RESPONSE TO THE PRODUCTIVITY COMMISSION'S DRAFT REPORT - INQUIRY INTO CARING FOR OLDER AUSTRALIANS: A MULTICULTURAL PERSPECTIVE BY ETHNIC COMMUNITIES' COUNCIL OF NSW INC.

The Productivity Commission's ('Commission') Draft Report was released on 21 January 2011. The Inquiry and the Report are long overdue as the aged care system shifts to accommodate a rising number of older Australians who are ageing including those from diverse cultural, linguistic and religious backgrounds.

We would like to commend the Productivity Commission on the Draft Report, informed in part by issues and solutions from individuals and organisations. We would however like the Commission to recognise that **less than ten percent** (approx 27) of the total 487 **responses were from multicultural or ethno-specific organisations** which limits the full understanding of aged care needs of people from culturally and linguistically diverse (CALD) backgrounds who are aged and ageing.

In addition we would like to advise the Commission that the Draft Report has a **high residential focus** with much lower focus on community services other than that funded by flexible packages of care. Such a focus creates the perception that community services (like HACC and similar) are unable to address the needs of older people from CALD backgrounds. If we support the notion that family support is the basis of care in CALD communities, we would argue that home and community care services needs to be given higher recognition in this Draft. It is highly likely that older Australians will use one or two community services (currently funded under HACC) at the young-old and middle-old stage with the likelihood of a small but increasing proportion of the cohort using higher levels of complex and intensive care for short periods in their lifetime. Therefore in caring for older Australians, we recommend that the Draft be revised to include residential **and** community care.

An initial submission was made by the Ethnic Communities' Council of NSW (193). The current response to the Draft Report uses a multicultural lens to explore the gaps, issues and opportunities particularly in Chapter 9, Cultural Diversity and its impact for NSW's older population from culturally and linguistically diverse backgrounds, as well as makes some recommendations to contribute to reform and a new framework for aged care. We understand that an Implementation Task Force will look at the finer details of provision as advised at the North Ryde RSL Forum on 14 March 2011. We recommend that the Task Force, at a minimum, engage with the Federation of Ethnic Communities Councils of Australia.

The response is informed by issues identified at forums, working groups or discussions with similar peak agencies such as NSW Transcultural Aged Care Service (360), Queensland Healthy Communities and the HACC Multicultural Access Project Network to get as broad an understanding of the new framework of service provision for older people from CALD backgrounds. All recommendations are highlighted in 14 point, bold font.

WHO WE ARE

The Ethnic Communities' Council of NSW (ECC NSW) is the peak body for all culturally and linguistically diverse communities in New South Wales. The ECC NSW's focus is to :

- ensure the retention of individual communities' culture, language, religious practice, aged, welfare or health services, sport and recreation and educational institutions
- promote and recognise multiculturalism as part of the Australian way of life and as a valued asset
- facilitate joint action and cooperation between ethnic communities
- advocate on behalf of communities to improve access to services

The ECC auspices the statewide HACC Multicultural Access Program Officer, funded by Ageing, Disability and Home Care who is responsible to identify and advocate on issues that affect the wider CALD community as well as contribute to social policy. This submission reflects the considered opinion of the ECC NSW and is not comprehensive. It is intended as an addition to, and not a replacement for, submissions from CALD communities or multicultural aged care services or community workers in NSW which will reflect their specific circumstances and aged care needs.

CHAPTER 9, CATERING FOR DIVERSITY – CARING FOR SPECIAL NEEDS GROUPS

We agree with the general discussion outlined in this chapter. However the following needs to be raised and addressed in the final report:

1. TITLE OF CHAPTER, P. 269

We would like to request for this chapter to be re-titled to something that is more inclusive of the diverse groups represented by the Aged Care Act, if that's the intent of the chapter. 'Catering for diversity' has negative connotations implying that people's diversity should be accommodated rather than considered as an integral aspect of the individual. One suggestion for the chapter title is 'caring for special needs' to align with the intent of the Aged Care Act. However, it must be pointed out that the term, 'special needs' is contentious in the provision of human services.

2. CATERING FOR DIVERSITY, P. 269, POINT 4 OF KEY POINTS

"The aged care system **should cater for diversity in all client groups** by ensuring access to services for all older Australians that are delivered in a culturally appropriate manner, to the extent feasible." (p. 269)

The Aged Care Act 1997 and associated Aged Care Principles provide the legislative framework for the provision of the majority of aged care services in Australia. These arrangements determine who can be a provider, who can receive care, types of care services and how that care is funded (DOHA 2010:1). Additionally, the Act may specify a proportion of places that must be provided for certain specified target groups in Aged Care Approvals Rounds (DOHA 2010:xii).

