

Submission to the
Productivity Commission
Inquiry

*“Caring for Older Australians –
a CALD Perspective”*

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**Federation of Ethnic
Communities' Councils
of Australia**

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Acronyms

AAA	Active Ageing Australia
ABS	Australian Bureau of Statistics
ACAR	Aged Care Approval Round
ACAT	Aged Care Advisory Team
AIHW	Australian Institute of Health and Welfare
CACP	Community Aged Care Package
CALD	Culturally and Linguistically Diverse
DADHC	Department of Ageing, Disability and Home Care, NSW
DoHA	Department of Health and Ageing
FECCA	Federation of Ethnic Communities' Councils of Australia
HACC	Home and Community Care
NESB	Non English Speaking Background
NHRR	National Health and Hospitals Review
RRC	Residential Respite Care

1. About FECCA

FECCA is the national peak body representing and advocating for culturally and linguistically diverse communities. Our role is to advise, advocate, and promote issues on behalf of our constituency to government, business and the broader community. FECCA promotes Australian multiculturalism, community harmony, social justice, community participation and the rejection of discrimination in order to build a productive, culturally rich Australian society. FECCA's policies are designed around the concepts of empowerment and inclusion and are formulated with the common good of all Australians in mind.

2. Introduction

One of the tasks identified in the issues paper prepared by the Productivity Commission on *Caring for Older Australians* is to “address the interests of special needs groups, including people living in rural and remote locations, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, and veterans”¹. This submission will focus on culturally and linguistically diverse (CALD) communities. FECCA's position as the peak body representing Australians from diverse, multicultural backgrounds, places us in an excellent position to advocate on behalf of our constituents on the question of aged care. This submission will provide an overview of Australia's CALD seniors and will identify the gaps in the current range of services funded by the Department of Health and Ageing (DoHA) across the states and territories. It will then suggest some alternative models of care, the need for culturally competent care and active citizenship to improve the future quality of life and care for Australia's CALD seniors. In the context of National Health and Hospitals Reform, now is an excellent time to address the vital issues resulting from the ageing of the post WWII migrant boom.

3. The Ageing of the Post War Migrants

3.1. The demographic reality

Australia is a very culturally diverse nation. Nearly half of our population is born overseas or has one parent born overseas. Over 16% of Australians speak a language other than English at home and Australians come from 200 different ancestries and speak more than 300 different languages at home². While diversity is our strength, it also poses a challenge for service providers to equally reach all sectors of Australia's culturally and linguistically diverse communities.

Research confirms that the community of older people from culturally and linguistically

diverse backgrounds (CALD), as a proportion of the population, is increasing at a significantly higher rate than the Australian born community. Older persons from CALD backgrounds in 1996 comprised 18% of Australians aged 65 and over. By 2011, this figure is expected to rise to 23% and will reach over one million and by 2021, 30% of older Australians will come from a CALD background.³

This is a growth rate of 66% over a 15 year period, compared with only 23% for the Australian born population.⁴ The rate of growth will slow by 2026 with older people from CALD backgrounds numbering 939,800 or 21.2% of the elderly population. Similarly, people from CALD backgrounds over 80 will increase from about one in eight in 1996 to one in five in 2011 to one in four in 2026.

According to the Australian Institute of Health and Welfare⁵ (AIHW), one in five older Australians come from non-English speaking countries and numbered over 583,200, compared with 370, 500 from English-speaking countries and 1,780,400 Australian born.

In 2006, the most common countries of birth for non-English-speaking older people were Italy (113,900) and Greece (57,200).⁶ Although people from non-English-speaking countries made up only 15% of the very old population (85 and over) they represented a more significant part of the population aged 75–84 years (21%) and of those aged 65–74 years (23%).⁷

With ageing English language skills often diminish, a process which is exacerbated by the greater social isolation associated with older age. Cultural issues and practices can also become more important⁸. According to the 2006 census 21% of the 65+ age group came from a non-English speaking background (NESB). That is, they were born in countries where English is not their first language.

Recommendation 1:

FECCA recommends that the Federal Government acknowledge the significance of the quantum and proportion of the CALD ageing population within the overall cohort and treat this group as a high level priority in its development of aged care services and approaches.

Recommendation 2:

FECCA recommends that research funding be provided to develop the evidence base for ethnic health and ageing through our key national collecting institutions such as AIWH, ABS & DoHA.

