PRODUCTIVITY COMMISSION INQUIRY INTO THE CARE OF OLDER AUSTRALIANS

Swan Hill Rural City Council Submission

Choice and care continuum

- Everyone is generally a "first time user" of the aged support and care system – the system is complex. However system might be more visible and known in small communities – but still not well understood. There is an opportunity for service providers to network more with community groups – this take time and time = money. However this is an important investment. An example was given of the Buloke Health and Disability Network's respite promotions project with both a client and workforce recruitment focus. This was a very well conceived, thought out and planned project which has been unable to proceed because of lack of capacity (person hours) to implement the project on the ground.

- A more flexible funding model together with opportunities to support strategic visioning and local community planning would enable these services to lock step with these community's needs (eg) operate a place as a place in the community; or respite; or permanent residential care or transition care.

- A contrived aged care system control and long standing legacy which impacts both how the system is structured to deliver care, and consequently funded and/ or financed is the low care / high care boundary. The question is asked as to where this boundary now sits. What purpose does it serve in a "continuum" of care and how relevant is it to continue with this particular system control?

- How will Consumer Directed Care (CDC) packages work in Rural and Remote locations – by what mechanism do we achieve choice some consumers are seeking if there is little or no choice of supplier.

Workforce

- It is difficult to organize training and staff development for remote workers and many RTO's won't do the training in small communities for up-skilling due to the small numbers. Yet, without training, it is difficult to retain staff. In small rural communities, staff are also looking for opportunities to work with people who have a range of needs whether this is related to ageing, disability clients or even child care. In the community setting home care workers are no longer "just a cleaner" they are a health worker (eg HACC. Active Services Model).

- In small communities (eg < 1000 population) there is often a reliance in community and residential aged care services upon a few people for knowledge capital – working them into the ground – and essential a high risk approach form a continuity of care or continuity of business perspective. The system has not been able to catch up with skill demands for complex care – especially in rural areas - a numbers gap.

This creates real difficulties that can impact on clients - in community care relying up in a few really skilled / expert workers can create a real challenge to continuity when the worker leaves/ is on leave. Shadowing, “shadow shifts” or “buddying ” less experienced staff with experienced workers can help build knowledge capital capacity across the team.

- There is a need to attract young people to aged care – make it a career path – the financial side does not help as much of the work is not full time.

- Ease regulations of funding and workforce. Disproportionately excessive time is spent in risk management, and addressing regulatory compliance – instead of innovating , improving and providing the support and care people want .

- Some towns particularly are particularly bereft of (Division 1) Registered Nurses and Enrolled Nurses (Division 2).

- Need a finer grained picture of skills shortages / opportunities (and government needs to respond with more sophisticated and finely focused workforce strategies) also taking into the account the needs of CALD and Koori elders and the opportunities form within their own communities

- A broader view is that providing people in small rural communities with the skills and competencies to care and support people with a variety of needs from across all ages in the lifecycle creates social support capacity

- Service providers might want to also become their own RTO. They could then walk into a small rural community and ask anyone who is interested in providing care (the right person who wants to provide care, has the right emotional intelligence, personality attributes and attitudinal disposition) - “ we will do the rest” as far as technical skills and competency are concerned.

- GP’s need to be seen as part of the health team – but not the controllers. An equal partnership – community support team. There is a potential opportunity to work with GP divisions to promote this. A person – centered approach - no one health professional, if is agreed to be at the heart of our approach could help reduce professional silos.

- Rural areas have relied extensively on volunteers, but there are ever fewer volunteers – how do we offset this? Government could extend its current volunteer grants scheme to specifically pay for their police certificates or volunteer card.

Information Technology and E-Health

- Electronic health record should be implemented as quickly as practicable into the aged car sector. The e-Health records should be able to share data sets with HACC Minimum data Set (HACC MDS) , Aged Care Client Record (ACCR) and Service Coordination Tool Templates, (SCoTT), Aged Community Care Needs Assessment (ACCNA) and Carers Eligibility Needs Assessment (CENA) subject to privacy controls to improve care transitions and increase service delivery and administration efficiencies.

- Information Technology, E-Health and Telemedicine are no longer regarded as an add-on in rural areas. These technologies must be embraced and invested in to improve client safety and to achieve work force efficiencies. There is greater potential to exploit such technologies as current generations of older people continue to become more technologically "savvy". The user interface issues are both about clients and staff.

- Examples include using IT/ Telehealth for assessment, 24/7 Nurse on-call via video and electronic link to support a number of small community of residential care services, running "telemedicine – teleclinics" where GPs are unable to easily or visit small communities.

- One current case example is that of the Loddon Mallee Packaged Care Consortium. This comprises 11 Local Government Areas covering some 15%-20% of the geographic area of Victoria who provided Community Aged Care Packages and Extended Aged Care at Home Packages. They have purchased videophones so that care workers can connect case managers with what is happening in people's homes. The video phone can be used to view a bathroom rail, environmental hazard, client wound injury etc. This visual information can often provide additional information sufficient to make a care planning decision without necessitating a home visit by the case manager.

- The need to invest in such technology needs to be reviewed by the Commonwealth. It appears not to be well recognized. In the2009 Federal Budget $29 million of funding earmarked for Community Care Information Technology initiatives were re-appropriated elsewhere outside of aged care.

Financial Viability and Capital

- It is very difficult to provide care to people in smaller and more isolated communities on a financially viable basis in the current funding model.

- Indexing is not working – no weighting to reflect scale. For example 4 community aged care packages might be sufficient to meet the community care needs of a small and isolated rural community, but here are still fixed overheads in addition to higher unit costs to deliver a unit of support or care. Services need a base load of funding to acquit organization and human resource overheads. Thus, small allocations should attract a weighting premium to offset small scale dis-economies.

- Growth and indexation seems to be used as a political tool. The calculations and mechanisms seem to be subject to political decision making and are not transparent. It is difficult to undertake long term strategic planning and budget development.

- Capital costs to build facilities in remote / rural areas can be higher due to:
    - premium on materials and cost of transport
    - less competition pressure on price
    - less productivity due to other community demands and obligations such as CFA, children's sport activities (the community premium) and which are integral to the fabric of rural communities, other inefficiencies arise from increased travel to access banks, trade suppliers etc
    - Commercial relationship are intertwined with social relationships

- However, local businesses also re-invest in their local community and often make other contributions back to the facility in fund raising, board membership, “after market servicing”.

- There is money (tied up in housing) in some communities. The capacity to pay bonds if the facility is built to attract this debt servicing costs are higher these days. However there are also fewer donations or bequests these days compared to the 1970’s. Factors include:
    - Fewer families remaining in a given area due to farm consolidation and or machine intensive approaches- eg in dry-land farming areas
    - Rural downturn seeing wealth and discretionary local philanthropy dry up
    - Earlier intergenerational transfers of farm wealth to enable survival of the next generation - again, due to downturn compounded by drought
    - Less certainty about the future - eg not leaving a bequest with the local health service as all of the family will have left the district
    - Possible negative perceptions about services consolidation – no longer owned by the local community when merged with the “big town” service up the road
- With regard to eligibility rating for the Rural and Remote Viability Supplement, ARIA works well for remote QLD / NT/ WA, NSW where there are fly-in / fly-out services, but not small but and as equally isolated places off the beaten track in Victoria or Tasmania. Km’s is not the only thing that affects access, but the means of transport.

- The impact of modern minimum awards - the new 74 cents per km will set the bar higher on delivering a level of service or care. There should be recompense – especially in rural areas..

- We need the Big Australia model of increased population to generate scale fiscal mass for health expenditure revenues and work force