SUBMISSION BY:

DutchCare Ltd

CARING FOR OLDER AUSTRALIANS:

AGED PEOPLE FROM A NON-ENGLISH SPEAKING BACKGROUND

July 2010

DutchCare Ltd

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PRODUCTIVITY COMMISSION – CARING FOR OLDER AUSTRALIANS

SUBMISSION BY DUTCHCARE LTD (VICTORIA)

AGED PEOPLE FROM A NON-ENGLISH SPEAKING BACKGROUND

INTRODUCTION

One of the tasks identified in the issues paper prepared by the Productivity Commission on *Caring for Older Australians* is to "address the interests of special needs groups, including people living in rural and remote locations, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, and veterans".

This submission will focus on culturally and linguistically diverse (CALD) communities. It will describe, where possible, how they are situated in the current range of services funded by the Department of Health and Ageing (DoHA). It will identify shortfalls in the current regime and suggest improvements in existing and possible future arrangements as posited in the recommendations of the National Health and Hospitals Review and the Productivity Commission's research paper *Trends in Aged Care Services: some implications - September 2008.*

Comment on the last two documents has been made separately because of their relevance to the terms of reference of the current Inquiry and to compensate for the lack of consideration of ageing CALD communities in each context.

STATISTICS

The 2006 Census revealed that of all people aged 65+ in Australia, 21% came from a non-English speaking background (NESB). That is, they were born in countries other than Australia, Canada, Ireland, the United Kingdom, New Zealand, South Africa and the United States of America.

For each State and Territory, this figure translates to 28.25% in Victoria, 22% in New South Wales, 12% in Queensland, 20% in Western Australia, 20% in South Australia, 20% in the Northern Territory and 8% in Tasmania.

These statistics, however, do not show the concentrations and composition of the NESB communities in each State and Territory. When revealed, they show quite a different picture which should significantly affect the planning, implementation and review of health and aged care services for NESBs.

Taking Victoria as an example, the 2006 Census confirmed that close to 90% of NESBs aged 65+ lived in the 4 metropolitan planning regions used by DoHA and its corresponding State Government Departments. These are the most densely populated areas of the State. **In the Western metropolitan planning region, 51% of the population aged 65+ came from a non-English speaking background. In the North, this percentage was 50%; and in the East and South it was 30%.** And these figures are now 5 years old.

Within some of the metropolitan planning regions, the local government areas (LGAs) had an even more stunning story to tell. The classic is the LGA of Brimbank where 73% (11,772) of the population aged 65+ was from a NESB. In Whittlesea, this figure was 67% and in Nillumbik it was 60%. In fact, at the time of the Census, 42% of LGAs in the metro planning regions had over 40% of their population aged 65+ from a NESB.

A comparison between LGAs also demonstrates the ethnic diversity in Victoria. For example, in the LGA of Yarra, the top 4 ageing ethnic groups are the Greeks, Italians, Chinese and Vietnamese. In the LGA of Glen Eira, the top ageing ethnic groups are the Greeks, Italians, Poles, Russians, Ukrainians, Germans and Hungarians.

NESBS AND SERVICES FUNDED BY THE COMMONWEALTH THROUGH THE DEPARTMENT OF HEALTH AND AGEING

Access to residential and packaged care

Two of the objects of the *Aged Care Act 1997* (the Act) are "to facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location", and "to encourage diverse, flexible and responsive aged care services that:

(i) are appropriate to meet the needs of recipients of those services and the carers of those recipients; and

(ii) facilitate the independence of, and choice available to, those recipients and carers".

In this regard, over the past 25 years, DoHA has allocated places for NESB consumers to both mainstream and ethno-specific providers. More importantly, since the introduction of its annual Aged Care Approval Rounds (ACAR) in 1997 it has targeted specific planning regions and sub regions for the allocation of places for use by NESBs. Unfortunately, the places are not identified as such in the published ACAR results on DoHA's website.

This means that after 12 years of ACARs, there is no cumulative or definitive information in the States or Territories on which mainstream providers have received aged care places for NESB consumers, how many there are, what type or category they are, where they are, or who uses them because DoHA does not monitor their use after allocation. This has been compounded by the specificity of NESB places being lost through sales of 'beds', and breaks in the corporate (and funding) history of individual agencies. (It is assumed ethnic agencies appearing in the ACAR approvals lists were allocated places for NESBs.)

This lack of data makes it difficult to ascertain whether culturally and linguistically diverse communities (CALD) have been accorded equitable, or proportional, access to residential and community aged care places through funding round mechanisms.

To add insult to injury, there is a lack of readily available data such as population statistics on people from a NESB at the local planning level. The Australian National Audit Office (ANAO) picked up on the general issue of data provision to the aged care industry in **Audit Report No. 40 2008-09 - Performance audit - Planning and Allocating Aged Care Places and Capital Grants** (p 37) as did the **2009 Senate Inquiry into Residential and Community Care.**

Access can be alternatively ascertained by obtaining statistics on the uptake by people from both an English speaking background (ESB) and a non-English speaking background (NESB) of residential care places, Community Aged Care Packages (CACPs), Extended Aged Care at Home Packages (EACH) and Extended Aged Care at Home Packages – Dementia (EACHD).

In this regard, the Australian Institute of Health and Welfare (AIHW) publishes national and State figures on these services.

In its publication ***Aged care packages in the community 2007-08*: *a statistical overview***, the AIHW indicated that **nationally** "people born in non-English-speaking countries made relatively high use of care package services compared to Australian-born and people born overseas in English-speaking countries. Combined care package use by people born in non-English-speaking countries was 21.7 per 1,000 for those aged 75–84 years and 58.2 per 1,000 for those 85 years or older, compared with 6.6 and 44.0 per 1,000 respectively for Australian-born care recipients and 15.7 and 46.5 per 1,000 respectively for people born overseas in English-speaking countries. The main non-English-speaking countries of birth for CACP recipients were Italy, Poland and the Netherlands."

Using figures from table 4.13 of AIHW's ***Residential aged care in Australia 2007-08: a statistical overview, June 2009***, DutchCare has ascertained that NESBs are relatively under represented as permanent residents compared to Australian-born and people born overseas in English-speaking countries, particularly in Victoria.

As the AIHW publications do not extend beyond State figures, DutchCare obtained figures via DoHA on the uptake of services by NESBs and ESBs in each planning region in Victoria as at June 2008 which, at the time, were the most recent statistics available. It confirmed the relative over representation of NESBs in packaged care, particularly at the high end of care. It also confirmed marked under representation of NESBs in residential care.

If the feeder service to residential and packaged care, i.e. Home and Community Care (HACC), is also factored into the planning context, **(an ANAO recommendation from 1998-99)** the situation of NESBs in Victoria becomes more dire.

