NATIONAL RURAL HEALTH ALLIANCE INC.

Improving the prospects for healthy ageing and aged care in rural and remote Australia

Submission in response to the Productivity Commission's Draft Report
Caring for Older Australians

April 2011

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.

Contents

**Improving the prospects for healthy ageing and aged care
in rural and remote Australia**

Submission in response to the Productivity Commission Draft Report
Caring for Older Australians

Executive Summary

The National Rural Health Alliance's vision is good health and wellbeing in rural and remote Australia. Fundamental to its work is the belief that all Australians, wherever they live, should have access to comprehensive, high quality, accessible and appropriate health services, and the opportunity for equivalent health outcomes. This belief encompasses the entitlement to healthy ageing and aged care.

Rural and remote Australians overall have shorter life expectancy, higher death rates and higher rates of certain chronic conditions than city dwellers, and are more likely to have a disability. This is the case even when taking into account the effects of the poorer health of Aboriginal and Torres Strait Islander people, who make up a greater proportion of the population in remote areas.

Improving health and ageing outcomes for rural people through national reforms

The aged care system must play its part in overcoming this disparity. In particular the Alliance believes that aged care and health reform must combine to achieve the priority COAG outcome for social inclusion and Indigenous health:

> *"Indigenous Australians and those living in rural and remote areas or on low incomes should achieve health outcomes comparable to the broader population."*

The Alliance recommends that the Productivity Commission frames an overarching policy, with indicative targets, progress measures and outputs, for the contribution that aged care will make to a combined health and aged care outcome:

> *"Indigenous Australians and those living in rural and remote areas or on low incomes should achieve health - **and ageing** - outcomes comparable to the broader population."*

By this means, the aged care system can claim its rightful place in health system reforms already underway. These reforms will result in greater regional responsibility and accountability for health service planning, integration and workforce development across primary, acute and aged care settings through the establishment of Medicare Locals and Local Hospital Networks.

Improving system navigation

To be fully effective in rural communities, the regionalised Australian Gateway Agency that is proposed will need to tap into local resources such as established local communication channels, existing services and support group activities, and gain the support of local champions for healthy ageing and aged care. Such local approaches can also be important avenues for developing a better awareness of local community and cultural groups and their requirements, to better engage with local needs.

The regional level Gateways serving rural and remote communities may have a particular role, in conjunction with Medicare Locals, in ensuring that clients and aged care service providers are able

to access the health care they need locally, for example through establishing appropriate transport arrangements or telehealth facilities, or negotiating for visiting medical specialists, allied health professionals and dental workers to run regular clinics. Formal communication channels between the regional level Gateways and the relevant Medicare Locals and Local Hospital Networks will be critical in rural and remote communities.

The Alliance recommends that aged care interests should be represented on Medicare Locals and Medicare Locals should support the establishment of and work with the Gateway for their region. At a time when Medicare Locals are being established to lead population health planning at a regional level, there will be major new opportunities to coordinate primary, acute and aged care services.

Quality and choice of care

The proposed Australian Gateway Agency consolidates responsibility for information, assessments and coordination of care at regional level and should minimise older people falling through the cracks. The coordination role taken on locally by health and aged care providers in rural and remote communities – with Medicare Locals taking a leading role – should not be underestimated or under-valued. All should be working together towards best practice care for older people using innovative service models to complement the range of standard services available locally.

The Productivity Commission has recognised the contribution informal carers make in caring for older Australians and recognised that, when assessing aged care needs, consideration must be given to the need for carers to be trained and supported. For any of the approaches taken, including extension of respite care, there needs to be a greater focus on how this is best achieved in rural and remote areas, where the distribution and capacity of carers is quite different and formal care is more difficult to access.

Existing successful models include multi-purpose services, which see health and aged care funding pooled to provide access to health, aged and community care services in consultation with the local community. These service models provide economies of scale, a stronger environment for peer support and professional development, and a range of services tailored to community needs in places where such care would otherwise not be feasible.

The Alliance recommends that flexible aged care service arrangements continue to be supported and developed further to ensure that older people in rural and remote communities have the choice to stay in their own communities for as long as possible, including:
- strengthening the Multi-Purpose Service (MPS) program, with the roll-out of extra aged care beds in existing MPSs and further expanding the number of MPSs to cover catchments of up to 12,000, as recommended by the National Health and Hospitals Reform Commission;
- further development of the Aboriginal and Torres Strait Islander Flexible Aged Care Program;
- further support for flexible respite care services in rural and remote communities; and
- how best to provide training and ongoing support and advice for carers.

The safety and quality of local health and aged care is highly valued, yet there remains a concern that increasing requirements may result in additional pressures on the scarce services available locally, or even in closure of existing services in rural and remote communities. It is critical that regulatory requirements take full account of the potential safety risks for older people, including the care available locally and the risks of not receiving care, and are supportive of aged care services and workers in rural and remote communities as best practice in aged care continues to evolve.

The Alliance recommends that the Australian Government provides targeted support to remote and Indigenous aged care services and their staff to ensure that they meet the best standards for safety and quality of aged care *(Draft Recommendation 9.3)*. This will require building local and organisational capacity to underpin continuous quality improvement as aged care evolves to provide better quality care for all Australians.

Paying for and financing aged care

There is anecdotal evidence and some data suggesting that, in rural and remote areas, there is a greater proportion of community (cf residential) care than in the major cities. Community aged care is therefore a strong focus of the Alliance submission.

Given the higher proportion in rural and remote areas of people with little or no capacity to pay for aged care services, coupled with poorer health outcomes and thus higher care needs, the Alliance submission also focuses on public funding mechanisms to support the delivery of quality aged care services.

The cost of running an aged care facility or community aged care services is higher in rural areas as, for example, goods and services cost more (due in part to the cost of transporting goods), smaller operations do not benefit from economies of size and coordination of care is more challenging.

The Alliance recommends:
- that there be improved reporting by remoteness classification on:
    - the delivery of aged care services, taking account of the full target group including Aboriginal population aged 50-69 years of age as well as the population aged 70 years and over;
    - the relative use of community and residential aged care; and
    - the relationship between the availability of aged care services and health performance measures such as potentially avoidable or prolonged hospitalisations;
- that the Productivity Commission proposal to establish independent and transparent pricing for aged care services should include the development of realistic viability supplements to ensure more equitable access to resources and provide for viable and sustainable services in rural and remote Australia, including:
    - the additional costs of travel and transport and the higher costs of running facilities;
    - recognition of the invaluable contribution both community and residential aged care providers make to coordination with the health system for people in rural and remote communities;
    - recognition of the increasing costs of daily care for clients who are ageing-in-place in the community and in residential care, for example in a Multi-Purpose Service; and
    - recognition of the constraints associated with the low asset base of many older rural and remote Australians;
- that there needs to be 'catch-up investment' by the Commonwealth in aged care places for rural and remote communities to meet national targets in terms of uptake and delivery of services, coupled with targeted infrastructure investment to expand and upgrade the services that aged care facilities offer to rural and remote communities and to improve the safety and quality of care.

Strengthening the rural and remote health workforce

As in many other areas affecting health and wellbeing in rural and remote areas, one of the main limitations on improving ageing and aged care services is the absence of an adequate and well-trained, well-supported workforce.

