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Services • Australia**



WE MAKE DO

A Review of the Community Care Viability Supplement

ACSA REPORT

June 2009

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Executive Summary

Introduction

Community care is, and will continue to be, the foundation for the support of our expanding ageing population. Community care services are extremely important in rural and remote areas in maintaining older people in their local communities. The costs of providing services in rural and remote areas are higher than in metropolitan areas due to a number of operating variables including travel, food and staffing costs. These costs were largely ignored in community care until 2006 when the Howard Government introduced the Community Care Viability Supplement (CCVS) at Aged and Community Services Australia's (ACSA's) urging. The CCVS was the companion supplement to the Residential Care Viability Supplement granted some years previous. Home and Community Care (HACC) programs are not yet covered by a viability supplement.

Packaged Care Delivery and the CCVS

Approximately 45,000 older Australians or Australians with disabilities receive packaged community care:

- A total of 680 Community Aged Care Packages (CACPs) were provided in remote Australia and 678 in very remote Australia in 2006-07.
- Around 30 Extended Aged Care at Home (EACH) or Extended Aged Care at Home – Dementia (EACHd) packages are allocated to clients in remote Australia.
- No EACH or EACHd packages are available in very remote Australia.¹

CACPs, EACH and EACHd packages all attract the CCVS at the same dollar rate on a sliding scale of remoteness, as do Multi-purpose Service packages and Aboriginal and Torres Strait Islander Flexible Care packages. Supplements range from \$2.72 per person per day to \$9.25 per person per day according to the ARIA remoteness rating of the client. The highest subsidy rate is therefore 26.6% above the daily care subsidy of \$34.75 (June 2008).

At the outset there was no objective logic to the rates for the CCVS. The Government divided a predetermined amount of available funds (\$19.4m over 4 years) and the model developers (Price Waterhouse Coopers) were instructed that 'funding should be distributed without exceeding available funds'. ACSA calculated that a figure of around three times that amount would have been required to fund a community care viability supplement at the same rate as for the residential care supplement.

First payments under the scheme were received in mid 2007.

CCVS Survey

Even with the CCVS, rural and remote services continued to report difficulties in meeting the costs of service delivery. ACSA's national Rural & Remote Working Group determined to review the impact and adequacy of the supplement.

In September and October 2008 ACSA conducted phone interviews with 30 randomly chosen eligible services. We included services in all States and Territories (excluding the ACT) and across the classifications of very remote, remote and moderately accessible.

The distances covered in travel by the services interviewed ranged from 2 or 3 kilometres (where a whole town was classified as remote or very remote), to services whose staff travel

¹ Australian Institute of Health and Welfare (AIHW), *Aged Care Packages in the Community 2006-07: A Statistical Overview*, August 2008, pp 11-16, Table 2.3 (Aged Care Statistics Series No. 27)

more than 200 kilometres (each way) to visit clients. The population of service districts ranged from a few hundred people to districts with populations of 70,000 or 100,000. The number of packages delivered ranged from 3 packages to around 60 packages, with half delivering 10 packages or less. All of the 28 services who completed our interview provide CACPs. Six also provide EACH packages. Only three moderately accessible services provide EACHd packages. None of the sample services identified themselves as Multi-purpose Services and only one service defined their Aboriginal and Torres Strait Islander (ATSI) specified packages as an 'ATSI Flexible'. Services interviewed receive supplements ranging from around two hundred dollars a month to over \$10,000 a month.

The survey questions focused on issues of financial viability, eligibility criteria and issues that have arisen with the implementation and ongoing delivery of the supplement. The survey also addressed the question of whether the supplement has assisted rural and remote services to provide individualised care comparable to that provided to metropolitan clients. In addition, we asked respondents to briefly speak about their wish list for remote community care - to identify what they are not able to do due to funding limitations.

ACSA would like to thank all of the participants who gave of their time and energy in this project.

Summary of Findings

While all services valued the extra income from the supplement – stating that any increase is welcome and useful – most also voiced the opinion that it does not recognise or meet the real extra cost of rural and remote community care. The major theme of responses highlighted that services “make do” with the funding they have, including the CCVS, to meet their clients and communities needs.

The backdrop to the survey has been a falling number of hours of care provided through packages from seven hours per week when first introduced to an average of 5-6 hours reported by the Productivity Commission in 2009.² This survey found that hours of care in remote Australia have fallen even further with a significant number of services stretching their resources to deliver as few as four hours per week for clients.

What this highlights is that there is just not enough funding for packaged care either in terms of the overall numbers available or the price being paid annually to deliver them. Adding supplements to this inadequate funding base does not allow the additional costs of rural and remote service delivery to be met.

Rural and Remote Context

To understand the survey results there are some context issues that need to be understood:

- Due to a lack of EACH (high level) packages many people continue to be supported on a CACP in order to remain living in their local community. This means that services are forced to provide less hours of care to clients with lower needs to support those with higher care needs.
- In remote areas, and Indigenous services, the concept of hours of care is not entirely relevant as the community does not accept some people being supported and others not. In the most remote Aboriginal communities, services routinely provide care to the whole community, regardless of who is assessed as eligible for packaged care. Most of the services we interviewed, from the very remotest services to services deemed 'moderately accessible', provide a substantial number of additional 'unfunded' services.

² DHA *Preliminary Findings from Data Analysis* (fact sheet); Productivity Commission, *Report on Government Services*, 2009: 13.28.

Additional Costs: Travel

Staffing costs take up to 80 to 90 per cent of all costs in community care nationally. We found that in remote community care, staffing costs may be proportionately lower because travel and transportation costs, in particular, take up a larger proportion of funds than in metropolitan care. One umbrella provider estimates that their travel costs for their remote services “are typically 3 times higher than travel costs for their metropolitan services”. The Western Australian *Fuel Watch* website provides clear evidence of the marginal costs per kilometre travelled by rural and remote care services. We found that in almost all cases, the cost margin for fuel over and above the price in Perth was higher than the margin paid to services through the C CVS. It’s a simple calculation: the viability supplement does not cover the travel component of rural and remote community care costs.

Additional Costs: Staffing

- Sole Practitioners

While only a small proportion of metropolitan packaged care providers deploy nurses (relying on referral as required), a much larger proportion of remote packaged care services employ nurses, as many are required to act as ‘sole practitioners’, with limited recourse to timely medical support. Twelve of the services we interviewed deploy a nurse (EN or RN). Another told us they wanted to do so but had thus far been unable to attract a nurse.

Under the Northern Territory Nursing Agreement 2008-2011, annual base rates for level 4 and 5 nurses range from \$74,100 to \$81,600, before increments and loadings. ACSA was reliably informed that the cost of actually putting a level 4 nurse ‘on the ground’ in remote Northern Territory communities where they need to be effective sole practitioners, can be as high as \$200,000 per annum. These figures underline the difficulty packaged care services have in competing for nurses, with on-the-ground wages able to be offered by providers being considerably lower than these rates. A domiciliary nurse was being paid around \$41,000 per annum; an OT manager was receiving \$57,000 per annum plus a rent allowance, and a nurse-manager was accepting just under \$51,000 per annum for full time work in remote community care. Another service offers “\$21 [per hour] for a nurse to be on-call for 15 hours” but that service has found that this rate was “hardly sufficient to attract qualified staff to a rural or remote locality”. For most services we interviewed, the C CVS has had little impact on the levels of remuneration able to be offered.

According to a recent report from the National Institute of Labour Studies (NILS), rural and remote community care also relies much more heavily on agency staffing for nurses and allied health staff than the national average (about 7 times more shifts!) and agency staff costs are particularly high.³

A remote service with CACP and EACH packages informed us that they have had to employ agency nurses at \$53 per hour; another stated that agency nurses cost \$500 per day. Others have resorted to fly in/fly out staffing at great expense. In one case, air fare expenses are currently being paid out of revenue that accumulated when the service provider was without their full quota of staff.

- Personal Care Staff

Personal care staff are also becoming increasingly hard to attract, with mining and tourism companies offering considerably more attractive remuneration packages.

³ Bill Martin and Debra King, *Who Cares for Older Australians?: A Picture of the Residential and Community Based Aged Care Workforce 2007*, National Institute of Labour Studies (NILS) and Department of Health and Ageing, October 2008.

Additional Costs: Food

Around 70% of remote providers deliver meals to clients as a core element of their care packages, compared to 29% nationally. Using a series of Food Basket surveys we found that the cost of food in remote Australia can be up to 70% higher than metropolitan basket prices. Anecdotally we were told that the price of standard foods can be 300% higher in very remote communities. Again, the supplement, with its highest rate set at 26% above the daily subsidy, falls far short of addressing these margins.

CCVS Administration

In addition to the extra costs of delivery not being adequately recognised in the supplement there are issues with its design and administration:

- We found that a considerable number of our sample services were unfamiliar with the supplement when we first contacted them. This lack of familiarity raises issues around Medicare's communication with services.
- Community care services are required to draw fees for service from non-concessional clients. Remote and very remote services in particular, have very limited capacity to draw in fees for service as the vast majority of clients are concessional. Unlike the Residential Care Viability Supplement, the CCVS provides no weighting for service size or special needs groups (including having a high proportion of concessional clients), and the highest community care viability supplement rate is only around 40% of the highest residential care viability supplement.
- Clients' postcodes identify their eligibility for the CCVS, rather than the location of the provider. Postcodes may not actually reflect the remoteness of the client from a service, or the distance covered to service a client. A number of services told us that their most remote clients do not attract the supplement, or attract a lesser supplement than clients who are more easily accessible. This anomaly in eligibility could easily be remedied by consulting with services and negotiating better outcomes, as has occurred with one remote service.

CCVS Impact

Most providers value the supplement but reported that it does not meet the real extra costs of care delivery.

Services that receive a substantial input from the CCVS each month – ie, those receiving some thousands of dollars each month – have been able to put the supplement to best use. One very remote service has employed an experienced business manager and has upgraded its food quality and governance procedures resulting in better care for clients and savings in some components of the care budget. Another large service has used it to take on permanent staff instead of the casuals and contract staff they were employing.

In a sense, these major improvements were not the intended outcome of the supplement but they do point to the sort of improvements in community care – and actual cost benefits – that can be produced when more adequate funding is made available to providers.

More services, however, are still struggling under heavy cost burdens and unfunded demands for packaged care within their communities, and each year the margin between incomes and costs widens as indexation of base funding and supplements fails to keep pace. The general view of the CCVS recipients we interviewed was summed up by a manager who said:

At the end of the day it's all extra dollars but with the increased cost of living over the last 12 months, I have to question whether it's enough. It is hard for us as a remote provider in a town, let alone those delivering to actually remote clients. It is not adequate to attract and retain staff or provide more adequate service to clients.

When the CCVS first came in we were very enthusiastic, however, it was laughable when we got it; postcodes don't always indicate how far, or how difficult it is to service them.

I have felt for a long time that the packaged care rates don't cover the cost of delivery. The design of the CCVS just doesn't "hit the mark".

RECOMMENDATIONS

Our research supports seven substantial recommendations and four related recommendations:

Recommendation 1: That a comprehensive study of the cost of community care in rural and remote Australia be funded by the Commonwealth Department of Health and Ageing, and undertaken.

Recommendation 2: The rates of the CCVS should be increased to the level of the residential care viability supplement until the research project in Recommendation 1 has been completed and a new viability supplement has been established.

Recommendation 3: Many of the clients in remote areas are Indigenous and they have particular cultural needs that impact on service providers. ACSA believes that the Government should assess these additional service requirements within its review of the Indigenous Aged Care Strategy and/or consider loading the CCVS for services with considerable numbers of Indigenous clients similar to the special needs loading made available in the residential care viability supplement.

