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1. Tell us about you

1.1 What is your full name?
-

1.2 What stakeholder category do you most identify with?
Peak body - consumer

1.3 Are you providing a submission as an individual or on behalf of an organisation?
Organisation

1.4 Do you identify with any special needs groups?
Nil

1.5 What is your organisation’s name?
National LGBTI Health Alliance

1.6 Which category does your organisation most identify with?
Consumer Peak Body

1.7 Do we have your permission to publish parts of your response that are not personally identifiable?
Yes, publish all parts of my response except my name and email address
2. Response to Criteria in the Legislation

2.1 Whether unmet demand for residential and home care places has been reduced

<table>
<thead>
<tr>
<th>Refers to Section 4(2)(a) in the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this context, unmet demand means:</td>
</tr>
<tr>
<td>• a person who needs aged care services is unable to access the service they are eligible for e.g. a person with an Aged Care Assessment Team / Service (ACAT or ACAS) approval for residential care is unable to find an available place; or</td>
</tr>
<tr>
<td>• a person who needs home care services is able to access care, but not the level of care they need e.g. the person is eligible for a level 4 package but can only access a level 2 package.</td>
</tr>
</tbody>
</table>

Response provided:

*The LGBTI Health Alliance notes the NACA submission that the only quantifiable data available on unmet demand is the period of time that consumers wait between being assessed and accessing services. While this is not a comprehensive indicator, as there could be a range of reasons for the delay, it would appear from the most recently published data that unmet demand continues to be an issue across the country. The LGBTI Health Alliance notes that in collecting data on unmet demand consideration must be given to collecting the demographics of those unable to access packages or residential places especially for people from diverse (special needs) groups. In addition data should also be collected on unmet need where a consumer has identified a service or support that is needed but this is not available. Only knowing general data on unmet demand does not provide a clear picture of who is or is not able to access aged care. It is essential that we understand if particular groups are facing specific barriers that will need to be addressed to ensure equity of access to aged care.*

2.2 Whether the number and mix of places for residential care and home care should continue to be controlled

<table>
<thead>
<tr>
<th>Refers to Section 4(2)(b) in the Act</th>
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<tbody>
<tr>
<td>In this context:</td>
</tr>
<tr>
<td>• the number and mix of packages and places refers to the number and location of residential aged care places and the number and level of home care packages allocated by Government; and</td>
</tr>
<tr>
<td>• controlled means the process by which the government sets the number of residential care places or home care packages available.</td>
</tr>
</tbody>
</table>

Response provided:

*Nil*
2.3 Whether further steps could be taken to change key aged care services from a supply driven model to a consumer demand driven model

Refers to Section 4(2)(c) in the Act

In this context:

- **a supply driven model** refers to the current system where the government controls the number, funding level and location of residential aged care places and the number and level of home care packages;
- **a consumer demand driven model** refers to a model where once a consumer is assessed as needing care, they will receive appropriate funding, and can choose services from a provider of their choice and also choose how, where and what services will be delivered.

Response provided:

following is a response to both 2.2 and 2.3:

1. **There must be appropriate and equitable access and outcomes for LGBTI elders.**
2. **Care is appropriate to the needs and preferences of special needs groups.**
3. **The aged care system responds to continues to evolve into a system that is designed to meet the needs of special needs groups rather than requiring special needs groups to fit a one-size-fits-all system.**
4. **Government commits to ensuring services are available in areas or to special needs groups where these services may not be provided.**
5. **Government will continue to regulate for consumer protections, safety and quality of aged care, especially for special needs groups, and establish a single overarching quality framework based on independent assessment which is co-designed with all stakeholders.**
6. **LGBTI elders have a genuine choice (that is there are options to choose from) about:**
   - a. Where they will receive their service (e.g. a place of their choosing)
   - b. The type of care and support they receive
   - c. Who provides that care and support
7. **Providers to have greater flexibility and incentive to develop innovative and responsive services that respond to the needs of special needs groups and their expectations including episodic, early intervention and restorative care programs.**
8. **Where there is insufficient market response, government will ensure the system delivers services to all LGBTI elders assessed as in need of support and care. This could include:**
   - a. Block or ongoing grant funding in areas where services might not have otherwise been provided.
   - b. Dedicated funding for services targeted to special needs groups, where market based approaches do not, or are failing to, achieve quality service delivery consistent with consumer preferences.
   - c. Ensuring that prices and supplements fully cover the increased cost of specialist service delivery for consumers with special needs who choose not to (or are not able to) enter specialist block-funded services.
9. **Ensure that while funding will follow the consumer, there will also be effective programs to address disadvantage.** The LGBTI Health Alliance believes it is important that the Review produce or commission robust financial modelling based on estimates of demand and a variety of user contribution scenarios. This must include modelling of the impact on all consumers, especially consumers from special needs groups who may face additional cost barriers to accessing aged care. In addition, the modelling must reflect the costs of providing services in areas where a market based system will not, or is unable to, operate. The level of change inherent in moving to a consumer demand driven model raises transitional risks for all consumers, especially those from special needs groups. An important means of mitigating these risks is a genuine co-design process, which recognises that consumers, aged care providers, and health, allied health, palliative care and disability providers all have an important role to play in ensuring an equitable and accessible aged care system.
2.4 The effectiveness of means testing arrangements for aged care services, including an assessment of the alignment of charges across residential care and home care services

Refers to Section 4(2)(d) in the Act

In this context:

- means testing arrangements means the assessment process where:
  - the capacity of a person to contribute to their care or accommodation is assessed (their assessable income and assets are determined); and
  - the contribution that they should make to their care or accommodation is decided (their means or income tested care fee, and any accommodation payment or contribution is determined).

Response provided:

Nil

2.5 The effectiveness of arrangements for regulating prices for aged care accommodation

Refers to Section 4(2)(e) in the Act

In this context:

- regulating prices for aged care accommodation means the legislation that controls how a residential aged care provider advertises their accommodation prices.

Response provided:

Nil

2.6 The effectiveness of arrangements for protecting equity of access to aged care services for different population groups

Refers to Section 4(2)(f) in the Act

In this context equity of access means that regardless of cultural or linguistic background, sexuality, life circumstance or location, consumers can access the care and support they need.

In this context different population groups could include:

- people from Aboriginal and/or Torres Strait Islander communities;
- people from culturally and linguistically diverse (CALD) backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- people who are veterans of the Australian Defence Force or an allied defence force including the spouse, widow or widower of a veteran;
- people who are homeless, or at risk of becoming homeless;
- people who are care leavers (which includes Forgotten Australians, Former Child Migrants and Stolen Generations);
- parents separated from their children by forced adoption or removal; and/or
- people from lesbian, gay, bisexual, trans/transgender and intersex (LGBTI) communities.

Response provided:

LGBTI elders face a risk of vulnerability by having to disclose their sexuality, relationships, bodies or genders. Historic and current experiences have shown many that ‘coming out’ is dangerous. It is therefore unlikely that an LGBTI elder will disclose that they are L, G, B, T or I and this can impact on their access to, and the delivery of, services. The LGBTI Health Alliance notes that there is an ongoing trend to conflate gender, relationships, sexualities and bodies into the single issue of sexuality or sexuality and gender across the aged care system, from the policy level down. While this is mostly unintentional it does mean that LGBTI elders are excluded or their issues...
remains unaddressed within aged care. While there have been many positive changes to improving inclusion of LGBTI elders within aged care the LGBTI Health Alliance notes that there are still areas that require further investigation and work.

Prioritisation of Access

There have been ongoing issues with the Aged Care Approval Rounds and specialist packages/places. Providers that tendered for these are able to assign these packages for general access if they were unable to fill the place with an LGBTI elder. Unfortunately, there was no monitoring or reporting on what strategies the provider used to engage with LGBTI elders, if at all. With the removal of ACARs concern remain around how people from special needs groups will be prioritised. Recognising special needs and assigning priorities of access to these groups is essential. The process also needs to be clear and transparent to people from special needs groups and their carers. There also needs to be a clear process around prioritisation related to having access to a service that is inclusive of your special need especially in remote and rural areas. Several questions arise around prioritisation which we ask the review to consider:

- Will LGBTI elders simply be part of a general prioritisation process that, by its very nature, will not recognise the additional needs and issues faced by people from special needs groups?
- How are needs assessed if there are a number of people with special needs who start on a home care package at the same time?
- If a person who has a special need is offered a place in a service that cannot support their special need do they then go back to the bottom of the waiting list or maintain their position on the waiting list?
- If a service that can meet the needs of a special needs person has a vacancy will a person with that special need gain priority over anyone that is in front of them on the waiting list that does not have that special need?