The Alliance recommends that the Productivity Commission builds on its proposals for special needs groups - including people who live in rural and remote communities - by developing a series of recommendations that will strengthen the aged care workforce in rural and remote communities now and into the future including through:

- continuing development of the aged care workforce through a special remote area program which encourages and supports people and organisations in training and career enhancement for local people in the aged care sector and; and
- parity in remuneration across aged and acute care settings, coupled with measures to support comparable living conditions, employment opportunities and career pathways as available in Major Cities in order to stimulate the desire to work in the rural and remote aged care sector.

Effective aged care services sustain the local community through jobs and business as well as through the care of older people. Better support for these services, including encouraging their utilisation, assists in maintaining the fabric of a community through the retention of a greater number of older people for a longer time and in better health.

**Improving the prospects for healthy ageing and aged care
in rural and remote Australia**

Submission in response to the Productivity Commission Draft Report
Caring for Older Australians

Introduction

The National Rural Health Alliance's vision is good health and wellbeing in rural and remote Australia. Fundamental to its work is the belief that all Australians, wherever they live, should have access to comprehensive, high quality, accessible and appropriate health services, and the opportunity for equivalent health outcomes. This belief encompasses the entitlement to healthy ageing and aged care.

People in rural and remote communities, as in other parts of Australia, generally want to remain independent and in control of how and where they live for as long as possible. They want to continue to be connected to their families, friends and communities and to be able to exercise some measure of choice if they require care – including the choice to age in their own communities.

The Productivity Commission's draft Report, *Caring for Older Australians,* [1] describes a shared vision for the aged care system from the submissions received:

> *a system that is focused on "enhancing the wellbeing of older Australians – promoting independence, connectedness and choice"*

The Alliance adds: *"wherever they live"*.

Further, the Alliance believes that healthy ageing initiatives and viable aged care services contribute to the sustainability of the diverse communities of rural and remote Australia as healthy and health promoting places in which to live, work and age. The importance of the proposed aged care reforms to the socioeconomic determinants of health for rural and remote Australians of all ages should not be under-estimated.

Productivity Commission Draft Report *Caring for Older Australians*

The Productivity Commission draft report identifies essential elements of structural reform for the aged care system. It proposes ways to achieve improved navigation of the system; more consistent quality and greater choice of care; pricing, subsidies and user co-contributions that deliver greater consistency within and between care settings and viability of services; and strengthening of the workforce through competitive wages and de-regulation.

Many of the rural and remote issues raised in the Alliance's earlier submission to the Productivity Commission inquiry[2] are recognised in Chapter 9 of the draft Report, 'Catering for diversity – caring for special needs groups', along with draft recommendations in response to some of them.

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[1] Productivity Commission, 2011. Caring for older Australians – Draft Report. http://www.pc.gov.au/projects/inquiry/aged-care/draft.
[2] National Rural Health Alliance, 2010. Ageing in rural and remote communities. Submission to the Productivity Commission Inquiry: Caring for Older Australians. http://nrha.ruralhealth.org.au/cms/uploads/publications/nrha-submission-aged-care-pc-inquiry.pdf

Improving health and ageing outcomes for rural people through national reforms

Effective reform of the aged care system is more likely if it is aligned with the national health care reforms agreed through the Council of Australian Governments (COAG).[3]

Rural and remote Australians overall have shorter life expectancy, higher death rates and higher rates of certain chronic conditions than city dwellers, and are more likely to have a disability. This is the case even when taking into account the effects of the known poorer health of Indigenous Australians, who make up a greater proportion of the population in remote areas.[4]

The aged care system must play its part in overcoming this disparity. In particular the Alliance believes that aged care and health reform must combine to achieve the priority COAG outcome for social inclusion and Indigenous health:

> *"Indigenous Australians and those living in rural and remote areas or on low incomes should achieve health outcomes comparable to the broader population."*

There are many similarities between the agreed directions for health reform and the policy objectives spelled out by the Productivity Commission for aged care reform, as outlined below.

The Productivity Commission framework for assessing aged care

To guide future policy change, the aged care system should aim to:
- *promote independence and wellness of older Australians and their continuing contribution to society*
- *ensure that all older Australians needing care and support have access to person-centred services that can change as their needs change*
- *be consumer-directed allowing older Australians to have choice and control over their own lives*
- *treat older Australians with dignity and respect*
- *be easy to navigate – Australians need to know what care and support is available and how to access those services*
- *assist informal carers to perform their caring role*
- *be affordable for those requiring care and for society generally*
- *provide incentives to ensure the efficient use of resources devoted to caring for older Australians and broadly equitable contributions between generations.*

A focus on independence and wellness

The proposed directions for policy change in aged care add strength to the health reform directions agreed by COAG – to encourage and enable independence and wellness for all Australians – by making it plain that this includes encouraging the continuing contributions of older Australians to society. The Alliance welcomes the emphasis on treating older Australians with dignity and respect - a core value for many groups within our country and one that deserves recognition by all policy makers and governments.

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[3] Council of Australian Governments (COAG) National Healthcare Agreement 2009, National Health and Hospitals Network Agreement 2010, and Heads of Agreement for Health Reform, 13 February 2011. http://www.coag.gov.au/
[4] Australian Institute of Health and Welfare (AIHW), 2008. Rural, regional and remote health: indicators of health status and determinants of health.
http://www.aihw.gov.au/publication-detail/?id=6442468076&libID=6442468074

Equitable access to health and ageing services

Both the health reform directions agreed by COAG and the proposed directions for policy change in aged care include a focus on equitable access to appropriate services for all Australians. This is particularly important in rural and remote areas, where access to health and ageing services is known to be relatively poor. The Alliance has estimated that aged care expenditures outside Major Cities fall short by close to $500 million per annum (2007-08 figures) compared with Major City rates. Together with the shortfall in primary care and related services, estimated at $2.4-2.7 billion, in 2006-07, the shortfall of aged care also affects hospital usage by rural people.[5] The end result is that people who live in rural and remote communities do not enjoy the "universal access" to health and ageing services which is one of the underpinning principles for the Australian health care system.

Shaped around needs

Both the health and aged care reforms are to be shaped around the health and ageing needs of individual patients, their families and communities. The Alliance welcomes the strong focus in the proposed aged care reforms on support for carers. The uneven distribution of both the ageing population and the carer population outside Major Cities, and the differing aged care and carer support needs for rural and remote people, are discussed later in this submission.

Setting the target: comparable health and ageing outcomes for all Australians

By complementing health reform commitments to social inclusion and Indigenous health, the aged care system can claim its rightful place in health system reforms already underway. These reforms will result in greater regional responsibility and accountability for health service planning, integration and workforce development across primary, acute and aged care settings through the establishment of Medicare Locals and Local Hospital Networks. Given their overall health status and poor access to specialised care, it is the people of rural and remote communities who stand to gain most from the more effective coordination of health and aged care.

Recommendation 1:
The Alliance recommends that the Productivity Commission frames an overarching policy direction with indicative targets, progress measures and outputs for the aged care contribution towards a combined health and aged care outcome for social inclusion and Indigenous health:
*"Indigenous Australians and those living in rural and remote areas or on low incomes should achieve health - **and ageing** - outcomes comparable to the broader population."*

Considering the structural reforms proposed by the Productivity Commission

In this submission the Productivity Commission's recommendations are considered under the following four headings:

1. improved system navigation;
2. quality and choice of care;
3. paying for care (including pricing, subsidies and co-contributions); and
4. strengthening the workforce.

