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Ageing in rural and remote communities

NRHA submission to the Productivity Commission Inquiry: Caring for older Australians

30 July 2010

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

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Ageing in rural and remote communities

Introduction

In this submission to the Productivity Commission Inquiry into Aged Care[1], the National Rural Health Alliance considers the current issues with ageing in rural and remote communities and the potential impacts of recent health and aged care reform announcements. Recommendations relate to improving opportunities for healthy ageing in rural and remote communities as well as improving choice, access to and affordability of aged care services.

The aged care reforms the paper considers include those announced in *National Health and Hospitals Network: Further investments in Australia's health*[2], the communiqué from the COAG meeting on 20-21 April, the COAG National Health and Hospitals Network Agreement in April 2010[3] and the Federal Budget 2010[4]. This current package of reform announcements includes action on some of the specific recommendations relating to aged care services from the final report of the National Health and Hospitals Reform Commission[5].

The increase in cost of health care due to the ageing Australian population is one of the fundamental reasons given for the current health reforms. The 2010 Intergenerational Report was quoted by the Prime Minister in March 2010 as highlighting that the Australian health system is not equipped to face the challenges of the combination of an ageing and growing population, the increased burden of chronic disease, ongoing workforce shortages and rising costs. Treasury concluded that by 2045-46, spending on health and hospitals could consume the entire revenue raised by state governments.

Nowhere is the ageing population likely to be more vulnerable than in many rural and remote communities, where health outcomes are worse and where the adequacy of the health workforce across all professions is markedly worse than in the major cities.

Overview of the Alliance position

In all parts of Australia, including rural and remote communities, many older people prefer to stay in their own home and in their local community for as long as they are able. Other older people want or need access to residential care as they become frail, for example, or when family members or carers are no longer able to continue providing their ongoing care due to increasing disability, severity of chronic conditions or deterioration of dementia. Key expectations for the provision of services for older people in rural and remote communities are *choice* of services in their local community, *access* and *affordability*[6].

Choice of aged care services in rural and remote communities is likely to be dependent on the viability of aged care services and health workforce availability in a local area. Viability is

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[1] Productivity Commission Inquiry into Aged Care, announced 27 April 2010. http://www.pc.gov.au/projects/inquiry/aged-care.

[2] National Health and Hospitals Network: Further investments in Australia's health. April 2010 http://www.health.gov.au/internet/main/publishing.nsf/Content/nhhn-report-2.

[3] National Health and Hospitals Network Agreement, April 2010 http://www.coag.gov.au/

[4] Australian Government Department of Health and Ageing. Federal Budget 2010-11: 'Building a national aged care system' http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2010-amedia07.htm and 'Building a health and hospitals network for Australia's future' http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2010-hmedia01.htm.

[5] National Health and Hospitals Reform Commission, June 2009. Final Report. A healthier future for all Australians. http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/nhhrc-report

[6] National Rural Health Alliance. Fact Sheet 3: Ageing in rural and remote communities. http://nrha.ruralhealth.org.au/cms/uploads/factsheets/fact-sheet-03-ageing.pdf

affected by the higher cost of goods and services, due both to their freight component and the relatively small volumes demanded. In addition, smaller rural populations do not provide opportunities for the economies of scale in services that are available to major city services. Further, rural services will generally have higher costs for attraction and retention of staff, with the need in some communities to provide suitable accommodation.

One service model that has demonstrated its capacity to overcome these natural challenges is the Multi-Purpose Service (MPS) approach. The Alliance supports further development of MPSs. They see Commonwealth funding for aged care pooled with State funding for acute care, some Home and Community Care and other funding, with some capacity for economies of size and scale, and with the shape of services being determined in consultation with the local community.

Lack of *access* to aged care services for people living in rural and remote communities is thought to be responsible for a drift of older people from *Outer regional* and *Remote* areas to *Inner regional* centres (using the ASGC-RA classification scheme)[7]. People in rural areas have generally higher health needs, poorer health services provision and lower socio-economic status - all of which contribute to higher per capita need for aged care support. These differential needs are not recognized in current aged care planning and funding systems.

Further, rural people are more independent in their approach, have lower levels of expectation of government-funded services and are heavily inclined to prefer support in their home rather than residential care. Currently, the provision of support for people with high care needs is skewed in favour of centre-based residential care.

Local government also contributes to and assists in the organisation of many home and community based services. Its funding contributions are especially significant in Victoria, while in many jurisdictions local government plays a key role in coordination and delivery of aged care services, and in promoting local citizens' knowledge of the availability of these services.

Unfortunately, local governments in rural and remote areas have significantly less financial capacity to engage in the provision of community services. The Australian Local Government Association (ALGA) reports that rural and other low socio-economic regions have relatively high local government tax rates but provide fewer services because of the higher cost of delivering basic services to the community. The ALGA estimates that additional resources of $2.3 billion would be required to provide lagging councils with the resources to reach current average standards across all areas of local government activity. In addition, another $112 million per annum (cumulating each year) will have to be found to prevent further increases in current local government financial imbalances.

