Submission by:

D utchCare L td

CARING FOR OLDER AUSTRALIANS:

SUBMISSION 2

D utchCare L td

AS AN ETHNO-SPECIFIC SERVICE PROVIDER

JULY 2010 – SUBMISSION 2

TABLE OF CONTENTS

PRODUCTIVITY COMMISSION
CARING FOR OLDER AUSTRALIANS
SUBMISSION 2 – PREPARED BY DUTCHCARE LTD
AS AN ETHNO-SPECIFIC SERVICE PROVIDER

PRODUCTIVITY COMMISSION – CARING FOR OLDER AUSTRALIANS

SUBMISSION 2 - PREPARED BY DUTCHCARE LTD
AS AN ETHNO-SPECIFIC SERVICE PROVIDER

JULY 2010

DutchCare has been prompted to write two submissions in respect of this current inquiry into the care of older Australians. The first was written from the perspective of both ageing people from a non-English speaking background (NESB) and the ethnic agencies which support them. Its purpose was to highlight the flaws in the current system of aged care provision in the expectation that they will not be perpetuated in a new system.

This submission has been written from the perspective of an ethno-specific service provider for the Dutch community.

Background

Statistically, the 2006 Census indicated that the Dutch are the fourth biggest ethnic group aged 65+ in Australia and Victoria. This factor alone has given the community a strength which is a rare commodity in the ethnic aged environment.

Culturally, the Dutch come from both a merchant and a 'giving' background which has led to a range of services for the aged being developed. Significant fund raising capital has enabled innovative services to be established such as the Eden principle of service delivery and more recently the development of "apartments for life".

Currently, DutchCare Ltd is the provider of high and low level residential care, Community Aged Care Packages (CACPs), EACH (Extended Aged Care at Home) packages and a Community Visitors Program which are all funded by the Department of Health and Ageing (DoHA). It has also received a one-off grant from DoHA in respect of a dementia awareness program. In addition, DutchCare receives funding from the Victorian Government in respect of social support programs, namely a Telelink service, Friendly Visiting and planned activity groups. It has also built independent living units.

All the services for the aged offered by DutchCare are aimed at Dutch-born people, i.e. they are Dutch specific. Despite the fact that the Dutch seem to be well assimilated, there are several reasons why Dutch specific services best suit the Dutch aged. The first is English language loss and language reversal among older migrants. Almost all mainstream services are at a loss when dealing with clients reverting to a language other than English, including Dutch or one of its dialects.

Secondly, experience shows that despite their best intentions, mainstream providers either do not really understand the needs of older Dutch Australians or find it extremely difficult to offer them a culturally appropriate service. There are few operators who do it well. This is evidenced by Dutch 'refugees' who transfer to DutchCare from mainstream services.

The Dutch word – gezelligheid – (cosiness, atmosphere, sharing, and company) has been an important building block in developing services for Dutch elders. People want the choice of communicating in either Dutch or English. They want to experience life the Dutch way which includes traditional meals, leisure activities, domestic activities and social interaction in a physical environment which reminds them of the Netherlands. They want to receive spiritual, medical and welfare interventions the way they are used to. They want to share their last years reminiscing with others about their life which includes the war years, the migrant experience and the positive and negative aspects of growing older in a country which is not quite home.

Challenges in the current aged care system

The biggest challenge facing ethno-specific providers and their constituents is the absence of a national strategy to accommodate the ethnic aged who are assuming significant proportions of the ageing population, particularly around capital cities.

Dutch Care's first submission discussed the flaws in the current system at length because no other organisation appears to have analysed the system as a whole in respect of the NESB experience.

In short,

- there is little evidence of CALD demographics being considered in the planning of aged and health care services,
- there is no systematic input from CALD communities in the planning process;
- the competitive allocation of places destroys cooperative arrangements between service providers,
- information in community languages on aged care and health services is virtually non-existent;
- NESBs' take up, or use, of aged care services at the local level is unknown despite government departments' so-called access and equity reporting;
- standards of care do not cover CALD considerations, particularly language/communication, across all their domains;
- funding does not cover the extra costs associated with CALD care, and
- Alzheimer's Australia and Carers' Australia, who provide essential support services, focus primarily on English speakers.

Assessment services

There is currently a plethora of assessment processes across the nation. DutchCare supports the development of universal assessment documentation and processes which will accommodate any level of care from light to acute. It is assumed that different agencies, with the appropriate skills level, will conduct the assessments, depending on the complexity of the presenting care needs.

Provision needs to be made for the use of language services, and assessments which are free from cultural bias.