As identified on p. 271 of the Draft and DOHA's 2010 report, the Aged Care Act 1997 already charges the aged care system to respond to people deemed to have 'special needs' (ALII 2011, DOHA 2010). However the 'broader needs' arising from diversity of gender, religion sexuality, culture and/or geography are ignored or insufficiently addressed by mainstream, multicultural and ethno-specific organisations. Failure to respond to the diversity of represented populations may in part be due to organisational barriers or funding inadequacies (short term or targeted) that deters intensive community development.

An example is a Government funded agency which has not successfully addressed the residential care needs of the CALD GLBTIQ community or multicultural/ethno-specific organisations that narrowly address the diversity of a community..

The failure by government and/or provider organisations to respond is clearly articulated in a number of submissions (para 2, p. 272) where a 'special needs status' should be an advantage in service provision (para 1, p.272). The failure of the current Aged Care Act almost demands the introduction of a New Aged Care Act that affirms the principles of care for older people, carers and care systems (Kendig sub. 431) and to which we would add the diversity of Australia's population.

The responsibility for care of CALD (or NESB according to the Act) population as a 'special needs' group is often the domain of ethno-specific and/or multicultural agencies by default as a result of

the lack of responsiveness by mainstream organisations (para 2, p.272). However, this separateness divides care for our older Australians and this difference will only be exacerbated as we see an increase in the numbers of older Australians from CALD backgrounds who are ageing over the next 20-40 years. Not all older Australians from CALD or NESB backgrounds necessarily want services that reflect their diverse backgrounds; choice could mean that they can 'pick' or 'reject' aspects of their culture to fit or meet a need while other needs are met by mainstream organisations.

We support the reform in part as it identifies opportunities for partnerships, between and within the community care industry and with ethno-specific or multicultural communities. **We recommend** that any partnership needs to be adequately resourced so that CALD communities are not disadvantaged. Ideally, we would like CALD communities to improve their capacity (financial, human and technical) to meet their older population's needs so that care can be delivered in a culturally appropriate way and meets deliverable outcomes in areas that are relevant to an ethnic organisation such as physical activity, nutrition, weight management with an intent to support people's inclusion in any care environment (home, community or residential) (FECCA 2011:4).

> South Asian Muslim Association of Australia (SAMAA) represents the interests of its ageing community. The community is unable to get funding on its own merits as it is unable to demonstrate the numbers of older people other than an estimate based on networks and attendance at events. It is difficult to identify the population by religion and ethnicity in ABS data. A volunteer-dependent organisation, SAMAA conducts small projects on adhoc funding but these efforts are unsustainable without funding for medium term community projects. Currently SAMAA has MOUs with two residential facilities and a project to deliver information about aged care through a positive ageing grant delivered on their behalf by a mainstream organisation.
> http://samaa.org.au/home/jashne-buzurg-2011/

The example of partnership between SAMAA and a mainstream organisation at this time does not seem to develop the organisation's capacity nor information sustainability beyond the project term. However, it does allow SAMAA to facilitate access to information for South Asian Muslims who are not necessarily members.

3. EQUITY OF ACCESS, P. 272, PARA 3 AND 4

The Commission proposes that reforms are likely to offer "greater equity of access … providers will be less constrained … greater competition between providers …. should drive improved service …" (para 3, p. 272) but recognises the risk from a market-driven system and therefore suggests that particular groups would need funding assistance.

While we support choice through an increase in providers for people from NESB (according to the Act) or CALD backgrounds, it appears that the federal government's 'approved provider process' is difficult and costly especially for small agencies.

We recommend that at least two years be allowed for smaller agencies to become approved providers and be supported through the process (HACC MAP Network 2011).

The Commission indicates alternate funding through "more market based approaches, such as competitive tendering" (para 4, p. 272). The risk of competitive tendering disadvantages regions (Central Coast, Central West NSW and similar) that have a smaller CALD older population relative to the total older population. Older people from CALD backgrounds may miss out on locally available quality service envisaged in the new framework particularly if non-government organisations (NGOs) are less than willing to include CALD populations in their submissions or if NGOs do not recognise their competency in delivering services. There is some concern that smaller organisations may not survive this reform (HACC MAP Network 2011).

The Commission addresses the burden of care that can fall inequitably on clients when services are inappropriate (para 4, p.272). Market-based models tend to translate to higher costs for clients from CALD or NES backgrounds. We therefore emphasise the need for the provision of funding against real costs. Alternately, brokerage options give clients more diversity of choice and are flexible enough to meet complex client needs. Agencies could account for brokerage funds on an annual or bi-annual basis.