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[5] National Rural Health Alliance, 2011. An overview of the shortage of primary care services in rural and remote areas. http://nrha.ruralhealth.org.au/cms/uploads/publications/nrha-final-summary-complementary-report.pdf

In its draft recommendations, the Productivity Commission has indicated where it sees potential risks of adverse impacts in rural and remote communities and how they might be overcome. For example, the risk associated with the lack of market forces may be minimised through block funding the required services to ensure access to them.

The final recommendations for reform in aged and community care must result in policy and practice that works well in rural and remote areas.

1. Improving system navigation

Australian Seniors Gateway Agency proposal
The Productivity Commission has proposed a simplified 'gateway' for easy-to-understand information, and for assessments of care needs, financial capacity to make co-contributions, and entitlements to approved services and care coordination - all at a regional level.

At present, information about aged care services is hard to find, there are multiple entry points and Aged Care Assessments can seem more like a hurdle to shy away from due to the risk of loss of independence, rather than a helping hand to care entitlements, at least until a crisis occurs. For people in rural and remote communities, the path to aged care can seem even more confronting as it may well carry with it the fear of having to move permanently away from place, home and friends for necessary care, or may stem from hospitalisation far from home and local support.

In formulating *Draft Recommendation 9.1* the Productivity Commission has considered people living in rural and remote communities and other special needs groups, many of whom are 'over represented' in rural and remote communities:

"The proposed Australian Seniors Gateway Agency should cater for diversity by: ensuring all older people have access to information and assessment services; providing interpreter services to convey information to older people and their carers, to enable them to make informed choices; and ensuring that diagnostic tools are culturally appropriate for the assessment of care needs."

However, for rural and remote communities, the relationship between the Gateway in the regional centre and the people at the local level (including those needing care, their friends and families, health and aged care providers and various support networks) warrants more detailed consideration.

No matter how supportive the proposed regional Gateway becomes, rural people will continue to benefit from local community access points and contacts.

Healthy ageing in the community
The regional Gateway needs to be easy to interact with and stand ready to offer timely services and support, in order to promote independence, connectedness and choice.

Some rural communities have developed healthy ageing centres to provide information, activities and services for older people in response to local needs (see box). The benefits of such services may go well beyond what the regional Gateway would be able to offer locally. These include a local face, a contact point for local information, a safe meeting place with important social benefits, opportunities for volunteer participation, links with local health and aged care providers through programs and activities and informal support for carers.

> **_Case Study – drop in centre_**
> A drop in centre with a shop front in Charleville, a town of about 5,000 people, provides a well-known and used local meeting place and source of information for older people. Activities at the centre are promoted through local radio and newspaper. There is an enthusiastic local coordinator and a team of volunteers, so there is always someone about during business hours. They include local presenters such as the police talking about safety in the home, a dietitian demonstrating low-fat cooking, a physiotherapist running sessions in Tai Chi or water exercise or falls prevention. Local people can work in the vegetable garden, play cards or pool, or participate in regular morning walks with the added safety and incentive provided by the group. Information about local healthy ageing strategies and aged care services is available through the centre.
> _RHealth, Southern Queensland_

Such local community based services may rely on funding patched together from diverse sources at present, but they would provide valuable links to the regional Gateway in the future, as well as providing a local focus for healthy ageing in rural and remote communities. These sorts of services may be run by a wide variety of providers and local interest groups, including divisions of general practice, state or local government community programs, support groups for dementia, diabetes or heart conditions and so on, service clubs, aged care providers, carer groups and many more. It is important that the proposal to establish a regional Gateway lends strength to the case for such community resources, rather than undermining them or putting their funding at risk.

Gateway between aged care services and health
Many older people are frequent users of the health system and will have expectations that their doctor, community or remote area nurse or clinic – if there is one locally – will be able to direct them to sources of aged care and carer support. The suggestion for involving local health professionals in supporting their patients through online completion of needs assessment forms could become an important initial link with the regional Gateway. Assistance with system navigation needs to be available at many stages in the patient journey as health needs fluctuate and personal circumstances change.

In rural and remote communities an ongoing two-way relationship through primary to aged care should be more easily achieved as the same health professionals are likely to be serving both systems.

When it comes to long term choices about future care needs, people may be safe to wait a day or two until a local centre is open, or for a return phone call – especially if it's a local person they can rely on or a one-stop shop they trust. It is a different matter for a hospital patient, maybe in a city far from home, with family members struggling to find information from hospital staff who may not be best equipped to provide it and know little of the patient's home circumstances. The patient, their families and friends can end up feeling like pawns within the system.

Information needs and system navigation become urgent in times of a health crisis or emergency and the regional Gateway will operate best through supportive links between acute care wherever it is and the patient's local primary health and aged care services and professionals.

Case study – the system must work
My mother had a major stroke in 2003. She spent several weeks in hospital, several more receiving totally inadequate rehabilitation, and was then assessed as needing high level care.

What I learnt from my mother's experience of the system was how critically important it is that it works. By virtue of my role, I was privileged to have hands on day-to-day knowledge of the system, to be able to rely on the professional expertise and advice of my colleagues and their simultaneous support. Beyond that, I speak English, I have an income, I was able to travel, I can fill in forms, I was supported by my siblings and yet we struggled.

What my whole experience taught me is how extremely difficult it is. The system, the experience and the staying on top of all those issues occurs at a time of intense pressure and stress. And if it was difficult for me, with all of my advantages, how completely impossible is it for those who are without resources, without language, without support, without guidance.

Health professional and carer

Gateway to innovation, more specialised health care services and broad support for rural people
In rural and remote communities where both health and aged care services are short, gaps can open up between aged care services and health care for residents in aged care facilities, or for clients receiving community aged care packages or the like.

The client or their service providers may need assistance through the regional Gateway or local coordinators to obtain suitable transport or to arrange travel and appointments so that effective health care continues. Also, as their care needs increase, older people may need additional assistance with arrangements for allied health care such as podiatry, optometry, rehabilitation, falls prevention, incontinence management, or assessment for home aids and appliances, where the full range of these services is unlikely to be available locally. Further, needs for allied health and medical care for patients in residential care continue, yet allied health services are in short supply in rural and remote communities and may be funded through programs that do not cater for provision of services in residential aged care. Dental health and oral hygiene are particular issues for older people in rural and remote communities.

Regional Gateways serving rural and remote communities may have a particular role, in conjunction with Medicare Locals, in supporting residential aged care services, residents and their carers to access the health care they need locally, for example through establishing appropriate transport arrangements or telehealth facilities, or negotiating for visiting medical specialists, allied health professionals and dental workers to run regular clinics. For rural and remote communities, this role will need to go far beyond the Productivity Commission Draft Recommendation 8.5*: "The Australian, state and territory governments should, subject to further evaluation, promote the expanded use of in-reach services to residential aged care facilities and the development of regionally or locally based visiting multi-disciplinary health care teams"*.

While the proposed Gateway Agency centralises responsibility and should minimise older people falling through the cracks, the coordination role taken on locally by both health and aged care providers in rural and remote communities should not be underestimated or under-valued. All should be working together towards best practice care for older people using innovative service models to complement the range of services available locally.