On this, the Dutch are good English speakers up to a point. Once they withdraw from the workforce and become older, their use of English declines and is less reliable. They may need language services in situations which will have a significant impact on their lives such as aged care assessment and admission to residential care.

Assessors also need to factor in cultural attitudes to ageing, aged care (particularly dementia care) and traditional family obligations.

Combined with electronic client records, this should lead to greater efficiency and accuracy for the consumer and care providers.

Recommendation:

The Australian Government should introduce one assessment document and one assessment process for the aged, ensuring that language services and culturally unbiased procedures are employed.

Cultural attitudes and responses to the various aspects of aged care should be factored into any assessment.

Regulation

DutchCare believes there is too much regulation in some areas of aged care and not enough in others, particularly where the ethnic aged are concerned.

Buildings

In the case of residential aged care facilities, certification should be replaced by the Building Code of Australia with perhaps a few measures to ensure the safety and security of frail, aged people.

The drive to provide one-bed rooms with ensuite bathroom and toilet facilities has led to some perverse outcomes. The extra area created by these developments means that care staff take more time to move between residents. This reduces hours of direct care and contributes to occupational health and safety concerns.

Market forces can determine whether multiple bed rooms will be an acceptable option for future residents. In the meantime, certification requirements add to the costs of establishing and retrofitting buildings.

Recommendation:

To reduce duplication, the Building Code of Australia should replace certification with a few additional measures to cover the safety and security of frail, elderly people.

Consumer costs

The legislative ceilings placed on consumer fees and charges have contributed to a situation where providers cannot provide the hours of care their care recipients require nor cover the costs of maintaining or replacing their buildings. This is particularly the case for high level care where bonds are not payable unless extra service status has been conferred on a service.

DutchCare believes that consumers should pay more for their care and that high care residents should pay a bond, or the equivalent of a bond, in the form of charges which meet the costs of a loan, interest and principal of buildings. In the case of financially disadvantaged residents, the Government should pay this amount. For those who can make a partial contribution, the Government should pay the difference.

DutchCare has canvassed the views of older Dutch people on this issue. Potential consumers are prepared to pay bonds in respect of high level care provided everyone else is required to do so. At the moment, they do not see value for money in an extra service situation where the "extra service" appears to be little more that a glass of wine at meal times and the delivery of the daily newspaper. They can buy that for themselves in a general purpose home.

Recommendation:

Residents, where possible, should contribute more to the costs of their accommodation and care. If the current regime persists, bonds or charges should apply to both high and low level care and that the costs of loans, interest and capital of buildings should be covered.

The Government should pay the difference between what the resident can pay and the full amount of charge or bond.

Accreditation

Because of the range of aged care services DutchCare provides, it must submit to a different accreditation process in respect of residential care, packaged care and Home and Community Care services. This is onerous and time wasting because of the different components to report on. For example, there is no overarching management standard in the community care standards whereas there is in the accreditation standards for residential care.

Although there have been recent attempts by the Department of Health and Ageing (DoHA) to rationalise the system, an existing accreditation system such as that operating under the JAS ANZ framework, would be more efficient.

Recommendation:

With the Commonwealth gradually assuming responsibility for the policy and funding of aged care services, one accreditation process should cover the lot.

Complaints

The Complaints Investigation Scheme has reached the stage of overkill. The investigation of 63% of complaints is more indicative of DoHA's need to protect ministerial interests than on protecting the rights of aged care consumers. In this regard, impartiality is perceived to be a casualty. An independent complaints handling body such as that recommended by Merrilyn Walton in her review of the CIS in 2009, is preferred.

It is not cost effective for an army of Complaints Investigators to pursue relatively minor complaints such as lost clothing and charging for generic goods. For this reason, a triaging system should be introduced to establish a hierarchy of seriousness.

Multiple visits by Complaints Investigation Officers, combined with the generation of copious documentation, take up much time which detracts from client care.

Conversely, despite the availability of information on user rights in community languages, residential and community care standards have not been translated into community languages by DoHA. In addition, DoHA does not register the ethnicity or country of birth of complainants or the relevant care recipient. It is therefore unknown whether NESB complainants or care recipients have equal access to, and use of, complaints processes.

In any complaints investigation scheme, consideration needs to be given to the cultural norms of complainants and care recipients. This needs to be factored into the training of investigators.

With the federal Government assuming responsibility for policy and funding of aged care services, the scope of the CIS should be extended to cover the Home and Community Care Program, transitional care and any other variant on aged care that emerges.

