Effective Service Provision in Rural and Remote Areas

Discussion Paper

1. Introduction

New England HACC Development Inc. has been contracted by the Department of Ageing Disability and Home Care (DADHC) to conduct research into Effective Service Provision in Rural and Remote Areas. A thorough review of relevant available local, national and international literature has been undertaken. Two on-line surveys, aiming firstly to identify the barriers to service provision in rural and remote areas and then to identify strategies that could overcome these barriers, have been completed. The first survey was aimed at service providers and 200 responses were received. The second survey targeted DADHC Officers, HACC Development Officers, Peak Bodies and consultants working in the sector and 46 responses were received. A series of focus group consultations and one-on-one interviews are also underway. This paper aims to develop themes from the research to date and to stimulate further discussion and feedback from stakeholders in the sector. A final report will be presented to DADHC in February 2008.

2. Context

The Australian population is ageing and people with congenital or acquired disabilities are living much longer, placing unprecedented demand on the services that support people in their communities. People living in rural and remote Australia face a number of additional disadvantages. The health status of populations living in these areas is worse than that of those living in metropolitan areas with mortality and illness levels increasing with remoteness. These populations experience relatively poor access to health services including General Practitioners, pharmacists, and residential aged care facilities. They have lower socio-economic status and have higher levels of unemployment. (Francis, 2005; Australian Institute of Health and Welfare, 2003; Larson, 2002). Some 28% of older Australian people live in rural areas. Rural areas also have significantly higher ratios of older single men than in metropolitan areas (Gibson et. al., 2000).

The percentage of Aboriginal and Torres Strait Islanders (ATSI) in the population increases with remoteness, with ATSI representing 2% of the overall population, 13% of the population in remote areas and 26% in 'other remote' areas. ATSI people are even more likely to be disadvantaged, to be reluctant to travel away from family and to be unable to meet the costs of transport and health care (Strong, et. al., 1998). Indigenous life expectancy is 20 years lower than the general population and ATSI populations have higher prevalence rates for disabilities.

The past few decades have seen profound change in Australia's rural communities. Many rural communities are declining and there is a net migration of people, particularly young adults, from country areas. This phenomenon is attributed to 'new managerialist practices', years of severe drought, changes in agricultural and other rural industries, and 'government policy that has embraced centralisation as an efficient strategy' (Francis, 2006). Literature from as early as 1987 suggests that 'new managerialism' would leave rural areas particularly vulnerable to cutbacks and rationalisation (McKenzie, 1987). New managerialist philosophy and practice 'legitimates the pursuit of cost-efficiency and administrative rationality as pre-eminent values'… "Rationalisation" often involves a reduction in service delivery in rural areas, a greater degree of privatisation, greater responsibilities being carried by the "voluntary sector" and reduced opportunities for communities to participate in the decisions that effect them' (Dunn and Williams, 1993).

This decade, within the community care sector generally, we have seen an increased focus on demonstrating compliance and accountability and on measurement and reporting of outputs.

In recent years many rural areas have seen dramatic decline in Home and Community Care (HACC) growth funding as a result of 'equalisation' under the Regional Allocation Formula (RAF) introduced in 2003. All areas of NSW west of the Great Dividing Range were deemed to be 'over equity' and a large proportion of the annual allocations of growth funding is being redistributed to more populated areas each funding round. Within DADHC there appears to be little supporting documentation for the RAF or the calculations on which it is based, the DADHC Manager Planning and Research reported: 'there is little detail concerning the mathematics of the formula and how conclusions around Under and Over Equity are arrived at' Goodger, B. unpub.).

The Community Transport Program (CTP) is funded by the NSW Government Ministry of Transport (MoT) and aims to address transport disadvantage at the local level by primarily facilitating efficient use of transport resources that exist within the community.