Affordability issues for older people living in rural and remote communities include the cost of transport, both within the community for health and related services and when travel is required for acute or more specialised health care. The Alliance advocates substantial improvements to Patients' Assisted Travel Schemes (PATS) which are of particular importance for older people with chronic and complex care needs. Public transport arrangements also need review and radical improvement.

[7] The Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system developed by the Australian Bureau of Statistics, uses 2006 Census data, is widely used by Commonwealth and state agencies for health service planning. The classifications are *Major cities, Inner regional, Outer regional, Remote, Very remote.*

Specific aged care policy for *Aboriginal and Torres Strait Islander people* should include well defined targets to meet the higher health needs and younger age profile of this population of Australians including:

- access to adequate and culturally appropriate service provision that takes account of differences in the age structure of the Indigenous population;
- culturally appropriate preventive strategies to maintain or restore independence;
- improved community care for older Indigenous people to enable them to remain in their own communities; and
- development of programs capable of meeting the needs of Indigenous carers of the aged, as defined within an Indigenous context.

As well as the emphasis on those already needing aged care services, the Alliance wants greater attention to the means by which ageing people can be kept healthy, including access to community services and networks, healthy local neighbourhoods, public transport and gainful employment.

Current arrangements including comments on some of the reform proposals

This section of the Alliance's submission considers some of the particular rural and remote issues with the current arrangements for aged care and includes some comments on the reform proposals the Government has announced so far.

The Productivity Commission issues paper, *Caring for Older Australians*, provides a more detailed overview of the current aged care system, including community care, residential care, flexible care for people with special needs and retirement villages[8].

Community aged care

At present

The complexities of the aged care system constitute a major barrier to good access, particularly for people in rural and remote communities that are poorly connected to service providers. The Alliance supports the National Health and Hospitals Network announcement of a one-stop shop for information about aged care services, especially if it includes a single entry point to case management to make it easier for older people and their families to know what their entitlements are, to navigate the system and to streamline eligibility assessment and progression between the various community and residential care services in a way that is timely and responsive to changing care needs.

Many people rely on a family member, health professional or community worker to act as a 'system navigator' for them, but others slip through the cracks and do not receive the support they need until an emergency occurs. It can be very difficult for older people and their families and friends to know what services are available and to find out how to access them. There can be a confusing round of eligibility assessments for the various service providers, which can result in overlaps and gaps in services and changes or uncertainties in who does what.

Home and Community Care (HACC) provides a range of social support services for people who are living in the community, such as 'meals on wheels', help with personal care, cleaning

[8] Productivity Commission Issues Paper, May 2010. Caring for Older Australians. http://www.pc.gov.au/projects/inquiry/aged-care/issues

or some transport assistance to attend a health appointment or to participate in a social activity. Other services available include occupational therapy assessments to minimise risk of falls or to maximise mobility, hire of aids and appliances such as shower chairs and walking frames, podiatry and short term community nursing support. These services are funded jointly by State and Commonwealth Governments but often involve contracted service providers. Local government or community groups may provide similar services too, or additional services relevant to local needs, such as an annual garden clean up or help with putting out wheelie bins in the suburbs. There is often a small copayment, but this can be waived so that people on low incomes do not miss out.

Community Aged Care Packages are available subject to assessment by the Aged Care Assessment Team (ACAT) for more comprehensive help with the activities of daily living such as personal care, shopping and medication management. Extended Aged Care at Home (EACH) packages provide a higher level care, including some nursing support for very frail older people but a new ACAT may be needed to obtain the higher level of care. Both CACP and EACH are designed to help people stay in their own homes rather than move to residential care and are funded by the Australian Government through contracted service providers. Specialised EACH dementia support packages are available too. The CACP and EACH service providers are not necessarily the same as for HACC, so people often have to change from the carers they are used to in order to receive additional services. Access can depend on the number of packages available in the area and the availability of service providers offering the sorts of help that are needed.

Older people who put their names down to move into public housing or private retirement villages or move into a granny flat as a way to retain their independence with a greater sense of security may still be eligible to receive support through HACC, CACP or EACH. Help with maintenance or 24 hour arrangements for responses to 'Vital Calls' may be a part of living in these types of accommodation. However independent living complexes for older people are more likely to be available in larger regional centres than in rural areas, partly because the capital to build this form of accommodation must be raised privately from outside the aged care system.

A hospitalisation, for example through a fall or a medication incident, may trigger a request for an ACAT by hospital staff to ensure that transitional care is available either in residential care or at home for up to 12 weeks, or for more permanent support if necessary. Otherwise finding out how or understanding why to get an ACAT, or even acknowledging the need for help or feeling entitled to receive it, can be a major challenge for older people.

The community care viability supplement

In the 2010 Federal Budget, the Government undertook to increase the viability supplement for rural community care to the same level as for residential aged care. The Alliance welcomes this additional support for community care services, given the important role they play in maintaining older people in rural and remote areas within their local communities. The costs of providing community services are higher than in metropolitan areas due to a number of operating variables including freight, travel, food and staffing costs.