Recommendation:

An independent complaints investigation body should be established in the interests of fairness and transparency.

DoHA should make a greater effort to extend the CIS to NESB carers and care recipients by translating more of its aged care information into community languages, particularly the standards relating to residential and community care.

Training of investigators should include cultural responsiveness.

The complaints Scheme be extended to cover all aged care which the Government funds.

User rights

Advocacy

There are numerous advocacy bodies in aged care which cover specific programs. For example, the advocacy services funded by DoHA cover residential and community care and those people who have been assessed by an Aged Care Assessment Team. The Victorian Government also funds advocacy services germane to the aged such as Senior Rights Victoria which addresses elder abuse.

Again, with the federal Government assuming responsibility for policy and funding of aged care services, there may be room to rationalise these sorts of services by establishing an older persons' ombudsman or commission which does not distinguish between programs but rather focuses on the elderly individual. Needless to say, provision should be made for NESB consumers in the way of language services and cultural responsiveness.

Recommendation:

Consideration be given to rationalising and consolidating advocacy services for the aged.

Information

The National Health and Hospitals reforms rely on ageing people having access to information on aged care options and lifestyle choices related to disease prevention. As many NESBs do not have competent English in respect of the medical or technical aspects of ageing or disease, they will be seeking information in their first language. The Dutch are no exception.

Logically, the information portals used by DoHA should be the first point of contact given the subject matter. In this regard, DoHA starts from a poor position in that it:

- does not advertise its own Aged Care Information Line in the ethnic media;
- does not advertise the Carelink service in the ethnic media;
- has not translated major documents associated with aged care into community languages. Examples include the "5 Steps to Entry into Residential Care", the Accreditation Standards for residential care and the standards for community care;
- 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;
- does not use enough community languages in its translated material. Currently it provides information in 17 languages. Compare this to the Commonwealth Ombudsman who uses 36 and Centrelink which uses 64.
- rarely uses ethnic media to convey its messages even though this is the most effective means of conveying information to NESBs;
- persists in referring poor, or non-English speaking people via English publications (!) to the Department of Immigration and Citizenship's Translating and Interpreting Service (TIS) but that, too, is counter-productive

because that service does not advertise its availability, modus operandi or costs in the ethnic media.

Recommendation:

- **To reduce duplication and cost, establish one health and welfare information site for the ethnic aged. The Department of Health and Ageing seems an obvious, but currently poor, agent to develop this. It could ensure that the health messages on specialist sites such as Quit, Diabetes Australia and Alzheimer's Australia meet its population health objectives.**
- **In a gesture of Departmental cooperation, DoHA could purchase language services from Centrelink. In this way, the Centrelink phone numbers could be used as an entry point (or conduit) for referral to the source of aged care information (Carelink, for example) 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[1] so this perception might be exploited to their advantage for a change.**
- **DoHA should advertise information sites in the ethnic media;**
- **The Government should make access to interpreter services more user friendly;**
- **Interpreter services should be advertised in the ethnic media so that their use becomes acceptable and commonplace;**
- **The range of translated health and welfare information should be extended to cover the key population health messages the Government wishes to disseminate;**
- **More community languages should be used for translated information. To cover numbers initially, the languages used by communities associated with poor English language proficiency might be considered.**

Community Visitors and Telelink services

As social connectedness is a social determinant of health, efforts to keep individuals connected to their friends, families and communities make a valuable contribution to averting or reducing care interventions associated with isolation. In this regard, the Community Visitors, Friendly Visitors and Telelink volunteers auspiced by DutchCare with the assistance of State and/or federal funding, keep Dutch speakers in contact with other Dutch speakers.

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

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

The use and function of language cannot be underestimated. Language is 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".[2]

The Community/FriendlyVisitors and Telelink programs are low cost programs which are highly valued by ethno-specific service providers and their constituents. They should be maintained and expanded in the current, and any changed, aged care regime even if the latter becomes market driven. They work well.

Recommendation:

The Community/Friendly Visitors and Telelink programs be continued and expanded to overcome social isolation in residential and community settings. Particular attention should be given to CALD consumers.

Funding

It has become increasingly obvious that subsidies for aged care have not kept up with the costs. The recent cost of living adjustments to subsidies reinforced this point.

Graham Shotter from Royal Freemasons Ltd in Victoria has eloquently expressed the situation of aged care providers like DutchCare who are finding the operating environment exceedingly challenging because of the declining value of subsidies. A copy of his letter to the Prime Minister is at Attachment A.