A reading of DoHA's **Home and Community Care Annual Report 2007-08** suggests that in Victoria, NESB individuals are also under represented in service uptake. (For future comparative purposes it would be useful to use only country of birth figures. Language spoken at home varies with age and is not a reliable or consistent measure.)

Again, using Victoria as an example, it appears that NESBs rely disproportionately on packaged care for aged care in preference to residential care or, indeed, HACC services with the exception of planned activity groups. This may be because:

- organisationally, it is easier to provide culturally and linguistically appropriate care in a community, rather than a residential, setting;
- there appear to be more ethno-specific packaged care providers than ethno-specific residential care providers;
- continuity of culturally and linguistically appropriate care cannot be guaranteed when a NESB needs to transfer from an ethno-specific package to a mainstream service which provides a higher form of care;
- relatively few ethno-specific groups can achieve the size and wealth to provide residential care in their own right;
- many NESB groups would rather care for their elders at home, rather than in a residential setting;
- NESBs leave residential care to the last possible moment when care needs are extreme;
- culturally and linguistically appropriate care in mainstream services is an unknown and variable thing because of the lack of benchmark provision and controls;
- mainstream providers avoid NESB residents because of the extra effort and costs required to provide culturally and linguistically appropriate care;
- there is a dearth of information in community languages on aged care services.

Planning – current system

If Victoria's situation can be generalized to the nation, the NESB uptake situation suggests that packaged care is compensating for the other types of care and this needs to be addressed in the ACAR pending investigation and action on the discrepancies in uptake. In these circumstances, the question has to be asked whether the skewed use of care types is appropriate and whether it should be maintained, and even built on, by government planners particularly in the area of HACC and packaged care. This has implications for the allocation and distribution of places.

Within the planning ratios, consideration should be given to increasing the numbers of NESB places in keeping with the regional NESB demographics and making a greater number available to viable ethno-specific or multicultural providers rather than mainstream providers.

Allocations to mainstream providers should also reflect NESB demographics in the relevant planning region. Instead of mainstream providers applying for a token number of NESB places in the ACAR in the hope this will get them over the line, they might realistically refigure the proportions of ESB to NESB places in their applications. Specific ethnic groups, dependant on relative need, might be targeted to overcome the dilution of effort inherent in general NESB allocations.

In the interests of transparency and accountability, DoHA could prepare for its approvals rounds by:

- providing standard data to the Aged Care Planning Advisory Committees and the general public in each State and Territory on the
    - percentage of people from a non-English speaking background in the targeted aged population in each of the planning regions. For the sake of consistency, place of birth, i.e., English speaking country versus mainly non-English speaking country, should be used;
    - information on the numbers, distribution and type of NESB places in each of the planning regions;
    - statistics as at 30 June of the ACAR year on the uptake of all types of care (separately – CACP, EACH, EACHD and residential) by NESB care recipients in each of the planning regions;
    - statistics as at 30 June of the ACAR year on the uptake of all the HACC services by NESB seniors.
- as a starting point, allocating NESB places to the planning regions in direct proportion to their percentage of the targeted aged population, factoring in the skewed use of services;
- fine tuning the indicative allocations in each planning region according to what is happening to CALD seniors in the range of Commonwealth funded aged care programs including HACC;
- providing more consideration to funding ethnic agencies, that is, agencies which provide ethno-specific care to either one community or several ethnic groups. The reality is that these services are perceived to provide more appropriate care to their clients than mainstream providers. Research also indicates that ethno-specific care results in more satisfied consumers who need fewer care interventions for "behavioural problems";
- allocating numbers of NESB places to individual mainstream providers in direct proportion to the percentage of NESBs in the targeted aged population in the planning region;
- publishing the outcomes of the ACAR in a way which identifies mainstream and ethno-specific agencies which were allocated NESB places, the numbers of places, the geographical distribution of those places by planning region, and the type of place. (If it can, it should do this retrospectively to make good the information deficit of the past 12 years.);
- monitoring the use of NESB allocations to all providers by CALD consumers. Not to do so raises the issue of providers receiving places under false pretensions;

- reporting to Parliament on CALD access and equity issues in terms of numbers of NESB places allocated, distribution, uptake and quality of care compared to elderly people born in an English speaking country. The current reporting on access an equity through the Department of Immigration and Citizenship and the *Report on the Operations of the Aged Care* Act lacks cohesion, direction, concrete goals and KPIs[1];

- introducing (**as per ANAO's recommendations in 2002**) an effective means to maintain project officers' local knowledge of aged care needs, including contact with State health agencies;

- developing a methodical, cohesive strategy on ethnic aged care. The current measures are piecemeal and unintentionally discriminatory;

- formally consulting with ethno-specific aged care providers and consumers.

NESBS AND ACCESS TO SUPPORT SERVICES

Information

Research and numerous focus groups have consistently reported that aged NESBs use the ethnic media, particularly radio, for their information needs. A recent research report [2] funded by VicHealth summed it up nicely in part of its executive summary when it stated:

"Middle aged and even older tertiary-educated community members with sufficient financial resources to have internet and computer access at home have also embraced ICT, but tend to use the more basic functionality. In contrast, those with lower levels of English, limited literacy and/or limited formal education, primarily use more traditional media such as television, DVDs and radio, and rely for their personal communications on the telephone, especially mobile phones.

Health messages communicated in English are not well understood by some members of the community.

Websites are predominantly in English and heavily text-based and still do not cater for the diverse range of languages that exist within Australia."

<u>Information on aged care</u>

Much has been said in recent years on the complexity of the aged care system. For the poor, or non-English speaker, negotiation of the aged care maze is even more difficult. Commonwealth government assistance in this regard is limited. For example:

- DoHA's Aged Care Information line is not advertised in the ethnic media;

[1] In fact DoHA's access and equity report focuses on funding a number of ethnic agencies, the Centre for Cultural Diversity in Ageing and the Community Partners Program

[2] O'Mara B, Babacan H, Borland H: ***Sending the Right Message: ICT access and use for communicating messages of health and wellbeing to CALD communities*** - Institute for Community, Ethnicity and Policy Alternatives, Victoria University – May 2010

- DoHA's Carelink service, comprising 'one stop' information and referral centres, is not advertised in the ethnic media;
- The Department of Immigration and Citizenship's (DIAC) Translating and Interpreting Service (TIS) is not advertised in the ethnic media. This service is frequently mentioned in DoHA's (English) literature as a means of obtaining translations or interpreted material;
- The TIS telephone service is manned by English speakers who respond to callers in only English prior to obtaining an interpreter;
- DoHA's website is not intuitive when it comes to seeking information in community languages;
- The limited aged care information on DoHA's website has been translated into 17 community languages only. Compare this to Centrelink's use of 64 community languages, the Commonwealth Ombudsman's 37 and even the Australian Electoral Commission's 26!
- There is little information on residential care for NESB groups and only occasional reference to community aged care packages. Information on Aged Care Assessment, and user rights do far better;
- The aged care part of DoHA's website contains translated information on continence to the exclusion of just about every other health condition such as diabetes and vascular disease. Updates are not obvious;
- The Accreditation Standards relating to residential care have never been translated into community languages by DoHA, nor have the *Specified care and services for residential care services* which appear in the Aged Care Act and Principles 1997. The same can be said of Community Care Standards and definitions.

