AGED CARE DIVERSITY CONSULTATIVE COMMITTEE SUBMISSION

7 September 2023

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1. About the Aged Care Diversity Consultative Committee

The purpose of the Aged Care Diversity Consultative Committee (Diversity Consultative Committee) is to provide stakeholder direction and guidance to the Department of Health and Aged Care (the department) on the ways the aged care system can better cater to people with diverse characteristics and life experiences. This involves:

- providing advice on aged care policy, program and service matters relating to older people from diverse backgrounds and those with diverse characteristics and life experiences; and
- supporting members on aged care reference groups that represent diverse cohorts.

The Diversity Consultative Committee focuses on older people from all diverse population groups, reflecting the diversity of our society. It seeks to address common and specific barriers impacting access to the aged care system by older Australians to drive cultural and systemic improvements and to ensure equity of outcomes, as the Royal Commission into Aged Care Quality and Safety identified as being needed.

Diversity groups include, but are not limited to, the following, noting the potential for intersectionality which means that many people belong to more than one group:

- Aboriginal and Torres Strait Islander peoples, including those from stolen generations
- people from culturally and linguistically diverse backgrounds
- people who live in rural, remote, or very remote areas
- people who are financially or socially disadvantaged
- veterans
- people who are experiencing, or at risk of, homelessness
- care-leavers including Forgotten Australians and former child migrants placed in orphanages
- parents separated from their children by forced adoption or removal

- lesbian, gay, bisexual, trans and gender diverse and intersex people
- aged care recipients with a disability and those with mental health problems or mental illness

The Diversity Consultative Committee members are attached an Attachment A, not including broader group members.

2. Permission to publish

The Diversity Consultative Committee agrees to this submission being published on the Department of Health and Aged Care's website.

3. Draft Principles

Thank you for the opportunity to provide views on the draft aged care funding principles which will inform the work of the Taskforce. The draft aged care funding principles are at Attachment 2.

4. Summary

The Diversity Consultative Committee considers that the full range of diversity, particularly older people from marginalised groups, are not represented in the Task force, and is very concerned the current aged care system will not ensure equity, access and inclusion for older people from marginalised groups, particularly older Australians in and at risk of homelessness.

Generally, the draft principles are accepted by the Diversity Consultative Committee. It is recognised that the current aged care system, is particularly challenged in providing high quality care that meets diversity and cultural needs. The implementation and outcomes against these principles are unlikely to achieve improved outcomes as identified in the Royal Commission into Aged Care Quality and Safety. In addition the will not meet current and future demographics, cohorts, needs and preferences, particularly of older people from marginalised groups, without significant changes in regulatory, design, programming and funding approaches which prioritise diversity and inclusion for older people, particularly from marginalised groups. Some examples are elaborated in the Diversity Consultative Committee responses to the consultation questions.

5. Consultation questions

The Diversity Consultative Committee feedback on consultation questions on the draft principles.

5.1. Is Australia's aged care system and how you pay for aged care easy to understand? If not, why not?

- For Veterans the system is too complicated and advocacy organisations usually advise consumers that Veterans should get additional financial advice.
    - Veterans are not empowered in the conversation about aged care costs (they understand DVA, not aged care),), and if they are socially isolated, they are further disempowered.
- For Culturally and Linguistically diverse (CALD) cohorts, inadequate language support is a key barrier to accessing and understanding aged care services and supports. Financial counsellors need to be accessible in the community to assist CALD cohorts understand the costs and how it will impact them and their families. We need agencies and organisations to help people make sense of the information, not just publish information.
- Information about the aged care system needs to be promoted in different languages. This may be the provision of information through ethnic and multicultural media outlets and information in accessible forms (plain English and community languages). Consideration

needs to be given to provide government information in-language, which may include multilingual phone lines and websites.