In addition, where the ethnic aged in residential are concerned, the Aged Care Funding Instrument (ACFI) does not cover the extra costs associated with their care, especially language services. In the 4 domains of the ACFI (diagnoses, activities of daily living, behaviour and complex health), there is not one mention of communication in either ascertaining overall dependency levels or contributing to them.

There are duty of care elements in this consideration. Failure to use language services results in providers guessing or ignoring the clinical, social, spiritual and environmental aspects of NESBs'care. NESBs are also disempowered from making informed decisions about their care and are isolated which leads to "behavioural problems" which are, in reality, communication impediments.

Even DutchCare must use interpreters when a more obscure dialect is involved. At a minimum cost of approximately $48 per half hour (after hours $39.05 per 15 minutes) for the telephone interpreting service (TIS) provided by the Department of Immigration and Citizenship, providers such as DutchCare, which are in the

[2] 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***

metropolitan regions of capital cities where the NESBs are concentrated, will have a higher cost burden than others in accessing this service.

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. Funding for each level of dependency does no cover these costs. In keeping with the 'Hogan" report, it is suggested that a regional pool of funds be set aside for these special imposts.

Additional comment is warranted in respect of community care packages. DutchCare provides ethno-specific care via CACPs and EACH packages. Our elders are dispersed throughout the metropolitan planning regions in which our packages have been allocated. Some of these regions are huge and, at their outer boundaries, could be described as semi-rural. While efforts are made to match care recipients with careworkers who live close by, this is difficult to achieve. This means that extra hours are spent in travel and extra dollars spent on fuel. Subsidies so not cover these costs. This method of care delivery is unsustainable especially in a country as big as Australia.

This situation is one of the reasons DutchCare is now pursuing the concept of "apartments for life" in which ageing Dutch people purchase, and move into, private apartments built by DutchCare so that when care is required, it can be delivered on one site.

Although DutchCare reached the building stage of this development earlier this year, its plans were thwarted in a successful VCAT challenge, however, DutchCare will persist in the face of this setback.

Recommendation:

The Government reviews the COPO formulas and introduces indexation structures which reflect real costs and accommodate growth in services to match the increasing population of aged people.

More cost effective, alternative means of delivering services be explored. 'Apartments for life' are an example.

A regional pool be set aside to meet the costs of language services.

Planning of services

The current planning processes for aged care services through DoHA's Aged Care Approvals Rounds are unaccountable in respect of provision of places for NESBs because NESB places allocated in the Rounds have never been publicly announced nor monitored for their use by the target group. This is discussed at length in DutchCare's first submission to the current Inquiry.

In addition, the competitive nature of the Rounds rewards good submission writers in the absence of a deliberate strategy to ensure NESBs have equal access to services.

While DutchCare has been allocated places in the Rounds, there is no mechanism in place to demonstrate that the Dutch have reasonable access to places based on their proportion of the population aged 70+.

DutchCare believes that the planning of aged care services should take place at the local level with input from the key players. This implies that ethnic agencies and consumers will be appropriately represented. In this regard, the Primary Health Care Organisations recommended in the National Health and Hospitals reforms offer some hope in more effective service planning provided there is broad membership across aged and health services including ethnic ones.

DutchCare would go one step further and float the idea that no service provider should accommodate more than 4 different CALD groups in significant numbers. This is because it is difficult enough to provide a reasonable level of culturally and linguistically appropriate care for one group let alone 14 which is the case in some homes in Victoria. The dilution of effort leads to tokenism which is inadequate.

For this reason it is suggested that incentives be provided to mainstream providers to voluntarily concentrate on a select group of ethnic aged communities in their planning region to form discrete clusters. For example, in the Western Metropolitan planning region of Victoria, it would be appropriate for mainstream providers to concentrate on 3 or 4 (i) Middle European groups, or (ii) Eastern European groups or (iii) Asian groups or (iv) Arabic speaking groups. In this way, the effort and costs involved in cultural training, bilingual staff recruitment and rostering, interpreting/ translating material, liaison with ethnic agencies and advertising could be rationalised. Although NESBs' choice in respect of provider and location might be compromised, the quality of care might be enhanced.

Recommendation:

Planning of aged care services take place at the local level with input from ethnic agencies and consumers.

Consideration be given to obtaining local agreement between service providers on which CALD communities they will give priority of access to. Financial incentives to do this would encourage the process.