What this means is that aged care information, such as the recent release of DoHA's *Directory of Services for Older People,* is confined to an English speaking enclave.

In addition, **conscientious service providers are left to translate basic government material into the languages of their residents, thus duplicating effort and costs around the country. Ethno-specific providers themselves need to translate material into English and their community language.**

<u>Information on health</u>

- DoHA has not translated enough health messages into community languages. Examples include the inconsistency and paucity of information on arthritis, cancer, cardiovascular disease, asthma and diabetes which were targeted in the National Chronic Disease Strategy of 2005.
- There is inconsistency in the variety of translated information between community groups. For example, information on falls has not been translated into all the 17 languages used by DoHA.
- The DoHA website contains links to related health websites but these, too, are limited because **the basic information is not available in the first place.**

  To test the system, a search was recently made for information in **Maltese** on **diabetes**. The following sites were interrogated:

- Centre for Cultural Diversity in Ageing
- Diabetes Australia
- HealthInsite
- NSW Health
- Queensland Health
- Health translations Victoria (State Government)
- Multilingual Publications Relating to Ageing and Aged Care
- Department of Health and Ageing

Not one item of information was available. The Maltese are the sixth most numerous ethnic groups aged 65+ in Victoria.

Respite care and Alzheimer's support

Although Carers Australia and Alzheimer's Australia, together with their respective State branches, acknowledge they need to do more for their NESB constituents, they have little idea of how deeply they are currently penetrating CALD communities. This is because they do not record the NESB status of carers or the individuals cared for unlike most State and Commonwealth government funded services. If they did, they might have a better idea of service needs and gaps with a view to developing more CALD appropriate responses.

Given the concentrations and numbers of NESBs in metropolitan planning regions and some regional centres, the expectation should be that NESBs are automatically core business. Instead, it is often the case that CALD communities approach these organizations with funding from another source to develop a more useable service. This reduces NESB agencies and users to 'add-on' status and supplicants.

Where dementia is concerned, DoHA fragments service planning and delivery further by making Dementia Community Grants available to eligible organizations for training, information and specific services with a view to consolidating and disseminating the learnings across the nation. The trouble is that Alzheimer's Australia and its branches also compete for, and succeed in obtaining, this funding which looks like double dipping. And although ethnic agencies get their fair share of funding, certain ethnic groups keep on being funded without evidence that previous information gleaned from the grants has been disseminated. This looks like duplication.

In the meantime, it cannot be demonstrated that anything like the basic and highly used Alzheimer's Dementia Helpline, or even the new online counselling service are accessed by elderly CALD consumers or their families.

EQUITY
Standards of care

Mainstream providers should be held more accountable for the care they provide to NESB consumers in terms of its cultural and linguistic appropriateness. ANAO's recommendation 8 (d) of the previously quoted 2009 report on the ACAR touched on this.[3]

Currently, the current Accreditation Standards for residential care do not sufficiently accommodate cultural and linguistic considerations across the management, health, welfare and social domains. Rather, Accreditation reports tend to concentrate comment on CALD matters in outcome 3.8 – Cultural and spiritual life - which is contained in the Resident lifestyle standard. This was demonstrated by A J Hughes in her study on standards of care for NESBs in Commonwealth funded residential care.[4]

If providers are serious about catering adequately for their CALD residents, this should be evident across all the standards in outcomes such as planning and leadership, education and staff development, continuous improvement, human resource management, information systems, comments and complaints, living environment and clinical care.

The standards themselves do not necessarily need to be rewritten but the considerations in the Results and Processes Guide certainly do. Revision might factor in the principles and measures identified in the Victorian State Department of Health's Cultural Responsiveness Framework.[5] In this way, individual interpretations of the provision of CALD care by assessors would be considerably reduced.

Language services

The provision and use of language services is an under appreciated factor in the assessment of services. Its consideration across the board is absent in the community care standards, and is minimal in the Accreditation standards for residential care. On the latter, the information outcome in standard 1 – Management systems, staffing and organisational development – focuses on the dissemination of information but not on its acquisition. There is no test for NESB consumers on whether information on their care needs is timely or accurate, or whether language services were required, or used, to obtain it.

The communication of needs is dependant on the use of a commonly understood language. Interpreters should be used when there is limited English language proficiency which has been described as the **"limited ability or inability to speak,**

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[3] Australian National Audit Office ***Audit Report No. 40 2008-09 - Performance audit - Planning and Allocating Aged Care Places and Capital Grants*** Commonwealth of Australia

[4] Hughes A J ***People From Ethnic Backgrounds in Commonwealth Funded Residential Care – Victoria:*** A Report funded by the Reichstein Foundation for Australian-Polish Community Services Inc – 2008

[5] Rural and Regional Health and Aged Care Services, Victorian Government, Department of Health, Melbourne, Victoria ***Cultural responsiveness framework - Guidelines for Victorian health services – September 2009 –*** www.health.vic.gov.au/cald

read, write or understand the English language at a level that permits the person to interact effectively with health care providers or social service agencies".[6] In circumstances where staff cannot communicate with, or understand, their care recipients, veterinary care is the result. That is, diagnosis or assessments are based on symptoms without the benefit of verbal descriptions from the care recipient.

Language is also the window on a culture which "gives meaning to life and influences the whole range of an individual's behaviours. It refers to daily practices and special rituals and has an emotional content. It informs how the body is experienced and influences how it is used in social situations. Culture is not a separate need, but rather a framework within which needs might be satisfied".[7]

Language also enhances social connectedness. For this reason, the use of first languages in the day to day activities of a home overcomes social isolation and the behavioural difficulties associated with it. This is one of the reasons why the Community Visitor scheme, funded by DoHA is much valued by NESB residents and agencies.

Costs of language services

Cost is frequently cited as the main reason language services are underutilized.

