

PRODUCTIVITY COMMISSION INQUIRY
INTO THE CARE OF OLDER AUSTRALIANS

ACCV CALD INTEREST GROUP DISCUSSION FORUM
WEDNESDAY JUNE 30TH 2010

Issues

- Why is CALD “Special needs” – the numbers don’t support it – as the CALD population is a very large proportion of the elderly population in many areas. Is “special needs” more pertinent under particular circumstances (eg) rural areas.
- The diversity of the cultural diversity is not just cultural diversity but also socio-economic diversity. Some more established CALD communities will have greater resources to develop responses to for the needs of their elders.
- Is there the need to consider an international perspective on aged care systems? For example, is there a possibility of using funds transfers between jurisdictions for aged care as for pensions and medical insurance (eg Medicare has agreement with some countries)? Might this be of fiscal benefit to Australia?
- We fund a system to provide care in a “satisficing” way for a range of important needs – dementia palliative; CALD, homeless etc – there’s no “fat” to take us from “3 sizes fits many” to much more tailored living and care given the range of “special needs” and other focal care issues that might be encountered (eg. falls, wound care, movement disorders, pain management, oral and dental health, extreme sensory impairment, environmental sustainability) It is challenging to achieve status of “best practice” or “change champion” on everything. How do we ensure a more flexible system and sufficient “energy” to be enable aged care providers to have their finger on the pulse of everything?
- One possible issue of why there are insufficient resources to allow flexible and innovative responses to be created is that the system is largely driven a “procurement” model of funding rather than a “create” model which permits the right service to be built. An average pricing point in the procurement model can only deliver the average product.

Solutions

- Develop a system of both “carrots and sticks”. The sticks are for services who do not address the most minimum standards or outcomes in relation to CALD care – where no effort is made at all and a service could be regarded as hostile or completely insensitive to the needs of CALD clients. On the other hand, meeting minimum standards still does not ensure that CALD care is highly effective – resource constraints are present and incentives are need to encourage organisations to progress their approach. A CALD supplement paid as part of ACFI or community subsidies and accounted for in ACFI validation processes or Community Care Quality Reporting.
- Add language support to the aged care standards.

- Restrain the diversity in facilities to promote threshold levels to encourage proper “clusters” to form. However this needs to be counterbalanced by permitting CALD elders the freedom to choose a facility
- Government to target aged care training to various CALD communities as represented in the profile of aged care users. At present there is also a culturally diverse workforce. This is not just about “Anglo-Celtic Aussies looking after non English speaking clients. However, the cultures and languages represented in the workforce does not necessarily match those of aged care residents or clients. Provide support to our diverse workforce to provide care to diverse clients (eg) Sudanese worker and Chinese client.
- Ensure that the aged care system and providers achieve broad culturally responsive approaches – not just a language focus
- Operate direct overseas partnerships on workforce. This requires attention to visa requirements and other regulatory barriers etc
- The children of CALD elders do not appear to place a priority on language and cultural responsiveness when selecting a facility for their parents. Community education could be targetted to the children of CALD elders about the benefits of a linguistically and culturally responsive aged care environment. This might influence these children to choose CALD / clustered choices.
- CALD must be an organisation wide priority of aged care providers and Outcomes on Cultural and Linguistic Diversity should found among all of the four residential aged care standards not just Standard 3. *The Standards are: Standard 1 – Management Systems, Staffing and Organisational Development, Standard 2 – Health and Personal Care, Standard 3 – Resident Lifestyle, Standard 4 - Physical Environment and Safe Systems.*
- The Victorian Department of Health’s new Culturally Responsiveness Framework visit: <http://www.health.vic.gov.au/cald/cultural-responsiveness-framework> also forms an important layer for standards outcomes. *The framework encompasses a strategic and whole- of-organisation approach and is designed to be aligned with health services’ strategic planning processes. It is based on the four key domains of clinical governance: organisational effectiveness; risk management; consumer participation; and effective workforce,*
It specifies six standards and improvement measures for culturally responsive practice.
Standards for cultural responsiveness:
Standard 1 - A whole-of-organisation approach to cultural responsiveness is demonstrated
Standard 2 - Leadership for cultural responsiveness is demonstrated by the health service
Standard 3 - Accredited interpreters are provided to patients who require one
Standard 4 - Inclusive practice in care planning is demonstrated, including but not limited to dietary, spiritual, family, attitudinal, and other cultural practices
Standard 5 - CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis
Standard 6 - Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness
- Auditing on Cultural Responsiveness must be supported by useful audit tools. (Eg refer to Dreaschlin Five Stage Process at http://www.eccnsw.org.au/assets/pdf/M6_Participant_Material.pdf)

- If we get Cultural and Linguistic Diversity right, then a lot of other needs will be better met (eg dementia care, behavioural manifestations of people's inability to communicate, even apparent incontinence because people cannot communicate their needs. The system i.e. service providers and government need to see that CALD done well = less behavioral problems, less continence problems etc as communication in any health or aged care setting is a key ingredient to achieving good care outcomes.
- Provide CALD elders with greater support to become more informed about the various lifestyle, support and care options available to them. A community education program conducted in multiple languages through the communication channels people use. Electronic media, especially radio, is an important medium where there are literacy issues.
- The Commonwealth Department of Health and Ageing could conduct an evaluation of its performance in providing culturally and linguistically appropriate information to older Australians and then address identified gaps. DoHA also needs to evaluate the benefits of its current effectiveness in engaging in constructive dialogue with individual CALD communities.
- Translating and interpreting is not just the responsibility of the Department of Immigration. This is especially the case if people migrated 50 years ago. At minimum, DoHA or any Minister for Ageing, should be proactively working with Dept. of Immigration if the responsibility is truly vested there. Otherwise it needs to start improving its own capacity to resource core needs of CALD Elders such as translating and interpreting.
- The DoHA website – especially those areas directed to consumers – needs to provide a range of language choices with intuitive language selection options - like a Paris Metro ticket machine.
- Multiculturalism is at its lowest ebb. The “heydays” of the 80's and early 90's have gone by when government funded ethno specific facilities, what did we learn from this period that could be re-visited, adapted or built upon? **A strategic re-vitalisation of CALD aged care could be initiated with a Ministerially led CALD aged care working party.**
- A government funded annual “CALD Aged Care open-house” week for both aged care providers and the public. The government could provide incentive grants for organisations to open their doors.
- We need data as a starting point to improve the systems, not as an excuse to do nothing.
- Partnerships and relationships between aged care organisations and cultural organisations can enable solutions to be developed which respond to the needs of CALD residents in a facility or clients in the community.
- DoHA could translate all essential materials into at least 10 languages. This would include client agreements, assessment tools such as pain, mood nutrition status and wellness tools. There should also be a general CALD assessment tool. This is far more cost effective to the taxpayer and aged care consumer than each individual provider doing this.
- Learning outcomes on CALD sensitivity/ culturally safe care should be established in all entry health and aged care worker training in both VET (certificate/ diploma) and higher education (undergraduate) programs
- Available off-the-shelf technology such as electronic translators and IPod “apps”, could be integrated into the care and support of older people in the same way Nintendo Wii has found a niche in aged care settings. Such technology could yield great benefits over a short period of time



ONE MESSAGE MANY VOICES

if Government were to intelligently invest in incentives to support the purchase/ uptake, training in its use, demonstration pilots and research evaluation.