> A CACP worker working with a Chinese client who has medical conditions deteriorating and complex care needs would benefit from brokerage in transition from CACP to EACH which can take up to three months in some areas, depending on vacancies and waiting lists. The process currently is referral by GP - assessment by ACAT – feedback to GP – wait for vacancy from EACH provider. Geography also plays a big part in service availability (HACC MAP Network 2011).

We recommend that brokerage models be part of all service types in the aged care sector.

4. PRINCIPLES, P. 272-273

We agree with the stated principles but would like to make further comments to enhance service provision for people from CALD backgrounds:

Point 1, access to services

Access is not sufficient as people may access a service but not have a need fully met due to one or more barriers (geography, health, housing, lifestyle, language or cultural difference, funding or human resources inadequacy). For example, a person from a Bhutanese background may have access to transport but in reality need a system of support to allow them to effectively utilise community and public transport.

> Older Bhutanese living in Blacktown were invited to attend a Seniors Week event in Parramatta in 2010. Although a key worker indicated that a group of people would attend, they were inhibited on the day due to a volunteer's unavailability. The group do not speak functional English and were hesitant to use a taxi even though it was possible to pay that cost from the project budget. The newly formed ethno-specific organisation runs on adhoc funding and highly dependent on volunteers who are young and whose focus is on employment and settlement (HACC MAP Network 2011).

We need to ensure that people in the 'special needs' group have **equitable access** to services and that in part can be driven by funding targets for providers, access and equity reporting for providers and improved data collection of markers of cultural diversity including gender and

sexual diversity (NHAa 2011). Similarly, FECCA (2011:4) reiterates the need for improved data collection to guide improvement in planning and targeting of program and service resources.

Point 2, specialised models of care
We support specialised models of care as long as there are adequate resources (financial, human and technical) to support the designated model.

Point 3, tailor services to meet particular needs
We support the tailoring of services to meet needs but without putting the onus on frontline care workers who are already heavily burdened in frontline service delivery. We need a whole-of-organisation approach to community care to respond to the diversity of older Australians.

Point 4, cost of delivery
We support the acknowledgement of higher costs associated with meeting special needs (interpreters, culturally matched workers, activities and supports) but would also like to recognise the difficulty of meeting the needs in a cost-effective manner for small numbers of diverse communities in regional and rural areas such as in Central West and Far West New South Wales. Lightning Ridge for example has small numbers of older people, generally men, from diverse CALD backgrounds who live on mining 'claims' far from the main town.

We recommend that the principles take into consideration the points identified above, particularly equity of access, variable costs of delivery and need to support mainstream, multicultural and ethno-specific organisations beyond language assistance or cultural awareness training.

5. TERMINOLOGY

GLBTIQ reference
We recommend that the Commission remove reference to GLBTI people in section 9.2 'people from culturally and linguistically diverse backgrounds'. See later section for more explanation.

Terms – CALD and NESB
The Report needs to clarify who is being described: NESB or CALD and if those statistics accurately reflect the population groups.

Non-English Speaking Background (NESB) is a less used term and generally refers to people who are born in countries where English is not the dominant language or who generally do not speak English as a first language. This descriptor failed to recognise differences among people from non-English speaking communities.

More commonly used is Culturally and Linguistically Diverse (CALD), an inclusive term as it recognises people who speak other languages as well as those whose first language is English and the diversity (religion, culture, language, ethnicity) of a population. The term, CALD is a social construct and is therefore fluid and contentious. It is likely that a return to the term, 'multicultural' may better describe the "amazing breadth and diversity of Australian society" (DOI 2011) in any geographic space.

We recommend that the Commission clarify the context of the descriptor.

6. ACCESSING INFORMATION ABOUT AGED CARE SERVICES, PP. 275 – 278

We agree that DoHA has provided information in different languages about aged care options (http://www.culturaldiversity.com.au/resources/multilingual-resources/options-in-aged-care) through the Centre for Cultural Diversity in Ageing in addition to funding the Community Partners Program and that of other Federal agencies.

However, the statement in the last para on p. 275, "Some state and territory governments also invest heavily in language services … but these services are not aged care specific…" (p. 275) appears to deny the role of state government agencies in facilitating access to information about aged care services. In NSW, the Multicultural Access Project Network, funded and supported by Ageing, Disability and Home Care, Department of Human Services NSW, has been supportive in responding to geographical and state-wide needs of its diverse population. Examples include funding of '*Get to know the aged care system*' using bilingual community educators, SBS Homereach radio series in targeted languages and translation projects that can be innovative. In addition, the MAP Workers conduct regular face-to-face information sessions, develop and deliver innovative projects and identify current best practice overseas and inter-state to enhance service provision. Similarly Victoria has a wealth of projects under the HACC Program that are innovative in their response to the aged care needs of multicultural communities. There is strong anecdotal evidence to suggest that ethno-specific or multicultural community development workers often work in a voluntary capacity to enhance their community's access to the breadth of aged care services and work with community leaders as external (unwaged) advisors.

