RESPONSE TO THE PRODUCTIVITY COMMISSION'S INTERIM REPORT ON THE CARE OF OLDER AUSTRALIANS

DUTCHCARE VIC – MARCH 2011

Introduction

As at 30 June 2010, ethno-specific providers in Victoria accounted for approximately 3615 out of 59,598 aged care places (residential, CACPS, EACH, EACHD), that is, a mere 6%. At the same time, approximately 12,270 people from a non-English speaking background (NESBs) occupied these places.

In its interim report on the Care of Older Australians, the Productivity Commission makes the comment that its "proposal to relax supply constraints over time is likely to facilitate the establishment of culturally appropriate aged care providers in specific areas (subject to them becoming approved providers) and enable existing providers of specialist services to expand." (p279 - Special Needs Groups).

DutchCare has explored how this might occur within the framework proposed by the Productivity Commission.

Possible responses to a free market environment by ethno-specific agencies

- Large ethnic agencies which already provide a full range of services could expand services e.g. set up day therapy centres, seniors' social groups or more frequent planned activity groups in their residential care centres. They can draw on existing referrals for their services and on their well established social and business contacts within their broad community in their planning region and State.

- Medium sized ethnic agencies providing, say, one kind of aged care such as community care in the form of packages and social visiting, can try to expand into more specialised areas requiring a nursing input e.g. EACH packages, day therapy or advanced dementia counselling. This is not so straight forward. Under existing arrangements, it may require collaborative arrangements with another ethnic or mainstream provider which employs nursing staff. This is because of the costs of nurses and their scarcity. In addition, there is no guarantee that the partnership arrangements will be honoured. They could also expand existing service provision, building on their infrastructure. Whether they could extend to their own residential care facility is questionable given the high costs involved.

- New, but small, ethnic agencies could independently attempt to establish a service for the aged. They are most likely to establish social clubs with volunteers and move on from there. To advance to something like a planned activity group, they will need to be very sure of the numbers, frequency of attendance and capacity to pay to ensure it can meet the costs of staff, premises, transport, insurances etc. It will also require the manpower to continually research future demand across a

wide geographical area if the community is dispersed. This will be a big challenge in the face of dwindling volunteer numbers, but not impossible. Again, their ultimate expansion to residential care of their own is questionable.

- Ethnic agencies can merge or create collaborative ventures to expand services, especially to "like" clients. Under the current approvals system for providers, the collaborative venture may prove to be problematic without formal company arrangements. These could become legally labyrinthine and costly given the possible numbers involved in any one collaboration.

- Ethnic agencies can partner with mainstream, also known as general purpose, providers, to enhance the life of their NESB consumers in respect of food, social activities, religious and cultural events. Some of these arrangements work well already but others fail dismally with the ethnic agency feeling exploited.

- Optimistically, ethnic agencies could respond to general service providers who take the lead by deliberately specialising in the care of one or more ethnic aged communities. In this way the general service provider could rationalise their recruitment and training effort in respect of bilingual and bicultural staff.

Choice of providers for ethno-specific care remains limited

In examining these permutations and variations, DutchCare predicts that the Commission's recommendations will overwhelmingly favour existing ethno-specific providers because of their established infrastructure. Even with this advantage, they are unlikely to accommodate demand for their services.

This means that NESBs' choice of provider in respect of ethno-specific services will be severely limited for some time. In terms of baseline provision for each of the principal care types, DutchCare has ascertained that as at 30 June 2010, ethno-specific providers in Victoria accounted for 10% of CACP places, 3% of EACH packages, 3% of EACHD packages and 6% of residential care places. This is a low position from which to advance in a situation where the 2006 Census indicated that NESBs in the 4 metropolitan planning regions of Victoria ranged from 30% to 51% of the population aged 65+. It also means that general service providers will continue to provide the bulk of care to NESBs.

Additional costs of culturally and linguistically appropriate care

Whilst the proposed new framework aims to encourage flexibility and capacity in service provision, NESBs will not be as attractive as their non-NESB counterparts to general service providers in a free market environment. This is because they cost more and require more effort to care for.