Recommendation 4: The widespread lack of knowledge about the CCVS is a significant finding in itself and we recommend that the Department of Health and Ageing, and Medicare which directly administers the supplement, ensure that communication with service managers is appropriate and ongoing, including for very remote service managers/coordinators.

Recommendation 5: ACSA recommends that in the long term the Department should consider a method, other than the ARIA system, for measuring remoteness. In the short term, the Department should be flexible and negotiate with providers where there are clear difficulties with particular clients.

Recommendation 6: To enable more accurate service planning, the CCVS should continue to be paid while the client is on leave.

Recommendation 7: The Department and Medicare should streamline the claim form to make receiving the CCVS easier for providers and Government.

It is impossible to view the CCVS in isolation as it is a relatively small component of community care funding. Without addressing the fundamental funding issues any supplements are likely to be largely unsuccessful in meeting additional costs. In recognition of this ACSA recommends the following:

Recommendation 8: That CACPs, EACH and EACHd be brought together as one stream of funding. The stream would include funding for mid level needs clients who currently fall between CACPs and EACH level care. Providers would be able to offer packages interchangeably based on the client need they are servicing.

Recommendation 9: That the Government should immediately increase the number of aged care packages by 10% to meet some of the unmet demand.

Recommendation 10: That the Conditional Adjustment Payment (CAP) be extended to include all community care service packaged care recognising that the current indexation does not meet the real cost of care delivery.

Recommendation 11: That the Government develop a sustainable indexation methodology as a long-term solution to the funding of all community care service packaged care.

“WE MAKE DO”

A Review of the Community Care Viability Supplement

Introduction

Community care is, and will continue to be, the foundation for the support of our expanding ageing population. In the past decade there has been a dramatic increase in the demand for community care services in Australia.⁴ Community care currently supports approximately one million older Australians and younger people with a disability, enabling them to remain in their own homes and communities.⁵ Approximately 45,000 of these people receive packaged care.

Community care underpins the efficiency and effectiveness of a range of health services, including acute care. Community care supports timely discharge from acute care, reduces and prevents costly readmissions to acute care and prevents premature entry to residential care.

Community care responds to the expressed desire of older Australians to be active and independent members of communities, and has a crucial role to play in advancing the Rudd Government’s Social Inclusion agenda.

Services in rural and remote areas are extremely important to maintaining older people within their local communities. Without effective community care people often have to move to major towns, miles away from their home, family and friends. The costs of providing these services are higher than in metropolitan areas due to a number of operating variables including travel, food and staffing costs. These extra costs have long been recognised by the Australian Government in residential care but were largely ignored in the provision of community care.

For some time ACSA had been calling on the Commonwealth Government to establish a viability supplement for packaged care services similar to that already in place for residential care. ACSA’s policy also recommended Government undertake a project to determine how Home and Community Care (HACC) providers could be supported with the additional costs they face in remote areas – a payment akin to a viability supplement.

In recognition of the extra costs incurred in providing packaged care in rural and remote Australia, the Government announced the payment of a Community Care Viability Supplement (CCVS) in the 2006 Federal Budget. The level of funding announced was well below that required to match the supplement paid to residential services. While ACSA fully supported the initiative, concerns were expressed by providers about the level of support and the eligibility guidelines. ACSA decided to review the CCVS after the supplement had been in place for at least a year.

Our Research Brief

The aim of the project was to add to the evidence base about the operation of the CCVS in order to assess its:

- Financial adequacy for remote and very remote services;
- Whether there are any issues relating to its eligibility criteria; and
- Whether there are any problems with its implementation and ongoing administration.

⁴ Grant Thornton, *Aged Care Survey 2008* (Summary findings October 2008), p 4.

⁵ AIHW, above, note 1.

In September and October 2008, ACSA conducted telephone interviews with the managers or coordinators of 30⁶ randomly chosen rural and remote community care providers with ARIA ratings above 350: 3 in NSW, 4 in the Northern Territory, 10 in Queensland, 3 in South Australia, 2 in Tasmania, 2 in Victoria, and 6 in Western Australia. Moderately accessible services were included in the sample because many of them receive the CCVS for their most remote clients, the supplement being based on the postcode of the recipient rather than the provider location. The sample included 9 very remote services, 8 remote services and 13 moderately accessible services.

The survey questions, which are contained in Attachment 1, particularly focused on financial adequacy by exploring the following areas with the services:

- The extent to which the CCVS has enabled remote care providers to cover the extra costs of care they incur due to the remoteness of client locations;
- To identify whether the CCVS has assisted these services to remain or become more 'viable'; and
- To identify whether rural and remote services are able to provide their clients with a service equal to that received by metropolitan recipients of packaged community care.

Packaged care providers are required to tailor individual care packages and the survey asked services if the supplement supports them to adequately provide individualised care and meet the needs and wants of clients. The survey also asked providers to identify what they are not yet able to do due to funding limitations.

In each case the interviewee was told that no identifying information would be used in the report. While this reduces the descriptive elements of the report, ACSA took this position in the hope that they would speak freely about the financial and operational circumstances of their services. ACSA would like to express its thanks to the interviewees and contacts who gave generously of their time and shared the complexities of rural and remote community care with us.

Rural and Remote Service Delivery

Packaged care is funded through three principal Commonwealth Government funded programs: Community Aged Care Packages (CACPs), Extended Aged at Home (EACH) and Extended Aged Care at Home – Dementia (EACHd). Two smaller aged care programs, the Multi-purpose Services (MPS) program and the Aboriginal and Torres Strait Islander Flexible Care program, bring together health and aged care services in rural and remote Australia. All of these programs attract the CCVS at the same rate.

CACP and EACH/D services may include nursing: wound dressing and medication control; allied health, physiotherapy, podiatry, occupational therapy; help with housework, home maintenance, home modifications and gardening; providing meals or assisting with cooking and/or eating meals; shopping; bathing, showering, personal hygiene, toileting; dressing and undressing; mobility; sensory communication or fitting sensory communication aids; social support and support for carers including in-home respite; transport for medical and other appointments and outings including shopping; rehabilitative support; care coordination and emergency response: all delivered at the level appropriate to the client.

Of CACPs, 3.6 per cent are allocated to remote and very remote areas, totalling 680 packages in remote Australia and 678 packages in very remote Australia in 2006-07 (AIHW August 2008: 11-16, Table 2.3). From 1 July 2008 the maximum subsidy rate for a CACP is \$34.75 per client per day.

⁶ Of the 30 services contacted, only 28 answered the questions. The other two did not know about the CCVS and they were directed to the Department of Health and Ageing's website.

Clients contribute a means tested fee for service ranging from \$6.78 per day for clients on the maximum aged pension to a fee limited to 50% of any income above the maximum pension rate.⁷ Client fees therefore can provide a substantial component of community care income, but those unable to pay due to financial hardship do not pay any fee. As the Northern Territory Department of Health and Families noted in its submission to the recent (November 2008) Senate Inquiry into Residential and Community Aged Care in Australia, “the NT has the highest rate of concessional, assisted or supported” clients of any Australian jurisdiction,⁸ which means that services, and remote and very remote services in particular, have very limited capacity to draw in fees for service. The CCVS does not take this anomaly in the income stream of rural and remote providers into account.

The EACH and EACH-Dementia programs target people who would be eligible for high level residential aged care. There are currently around 4,250 EACH packages and just under 2000 EACH-D packages allocated nationally, but only around 30 of these are allocated to clients in remote Australia. None are available in very remote Australia⁹. It has been argued by some that this is largely due to considerations of service viability in areas with small and sparse population areas and because none of the current remote area providers has adequate infrastructure or staff skilled enough to meet the requirements for these packages under the *Aged Care Act*.¹⁰ This assertion may need to be tested and challenged.

The operational brief for each packaged care program invites providers to develop flexible programs of care to address the individual needs of each client. Funds are distributed amongst clients by agencies according to client need. An average CACP was initially intended to supply approximately 7 hours of direct ‘personal care equivalent’ care, or cost-weighted nursing care with capacity to expand direct care to 10 hours a week if required for short intervals of care¹¹.

However, the 2008 *Report on Government Services* published by the Productivity Commission notes that “a CACP [now] typically provides 5 to 6 hours of direct assistance per week”¹² indicating some decline nationally in service provision since the program was initiated in 1992. The Stewart Brown Business Solutions *Aged Care Financial Performance Survey* similarly indicates some decline in average hours per week of direct care nationally, with CACPs during 2008 averaging 5.85 hours, a decline of around 16% in care hours per client¹³.

As there are generally a smaller number of providers – or one only – in rural and remote areas they most often provide a range of other services alongside their packaged care program. Funding comes from a variety of sources and is managed within the budget to provide the best outcomes for individual clients and local communities.

The Geography of Remote and Very Remote, Community Care

While some remote community care services primarily service a geographically-concentrated community, others deliver aged care across many thousands of square kilometres. The geographical area covered by services in our survey was most readily expressed in terms of kilometres to the most distant client or hours travelled. Distances ranged from 2 or 3 kilometres

⁷ Department of Health and Ageing, *Community Aged Care Packages*, available at:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-cacp.htm>

⁸ NT Department of Health and Families, *Submission to the Senate Inquiry into Residential and Community Aged Care in Australia*, November 2008, available at:

http://www.aph.gov.au/Senate/committee/fapa_ctte/aged_care/submissions/sub25.pdf

⁹ AIHW, above, note 1.

¹⁰ NT Department of Health and Families, above, note 8.

¹¹ Marita Walker, *Submission to Senate Finance and Public Administration Committee*, 19 November 2008;

Department of Health and Ageing, *Preliminary findings from data analysis to inform the development of the Packaged Care Tier*, available at:

[http://www.health.gov.au/internet/main/publishing.nsf/Content/6F9EFF835C9B5151CA25742600032F52/\\$File/Packaged%20Care%20Jan%202007.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/6F9EFF835C9B5151CA25742600032F52/$File/Packaged%20Care%20Jan%202007.pdf)

¹² Productivity Commission, *Report on Government Services 2008*, 13.23.

¹³ Stewart Brown Business Solutions, *Aged Care Financial Performance Survey*, January 2009, p 3.

to clients in a town where the whole town was classified as remote or very remote, to services whose staff travel more than 200 kilometres (each way) to clients. Some providers operate from a single location while others deploy care staff based as close as possible to clients.

The population of service districts ranged from a few hundred people to districts with populations of 70,000 or 100,000. The number of packages delivered by the 30 services ranged from 3 packages to 59 packages, with half delivering 10 packages or less. All of the 28 services who completed our interview provide CACPs. Six also provide EACH packages and three provide EACHd packages. None of the sample services identified themselves as Multi-purpose Services and only one service defined their Aboriginal and Torres Strait Islander [ATSI]-specified packages as an 'ATSI Flexible' package.

Aboriginal and Torres Strait Islander Clients of Packaged Care

Ten of the 28 services in our sample had between 50% and 100% of ATSI clients. Five of the 7 very remote services had 100 % of ATSI clients. One New South Wales service, with 90% Aboriginal clients, had had their ATSI Flexible packages taken away and replaced with general CACPs and they were not sure why. A Western Australian very remote service manager expressed the opinion that she "would like to be an ATSI flexible service, which would give more money". All 4 Northern Territory services in our sample had 100% ATSI clients but none had ATSI Flexible packages as far as they were aware. Two managers noted that local ATSI clients are serviced by a separate service in the district. Only 12 of the 28 services had no ATSI clients at the time we interviewed them.