- It is hard for consumers to know what they are purchasing; this is not about "product disclosure" but about how the information is presented. It is an extremely complicated system for consumers to navigate, even eligibility is unclear. Also, there is no consideration that people are navigating information and making hard decisions at a very stressful times of their lives. It is not enough to provide fact sheets as the information is too broad for individual circumstances.

5.2. What does "fairness" in aged care funding and care services look like?

- Equity of access is challenging for Veterans due to barriers such as their ability to negotiate and cultural safety and services need to be trauma informed. Barriers to access need to be addressed to enable fairness. Services need to be available that continue to work with individuals through their Aged Care journey, and not 'leave them at the door'.
- Aged Care needs to look at the risk issues such as when industry decides it will not provide services. This impacts on consumers from marginalised groups. Regulatory compliance can act as a barrier to wellbeing and dignity, and managing the complexity of individuals needs and preferences i.e., Vietnam veteran with behaviour-related alcohol problems or who smoke.
- There is currently a need for dual accreditation of Aged Care and NDIS, but providers can't afford to have dual accreditation. The risks of failure to comply with regulatory requirements are too high, including funding risks. This is also a barrier to entry to aged care services for consumers with complex needs as providers do not have the capacity to manage the risks associated with complex needs of consumers (or families).There are regulatory and financial risks associated with engaging with older people with complex needs.
- People living in rural and remote areas are faced with no or limited-service availability. Those aged care providers that do operate in these areas face financial difficulties of providing services to small numbers of people. As a result People are forced to leave their community- including extended family to access aged care. There is no data on this and the negative impacts this can have on older people themselves, their families and, and their communities. Aged Care does not show where consumers were before entering aged care and there is no consideration or mapping of the consumer journey into aged care.
- Compliance creates a burden for providers, and often it is ever increasing, with a lack of capacity of services to meet baseline compliance standards without then adding in the complexities of people from marginalised groups.
- Poverty should not be a barrier to accessing aged care. Fairness in aged care means that regardless of status, such as sexual orientation, older people receive the same access. Older people without appropriate housing (affordable, accessible and long-term) have limited access to aged care. cohorts of marginalised. Fairness includes being able to have home care regardless of housing circumstances. There needs to be housing available for people with low incomes, so they can access aged care.
- Wintringham was formed as this gap existed and it receives less funding than the mainstream. This is not a fair funding model that enables equity of access.
- Capital funding isn't available for marginalised groups such as veterans or people who are homeless and this impacts on their access to services i.e., marginalised groups can't put down a bond for residential care.
- Services can't charge their marginalised clients as they are too impoverished, so organisational financial sustainability is a high risk. The funding system does not provide transparency and accountability for capital funding rounds such that services can plan. Aged care also needs a housing arm in which aged care is then provided, to meet the needs of these marginalised cohorts.

- Carefinders and similar navigation services need to be adequately funded to address barriers to accessing to aged care services among CALD cohorts. There are providers unable to provide services to older persons requiring interpreting and translation services and cohorts with hearing and visual impairment. Is it right that we should pay more because we have different care needs? In a fair and equitable system, this would not be an issue.
- The lived experience of diversity in diversity is not addressed. Globally, women tend to live longer and end up the poorest. CALD women ,take on caring responsibilities as there are limited options for culturally appropriate care. Caring full time or taking on casual jobs impacts on their ability to accumulate good superannuation balance in time for their own old age. marginalised
- Inequity exists because there is currently urban bias, with service design for the wealthy. The Government should subsidise marginalised groups more or use other levers i.e., means tested.
- What fairness would look like is that you will have the same care, regardless of ability to pay, rather than being able to buy good care if you are wealthy.
- Workforce development for care needs must include language, diversities, and inclusion. This needs to include targeted training on culturally appropriate aged care.
- Two options: Government to subsidise more or change the criteria for the means test.
- Aged care providers need to receive stronger incentives to provide culturally appropriate aged care to ensure people from culturally and linguistically diverse backgrounds receive high quality care.
- It is important to ensure that funding principles are equitable and ensure the sustainability of small providers, such as ethno-specific CHSP providers and regional, rural, and remote providers.
- There is a need to recognise fairness in relation to equity. Diversity is central to all aged care provision and is not an added extra. For LGBTI older people, having access to 'fair' aged care provision means having access to appropriate and safe care. This is not an 'added' extra.