Data Collection

Currently the collection of data to identify most of the special needs groups are inconsistent and often not asked of consumers at all. Certainly, within the My Aged Care system no data is collected on LGBTI elders. The LGBTI Health Alliance is deeply concerned at the lack of data this generates, thus reducing the ability to conduct a thorough investigation of the access issues faced by LGBTI elders. Without the collection of this data, it will continue to be impossible to report efficiently on the effectiveness of any measures to address equity of access. In addition data collection must be sensitive to the needs of LGBTI elders. In particular the ongoing use of the option “intermediate/intersex/unspecified” is offensive to many LGBTI elders and does not reflect the diversity of genders and bodies within the population. In particular, many of the culturally-specific genders held by people across Australia - kathoeys, sistergirls, brotherboys. Where data is collected through the National Assessment and Screening Form (NASF) the nature of the questions actively excludes many LGBTI elders (see below under 2.9).

The LGBTI Health alliance recommends the review consider how appropriate data can be collected in a sensitive manner that reflects the diversity of special needs groups.

National LGBTI Ageing and Aged Care Strategy

The LGBTI Health Alliance notes that the implementation of some aspects of the strategy have been very successful, where we have been funded to deliver on key aspects of the Strategy and where providers and other organisations have actively engaged in being inclusive to LGBTI elders. There have also been some successes in areas that are the responsibility of DSS then DoH, however many of these goals have not been achieved due to:

- Delays in creating a working group to help deliver on the Strategy Goals and when the working group was formed continual changes in DSS and then DoH staffing that meant that actions were not followed through (this has settled in 2016).
- Delays in communicating about the Strategy by DSS/DoH to the ageing and aged care sector, with the only communication happening in the last 6 months.
- No annual reporting by DSS/DoH on the implementation of the Strategy With the cessation of the Strategy in June 2017 the Alliance has been working closely with FECCA, NACCHO and the AAG to promote the creation of a Diversity Framework. In November 2016, we met with Assistant Minister Wyatt and
obtained in principle support for the development of a Diversity Framework supporting different population groups to age well, with the creation of specific action plans for LGBTI, ATSI and CALD groups. Further details are available in our Briefing Paper (copy attached).

- There does not appear to be any specific reference to access by people of special needs groups with regard particular support that may be needed for access.
- The underlying belief of the proposed changes is that consumers will have choice. However there does not appear to be any actions addressing the potential lack of choice for consumers in rural, regional and remote areas, and possibly some urban areas, where there may only be a single provider or for people from special needs groups, the local providers may not cater for them.

Other Issues

- Targeted funding to support outreach – outreach to LGBTI elders is far more than a communication strategy. It must also include people engaging with LGBTI elders where they live in a safe and inclusive way and connecting to elders through organisations that elders are already engaged with. It is about having the right type of support person, that the elder feels comfortable with, to facilitate access to the ageing and aged care system. Outreach workers could be co-located in LGBTI services.
- Identification of Special Needs Groups must be collected at the point of registration for all groups. Currently this only occurs for Aboriginal and Torres Strait Islander elders and CALD elders. This should be expanded to include identification of LGBTI elders.
- While some ACATs and RAS’s are safe for LGBTI elders, and actively employ LGBTI peoples, many are not. A possible solution is the location of an LGBTI specific RAS support worker within an LGBTI service as the contact and assessment point for LGBTI elders.
- Ongoing national representation of LGBTI elders is essential as the aged care reforms continue to be implemented to ensure their needs are not overlooked or reforms result in unintentional, or intentional, exclusion from aged care.