The culturally specific needs of Aboriginal and Torres Strait Islander aged people should therefore be of prime concern when planning for the funding and support of all remote services as they make up a very substantial proportion of the clients of remote services in a number of States and Territories.¹⁴ Packaged care in Aboriginal communities differs in essentials from metropolitan and regional community care in that packages tend to be seen as a means of support to all 'old people' in a community, regardless of their ACAT eligibility. Workers report that it is simply unacceptable to Aboriginal communities for services to be provided only to ACAT-assessed clients. Packaged care funds and hours are therefore often spread very thinly across a community of need. As our survey found, an essential element of caring for members of this population may also include the cost of transporting people long distances to funerals and related 'sorry business'. Services should therefore be compensated for staff who are involved in funerals and 'sorry business' as these cultural commitments may take staff away from a service for extended periods of time. Participation in these cultural activities is essential to cultural continuity and directly contributes to maintaining the health and wellbeing of older Australians.

While the operation of packaged care for Indigenous people is beyond the scope of this review ACSA believes that the proposed review of the Government's ATSI Flexible Services Program should also address the fact that additional costs are faced by providers as a result of remoteness and the cultural needs of Indigenous elders. Consideration could also be given to loading the CCVS for services with over 50% Indigenous clients in line with the RCVS.

The Community Care Viability Supplement

The Commonwealth Government announced the CCVS in the 2006 Budget. Payments to providers commenced in June 2007 but were back-dated to January 2007. Eligibility for the supplement is based on the location of individual clients in rural, remote and very remote areas using postcodes which correspond with ARIA ratings from 3.51 (moderately accessible) to 12 (the most remote of the very remote).

¹⁴ Professor Fiona Stanley made this point in her 2008 Hawke Lecture 6/11/2008.

The CCVS payment model is quite different to that for residential care which is based on the ARIA score of the location of the care service.

Viability Supplement Rates

The amount initially paid through the CCVS ranged from \$2.61 per eligible person per day in a ‘moderately accessible’ location, to \$8.85 per eligible person per day in a very remote location. In July 2007 the rates were increased and ranged from \$2.66 to \$9.03. They were further increased in July 2008 ranging from \$2.72 to \$9.24. These supplements amount to a marginal payment to rural and remote community care services of between 7.8% and 26.6% of the universal daily subsidy for CACPs.¹⁵

The CCVS net amount received by services differs widely, according to the number of clients who attract the supplement and their remoteness rating. Services interviewed by ACSA received supplements ranging from around two hundred dollars a month to over \$10,000 a month.

Table 1. The Community Care Viability Subsidy at July 2008: actual amount and as a percentage of the basic CACP Subsidy which is \$34.75 as at July 2008:

ARIA Score	Amount of Supplement from 1 July 2008	CCVS as % of CACP daily subsidy
ARIA Score 0 to 3.51 inclusive	\$0	
ARIA Score 3.52 to 4.66 inclusive	\$2.72	7.8%
ARIA Score 4.67 to 5.80 inclusive	\$3.27	9.4%
ARIA Score 5.81 to 7.44 inclusive	\$4.58	13.2%
ARIA Score 7.45 to 9.08 inclusive	\$5.50	15.8%
ARIA Score 9.09 to 10.54 inclusive	\$7.70	22.2%
ARIA Score 10.55 to 12.00 inclusive	\$9.24	26.6%

Comparing the Residential and Community Care Viability Supplements

The concept of the CCVS is consistent with the residential care viability supplement (RCVS) but the eligibility criteria and rates differ. The RCVS is paid “in recognition of the difficulties faced in relation to isolation, small size and high cost structures and where small services are largely caring for financially disadvantaged people and other groups with special needs.”¹⁶ Three criteria determine eligibility for viability funding:

- The remoteness of the service’s location as determined by its ARIA score;
- The size of the service, with smaller services receiving greater weighting; and
- Whether 50% or more of a service’s residents are people who have special needs.

The CCVS “recognises the higher costs associated with attracting and retaining staff and other resource implications faced in providing community care services in rural and remote areas.” There is no mention of, and no loading for, service size and special needs groups.

¹⁵ The same *dollar* level of viability supplement is applied to EACH and EACHd packages.

¹⁶ Professor Warren Hogan, *Review of Pricing Arrangements in Residential Aged Care – Final Report*, Commonwealth of Australia, 2004, p 192.

At January 2007, comparable levels of the viability supplement for *residential* care ranged from approximately \$2 per head per day for clients living in 'moderately accessible' residential care to \$22.42 per person per day for those in very remote residential services. Thus, the highest level of the CCVS was set at only around 40% of the highest daily supplement level set for residential care clients. The CCVS rates were decided upon without reference to the actual costs of delivering care in remote Australia. Instead, the previous government set the levels of the CCVS by subtending a predetermined amount of available funds (\$19.4 million), and the model developers (Price Waterhouse Coopers) were instructed that "funding should be distributed without exceeding available funds."¹⁷

In its 2006-7 Federal Budget Submission, ACSA argued that community care services should be compensated at the same level as their residential counterparts because they face the same cost pressures and challenges to viability. ACSA calculated that in 2006, approximately \$16.8 million would have been required annually to fund a CCVS at the same rate as residential care. Instead, the 2006-7 Federal Budget provided a total of \$19.4 million for the CCVS over 4 years: meeting just one-third of the calculated need.¹⁸ ACSA considers that the failure to set the CCVS at an equivalent level to the residential care viability supplement – which Warren Hogan already regarded as having been set too low¹⁹ – has seen community care short changed.

Neither viability supplements were designed to cover all the additional costs created by a service's location, but there is no objective data or rationale for the levels paid. ACSA believes that further work is required to understand the additional cost pressures in remote areas in order to underpin more appropriate viability supplements.

Understanding the Cost of Care in Rural and Remote Areas

This section attempts to present and analyse the differences in the cost of providing packaged care in rural and remote Australia when compared to the cost of care in metropolitan areas. Information from the survey interviews plus a range of objective data from various sources is presented. Most of this data does not come from packaged care providers as such data does not exist. However when brought together the data paints a powerful picture of the cost pressures faced by those living and providing services in remote areas. The costs focused on are staffing, food and fuel.

Staff Recruitment and Retention

Staffing is the chief item of expenditure for all community care services, around 90% of expenditure nationally. Direct care staff in all community care services (including HACC) are made up of:

- Registered Nurses 10.2%
- Enrolled Nurses 2.4%
- Community Care Workers 82.6%
- Allied Health Workers 4.8%²⁰

Services can also have a range of non care staff such as managers and administration staff depending on the size of the service.

¹⁷ Price Waterhouse Coopers, *Viability Supplement for Community Care Programs*, Powerpoint presentation to the Department of Health and Ageing, 6th December 2006.

¹⁸ Aged and Community Services Australia (ACSA), Correspondence to Stephen Dellar, 18 May 2006.

¹⁹ Prof Warren Hogan, above, note 16, p 22.

²⁰ Martin and King, above, note 3.

Nurses

Twelve of the services we interviewed deploy a nurse (EN or RN) as part of their direct care team, either as nurse-manager, as a team member or through brokerage from an allied service. One other respondent indicated her service would employ a nurse if they could recruit one.

Employment of an RN is not required for delivery of CACPs, but is required for the delivery of EACH and EACHd packages. However, 5 of the interviewed services with nurses do not deliver EACH or EACHd packages. In all cases, nursing award rates are paid for the nursing hours as well as the travel time taken to reach the client. As one respondent stated:

This means that you have to have for example an RN for an 8 hour shift who in fact only sees a client base for 4 hours, as we have to factor in kilometres and time for travel. There are areas where we have nurses doing some domestic assistance and personal care work due to the small amount of need of the various service types.

It is likely that packaged care programs have a higher level of nurses than the 12.6% for all community services given the needs of their clients but these figures are not known.

Under the Northern Territory Nursing Agreement 2008-2011, base rates for level 4 and 5 nurses range from \$74,100 to \$81,600, before increments. ACSA is reliably informed that the cost of actually putting a level 4 nurse 'on the ground' in remote Northern Territory communities where they need to be effective sole practitioners, can be as high as \$200,000 per annum (based on a base rate of around \$80,000 plus allowance and incentives such as rental, recreation leave, on-call allowances, utilities allowances etc). This suggests that packaged care services would have difficulty competing for nurses in this environment. Indeed, we found that on the ground wages were considerably lower than these rates. A domiciliary nurse (RN or EN plus domiciliary nursing certificate) was being paid around \$41,000 per annum; an OT manager was receiving \$57,000 per annum plus a rent allowance; and a nurse-manager was accepting just under \$51,000 per annum for full time work in community care.

The employment of nurses has become particularly difficult for community care providers. A study by the National Institute of Labour Studies found that the general shortage of RNs worsened between 2003 and 2007 with an increasing number of community care services resorting to the employment of agency nurses or having vacancies for a considerable period of time.²¹ A remote service with CACP and EACH packages informed us that they have had to employ agency nurses at \$53 per hour.

Staffing is an issue. We pay accommodation of about \$500 per week for 2 senior staff: huge on-costs. We endeavour to give our CACP clients at least 5 hours a week. We have just appointed an RN [and] we have been using agency staff for months at \$53 an hour.

A number of services indicated that inability to recruit staff is the overriding issue for the viability of their service, and that the CCVS had not improved their ability to attract staff to remote and very remote services. As one reported:

It has been very difficult to employ a relief nurse as there are very few qualified persons in our community. Our local hospital has to employ agency nurses who cost (I am told) \$500 per day. Carers are [also] very difficult to employ as most eligible persons receive much better wages working for the local mines.

According to salary tables jointly published by the Australian Department of Health and Ageing and the Royal College of Nursing for December 2007, to attract nurses to remote Australia, States and Territories now offer a range of salary loadings including free or subsidised accommodation, professional development leave, relocation allowances, utility subsidies,

²¹ Martin and King, above, note 3.

recreation leave, isolation bonuses, bonus payments for each year of service, remote area allowances and other incentives under 'isolated nursing incentives packages'.²²

According to the Queensland Government's remote nursing information website, "these benefits alone may be worth up to \$25,000 per year on top of standard incremental salary rates", or around a 37% loading for a Grade 6 remote area nurse.²³ This is a cost margin to providers who need to employ nurses considerably above any compensation provided through the CCVS.

Without qualified nurses, services are unable to deliver high level EACH and EACHd packaged care. One result is that clients whose needs become high either remain on CACPs, straining CACP services beyond their intended capacity and raising duty of care issues – so that some services report the need to employ qualified nurses even though CACPs were not intended to deliver that level of care. Or alternatively, aged people with high care needs may have to enter residential care if that is available, or actually leave their home community.

Agency staffing of RN's is higher in remote Australia than in rural, regional or metropolitan Australia. According to the National Institute of Labour Studies while the nationwide percentage of total shifts performed by agency staff in community care is 1.3%, in remote community care, as many as 10.1% of all RN shifts are performed by agency-derived RNs.²⁴ The length of time taken to fill a vacancy for an RN is also attenuated in remote Australia with almost one-third of RN vacancies taking more than 4 weeks to fill compared to a national average of one-fifth taking more than four weeks to fill.

The wages and increments able to be offered by packaged care providers are relatively small. As one of our own interviewees commented, "a rate of \$21 for a nurse to be on-call for 15 hours is hardly sufficient to attract qualified staff to a rural or remote locality".

Community Care and Other Workers

There is very little data about the availability of Community Care Workers but the picture that emerges is equally bleak. Inability to easily recruit care and managerial staff adds a cost burden to remote community care for advertising, training, the indeterminate costs associated with loss of organisational capital, and the high cost of deploying non-residential employees. According to one remote service manager in WA, "12 months is 'long service' up here. In eight years we have had four regional directors". A number of providers have resorted to fly in/fly out staffing. One manager reported:

Staff turnover is our biggest problem. We are now brokering care services from outside agencies, out of the region, which means they have to fly up here and go out and stay in the community for 2 weeks-on/2 weeks-off, but we have to negotiate housing. We have a budget surplus because we have not been able to attract staff, so now we can spend it to enhance our service with the fly-in/out program. It is not yet happening, but we are hopeful. ... Air fares are a daily cost up here.