CTP is a relatively small program (approx. $2.8 million per annum) aimed at people who are "transport disadvantaged". Transport disadvantage is defined as "a circumstance or set of circumstances that leaves those who are affected by it in a situation where they have limited or no access to private transport and they have difficulty in gaining access to conventional transport services and systems."(MoT web page). Many people in rural and remote areas qualify for CTP as they have limited or no access to either private or public transport, however CTP is not available in all areas. There has been no growth in CTP since 1998/99.

3. Funding

Both surveys identified distance and cost/resources as the major barriers to service provision. Many respondents reported severe financial constraints. Given the impact of increased demand for service due to demographic change, plus increased paperwork, data reporting and demonstration of compliance combined with drought, depressed rural economies and the lack of growth funding in both HACC and CTP it is hardly surprising that rural services are feeling the pinch. Under the current funding and reporting arrangements there appears to be little incentive, or indeed capacity, for many providers to take on clients living in isolated areas. As one survey respondent put it: 'funded for LGAs but in practice mainly operate within town limits due to limitations with resources'.

This problem is compounded by the fact that many clients in rural and remote areas have very limited capacity to contribute to the costs of service provision.

Recommendation 1: that the Department of Ageing Disability and Home Care follow social justice principles in a review of the regional allocation formula for rural areas.

Recommendation 2: that the Ministry of Transport expand the Community Transport Program in rural areas.

4. Recognition that it is different

This was a strong theme in both surveys. Survey respondents clearly voiced the opinion that current service provision models took a 'one size fits all approach' and 'imposed city based models on rural communities' (survey respondent).

'Standardised service models and funding formulae do not respond effectively to the operational imperatives and costs of rural service provision' (survey respondent).

Survey respondents were particularly critical of the lack of clarity in Funding Agreements, with the current outputs described in DADHC and MoT Service Description Schedules (SDS) and with the reporting of outputs in minimum data set returns.

Participants in the research have reported that SDS in their current funding agreements often give little guidance as to the geography of the service. Some service providers are currently funded to cover LGAs that, following council amalgamations some years ago, no longer exist. Other providers report that they are funded to service a specific village and 'surrounding area'

with no definition of that area. Many schedules for transport services may specify the catchment for clients but mostly place no limitations on the destination. It is seen as the responsibility of each Community Transport service to consider Occupational Health and Safety and risk management issues, and thus to determine the limits its drivers can safely drive.

Service providers are required to make the decisions around the scope of their service. Not surprisingly one survey respondent reported that she 'considered the boundaries to be a bit fuzzy'.

The three-year DADHC and MOT funding agreements issued in 2006 have included outputs in the SDS. Brendan Goodger, DADHC Manager Planning and Research, has confirmed that 'the outputs recorded in the SDS are based on a unit cost and are state-wide costs (not LPA specific)' (Brendan Goodger, unpub.). This is in line with one respondent's comment: 'HACC service agreements set outputs required in relation to the amount of funding. Cost of providing services in the rural region in comparison to the metropolitan is not taken into consideration.'

Survey respondents strongly voiced the opinion that outputs for rural services need to include consideration of distance travelled to provide the service: 'obviously a trip of 3kms in the city on a bus does not equal a 350km round trip in a volunteer vehicle' (survey respondent). For services delivered in the home this is also a huge issue with travel time often exceeding hours of service: 'You can send a worker out and they are gone all day and even with a couple of clients you've only got a few hours to record'(survey respondent).

Several respondents also commented on the reduced flexibility of Multi-Service Outlets (MSO) under the new SDS. In rural areas many organisations had multiple funding agreements with DADHC. Many of these were encouraged to collapse their funding into an MSO. For the service provider the prime advantage of doing this was the ability to move funding across service types in response to community need. This was conditional, where transport funding was involved, in maintaining a minimum level of transport services. With the introduction of the outputs to the SDS service providers have lost the ability to move funds across service types and the flexibility and responsiveness of the MSO model may be lost.

Recommendation 3: That funding bodies work with providers to develop funding agreements that clearly define catchment and intention of funding with flexible outputs that recognise that the costs of service provision are variable.