In 2009, Aged and Community Services Australia (ACSA) conducted a review of the Community Care Viability Supplement which was introduced in 2006-07 in recognition of these additional costs. The Viability Supplement applies to the Commonwealth CACP and EACH packages, not to HACC services. Due to the limited number of EACH packages funded, many people remain on CACP as their care needs increase. Where the capacity to

provide community aged care services is limited, the time available to support people with lower care needs tends to decrease as the services stretch to try to cover people with higher care needs.

The ACSA survey of service providers found that the drop off in hours of care per client to help people stay living in their communities was particularly marked in rural and remote areas. More recently, the Campaign for Care of Older Australians Group has highlighted that around Australia, Community Aged Care Package clients who once received seven hours support, now receive only five hours of care[9]. The Alliance is concerned that the time available for personal care for people in rural and remote communities may have diminished well below this average figure, where the pressures on services are even greater.

Also the ACSA survey found that the concept of the packages, with a certain number of hours of care per person, was not entirely relevant to Indigenous services. Aboriginal and Torres Strait Islander communities do not accept some people being supported while others are not, so a substantial number of 'unfunded' services are provided.

In addition, in remote areas it is most likely that the same person will provide all the services required, so it is often necessary to employ a nurse who can provide a more complete range of services beyond personal care. In more accessible areas with more clients, a number of personal carers might supplement the services of a single nurse. Personal carers are becoming harder to attract too in some areas, because salaries are not competitive with mining, tourism and the public hospital sector. The Community Care Viability Supplement was valued in the ACSA report, but didn't cover the additional costs of providing care in rural and remote communities.

Other issues arising

Community care has become increasingly important to aged care provision over the last twenty years, in response to the preference shown by most people who need support.

At 30 June 2006 around 780,000 people used HACC services (no ACAT required) and there were 29,972 CACP recipients (ACAT required) nationally. This usage of the two largest community aged care programs compares with 145,175 permanent aged care residents at 30 June 2006[10].

The demand on community services continues to increase nationally; in 2009 nearly a million people were helped to remain in their own homes and 211,345 people were provided with accommodation and care in aged care homes[11].

Community care is likely to be even more important in rural and remote communities due to several contributing factors, including:

- difficulties with providing financially viable residential aged care services in remote Australia
    - viability challenges increase as the average number of beds per residential aged care service decreases, which relates directly to remoteness: *major cities* have an

[9] Campaign for Care of Older Australians Group, 2010. The grand plan: a new vision for the care of older Australians. www.thegrandplan.com.au

[10] Australian Institute of Health and Welfare, 2009. Pathways through aged care services: a first look. Bulletin 73. http://www.aihw.gov.au/publications/aus/bulletin73/aus-116-10781.pdf

[11] Campaign for Care of Older Australians Group, 2010. The grand plan: a new vision for the care of older Australians. . www.thegrandplan.com.au

average of 68 beds per facility, *inner regional* 55, *outer regional* 41, *remote* 28 and *very remote* 16.[12]

- higher proportions of 'special needs' groups defined by the Aged Care Act 1997 (data drawn from AIHW, 2009[13]) including:
    - Aboriginal and Torres Strait Islander people – high proportion of Indigenous CACP recipients at 30 June 2008 in *Remote* (36%) and *Very remote* (71%) areas;
    - people born overseas in countries where English was not the main language (who are more likely to prefer home based care) – 21% of CACP recipients across Australia at 30 June 2008 – no breakdown by geographic area but significant population groups in many rural communities;
    - people with personal financial hardship – there are high proportions of recipients recorded in this category for *Remote* (46.6%) and *Very remote* (30.5%) areas compared with 23.6% across Australia, although data is limited as financial hardship status of 32% of CACP recipients across Australia is not known;
    - living in *outer regional* and *remote* areas – almost 12% of all CACP recipients at 30 June 2008 lived in *Outer regional* (8.3%), *Remote* (1.8%) and *Very remote* (1.7%) areas. The age profile of care recipients was younger, likely to be influenced by younger age of entitlement for Aboriginal and Torres Strait Islander people due to their higher health needs (50 years compared with 70 years).

A needs-based distribution of community services is likely to require a higher level of service delivery than is available at present in *Outer regional* communities (see the table below).

The combined distribution of aged care packages per 1,000 persons aged 70 years and over in the table are likely to be skewed by the small numbers of people over 70 who continue to live in *Remote* and *Very Remote* areas and the lower survival rates of Aboriginal and Torres Strait Islander people.