Even when substantial allowances are able to be offered, aged care wages cannot compete with the lucrative wages and supplements paid by competing employment options. As one of our respondents put it:

We would all like to provide more hours of service but staffing is the big issue. The CCVS has not made us more competitive with other industries to attract staff. Tourism pays much better and we can't compete.

²² Australian Nurses Federation NT Branch, Union Collective Agreement 2008-2011; Queensland Health, *Rural Nursing: In many ways it pays to nurse in rural Queensland*, available at: http://www.health.qld.gov.au/nursing/rural_remote.asp

²³ Queensland Health, *Rural Nursing: In many ways it pays to nurse in rural Queensland*, see above note 22.

²⁴ Martin and King, above, note 3, Table 5.46, p 91.

The National Institute of Labour Studies similarly found that aged care struggled to compete with more lucrative work opportunities in remote Australia. A remote aged care employer told Martin and King:

Why would you work in an industry like aged care when you can make much, much more money elsewhere?...being in a remote area if you work for the public sector they give you a 100 per cent rebate on rental, a transport allowance to transfer food from Alice Springs to Tennant Creek from Woolworths or Coles and they also give you a car rebate.²⁵

Employing and retaining allied health workers is also difficult with 1.4% of allied health shifts Australia-wide being provided by agency staff compared to 15.3% of allied health shifts in remote Australia.²⁶

Other remote area respondents to the Martin and King census of aged care workers particularly noted the difficulties associated with the cost of, or lack of, transport and accommodation in remote Australia. This was a major issue, affecting the uptake of employment opportunities, especially in locations where salary growth has been driven by mining or tourism, resulting in “a general rise in rental costs, which were seen as beyond the means of low-paid, direct care workers” and even beyond the means of RNs who attract remote location allowances.²⁷ ACSA’s own informants similarly indicated that accommodation is difficult to obtain and extraordinarily expensive in some remote areas. One interviewee told ACSA that when staff, unfamiliar with remote area accommodation arrive ‘in town’ many have been near to turning around and leaving. “I have resorted to crying at this point to stop them leaving” she said, only half jokingly.

Conditional Adjustment Payment (CAP)

In 2002-03 the Commonwealth Government introduced the Conditional Adjustment Payment (CAP) which provided an extra \$211 million in subsidies over four years “to assist residential aged care providers to meet increased costs of nurses’ wages.”²⁸ This CAP was not extended to packaged care.

The CAP for residential care providers enabled some improvement to be made to rates of pay in residential care and the 2007 NILS report bears this out showing residential care staff have a slightly higher level of satisfaction than in 2003 as a result.

ACSA has lobbied for a packaged care CAP which it estimates will cost \$10.3 million per year.²⁹ This would assist rural and remote providers but it is only part of the solution.

Food Price Margins

While only around 29% of all community care programs deliver meals to clients nationally,³⁰ our research suggests that around 70% of rural and remote community care services deliver meals to clients with food costs constituting as much as 15% in some service budgets. The cost of food in rural and remote Australia therefore impacts significantly on community care costs.

A series of ‘food basket’ or ‘market basket’ surveys conducted in Australia, with a standardised methodology and standardised food items since 1998, clearly demonstrate the magnitude of food cost margins in rural and remote Australia.

²⁵ Martin and King, above, note 3, p 137.

²⁶ Martin and King, above, note 3, p 91, Table 5.45 & 5.46

²⁷ Martin and King, above, note 3, p 141.

²⁸ Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997: 1 July 2004 – 30 June 2005*, p 35.

²⁹ For details of ACSA’s position see *Aged & Community Services Australia (ACSA) 2009-2010 Federal Budget Submission* and Aged Care Industry Council (ACIC) *Review of the Conditional Adjustment Payment*, October 2008 both available at: www.agedcare.org.au

³⁰ L.E.K. (Consulting) and Amity Group (Consulting), *Review of Aged Care Delivery Costs*, 12 December 2005.

Three food/market basket surveys were conducted in 2006, providing a unique opportunity for price comparisons between metropolitan Sydney, Brisbane and Darwin and remote centres in New South Wales, Queensland and the Northern Territory. Prices were relatively stable across 2006 prior to the inflation 'take-off' of mid-2007.

Using these surveys, we calculate that the difference in cost between the average Sydney basket in December 2006 (\$435.59) and a basket of the same foods (as far as availability allows) at Barkly, a remote centre in the Northern Territory (\$765) is 75%. We get a similar margin, 72%, if we compare an average Brisbane basket (\$446.37) in May 2006 with the Barkly basket.

Within NSW, remote area food baskets were up to 54% higher than Sydney prices.³¹ In Queensland, remote area prices were up to one third higher than Brisbane baskets.³² The Northern Territory survey found that remote area prices could be as much as 56% above Darwin prices.³³ Anecdotal evidence suggests however that cost margins in the most remote communities including many Aboriginal communities, may be up to 300% higher than metropolitan costs for healthy foods.³⁴ One very remote service manager informed us that food can cost up to 60% of family budgets in her community.

Table 2. Summary of food basket price margins 2006, NSW, Queensland and Northern Territory

Northern Territory			Queensland		NSW	
Darwin: average basket	Remote district: average basket	Very remote district: highest average price	Brisbane: average basket	More than 2000 km from Brisbane: average basket	Sydney: average basket	Remote district: highest price
\$490	+29%	Barkly district + 56% (\$765)	\$446	+33%	\$436	+54%

See Appendix 2 for the details supporting this table.

Fuel Price Margins

Fuel is a component cost in every aspect of the delivery of community care. The Western Australian *Fuel Watch* provides a readily accessible record of the fuel price differentials between metropolitan and remote Australia (although *Fuel Watch* does not extend its price surveillance to very remote communities). ACSA compared fuel prices via *Fuel Watch* on 25th November 2008, and again on 20th January 2009, by which time the fuel price spike of 2008 had been reversed for most consumers across the nation.³⁵ However, our respondents tell us that very remote communities, reliant on one carrier and/or one retailer, have, in many cases, not benefited from this reduction.

ACSA interviewed seven WA community care services and we were able to compare the cost of fuel in four comparably located communities using *Fuel Watch*: Kalgoorlie, Broome, Kununurra

³¹ Cancer Council NSW, *NSW Healthy Food Basket: Cost Availability and Quality Survey 2007*, p 8, available at: <http://www.cancercouncil.com.au/editorial.asp?pageid=2397&fromsearch=yes>

³² Queensland Health, *Health Food Access Basket (HFAB) Study*, 2006, p 4.

³³ Northern Territory Department of Health and Community Services, *Market Basket Survey 2006*, p 1, 6, 7.

³⁴ Personal communication (Dec. 2008) with the original director of the CACP service at Lajamanu, NT. This figure was readily agreed to by the current coordinator of a remote NT service.

³⁵ Western Australian Fuel Watch, accessed 25/11/2008, 20/1/2009 at: <http://www.fuelwatch.wa.gov.au/>

and Manjimup. The following table indicates the cost relativities between fuel costs in Perth and fuel costs in rural and remote Western Australia, and compares the supplement rates.

	ARIA	CCVS as % of daily subsidy for this ARIA	Cents per litre (25/11/08)	Percentage above Perth average price (25/11/08)	Cents per litre (20/1/09) price range	Percentage above Perth average price (20/1/09)
Metropolitan Perth diesel	n/a	n/a	137.7	n/a	125.4	n/a
Metropolitan Perth ULP	n/a	n/a	107.7	n/a	103.8	n/a
Kalgoorlie diesel	387	7.8%	155.9	13.2%	137.9	9.9%
Kalgoorlie ULP			136.9	27.1%	120.9	16.4%
Manjimup diesel	418	7.8%	149.9	8.8%	131.9	5.1%
Manjimup ULP			125.9	16.9%	114.9	10.6%
Broome diesel	900	15.8%	176.0	27.8%	176.0	40.3%
Broome ULP			161.0	49.5%	161.0	55.1%
Kununurra diesel	1200	26.6%	171.9	24.8%	160.9	28.3%
Kununurra ULP	n/a	n/a	167.9	55.9%	141.9	36.7%

These figures indicate that fuel price margins between Perth and rural and remote Western Australian outlets vary widely, but that in most cases, the margin cost of fuel in rural and remote Western Australia is not matched by the CCVS payment levels. Remote services are usually accessing fuel at the higher end of the price range in any region and often cover vast distances to deliver services to clients, hence the price of fuel is a major component of service costs.

While the spike in fuel costs has now reversed for many services, this is not so for some very remote services reliant on one fuel retailer or carrier not subject to 'market place' competition. As of April 2009 we are informed that fuel in a very remote Northern Territory community remains at \$2.50 a litre, ie, more than twice the going metropolitan price, and the price has not altered from 2008 prices. The 40% average rise in fuel costs incurred during 2008³⁶ saw service cost profiles everywhere stretched to breaking with many services reporting that the CCVS for 2008 has been largely taken up by the rising costs of fuel and food. Hence the CCVS to date has not in general enhanced service viability.

Nationally, Stewart Brown Business Solutions calculates that travel costs in the year to September 2008 [ie, in the petrol 'spike' year] constituted 3.8% of all CACPs costs.³⁷ In comparison, some services interviewed by ACSA (also in the petrol 'spike' period), reported that up to 15% of all costs were allocated to travel.

Travel components of remote service budgets differ according to the location of clientele and the road surfaces traversed. Travel may be only a small component when remote and very remote services deliver *within* a remote or very remote community. In other cases, services travel some hundreds of kilometres out to very remote clients.

These price margins for fuel and food are indicative of the magnitude of price differences between metropolitan and remote Australia. The impact of each factor on the costs profile of any individual service will depend on the precise expenditure pattern of the service. Nevertheless, a

³⁶ Western Australia Department of Agriculture and Food, *Submission to Senate Select Committee on Fuel and Energy*, 28 August 2008, Table 1, p 3.

³⁷ Stewart Brown Business Solutions, above, note 13, p 31.

ready cross-check of the broad impact of these fuel and food cost margins is available. The WA Department of Health's Aged Care Policy Directorate is currently preparing a report on the unit costs of HACC services across the state based on comprehensive returns from HACC services. The early data indicates that the cost of providing HACC services in remote WA is up to 59% higher than the cost of services in metropolitan Perth.³⁸ These figures give strong support to our own estimates of remote service cost margins as outlined above.³⁹

Fuel Price Margins: What Our Respondents Say

One umbrella community care provider informed ACSA that their travel costs in remote NSW are:

typically three times higher than travel costs for our metropolitan services. There is also the added need for staff to have a suitable car (4wd, night lights) to travel down dirt roads and we have had to provide this to our management team.

A very remote WA service, which draws on HACC funds to enable them to provide a higher level of care than CACP funding alone would allow, delivers three meals a day every day of the year to elderly Aboriginal clients. Travel costs include taking the elderly clients to visit their families in a community two hours away, and transporting them to health and allied health specialists as required. While the service receives the CCVS at the highest level, the manager notes that it has still not kept up with the rising costs of food and fuel in this very remote location. Here too, staffing is an issue that only extra money will address.

Another very remote WA service also noted that the CCVS "has helped, but then costs have also gone up in the last 12 months and so the CCVS has not kept up". A Queensland service similarly noted:

We pay a travel allowance but it just covers the kilometres. The CCVS has helped us with the rising cost of fuel but it still does not allow us to pay proper travel allowances.