If ACARs continue, DoHA could prepare 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;**

- **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, NESB places could be allocated to the planning regions in direct proportion to their percentage of the targeted aged population, factoring in the skewed use of services.**
- **The indicative allocations in each planning region could be fine tuned according to what is happening to CALD seniors in the range of Commonwealth funded aged care programs including HACC.**
- **More consideration could be provided 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";**
- **NESB places could be allocated to individual mainstream providers in direct proportion to the percentage of NESBs in the targeted aged population in the planning region;**
- **The outcomes of the ACAR should be published 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.);**
- **All providers should be monitored on the use of NESB allocations by CALD consumers. Not to do so raises the issue of providers receiving places under false pretensions;**
- **DoHA should report 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.**
- **As per the ANAO's recommendations in 2002 an effective means to maintain project officers' local knowledge of aged care needs, including contact with State health agencies, should be introduced;**

- **A methodical, cohesive strategy on ethnic aged care should be developed. The current measures are piecemeal and unintentionally discriminatory;**
- **Ethno-specific aged care providers and consumers should be consulted in the planning process.**

Quality of care

As an ethno-specific provider of aged care, DutchCare must automatically inform itself on Dutch demographics in planning regions. It reaches out to the Dutch community via newsletters and ethnic media. From the Board of Management down, the organisation is attuned to accommodating cultural and individual difference.

It meets the ethno-specific needs of its elders by recruiting and training bilingual workers; it accesses Dutch television and radio news as well as other Dutch programs; it acquires Dutch books, CDs, food, and traditional decorations such as wall plates and tapestries; it celebrates traditional days such as the Dutch queen's birthday; it engages special Dutch services such as dance groups, choirs and instrumentalists; it conducts its 'hotel' services such as cleaning in the Dutch way and provides care which respects traditional practices and expectations. Dutch is spoken as a matter of course in day to day activities.

This approach to CALD care can be clearly demonstrated across all the management, health, welfare and social domains of the Accreditation standards for residential aged care yet where NESBs are concerned, this is not asked of this organisation or any other in the accreditation process. It should be. 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.

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 provision of language services, together with the use of first languages in the day to day operations of a home are pivotal to this.

Recommendation:

- **the considerations in the Results and Processes Guide associated with the Accreditation audits for residential care be rewritten. Revision might factor in the principles and measures identified in the Victorian State Department of Health's Cultural Responsiveness Framework.[3]**

[3] 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

Support services

In 2009, DutchCare planned on submitting an application under the Dementia Community Support Grants Program. It had received a precious grant for raising awareness of dementia in the Dutch community. The project was labour intensive and involved information sessions at meetings throughout Victoria.

In building on this 2007 project, DutchCare Ltd planned to trial ethnic television to raise awareness of dementia in the Dutch community and to provide information on Alzheimer's Victoria and the support services it provides. The measure of success would have been an increase in contact to Alzheimer's Victoria by Dutch carers or Dutch people with the disease.

DutchCare sought information on the current level of Dutch people's contact with Alzheimer's Victoria and learned that the ethnic background of the users of the Helpline and counselling service is not automatically recorded. This means that Alzheimer's Victoria has little idea on how deeply it is penetrating culturally and linguistically diverse (CALD) communities whose members now average at least 40% of the population aged 65+ across the 4 metropolitan planning regions. It is also where 90% of the ethnic aged live in Victoria.

Without a more detailed knowledge of its users, Alzheimer's nationally can only guess through anecdotal evidence where it is missing the mark with CALD communities and how it can promote services which are more appropriate for them. This probably explains its occasional projects directed at specific ethnic communities. However, this approach is piecemeal when the population numbers indicate that ethnic considerations should constitute a major portion of Alzheimer's core business, funding and effort in Victoria and New South Wales where at least 50% of the ethnic aged live in Australia.

Alzheimer's support services are much used as evidenced by their annual reports, however a significant, and growing, proportion of the population may be missing out on them.

Much the same comment can be made about Carers' Australia.

Given NESBs' reliance on community care, these "life saving" supports become even more critical.

Recommendation:

The branches of Carers' Australia and Alzheimer's Australia in each State 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.**

Workforce

One of the most trying issues facing DutchCare at the moment is the recruitment of Dutch speaking care workers. Ordinarily the migration program would be explored to attract appropriate candidates but the conditions attached to the 457 visas are too limited.

Recommendation:

The Government review its immigration policies to enable direct care workers from overseas to train and work in Australia.

A market environment

Ina free market environment, such as that proposed in the NHHR reforms, care of the CALD elderly will not be an attractive proposition for mainstream providers because of the extra costs involved. In fact NESBs may be eased out of existing services and excluded from others. For this reason, safety nets and funding for specialist services may need to be provided.