5.3. Is funding for Australia's aged care system sustainable? If not, what is needed to make it sustainable?

- See comments above regarding services that support the most marginalised.
- What's the cost of not doing it?
- If not funded under the aged care system, then problems are displaced to other areas and complexity of navigation increases for the client, making more challenges, particularly for marginalised groups i.e., homelessness
- There are issues of hospitals and high costs funded by state government vs aged care funded by Commonwealth.
- No, changed trends of superannuation and issues for aged care i.e., large mortgages for older people. Retirement is based on the assumption of older people owning their own homes (an asset which can be used to access residential aged care, and a safe and stable place to receive in-home care) however the data indicates this is increasingly not the case with more older people retiring with a mortgage, and more older people living in expensive and insecure private rental.
- The sector needs to look at up-stream supports that better support older people to be well, socially connected and not isolated in the community which are more sustainable.
- Look to other countries leading by example in the aged care system. Including reimagining what aged care could look like.
- Australia spends half as much as a proportion of GDP on aged care compared to some other developed countries, this must change.

5.4. What costs do you think consumers in aged care should contribute to and to what extent? How is this different for care, compared with everyday living expenses or accommodation?

- The home should be used to fund aged care and be included in means testing.
- It is important to note the asset rich/cash poor. For example, someone who bought a house 50 years ago in an area that has now gentrified but is living on the pension.
- The accommodation cost of care should be provided by government and include a baseline for accommodation. Government services need to provide funding to meet basic standards of residential care (i.e., public health).
- Basic standards of care must include addressing diversity as a function and not something that consumers from diverse backgrounds should need to pay extra for.
- The circumstances of residential care are not the same as independent living, and accommodation costs are more expensive in residential aged care, including basic costs such as replacing carpets more often. There is an assumption of equivalence, and they are not.

5.5. What does quality and appropriate care mean to you?

- See Aged Care Diversity Framework[1] and action plans for CALD, LGBTI, First Nations and overarching plans which articulate what best practice quality care looks like.
- Quality care needs to include access to culturally appropriate food options.
- In terms of culturally appropriate care, the Centre for Cultural Diversity in Ageing's Inclusive Service Standards[2] have been recognised by the Aged Care Quality and Safety Commission as a key resource to support providers to deliver culturally inclusive care.
- Good care is defined in the standards. However, the opportunity for improvement is accessibility, addressing the barriers and modifying service behaviours to meet the individuals care, including trauma informed care. Levers of accessibility need to be addressed.
- Individuality needs to be part of what quality and appropriate care is. Dignity of care needs to be a key part of this.

5.6. What does innovation in aged care mean to you? How can funding support it?

- There is a dichotomy of innovation and high risk:
    - There are increasing responsibilities being faced by aged care providers. The current context does not enable innovation and innovative models of care. For example, moving to small cottage-based services that better meet the needs of many diverse and marginalised groups. Incentivising innovation and creating ways for providers to share innovative practices (such as through a Community of Practice) and learn from each other must be explored.
    - Risk adverseness by the Aged Care Commission is so complicated that its acting as a disincentive to sit on boards. This impacts on the ability of aged care providers to operate, innovate and enable diversity initiatives that cater to care recipients with complex needs and marginalised groups.
- Pilot programs are not upscaled into ongoing programs, and funding cycles and design limit innovation and growth

[1] https://www.health.gov.au/our-work/aged-care-diversity-framework-initiative
[2] https://www.culturaldiversity.com.au/inclusive-service-standards

- The role of government and investment in rural and remote is inadequate, with basic needs not being met so aged care provision isn't possible. Funding models need to be based on measuring wellbeing, equality and needs, not only cost, and include impacts of relocation on the individual and family.