The Draft Report's high focus on residential care to the exclusion of community based care programs such as HACC (or similar in the future) appears to reiterate the belief that mainstream organisations are unable to meet the care needs of CALD populations. Continuing emphasis on '*residential care as aged care'* will deny opportunities for older people from CALD communities to explore the depth of community services that will allow them to remain at home. It also hinders ethno-specific or multicultural organisations to further develop their capacity to deliver culturally-appropriate services where they could be more successful such as in the provision of bilingual/bicultural workers.

On the other hand, we support the need for improved access to information about residential care in terms of end-of-life / palliative care, and care associated with dementia, both deemed to have high impacts on residential services and higher and complex levels of care at home.

We recommend that this section better reflects the population as described today as well as the services that are available to multicultural communities whether funded by DoHA or jointly with State Governments. It would be erroneous to offer a perspective that excludes the efforts of State Government and multicultural community development workers in improving and enhancing access to information about aged care services across the spectrum.

7. AUSTRALIAN SENIORS GATEWAY (ASG)

While we agree with a centralised information system such as the ASG, the aged care sector has had very little access to information about the current system, Commonwealth Respite and Carelink Centre in terms of its response to older people from CALD backgrounds. What works and doesn't work as a 'single information point'? How will the ASG improve access for multicultural communities?

The 'gateway' assumes that all older Australians will access regional hubs of information and assessment. This is true for a large proportion of the population but does not address the more difficult social groups, that is for people from a CALD background who are homeless, have a mental illness, have poor mobility, illiterate, of diverse sexuality, sex and gender or even un-partnered women or men.

Centrelink is proposed as an access point. How effective has it been as a central point for carers to receive income support? We need to be careful that we don't conflate income support with the delivery of human services namely community or residential care irrespective of how effective the economies of scale in delivering information in multiple languages. We believe that human needs like 'care' deserve far human responses. Were Centrelink to deliver information about aged care, it would run the risk of failing like TIS who are unable to effectively interpret health and community concepts of service. **We recommend** that the aged care section build on a skilled health and community interpreter network with specialised knowledge of health and aged care terminology so that they are effective in delivering information about care for people from CALD backgrounds. The current NSW Health funded *health care interpreter service* is a model with huge potential.

We agree with a central assessment of need to reduce the burden on providers and consumer but that assessment must include a face-to-face option (home or central point) due to older people's debilitating hearing, eyesight and host of other health crises. **We recommend** for high recognition of family and friends as central to the assessment particularly for those with less formal relationships including people in the GLBTIQ community who may be supported by 'families of choice' to provide care and support (NHAb 2011).

Like FECCA, we support the Gateway as a 'notion' not necessarily the sole 'place' to access information. Therefore we will **continue to recommend for multiple points of access** and 'no wrong door' using community based services. The focus on health or government agencies (GPs, health clinics, Centrelink on p. XXVI) accords little respect for the plethora of community agencies and community development workers as dissemination points.

8. FUNDING STREAMS

We agree with the separation of funding for accommodation, everyday living expenses and care as well as the notion of individual responsibility where people can afford to pay. Currently in community care, individuals are responsible for their accommodation + everyday expenses while care is subsidised or free in exceptional circumstances.

At the recent Productivity Commission forum in North Ryde (14/3/2011), there was some indication that individuals would be responsible for care costs anticipated as a maximum of $60K

(excluding residential care) which would also be the stop-loss limit. For people that have family, assets or been longer in well paid work, this is achievable. However, some community and residential care workers, migrant labourers (Asian Women at Work), carers from CALD backgrounds particularly disadvantaged by work, and any one in low waged or casual jobs are disadvantaged by their income and superannuation and dependence on subsidies to supplement their care as they age. For them 'choice' is not so clear cut; their dependence on a system is reinforced. This disadvantage is not limited to people of a low socio-economic status but also a growing reality for the so-called middle class who need to save for future care costs. For some, this fear of self-funded care would effectively mean a reduction in enjoyment of the retirement period which would go against the notion of positive and healthy ageing.

We recommend that the Commission look closely at issues of funding that inhibit or detract from the notion of positive ageing for all.