3.2. The geographic distribution of CALD Seniors

The population of CALD seniors will be unevenly distributed and concentrated in Australia's capital cities. For example, by 2011 an estimated 40% of older people living in Melbourne and 34% living in Perth will be from non-English speaking backgrounds.⁹

At present up to 80% of older Australian from CALD backgrounds reside in capital cities, except for Queensland and Tasmania. Victoria has the most culturally diverse population with one third of all older Victorians speaking a language other than English at home.¹⁰

For each State and Territory, this figure translates to 28.25% in Victoria, 22% in New South Wales, 12% in Queensland, 20% in Western Australia, 20% in South Australia, 20% in the Northern Territory and 8% in Tasmania.¹¹

The 2006 Census confirmed that close to 90% of NESBs aged 65+ in Victoria lived in the 4 metropolitan planning regions used by DoHA and its corresponding State Government Departments. These are the most densely populated areas of the State.¹²

Recommendation 3:

FECCA recommends that demographic and ethnicity planning data is accessed and analysed relevant to service geographies and to individual service structures so that aged service planners can attribute both relevance and specificity to CALD aged care considerations.

4. The Need for a National CALD Age Care Policy

FECCA is aware that there is a current federal policy void covering the area of CALD ageing and aged care. In fact the last Federal Government policy in this area dates back to 1996. This is clearly unacceptable, especially when considered in light of the changing demographics and the ageing of the post war migrant population.

This deficit needs to be immediately addressed as a matter of urgency with a comprehensive CALD Aged Care Policy. This policy would provide not only a legitimate framework, but also a practical framework for the planning and coordination of aged care service for this significant group.

The development of the policy should be informed by an expert group of academic and community representatives who can inform its development as well as the development of community infrastructure under the FECCA auspice to deliver an important conduit for the needs and expectations of ageing CALD Australians.

Recommendation 4:

FECCA recommends that a national CALD Ageing policy and planning framework be developed by the Federal Government, to direct the development of aged care services for CALD Australians.

Recommendation 5:

FECCA recommends that this policy development process be informed by a high level expert CALD Ageing advisory panel, who would be appointed for this task.

Recommendation 6:

Additionally, FECCA recommends that a national CALD Ageing network be funded and developed, under the auspice of FECCA, to provide a conduit for consumer perspectives

and information sharing on the aged care issues relevant to this group.

5. The Care Needs of the CALD Ageing

5.1 Issues Around Access

The consideration of access is an important starting point for the discussion of CALD aged care services as access, or its lack in many cases, is key to understanding how to position and deliver specific aged care services.

Research indicates a growing population of CALD seniors with diverse needs¹³. To ensure *better health and active ageing* for all Australians in accordance with the vision of the Department of Health and Ageing¹⁴, all levels of Government must^{15 16 17}:

- Achieve an accelerated and deeper understanding of the needs of CALD older people;
- Meet the diverse needs of the carers of CALD seniors;
- Identify how to address these needs appropriately and flexibly;¹⁸
- In addition, a positive Government commitment to education and training that builds the cultural competence of Australia's aged care workforce will benefit all Australians, through the provision of more responsive and appropriate aged care services¹⁹.
- Given the concentration of CALD seniors in urban areas, it is important not to overlook those who reside in rural and regional Australia who face a double disadvantage in accessing culturally appropriate aged care services²⁰.

The consequence of CALD seniors not receiving timely and appropriate care and support will result in the following problems:

- Poorer health.
- Increased isolation, withdrawal and depression.
- Increased stress and physical demands on carers.
- Increased use of prescribed medication.

These issues will be expanded on in the body of this submission

5.2 Planning Ahead (Planning for Later Life)

Due to cultural considerations, such as extended family and religious perspectives, insufficient attention is given to end of life planning in many CALD communities in Australia²¹. However, as the CALD population ages, Planning Ahead initiatives become a more significant need, which policy makers need to address. Planning Ahead is the process by which people choose a trusted person to make financial, health medical and lifestyle decisions on their behalf in the instance they cannot do so for themselves. Such

circumstances may result from dementia, severe physical injury or brain injury. Planning Ahead involves one or more of the following processes²²:

- **A will** which legally outlines an individual's wishes in regards to the distribution of assets after death.
- **Enduring Power of Attorney** which gives a nominated person authority to make decisions about financial issues.
- **Enduring Guardianship** which gives a nominated person the authority to make decisions about personal, health and lifestyles matters.
- **Advanced health Care Directives** which provides doctors with clear guidance about a person's intentions for future medical treatment.

Three steps need to be considered when developing a strategic plan for Planning Ahead in CALD communities. Firstly, the need to explain wishes to significant people in one's life, secondly, the need to identify a suitable and trusted person and thirdly, deciding whether to make a formal arrangement or entrust that process to family or friends.

In considering Planning Ahead issues in CALD communities it is important to consider the barriers to end of life planning including: the sensitivities that underpin losing one's decision-making ability, legal costs, trust, family conflict, lack of prior experience in country of origin and handing over control over finances. It is important to promote effective Planning Ahead to ensure that older people effectively plan their future, especially amongst CALD seniors.