At a minimum cost of approximately $48 per half hour for the telephone interpreting service (TIS) provided by the Department of Immigration and Citizenship, providers in the metropolitan regions of capital cities will have a higher cost burden than others in accessing this service. After hours rates are $39.05 per 15 minutes.

It is likely, for example, that **a resident with poor English speaking skills will need at least 6 half hour episodes per year of TIS which would cost $288**. Using the actual case of a 90 bed home in Melbourne in which half the residents are from a NESB involving 14 different language groups, TIS would cost at least $12,960 per year for 45 NESB residents. More realistically, probably half this number would need language services which would reduce this figure to about $6,500.

On-site interpreting comes at a higher cost : $159.06 for the first 90 minutes or part thereof. After hours rates are $254.32 for the first 90 minutes or part thereof.

Despite DoHA's insistence that interpreting and translating costs are covered by the Aged Care Funding Instrument (ACFI), this has yet to be demonstrated. In the 4 domains of the ACFI (diagnoses, activities of daily living, behaviour and complex health), there is not one mention of communication (or lack of it) as a dependency indicator or a contributing factor. **This omission suggests that a subsidised language service should be considered in the same way that oxygen and enteral feeding supplements are paid to providers. Alternatively, the concept of a central national pool of funding being quarantined for NESB use**

[6] Ibid

[7] Victorian Association of Hospitals and Extended Care (VAHEC) paper ***The Provision of Aged and Community Care Services to People from Culturally and Linguistically Diverse Backgrounds - 2005***

might be revived. This is reminiscent of Aged and Community Services Australia's (ACSA) policy on CALD care in the last federal election.

Language services are also required for community care for case management, care reviews and assessments at the very least. Where packaged care is concerned, subsidy levels have not kept up with the costs of interpreters or translators or bilingual case management. It should be added that ethno-specific providers also incur these costs.

The provision of language services in Commonwealth funded services, at least in Victoria, would complement the subsidised language services provided by the State Department of Health to those services it funds. **When the Commonwealth assumes responsibility for funding all aged care services, there is an expectation that subsidised language services would continue and extend to all aged care services.**

In the meantime, both ethno-specific and mainstream providers complain at length about the costs of translating basic material with accredited providers and using face to face interpreters.

User rights

Even though NESBs are named as a special needs group in the *Aged Care Act 1997*, DoHA does not indicate in the *Report on the Operations of the Aged Care Act* or its *Annual Report* whether they are exercising their rights relative to their counterparts born in English speaking countries. Given the lack of translated material on residential care, the Accreditation standards and the Community Care standards, the question is raised whether NESBs have sufficient information with which to provide feedback to providers, or to use the Complaints Investigation Scheme despite translated material produced by DoHA on complaints, advocacy and user rights and responsibilities.

DoHA has the data and the technology to trace those care recipients who are the focus of complaints, more particularly whether they come from a NESB. It would be an interesting and informative exercise if this were done.

REGULATION

General comment

Much has been said and written about the over regulation of the aged care industry. Efforts to refine regulatory and financing arrangements, as outlined in the Productivity Commission's *Trends in Aged Care Services: some implications (2008)* are supported.

There are, however, other compliance regimes which are infrequently mentioned in connection with care of the CALD elderly. In this regard, reference is made to anti-discrimination legislation and, in Victoria, recent Human Rights legislation together with the Department of Health's Cultural Responsiveness Framework for health services (including HACC services and public sector residential care facilities) which has been adopted as policy. These developments mean that accountability for CALD care is more rigorous in Victoria and, given the influence that Victoria has had on national aged care policy, will probably set the standard in this area as well.

Cultural responsiveness framework

The framework states that "**Cultural responsiveness …may be viewed as a viable strategy to improve the links between access, equity, quality and safety, better health outcomes for culturally and linguistically diverse populations and as a strategy to enhance the cost effectiveness of health service delivery."**

It contains **4 quality and safety domains with 6 standards** as follows:

Organisational effectiveness

Standard 1
A whole of organization approach to cultural responsiveness is demonstrated.

Standard 2
Leadership for cultural responsiveness is demonstrated by the health service.

Risk management

Standard 3
Accredited interpreters are provided to patients who require one.

Consumer participation

Standard 4
Inclusive practice in care planning is demonstrated, including but not limited to: dietary, spiritual, family, attitudinal, and other cultural practices.

Standard 5
CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis

Effective workforce

Standard 6
Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness.

More interestingly, the outcomes of the framework are distinctly measurable unlike the woolly KPIs adopted by DoHA in its access and equity reporting. An example of one of the sub-measures related to standard 3 is "Evidence of appropriate translations, signage, commonly used consumer/patient forms, education and audio visual materials, in languages other than English for predominant language groups using the service".

This framework is a promising guide to establishing CALD friendly services. It might usefully be adopted as a common guide across health and welfare services nationally.

NATIONAL HEALTH AND HOSPITALS REFORMS

DUTCHCARE RESPONSE

Some of the recommendations emanating from the National Health and Hospitals Review (NHHR) have profound implications for ageing NESBs and those agencies which support them. Comment has been made against the major domains and some of their recommendations because of their relevance to the Productivity Commission's terms of reference and because the ethnic aged received scant attention in the NHHR.

Building good health and wellbeing into our communities and our lives

***Recommendation 3: "Listening to the views of all Australians about our health system and health reforms**….."*

The establishment of Primary Health Care organisations offer some hope of the views of CALD communities and their agencies being obtained on health and welfare issues, assuming there is adequate representation from CALD individuals, practitioners or people closely associated with them. This would be more the case if Victoria's *Cultural responsiveness framework* were adopted because consultation with the various communities would be a 'given'.

Recommendation 4:"We recommend that public reporting on health status, health service use and health outcomes…identifies the impact on population groups who are likely to be disadvantaged in our communities"

There is already sufficient evidence and research, at least in Victoria, which indicates that the NESB aged are to be found at the lowest socio-economic levels in the community and have a higher disease burden than their average Australian born counterparts.[8] This is compounded by language and cultural barriers contributing to their under representation in allied health services, residential care services and community support services.

Recommendation 6: "We recommend the development of accessible information on the health of local communities.

The comments made against recommendation 4 also apply here. The stress related to the migration experience together with trauma and torture that may have occurred before NESBs' arrival in Australia needs to be factored into the 'wellness footprint'.

Recommendation 12: We urge all relevant groups ….to provide access to evidence-based, consumer friendly information that supports people in making health choices and in better understanding and making decisions about their use of health services".

[8] Johnstone M-J and Kanitsaki O: ***The Neglect of Racism as an Ethical Issue in Health Care*** - published in J Immigrant Minority Health DOI 10.1007/s10903-008-9210

Comments on pages 6, 7 and 8 in relation to the non-availability of information on aged care and health care to NESBs apply here. DoHA really needs to lift its game to meet this recommendation.