For example, doctors have a role in referring their patients to oncologists and gerontologists, but where there is not a GP locally or where a trip to a distant specialist is not feasible, options such as

the new Medicare items for telehealth, community nursing support through video monitoring at home, and outreach clinics need to be explored. Similar approaches that extend to more specialised allied health support for older people and for oral health should also apply. Investment in and establishment of these options is more realistically tackled as a regional issue than case by case. The Gateway, in collaboration with Medicare Locals and aged care providers, has a potential role to play in establishing the locus for such innovation. For example, an aged care facility could host a telehealth treatment room or outreach clinic for residents and local community members. Aged care service providers may become instrumental in providing video monitoring services, for example, to provide regular nursing support for outlying patients with early dementia or a chronic condition.

The Gateway will also need to extend to links with much broader services than ageing alone. This will include work with local government authorities to plan and build local environments that are safe and appropriate for older people. For example, safe housing, and the standards or home modifications to achieve it, are particular concerns in rural and remote communities. Long waiting times for occupational therapy assessment, followed by long delays in obtaining aids and appliances, with shortages in tradesmen resulting in further delays in installations of hand rails in the bathroom can all add up to an unsafe environment for too long. Formal communication channels between the regional level Gateways and the relevant Medicare Locals and Local Hospital Networks will be critical in rural and remote communities.

Gateway to carer support
The Alliance welcomes the acknowledgment by the Productivity Commission of the valuable contribution informal carers make to caring for older people in our community, which is signalled by the following recommendation:

"The proposed Seniors Gateway Agency, when assessing the care needs of older people, should also assess the capacity of informal carers to provide ongoing support. Where appropriate this may lead to approving entitlements to services and/or assisted referral for: carer education and training; planned and emergency respite; carer counselling; peer group support; and advocacy services. Carer support services should be developed from the existing National Carelink and Respite Centres to provide a broad range of carer support services."

However informal care must not be exploited to place an unfair expectation on carers by the aged care system. The "assessment" of the capacity of informal carers will need to be handled in a supportive way so as not to intimidate carers, undermine their extraordinary contributions to care, increase their anxieties, or create unrealistic expectations about managing the burden of care they feel they must shoulder.

According to the 2006 Census, unpaid carers make up 11.2 percent of the population across Australia. Regional differences are not large, but there are carer 'hot spots' in a number of Remote and Very Remote areas in NT, WA and SA associated with a high proportion of the caring population in certain statistical local areas being Indigenous. In Very Remote areas a greater proportion of carers are aged 24 years or less and there are far fewer carers aged 65 years or more than in other regions.[6]

Wherever they live, carers are slightly more likely to self-report fair or poor health than people without caring responsibilities, rather than good, very good or excellent health. The gap is greatest for people living in Outer Regional and Remote areas of Australia where 22.1 per cent of carers

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[6] http://nrha.ruralhealth.org.au/cms/uploads/factsheets/fact-sheet-22-carers.pdf

report fair or poor health compared with 17.8 per cent of non-carers in the same regions and 18.0 per cent of carers in Major Cities.

Carers living in Outer Regional and Remote areas experience higher rates of disability or a long term health condition (20%) compared with non-carers in the same regions (12.3%) and carers in Major Cities (14.3%). Carers, particularly in non-Metropolitan areas, report having strong social networks for information and advice and in Outer Regional and Remote areas are more likely to personally know someone they could ask for information and advice (84.2% and 72.6% respectively) than carers and non-carers in Major Cities (77.7% and 68.8% respectively).[7]

The Productivity Commission has recognised the contribution informal carers make to aged care and recommended consideration of the capacity of carers and strengthening of their training and support when assessing aged care needs. For any of the approaches taken, including extension of respite care, there needs to be a greater focus on how this is best achieved in rural and remote areas, where the distribution and capacity of carers is quite different and more formal support mechanisms are more difficult to access.

Strengthening local partnerships between health and aged care
To be fully effective in rural communities, the proposed regional Gateway will need to tap into local resources such as established local communication channels, existing services including activities and support groups, and gain the support of local champions for healthy ageing and aged care. Such local approaches can also be important avenues for developing a better awareness of local community and cultural groups and their needs.

Medicare Locals being established for population-based health planning at a regional level will need such links with their communities as well. The opportunity for partnerships between these agencies should not be missed. The partnership must extend to local structures for working with community members to identify strengths and gaps in local information, system navigation and service provision for older people and their families and friends which, especially in rural and remote communities, will be closely linked with health issues.

However, it is wrong to assume that such local partnerships can flourish unsupported. Their access to and provision of information will rely on strong coordination that is underpinned by reciprocal systemic knowledge, literacy, financial resources and infrastructure, that is respectful of the capacity of local service providers and community participants. These requirements must be part of initial and ongoing plans and funding considerations for the Australian Gateway Agency and its regional network as well as the Medicare Locals – but a shared approach will bring opportunities for improved economies of scale and pooling of resources.

Recommendation 2:
The Alliance recommends that aged care interests should be represented on Medicare Locals and Medicare Locals should support the establishment of and work with the Gateway in their region. At a time when Medicare Locals are being established to lead population health planning at a regional level, there will be major new opportunities to coordinate primary, acute and aged care services.

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[7] Ibid.

2. Quality and choice of care

The proposed Australian Seniors Gateway Agency at a regional level should make it easier for older people to find out about and obtain services that are tailored to their needs. They should no longer have to switch between Home and Community Care (HACC), Commonwealth funded community care packages (CACP, EACH, EACH-d), community nursing and other local programs, with all the associated paperwork, eligibility assessments and changes in personnel. The regional Gateway will consolidate eligibility assessments, include assessment of carer capacity as well as client needs, and provide a single entry point to the full range of community care services from the most basic assistance with housework or meals through to complex support for frail people with medical or special needs such as dementia. Additional support with changing care needs should be more timely and straightforward to obtain, including the transition to residential care when care needs can no longer be met at home.

Critical collaborations between local health and aged care in rural and remote communities

The establishment of Medicare Locals and Local Hospital Networks provides an opportunity for more detailed regional population needs analyses and support for older people to maximise their choices for healthy ageing where they live in rural and remote communities.

The Alliance has argued that Medicare Locals in rural and remote communities will need special partnership and capacity building features to develop integrated and coordinated services to provide health care as close to home as possible. This must include effective and efficient coordination of primary care with aged and community care, local acute, rehabilitation and palliative care services through the local hospital or Multi-Purpose Services and continuity of care for patients who need to travel for more specialised treatment within the region or to specialised services in urban centres.

The strengths of health services in rural and remote areas include the living examples they provide of good multidisciplinary care:

- Multi-Purpose Services combine primary, aged and acute care;
- GPs have multiple roles in aged and acute care in local hospitals as well as in primary care;
- rural hospitals include elements of community care, aged care, health promotion such as immunisations and diabetes education, primary care and various allied health services; and
- the mix of health and community professionals available locally may foster and support the development and sustainability of innovative services (eg outreach services; telehealth support for local health professionals and patients).

The existing collaborative arrangements that are working well between organisations such as Divisions of General Practice, Aboriginal Community Controlled Health Services (ACCHOs), fly-in service providers and NGOs, should be built on and formalised as part of aged care reform.