2.7 The effectiveness of workforce strategies in aged care services, including strategies for the education, recruitment, retention and funding of aged care workers

Refers to Section 4(2)(g) in the Act

In this context aged care workers could include:

- paid direct-care workers including nurses personal care or community care workers, and allied health professionals such as physiotherapists and occupational therapists; and
- paid non-direct care workers including: managers who work in administration or ancillary workers who provide catering, cleaning, laundry, maintenance and gardening.

Response provided:

Supporting the education of our workforce to address the diverse care needs of older Australians has multiple layers of benefit. For example, awareness training works to help better support elders and their chosen families and networks, but also to support staff relationships across the workforce. The LGBTI Aged Care Training delivered by the National LGBTI Health Alliance through our partners in each State and Territory has had a significant impact on aged care workers. This program provides a free national workforce training program fully funded by the Government to build the skills of the aged care workforce to provide inclusive, accessible and appropriate care to each population of older people within LGBTI. This training has seen a greatly improved understanding of the particular care needs and context of these clients by those participating and recognition of the distinct but sometimes overlapping needs of each population within LGBTI. We also know that the training has provided a safe space and opportunity for attending staff to share the challenges they themselves have faced as a person who is L, G, B, T or I, some for the first time. Projects such as this support communities. Staff attending the training have discussed the impact on their relationships with LGBTI friends and family members. This increased consideration and awareness is also valuable for clients visiting friends and family in care. We need to
consider more inclusive definitions of ‘family’ that recognise some LGBTI people’s desire for protection from biological relatives, their wish not to consider such biological relatives as ‘family’, and their need for their important non-biological relations to be considered ‘family’ — not only as a default. We know that some visitors hide their sexuality and/or relationships, their current gender identity or expression, their body, their past gender experience, or that they were born intersex from care providers in case it impacts the quality of care for their older loved one. The aged care community work hard to provide a safe and caring environment for all older Australians and want the community to know that their local facility or home care business is a safe and inclusive place. Please find attached the Evaluation of the Training Program.

2.8 The effectiveness of arrangements for protecting refundable deposits and accommodation bonds

| **Refers to Section 4(2)(h) in the Act** |
| **In this context:** |
| • arrangements for protecting refundable deposits and accommodation bonds means the operation of the Aged Care Accommodation Bond Guarantee Scheme. |

Response provided:

Nil

2.9 The effectiveness of arrangements for facilitating access to aged care services

| **Refers to Section 4(2)(i) in the Act** |
| **In this context access to aged care services means:** |
| • how aged care information is accessed; and |
| • how consumers access aged care services through the aged care assessment process. |

Response provided:

If an LGBTI elder does disclose that they are L,G,B,T or I to the My Aged Care call centre staff, the options within the documentation that they need to complete and their experiences with Regional Assessment Teams and ACATs/ACAS will determine whether that elder will continue to engage with the aged care system. If that experience is negative the elder will not follow-through and can withdraw from the whole process resulting in a person and/or their carer missing much needed supports or not re-engaging with the system until a time when their health and wellbeing has significantly deteriorated. Unfortunately, while there are some positive changes happening the alliance is still being informed of issues that impact significantly on LGBTI elders.

Following are the key issues and changes needed to ensure that My Aged Care is inclusive of and for LGBTI elders.

- **People should be able to self-identify gender if they feel comfortable doing so but there should be no requirement that someone must provide their gender to access services.**

- **It was noted in one of the data capture forms that call centre staff should ask a person if they are male or female as the person cannot necessary tell by a person’s name. Instead call centre staff should be trained in using gender neutral language that does not require people to disclose their gender before they are comfortable to do so, if at all. We acknowledge that there could be data match issues and are willing to collaborate with the Gateway team to find solutions.**

- **Wallet-check – this is done prior to a face-to-face assessment with a client. However, this has implications for intersex, transgender and gender diverse elders whose personal identification may not reflect their current gender. While some elders will be able to negotiate this on a personal level with an assessor many will not as there has been no relationship of trust established. This will be of concern for elders in rural, remote and regional communities where they may not be ‘out’ and where having to disclose to another member of the community or an organisation may not be safe for them. While some ACATs and RAS’s are safe for transgender, intersex and gender diverse elders, and actively employ LGBTI peoples, many are not.**
Call Centre staff, assessors and providers must be trained to understand the sensitivities around engaging with LGBTI elders in a safe and respectful way. For example, in the language they use. The Alliance has reviewed the training that staff receive however it is very brief and not sufficient to enable staff to interact appropriately with LGBTI elders. This is particularly important when asking sensitive questions around gender and relationships. At this stage we have been unable to determine who asks a person about their gender or whether gender is assumed based on name, voice etc.