Recommendation

In a market environment, safety nets and funding for specialist services may need to be provided to ensure NESBs have access to places which is culturally and linguistically appropriate.

CONSOLIDATED LIST OF RECOMMENDATIONS

The Australian Government should introduce one assessment document and one assessment process for the aged, ensuring that language services and culturally unbiased procedures are employed.

Cultural attitudes and responses to the various aspects of aged care should be factored into any assessment.

To reduce duplication, the Building Code of Australia should replace certification with a few additional measures to cover the safety and security of frail, elderly people.

Residents, where possible, should contribute more to the costs of their accommodation and care. If the current regime persists, bonds or charges should apply to both high and low level care and that the costs of loans, interest and capital of buildings should be covered.

The Government should pay the difference between what the resident can pay and the full amount of charge or bond.

With the Commonwealth gradually assuming responsibility for the policy and funding of aged care services, one accreditation process should cover the lot.

An independent complaints investigation body should be established in the interests of fairness and transparency.

DoHA should make a greater effort to extend the CIS to NESB carers and care recipients by translating more of its aged care information into community languages, particularly the standards relating to residential and community care.

Training of investigators should include cultural responsiveness.

The complaints Scheme be extended to cover all aged care which the Government funds.

Consideration be given to rationalising and consolidating advocacy services for the aged.

To reduce duplication and cost, establish one health and welfare information site for the ethnic aged. The Department of Health and Ageing seems an obvious, but currently poor, agent to develop this. It could ensure that the health messages on specialist sites such as Quit, Diabetes Australia and Alzheimer's Australia meet its population health objectives.

In a gesture of Departmental cooperation, DoHA could purchase language services from Centrelink. In this way, the Centrelink phone numbers could be used as an entry point (or conduit) for referral to the source of aged care information (Carelink, for example) 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 so this perception might be exploited to their advantage for a change.

DoHA should advertise information sites in the ethnic media.

The Government should make access to interpreter services more user friendly.

Interpreter services should be advertised in the ethnic media so that their use becomes acceptable and commonplace.

The range of translated health and welfare information should be extended to cover the key population health messages the Government wishes to disseminate.

More community languages should be used for translated information. To cover numbers initially, the languages used by communities associated with poor English language proficiency might be considered.

The Community/Friendly Visitors and Telelink programs be continued and expanded to overcome social isolation in residential and community settings. Particular attention should be given to CALD consumers.

The Government reviews the COPO formulas and introduces indexation structures which reflect real costs and accommodate growth in services to match the increasing population of aged people.

More cost effective, alternative means of delivering services be explored. 'Apartments for life' are an example.

A regional pool be set aside to meet the costs of language services.

Planning of aged care services take place at the local level with input from ethnic agencies and consumers.

Consideration be given to obtaining local agreement between service providers on which CALD communities they will give priority of access to. Financial incentives to do this would encourage the process.

If ACARs continue, DoHA could prepare 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;**
- **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, NESB places could be allocated to the planning regions in direct proportion to their percentage of the targeted aged population, factoring in the skewed use of services.

The indicative allocations in each planning region could be fine tuned according to what is happening to CALD seniors in the range of Commonwealth funded aged care programs including HACC.

More consideration could be provided 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";

NESB places could be allocated to individual mainstream providers in direct proportion to the percentage of NESBs in the targeted aged population in the planning region;

The outcomes of the ACAR should be published 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.);

All providers should be monitored on the use of NESB allocations by CALD consumers. Not to do so raises the issue of providers receiving places under false pretensions;

DoHA should report 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.

As per the ANAO's recommendations in 2002 an effective means to maintain project officers' local knowledge of aged care needs, including contact with State health agencies, should be introduced;

A methodical, cohesive strategy on ethnic aged care should be developed. The current measures are piecemeal and unintentionally discriminatory;

Ethno-specific aged care providers and consumers should be consulted in the planning process.

The considerations in the Results and Processes Guide associated with the Accreditation audits for residential care be rewritten. Revision might factor in the principles and measures identified in the Victorian State Department of Health's Cultural Responsiveness Framework.

The branches of Carers' Australia and Alzheimer's Australia in each State 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.**

The Government review its immigration policies to enable direct care workers from overseas to train and work in Australia.

In a market environment, safety nets and funding for specialist services may need to be provided to ensure NESBs have access to places which is culturally and linguistically appropriate.