CACP, EACH, EACH dementia by remoteness, 30 June 2008 (From AIHW, 2009[11])

Packages	Major cities	Inner regional	Outer regional	Remote	Very remote	All regions
CACP	26,570	8,953	3,337	736	684	40,280
EACH	2,816	1,010	383	30	5	4,224
EACH dementia	1,390	403	198	5	-	1,996
Combined (CACP, EACH, EACH dementia)	30,698	10,309	3,688	632	551	45,878
Combined – percentage	66.9	22.5	8.0	1.4	1.2	100.0
Combined – per 1,000 persons aged 70 years and over	23.1	22.9	20.4	37.8	104.4	22.7

Maintaining the strengths of community aged care in rural and remote communities

Reforms such as the Commonwealth taking full responsibility for aged care including community services such as HACC, which are still likely to be contracted out, provide opportunities for streamlining and coordinating services better and should simplify financial

[12] Australian Institute of Health and Welfare, 2009. Residential aged care in Australia 2007-08. Aged care statistics series no. 28. Cat. NO. AGE 58. Canberra: AIHW

[13] Australian Institute of Health and Welfare, 2009. Section 3.6 'Special needs' groups, pp 25 – 29 in Aged care packages in the community 2007-08: a statistical overview. Aged care statistics series no. 29. Cat. No. AGE 60. Canberra: AIHW

and quality reporting. However it is critical that changes in funding arrangements sustain the strong sense of community that prevails in many rural and remote communities.

For example, in rural and remote communities where services and resources may be stretched, service providers often need to patch funding together from several different sources to meet individual needs, or the needs across a small community. It will be important that the full cost of providing this mix of services is recognised as funding sources are streamlined.

In addition, older people are particularly vulnerable to social isolation which can impact heavily on their health. Community support from someone to drop in for a cup of tea or help with transport to a Senior Citizens craft session can be extremely important for people living in small communities. People need to be asked about their different cultural expectations and personal needs so that social supports can be adapted to accommodate current community needs. The strategies that rural and remote communities have in place for supporting social inclusion of older people with diverse needs and expectations must continue to be valued, strengthened and supported.

Residential aged care

At present

Eligibility for access to residential aged care depends on a recommendation for residential care from the Aged Care Assessment Team (ACAT), which classifies the older person as entitled to low level, high level or short term respite care in a residential aged care facility.

Although everyone who is eligible for residential care should be accommodated, access depends on the availability of residential care beds at the level required in the area. In this context the 2010-11 Commonwealth Budget redirected $276 million from aged care funding to the states to recognise the number of aged care type patients who remain in hospital because of the lack of aged care services. While the extent to which this issue applies in rural and remote areas is not clear, these funds will need to be applied in ways that deliver necessary capacity rather than supplementing short term operating costs alone.

Affordability is not supposed to be an issue as accommodation costs are means tested, but choices and availability can depend on level of care required and ability to pay. The time and anxiety involved in obtaining the assessment, locating and negotiating for suitable accommodation, completing the paperwork required and negotiating the financial arrangements can be extremely challenging. People from rural and remote communities, who often have to move to a larger town for residential care or who want to move closer to family, face particular challenges and would benefit from additional support and assistance to find the best solution.

Issues around ACAT assessment

For many older people, the path to an ACAT is through hospitalisation when a staff member makes a request on behalf of the patient ahead of discharge. One of the challenges for people who live in rural and remote communities, whether they are carers or older people needing care, is that the older person may be in hospital a long way from home and friends and family. The ACAT assessment may occur when family or carers are not present and they may not have the opportunity for input or to receive much needed advice and support in locating appropriate care from a distance.

Also the daily rate the hospital receives for patient care may drop off after 30 days of care, which can result in people feeling pressured to take up an immediate offer of residential care, although it is distant from home or family or unsuitable in some other way. Families may also feel particularly hurt and frustrated when they end up spending the last few days of a loved one's life looking for suitable aged care accommodation, when it turns out that palliative care or a few more days in acute care would have been a better option.

Older people often take longer to recover after surgery or illness too, so may need to enter a residential aged care facility for transitional care until they are strong enough for rehabilitation treatment or to return home. Transitional care provides for additional allied health care such as physiotherapy to regain mobility after a fractured hip, occupational therapy to help with managing activities of daily living or speech therapy to assist with swallowing after a stroke, but these services can be scarce in rural and remote communities.

People seeking residential aged care from the community also face anxiety and confusion. They may not realise that an ACAT is required to be considered for entry to a nursing home, which can take a little time to organise. There is considerable information available on the internet[14], through the Aged Care Information Line (free call) on 1800 500 853 or the Commonwealth Respite and Carelink Centre on 1800 052 222. The problem can be filtering the information or finding the entry point most appropriate to the current need. Even when the Aged Care Assessment Team becomes involved and conducts the assessment, people may still need additional help to find the most appropriate arrangements. The Alliance notes that private businesses in aged care consultancy services are starting to spring up to fill this unmet need, but the cost is high. The Alliance supports steps being taken by the Commonwealth to develop single access points for aged care to assist older people and their families with the transition to residential care. Timely implementation is needed, which also involves training of suitable support staff, for example, in respite care centres.

Issues around level and availability of residential aged care

The complex mix of incentives and disincentives for the providers of aged care facilities can mean that potential residents do not actually have the choice of certain facilities. The smaller absolute numbers of people needing care in rural and remote communities mean greater challenges to financial sustainability for aged care service providers and therefore to the choice of residential aged care near to home for older people.