A WA very remote service (with an ARIA rating of around 1100) which also noted that their margins have improved since the introduction of the CCVS, remarked on the difficulties that transport costs create for remote community care. The manager said:

Our biggest costs are transport and meals: we do some meals, but transport is a major issue. We are a small town with a fly-in doctor, so when clients need medical attendance, they need to go to [Town X] four hours away. People have to organise this themselves now. We would like to be able to organise this for them.

The issue of travel time/travel costs came to the fore throughout the interviews. Many hours are spent getting to and from clients, or transporting clients to and from services. At present, the cost of travel is subtracted from the funds left to deliver actual services to clients. Whether this time is paid as a wage rate or as a subsidy to volunteers or staff for their kilometres, it substantially reduces the dollars left to provide actual services to clients. One service in south-eastern Australia told us they reimburse their volunteers at a rate of 70c per kilometre. A remote SA service reimburses at 67 cents per kilometre. Given that some of our interviewed services do round trips of up to 400 kilometres to service clients, the loss of actual service dollars is very substantial, amounting to around \$270 in reimbursements alone for a trip of that length.

Some indication of the cost of community care travel, even in the less remote parts of regional Australia, was provided by a moderately accessible SA service manager who told us:

³⁸ Personal communication with Rob Willday, Assistant Director Aged Care Policy Directorate, WA Dept of Health, December 2008.

³⁹ Results from the 2007 Department of Health and Ageing nationwide Community Care Census were unavailable at the time of publication.

The CCVS amounts to about \$800 per year per client (to our service). ... We have one worker who visits our most remote client: we pay her \$800 per fortnight in mileage reimbursement. We pay large mileage to others also but none of these workers are visiting VS clients.

A Northern Territory very remote service told us that:

About 12 months ago we started assisting people to get to and from ceremony and funerals. ... We have to limit this. Each time might cost \$570 each way to fly if [the person is] frail. Others go by car if possible. If the family has a vehicle, we give the family a voucher of \$100-200 for petrol.

Another service employs care staff living as close to the client as possible; however, they do care reviews from a central base. The manager noted that “doing reviews is a whole day, 700 kilometres: it takes the whole subsidy for the month”.

Transporting people is a basic task of community care, and a major factor in fostering community cohesion and overcoming isolation. In remote Australia, it is also a major logistics effort and a major cost factor.

Packaged Care Indexation

According to Stewart Brown Business Solutions staff costs constitute just under 89% of all CACPs costs and just under 90% of EACH costs nationally, so staff cost is the primary determinant of overall costs in community care.⁴⁰ Our survey found that while staffing costs constitute the main cost component in rural and remote packaged care, it is often in the range of 50% to 75% of overall care costs in remote Australia because of the higher proportional cost of travel, freight and food.

CACP subsidies have not kept pace with wage increases from 1995/6 to 2005/6. While CACP subsidies have increased by 21.6% between 1996 and 2004, average wages have increased by 47.3% for full-time adult males and by 49.3% for full-time adult females in the same period.⁴¹ The aged care industry’s average annual wage increase for staff was around 4% in 2007-8. The annual Consumer Price Index (CPI) to September 2008 was 5%.⁴² The Brotherhood of St Laurence estimates that the cost of providing community care increased from between 4% to 10% in financial year 2007-8. In contrast, the annual Commonwealth Own Purpose Outlays (COPO) for community aged care in 2007-8 was around 2.3%, leaving a gap of more than 1.7% in one year alone.⁴³

Aged and Community Services SA&NT also notes that the recent granting of an increase in indexation in the health sector to 7.3% in South Australia “further exacerbates the existing disparities between the two sectors (health and ageing).”⁴⁴ UnitingCare Wesley, Adelaide, has similarly argued that the gap between funding increases and service costs has resulted in funding that is insufficient to sustain community care services in the way they were originally envisaged.⁴⁵

⁴⁰ Productivity Commission, above, note 12, p 31.

⁴¹ Aged and Community Care Victoria (ACCV), *From Good to Better: Issues, challenges and recommendations for the Community Aged Care Packages in Victoria*, June 2006, p 19, based on data from Australian Institute for Primary Care LaTrobe University and the Australian Bureau of Statistics.

⁴² Australian Bureau of Statistics, Consumer Price Index, September 2008. ABS Cat No. 6401.0

⁴³ Brotherhood of St Laurence (BSL), *Submission to the Senate Finance and Administration Committee*, 18 November 2008. The COPO Index measures both wage and non wage costs. It is a combination of the CPI and the Safety Net Adjustment. COPO has not kept pace with actual wage increases in aged care since 1996..

⁴⁴ Aged & Community Services SA&NT, *Submission to the Senate Inquiry into Residential and Community Aged Care in Australia*, November 2008.

⁴⁵ UnitingCare Wesley, *Aged Care at the Cross Roads*, 2004.

Failing to provide adequate care subsidies with realistic indexation will mean a reduced standard of service to clients. If revenue continues to fall behind the increasing cost of care labour, then fewer hours of care per day, per week and per resident or client will be able to be provided.

ACSA is calling on the Government to review the indexation calculation so as to better reflect the real and increasing costs of providing care.

Impact of Costs on Direct Care Levels

The originally prescribed average of direct care hours for the CACP program is between seven and ten hours. As we noted above, Stewart Brown Business Solutions' report of January 2009 indicates that the average direct care hours for CACPs in the year to September 2008 was 5.85 hours. Each hour of 'undelivered' care represents around 15% less direct care from the deemed quota of average need.

Remote community care survey respondents indicated that they are often not able to provide care hours on a par with the (declining) national average. Three of the surveyed services (two in Queensland and one in Western Australia) report providing as few as four hours a week for clients.

A variety of strategies are employed by rural and remote services to maximise hours of direct care. Often these strategies involve many hours of unpaid overtime, unpaid volunteer hours, or cross-subsidisation from high care packages or from associated health services.

A relatively large Queensland service with CACPs and ATSI Flexible packages provides four hours a week to clients on average. This service reported:

A lot of them live on properties, they need to be picked up for doctors appointments, also meals three days a week, which is six meals a week. We have to have eskies et cetera to take meals to clients; meals-on-wheels don't deliver out of town. Some of our clients should be on EACH. We provide eight hours per fortnight to those who need it.

Significantly, this respondent commented that "the CCVS means we can afford to do that", ie, provide eight hours of direct care *a fortnight*, which suggests that prior to the CCVS, they may have been providing less than four hours of direct care a week.

Another Queensland service provides five to seven hours a week of care but a substantial proportion of this is delivered in a group setting with the 14 CACP clients being brought into the town's aged care activities centre. The service also visits most clients three days a week for a period of about 20 minutes. Two of their CACP clients have high care needs but have not been allocated EACH packages. The service sees one of these high care clients three times a day, seven days a week; the program has allocated the other high needs client a live-in personal carer. Nine of the 14 clients get the CCVS, all at the lowest rate.

This service description illustrates the extent to which packaged care provides an 'all hours' support service in small remote communities. In this context, 'hours of direct care' is not an entirely relevant concept.

A NSW service reports:

We try to be fair and equitable...we visit our most remote client twice a week: four hours travel for a nurse. She gets ten hours a week, including travel. Our average service is six hours a week. We would have provided the service anyway, so the CCVS has helped a bit, but hasn't really covered our service costs: we cross-subsidise from EACH and EACHd programs run by the same service. We don't run at a deficit but we have to cross-subsidise. We could not run a stand-alone service just with CACPs. Some remote clients may need 10-12 hours (including travel) and we can't sustain this on our CACPs. The CCVS has not solved the problem; it has not addressed issues of remote area access.

Doing reviews is a whole day, 700 kilometres travel; it takes the whole subsidy for the month, so we call it something else, not CACPs. We make it work, make it happen.

A South Australian remote service also indicates the way that packaged care is spread across the community. Its approved funding is distributed across many more clients, including Indigenous clients, than the allocated number of packages provide for. The service manager commented: "We have provided so many unfunded services, we haven't noticed the difference" in relation to the CCVS. Another manager of a very remote service in Western Australia commented "if a client needs more visits, we just deal with it. Going out to a community and saying we don't have the money just doesn't cut it, so we work out ways to make it work. We take money from another area, or put it under another funding umbrella".

'Hours of direct care' is in many ways an irrelevant accounting concept in remote Aboriginal communities where packaged care dollars provide an 'all hours' community support service for community elders. A manager in a remote Aboriginal community remarked: "we just provide the service that is needed to the clients." This service has eight CACPs but looks after some 60 older people in the community.

Another very remote service in the Northern Territory, has six CACPs and receives the CCVS at \$9.24 for all six packages, but the provider also delivers HACCC services to another 35 aged clients who "are on the waiting list for CACPs". The service receives around \$1600 per month through the CCVS. Essentially the same 'all hours' services are delivered to all 41 people.

A Western Australian service with six packages similarly informed us that they provide an 'all hours' service for all aged community members. As in many other remote Aboriginal communities, the meals service is the centrepiece of community care:

Every day [we deliver] three meals a day, plus morning and afternoon tea. Our service is run like a hostel but is not considered as such by the government: 365 days a year. HACCC funding is also combined to enable this service level. Also, we receive philanthropic money from the mine which is put into the aged care hostel. Wages are very high. There is an expectation that we will provide a full service to keep people in the community for as long as possible, even when they have high care needs.

A moderately accessible Queensland service manager calculated the value of the CCVS (received by her service at the rate of \$3.27) in these terms:

[It] approximately pays for one hour transport or one and a half hours of care for each client across a month. ... [It is] a small improvement.

Impact of the CCVS on Packaged Care Services

While most of our interviewees report that the value of the CCVS has been eroded by fuel and food price increases in the past 12 months, and that it has not assisted services to address the fundamental issue of staff recruitment and retention in remote Australia, there were exceptions.

The CCVS has positively contributed to one very remote service in the Northern Territory being able to employ an experienced business manager with the experience and skills to reduce food waste and upgrade the overall direction and governance of the service. The CCVS for this service is received at the highest rate providing over \$4000 extra per month, and the new manager is confident that "it will have had a major impact". The service relies on a barge to deliver all its resources. The CCVS has been associated with bringing:

...more efficiency in[to] the system. If you think, everything that comes in here takes a five day barge trip: all our food is shipped in: all has to be planned and organised. Our meals service quality of food has improved, the quality was appalling. Now we do stock control on food, diet. Without the CCVS it would not be possible to employ the people

who now run the food system. Better management (enabled by the VS) has enabled the food quality to be improved without increasing the price. For example, we had the wrong blades in the cutting machine: one big spend on these has saved many dollars on labour and food costs, and [we] have been able to cater now on a contract basis to the community; so we are now raising money, people are healthier.

Another service which also received the CCVS at the top rate, noted that the supplement had enabled the service to reschedule its service visits, with a knock-on impact on their ability to recruit staff:

More visits? Yes. One particular client we went from one long visit to two shorter visits which suited their need better. We couldn't find staff for the two visits and the CCVS allowed us to.

Where the CCVS is paid at the highest rate, we found limited evidence that it has enabled some improvements in services' ability to recruit staff. But most services reported that the CCVS has been eaten up by cost increases in 2007 and 2008 and has not in any way enabled them to consolidate or improve service. Inability to attract appropriately qualified staff remains the issue of most concern in remote community care.

Interviewees were asked whether the CCVS had enabled the service to provide increased service cover. The question drew heavily qualified responses. Only one respondent gave an unqualified affirmative to this question, saying she has been able to employ a part-time assistant because of the CCVS. But the increases were identified as minimal in all cases.