Given these cultural barriers and sensitivities, there is a need to develop effective communications approaches for individual CALD communities so that these services and rights are understood and able to be accessed if desired.

Recommendation 7:

FECCA recommends the development of a national CALD education strategy on issues and services relevant to later life planning as these decisions greatly affect not only the lives of individuals as they age but also the lives of those who care for them and close family members.

6. Changing Patterns of Disease

6.1 Chronic Disease and Inactive Lifestyles

Migrants, with the exception of refugees, are generally healthier than the Australian born population when they arrive in Australia, referred to as the "healthy immigrant effect"²³, but after five years in Australia migrant health deteriorates, due to a range of factors from lifestyle transformation to stresses involved in the settlement process²⁴. Indeed,

CALD Australians experience systemic barriers to accessing Australia's healthcare system^{25 26}. These include:

- English as a second language,
- insufficient use of interpreters,
- lower levels of health literacy,
- lack of cultural competency amongst service providers and
- socio-economic barriers²⁷

In the case of refugees, there are a range of special circumstances which affect their health including: pre-migration trauma from war, persecution and displacement, lack of access to quality health care prior to migration, limited social networks in Australia and inequities in accessing the health care system²⁸. Indeed, the demands of the settlement process, such as finding housing and employment compete with health as a priority for new and emerging communities.²⁹

Migrant health must be embedded, therefore, in the wider social context³⁰. A social model of health recognizes that improvements in health and wellbeing are achieved by directing efforts towards addressing the social and environmental determinants of health in tandem with biological and medical factors.³¹

For many CALD communities these lifestyle issues are resulting in chronic health issues in their later years. It is for this reason that aged care services need to specifically consider and respond to those chronic conditions that disproportionately affect the CALD ageing.

6.2 Smoking Rates

While the 'healthy immigrant effect' contributes to lower discharge rates from hospitals and lower presentation rates for most major categories of disease amongst CALD Australians³², intersecting factors contribute to higher smoking and diabetes rates amongst particular categories of immigrant men, in particular.

Male smoking is significantly higher than female smoking in many CALD groups, reflecting trends in their country of origins³³ and smoking rates are higher amongst immigrants than the Australian born population.³⁴ The highest lung cancer rates are amongst migrants from UK, Ireland and the Netherlands. But, Croatian, Lebanese and Italian born migrants also have statistically significant lung cancer rates³⁵. The highest concentration of daily smokers is amongst migrants from Oceania – including the islands of the Pacific. Indigenous Australians also have high smoking rates with 50% of those over the age of 18 reporting they smoke daily.³⁶

6.3 Obesity and Diabetes

The second most significant health issue amongst CALD Australians is sedentary lifestyles. This is most significant amongst migrants who were born in Southern and

Eastern Europe who are more likely to be overweight or obese than people born in Australia. This also contributes to high diabetes rates amongst migrants from Croatia, Greece, India, Italy, Lebanon and Poland³⁷.

Sedentary lifestyles are linked with the transition to chronic disease, the transformation in lifestyle following migration to Australia and dietary transition to refined foods, high in sugars and fats with lower intakes of fresh fruit and vegetables. However, there may also be particular cultural associations between girth and wealth, which need to be taken into consideration in any health promotion campaign³⁸. Health promotion can be defined as a process of enabling people to increase control over and to improve their health through addressing social determinants and, thereby, reducing inequalities in health.³⁹

Obesity is also an issue in the ethnic ageing sector due to cultural attitudes towards physical activity and ageing. CALD seniors are sometimes “shy” to go to gyms or swimming pools and are not motivated to walk. The following points should be considered:

- Sedentary approaches to the concept of ageing are very common in many cultures and there may be resistance to Australian health promotion messages about “active ageing.” Many cultures regarded such conditions as “normal” processes of ageing and did not think it necessary to seek medical intervention. Cultural beliefs thus determine the responses of carers to chronic conditions “including in the role families in care provision and issues around the use of medicine.”⁴⁰
- Research in the United States has indicated that religious beliefs around fate and the perception of disease as “sin” were also factors to be considered in working with older CALD clients.⁴¹
- It is well established by medical research⁴² that specific cultural and linguistic communities have higher prevalence of specific chronic illnesses. For example, the South Asian older population are more susceptible to vascular issues and as a result of increased vascular burden in their brains, they presented with higher rates of hypertension, dementia, depression and stroke.
- Health Promotion and information messages that pathologise conditions, particularly where they were designated as a “Mental Health” issues, reduce the uptake of information and intervention due to the stigma associated with mental illness in many cultures.