Low care (hostel) residents are means tested; someone who only receives the aged care pension pays a fixed amount (85%) of their pension fortnightly, but someone with an income greater than the pension will pay an additional income tested fee on a sliding scale, up to a daily maximum. In addition, legislation allows that a person with assets above the pension limit can be asked to pay an accommodation bond. People often sell their family home to pay the accommodation bond although in certain circumstances where a partner or family member still lives in the house, it may be excluded from their assets.

Accommodation bonds are negotiable but residents must be left with minimum assets (at least $37,500 at this time). The bond is invested by the residential care provider who is entitled to keep the interest and a current maximum of $299 per month for up to 5 years, to be used for maintenance and capital reinvestment in the facility. The balance of the accommodation bond is refunded to the resident or their estate when they leave the home.

[14] For example, see http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-index.htm or www.agedcareaustralia.gov.au

A low care facility may be required to provide a minimum number of unbonded places for people on the aged care pension alone, but it will have more money to spend in the long term if it fills many of its places with residents on good incomes paying near the maximum bond.

Small populations and the lack of community supports available to assist older people to remain at home, mean that rural aged care providers often have a larger number of residents with minimal assets who cannot afford to pay a bond, which can impact negatively on their capital resources. The generally much lower value of private residences in lower socio-economic areas also means that rural people have less by way of bond to offer to gain access to residential aged care and will therefore be less financially attractive than those with capacity to provide a higher bond. In more remote areas, where the demand for aged care services is low, provision of services for the small number of people who need them is financially unprofitable. While the service providers operating in rural and remote communities are committed to looking after the people in need in the local community, existing frameworks for raising capital are inadequate, making commercial investment in aged care facilities in many rural and remote areas unattractive and difficult financially for the not-for-profit sector.

High care (nursing home) residents do not pay an accommodation bond but the Government pays more per day for their care, dependent on the level of ongoing care provided. The resident may also pay an additional daily accommodation charge, subject to a means test. However, this additional daily charge is capped to a maximum which may not reflect the full cost of care.

A high care facility may focus on high dependency residents who attract higher daily rates for care under the Aged Care Funding Instrument, such as people who are severely disabled through stroke, rather than residents who are assessed by ACAT as high care due to dementia, but are still mobile. The care and support needs for these residents are quite different. Either way, a facility that is predominantly for high care residents is likely to have less capital available through low care bonds from residents to support maintenance and capital improvements.

The choice of direct entry to high care accommodation in regional or urban areas may be quite limited for people who wait to leave their rural or remote community until their care needs are high. While the Alliance supports ageing in place, which means that people are supported to stay in the same facility as their care needs increase, the result for rural people can be that there are very few direct entry places available for high care residents. Vacancies are more likely to be filled by new low care residents who pay a bond.

The Grand Plan proposed by the Campaign for Care of Older Australians recommends refundable accommodation deposits for high care and removing the distinction between high and low care, as well as increasing the daily accommodation charge for people who can afford to pay to match the cost of housing, all of which would be at no cost to Government. It also recommends linking government payments (the accommodation subsidy) for concessional residents to the real costs of providing accommodation.

These recommendations may assist to overcome some of the tensions for rural and remote people who can afford to pay bonds in seeking high care accommodation in a regional or urban centre.

Particular challenges would remain for the business of aged care in rural and remote communities including the higher costs of service and lower potential for generation of income in areas where the population is less affluent. Health care for people in residential facilities in rural and remote communities is also a crucial issue which is discussed further under 'Primary care'.

Respite care: Most residential aged care facilities provide an allocated number of days for respite (short term) care, which attracts higher daily rate subsidies by the Commonwealth than permanent places. Various management options exist for effective use of the capacity, including planned respite admissions booked in two weekly blocks, or regional coordination of emergency respite beds.

In addition, certain residential care facilities offer ***'extra service places'*** where people who can afford to 'buy' additional 'hotel type' services may increase the choice of low or high care facilities available to them.

Multipurpose services, mobile outreach services, flexible funding solutions

The Alliance supports further investment by government in flexible service delivery models such as mobile community outreach services and the funding of small hospitals as Multi-Purpose Services through flexible pooling of aged care and acute care funds. Further development of the funding and service delivery models available for Multi-Purpose Services is needed to incorporate the strong focus on community aged care and the higher primary care needs of older people where this is appropriate for the local community.

The Multi-Purpose Service approach has been used with some success in rural communities as a way of keeping an acute facility open while addressing the need for a small number of aged care beds. However some concerns have been raised, such as the potential for the aged care funding to be absorbed by the more pressing demands of the acute care facility. Broad and inclusive community consultation about the establishment of a Multi-Purpose Service is important to avoid adverse impacts on existing aged care service providers in the region.