Seventeen respondents saw no change in their service provision. Seven indicated that the CCVS had enabled them to keep up with existing service patterns as fuel and other costs have increased, but had not enabled any enhancement in service delivery. Two of the seven indicated that they already provide services beyond what they are funded for and the CCVS had not made up their existing deficit.

One respondent noted that as clients change across any year, or as clients' needs change, so too their service pattern changes, making it difficult to attribute service changes to the CCVS. Another noted that "the CCVS hardly registers".

Meeting the Increasing Demand for Community Care

The CCVS does not, and was not designed to address the need for more packages of care to be available to meet the increasing demand for services. However, in rural and remote communities it can be more difficult to restrict access to the existing services, particularly where a person has been assessed as needing care and is eligible to receive care. As a result of this, providers often deliver services additional to what they are funded to provide. A number of our respondents indicated that, despite the addition of the CCVS, they continue to be under-funded in relation to service demand. As one remote SA service provider put it:

We have provided so many unfunded services, we haven't noticed the difference. In the past 12 months all costs have increased. So we haven't noticed any great difference.

Another indicated their service also carries substantial numbers of 'unfunded packages': services delivered to clients for which they are not paid by the funding body. We have "excess recipients, but nothing happens" the manager said:

We just spread the funding further..... We also have a waiting list, people just survive on HACC etc. The VS is helping us maintain our additional clients, eases some of the stress on the waiting list. But we are unsure as to how they work out amounts for each VS category; some further out get less.

A moderately accessible Tasmanian service provider put it similarly but with a more positive emphasis:

We do what we have to do, regardless of the cost, but it [the CCVS] probably does help in the overall picture.

Other responses reveal the way services 'make do'. The most surprising answer, frequently given, is that services have always done what needs to be done for their clients, regardless of costs: that they have always juggled money to make this happen. A number informed us that they cross-subsidise between HACC, CACPs and EACH (when available) and with other community service providers, such as community health services. The manager of one moderately accessible Queensland said:

A lot of our clients don't pay, because their farms are not viable: we cover this by (the auspice body's) compassion. The policy is that we don't refuse a service; if there is money there at end of the month we stretch it to cover.

Many services rely on the provision by staff of unpaid overtime. As one service put it: "we all do extra [unpaid] hours: don't we all?". The NILS study found that nationally, "working unpaid is a regular occurrence in aged care organisations"⁴⁶, with 23.4% of respondents in their very substantial census working unpaid. RN's and Allied Health workers were most likely to work unpaid overtime in community care. Unfortunately there is no locative breakdown of these figures. ACSA has consistently argued that the number of packages should be increased by 10% immediately in order to cater for this unmet demand.

Remote Service Viability

The question 'has the CCVS assisted your service to become more viable?' initially drew a blank from many managers. When prompted with 'are you better able to balance your books?'; 'have you been able to pay higher travel allowances?' the question drew further information as to how services operate but solicited few 'yes/no' answers to the question of whether they are 'more sustainable' as a result of the CCVS. Amongst those who answered positively, was this response from a very remote Western Australian service:

We were struggling to make ends meet and now we can: we were quite often in deficit with our budget, and now we can manage it a lot better. (The auspice body) now manages the budget, and sends a monthly statement and I keep an eye on it, but if our costs have blown out, eg if a client needs more visits, we just deal with it.

A number noted that their travel costs were better covered as a result of the CCVS, but that travel costs remain a major cost burden on remote Community Care services. Answers were often equivocal. As one manager put it: 'no [it has not made us more sustainable]: the extra dollars help obviously, but [pauses] ... we would hate not to have it, especially in recognition of the distances we travel'. Another manager said:

Tricky question, yes, [the CCVS has helped] to a point; but we would like to see it increased. Fuel costs are rising, it has only helped to contribute to an hour of travel costs, we are still paying the hourly rate, so it should be doubled to about \$7.00 per day for our remote clients. For example, if we need to take a client to a medical or allied health appointment it is a 50 kilometre trip from our office, but we have to get the client first and return them home, so it is a round trip of 200 kilometres.

But other services are less able to cover transport costs and the CCVS has barely assisted. One manager indicated that her staff have to use their own cars, and the service is only able to reimburse them to cover fuel costs with no additional depreciation for wear and tear coverage.

⁴⁶ Martin and King, above, note 3, p 110 and Table 7.2.

Others noted positively that the CCVS has contributed to the way they employ and deploy staff and volunteers, suggesting that services have a strong vision around what they would want their service to be and do if extra funds become available. There is, therefore a strong view of community priorities and commitment to building excellence that is currently hampered by lack of funds. One service told us “We are now employing staff instead of contracting care workers on a contractual basis. Now we ‘employ’ for casual positions which means their pay rate goes up. The CCVS has enabled this”.

Another large Western Australian service, getting the CCVS for all its clients at the maximum rate, noted that the extra supplement has partially contributed to a major reframing of the service model:

Yes, definitely [the CCVS has made us more sustainable]. We often now broker services, flexibly. One client was attending ‘sorry business’ in town and we bought a local service for him while he was there. Some of our packages have been specific to certain areas so we could not [previously] service this man, but we have now negotiated to make them ... follow the person wherever they go: many of our clients are transient. The State office has been easy to negotiate with. All [region] CACP providers work together now, with lots of phone hook-ups.

This service is now contemplating a fly-in/fly-out roster to attract staff to their remote outpost services through a brokerage process as they have been unable to attract permanent live-in staff. The huge funds required for this are currently available to the service *because* they have *not* been able to recruit staff for some time now, and will only be partially covered by the CCVS.

As noted above, the injection of funds through the CCVS has aided the significant remodelling of some very remote services by enabling them to attract qualified, skilled staff who have enhanced service governance procedures and operational systems. Those most able to use the CCVS to positive ends are those receiving the supplement at the higher rates so that there is a significant injection of funds that can be readily earmarked for a specified project.

Visions of Quality Packaged Care

While conducting the interviews we took the opportunity to ask ‘What is your service still *unable* to do that you would like to do?’ which was asking the respondents to answer more broadly than just about the effects of the CCVS. To this we got some very interesting and useful answers for future planning. More transport options, more respite options and higher wages for staff emerged as the primary needs, but other issues are also critical, such as training. Most respondents indicated that the CCVS does not in any substantial way enable them to address these needs.

For services delivering care to isolated elderly folk even in moderately accessible districts, and for services in remote communities, especially remote Aboriginal communities, the ability to transport people to centrally-located day activity centres, to medical appointments, to community cultural events and gatherings (including funerals), to meetings with family and friends, is a fundamental need that is about overcoming isolation and addressing the health and ageing issues associated with isolation. One manager of a South Australian service said:

[We would like] to be able to offer more social support to people, but by the time we have provided the ‘necessities’ people don’t get the ‘nice things’ like church, outings.

Another replied that:

We offer centre-based day care locally, but no transport to bring in remote clients; we would like to be able to take elderly clients to cultural activities. [For some of our clients] it is 150 kilometres to get to the day centre at [Town X].

Another opted for:

More recreational time for clients: we have to limit this now to one day a week. ... [We are] now only funded for social support which is given in the home for 15-30 minutes only. We use some of this social support fund to bring them in to our centre, but we want funds designated for centre-based recreational programs.

For others, their 'wish list' priority was to be able to broker services to bridge the gap for clients in transition from CACPs to EACH level care. One service manager of a remote Queensland service said:

We would love to be able to offer allied health; we don't offer this now. This would be the main thing: occupational therapy in particular.

Services that are taken for granted in metropolitan Australia remain unavailable luxuries to remote aged care recipients.

A number of service managers expressed some of the frustrations of remote service providers. "Where does the list end?" asked one. There is:

Lots we could do but [we have] no resources. The subsidy doesn't create people to do the work. Staff is the issue. [There are] no volunteers here because staff need to be minimum of Certificate III. We use volunteers to drive clients to medical appointments. And general [items of] equipment? We can't afford to purchase these. \$3500 minimum for a hospital bed, the CCVS does not extend to this. Case management, 24 hour on call, weekly check visits which is not part of the client's quota. The CCVS doesn't cover any of this.

Another Western Australian very remote provider has been trying to get a respite and day centre for the last two years and now says: "I have no fight left in me". At this very remote Western Australian service location:

We don't have a centre for day respite, that is the real issue here. ... And then we would need more staff. ... Now, clients have to go to Darwin for respite and they won't go. If they go to Darwin it has to be for weeks at a time, families want that but the client won't go. If we had a decent house we could use it for longer respite. They won't leave the community.

Caring for the carers is the main thing here and we have no respite centre here. Carers need to be looked after. ... We can't do what we want because of lack of a centre; we're actually not spending all we get because we haven't got the facilities to do what we want to do. This service has been going for 12 years and still nothing is in place. About 60 people here are aged over 60 years. They have to go to Darwin when they need residential care. Old people want to stay in their country.

Interviewees were concerned about program progressions to EACH and whether they are as streamlined as possible in remote Australia as they are in metropolitan Australia. As one service noted:

Some of our clients should be on EACH, we provide 8 hours per fortnight to those who need it. The CCVS means we can afford to do that.

But this service manager also noted the heavy cross-subsidisation they rely on from the local health centre. Another also drew attention to issues with delayed transfers to higher level packages. She told us:

The one thing we would really like to be able to do: when a CACP is no longer viable, and we would like to move them on to an EACH package, or [when they need] loads of extra transport (when they're at the edge of CACPs), we would like to be able to provide more care. There is a delay in formal transfer to EACH (we can't do EACH because we don't have a RN on staff) then we need to broker it from a provider but there may be a three to

six week gap: we would like to be able to provide the care needed in the interim: we do it anyway but would like more help to do it. Transport is really the big issue. We do it anyway, it strains the service to a point, depending on how long the transfer takes. We have one woman who needs to move to EACH, but one on leave/holiday at the moment so we can juggle this, but if no one is on holidays it would be really tricky. Sometimes we get emergency respite.

Another very remote service in Western Australia, which delivers services within a predominantly Aboriginal community – and therefore has manageable travel costs - is in receipt of additional funds from the mining industry. Noting the difficulties of getting clients transferred to higher care packages, the manager highlighted that:

Wages are very high because there is an expectation that we will provide a full service to keep people in the community for as long as possible, even when their needs become high care needs.

Issues of Eligibility for the CCVS

Service managers identified concerns over a number of structural issues with the way the CCVS is administered. A primary issue of concern is with the way clients' postcodes identify their eligibility for the CCVS. Client locality data may not actually reflect the remoteness of the client from a service, or the distance covered to service a client. According to one service:

Our remote clients can now get multiple visits per day, with more oversight, maybe stay longer, have more visits. The problem is that it isn't applied to our most remote clients. Our rural centre is [Town A] which doesn't get the VS but we service some remote clients from [Town B] and they may live quite isolatedly (sic): no doctor, no chemist, and we can't attract Community Care Workers to visit them, yet they still don't get the VS, because they are within a certain radius of [Town A]. ... When these clients need to go to doctor, dentist, shopping, we have to program a five hour shopping trip: one staff, one client. In contrast,... we have clients who live in [Town B] who do get the VS, in a town where there are supermarkets, chemists, doctors etc. The way the VS has been designed is all wrong.

If they used a population-based model it would be better, eg if a person lives in a town with less than 1000, can they shop in the local community? This would make more sense, rather than just a postcode cluster.

The sort of service we can provide to clients in [Town A] is quite different from the sort of service we can provide to remote clients. Many of our CACP clients in [Town A] or [Town B] get two or three visits if they have medication management, but most remote clients get one only and then their carer has to manage medications.