6.4 Dementia and Alzheimer’s Disease

Currently some 12.4% of Australians with dementia, or one in eight, do not speak English at home.⁴³ Language and culture plays a vital role in all aspects of care and treatment of CALD seniors. Indeed, elderly residents with dementia are calmer and need less medication in ethno-specific nursing homes where staff and other residents speak their language. The impact of dementia among older refugees can trigger distressing memories of torture experiences or time spent in concentration camps, for example,

creating distress and leading to behaviour change and suspicion of institutional settings.⁴⁴

As part of preparing this submission, FECCA undertook informal consultations with specialist clinicians in the area of ethnic ageing⁴⁵. The feedback confirmed that stigma was a barrier to accepting some forms of chronic illnesses, particularly mental health related issues such as dementia and depression. For example, the translation of the word “dementia” in many languages expressed very negative associations including “not of right mind” (Greek), loss of memory (Italian), dumb, funny, old, crazy, senile (Chinese) and senility (Arabic). Support services need to take into consideration these factors.⁴⁶

6.5 Promoting Active Ageing in CALD communities

It is widely recognised that improving the health of the elderly is contingent upon building healthy, active life styles into the structure of our communities. The link between inactivity, diabetes, obesity, heart disease, cancer, musculoskeletal deterioration and depression are well supported in the literature.⁴⁷ Promoting physical activity and social engagement amongst the elderly addresses the causes of chronic disease and also improves mental health. These preventative health measures will, therefore, save the government money in the long term by preventing the development of chronic disease.

DoHA defines “active ageing” as the ways to maintain health and to increase your physical, emotional and mental health in old age. Suggested activities include:

- get out and about with friends and family
- try a word or number puzzle
- take the dog (or your neighbour’s dog!) for a walk, and
- Become a volunteer.⁴⁸

Active Ageing Australia (AAA) provides a range of programs and services to promote positive ageing experiences focused on physical activity (aimed at people 50+), such as leadership training and information regarding physical activity opportunities and falls prevention. The activities promoted include exercise programs for mental and physical fitness such as Tai Chi, Falls Management measures and home based individual fitness regimes and support including telephone coaching⁴⁹.

However, health literacy and the knowledge of health promotion tends to be lower amongst CALD communities due to barriers to accessing health information including literacy and language proficiency issues as well as the ‘digital divide’⁵⁰, with generally lower uptake of home computers and internet services, an increasingly important source of health information⁵¹, amongst CALD seniors. It is important, therefore, that aged care services find new strategies to improve the general health literacy of CALD seniors.

Recommendation 8:

FECCA recommends that ageing Australians from CALD backgrounds must have equal access to the range of positive ageing programs now becoming available so that the proliferation of chronic disease can be halted which would in turn reduce the aged care needs of this group.

Recommendation 9:

FECCA recommends that the Federal Government give particular priority to the funding of services that address the chronic health needs of the CALD ageing population, especially those areas of health in which this group is overrepresented.

Recommendation 10:

FECCA recommends the development of guidelines for Federal Government initiatives that promote better health among CALD seniors and acknowledge the differences that exist in CALD communities on issues of digital and English language literacy.

7. Models of Care for CALD Seniors

In discussing care models it is important to understand the role of both family carers as well as ethnic community structures that have developed to meet the specific needs of the ageing.

7.1 A Profile of CALD Carers

It has become an unfortunate truism that in many CALD communities, older people are taken care of by their families. The role of CALD carers cannot be overstated but FECCA believes that this should not lead to an abrogation of responsibility for governments and care providers to assist with the care needs of the CALD ageing.

By 2031 older carers (aged 65 years and over) are likely to comprise 56 per cent of all carers⁵². Demographic trends and population profiles indicate that an increasing proportion of carers are likely to be from culturally and linguistically diverse backgrounds⁵³. According to Carers Australia⁵⁴, the aged care service system should include "...a range of easily accessible services aimed at enabling carers, and those they support, the same rights, choices and opportunities as the general community"⁵⁵. This framework should include:

- Assessment and care plans inclusive of carers.
- Information and referral services that link carers to the community care system as well as other relevant programs and services.
- A range of flexible respite care options, delivered in the home, the local

community and in residential and other facilities. The options should include overnight and weekend support, cottage-style accommodation and extended hours in day centres.

- In-home support services.
- Counselling.
- Education and skills development that supports carers in their caring role.
- Access to quality residential care.

Carers Australia suggest that “...within this framework, ethnicity and cultural attitudes to care giving will influence the type of care needed and sought by families. For many cultures ageing is a family supported context where the whole family is involved in making decisions and in supporting care. While some of these expectations are reduced within the practical reality of the Australian context, the concept of the role of the family is still strong. It causes distress when there is no recognition of this in the current protocols of care in mainstream service provision.

In many CALD communities services such as maintenance, home care, meals and transport are considered family responsibilities, while nursing services are “considered a professional health service, something that the person and their family acknowledge is best delivered by a qualified practitioner.”⁵⁶

However when care is delivered by an ethno specific provider, the CALD participation rates in these services show a marked increase. This was confirmed by the AIWH⁵⁷ who found that a higher proportion of CACP (community and aged care package) clients were from CALD backgrounds.