Several survey respondents have commented on the restrictions of program eligibility and the difficulties encountered in isolated communities. This issue was identified in the Home But Not Alone Report from House of Representatives Standing Committee on Community Affairs in 1994: 'From our experience the most useful thing to do is to treat the whole needs of the community in a very holistic way. So when you have a program that is very specific about the types of services that it is eligible to fund … it can be quite difficult to fit that into the dynamics and operating practices of a small community.'

Recommendation 4: That the Department of Ageing Disability and Home Care initiate work with other departments and funding programs to develop and trial cooperative arrangements and models tailored to the specific needs of rural isolated communities.

5. Clarification of Guidelines

The National and NSW Guidelines for Home and Community Care recognise that HACC eligible people living in remote and isolated areas 'may experience particular difficulties in gaining access to HACC services' and under the HACC Act, this group is included in the HACC Special Needs Groups. The HACC Special Needs Groups are:

- people from culturally and linguistically diverse backgrounds;
- Aboriginal and Torres Strait Islander people;

- people with dementia;
- financially disadvantaged people; and
- people living in rural and remote areas.

Under the National HACC Service Standards all service providers are required to 'demonstrate that they have considered and taken action to overcome barriers of access to services for special needs groups'. However, the guidelines also advise that 'services should attempt to allocate resources in a way that provides the most benefit to the greatest number of people' and that a key consideration in determining priority for service should be the 'effect on other existing and prospective consumers of providing services for this individual'. The guidelines do not appear to recognise the tension between these two positions.

Where resource levels are unable to meet demand there must be a reduction in availability of services for clients from the special needs groups who require greater than average resource inputs. The guidelines offer no guidance on this matter. As one survey respondent pointed out 'balancing the costs of service provision in rural and remote areas with the number of people that can be allocated a service falls to the services to manage'. This is demonstrated in the service provider survey where 49% of respondents to the transport questions identified the 'cost of the service in proportion to project budget' as the major factor limiting their ability to provide transport to an isolated rural client.

Clarity around the servicing of the special needs groups would be particularly valuable in rural areas where HACC clients are likely to fall into several of these groups (see Section 2).

Recommendation 5: That the National and NSW HACC guidelines be reviewed and adapted so as to remove contradictions around the special needs groups and provide real guidance for service providers.

6. Transport

A major theme throughout the research has been the need for improved transport services. Lack of specificity in funding agreements, as outlined in section 4, leaves decisions about the scope of service provision with the provider. While many successful negotiations take place and service providers with different funding sources are often able to come to cooperative arrangements, these arrangements are based on good will and personalities. There is a need for MoT, DADHC, and NSW Health to clarify areas of responsibility and identify gaps and overlaps in service provision. This is particularly important for isolated people who need to travel regularly for repeated medical procedures such as renal dialysis and chemotherapy. Anecdotal evidence suggests that in some cases the lack of an affordable transport system has resulted in patients not receiving the required treatments and suffering accordingly.

Several respondents have suggested the establishment of state-wide accessible transport corridors for non-emergency Health Related Transport. Providers could use web-based technology to link service on established routes. To be effective this would require both interdepartmental cooperation and the quarantine of funds for this purpose.

Recommendation 6: That the Ministry of Transport, the Department of Ageing Disability and Home Care and NSW Health, in conjunction with the sector, develop joint guidelines clarifying areas of responsibility for transport in rural areas.

Recommendation 7: That the Ministry of Transport, the Department of Ageing Disability and Home Care and NSW Health, in conjunction with the sector, develop and trial accessible transport corridors for non-emergency Health Related Transport.

7. Capital Investment

A strong theme in the survey responses was the need for increased access to centre-based services in isolated villages. As one survey respondent commented: 'by having a small group come together you provide a focal point for service provision. Other providers e.g. Community nurse, can call in and also see more than one client at a time. When a new service is being introduced they can talk to the group and watch the bush telegraph do its work.'