A NSW service also noted the anomalies that can arise from the postcode-based eligibility criterion. The manager told us:

One of our Indigenous clients lives in an isolated settlement and still only gets \$2.72. This is our most difficult to get to client. The postcode that attracts a higher CCVS is much easier to service. We get the same supplement for in-town as we get for going 50 kilometres out and an hour travelling. This impacts on the amount of care we can give the client. Part of it is on dirt road 50 kilometres out; it is a large postcode area.

A similar issue affects services in northern Western Australia but, as noted above, some flexibility has been negotiated between one service provider and the State office administering community care to the benefit of all, such that the package now follows transient older people.

The same manager also spoke about the issue of clients who are very remote from a service centre but, having a postcode that stretches across a huge area, are rated according to the same postcode as the serving centre.

Another manager also expressed frustration with the way eligibility is designated. “We have people out on farms who are distant, but are not considered for CCVS, whereas others we travel the same distance to, do get it”. Another said she is “confused as to how they work out amounts for each category: some further out get less”. One service told us they travel 60 kilometres to one client (each way) who is not eligible for the CCVS while other clients, closer to the service centre, are eligible.

Consultation with services, as has occurred in Western Australia, could easily solve these issues of eligibility and access, with services easily able to identify the inconsistencies in their own area.

Providers also suggested that the CCVS should be paid while a person is on leave.

Implementation and Administration

The most telling finding regarding the administration of the CCVS is that of the 30 services interviewed, ten service managers or coordinators were initially unsure of whether they received the CCVS. For many, the source of funds is less important than the global amount with which they have to work. After talking to these managers about the CCVS, all but two managers or coordinators were able and willing to provide us with some data including the number of clients for whom they received the CCVS, and the rate at which they receive it. Both of the uncompleted interviews were with very remote services. In each case the interviewer forwarded the Commonwealth Government’s Viability Supplement web link to the service at this point.

The lack of familiarity with the CCVS was confirmed by the finance manager of one umbrella service covering three of the interviewed services in WA. The service has recently conducted in-service training on the CCVS for remote community care managers after they found that services were not getting the right amount due to CCVS returns not being filled in properly. They advised us that services should now be familiar with the CCVS, but our interviewer found this not to be the case. Other small remote services were not familiar with the CCVS because a central umbrella service prepares their returns each month and the service outlet gets a global budget not broken into funding categories.

The widespread lack of knowledge about the CCVS is a significant finding in itself and ACSA recommends that the Department of Health and Ageing, and Medicare which directly administers the supplement, ensure that communication with service managers is appropriate and ongoing, including for very remote service managers/coordinators.

Some providers commented that the claim form should be simplified to ensure that correct claiming was taking place.

Conclusion

The general view of the CCVS recipients we interviewed was summed up by managers who said:

At the end of day it's all extra dollars but with the increased cost of living over the last 12 months, I have to question whether it's enough. It is hard for us as a remote provider in a town, let alone those delivering to actually remote clients. It is not adequate to attract and retain staff or provide more adequate service to clients.

When the CCVS first came in we were very enthusiastic, however, it was laughable what we got it; postcodes don't always indicate how far, or how difficult it is to service them.

I have felt for a long time that the packaged care rates don't cover the cost of delivery. The design of the CCVS just doesn't 'hit the mark'.

Community care is an essential plank of the Australian aged care system. Effective community care enables older Australians to remain in their own homes and communities, prevents premature entry to expensive residential care and enables safe and timely exits from acute hospital care. It provides the most economic care to older Australians and as such it should receive fulsome support from government.

All of the services we interviewed aim to meet the individual needs of their clients as per the brief of community care, but many are now delivering only three or four hours of care per client, a figure that is around half of the hours envisaged. Services balance their available funding between people with relatively high cost needs and those with lower cost needs. Remote services are less able to draw fees for service from clients than are metropolitan services. Many of our respondents indicated that they rely substantially on cross-subsidisation between packaged care allocations and with community health services in their region.

Costs of care to any client depend on the availability of staff and the increments necessary to attract them to any area, the time taken to travel to and from the recipient, whether the client's care necessitates a qualified EN or RN or can be satisfactorily undertaken by a less qualified carer, the cost of fuel and travel allowances, and the costs of the various care inputs including food, labour, cost of aids and equipment. The CCVS amounts to a marginal payment to rural and remote services of between 7.8% to 26.6% of the universal daily subsidy for CACPs to community care providers. The costs of fuel and food in rural and remote Australia may be as much as 30% to 70% above the costs for the same items in metropolitan Australia and have blown out even further as a result of the prolonged drought, the flow-on effects of the oil price spike and the current global economic crisis. The on-cost of getting qualified carers on the ground (nurse and PCAs) is inordinately high, yet, almost contradictorily, services are unable to offer wages high enough to attract the staff they need. Community care services have already seen their program budgets stretched towards breaking point in many cases.

The CCVS rates, while recognising the extra cost of caring in rural and remote community care, were originally set at unrealistically low levels, and indexation-only increases since the beginning of 2007 have seen service incomes fall even further behind the actual costs incurred by providers. Service managers appreciate the acknowledgement contained in the CCVS that care costs more in rural and remote Australia than in metropolitan Australia; but most consider the current rates inadequate to meet those extra costs. The CCVS has not bridged the gap. Rural and remote clients have a right to expect equitable treatment and rural and remote providers should not be endlessly condemned to 'making do'.

Many services report that they provide support to more older people than their allocated numbers and this is achieved through hard work and commitment beyond all expectations. Their strong values base and 'mission' dictates that they provide support to all who need it. Governments should not exploit this good will by not funding programs to appropriate levels for the number in need.

Recommendations

This review was designed to look at the operation of the CCVS and we have made a number of recommendations about improvements required. Inevitably, the interviews identified a range of other areas, such as the design of packaged care and Indigenous services that are important in their own right. Therefore we have also developed a set of recommendations on these issues that are outside the terms of reference of this review but that need to be taken forward to ensure quality care is provided.

RECOMMENDATIONS

Our research supports seven substantial recommendations and three related recommendations:

Recommendation 1: That a comprehensive study of the cost of community care in rural and remote Australia be funded by the Commonwealth Department of Health and Ageing, and undertaken.

Recommendation 2: The rates of the CCVS should be increased to the level of the residential care viability supplement until the research project in Recommendation 1 has been completed and a new viability supplement has been established.

Recommendation 3: Many of the clients in remote areas are Indigenous and they have particular cultural needs that impact on service providers. ACSA believes that the Government should assess these additional service requirements within its review of the Indigenous Aged Care Strategy and/or consider loading the CCVS for services with considerable numbers of Indigenous clients similar to the special needs loading made available in the residential care viability supplement.

Recommendation 4: The widespread lack of knowledge about the CCVS is a significant finding in itself and we recommend that the Department of Health and Ageing, and Medicare which directly administers the supplement, ensure that communication with service managers is appropriate and ongoing, including for very remote service managers/coordinators.

Recommendation 5: ACSA recommends that in the long term the Department should consider a method, other than the ARIA system, for measuring remoteness. In the short term, the Department should be flexible and negotiate with providers where there are clear difficulties with particular clients.

Recommendation 6: To enable more accurate service planning, the CCVS should continue to be paid while the client is on leave.

Recommendation 7: The Department and Medicare should streamline the claim form to make receiving the CCVS easier for providers and Government.

It is impossible to view the CCVS in isolation as it is a relatively small component of community care funding. Without addressing the fundamental funding issues any supplements are likely to be largely unsuccessful in meeting additional costs. In recognition of this ACSA recommends the following:

Recommendation 8: That CACPs, EACH and EACHd be brought together as one stream of funding. The stream would include funding for mid level needs clients who currently fall between CACPs and EACH level care. Providers would be able to offer packages interchangeably based on the client need they are servicing.

Recommendation 9: That the Government should immediately increase the number of aged care packages by 10% to meet some of the unmet demand.

Recommendation 10: That the Conditional Adjustment Payment (CAP) be extended to include all community care service packaged care recognising that the current indexation does not meet the real cost of care delivery.

Recommendation 11: That the Government develop a sustainable indexation methodology as a long-term solution to the funding of all community care service packaged care.

Appendix One

Survey Questions

1. Has your service claimed the community care VS on behalf of any clients in the last financial year? July 07 – July 08.
2. What is the geographical area covered by your service in square kilometres? (Or distance/time to outlying clients.)
3. What is the total population of your catchment area?
4. How many places does your service have?:
 - CACP
 - EACH
 - EACHd
 - MPS
 - Aboriginal and Torres Strait Islander Flexible Service places
 - How many Aboriginal and Torres Strait Islander clients?
5. For each category, how many client days overall of service was delivered over the past 12 months? (These details should be available on the claim forms that have been submitted.)
6. For each category, how many client days attracted the CCVS over the past 12 months at the different CCVS increments? (Eg 300 days, at what level of funding?) The payment advice should show how many days have been paid and at what rate.
7. Has the CCVS enabled your service to provide enhanced service cover. If so how? And specifically have you increased the hours of service to remote CCVS clients? Have you increased the number of visits to remote CCVS clients?
8. Has the CCVS assisted your service operations to become more sustainable? If so how? [Prompt] And specifically have you been able to pay or increase travel allowance for workers or volunteers?
9. What is your service still unable to do that you would like to be able to do? What do you do that the subsidy does not cover you for, eg, case management, travel time?
10. Has implementing the CCVS led to any increased costs? [Prompt:] Administrative hours? If so how many hours over the 12 months? Software modifications? If so, how much has this cost?
11. Are there any other comments you would like to make about the CCVS?

We subsequently emailed two supplementary questions to respondents:

1. What proportion of your budget goes to meals/food, travel, staffing. (Seven responses added to the information already provided.)
2. Do you employ nurses, ENs and RNs? (Four responses added to the information already provided, three of whom generously provided us with remuneration details).

Appendix Two

Details of the food basket comparisons that support Table 2:

New South Wales

The most recent standardised 'market basket survey' was conducted by the Cancer Council of NSW in December 2006.⁴⁷ It involved the costing of a standard basket of goods in 150 supermarket outlets, including a proportion of outlets in remote NSW. It found that:

- The mean basket price in NSW in December 2006 was \$435.59
- The cost of the same basket ranged from \$337.29 in Blaxland (Western Sydney) to \$519.71 at Murrurundi in the Hunter Valley, a difference of \$182.42 between the cheapest and the most expensive basket. This is a difference of up to 54% in the cost of food between metropolitan and rural NSW.

Queensland

The Queensland 2006 Healthy Food Access Basket (HFAB) study, conducted by Queensland Health, surveyed 89 food stores across the five ARIA remoteness categories in May 2006. It excluded towns that were 'very small' (less than 200 people).

The average cost of the basket in Brisbane supermarkets ['Major cities', Queensland] was \$446.37. This survey found that "in the *very remote* category the cost of the ... basket was 24.2% (\$107.81 per week) higher ... compared with the [Queensland] *major cities* category".

The *very remote* category was further divided in this Queensland study into towns less than 2000 kilometres from Brisbane and towns more than 2000 kilometres from Brisbane. For towns greater than 2000 kilometres from Brisbane (n=12) "the cost of the Healthy Food Access Basket was 32.6% (\$145.57) higher ... compared with the *major cities* category".⁴⁸ For very remote towns less than 2000 kilometres from Brisbane the corresponding figures were 14.0% (\$62.50).

Northern Territory

Northern Territory Health also conducted a standardised 'market basket survey' in April and June 2006. The project surveyed 74 rural and remote stores. It found that the basket price in Darwin supermarkets was \$490 while "[o]n average, the cost of the food basket in remote stores was 29 per cent more expensive than the Darwin supermarket, and 19 per cent more expensive than the Darwin corner store".