The Government included increased access to care through Multi-Purpose Services in rural and remote communities in the 2010 Federal Budget, with an allocation of $122 million, starting with $50.7 million in 2010-11 for capital funding and changes to guidelines. Immediate implementation activity flagged in July 2010 includes:

- commence developing guidelines for state and territory governments to apply for capital funding; and
- analyse impact of new geographic boundaries due to increase in size of eligible regional and remote communities[15].

The Alliance notes that the numbers of beds in the existing 126 Multi-Purpose Services are to be extended with eligibility for Multi-Purpose Services to catchments of up to 5,000 (currently 3,000). However, the National Health and Hospitals Reform Commission recommended consideration of MPS models in towns with catchment populations of 12,000, and the Alliance considers that the economics of these single organisation pooled funding models in these larger communities are worthy of further consideration.

[15] Australian Government. A national health and hospitals network for Australia's future: delivering the reforms. Commonwealth of Australia, 2010.

In the past the lack of Commonwealth funding for capital has been a considerable difficulty for Multipurpose Services. The Alliance is particularly pleased to see that the Commonwealth is now prepared to provide capital funding for these facilities. The Alliance is also concerned to ensure that these valued rural services also come within the ambit of the overall Commonwealth 60 per cent funding for hospitals including for training, research and capital so that these facilities can continue to provide services in well equipped and attractive environs, to both maintain and improve the quality of service and to attract and retain essential staff.

Primary care

In the community at present

Visits to the doctor for older people living in the community are funded through Medicare and the doctor gets a small co-payment over and above the standard Medicare payment when an older person is bulk billed. In addition there are a number of primary care programs that are usually funded through general practice, but sometimes involve the practice nurse or allied health professionals, for example, through a case conference, as part of a care plan, or a medication review, to provide better integrated care for people with chronic conditions. Access to these additional programs depends on having a GP nearby. Medicines are available at concessional rates subject to eligibility on the basis of age and a means test, through the Pharmaceutical Benefits Scheme.

The Alliance wants to see improved access to primary care as close to home as possible for all people who live in rural and remote communities, including older people who often have higher health care needs.

As well as the emphasis on those already needing aged care services, there also needs to be greater attention to the means by which ageing people keep healthy, including access to community services, healthy local neighbourhoods, public transport and gainful employment.

In residential aged care facilities

In residential aged care facilities, visits to the doctor are still funded by Medicare, but there are special incentives to encourage GPs to visit residents in residential aged care, recognising that these visits, which involve leaving the surgery, take time out of their appointment schedule for the day. There are often several doctors who visit a particular residential aged care facility and the facility usually suggests that a new resident who has moved some distance away from their home and previous GP chooses one of them. However, GP shortages in rural and remote communities may be a limiting factor.

Medicines are still provided through the PBS, often through a pharmacy associated with the residential aged care facility. There can be additional costs for residential care facilities in rural and remote communities such as higher costs of preparation of Webster packs for dispensing the medicines, or pharmacy services may need to be contracted out if they are not available locally. For example, there may not be a local accredited pharmacist to perform medication reviews, but contracting out can affect continuity of care with other local health care providers.

Some other primary health care services similar to those available to older people in the community through HACC services or CACP are also available through aged care facilities, at a cost for low care residents or included for high care residents. For example, an activities program is provided and podiatry or a basic physiotherapy assessment may be available. The

daily fees cover personal carers to help with showering, dressing and meals. Other services may be available at cost such as hairdressing and some social activities.

The Aged Care Standards require higher staff-to-resident ratios for registered and enrolled nurses as the ratio of high care to low care residents increases.[16] The Aged Care Standards and Accreditation Agency Ltd assesses residential care facilities and monitors them to make sure they comply with the standards.

However, further attention is needed to provision of allied health services such as physiotherapy, occupational therapy, speech therapy, optometry and dentists for residents of aged care facilities in rural and remote communities, where there are severe shortages of these health professionals. Options such as visiting health professionals and mobile services face additional challenges including the need to maintain continuity of care with local health professionals and provision of appropriate facilities such as a dental chair.

Acute and sub acute care

Older people are entitled to receive acute care in hospital when they need it just like the rest of the population – and they are more likely to need it due to frailty, falls or poor health. The effect of longer recovery times for frail elderly people on hospital bed occupancy rates is compounded through limited availability of suitable convalescence and rehabilitation facilities, or even for palliative care.

The complexity of the arrangements for finding a suitable bed in an aged care facility discussed above, as well as the time lags involved, contributes to longer hospital bed occupancy rates for older people.

1,316 new sub-acute beds in the public hospital system which could be directed to rehabilitation, step down, palliative care, mental health and palliative care beds were included in the COAG reforms. An additional $200 million of flexible funding could be directed to emergency departments, elective surgery of sub-acute care.

Travel and transport

Travel costs and transport availability for health, aged and community care are significant issues for consumers and carers in rural and remote Australia. This applies to travel required locally and, especially, to travel outside local areas.

Australian Farm Institute studies have estimated that the costs of access for rural people to a range of essential services including health, aged care and other services are many times the cost incurred by people in major cities.[17] These substantial additional costs can and do result in barriers to access to services.