The following options might be considered:

- Establish one consolidator of health and welfare information sites for the ethnic aged. The Department of Health and Ageing seems an obvious, but currently poor, agent. It can ensure the health messages on specialist sites such as Quit, Diabetes Australia and Alzheimer's Australia meet its population health objectives. DoHA itself could translate far more of its own information into community languages;
- In a spirit of departmental cooperation, DoHA could purchase language services from Centrelink. In this way, the Centrelink phone numbers for specific community languages could be used as an entry point (or conduit) for referral to the source of aged care information (e.g. DoHA and Carelink,) and associated language assistance. An army of multilingual staff already exists. Their services could be extended or expanded to be a first point of contact for aged care information. As it happens, the ethnic aged already see Centrelink as a source of aged care information[9] so this perception might be exploited to their advantage for a change;
- Alternatively ethno-specific providers might be funded to provide point of entry information using existing scarce resources;
- Advertise information sites in the ethnic media;
- Make access to interpreter services more user friendly;
- Advertise interpreter services in the ethnic media so that their use, including cost, availability and modus operandi, becomes acceptable and commonplace;
- Expand the range of translated health and welfare information to cover the key population health messages the Government wishes to disseminate;
- Use more community languages for translated information. To cover numbers initially, the languages used by communities associated with poor English language proficiency might be considered.

Recommendation 14: "We acknowledge the vital role of informal/family carers in supporting and caring for people with chronic conditions, mental disorders, disabilities and frailties…We recommend improved access to respite care arrangements….health of carers should be a priority."

Respite services need to automatically quarantine a substantial amount of their funding, commensurate with NESBs' proportion of the population aged 65+ in each planning region, to CALD service development instead of regarding NESBs as marginal consumers.

As government funded mainstream services, Carers Associations in each State should:

[9] Vainshtein K ***Reaching Out*** - Centre for Cultural Diversity in Ageing – Article in Aged Care INsite – August/September 2008

- be required to maintain minimum data sets (including mandatory reporting items such as country of birth and proficiency in English) on its users (both the carer and the cared for) so that they can ascertain with certainty who they are serving and where the gaps lie;
- be cognisant of the numbers, distribution and composition of the ethnic aged in their respective States and planning regions;
- automatically advertise their presence and services in the ethnic media;
- develop models of support which are culturally and linguistically appropriate for their diverse consumers.

Create strong primary health care services for everyone

Recommendation 21: Service coordination and population health planning priorities should be enhanced at the local level through the establishment of Primary Health Care Organisations, evolving from or replacing the existing Divisions of General Practice….."

In this recommendation, the emphasis should be on "population" which includes people from a NESB, not just those from an English speaking background. Given the current drive for increased migration, this will become the case even more so. This means that ethnic representation is essential in any Primary Health Care Organisation.

Representation, in whatever form it takes, should be in direct proportion to the percentage of the population that the ethnic population occupies.

Ensuring timely access and safe care in hospitals

Recommendation 32: "To support quality improvement we recommend that data on quality and safety should be collated, compared and provided back to hospitals, clinical units and clinicians in a timely fashion to expedite quality and quality improvement cycles. Hospitals should also be required to report on their strategies to improve safety and quality of care and actions taken in response to identified safety issues".

The data collected should include incidents of medical misadventure involving patients who were born in a non-English speaking country. Anecdotally this is said to be extraordinarily high because of communication difficulties.

The adoption of the Victorian Government's Cultural Responsiveness Strategy should go some way to addressing this issue. This is another reason why it should be adopted nationally.

Increasing choice in aged care

Recommendation 42: "We recommend that government subsidies for aged care should be more directly linked to people rather than places

This recommendation has profound implications for ethnic service providers for the aged. It implies that the Aged Care Approvals Round (ACAR) as we know it will

cease. If that is the case, small to medium 'would be' ethno-specific providers will never develop packaged care services on which NESBs unduly rely. Existing agencies may go out of business without adequate indexation and the inability to expand services confidently.

This is because small ethno-specific providers rely on the certainty of places (usually packaged care) allocated in the ACAR, together with establishment funds, to develop new services. If this ceases, they will be required to advertise their services at a cost they may not be able to support, and to start up services (rental of premises, purchase of cars, recruitment of staff) without sufficient fund raising capacity or the ability to service a loan. This means that mainstream services will assume the bulk of care for CALD individuals. Choice will be reduced.

In addition, if the free market reigns, mainstream providers can choose not to accommodate the ethnic aged, or phase them out, on the grounds they belong in the "too hard basket". With no allocation or monitoring of NESB places, how will DoHA know what is happening in respect of access and equity for this client group?

Safety nets for ethno-specific agencies might be developed. For example:

- DoHA could provide incentives to small ethno-specific providers to amalgamate. There is a precedence for this in the "Small Homes Initiative" of the early 1990s or thereabouts;
- incentives for multicultural services could be established. "Multicultural" in this instance means ethno-specific providers (i.e. not mainstream) who provide for more than one ethnic group. Experience suggests that providers would go for a 'best match" arrangement in which the new groups share similarities in language and cultural practice;
- establishment grants (and perhaps capital funding) could be provided to viable ethnic groups who can demonstrate a market for their services in respect of sizeable numbers of NESB consumers;
- compensation could be made for 15 years of under service provision by over-targeting NESB communities in the next 10 years;
- incentives could be established for mainstream services to incorporate (in the legal sense) with one or more ethno-specific groups, the idea being that there would be ethnic representation on the Boards of the organisations and legal obligations towards providing ethno-specific services for the NESB groups in question;
- in the absence of NESB allocations, a proportion of all aged care places in a planning region could be declared for use by NESBs. (This is akin to the ratios of places that need to be set aside in each region for concessional residents.) These proportions could be reviewed every three years. Needless to say, the use of these places should be monitored.

Supporting people living with mental illness

Recommendation 78: "As a matter of some urgency, governments must collaborate to develop a strategy for ensuring that older Australians, including those residing in aged care facilities, have adequate access to speciality mental health and dementia care services".

Post war migrants have experienced trauma and stress above and beyond the average Australian. Although borne stoically, these scars become evident in later life in the form of anxiety disorders, depression, post traumatic stress and alcohol/substance abuse. Psychogeriatric services need to accommodate this.

Strengthening the governance of health and health care

Recommendation 88.1: "The Commonwealth Government would assume full responsibility for the policy and public funding of primary health care services".