This indicates that the ability to be flexible is a key element in the provision of services in the CALD aged services sector. While the availability and cost of interpreters are a key consideration, confidentiality is another aspect. In small ethnic communities, interpreters are often known to the community. This creates issues with confidentiality and feelings of security for the client.

Recommendation 11:

FECCA recommends that the funding of respite services include a requirement to automatically quarantine a substantial amount of their funding, commensurate with the CALD proportion of the population aged 65+ in each planning region, for CALD service development and delivery.

Recommendation 12:

FECCA recommends that as a condition of their funding, Carers Associations in each State 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;*

- *Advertise their presence and services in the ethnic media;*
- *Develop models of support which are culturally and linguistically appropriate for their diverse consumers.*

7.2 Providing Care in the Home

It is important to increase the capacity of older people with high level care needs from CALD backgrounds to stay at home with their families and delay the need for residential care by ensuring the funding of ethno-specific individual packages such as extended aged care at home, extended aged care at home, dementia packages and community aged care packages (CACP) proportional to CALD population ratios.

Indeed AIHW⁵⁸ has hypothesised that the lower uptake of respite residential care (RRC) by CALD seniors can be attributed to the acceptance of dementia as a normal part of ageing. However, there can also be resistance to residential care and a preference for at home care among CALD families. There are also systemic barriers to accessing services, the most important being English language proficiency. The use of RRC has been identified by AIHW⁵⁹ as an important pathway to the subsequent transition to permanent residential care and it also provides important support to carers. It is important, therefore, to improve the uptake of these services amongst CALD families. Indeed, it is a common finding in the literature that CALD carers resist accessing services until there is a crisis and they no longer can care for their aged relative at home themselves⁶⁰

Recommendation 13:

FECCA recommends a significant increase in the amount of funding available for the delivery of aged care services in the home with a particular emphasis on the funding of care packages which have been demonstrated to overcome service access barriers in CALD communities.

7.3 Ensuring the Adequacy of Ethno-Specific and Multicultural Aged Care Services

In order to meet the short terms care needs of the CALD ageing it is important that ethnic specific and multicultural community organisations are supported to provide a full range of aged care services which would cover community based, centre based and home based services.

There are many highly successful examples of both ethnic specific and multicultural agencies delivering effective aged care services and delaying the need for institutional care in a number of CALD communities. While some communities have highly developed capacity and infrastructure others do not. Therefore it is imperative that the Federal Government seeks to build the capacity of this sector so that it is able to provide this

effective and economically efficient service base.

Recommendation 14:

FECCA recommends that the federal Government undertake a review of the CALD aged service sector and identify those communities with aged care needs and minimal infrastructure as a way of determining developmental funding to increase this capacity.

Recommendation 15:

FECCA recommends that ethno-specific and multicultural service providers must have the opportunity to provide aged care services on an equal footing to mainstream service providers where they can demonstrate capacity and scale. This includes HACC services which are often managed by state governments with significant federal government funding.

Recommendation 16:

Incentives for multicultural services could be established through ethno-specific providers who provide for more than one ethnic group. Experience suggests that providers would go for a ‘best match’ arrangement in which the new groups share similarities in language and cultural practice;

- *Establishment grants (and perhaps capital funding) could be provided to viable ethnic groups who can demonstrate a market for their services in respect of sizeable numbers of NESB consumers;*
- *In the absence of CALD allocations, a proportion of all aged care places in a planning region could be declared for use by CALD seniors. These proportions could be reviewed every three years.*

7.4 Building Partnerships with Ethno-Specific Organisations

Aged care professionals indicate culture and language has an impact on the provision of services to older Australian's. For example, generalist providers are turning to ethno-specific and multicultural agencies for advice on how to deliver culturally appropriate services because they do not have the expertise themselves.⁶¹

There are many CALD-specific organisations that are willing and able to work in partnership with government and service providers at all levels to deliver high quality services to older people from CALD background. Moreover, ethno-specific agencies and multicultural services play an important role in care management for people from CALD backgrounds. They are often an entry or referral point into the aged care system for many CALD older people and their carers and are trusted by the communities with which they work.^{62 63}

A clear commitment by government on encouraging partnerships with communities, appropriate funding streams and clear policies, processes and protocols must be

established to enable this to happen. FECCA's consultations indicate very clearly that the current model of competitive tendering both undermines sustained partnerships between CALD ethno-specific and mainstream organisations, particularly in rural and regional areas, as well as in many instances excluding the opportunity for ethno-specific and multicultural services to tender for relevant services, eg Home and Community Care (HACC). The current competitive tendering process needs to be considered in light of available service choices and therefore ultimately the quality of support that older Australians from CALD backgrounds can rely on from their service system.