9. COMMUNICATING NEEDS AND PREFERENCES, PP. 278-279

We concur with other submissions that a lack of culturally specific staff and a rising demand for culturally-specific services is one of the barriers to adequate service provision for multicultural communities.

The partnership model proposed by Sub. 379 (p. 278) allows individuals and multicultural communities to build their capacity to provide for the community by providing linkages with mainstream and multicultural services and assisting services to improve their responsiveness to targeted populations. In NSW, the role of migrant resource centres (MRCs) is changing as they move beyond settlement needs to address family, youth and older people's needs. Some MRCs auspice a Community Partner Program while others provide HACC services. Victoria's Planned Activity Groups (PAGs) are effective in providing culturally relevant activities which have a high take up rate among older people from CALD backgrounds (identified by Sub. 154). One of the possibilities of a Commonwealth aged care system is the reduction in artificial barriers so that there is a possibility for people from CALD backgrounds in residential care to be supported in the community. This would reduce the need for residential providers to respond to small numbers of people from a range of diverse backgrounds.

Increasingly the aged care sector particularly residential care is becoming attractive to employment for older and younger people from CALD backgrounds. Often that choice is determined by fewer demands on the individual such as a vehicle or mobile that is required in community care work, even though such choice of work reduces their choice. The sector's attractiveness therefore augurs support for the introduction of a Community Language Allowance Scheme (CLAS) or similar in the aged care sector with appropriate guidelines. At a recent meeting with students of the Diploma of Community Services at Granville TAFE, almost 90% of the students were from CALD backgrounds and where women outnumbered men. In order to improve the communication of needs and preferences of older people from CALD backgrounds, we need to take a step back and build the workforce and support that workforce from a learning institution to a place of work where their skills (not only language) can be matched with the individual and community's needs.

We recommend that FECCA and multicultural organisations be consulted on guidelines to introduce Community Language Allowance Scheme (CLAS) or similar in the aged care sector.

We recommend that students from CALD backgrounds in VET courses be supported to transition from study to work so that we have a vibrant aged care sector and one that can increasingly match or support people in a cross-cultural environment.

10. GAY, LESBIAN, BISEXUAL, TRANSGENDER, INTERSEX AND QUEER PEOPLE (GLBTIQ), PP. 280-281

We are supportive of the inclusion of people from GLBTIQ communities in this Inquiry but **cannot support** the inclusion of the group under 9.2 People from culturally and linguistically diverse backgrounds.

The GLBTIQ community have quite distinct needs that need to be recognised so that funding agencies, service providers and community care workers respond appropriately. It might be more appropriate that the group is discussed under a separate sub-section in chapter 9 (9.8?) or a separate section of the final report.

While the provision of services needs to be 'respectful and sensitive to the needs and preferences … identify as GLBTI people or otherwise' (p. 280), in essence the CALD GLBTIQ community do not have an adequate cohort of community workers that can provide services within the community. DOHA's recent pilot GLBTI sensitivity training initiative (Star Online 2011) while welcome, places careworkers in frontline positions to be challenged at every level (elder abuse, mental illness, social isolation, gender and sexual diversity) particularly when that care contests with their religious or moral codes or identity. How then can we build a careforce to better respond to the needs of the CALD GLBTIQ community?

We recommend for a sub-section (or section) on the GLBTIQ community **including a focus on the CALD GLBTIQ community** as follows :

CALD gay, lesbian, bisexual, transgender and intersex people

The ageing of the CALD GLBTIQ community has not attracted as much attention as the mainstream GLBTIQ community. There are some common experiences with the mainstream community as identified by the National LGBT Health Alliance such as generational differences between the pre-gay liberation and baby boomers, and invisibility of needs in residential care or vilification as a community.

However members of the CALD GLBTIQ community do not necessarily experience the sexual or gender liberation of the mainstream GLBTIQ community. Members of the CALD GLBTIQ community tend to live in their local community connected to their ethnic and/or faith communities while their distinct identity marginalises them as a 'minority within a (GLBT) minority'. There is practically no research that explores the needs of the ageing CALD GLBTIQ community. At the recent Sydney forum, *Sharing our Stories,* a significant number of findings were identified, some shared with the mainstream GLBTIQ community and some more relevant to the CALD GLBTIQ community :

Ageing and disability – relatively new concepts and life stages being negotiated as people start to advocate for recognition of their needs

Identity – There is a dearth of understanding of the complex and dynamic intersection of sexual, gender, cultural and religious identities for multicultural GLBTIQ people; current language around sexuality, sex and gender is underpinned by Western understandings of sexual diversity and fails to reflect meanings across multicultural communities