Flexible and relevant models of care

Community and residential aged care must find expression in ways that sustain or create 'homes' rather than 'places of care'. They must be acceptable and relevant to elderly Australians in rural and remote Australia. The interface between the model of care and client need in remote areas is not well understood at the policy level, which undermines the capacity of the service to meet need.

A responsive service means taking the model of service to the community in a way that is responsive to their needs. Enhanced service delivery will be the result of working with the community to identify the 'what' and 'how' of appropriate service delivery.

For example, Meals on Wheels is a "white fellah" approach to how to best provide nutritional support to people within their own home. The standards supporting Home and Community Care reflect this. Yet what is the real outcome for the supply of these meals for an Aboriginal person? Is the type and placement of the food culturally and age relevant? Do the standards embrace the need for cultural relevance and sensitivity?

Care that is relevant

Aboriginal person interviewed: "You can go to Community Health but they aren't really doing that either (supporting us). With the sort of health issues my people have, it's no good to sit back and wait for people to come to you when they are sick, they should be reaching out to people and making themselves more available. They should come out and visit. A visit means I care, sitting in your office means you come and see me if you got a problem, otherwise I'm not really worried about you."

Indigenous People and the Pilbara Mining Boom, a baseline for regional participation. Research Monograph No. 25, Centre for Aboriginal Policy Research, ANU, p. 128.

Encouraging and enabling independence and promoting healthy ageing

At present the provision of care is skewed towards 'the ambulance at the bottom of the cliff' rather than investing in early intervention services that facilitate healthy ageing. This is due in part to current aged care funding models, which pay more for clients with greater disability.

Due to the scarcity of support services in remote areas, people are vulnerable to losing their independence at an earlier stage of disability or frailty than would be the case in the Major Cities. Everything possible needs to be done to rectify this situation.

This must be addressed in the detail of the reform, including through provision of flexible services that have been shown to work well in rural and remote communities and through links with other health reform initiatives:

- outreach services (such as those provided by Frontier Services);
- a network of hubs large enough to outreach to small areas which are developed cognisant of the other reform initiatives in health, such as the Medicare Locals and Local Hospital Networks;
- recruitment, training and support of local people to be care and service providers for older people in their own homes;
- the National Broadband Network as the platform for e-health which facilitates supporting people to stay and be comfortable in their own homes for longer, and will assist with diagnosis and provide opportunities for early intervention and support;
- more closely linking preventive health care and best practice in care for chronic conditions with aged care;
- facilitating home development and modification that maintain independence and linking with plans for healthier, more active communities (for example, *Healthy Spaces and Places*[8])
- creating the reality of health infrastructure in more remote areas; and
- realistically supporting access to public or community transport.

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[8] Australian Local Government Association, National Heart Foundation of Australia and Planning Institute of Australia, 2009. Healthy spaces and places. Funded by the Australian Government Department of Health and Ageing. http://www.healthyplaces.org.au/userfiles/file/HS&P%20An%20overview.pdf

Accessible respite
The use of respite care has increased as a result of greater access to programs. For example, under the HACC program, in 2004-05 respite care, centre based care and home meals provided the highest number of hours per client of all types of HACC assistance.[9] As noted by Karmel and others, the use of respite delays the entry of people into residential aged care. They also report that the use of respite and community care helps people to remain living in their place of choosing for as long as possible.

Respite care is much more than 'carer support'; it is integral to healthy ageing. Respite and transition care, with a pathway back to living in the community, underpin the maintenance of independence for the client as well as their carer(s). But in rural and remote communities, respite care must also be flexibly delivered if it is to be a viable choice. A short term stay of ten days or so in an aged care facility in a regional centre must not be the only solution. Older people and their carers should be encouraged and able to seek a little extra help for themselves in times of need, for example following an illness or when friends are away, which means it needs to be close to hand.

Mobile respite care serving remote communities
Mobile respite services use linkages with the CACP and HACC services and provide respite to remote communities, most particularly to Indigenous Australians and younger people with disabilities. An example is that which operates in the Pilbara where mobile teams deliver respite to carers in settings deemed appropriate by the carer and the service and as a result of referral by other government funded services, including the Carelink Centre. These services are vital but continuing operation requires greater support to ensure the following issues (which affect viability and continuity) are addressed:
Staffing: Relatively high staff turnover, wage competition with the mining industry, difficult work environment, high costs of accessing training.
Knowledge and information: Lack of knowledge of service availability, lack of consumer understanding of respite; of service eligibility and government benefits payable.
Communication: No centralised communication hub at present to assist agencies and clients better understand availability and access to services; difficulties of technology preventing dissemination of and access to information; cross cultural communication, English as a second language.
Service type: Options tend to involve removing Aboriginal and Torres Strait Islander people from traditional country and connections thereby heightening anxiety and lessening confidence in the service.
Facilities: Lack of facilities to support different models of respite; delays in providing facilities and difficulties with ongoing maintenance.

Maintaining quality
The Alliance has a strong focus on improving access to health and aged care in order to address the current inequities and overall poorer health outcomes for people who live in rural and remote communities. The safety and quality of local health and aged care is highly valued, yet there remains a concern that increasing safety and quality requirements may result in additional pressures on the scarce services available locally, or even to closure of existing services.

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[9] Karmel, R. The ins and outs of residential respite care, Bulletin No. 43 AIHW Cat. No. AUS80

The case study continues – what makes quality care?
The care Mum received was adequate. There were some outstanding individuals and plenty of good intent, but staff turnover was absolutely constant. Agency staff filled almost all the RN positions, carers came and went. Mum's needs were met, but only just. The staff were caring and willing, but run off their feet and burdened by the environment in which they sought to operate.

By the time my mother died, she had a file which was 8cm thick. Not that anyone ever had time to read it – I just hope the accreditors did! Notes were written while bells rang unanswered. Documented and documented it did not assist her care, because no-one had time to read those files!

The most distressing issues for my mother and for us were around access to lifting machines (particularly the one which did not hurt her shoulders); the long waits for assistance in visiting the toilet (and the hard fought argument that continence products would overcome the need to "go"); two or three days waiting for the doctor to diagnose a perfectly apparent UTI and our inability to do very much to ease the distress which was constant and often extreme.

A proud woman reduced to tears, frustration and pain. The need to be dependent on others for practically everything, unable to decide the slightest thing, and needing to be grateful for anything done is the biggest adjustment it is possible to imagine needing to make. And the system does not help us do that … it takes the power out of our hands and reduces our capacity to function well in a stressful situation.

I was, moment by moment, for four years, confronted by my own inability to cope well with the issues, the system and with my own frustration at what could not be changed. I learnt that the system has to work to meet the needs. And it can - even in remote areas. I think we have our opportunity. We should seize it with both hands.

Health professional and carer

Accordingly, it is critical that regulatory requirements to underpin quality of aged care take full account of the potential safety risks for older people, not only of the care that is available to them locally, but also the risks of not receiving such care. These include the risks associated with travelling large distances over poor roads or in difficult conditions to receive care, travelling when injured or in ill health, receiving care a long way from home without the support of family and friends – or not receiving care because it is too distant to be reachable, not affordable or too far from family and friends.