For example, there are costs associated with interpreters and translators, the acquisition and preparation of ethnic food, the purchase of ethno-specific entertainers such as singers, dancers and musicians, the development and implementation of special ethnic

and/or religious celebrations, the installation of satellite dishes for the transmission of overseas news, films and television programs, the training of staff in basic foreign language expressions and cultural mores, the recruitment and training of bilingual and bicultural staff or volunteers, the recruitment of overseas staff, ongoing training for NESB staff in English as a second language, research in respect of (i) the demographic composition of the planning region or catchment area and (ii) the cultural/linguistic considerations of the dominant CALD communities, and organising groups of "like" care recipients to overcome social isolation.

Currently, subsidies do not cover these costs, particularly in residential care. In an environment where care recipients will pay more for certain services, NESBs will need to pay above that for the same lifestyle as their non-NESB counterparts.

Articulating benchmarks and costs of CALD care – layered funding implications

DutchCare is chairing a CALD interest group sponsored by Aged and Community Care Victoria, which aims to identify the benchmarks of service provision to CALD individuals together with their associated costs which will continue to be an impediment to NESBs accessing services, or will be a factor in them receiving less care.

The group will be building on the work already undertaken by Fronditha from whom the Commission will also be hearing.

To level the playing field, DutchCare supports the notion of a layered funding arrangement (p 236 of interim report). In this way, there would be an additional funding component for language services and/or cultural factors and/or religious considerations, just as there might be a loading for dementia. It is assumed the Australian Aged Care Regulation Commission (AACRC) would factor in the additional costs of CALD care when setting prices of care across the board.

Equitable access revisited

DutchCare welcomed the Productivity Commission's attention to special needs groups and their need to have equitable access to health and aged care services.

Where CALD communities are concerned this approach corresponds with the Government's recent reiteration of its policy on multiculturalism which "acknowledges that government services and programs must be responsive to the needs of our culturally diverse communities. **It commits to an access and equity framework to ensure that the onus is on government to provide equitable services to Australians from all backgrounds.**"

To meet this commitment, the Government needs to overcome its piecemeal approach to care for the ethnic aged. The Department of Health and Ageing (DoHA), in particular, needs to address this issue especially as it will have the principle responsibility of implementing the recommendations of the Commission.

It is a sad reflection on the Department that in its annual report of 2009 – 2010, it could not report on the "Proportion of aged care recipients from culturally and linguistically diverse communities accessing culturally appropriate residential care and community based care". This is because "Data for this performance indicator is currently not available. Although the department collects information about clients from culturally and linguistically diverse communities, no appropriate measure or proxy measure was able to be identified for this indicator. The department will continue to develop such a measure in 2010 – 2011."

Action required by DoHA

DutchCare agrees with the Productivity Commission that the system for care and support for older Australians should be assessed against the criteria of equity, efficiency, effectiveness (choice, quality, appropriateness) and sustainability. In this regard, DoHA needs to develop concrete and measurable KPIs against all these criteria so that it is more accountable for its policies and their implementation.

Stocktake – research implications

DoHA needs to be in a position where it can measure and compare access to services by NESBs. It can start by conducting a stocktake on the uptake of the current aged care types by NESBs in every planning region in Australia with a view to ascertaining which CALD groups are better represented than others, and why. It can then institute research into the reasons for the differential uptake and develop incentives for providers to admit the CALD aged to their care. DoHA, or perhaps the AACRC would need to conduct this stocktake annually.

A by product of this stocktake could be the introduction of quotas for NESBs in aged care services. The Productivity Commission has suggested that there be regional quotas for supported residents. Something similar could be done for NESBs.

Associated with these quotas, DoHA could reward local planning initiatives which ascertain service deficits to individual CALD communities and address these. Ideally there would be coordination with bodies such as Medicare Locals.

Language services

DoHA must act on the Government's pre-election commitment which stated that "$2.2 million would be directed to engage interpreter services to help older persons from non-English backgrounds (NESBs) undertake critical communications for health and aged care matters."