Royal Freemasons
FOR YOU FOR LIFE

Royal Freemasons Ltd
ABN 52 087 106 821
45 Moubray Street
Melbourne, Victoria 3004
Telephone (03) 9011 7200
Facsimile (03) 9521 3689
info@freemasons.net.au
www.freemasons.net.au

14 July 2010

The Hon Julia Gillard MP
Prime Minister
PO Box 6022
Parliament House
CANBERRA ACT 2600

Dear Prime Minister

Royal Freemasons Ltd has been totally committed to providing high quality aged care to older Victorians since 1867. We currently receive Government subsidy payments of approximately $21.5M covering a combined total of 763 places in residential aged care and community age care packages.

I wish to bring to your urgent attention the fact that this proud organisation is among many others in the aged care industry which are fighting for survival as a consequence of the continuing Government policy to use the COPO index to dramatically reduce aged care subsidies relative to real costs.

In simple terms the cumulative effect of the COPO index being used in this manner has reduced Government subsidies in real terms since 1997 by a staggering 16.93%.

This year alone the increase in Government subsidies for aged care was only 1.7% when the cost of living indicators (CPI) has risen by 2.9%. Utilities in some area have gone up by as much as 10% and the minimum wage has been lifted by 4.8%.

Since the introduction of the Aged Care Act 1997 and a new funding instrument, government subsidies have been increased by the Commonwealth Own Purposes Outlay (COPO) Index.

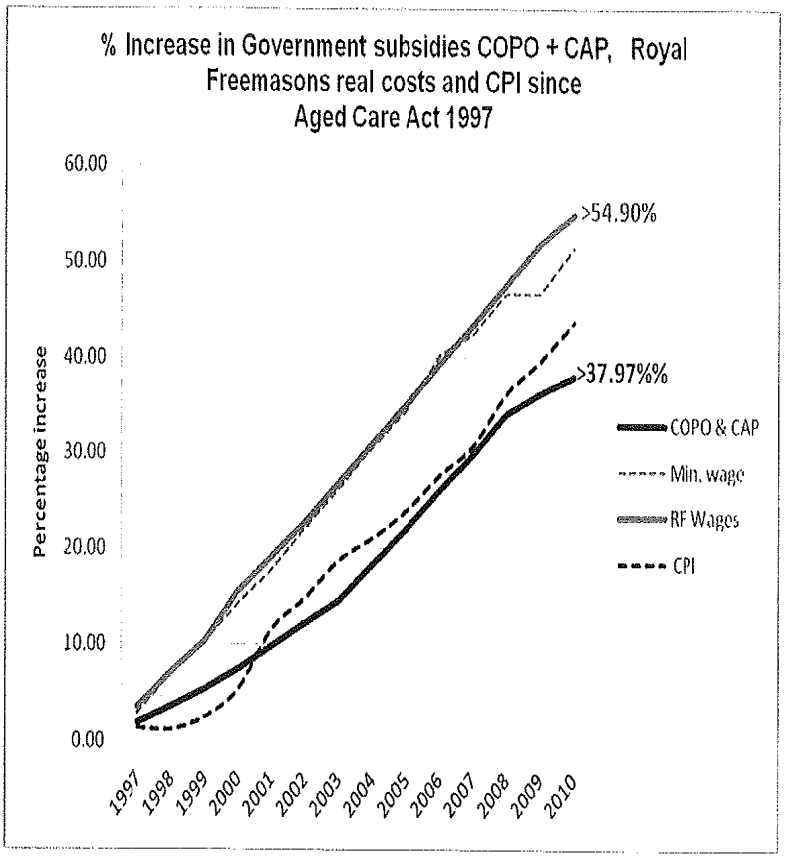
COPO is universally regarded within the aged care sector as being hopelessly inadequate and completely disconnected from the movement in real costs. This becomes startingly obvious when one examines the basis of the index which is calculated using the following algorithm:

- COPO% = **(annual CPI % x 0.25)** + (annual *SNA % x 0.75)
- *SNA Safety Net Adjustment: SNA% = Safety Net Increase per week/average weekly.

As part of the Commonwealth's initial response to the Hogan Review, from the 2004-05 financial year, a Conditional Adjustment Payment (CAP) for residential aged care was provided. CAP was calculated as a percentage of subsidy amount payable in respect of a resident. In 2004–05, CAP was 1.75% and then rose annually by 1.75% increments and ceased in 2008 at 8.75%.

The following graph clearly indicates the gap in funding that has built up so that for the financial year to 30 June 2010 the cumulative 16.93% loss in funding represents in excess of $4M for the year for our organisation.