It is also critical that aged care safety and quality requirements take into account the nature of aged care services and the composition of the aged care workforce in rural and remote communities. Safety requirements must be designed to be supportive and achievable for health and aged care professionals in the rural and remote environments in which they work. Compliance and safety documentation must be practical and reasonable, supporting, not impinging on the capacity to provide good quality care at home or as close to home as possible for older Australians in rural and remote communities.

The Alliance commends the Productivity Commission's *DRAFT Recommendation 9.3* which draws some attention to these challenges:

"The Australian Government should ensure that remote and Indigenous aged care services be actively supported before remedial intervention is required. This support would include but not be limited to:

- *the construction, replacement and maintenance of appropriate building stock;*
- *meeting quality standards for service delivery; clinical and managerial staff development including locally delivered programs and enhanced use of technology assisted training; and*
- *funding models that are aimed at ensuring service sustainability and that recognise the need for the building of local capacity to staff and manage such services over time."*

As well as building on the capacity for rural and remote aged care providers to achieve current standards for accommodation and care, the aged care reforms must embrace continuous quality improvement over time as best practice in aged care continues to evolve. For example, the shared room and bathroom proposed as the basic standard in the current draft report is below current accommodation expectations generally. Such standards for public aged care, which is prevalent in rural Australia, must look to delivery of public aged care that measures up across Australia into the future while valuing what is available at present.

Recommendation 3

The Alliance recommends that flexible aged care service arrangements continue to be supported and developed further to ensure that older people in rural and remote communities have the choice to stay in their own communities for as long as possible, including:
- strengthening the Multi-Purpose Service (MPS) program, with the roll-out of extra aged care beds in existing MPSs and further expanding the number of MPSs to cover catchments of up to 12,000, as recommended by the National Health and Hospitals Reform Commission;
- further development of the Aboriginal and Torres Strait Islander Flexible Aged Care Program;
- further support for flexible respite care services in rural and remote communities; and
- how best to provide training and ongoing support and advice for carers.

Recommendation 4

- The Alliance recommends that the Australian Government provides targeted support to remote and Indigenous aged care services and their staff to ensure that they meet the best standards for safety and quality of aged care *(Draft Recommendation 9.3)*. This will require building local and organisational capacity to underpin continuous quality improvement as aged care evolves to provide better quality care for all Australians.

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3. Paying for and financing aged care

The choice and availability of care in rural and remote communities are limited by the high cost of maintaining viable services, generally higher health needs, poorer access to health services and lower socio-economic status - all of which contribute to higher per capita need for aged care support, on top of the needs of larger proportions of Aboriginal people and other special needs groups.

The Productivity Commission has proposed two key strategies to better target investment in aged care:

- fair pricing through the establishment of a new regulatory agency, one function of which would be: "*monitoring and assessing costs and transparently recommending a scheduled set of prices, subsidies and a rate of indexation for subsidised aged care services";* and
- removal over time of current restrictions to supply of services which are thought to result in a mismatch between what the aged care system currently offers and what older people want and need, including quotas on bed licences and aged care packages and the current distinctions between low and high care places and packages.

Quality is to be maintained through accreditation and costs are to be contained through introducing 'user pay' elements with various protections for people who do not have the capacity to pay.

In formulating its recommendations the Productivity Commission has recognised these challenges and flagged that block funding may continue to be appropriate in rural and remote areas where markets might not support the provision of a service (and where block funding might be cheaper than direct government provision), such as multi-purpose services and Indigenous specific services. The Productivity Commission's Draft Recommendation 8.4 is that *"The Australian, state and territory governments should only continue to directly block fund programs where there is a demonstrated need to do so, based on a detailed consideration of scale economies, generic service need and community involvement."*

The key point for rural and remote communities is that most aged care will need to be publicly subsidised or funded to provide adequate quality, appropriateness and choice for a group of people who have limited capacity to pay for their own care – thus the needs for and costs of aged care in rural and remote communities must be well understood.

Understanding the ageing population and patterns of care in rural and remote communities
The ageing population is not distributed evenly outside Major Cities. Fourteen percent of the population in regional centres are over 65, compared with 12 per cent in Major Cities and 7 per cent in remote areas.[10]

Aged and community care services are complementary to health services and, in many cases in rural areas, an integral part of the health care system, for example through the 130+ (and growing) number of Multi-Purpose Services. An AIHW report on aged care (2008-09) shows that country regions other than Very Remote have at least a 2 per cent shortfall in the provision of aged care, compared to Major Cities.[11] It also notes that, if adjusted for Aboriginal aged care needs for people age 50 -69, the provision of aged care services falls short nationally by an additional 2.9 per cent. Given that 70 per cent of Aboriginal people reside in rural and remote Australia, it can be concluded that most of this additional shortfall would also be in rural areas.

With government aged care outlays of $10 billion in 2008-2009, the Alliance considers that aged care provision could be short by close to $500 million, even before considering the likely higher costs of providing aged care services in rural and remote areas.[12] Equitable provision of aged care services is crucial now, and will become increasingly so as the population ages and as the share of

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[10] : AIHW, 2007. Rural, Regional and Remote Health: a study on mortality (2nd Edition) Dec, 2007 http://www.aihw.gov.au/publication-detail/?id=6442468054

[11] AIHW, 2010 Residential Aged Care in Australia 2008-09: A statistical overview. Aged care statistics series no. 31. Cat. No. AGE 62. Canberra AIHW

[12] NRHA, 2011. An overview of the shortage of primary care services in rural and remote areas. http://nrha.ruralhealth.org.au/cms/uploads/publications/nrha-final-summary-complementary-report.pdf

older people in regional areas (especially Inner Regional) increases. Information on the adequacy of aged care services is therefore vital to assess the adequacy of the health care system in rural areas.

Aged care service usage also varies by region. Anecdotal reports suggest that higher proportions of aged care services are community-based in remote and outer regional areas than in the city. The AIHW report on actual delivery of aged care nationally for 2008-09 shows higher numbers of community aged care packages (61.4 per 1000) in the Northern Territory and lower numbers of residential aged care places (47.7 per 1000) than national targets (25 per 1,000 and 88.8 per 1000 respectively, for the population over 70 and Aboriginal and Torres Strait Islander people aged 50-69). Thus the proportion of community aged care packages delivered in this predominantly remote area setting is well over 50% compared with the national target of 22%. Overall delivery of services at 109.1 per 1000 is closer to but under the national target of 113 per 1000.[13]

The strong focus on community aged care in the Alliance submission reflects its relative importance in rural and remote communities, without detracting from the importance of improved access to publicly-subsidised residential aged care places as close to home as possible. For example, if the figures above reflect a choice to stay at home rather than the need to relocate to access residential services or early mortality, a considerable investment in improving home safety and care for people as they age in rural communities is justified in terms of aged care as well as health. Yet usage of community aged care packages is relatively short term nationally, although the variation can be quite large. The Productivity Commission reports that the median length of stay on a community care package for anyone who received community care between July 1997 and December 2009 was just under 12 months for males and 14 months for females, based on data from the DoHA Aged Care Data Warehouse. It is troubling that differences in usage patterns and movements between community and residential aged care services by remoteness are largely unexplored.[14]

Higher costs of rural and remote aged care, including residential and community care
Entities providing residential and community care in rural and remote settings have unique operational costs. These must be better understood and accommodated in the development of funding formulae, so that they reflect the real costs of service delivery.