5.7. What is the role of Government versus private investment in funding upgrades and constructing new facilities? Is the role different in rural and remote locations?

- Both need to include all diverse and marginalised groups. Yes, the roles are different in rural and remote locations.
- There is very little government investment in rural and remote areas and there needs to be, otherwise there is no service.
- The funding model needs to be around measuring equity rather than cost. Funding and investment need to be benchmarked according to need, not according to cost.

5.8. Is there anything else you think the Taskforce members need to know about Australia's aged care system?

- Is the taskforce knowing and listening to marginalised and diverse communities, which represent a sizeable proportion of the population?
- Aged care should not focus on institutionalisation of older people. People are being disengaged from their communities. It should be an ageing and aged care system with concerns of older people and upcoming cohorts of older people. Looking at the system in its current form is limiting.
- The Taskforce considerations need to consider the intersection of fundamental principles with the health and the housing system, i.e., home ownership, changing demographic CALD etc. Intersectionality needs to be addressed.
- The aged care system needs to be fit for purpose in the long term, accommodating generational and societal change, and be greater in relation to the rights of older people.
- It is paramount the aged care system ensures equitable access of people from culturally and linguistically diverse backgrounds through targeted navigation programs including culturally, linguistically, and spiritually responsive care finders, and that care received is culturally appropriate.

Attachment 1 Diversity Consultative Committee

	Diversity Representation	Name	Position / Organisation
1	Chair	Samantha Edmonds	Director, Policy and Systemic Advocacy Older Persons Advocacy Network
2	Aboriginal and Torres Strait Islander	Kylie O'Bryan	Executive Manager, Booroongen Djugun – member of the National Aboriginal and Torres Strait Islander Ageing and Aged Care Council Inc
3	Aboriginal and Torres Strait Islander	Matthew Moore	General Manager, Aged Care Institute for Urban Indigenous Health
4	Culturally and linguistically diverse	Mary Ann Geronimo	Director of Policy, Health & Ageing The Federation of Ethnic Communities' Councils of Australia
5	PICAC Alliance	Nikolaus Rittinghausen	PICAC Victoria The Centre for Cultural Diversity in Ageing
6	Consumer	Sophia Petrov	National Manager, Policy and Engagement COTA
7	Housing and Homelessness	Bryan Lipmann AM	CEO Wintringham
8	Homelessness	Fiona York	Executive Officer Housing for the Aged Action Group Inc
9	LGBTI	Nicky Bath	CEO LGBTIQ+ Health Australia
10	Aged Care Quality and Safety Commission	Tara Pamula	Executive Director, Engagement, Education and Sector Capability, Aged Care Quality and Safety Commission
11	Rural and remote	Melanie Avion	Professional Officer CRANAplus
12	Veterans	Nathan Klinge	CEO RSL Care SA
13	Department of Health and Aged Care	Rob Day	Assistant Secretary Dementia, Diversity and Design Branch Market and Workforce Division Ageing and Aged Care Group

Observer Aged Care Council of Elders- Diversity Representative	Bill Jolley

Attachment 2 Draft Principles

The draft aged care funding principles:

Principle 1 – The aged care system should enable and encourage participants to remain in their home for as long as they wish and can do so.

Principle 2 – Aged care funding arrangements and their outcomes should be fair, simple, transparent and sustainable.

Principle 3 – Government is and will continue to be the major funder of aged care. Government funding should be focused on care costs. Personal contributions should be focused on accommodation and everyday living costs with a sufficient safety net.

Principle 4 – Government and participant contributions should be sufficient to provide quality and appropriate care delivered by a skilled workforce, allowing and encouraging innovation by the health, hospital and aged care systems.

Principle 5 – There should be accountability for funding received from government and participants, how it is spent, and the quality of the services provided.

Principle 6 – The residential sector should have access to sufficient, and new, capital to encourage the development of new accommodation and upgrades to existing accommodation.