The importance of culture and language to older people is evident in HACC funded social support programs, including planned activity groups which are highly used by older people from CALD backgrounds, delivered by ethno-specific agencies and multicultural services.⁶⁴

7.4.1 Good Practice Models

The characteristics of these approaches include increasing community participation, working in partnership and taking a community development approach.

Specific projects that have utilised this approach include:

- The Mind Your Memory Culturally and Linguistically Diverse (CALD) Project in Queanbeyan. Responding to an under representation of CALD referrals, this project worked through local ethnic communities and bilingual educators to run training and information sessions. The initiative was supported by a DADHC (Department of Ageing, Disability and Home Care, NSW) grant and achieved a significant increase in referrals and a marked increase in the level of knowledge about dementia and dementia services by participants:
- The Multicultural Dementia Care Service Program hosted by the QLD Transcultural Mental Health Centre, Islamic Women's' Association of Qld and Multicultural Communities Council of the Gold Coast. This is a brokerage service following ACAT (Aged Care Advisory Team) assessment. The service matches clients with professional consultants from their own language and cultural backgrounds to ensure that they receive culturally appropriate assessments and care plans⁶⁵
- The 'Una Vita Migliore' which brought together Alzheimer's Australia Victoria with CoAsIt and the Italian media in Melbourne to run a series of public education programs targeting Italian seniors⁶⁶.

Recommendation 17:

FECCA recommends that where mainstream aged service organisations have responsibility for an area or constituency which has significant CALD aged populations that funding contracts include a requirement to either work in partnership with CALD organisations or be able to demonstrate internal competency to meet the needs of the CALD ageing in their catchment.

7.5 Developing Cultural Competency in the Aged Care Workforce

It is important to ensure a quality framework aged care system with benchmarks, which include culture as a central need for consumers. This should include national standards of cultural competence in aged and community care service provision to be developed and adopted by all service providers and be linked to accreditation. Cultural competency can be defined as “a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals which enable those systems, agencies or professionals to work in cross-cultural situations”.⁶⁷ To become culturally competent a health system needs to work at the systemic, organisational, professional and individual levels. A culturally competent health system should:

- Value diversity
- Have the capacity for cultural self-assessment
- Be aware of the dynamics which occur when cultures interact
- Institutionalise cultural knowledge
- Adapt service delivery so that it reflects an understanding of the diversity between and within cultures⁶⁸

With the ageing of Australia’s post-war migrants it is important to bring cultural competency training into the aged care sector and to build cultural competency training into staff development.

Recommendation 18:

FECCA recommends that the Federal Government build the capacity of the mainstream aged care services industry to cater for the changing needs and demands of the growing population of CALD seniors through appropriate standards and cultural competence training, and through encouraging the recruitment of staff from language and cultural backgrounds relevant to service catchments.

7.6 Servicing the aged care needs of CALD older people in regional and rural areas.

It should be noted that the needs of CALD ageing in rural and regional areas are becoming critical. While most attention goes to the urban areas, there are a number of rural areas in which CALD groups have aged in place and are now coming forward with aged care needs.

This is a particularly difficult area as very few of these locations contain groups with the critical numbers to support an ethnic specific or multicultural aged care services. Therefore consideration needs to be given to the structuring of mainstream services, issues of cultural competency and potential partnerships which could be developed to

deliver aged care services to these groups.

Recommendation 19:

FECCA recommends that the Federal Government investigate the aged care service needs of the CALD ageing in rural and regional areas to identify and develop appropriate aged care models to meet their needs.

7.7 Funding Ethnic Specific Institutional Care

While research in the area of CALD aging identifies that institutional care is not preferred and is often used as a last resort, there is an increasing community acceptance that high level care and end of life care may not be able to be provided in the home. As such there is a need to consider the high level institutional care needs of CALDS communities both at present and over the next 10 years in which numbers will make this issue critical.

Nursing Homes are an area in which communities have become involved. While the capacity to build community infrastructure for institutional care is limited and the costs and expertise thresholds are high, some communities have had the numbers and resources to develop highly effective institutional care. FECCA's concern is that other smaller communities will not be able to achieve this and this will lead to a major inequity between communities.

As such there is now a need to consider alternate models to develop high level care facilities for smaller or less well resourced communities and we believe that this will only take place if incentives are developed to encourage collaborations between existing service providers and smaller CALD communities.

Recommendation 20:

FECCA recommends that the Federal Government develop specific funding models to allow the development of high level care facilities in CALD communities with limited financial or resource infrastructure and that this be built into the planning model of high level care funding and support.