The viability of aged care services for people in rural and remote communities - and thereby their choice and access - is affected by the higher cost of goods and services, due both to their freight component and the relatively small volumes. 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, discussed in more detail in the following section, 'Strengthening workforce'.

Home and Community Care (HACC) service providers travel vast distances not only to deliver services but also to coordinate services with other providers. Patients and clients too bear higher costs for their health and aged care in rural and remote communities – or may become less prepared to travel to receive care as they get older. This adds a level of complexity that results in higher transport costs and greater staff time compared to their equivalent service providers in Major Cities which must be reflected in reform.

Older people's accommodation may require considerable modifications or alternative arrangements for a safe environment that supports them to remain independent. Acknowledgement that this is an

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[13] AIHW, 2010 Residential Aged Care in Australia 2008-09: A statistical overview. Aged care statistics series no. 31. Cat. No. AGE 62. Canberra AIHW
[14] AIHW, 2011 Pathways in Aged Care: program use after assessment.

underfunded area of support warrants further analysis in the remote setting, both in terms of the quantity and type of resourcing. For those eligible and seeking home modifications there is little opportunity to have that completed in the short term due to the lack of tradespeople and distances to be covered. Organising tradespeople and supervising the work is also exacerbated by remoteness, yet ensuring this occurs is fundamental to maintaining independence and reducing the need for (higher cost) residential care.

Hypothetical clients identified in the planning process may not have the same characteristics or needs as those in the real world. For example, the client in the care of a HACC provider at a particular location may be an Aboriginal woman for whom one of the constraints is that whatever care is provided must be provided to all of her peer group – with the result that much more care needs to be provided than is 'on the books'. In assessing need for care, allowance has to be made for making a service culturally appropriate.

While the Alliance welcomes the start the Productivity Commission has made in recognising some of the additional cost of providing services in rural and remote communities, more detailed work is required, leading to more generous allowance for conditions on the ground.

Capacity to Pay

The family home is pinpointed by the Productivity Commission as an asset that can be better utilised to support the cost of care. In rural and remote Australia the value of the assets owned by older people is often lower (and may well be very much lower) than for those in metropolitan areas.

The characteristics of home and business values in remote Australia means that the capacity of older people in remote Australia to contribute to the cost of their care will be lower than that of their urban counterparts. Rural and remote areas have a high rate of concession card holders overall. The majority of the Aboriginal and Torres Strait Islander population are not home owners and therefore have little or no asset to contribute towards the cost of their care. For farmers and other small businesses, the family home may be a part of the business where family members other than a spouse continue to live. Multicultural issues relating to assets and the care and needs of older people will also be particularly relevant for consideration in rural and remote communities.

Disadvantaged clients rely on a major aged and community service provider in remote Australia
Of the states and territories, the Northern Territory has the largest proportion (45%) of its population living in Remote and Very Remote areas, with four-fifths (79%) of its Indigenous population living in these areas (ABS, 2006[1]). For the financial year 2002-03, the median individual annual wage and salary income for wage and salary earners in Very Remote areas was $31,243 compared with $33,982 in Major Cities (ABS, 2006[2]).

This is reflected in the profile of the residents of this provider. The level of disadvantage is acute and impacts on capacity to draw income. It highlights the importance of government support for both capital and operational costs. Translated into the current aged care context, the organisation has only 22 bonded residents producing a total amount $3.2m, and an average bond is $149,000.

References:
Australian Bureau of Statistics, 2006[1]. 4713.0 - Population Characteristics, Aboriginal and Torres Strait Islander Australians, 2006 (updated 2010). Where Indigenous people live.
http://www.abs.gov.au/AUSSTATS/abs@.nsf/0/1B40E5C07AF557C9CA257718002A70EC?opendocument
Australian Bureau of Statistics, 2006[2]. 6261.0.55.001 - Characteristics of Wage and Salary Earners in Regions of Australia, 2002-03.
http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/A8775332423EC0C6CA256E4D0074347D?ope

While the Alliance supports the proposed removal of the current distinctions between low and high care so that the same payment arrangements apply to each, this measure will not provide rural and remote service providers with the same level of opportunity to raise capital through 'user pay' arrangements as the cities.

Rural and remote aged care services have much less potential for raising capital through low care accommodation bonds at present, so struggle to pay for new technologies, to extend the services they provide and to keep up with increasing standards of safety and quality. For example, building or upgrading treatment and training rooms in rural and remote aged care facilities that would enable them to accommodate allied health and medical specialist outreach visits, telehealth support or student placements, may be beyond reach as day to day care needs must be prioritised. Rural services struggle to keep up with their urban counterparts in such things as the purchase and installation of new management technology infrastructure and the associated costs of staff training and technical support.

The Productivity Commission has recommended that a certain number of publicly funded aged care places will be guaranteed within a region, with flexibility for transfer between providers according to need and service profile. The Alliance notes that rural and remote providers may need to offer and be able to run with almost all public places across an entire region – which means that viability supplements are likely to be needed for both residential and community care.

Recommendation 5
The Alliance recommends that there be improved reporting by remoteness classification on:
- the delivery of aged care services, taking account of the full target group including Aboriginal population aged 50-69 years of age as well as the population aged 70 years and over;
- the relative use of community and residential aged care; and
- the relationship between the availability of aged care services and health performance measures such as potentially avoidable or prolonged hospitalisations;

Recommendation 6
The Alliance recommends that the Productivity Commission proposal to establish independent and transparent pricing for aged care services should include development of realistic viability supplements to ensure more equitable access to resources and provide for viable and sustainable services in rural and remote Australia, including:
- the additional costs of travel and transport and the higher costs of running facilities;
- recognition of the invaluable contribution both community and residential aged care providers make to coordination with the health system for people in rural and remote communities;
- recognition of the increasing costs of daily care for clients who are ageing-in-place in the community and in residential care, for example in a Multi-Purpose Service; and
- recognition of the constraints associated with the low asset base of many older rural and remote Australians.

Recommendation 7
The Alliance recommends that there needs to be 'catch-up investment' by the Commonwealth in aged care places for rural and remote communities to meet national targets in terms of uptake and delivery of services, coupled with targeted infrastructure investment to expand and upgrade the services that aged care facilities offer to rural and remote communities and to improve the safety and quality of care.

4. Strengthening the rural and remote aged care workforce

Whilst there are recommendations that address the issues associated with workforce development and support in the Productivity Commission's draft report, there is much detail to be determined before enhanced workforce outcomes are realised in the rural and remote setting.

Staffing characteristics
There is an ongoing demographic shift in the population of remote Australia. The Productivity Commission draft report has identified that older people are making up a much greater share of the local population, which raises concerns about the provision of not just informal care, but also the sustainability of the workforce in general and the health and aged care workforce more specifically.

Some smaller places that were originally established as mining and pastoral industry service towns may be populated primarily by people on government benefits as such industry moves on, partly because of the relative affordability of houses.[15] In such places there are likely to be very few skilled workers and a sharply reduced individual capacity to pay for aged and health care.

Whilst services operating in these areas support local and Indigenous training and employment, it comes largely at a non-subsidised cost to the organisation, both in terms of operational costs and workforce support. The onus is on the organisation to provide the means through which staff can be up-skilled to ensure quality of care. There has been limited assistance to meet the high costs of recruiting and training staff, to cover the necessary use of agency staff as well as to engage more staff and service support to enhance preventative health initiatives.