Availability of suitable transport is especially an issue. Travel for specialist visits and geriatricians can be a particular problem for people in older communities and a barrier to obtaining timely health care. Community transport, which is sometimes provided by local government, can become critical when driving is no longer an option, for example when the

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[16] http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Standards+of+care-2

[17] National Institute of Economic and Industry Research (NIEIR), 2009. Essential Services in Urban and Regional Australia – A Quantitative Comparison. Australian Farm Institute. www.farminstitute.org.au

partner who is the driver passes away, vision, mobility or dementia deteriorates and so on. There is a strong need for improved public transport to service rural and remote communities. Even a weekly bus service through remote areas to a major centre could make a difference for people needing to keep medical and other health appointments as well as access a range of other services. The cost of ambulance services is also an issue that may affect access to health care. People in residential aged care facilities continue to have transport issues too, unless mobile services come their way.

The Australian Government has a clear responsibility for providing clinically timely access to specialist and acute health services for our older people as well as others in rural and remote communities. Where these are not available locally, an affordable and effective patients' assisted travel scheme is needed – one that is flexible enough to accommodate the best available transport options within a rural or remote community, including effective use of paramedics and ambulance services as appropriate, meaningful contributions to the costs of travel in private vehicles or commercial travel costs appropriate to care needs, as well as consideration of the accommodation needs of residents, their carers and families during treatments away from home.

Health workforce

The Productivity Commission terms of reference include 'systematically examining the future workforce requirements of the aged care sector, taking into account both the supply and demand for the aged care workforce, and develop options to ensure that the sector has access to a sufficient and appropriately trained workforce'.

Rural, regional and remote areas face serious shortages of doctors, dentists, medical specialists and allied health professionals, all of whom are needed for effective aged care. Although nurse-to-population ratios are relatively well maintained, there are serious shortages of nurses in the aged care sector. These pressures on health professional staff also highlight the need for the development and support of aged care services managers and health service managers more generally to ensure the provision of high quality, compliant and financially sustainable services. Special consideration should be provided for rural and remote aged care staff for career development, fair wages for aged care nurses and personal carers, and support for the accreditation of facilities in more remote areas. Continuing professional development requirements, now more clearly defined under the National Registration and Accreditation Scheme, will also impose particular challenges for health professionals in rural and remote areas. Local training opportunities and the availability of suitably qualified locums or back-up staff to maintain service provision levels during training sessions are in short supply in rural Australia.

The costs of tertiary education are higher for people who live in rural and remote Australia and there is substantial unmet demand for the existing rural medical, nursing and allied health scholarships. Scholarships for rural dentistry and oral health professionals are minimal.[18] Ongoing training initiatives are hard for people to attend unless they can be delivered locally, including through e-learning and distance education. Supportive training and continuing education strategies are needed to increase the available workforce including aged care nurses, nurse practitioners and personal carers in rural and remote communities.

[18] The 2010 Election campaign offers some prospects in this regard.

Such approaches would also contribute to more effective involvement in aged care of other health professionals available locally including social workers, occupational therapists, physiotherapists and a range of community workers. With the greater shortages of health professionals in rural and remote areas, the models of aged care will inevitably be tailored to meet local circumstances. This requires appropriate training to properly equip rural health professions to cover a wider range of responsibilities than generally applies in major cities, as well as research and analysis into effective models of care in rural and remote areas at a distance from specialist and other support services. Multidisciplinary approaches to health workforce and service policies and programs are crucial.

Aboriginal and Torres Strait Islander Health Workers play a key role in the provision of health and aged care services in their communities. The contribution made by Remote Area Nurses to aged care also needs to be considered, valued and supported.

However, we actually need more people working on the ground in aged and disability care in rural and remote communities, which requires new investment and better integration with broader primary care. Aged care needs to go beyond clinical care alone, to provide various kinds of human support, which at present are difficult to obtain through Medicare and thus not affordable to many older people living in rural and remote communities.

The Alliance is particularly concerned about the very serious shortage of dental practitioners in rural and remote regions. There are 55 dentists per 100,000 people in the major cities compared with 17 per 100,000 in western NSW and even less in remote Queensland. In many parts of Australia people have to wait up to four years for non-emergency public dental treatment.

The Alliance supports the establishment of a well-funded public dental health program, a rural Australian dental undergraduate scholarship scheme, better funding for dental student rural outplacements, the establishment and funding of a foundation year for first year dental graduates and extending workforce recruitment and initiatives such as scholarships and retention payments to dentists.

In particular, for older people on fixed incomes in the community and in residential care, the Alliance wants the Australian Government to invest in public dental care, including dentures.

Where to next?

The Alliance is supportive of the indicated intention of the Australian Government to become not just the policy driver, but also the single funder for aged care. This should help to provide more seamless care and to minimise obstacles to receiving good care through multiple entry points, without complicated and repetitive assessment and application processes.