If this arrangement overcame barriers to the ethnic aged accessing care to a range of programs, it would be supported. The Commonwealth would need to adopt practices which ensure it is aware of what is happening at the grass roots level and adopt a comprehensive strategy for addressing the care needs of the ethnic aged rather than continuing with the current piecemeal approach which is unintentionally discriminatory.

This might include acting concretely (and in a measurable way) on its access and equity principles, factoring in the NESB demographics in its planning considerations, introducing subsidised language services across the board, annually assessing the position of the ethnic aged nationally across government funded services, researching the reasons for differential uptake of services, introducing service types (in consultation with NESB individuals and providers) which are more likely to be used by the client group, and rewarding the employment of practitioners who speak the language of the NESB care recipients.

Recommendation 88.6: "The Commonwealth Government would assume full responsibility for the public funding of aged care"

Previous comments apply with the added qualification that Commonwealth would need to improve its performance in information provision, targeting and coordination.

Recommendation 89: "We believe that there is a real need to further improve the responsiveness and efficiency of the health system and capacity for innovation. We agree that greater consumer choice and provider competition and better use of public and private heath resources could offer the potential to achieve this……"

Consumer choice in the case of people from a NESB would include ethno-specific providers and services. For that reason, their existence in the aged care sector needs to be preserved and expanded.

The cast-iron nature of Budget appropriations militates against innovation. These need to be relaxed. For example, the Homeshare program battled for 10 years to get

funding under the Home and Community Care Program in Victoria because it did not sit easily in community care or housing programs. It does, however, have the capacity to be generalised across community groups with a range of auspices.

To elaborate, Homeshare provides a professional matching and monitoring service to bring together older people (defined as the householder) who need some help around the home and would benefit from having someone in their home at night, and younger people (defined as the homesharer) who need affordable and stable accommodation. The younger person also provides up to 10 hours of (non personal care) support per week to the older person.

Experience in Victoria has shown that householders and housesharers have come from different ethnic backgrounds. Pilots might demonstrate whether the scheme could be extended to specific CALD communities, using overseas students as housesharers while they are in Australia and perhaps beyond if citizenship is sought. Extra care would need to be taken that there is cultural and linguistic compatibility.

Homeshare keeps the householder in the community with all his or her usual social connections. It has been demonstrated to delay the admission of householders to residential care and comes at a lower cost to Government for that reason.

Wesley Mission Victoria currently administers Homeshare in Victoria.

Working for us: a sustainable health workforce for the future

Recommendation 101 "To ensure better collaboration, communication and planning between the health services and health education and training sectors we recommend the establishment of a National Clinical Education and Training Agency……."

Nationally consistent education and training across all States is welcomed.

In an environment marked by an ageing population and increasing difficulty in recruiting sufficient numbers of aged care workers, especially bilingual ones, there is scope for a national education and training agency to:

- consider a sliding scale of incentives to attract bilingual school leavers or individuals seeking a vocational change to undergo nursing or other professional training. The most lucrative incentives could be directed towards individuals who speak one of the languages of the current cohort of NESB aged care recipients. A lesser incentive could be paid in respect of those who speak the languages of the future cohort of aged care recipients, followed by those who speak any other language in addition to English, the assumption being that they will be more culturally sensitive to diversity in the workforce and client composition;
- consider extending the national training body to include community care work or establish a separate body for this purpose;
- consider building on the need for older workers to stay employed by encouraging older NESBs (possibly retrenched in the international financial

climate) to consider employment in aged care as personal carers in the community, residential care or hospitals;

- consider the establishment of employment and training agencies specifically for workers from NESBs to make it easier for potential employers to recruit suitable, trained personnel who can communicate with their NESB care recipients. Training in English as a second language could also be considered in this context to improve or maintain English language skills;
- establish a career structure for interpreters and translators. Skilled migration intakes could include interpreters and translators instead of hairdressers.

PRODUCTIVITY COMMISSION RESEARCH PAPER

TRENDS IN AGED CARE SERVICES: SOME IMPLICATIONS

SEPTEMBER 2008

DUTCHCARE RESPONSE

Comments made previously in this submission on how people from a non-English speaking background (NESB) are situated in respect of the current system of aged care and the National Health and Hospitals Review are also germane to the options presented in the Productivity Commission's research paper cited above. For ease of writing, and to avoid repetition, additional or qualifying, comment has been made against the same thematic headings as the Commission.

Profile of aged care

The 2006 Census confirmed the increasing numbers and diversity of ageing people from a NESB.

Whether by accident or design, the ethnic aged have preempted the preference for community care over residential care. As previously indicated, however, they are proportionally over represented at the high end of packaged care compared to their counterparts born in English speaking countries. By contrast, they are under represented at the low end of care in the Home and Community Care Program especially in allied health and respite care. Residential care appears to be an option of last resort by which time care needs are at the high end of the spectrum.

While the preference for community care is likely to continue, service providers will need to increasingly accommodate the role of family in the care giving role and, conversely, make provision for those NESBs living alone, or without transport, who are more vulnerable to social isolation. On the latter, the understated social support programs such as visiting services, planned activity groups and telephone contact schemes funded under the Home and Community Care Program deserve a special mention because of their importance in maintaining social connectedness in CALD communities.

Early action in respect of illness prevention and disease maintenance is seen by the Government as a means of reducing the use and costs of aged care in acute and residential settings. These measures, however, rely on healthy lifestyle and chronic disease information being available to the target population. In this regard, there needs to be a monumental effort on the part of DoHA to improve the dissemination of information to ethnic communities by means that are likely to be accessed and understood.

Access and equity provisions of the various levels of government indicate that ethno-specific services will remain a preference for many NESBs even though mainstream services will continue to provide the bulk of services to this client group because of financial imperatives. Maintaining ethno-specific continuity of care from low level care upwards will remain a challenge while CALD care in mainstream services remains questionable.

Future demand for aged care services

Comments above also apply to this aspect of care, however, additional comment is made as follows.

Aged care providers, Alzheimer's Australia and Carers Australia will need to accommodate ageing people from CALD communities with dementia. To do so they must appreciate how different communities view the disease, the role of family members and how they can be assisted in a culturally appropriate manner.[10] The objectives of Alzheimer's Australia and Carers Australia suggest they should be doing this kind of investigation automatically as part of their core business but currently it is being done on a piecemeal basis. There is no national strategy on addressing this issue.

Once again, community education on dementia needs to be provided by means which will be accessed by the communities in question. Ethnic media again comes to the fore.[11]

Needless to say, the use of community languages becomes paramount as people with dementia increasingly revert to their first language. This also has repercussions for assessments for dementia which need to avoid cultural bias. On this subject, the RUDAS assessment tool, developed in Australia, is a welcome development.