Further, potential employees are excluded from employment in areas of high demand because there is no right of appeal when excluded from employment for an offence that does not impact on their ability to provide competent levels of care for local, older people. For example, a juvenile record of conviction or a jail term years ago should not automatically exclude employment today.

Staff retention issues combined with the issue of with low wages, shift work, the demands of kinship and family structures, difficulties accessing training and backfilling positions when staff are offsite to attend training, compounds the operational management challenges and operational costs. Current staffing profiles which of necessity focus on day to day care make it a challenge to keep abreast of all policy and program changes and develop upgraded skills to ensure compliance. For example, the introduction of the new Aged Care Funding Instrument assumed that service providers would readily absorb the changes and transition to the new care instrument. In remote areas this assumption is fraught with risk because of staffing profiles, retention and recruitment issues and access to training.

Viability is also further compromised because the current indexation of care funding has not kept pace with the real costs of service delivery including wage increases. Care subsidies have only had the benefit of minimum wage adjustments. It should be noted that minimum wage adjustments (Commonwealth Own Purpose Outlays - COPO) indexation was supplemented for five years by the Conditional Adjustment Payment (1.75% annual increment) but indexation reverted to COPO after the 2010 Budget.

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[15] Op. Cit. page 7

In terms of attracting staff the aged care industry does not have wage parity with the acute care sector and this means reduced attractiveness for staff. For example, wages paid to Registered Nurses in Darwin Hospital are 11% higher than for aged care in the same city.

Other additional staffing costs not factored into the current viability funding are those related to the need to use agency staff. In remote locations agency staff cannot be called on to fill a position day by day or week by week. They provide staffing over usually a four week period and need to have covered, in addition to wages, travel costs and accommodation over that period. Short term accommodation is expensive and often very difficult to obtain particularly in regions where services compete for accommodation with the mining companies.

There is no government funding to meet these costs.   They are not covered in viability or indexation funding. In addition it must be noted that Darwin rents are high and exacerbate the housing situation for a low paid workforce. This often diminishes the attractiveness of working in the Top End.

Training Commitment
The Productivity Commission's draft report refers to workforce training in Recommendation 11.3 yet makes no reference to workforce cost and the lack of capacity to support the necessary backfill that has become an enduring part of staffing these areas. There is also no reference to the need for funding ongoing staff training that reflects the true costs to providers and underpins current government strategies for career development in aged care through training in place.

Local training and empowerment of local people must be better facilitated across aged and community aged care – and the role of aged care service providers in rural and remote communities in making this commitment to their staff and their clients must be recognised and funded. While a rural focus is included in some elements of recent scholarship and training programs to develop the aged care nursing workforce[16], much more needs to be done.

Despite issues with viability and access to training funds, aged care services operate with a very strong commitment to providing career access and pathways to those in remote Australia. For example in 2009 one of the Alliance members graduated 12 Registered Nurses as a result of a partnership between Batchelor Institute and Frontier Services in which the Tennant Creek Hospital, Bachelor Institute and Pulkapulkka Kari provided the opportunity for local people to undertake their Registered Nursing Training.

With a growing proportion of older people in rural and remote communities, including the likely increase in frailty and care needs, there will be increasing expectations of the aged care workforce. For example, recommendations such as the Australian Nursing Federation proposal for licensing Aids in Nursing based on their overall standard of educational qualifications, knowledge, skills, experience, competence, diligence, judgement, character, honesty and integrity required to satisfactorily discharge their duties and responsibilities in performing aspects of nursing care in health and aged care settings, are likely to become community expectation for the quality of care of our most frail community members in the future, wherever they live.

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[16] For example, Aged Care Workforce Vocational Education and Training (ACWVET) 2011 Australian Government Department of Health and Ageing, 2011.
http://www.health.gov.au/internet/main/publishing.nsf/Content/432FF4B67BDFC915CA2577ED00114DA9/$File/Funding%20now%20available%20for%20regional%20and%20remote%20Aged%20Care%20Workforce%20training.pdf

Rural and remote communities will be highly disadvantaged in maintaining and developing their local aged care workforce without special considerations to support aged care service providers and their staff in their training commitments over time. The workforce component of the Productivity Commission's Draft Recommendation 9.3 is worthy but not sufficient: *"That the Australian Government should ensure that remote and Indigenous aged care services be actively supported before remedial intervention is required. This support would include but not be limited to:... clinical and managerial staff development over time, including locally delivered programs and enhanced use of technology assisted training"...*

Indigenous Employment
The number of Indigenous people who have the relevant qualifications to work in aged and community care is still very low. Despite recent initiatives, such as the Indigenous Remote Service Delivery Traineeships, there needs to be an even greater focus on supporting Indigenous people entering and staying in the workforce. At the moment workforce initiatives have attached the incentives to the person. There is little support at the organisational level to support encouragement of training, and training efforts are also dissipated in terms of value adding to the sector because of the wage disparity between acute and aged care settings. The unique conditions surrounding Indigenous employment also need to be factored into the unique operational environment. For example 'sorry business' and 'family business' are major causes of staff absences from work but there is no capacity to cover such absences within current funding constraints.

Cultural Awareness Training
Cultural awareness and sensitivity training for non-Indigenous staff working in aged and community care is expensive to provide and often inaccessible to remote locations without incurring high, unfunded costs. Yet teachers and the public service have this as a mandatory and funded requirement prior to working with special needs groups. There is no such funding for aged care. Another complication to supporting staff is the view of many Indigenous people that it is a 'Shame' job. This prevents using culturally appropriate staff and means there is an increasing need to bring 'white fella' workers into the community.

Likewise assimilated European migrants in the Riverland who revert to their mother tongue as they age and middle-Eastern cultural groups that remain relatively self-contained have additional barriers to overcome when they finally need to obtain help for the group and for their elderly family members. This also reflects on the need for more specific accommodation and support for special needs.

The Productivity Commission's *Draft Recommendation 9.2* acknowledges some of these issues: *"The proposed Australian Aged Care Regulation Commission (draft recommendation 12.1) in transparently recommending the scheduled prices for care services should take into account costs associated with catering for diversity including:*
- *providing ongoing and comprehensive interpreter services (either within facilities or through telephone translators) for clients from non-English speaking backgrounds*
- *ensuring staff can undertake professional development activities which increase their cultural awareness."*

Recommendation 8
The Alliance recommends that the Productivity Commission builds on its proposals for special needs groups - including people who live in rural and remote communities - by developing a series of recommendations that will strengthen the aged care workforce in rural and remote communities now and into the future including through:

- continuing development of the aged care workforce through a special remote area program which supports and encourages people and organisations in training and career enhancement for local people working in the aged care sector; and
- parity in remuneration across aged and acute care settings, coupled with measures to support comparable living conditions, employment opportunities and career pathways as available in Major Cities in order to stimulate the desire to work in the rural and remote aged care sector.

Conclusions

Effective aged care services sustain the local community through jobs and business as well as through the care of older people. Better support for these services, including encouraging their utilisation, assists in maintaining the fabric of a community through the retention of a greater number of older people for a longer time and in better health.

At this time of health and aged care system reform, there is the opportunity to make a real difference and improve the health and ageing outcomes of people who live in rural and remote communities.