria for authorship credit (www.icmje.org/ethical_1author.html), as follows: (1) substantial contributions to conception and design of, or acquisition of data or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content; and (3) final approval of the version to be published.

Conflict of interest
There are no conflict of interests to declare.

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