Services - lack of culturally appropriate services as well as a lack of knowledge of sexuality, sex and gender diversity within multicultural communities and among service providers

Funding - aged services tend to be funded through blanket funding which does not target the diversity within such as the needs of older GLBTIQ multicultural people

Fear – not doing it 'right' and fear of 'abnormal' behaviour

Education - older people and sexuality is rarely addressed as a topic in the general community as there is an assumption that older people do not have an active sexual identity or sexual life; nor lack of recognition of the diversity of older people or those with a disability

Advocacy: lack of advocacy organisation for CALD GLBTIQ communities

While the CALD GLBTIQ community of older people is small, we can expect an increase in numbers over the next 10-15 years with legislation change, skilled migration, greater acceptance of same-sex relationships in Australia and overseas.

We recommend that service provision for the CALD GLBTIQ community is delivered in consultation not only with mainstream GLBTIQ organisations but with a range of community organisations, local councils and peak organisations that are either involved with or support the CALD GLBTIQ community.

11. (9.5) SOCIALLY DISADVANTAGED, PP. 290-292

While some social groups are more easily identifiable, others are less so. People from a homeless background and care leavers are certainly worthy of recognition of their special needs as a result of their prior or current experiences. To this group **we recommend** for recognition of a group of people from CALD backgrounds who would experience social disadvantage at some point and in varying degrees:

- People from a refugee or refugee-like background
- Childless women
- Men
- People with mental illness
- People with a disability

When ethnicity (race), religion, language and culture intersect each of these social groups, their disadvantage is multiplied and access to services becomes increasingly difficult usually at a crisis

point. Sharam (2010) suggests that unless identified by the Supported Accommodation and Assistance Program (SAAP), it appears then that there is invisibility of certain groups including people from CALD backgrounds who experience homelessness. It is likely that women and men from CALD backgrounds will not access mainstream homelessness services which reduces their visibility as a 'needs' group. While not exclusive, there is anecdotal evidence to suggest that within the South Asian community for example, some older people are at risk of homelessness as a result of loss of assets and income support which are transferred under pressure to their children who either seek to manage their parents' income or absorb it in the cost of caring by their adult children. Lack of independent finances puts pressure on older people's ability to access appropriate services or seek support.

We recommend that the Commission consider (older) women from CALD backgrounds as a new and emerging group whose social disadvantage primarily stems from domestic violence and associated factors (breakdown in marriage, loss of assets including house, low housing affordability, rental trap) but other contributory factors may be death of a spouse, dependence on a life structured around the male partner, mental illness, continuing care for a young adult with a disability, unpartnered or childless, poorer economic status and reliance on unfunded and poorly resourced ethno-specific community supports or even entry into paid work at later ages due to their social circumstances.

12. (9.6) FINANCIALLY DISADVANTAGED, PP. 292-294

It is a paradox that indeed a large proportion of older Australians who are financially disadvantaged are asset rich due to rising land values irrespective of the state of their property.

An equal paradox is that the introduction of the superannuation guarantee on 1 July 1992 will not advantage at least 10-20% of all older Australians who will retire in the near future. Women will experience this disadvantage as will women from CALD backgrounds in low income work including roles in the community care or aged care sector. For some, a house is the only tangible asset that offers security for the current and future generation. **We recommend** that 'financial capacity' (p. 294) be clearly defined to reduce disadvantage to people from CALD backgrounds.

13. (9.7) RURAL AND REMOTE LOCATIONS, PP. 294-298

We agree with the challenges identified in delivering services in R&R locations but would also add

Shifting landscape: decline in younger population; ageing of R&R population

and agree with suggested solutions (last para, p. 295 - 297) including recognition of additional costs incurred in supplying services such as interpreters, cultural competence training and recruiting and retaining culturally-appropriate care workers.

One of the challenges of service delivery in R&R locations is the identification of people from CALD backgrounds. It appears that older people's experience of earlier migration policies has resulted in their disconnect from ethnicity as a marker of identity. For them choice in care may be less a concern as the region already suffers from a dearth of adequate aged care options.

14. RESPONSE TO RECOMMENDATIONS, PP. 298-299

Recommendation 9.1, point 1 – access to information

Valid but agencies need to be funded to deliver the information in consultation with relevant community workers and members so that the information content is appropriate (language, terms, images).

Recommendation 9.1, point 2 – interpreters

Interpreters do not 'convey' information but interpret the conversation into another language. Access and funding to interpreter services needs to be strengthened as access to interpreters is not uniform particularly in rural and remote locations and need to be factored as 'additional costs' of service provision.