7.8 Expanding services with a tighter labour market

For the ethnic aged care sector the biggest shortages are in providing staff suitably trained with competency in the major European languages represented amongst CALD seniors in Australia, especially Italian and Greek. FECCA recommends that this shortage can be remedied through two mechanisms. The first is to target our skilled migration scheme to recruit suitably trained aged care workers who speak the relevant languages

needed by the ethnic aged care sector. The second strategy is to provide pathways of training for migrant women from these linguistic communities in Australia, who are currently out of the workforce, to become suitably trained to work in the aged care sector. This step would increase the supply of workers available to the sector during a period of workforce decline, but also build upon linguistic skills that are currently untapped by the Australian labour force.

Recommendation 21:

FECCA recommends that the Federal Government develop strategies to provide the staff language and cultural skills to fill the growing gaps for services for the ethnic aged. This can be achieved, firstly, through a targeted skilled migration program for the sector, which prioritises recruiting skill aged care workers who speak the relevant languages needed. Secondly, incentives should be made to recruit women from the relevant language communities in Australia to join the work force, through a skills re-training pathway. These measures will expand the labour force during a period of decline and provide vital gaps of language knowledge and skills to the sector.

8. The Social Inclusion Agenda and the CALD Ageing

8.1 Towards Active Citizenship

Active citizenship acknowledges that in a democratic society all individuals and groups have the right to engage in the creation and re-creation of that democratic society; have the right to participate in all of the democratic practices and institutions within that society; have the responsibility to ensure that no groups or individuals are excluded from these practices and institutions; have the responsibility to ensure a broad definition of the political and includes all relationships and structures throughout the social arrangement.⁶⁹ It is important, therefore, to support CALD seniors to stay connected to their communities and to actively participate in the Australian nation by increasing the funding for social programs to help people to be part of the Australian community and to build resilience and wellness as they age.

8.2 Access and Equity

FECC's National Access and Equity Consultations (2009-2010) revealed that the lack of disaggregated data is a cross sectoral issue that has impacts on planning and delivery of services in the CALD sector. As discussed before, CALD representation in the ageing demographic in Australia is disproportionately high. The distribution of CALD seniors is also a significant issue to be considered in the planning of services including staffing and cultural competence requirements.

For example, in Victoria the 2006 Census confirmed that close to 90% of the over 65 CALD group lived in some of the most populated regions of the state. In some of these regions, up to 51% of the aged demographic was from CALD background. In Brimbank in Victoria this percentage increases to 73%⁷⁰.

DoHA has plans to create "One Stop Shops" for Aged Services in the next 2 years. The

location, staff criteria and the modes of information provision will need to be culturally aware of the specific aspects of the dominant communities from which they would draw their clients. It is important to ensure the disaggregated data is available to create effective and targeted access to services.⁷¹

FECCA is committed to the access and equity agenda. Therefore, it recognises the need to remove linguistic, cultural and socio-economic barriers to accessing services in Australia and to promote full and equal participation in the Australian nation for all citizens irrespective of their age and country of birth.

9. Summary of Recommendations

Recommendation 1:

FECCA recommends that the Federal Government acknowledge the significance of the quantum and proportion of the CALD ageing population within the overall cohort and treat this group as a high level priority in its development of aged care services and approaches.

Recommendation 2:

FECCA recommends that research funding be provided to develop the evidence base for ethnic health and ageing through our key national collecting institutions such as AIWH, ABS & DoHA

Recommendation 3:

FECCA recommends that demographic and ethnicity planning data is accessed and analysed relevant to service geographies and to individual service structures so that aged service planners can attribute both relevance and specificity to CALD aged care considerations.

Recommendation 4:

FECCA recommends that a national CALD Ageing policy and planning framework be developed by the Federal Government, to direct the development of aged care services for CALD Australians.

Recommendation 5:

FECCA recommends that this policy development process be informed by a high level expert CALD Ageing advisory panel, who would be appointed for this task.

Recommendation 6:

Additionally, FECCA recommends that a national CALD Ageing network be funded and developed, under the auspice of FECCA, to provide an important conduit for consumer perspectives and information sharing on the aged care issues relevant to this group.

Recommendation 7:

FECCA recommends the development of a national CALD education strategy on issues and services relevant to later life planning as these decisions greatly affect not only the lives of individuals as they age but also the lives of those who care for them and close family members.

Recommendation 8:

FECCA recommends that ageing Australians from CALD backgrounds have equal access to the range of positive ageing programs now becoming available so that the proliferation of chronic disease can be halted which would in turn reduce the aged care needs of this group.

Recommendation 9:

FECCA recommends that the Federal Government give particular priority to the funding of services that address the chronic health needs of the CALD ageing

population, especially those areas of health in which this group is overrepresented.

Recommendation 10:

FECCA recommends the development of guidelines for Federal Government initiatives that promote better health for CALD seniors and acknowledge the differences that exist in CALD communities on issues of digital and English language literacy.