Cleary this is not sustainable without compromising standards of care or depleting reserves carefully built up over the past 143 years which are needed to update facilities in line with society's expectation.



Royal Freemasons Ltd. is therefore now giving careful consideration to its ability to make any ongoing commitment to providing residential aged care.

Royal Freemasons Ltd. contends that older Australians, the people who made this country great, are being let down by the Federal Government's failure to address the funding crisis in aged and community care.

We welcome the Productivity Commission's inquiry into aged care but make the point that until such time as this absolutely critical issue of adequate funding is resolved and urgently, then the Productivity Commission's findings will be very akin to "Shuffling deckchairs on the Titanic".

Royal Freemasons Ltd. is calling on the Federal Government to take immediate steps to provide additional funding by initially immediately restoring the 1.75% Conditional Additional Payment (CAP) supplement for residential care that was abandoned in 2008.

Right now, today, our older people need the immediate attention of Government so this organisation and the aged care sector industry can survive and continue to provide high quality care to those in need.

Yours sincerely

Graham Shotter
Managing Director

Address List:

The Hon. Julia E. Gillard, MP, Prime Minister.
The Hon. Wayne Swan, MP, Treasurer and Deputy Prime Minister.
The Hon. Nicola Roxon, MP, Minister for Health and Ageing.

The Hon. Tony Abbott MP
The Hon Joe Hockey MP
The Hon Peter Dutton MP

Parliament of Australia, Senate:

The Hon. Kim Carr, Senator for Victoria, Minister for Innovation, Industry, Science and Research
The Hon. Jacinta Collins, Senator for Victoria.
The Hon. Stephen Conroy, Minister for Broadband, Communications and the Digital Economy, Deputy Leader of the Government in the Senate.
Senator David Feeney, Senator for Victoria.
Senator Steve Fielding, Senator for Victoria, Leader and Whip of the Family First Party.
Senator Mitch Fifield, Senator for Victoria.
Senator Helen Kroger, Senator for Victoria.
Senator Julian McGauran, Senator for Victoria.
Senator Gavin Marshall, Senator for Victoria.
Senator The Hon. Michael Ronaldson, Senator for Victoria.
Senator Scott Ryan, Senator for Victoria.
Senator The Hon Judith Troeth, Senator for Victoria.

Parliament of Australia, House of Representatives:

The Hon. Kevin Andrews, MP, Electoral Division of Menzies (Vic).
The Hon. Bruce Billson, MP, Electoral Division of Dunkley (Vic).
Ms. Anna Burke, MP, Deputy Speaker, Electoral Division of Chisholm (Vic).
The Hon. Anthony Byrne, MP, Parliamentary Secretary for Trade; Parliamentary Secretary to the Prime Minister, Electoral Division of Holt (Vic).
The Hon. Simon Crean, MP, Minister for Trade, Electoral Division of Hotham (Vic).
Mr. Michael Danby, MP, Electoral Division of Melbourne Ports (Vic).
Mr. Mark Dreyfus, QC, MP, Electoral Division of Isaacs (Vic).
The Hon. Martin Ferguson, AM, MP, Minister for Resources and Energy, Minister for Tourism, Electoral Division of Batman (Vic).
The Hon. Alan Griffin, MP, Minister for Veterans' Affairs, Minister for Defence Personnel, Electoral Division of Bruce (Vic).
The Hon. Greg Hunt, MP, Electoral Division of Flinders (Vic)
The Hon. Jenny Macklin, MP, Minister for Families, Housing, Community Services and Indigenous Affairs, Electoral Division of Jagajaga (Vic).
Ms. Kelly O' Dwyer, MP, Electoral Division of Higgins (Vic.)
The Hon. Chris Pearce, MP, Electoral Division of Aston (Vic).
The Hon. Andrew Robb, AO, MP, Electoral Division of Goldstein (Vic).
The Hon. Bill Shorten, MP, Parliamentary Secretary for Disabilities and Children's Services, Parliamentary Secretary for Victorian Bushfire Reconstruction, Electoral Division of Maribyrnong (Vic).
The Hon. Tony Smith, MP, Electoral Division of Casey (Vic).
Mr. Mike Symon, MP, Electoral Division of Deakin (Vic).
The Hon. Lindsay Tanner, MP, Minister for Finance and Deregulation, Electoral Division of Melbourne (Vic).
Mr. Kelvin Thomson, MP, Electoral Division of Wills (Vic).
Ms. Maria Vamvakinou, MP, Electoral Division of Calwell (Vic).
Mr. Jason Wood, MP, Electoral Division of La Trobe (Vic).