Translating and Interpreting Services (TIS) is a generic service that does not have the in-depth understanding of health and community concepts. In the past we have seen the difficulty in translating the concept of 'meals on wheels'. In future, concepts such as 'consumer-directed' and 'individualised packages of care' are terms that community workers and community members will grapple with unless we have trained and supported interpreters or translators with specialised knowledge of health and community care services. We also argue for recognition of specialised bilingual and bicultural workers trained in aged care as an additional information source in a language other than English.

Recommendation 9.2, point 1 – interpreter services cost

The AACRC also need to take into account the cost of 'translation services' which can be high and a substantial cost to providing services in different languages including new forms of technology.

Recommendation 9.2, point 2 – cultural awareness

We recommend that cultural awareness training is raised to a mandatory level within the sector to increase individual and organisational awareness of and sensitivity to differences in race, gender, social class, sexual orientation, ability and migration experience. Mandatory cultural awareness training and progression to cultural intelligence would be the hallmark of a mature service provider.

We advocate that the service population reflect the population in a determined area so that mainstream organisations have clients, staff and volunteers that reflect their community and that funding regimes incorporate a provision for organisations to respond to the diversity of needs. This increases providers' awareness and response especially where there are small numbers of people with particular needs. The sector might then be able to argue less about 'lack of awareness' or that '… being very few clients' (p.271).

CHAPTER 11, DELIVERING CARE

We agree in essence with the key points of this chapter. However we would like to raise the following :

15. 11.1 WHO DELIVERS CARE? PP. 346-347

Personal carers : the Commission focuses on personal carers (p. XXXIX) as part of the care force in residential care (also know an Personal Care Assistant, PCA) and may extend to work done at home under flexible packages of care. However the understanding of a personal carer must be more clearly defined as they have varying roles depending on the setting. For example, an agency might require a 'personal carer' to do the following which could go beyond the description of 'activities of every living, such as showering, feeding and laundry' (p. 346) in the report.

> http://www.bestofcarebarwon.com.au/images/duties-personal-carer.pdf
> - social and emotional support
> - personal care tasks of a non-nursing nature
> - respite
> - personal assistance with small tasks
> - household/environmental maintenance
>
> Yet another agency advertises a personal carer's tasks as follows :
> http://www.kindercaring.com.au/OurServices/Personalcare.aspx
> Showering Dressing Shaving Brushing teeth Applying makeup
> Host/ Lifting machine transfers Continence Management Skin Integrity Management
> Nutrition & Hydration Management Medication reminders
> Preparing meals and snacks

There are a range of community workers that provide support to people at home and in the community which are not addressed in this report. Such aged care specific skills are gained through a combination of personal experiences, tertiary qualifications or on-the-job training. These workers are 'qualified care workers'.

The shortage of qualified workers in the sector can be addressed by improved integration between aged care organisations and TAFE or other training organisations to recruit directly. The inability to recruit people from multicultural communities is to some extent related to wages, limited full time employment opportunities, mismatch between supply and demand for workers and lack of value of care work.

We recommend that the Commission clarify the description of 'personal carer'.

16. 11.2 INFORMAL CARERS, PP 347-355

We strongly argue for informal carers to be allocated a separate section in the final report with recognition and respect for the role of carers.

We would advise the Commission to view the submission from Carer organisations such as Carers NSW.

17. RESPONSE TO RECOMMENDATIONS, PP. 355-379

Recommendation 11.1 (p. 355)

Currently carers from CALD backgrounds have low access to existing centres or advocacy agencies like Carers NSW so the promotion of a dedicated 'carer support centre' would require continuing and focused

- education about the recognition of a 'carer' within multicultural communities; their role and need for support to complement their caring;
- community development workers within local communities to identify and respond to needs including assistance to access services

Carers from multicultural backgrounds need 'flexible' and 'responsive' support services particularly flexible respite options so that carers can have increased weekend and after hours access to services to assist them their family members to participate in a range of activities that contributes to their social inclusion.

Recommendation 11.3 (p. 371)

We agree with some of the recommendations in particular 'improved classification of the workforce to assist data collection' (p. 376). Currently it is difficult to find specific information about the aged care workforce as demonstrated in AIHW's publication, *Health and community services labour force 2006,* where data includes child care services making it difficult to extrapolate aged care workforce data.

We would also like make the following comments :

Community care workforce snapshot, p. 358

The comment on p. 358 (rising numbers of personal care workers, large number of low intensity services and non-requirement of clinical skills and qualifications) appears to devalue the skills, qualification, experiences and value of community care workers which contradicts the 'skills' sought in the future workforce. Low intensity care services in community settings is largely of an intervention nature that assists people to prevent their inappropriate admission to high levels of care at an early stage. Community care workers do not require high levels of clinical skills but do need support to gain qualifications and be qualified to provide care in a community setting.