Similar comments also apply to palliative care for individuals from a CALD background.[12]

[10] Cultural and Indigenous Research Centre Australia (CIRCA) ***CALD Dementia Strategic Model*** (Literature review, report, model) prepared for NSW Department of Ageing, Disability and Home Care – April 2008

[11] Ibid

[12] Cultural and Indigenous Research Centre Australia (CIRCA***): Planning Ahead in Culturally and Linguistically Diverse (CALD) Communities*** prepared for NSW Department of Ageing, Disability and Home Care – April 2008

Equity, efficiency and sustainability

In terms of equity, the lack of language services and available, accessible information continue to act as impediments to CALD individuals accessing various types of aged care.[13] In an environment where elderly NESBs have already voted in favour of community care, information in a language they can understand becomes even more important in terms of their knowing what is available and how the system works.

There are efficiencies to be gained by interdepartmental cooperation at the federal level in respect of translations of government material, the use of existing multilingual resources such as the Centrelink newsletters and telephone contact points, and the use of government funded translators and interpreters via the Department of Immigration and Citizenship.

There are hidden costs associated with the lack of information and language services, namely, the costs of dealing with the hard end of chronic care, and challenging behaviours resulting from isolation and communication difficulties.

Compounding this problem is the fact that care hours of packaged care are reduced when language services are used and/or bilingual case management needs to be purchased via a brokerage system for NESB consumers. As a general comment, the lack of indexation in community care to match increased costs has also added to the decrease in the care hours on which NESBs rely especially at the high end of care.

Comment has previously been made on the Aged Care Funding Instrument in residential care not accommodating the lack of every day communication as a dependency issue, or the provision of language services as a cost issue.

Although the unbundling of accommodation from care services has been suggested as a means of directing subsidies more fairly across the board, the implication is that the consumer has greater freedom to choose the care he or she needs. Again this assumes the consumer knows about the options and indeed, the system as a whole.

Quality and choice

Efficiencies are to be gained in the national adoption of a cultural responsiveness strategy and standards in both the health and welfare sectors. This is especially the case now that the Commonwealth has assumed responsibility for the major funding of aged and health care services.

Quality of care standards do not address CALD considerations across all their dimensions in both residential and packaged care. Amending the auditing guidelines might correct this. Underwhelming CALD appropriate care contributes to the lack of continuity in ethno-specific care when mainstream providers are called on to provide the next level of care.

[13] Vainshtein K ***Reaching Out*** - Centre for Cultural Diversity in Ageing – Article in Aged Care INsite – August/September 2008

Consumer directed care might enhance choice but the information needs of the consumer will increase. On current indications, CALD care recipients will be seriously under informed on what is available.

Given the greater responsibilities that some CALD communities assume in respect of their elders, consideration might be given to enabling family members to be paid via subsidies for the care they provide.

The scope of services might also include permutations and variations in transport arrangements so that social connectedness can be maintained, and, say, matching services required to organise alternative, shared living arrangements such as Homeshare.

Workforce: emerging issues

Financial incentives might be provided to students and staff who speak the first languages of CALD care recipients.

Skilled migrants might include people who wish to work in aged care or who wish to become accredited interpreters and translators in the predominant languages used in aged care.

Volunteers, although motivated by altruism, still require a great deal of maintenance in terms of recognition and social reward. This comes at an administrative cost to sponsoring organizations which is conveniently overlooked by government. Petrol costs are the subject of frequent complaint.

Productivity in aged care

Areas for productivity gains in the area of CALD care would appear to be limited. The bulk of ethno-specific providers tend to be small to medium sized. Amalgamating might be one way to obtain cost efficiencies together with diversification into the training of personnel in aged care or English as a second language.

The best gift to ageing CALD consumers would be the development of a cohesive national strategy on their care. If a whole of government approach is too difficult to achieve, at least DoHA might develop one instead of administering the current miscellany of programs which are aimed at individual organisations rather than the ethnic aged as a whole. Social inclusion principles suggest a more cohesive, consultative approach.

CONSOLIDATED LIST OF RECOMMENDATIONS

Planning of services by the DoHA for the CALD elderly

In the interests of transparency and accountability, DoHA could prepare for its approvals rounds by:

- providing standard data to the Aged Care Planning Advisory Committees and the general public in each State and Territory on the
    - percentage of people from a non-English speaking background in the targeted aged population in each of the planning regions. For the sake of consistency, place of birth, i.e., English speaking country versus mainly non-English speaking country, should be used;
    - information on the numbers, distribution and type of NESB places in each of the planning regions;
    - statistics as at 30 June of the ACAR year on the uptake of all types of care (separately – CACP, EACH, EACHD and residential) by NESB care recipients in each of the planning regions;
    - statistics as at 30 June of the ACAR year on the uptake of all the HACC services by NESB seniors.
- as a starting point, allocating NESB places to the planning regions in direct proportion to their percentage of the targeted aged population, factoring in the skewed use of services;
- fine tuning the indicative allocations in each planning region according to what is happening to CALD seniors in the range of Commonwealth funded aged care programs including HACC;
- providing more consideration to funding ethnic agencies, that is, agencies which provide ethno-specific care to either one community or several ethnic groups. The reality is that these services are perceived to provide more appropriate care to their clients than mainstream providers. Research also indicates that ethno-specific care results in more satisfied consumers who need fewer care interventions for "behavioural problems";
- allocating numbers of NESB places to individual mainstream providers in direct proportion to the percentage of NESBs in the targeted aged population in the planning region;
- publishing the outcomes of the ACAR in a way which identifies mainstream and ethno-specific agencies which were allocated NESB places, the numbers of places, the geographical distribution of those places by planning region, and the type of place. (If it can, it should do this retrospectively to make good the information deficit of the past 12 years.);

- monitoring the use of NESB allocations to all providers by CALD consumers. Not to do so raises the issue of providers receiving places under false pretensions;

- reporting to Parliament on CALD access and equity issues in terms of numbers of NESB places allocated, distribution, uptake and quality of care compared to elderly people born in an English speaking country. The current reporting on access an equity through the Department of Immigration and Citizenship and the *Report on the Operations of the Aged Care* Act lacks cohesion, direction, concrete goals and KPIs;

- introducing (**as per ANAO's recommendations in 2002**) an effective means to maintain project officers' local knowledge of aged care needs, including contact with State health agencies;

- developing a methodical, cohesive strategy on ethnic aged care. The current measures are piecemeal and unintentionally discriminatory;

- formally consulting with ethno-specific aged care providers and consumers.

Standards of care

- Mainstream providers should be held more accountable for the care they provide to NESB consumers in terms of its cultural and linguistic appropriateness. Considerations in the Results and process guide used in connection with residential care should be revised to accommodate CALD considerations.