Recommendation 11:

FECCA recommends that the funding of respite services include a requirement to automatically quarantine a substantial amount of their funding, commensurate with the CALD proportion of the population aged 65+ in each planning region, for CALD service development and delivery.

Recommendation 12:

FECCA recommends that as a condition of their funding, Carers Associations in each State 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;*
- *Advertise their presence and services in the ethnic media;*
- *Develop models of support which are culturally and linguistically appropriate for their diverse consumers.*

Recommendation 13:

FECCA recommends a significant increase in the amount of funding available for the delivery of aged care services in the home with a particular emphasis on the funding of care packages which have been demonstrated to overcome service access barriers in CALD communities.

Recommendation 14:

FECCA recommends that the federal Government undertake a review of the CALD aged service sector and identify those communities with aged care needs and minimal infrastructure as a way of determining developmental funding to increase this capacity.

Recommendation 15:

FECCA recommends that ethno-specific and multicultural service providers must have the opportunity to provide aged care services on an equal footing to mainstream service providers where they can demonstrate capacity and scale. This includes HACC services which are often managed by state governments with significant federal government funding.

Recommendation 16:

Incentives for multicultural services could be established through ethno-specific

providers who provide for more than one ethnic group. Experience suggests that providers would go for a 'best match' arrangement in which the new groups share similarities in language and cultural practice;

- Establishment grants (and perhaps capital funding) could be provided to viable ethnic groups who can demonstrate a market for their services in respect of sizeable numbers of NESB consumers;
- In the absence of CALD allocations, a proportion of all aged care places in a planning region could be declared for use by CALD seniors.

Recommendation 17:

FECCA recommends that where mainstream aged service organisations have responsibility for an area or constituency which has significant CALD aged populations that funding contracts include a requirement to either work in partnership with CALD organisations or be able to demonstrate internal competency to meet the needs of the CALD ageing in their catchment.

Recommendation 18:

FECCA recommends that the Federal Government build the capacity of the mainstream aged care services industry to cater for the changing needs and demands of the growing population of CALD seniors through appropriate standards and cultural competence training, and through encouraging the recruitment of staff from language and cultural backgrounds relevant to service catchments.

Recommendation 19:

FECCA recommends that the Federal Government investigate the aged care service needs of the CALD ageing in rural and regional areas to identify and develop appropriate aged care models to meet their needs.

Recommendation 20:

FECCA recommends that the Federal Government develop specific funding models to allow the development of high level care facilities in CALD communities with limited financial or resource infrastructure and that this be built into the planning model of high level care funding and support.

Recommendation 21:

FECCA recommends that the Federal Government develop strategies to provide the staff language and cultural skills to fill the growing gaps for services for the ethnic aged. This can be achieved, firstly, through a targeted skilled migration program for the sector, which prioritises recruiting skill aged care workers who speak the relevant languages needed. Secondly, incentives should be made to recruit women from the relevant language communities in Australia to join the work force, through a skills re-training pathway. These measures will expand the labour force during a period of decline and provide vital gaps of language knowledge and skills to the sector.

Appendices

1. FECCA's Alliance on Aged Care

FECCA has formed a national alliance of peak bodies within the Ageing sector to promote the vital issues associated with CALD ageing. The members of this alliance include: FECCA, National Seniors, Alzheimer's Australia and Carer's Australia.

2. List of FECCA member organisations

ACT MULTICULTURAL COUNCIL

ETHNIC COMMUNITIES' COUNCIL OF NSW

MULTICULTURAL COUNCIL OF THE NORTHERN TERRITORY

ETHNIC COMMUNITIES' COUNCIL OF QUEENSLAND

MULTICULTURAL COMMUNITIES' COUNCIL OF SA

MULTICULTURAL COUNCIL OF TASMANIA

ETHNIC COMMUNITIES' COUNCIL OF VICTORIA

ETHNIC COMMUNITIES' COUNCIL OF WA

BALLARAT REGIONAL MULTICULTURAL COUNCIL

DIVERSITAT (GEELONG) ETHNIC COMMUNITIES COUNCIL

GIPPSLAND ETHNIC COMMUNITIES' COUNCIL INC

MULTICULTURAL COMMUNITIES COUNCIL GOLD COAST

MULTICULTURAL COMMUNITIES' COUNCIL OF ILLAWARRA

ECC OF NEWCASTLE & HUNTER REGION

NORTH EAST MULTICULTURAL ASSOCIATION

ETHNIC COMMUNITIES' COUNCIL OF NORTHERN TASMANIA

ETHNIC COUNCIL OF SHEPPARTON & DISTRICT

SUNRAYSIA ETHNIC COMMUNITIES' COUNCIL INC

MIGRANT RESOURCE CENTRE TOWNSVILLE

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