Projections of aged care workforce requirements, p.359

We are aware that Government has invested in courses for care workers to achieve minimum qualifications (p. 360) but it appears that there is still insufficient knowledge about how to obtain work in the sector. There also appears to be a lack of integration between employing agencies and RTOs including TAFE where 'qualified students' are not being directly absorbed into the sector therefore creating a gap in access to a pool of multicultural community workers. The sector possibly needs dedicated Recruiters similar to that in the Job Network where relationship building with schools, RTOs, migrant communities and migrant interagencies will allow direct referral of candidates into aged care agencies and even channel into training across a range of community services (residential, disability and community care).

Improving the attractiveness of aged care and quality of care, p. 362

While the sourcing of overseas care workers is a future option (p. 362), it raises several social concerns including the loss of care supports in the 'migrant sending country' while the 'host country' gains additional workforce. In addition there are concerns about the gap in quality of social care, language barriers and other issues identified in research in this area (see Hoff, Feldman & Vidovicova 2010 and Martin-Mathews, Sims-Gould and Naslund 2010 in the International Journal of Ageing and Later Life).

An interesting development is the formation of the Human Services Industry Curriculum Committee which is charged with identifying a selection of units of competencies in selected courses. Students will be able to work towards partial completion of a qualification while still at school. We can anticipate an exciting period of growth should the take-up of Certificate III Aged Care and Health by senior high school students transfer to tertiary level at TAFE or university (ACS 2011).

We disagree with the statement that "most of the solutions lie with aged care providers as … principle responsibility for …. an attractive workplace" (p. 362). A whole of community or aged care industry approach with government is more likely to deliver success in improving the attractiveness of the aged care sector.

Working environment and skills development & career paths, p.364, 368-371

The numbers of women and people at older ages employed in the aged care sector including community care is testament to the positive aspects of working in this sector, identified by the Commission as "positive characteristics" to be promoted to potential workers. However these benefits often come at a price to women in terms of low wages, insecure positions tied to term funding and lack of real career progression. At a local level, the community sector in Bankstown (NSW) have developed a local recruitment campaign to target tertiary students (university and TAFE) but the outcome is less clear in terms of people recruited due to lack of resources to follow up promotion.

The Commission advocates for "clinical placements in teaching aged care facilities'' and "introduction of undergraduate electives" (p. 365) but we would argue for recognition of non-clinical courses at universities where internships are available at Macquarie University's third-year Sociology program or similar institutions where students develop applied skills in research, policy and advocacy that are relevant in the delivery of human services. The aged care sector needs to viewed as an industry with opportunities across different levels, not just nursing but nutrition, personal training or even financial management in response to changes anticipated with individualised funding. Equally, the mandatory placements at TAFE for human services (community, aged and disability) are opportunities to recruit and support students to enter the sector.

Recommendation 11.5 (p. 379)

We agree with the recognition of volunteers as part of the formal workforce and issues identified to attract, recruit and retain volunteers including ongoing issues of background checks. But the volunteering landscape is changing in response to economic and social changes. It is unlikely that Recommendation 11.5 can sufficiently address the shortfall projected with an ageing population. We recommend that costs associated with volunteering should be separate to recommended scheduled care prices, that is funded separately.

GENERAL COMMENTS

Older Australians, p. XXI
The report should clearly qualify the description of older Australians to include the diversity within this cohort.

Workforce, p. XXXIX
The 'Commission has focused mainly on nurses, personal carers, allied health professional and medical specialists …. Recognises the important contributions made by supporting workers in residential facilities and in home maintenance services …. And primary and acute health care workforce…'

In doing so, the Commission has failed to recognise the diversity the care workforce and inherently created division by exclusion. In addition, a large proportion of the workforce is female which raises several issues.

The Draft does not consider the involvement of 'grey' workers like community development workers and bilingual educators.

Concepts

> Independence – wellness - person-centred – dignity - respect
> easy to navigate – affordable – choice - consumer-directed
> incentives – equitable – entitlement - assessed need

need to be clearly defined in the final report so that readers have a common understanding for this report.

Building block approach to care, p. XXIX
This approach excludes a whole range of HACC services (linen care, social support, neighbour aid, respite, centre based activity) which are important in facilitating social inclusion.

Policy research and evaluation, 13.1
While we agree with government funded research which often is only possible in funded positions in the sector, we need to support research by community development workers and similar who have in-depth knowledge of local communities and local issues. Such research support grassroots activism and often includes better social inclusion outcomes.

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