  The principles contained in the Victorian Government's Cultural Responsiveness framework might be used for this purpose.

Cultural responsiveness by service providers

- The Victorian State Department of Health's *Cultural Responsiveness Framework* might be usefully adapted and adopted as a common guide across all health and welfare services nationally.

Information services for the ethnic aged

- Establish one consolidator of health and welfare information sites for the ethnic aged. The Department of Health and Ageing seems an obvious, but currently poor, agent. It can ensure the health messages on specialist sites such as Quit, Diabetes Australia and Alzheimer's Australia meet its population health objectives. DoHA itself could translate far more of its own information into community languages;
- in a spirit of departmental cooperation, DoHA could purchase language services from Centrelink. In this way, the Centrelink phone numbers for specific community languages could be used as an entry point (or conduit) for referral to the source of aged care information (e.g. DoHA and Carelink,) and associated language assistance. An army of multilingual staff already exists. Their services could be extended or expanded to be a first point of contact for aged care information. As it happens, the ethnic aged already see Centrelink

as a source of aged care information[14] so this perception might be exploited to their advantage for a change;
- alternatively ethno-specific providers might be funded to provide point of entry information using existing scarce resources;
- advertise information sites in the ethnic media;
- make access to interpreter services more user friendly;
- advertise interpreter services in the ethnic media so that their use, including cost, availability and modus operandi, becomes acceptable and commonplace;
- expand the range of translated health and welfare information to cover the key population health messages the Government wishes to disseminate;
- use more community languages for translated information. To cover numbers initially, the languages used by communities associated with poor English language proficiency might be considered.

CALD use of services provided by Alzheimer's Australia and Carers' Australia

Both Alzheimer's Australia and Carers' Australia should

- be required to maintain minimum data sets (including mandatory reporting items such as country of birth and proficiency in English) on its users (both the carer and the cared for) so that they can ascertain with certainty who they are serving and where the gaps lie;
- be cognisant of the numbers, distribution and composition of the ethnic aged in their respective States and planning regions;
- automatically advertise their presence and services in the ethnic media;
- develop models of support which are culturally and linguistically appropriate for their diverse consumers.

Strong primary health services for everyone

- Ethnic representation in Primary Health Care Organisations should be in direct proportion to the proportion of the population that the ethnic population occupies.

Ensuring timely access and safe care in hospitals

- The adoption of the Victorian Government's Cultural Responsiveness Strategy should be adopted nationally to address this issue.

Increasing choice in aged care for CALD consumers in a market economy

Safety nets for ethno-specific agencies might be developed. For example:

- DoHA could provide incentives to small ethno-specific providers to amalgamate. There is a precedence for this in the "Small Homes Initiative" of the early 1990s or thereabouts;

[14] Vainshtein K ***Reaching Out*** - Centre for Cultural Diversity in Ageing – Article in Aged Care INsite – August/September 2008

- incentives for multicultural services could be established. "Multicultural" in this instance means ethno-specific providers (i.e. not mainstream) who provide for more than one ethnic group. Experience suggests that providers would go for a 'best match" arrangement in which the new groups share similarities in language and cultural practice;
- establishment grants (and perhaps capital funding) could be provided to viable ethnic groups who can demonstrate a market for their services in respect of sizeable numbers of NESB consumers;
- compensation could be made for 15 years of under service provision by over-targeting NESB communities in the next 10 years;
- incentives could be established for mainstream services to incorporate (in the legal sense) with one or more ethno-specific groups, the idea being that there would be ethnic representation on the Boards of the organisations and legal obligations towards providing ethno-specific services for the NESB groups in question;
- in the absence of NESB allocations, a proportion of all aged care places in a planning region could be declared for use by NESBs. (This is akin to the ratios of places that need to be set aside in each region for concessional residents.) These proportions could be reviewed every three years. Needless to say, the use of these places should be monitored.

On the Commonwealth Government assuming full responsibility for the policy and public funding of primary health care services

- The Commonwealth would need to adopt practices which ensure it is aware of what is happening at the grass roots level and adopt a comprehensive strategy for addressing the care needs of the ethnic aged rather than continuing with the current piecemeal approach which is unintentionally discriminatory.

  This might include acting concretely (and in a measurable way) on its access and equity principles, factoring in the NESB demographics in its planning considerations, introducing subsidised language services across the board, annually assessing the position of the ethnic aged nationally across government funded services, researching the reasons for differential uptake of services, introducing service types (in consultation with NESB individuals and providers) which are more likely to be used by the client group, and rewarding the employment of practitioners who speak the language of the NESB care recipients.

On the Commonwealth Government assuming full responsibility for the public funding of aged care

- Previous comments apply with the added qualification that Commonwealth would need to improve its performance in information provision, targeting and coordination.

Innovation

- The rigidity of Budget appropriations needs to be relaxed to encourage innovation.

Sustainable health workforce for the future

The Government needs to

- consider a sliding scale of incentives to attract bilingual school leavers or individuals seeking a vocational change to undergo nursing or other professional training. The most lucrative incentives could be directed towards individuals who speak one of the languages of the current cohort of NESB aged care recipients. A lesser incentive could be paid in respect of those who speak the languages of the future cohort of aged care recipients, followed by those who speak any other language in addition to English, the assumption being that they will be more culturally sensitive to diversity in the workforce and client composition;
- consider extending the national training body to include community care work or establish a separate body for this purpose;
- consider building on the need for older workers to stay employed by encouraging older NESBs (possibly retrenched in the international financial climate) to consider employment in aged care as personal carers in the community, residential care or hospitals;
- consider the establishment of employment and training agencies specifically for workers from NESBs to make it easier for potential employers to recruit suitable, trained personnel who can communicate with their NESB care recipients. Training in English as a second language could also be considered in this context to improve or maintain English language skills;
- establish a career structure for interpreters and translators. Skilled migration intakes could include interpreters and translators instead of hairdressers.

Future demand for aged care services

- Aged care providers, Alzheimer's Australia and Carers Australia will need to accommodate ageing people from CALD communities with dementia. To do so they must appreciate how different communities view the disease, the role of family members and how they can be assisted in a culturally appropriate manner.

A national strategy for CALD care

- Repeating a comment on page 27, this might include DoHA acting concretely (and in a measurable way) on its access and equity principles, factoring in the NESB demographics in its planning considerations, introducing subsidised language services across the board, annually assessing the position of the ethnic aged nationally across government funded services, researching the reasons for differential uptake of services, introducing service types (in consultation with NESB individuals and providers) which are more likely to be used by the client group, factoring in CALD considerations to the standards of care and rewarding the employment of practitioners who speak the language of the NESB care recipients.