Information, assessment and referral

DoHA must develop or accept policies which actually provide equitable services to Australians from all backgrounds. Where information, assessment and referral are

concerned, there must be a preparedness to advertise the proposed Gateway service in the ethnic media such as radio, television and newspapers.

Given the growing numbers of aged people with dementia, assessments for NESBs must be culturally and linguistically unbiased. DoHA must advance the development and testing of the Australian based Rowland Universal Dementia Assessment Scale (RUDAS).

Connected with this disease, the services of the related support agencies - Alzheimer's Australia and Carers Australia - also need to be an integral part of the aged care framework. DoHA should impose funding, targeting and reporting obligations on these organisations in respect of their reach to CALD communities. NESBs should be core business. It may be counterproductive to impose a cost on these services because of the deterrent effect on uptake.

For the Gateway service to be of use to NESBs, there needs to be information available in community languages. At the moment, this is an area of grave omission. It will take years to develop and provide information in community languages relating to aged care, chronic disease, healthy lifestyle, care choices and costs. In the meantime, the Productivity Commission's suggestion that the Commonwealth Department of Human Services provide aged care information via Centrelink, Medicare etc to NESBs is supported.

Workforce

DoHA has created incentives to encourage doctors to work in regional Australia. In much the same way it could consider providing bilingual school leavers with scholarships to develop aged care skills on the proviso they remain in the aged care workforce for 3 – 5 years.

While 457 visas prevent the ready importation of overseas staff who speak the languages of NESB care recipients, agencies like DutchCare recruit final year nursing students in the Netherlands to complete their nursing placements in Australia. They are not employed as nurses but provide support services to residential care staff or conduct research into, for example, the value of speech therapy for stroke victims. They bring with them the Dutch language which can be used in the work setting, and contemporary nursing practice. This kind of recruitment effort represents an added cost to the organisation which should be unnecessary in an egalitarian society.

Standards of care

CALD considerations should be evident across all the domains of accreditation standards. DoHA is currently reviewing the accreditation standards for residential care. In its response to this, DutchCare will certainly be reinforcing the message that cultural and linguistic sensitivities should be enshrined in providers' vision, values and actions from Boards of Management down.

The reality is that in the absence of CALD care, a great deal of damage can be done to the NESB individual such as social isolation, misdiagnosis or ignorance of critical needs. Currently there is no measure of what constitutes a baseline level of CALD care, hence the project espoused by the ACCV's interest group in articulating that care

Reform implementation

CALD considerations require immediate action because this group has been under-serviced for over a decade. For this reason, Stage 1, i.e., "expedited measures within two years" should include:

- **the development of information in community languages on service types, costs, chronic disease and healthy lifestyle;**
- **the introduction of a fully subsidised national interpreter and translation service for the aged;**
- **validation of the factors and costs associated with CALD care;**
- **research on models of CALD care;**
- **the development of a planning model for the ethnic aged which promotes equitable access to aged care services;**
- **the development of a Government reporting mechanism on access and equity for all the special needs groups, NESBs in particular;**
- **research into CALD communities' preferences for aged care including services for respite and dementia support.**

The current population of ageing NESBs was instrumental in building this nation. There must surely be a moral obligation to ensure that their last years are spent in a milieu in which they are most at ease. One could express this as their last rights – no pun intended. Time is running out for these Neglected Migrant Nation Builders

Leadership

Government must have a will to make aged care services more accessible to NESBs. This presupposes that leadership starts at the top. On this, government agencies, DoHA in particular, need to shift their attitude dramatically on addressing the needs of the ethnic aged. Their continuing Anglo centric position is simply out of tune with the times. From the top level down, they, too, need to implement training with associated KPIs in respect of cultural and linguistic sensitivities when it comes to acting on that value in the *Public Service Act 1999* which requires the Public Service to deliver "services fairly, effectively, impartially and courteously to the Australian public and is sensitive to the diversity of the Australian public". This extends to policy making.