Further training design has only been explored for CALD, Aboriginal people and Carers, and this training is elective. Currently RAS and ACAT teams can access LGBTI awareness training offered through our partners in each state and territory however no call centre staff receives this training. Training on working with all these groups should be a core component of the statement of attainment.

Having a specialist unit or key staff who are knowledgeable and skilled in working with LGBTI elders on hand for call centre staff to refer to.

Marital Status must be changed to Relationship Status to be fully inclusive. Marital Status presumes that marriage is an option and the list under this heading also presumes a marriage-like status.

As noted above the NASF uses the 3rd gender choice of “intermediate/intersex/unspecified”, which is not supported by the LGBTI sector. Intersex as a 3rd ‘gender’ option is offensive to many people with Intersex variations who identify as either male or female and we understand this to be most people with Intersex variations. While it’s true that some people with Intersex variations may self-identify as intersex, it’s more likely they would use a range of other labels. Retaining the option of Intersex as a label for something other than male or female reinforces stigma and the incorrect assumption that Intersex is a 3rd gender.

We have also heard from skilled ACAT/ACAS and RAS practitioners who want to know why the NASF does not reflect best practice and offers options that are incorrect. They note that people are being upskilled in LGBTI inclusive practice across the ageing and aged care sector and yet the forms are not reflecting the requirements of the training. It is also important to note that with the changes in South Australia to gender ID change requirements, which could possibly role out across Australia, the system needs to be bought into line to ensure that gender is appropriately captured and considered. This includes being able gather information about a person’s gender history, if the person feels comfortable providing this information. This is important at assessment as there will be specific health issues and needs that providers may need to know about in order to provide appropriate care and support.

System changes will need to be followed by training for staff on how to ask these types of questions sensitively and respectfully.

My Aged Care Website

The LGBTI page on the My Aged Care website is somewhat misleading and/or aspirational. It states “... should be able to access care that is responsive ...” This might lead LGBTI elders to think that the service continuum - from the portal through to screening, then assessment and then service delivery - with a range of potential players and organisations, is going to be LGBTI inclusive. Assessors can only guarantee their portion of the service journey. Feedback from some assessors has indicated they feel it necessary (where they have knowledge) to point out the attributes of the care/service delivery options/providers available for the elder to choose - such as this service provides specialist services to Greek clients, this service is generalist, this service has a Rainbow tick etc. so that the elder can hopefully choose a service that will be inclusive of their needs. The portal makes it sound like this might or should occur.

LGBTI Inclusive Services on My Aged Care

Additionally, concerns remain about the ability of providers to “tick the box” that they are LGBTI inclusive without any type of guarantee that they are. Some providers have obtained Rainbow Tick accreditation and therefore can be considered fully inclusive; many others find the cost of this accreditation prohibitive. While attending the LGBTI awareness training is a very positive being inclusive also means having policies and procedures, ongoing training and a commitment at all levels of the organisation. The Alliance believes, at a minimum, there should be some form of external review process of providers to confirm if the provider is LGBTI inclusive, or working towards being LGBTI inclusive. If it is not possible to indicate different levels of inclusivity through a tick-the-box process then there must be a requirement that providers have to indicate what they
mean by being inclusive in a free text section. For example, their staff have been trained or they have completed a Self-Assessment and Planning Tool or developed an inclusive practice policy etc. There is a need to balance between having a shortlist of a wide range of providers who are appropriate for LGBTI elders (not too restrictive) with the need to ensure that the outcomes for LGBTI elders are good. It should also be noted that some providers have indicated that they feel that they must tick all the special needs boxes to meet their legislated obligations, this must be clarified.
3. Other comments

Response provided:

Nil