Small Multi Service Outlets located in villages across the New England area, mostly established in the early 1990s have proven extremely effective in meeting the needs of the local community. Where possible, premises were purchased and modifications made for accessibility and function. Local volunteers were recruited and supported to provide cost effective services in the community. Transport to larger regional centres, mostly for health related reasons, and to a lesser extent transport to and from the centre is still a major area of expenditure.

There has only been very limited access to HACC capital funding during the current decade and new competitive arrangements for funding applications do not augur well for rural communities. Local community-based management committees are not generally well equipped for the development of complex tender documents and are unable to afford to outsource this service. It is not possible for rural centres to demonstrate a pattern of usage for proposed works that is comparable with city-based centres. There is also serious difficulty in attracting interest from a number of architects and builders when calling for quotations

As a result of years of ongoing drought and depressed rural economies rural Australia is currently characterized by declining housing stock and low levels of available rental accommodation. The expansion of small centre-based HACC services in small villages would be reliant on significant capital investment by government.

Recommendation 8: That significant capital funding is made available through simple and appropriate arrangements to develop the infrastructure for centre-based services in rural and remote areas.

8. Promotion of, and Access to, Services

Many survey respondents suggested that there would be much benefit in DADHC and other funding bodies talking a greater role in promoting the sector in the general community. Workforce recruitment and retention were identified by survey respondents as major barriers to service provision in rural areas. One respondent suggested that through a series of ongoing advertisements in the media the community could be made aware of service availability, the need for volunteers and that there are workforce opportunities and career options in the sector. The suggestion was that this promotion use 'positive images of country people helping each other'.

Recommendation 9: That the Department of Ageing Disability and Home Care and other relevant funding bodies develop a state-wide approach to promotion in mainstream media.

Respondents also suggested that the HACC services be clearly listed as a group in the White Pages of the Telephone Directory. Older country people use the telephone directory and listings under auspice bodies can prove confusing. In 2003 when DADHC decided to remove the listings, the HACC State Advisory Committee identified this as an issue, particularly a rural issue.

Community Care clients living in rural and remote areas are further disadvantaged by having to make long distance telephone calls to contact service providers. Service providers consulted reported that they are unable to afford 1300 or 1800 telephone lines for their clients.

Recommendation 10: That service providers in regional areas are funded recurrently to support 1300 or 1800 telephone lines and that this becomes a minimum access requirement for these providers.

Recommendation 11: That regional Department of Ageing Disability and Home Care offices take responsibility for ensuring that contact details for funded services are included on a designated page in rural White Pages.

Several respondents commented on Hospital Discharge Planning. 'Effective discharge planning makes it all work. Going home from hospital and knowing that help is on the way, when they need it is really the key to rehabilitation. If they get out there and struggle they lose confidence and then panic' (survey respondent). Suggestions to improve Discharge Planning include having Discharge Planners work from the community rather than the hospital. As one participant in the research stated 'It changes the focus of their work to getting the patient home rather than freeing up the bed'.

Recommendation 12: That the Department of Ageing Disability and Home Care and Area Health Services trial jointly funded rural community based Discharge Planning.

9. Models and Strategies

The key strategy reported by respondents to overcome the barriers to service provision in rural and remote areas was undoubtedly cooperation, teamwork and networking. Providers work in partnerships, share staff and broker services from each other.

Other strategies or models suggested include:

- Rural Community Worker/Centre with multiple funding sources (see section 4);
- increased flexibility in types of services offered with a focus on increasing independence e.g. equipment, vouchers and assistance with vehicle maintenance etc.;
- mobile services – designed to meet the needs of the local community;
- no interest loan schemes for equipment, furniture etc. ;
- quarantine of funding for isolated areas;
- expansion of ComPack and 'Healthy at Home' to smaller hospitals;
- continued and expanded support for Primary Health Care and Palliative Care Nurses working in remote areas; and
- the use of technology /teleconferencing – pre-op, carer support, client support.

These models and strategies will be further examined and developed in the Final Report.

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