The April 2010 COAG reforms includes, as part of the agreement, that the Commonwealth will become the sole funder of a nationally unified aged care system, a transfer to the Commonwealth of current resourcing for aged care services from the Home and Community Care Program (HACC). The Commonwealth will assume funding and program responsibility for basic community care services currently provided under HACC for people 65 years or over (50 years and over for Indigenous Australians) and funding responsibility for special disability services provided under the National Disability Agreement for these age groups.

This will enable the development of a nationally consistent aged care system covering the basic home care currently provided by HACC right through to nursing homes.

The States will assume responsibility for funding and regulating basic community care services currently delivered under HACC for people under the age of 65 (under 50 for Indigenous Australians) and funding packaged community care services delivered on behalf of the Commonwealth for these age groups.

The Alliance supports the Government's one-stop-shop approach to information about aged care services, especially if it includes a single entry point for case management to make it easier for older people and their families to know what their entitlements are and to navigate the system.

People living in rural and remote communities who need to relocate to receive care should receive special support and assistance to find the best solution for them and their carers.

Recommendations

Recommendation 1
The Alliance recommends that the Government's one-stop-shop approach to information about aged care is provided through appropriate means to people in rural and remote communities and complemented by more effective and comprehensive case management across the range of services available.

The Alliance supports further investment by government in flexible service delivery models such as mobile community outreach services and the funding of small hospitals as Multi-Purpose Services through flexible pooling of aged care and acute care funds. Further development will need to incorporate the strong focus on community aged care and the higher primary care needs of older people where this is appropriate for the local community.

The Alliance will be seeking timely implementation of the 2010 Budget announcement to improve the sustainability of community aged care services in rural and remote communities through increased investment in the Aged Care Viability Supplement in community and residential settings and the ongoing development of targeted programs to fund and deliver rural and remote aged care effectively. There need to be flexible approaches to funding, including both capital and operational costs and for mobile and outreach service options.

Recommendation 2
The Alliance recommends further development of aged care funding arrangements that are based on the Flexible Care approach and which cover the real costs of delivering services for the aged in rural and remote communities.

Recommendation 3
The Alliance recommends further extension of the Multi-Purpose Service program for rural communities for more comprehensive funding of aged care needs including residential, acute, community and primary care.

Recommendation 4
The Alliance recommends additional capital grants to aged care facilities in rural and remote areas so that smaller services can maintain appropriate certification requirements.

The Alliance has made much of the critical role played by the relationship between primary care through Medicare Locals and acute care through Local Hospital Networks, for improved effectiveness, cost efficiency and breadth of services offered by hospitals serving small rural communities. Nowhere is this more important than in improving healthy ageing and access to aged care in rural and remote communities.

In smaller communities the local hospital fulfils a range of functions. As well as providing essential services close to home such as accident and emergency, local hospitals are vital for the provision of rehabilitation and end-of-life care. Hospitals play a key role in meeting 'community service obligations' and are centres for health professional learning, important employers and hubs for outreach to smaller centres. As such, hospitals play a key role in attracting and retaining the doctors, nurses and allied health professionals who are fundamental to aged care.

The boundaries of the new Local Hospital Networks should be based on communities of interest, not population numbers alone. Also where the community and clinicians support the idea, the Local Hospital Networks and Medicare Locals should be amalgamated into a single entity.

Recommendation 5
Consistent with the COAG National Health and Hospitals Network Agreement, agreed definitions of Community Service Obligations for small hospitals should be developed as a basis for the block funding to be provided to them, and should include specified functions and services in aged care.

Recommendation 6
In consultation with local health service providers and community members, to extend the Multi-Purpose Service model according to the health needs of the particular community and to provide Commonwealth funding for the MPS to deliver greater amounts of more specialised care, health promotion and community services.

The Commonwealth's responsibility for primary care, aged care and majority funding of acute care means that it is now, more than ever, responsible for a more equitable distribution of health professionals.

Recommendation 7
The Alliance recommends that the Government develops a comprehensive health and aged care workforce recruitment and retention strategy - including for dental health - as part of national health and ageing policy.

Recommendation 8
To establish a staff support scheme for rural and remote aged care services including support for e-learning and other forms of distance education.

Also in the new Agreement, the Commonwealth and States commit to undertaking further work in regard to Patients' Assisted Travel Schemes (PATS), with a view to higher and more consistent national standards. As yet, however, no time frame has been set.

Recommendation 9

The Alliance recommends that the Australian Government invest directly, in collaboration with the States, in better funded and more widely promoted patients' accommodation and travel schemes (PATS) for all jurisdictions.

Recommendation 10

The Alliance recommends that the Australian Government commit to inclusion of national access targets for PATS in the National Healthcare Agreements between it and the States and Territories. The schemes in all jurisdictions should accommodate the particular barriers faced by Indigenous Australians, and be relatively generous to reflect the fact that public transport in many rural and remote areas is very limited.

Recommendation 11

The Alliance recommends that, in the medium term, the Government considers development of a broader patients' accommodation and travel scheme that covers any intervention that is not available locally and includes a focus on illness prevention, early intervention and the management of health risk factors.