But prices in remote stores could be considerably higher than the average figures indicate. For example, while the basket price in Darwin *supermarkets* was \$490. Findings included:

- The average basket in Darwin District [which includes some remote stores] was \$617 (26% higher than the Darwin average);
- The average basket price in remote stores was \$632 (29% higher than the Darwin average);
- The most expensive corner store basket price was in East Arnhem at \$730 (49% higher than the Darwin average); and
- Barkly remote district had the most expensive basket prices average (which included supermarkets) at \$765 (56% higher than the Darwin average).

⁴⁷ A Market Basket Survey was conducted in two major supermarket chains across Sydney and its surrounding suburbs in June 2006 by the Sydney Food Fairness Alliance through the University of Western Sydney. The average basket price in this survey was \$216.80 which indicates that the basket in this survey was not the 'standard' basket, which somewhat reduces the value of the survey as a tool for national comparison.

⁴⁸ These figures were also quoted in the ACCC *Report into the Competitiveness of Retail Prices for Standard Groceries*, July 2008, Part 1, p. 86. Available at:

<http://www.accc.gov.au/content/item.phtml?itemId=838251&nodeId=1e2f1fbbc813e1559b54c8e91c31d0dc&fn=Grocery%20inquiry%20report,%20chapters%201%E2%80%9310.pdf>

Appendix Three

What a remarkable thing is Rural and Remote Community Care!

Our interviews provide a snapshot of how remote area community care operates. We did not specifically ask clients to describe their service but many provided us with an invaluable insight into the day-to-day running of rural and remote community care. While some services operate five days a week, others are effectively 'open all hours'. A few service profiles will give some sense of the tasks undertaken by remote services, and the burdens they carry. The phrase most commonly issuing from coordinators/managers in response to our question of how 'sustainable' their service is, was to the effect that "we make do: we provide what our clients need".

Service 1 is in western NSW. The community care service has about ten CACPs. Almost all of the service clients are of Aboriginal descent. The rating of the service centre is very remote.

We are constantly trying to streamline the service, because that is what we want to do, not because of the supplement. Because the service [provider] is a health service, we will get paid anyway, so how much money we get is irrelevant to what we do, we do what we want, we go to the local area health service, we order through them, they give us stuff, and they pay the bills. Not a bottomless pit, but, we do the best we can. The CCVS hardly registers. Staffing is the issue for us. [We provide] services within the community, [and only travel] about two to three square kilometres. We visit every one of our 12 clients once a day every day.

Service 2 in the NT has less than ten CACPs and receives the CCVS at \$9.24 for all packages. The service centre location is rated very remote.

We receive around \$1600 through the CCVS each month. [Service] also has [a significant number of] HACC clients, some are on waiting list for CACPs. The service brings people in to the women's centre for breakfast and delivers a hot meal five days a week to all clients at their home. We also drop shopping home for people. We see some people 3-4 times a day. When they come in to the women's centre they watch DVDs and socialise for 4-5 hours sometimes. We also assist people to do banking through a traditional credit union and assist them with financial management. We have a cash tin for people to keep their money safe. We also assist the health clinic to deliver evening medications for two clients every day and for one client over weekends. Most of our clients live in the community, at most about seven minutes travel. Sometimes we visit outstations: we prepare meals here [at the Women's Centre], and the clinic takes them out. They also pick up laundry for us. So essentially we are delivering to outstations. We take people to [Town X] for a shopping trip, once every six weeks. [We have been affected by] increasing costs of petrol, food from Darwin, everything comes via barge, fuel costs \$2.30 a litre for diesel. So the CCVS has enabled us to keep the same level of service as petrol has gone up from \$1.90 to \$2.30: 80 litres each tank for the troop carrier. On Tuesdays and Thursdays we do bush trip days, back to country, fishing, collecting pandanus and other fibres for string bags. The clients make these to sell or keep them. Sometimes the two disabled children in the community go out with the elders, so the community care service sends workers out with them. We have nine staff all together: the coordinator plus the HACC supervisor, and seven others, CACP workers and HACC workers all do the same work. We travel to [Town X] 220 kilometres north, also drive to homelands, 200 kilometres one way. Occasionally we charter a plane to take people to their homelands, for funerals and ceremony: 400kilometres, cost \$570 each way. About 12 months ago we started assisting people to get to and from ceremony. In the 'Top End', there are a couple of months where people want to attend ceremony, so we have to limit this: each time might cost \$570 each way if they are frail and have to fly. Others go by car if possible. If their family has a vehicle, we give vouchers of \$100-200 for petrol. The CCVS money has assisted us in a bush medicine

project. Two of the older CACP ladies are involved: collecting and documenting local bush medicines, demonstrating how to prepare them, we have done this ourselves, as a bush outing. We go to a local river, and we are videoing and photographing to make a booklet. The women came up with this idea themselves: they want to get this information recorded before it is too late. We may talk to AIATSIS [Publishing] in Canberra about this. I [the community care coordinator] have paid for some of the equipment, but the CCVS has also contributed to being able to do this project. Clients would like to be able to go to more ceremonies; at the moment we have to limit this.

Service 3 is located in the Northern Territory. The service centre has an ARIA rating of 1200, very remote, and receives the CCVS at the rate of \$9.24. The service has less than 20 CACPs.

[Town] is a very small community, only, 4 kilometres by 3 kilometres. We have a moving population of from 2000 to 2700, with people coming and going on a seasonal basis: all our clients are Indigenous people. All our staff are local Indigenous people. Some of our packages are daily services, some are three days a week. What the CCVS has done is allow the service to employ an experienced community care manager which it didn't have before. This is a very significant advantage to make the service operate well, it's a quality issue. We have been able to pick up on management, administration, governance across the board. What do we want?: better skills, more efficiency in the system. If you think, everything that comes in here takes a five day barge trip: it all has to be planned and organised. Fuel still costs \$2.50 a litre up here and there is no competition between carriers or suppliers to control the price.⁴⁹ Food can cost up to 60% of family incomes up here. Our meals service, the quality of the food has improved [with the new management], the quality was appalling. Now we do stock control on food, diet. Without the CCVS it would not be possible to employ the people who now run the food system. All of our food is shipped in. Better management has enabled the food quality to be improved without increasing the price. For instance, we had the wrong blades in the cutting machine, and it was a domestic cutting machine instead of an industrial machine: one big spend on these has saved many dollars on labour and food costs, and we have been able to cater now on a contract basis to the community, so now we are raising money, and people are healthier. Many of these remote services are very poorly administered, very poor governance, and people have very low expectations about what a good service looks like, and there are very specific remote community (especially Indigenous remote community) needs, such as staff time-off for funeral business and other cultural business etc, getting fresh and affordable food into communities, maintenance of equipment is an issue for people who don't do equipment well, eg the wrong blades so cutting machine is useless. A good manager makes a huge difference and the CCVS has enabled the employment of a capable, experienced community care manager.

Service 4 located in the NT has less than ten CACPs. The service centre is rated as remote with an ARIA rating of around 800.

They get morning and afternoon visits, weekend shopping etc., but the trouble with [Town] is that we don't have a centre for day respite, that is the real issue here. We have been arguing for this for two years but now we have no fight left in us. And then we would need more staff. Currently staff work 8-12 hours each day. Now, clients have to go to [regional centre] for respite and they won't go. If they go to [regional centre] it has to be weeks at a time: the clients won't go. They won't leave their community. If we had a decent house we could use it for longer respite. The respite centre is our main wish, or a house as a centre. We have an office only and a laundry. We take people shopping, and we have a carers program with a vehicle to take people out hunting, fishing, culture stuff, bush tucker. But too wet three months of the year. Caring for the carers is the main thing here and we have no respite centre here. Carers need to be looked after. We can't do what we want because of the lack of a centre: we are actually not spending all we get because we haven't got the facilities or the staff to do what we want to do. This service has been going for 12 years and still there is nothing in place. The old people want a centre for all sorts of reasons and we need a centre for the better quality of life for the old

⁴⁹ The price of fuel at this centre remains at this level in April 2009, despite price reductions in much of the rest of the country.

ones. There are about 60 people here aged over 60 years. They have to go to [regional centre] when they need residential care. Old people want to stay in their country. All the services have been taken over by the new shire which has brought other stresses.

Service 5 is in western Queensland. The service centre is rated as moderately accessible with an ARIA rating of around 500. The service has about ten CACPs and a significant number of ATSI flexible packages.

[We] probably provide more hours of service [than the allocated packages allow]. We travel up to one hour each way to clients. A lot of [our clients] live on properties, they need to be picked up for doctors appointments, also meals on wheels three times a week, that is six meals a week each, we have to have eskies etc to take meals to clients. Meals on wheels don't deliver out of town. Some of our clients should be on EACH. We are short of cars; staff have to use their own cars. We pay a travel allowance but it just covers the kilometres. The CCVS has helped us with the rising cost of fuel but it still does not allow us to pay proper travel allowances. We provide eight hours per fortnight to those who need it. The CCVS means we can afford to do that. We have case management meetings once a week, a one hour team meeting in each of the four towns. We re-do care plans tailored to suit the client, and are able to put in more care with the CCVS. We also take them to specialist medical appointments, 200 kilometres each way. The CCVS has helped towards these trips. We also provide lawn mowing. A lot of our clients don't pay, because their farms are not viable: we cover this by [the auspice body's] compassion: the policy is that we don't refuse a service, if there is money there at end of the month we stretch it to cover. We have 15 unfunded packages over four towns. So far we have been able to keep any unused CACPs for 'unfunded packages' but we understand that we now have to spend it by the end of June [2009]. In the last 12 months quality reporting has come in and now they have to use up this money. We are using it to buy equipment for clients, white goods, clothes blankets, sheets, towels, kitchen goods, Webster packs, wheelchairs, kylie sheets, walkers, equipment on loan: all necessary. We pay a contractor for lawn mowing. We supervise trainees each year for Certificate III.

Service 6 is on the Queensland coast. It has less than 15 CACPs and services clients in a limited area, travelling up to 20 minutes each way. The service centre is moderately accessible with an ARIA rating of around 400. The service receives the CCVS at the rate of \$2.72 for nine clients.

We visit our clients three days a week on average, all are allocated 5-7 hours, and two with high care needs have a whole package of care. We see [these high care clients] on a daily basis seven days a week, one we see three times a day: breakfast, lunch, dinner and medications. The other whole package CACP client has a carer who lives in with clients. Both of these high care clients get the CCVS. We have increased outings for clients to our recreation room and socially supported outings. We give them domestic assistance in home. But these have not increased due to the CCVS. We are covering costs better, since we moved from our little office, now in a better office, we are able to share costs with HACC better. Our 'wish list'?: to have more recreational time for clients: we have to limit this to one day a week. We are in the process of applying for centre-based recreation, which is now only funded for social support which is given in the home 15-30 minutes only. We use some of this social support funding to bring them into our centre, but we want money designated for centre-based recreational programs. The CCVS has not enabled us to increase our services, but our clients would really benefit from an increase. We do out of town appointments to Townsville, we would do it twice or three times a month. One of our paid workers does this, we keep hours back for this, and this pays for the trips.

Service 7 is in inland Queensland. The service has less than five CACPs. The service centre is rated as moderately accessible with an ARIA rating of around 400. It receives the CCVS at the rate of \$2.72 for all clients.

We travel in a 50 kilometre radius. We provide our client with approximately 21 hours per month. Most clients are visited five days a week, one seven days a week. We see one client three times a day. We have increased the hours for one client, another we can now visit twice a day due to the CCVS. Generally our average hours per client have probably increased and the CCVS would have helped with this. I think we provide a comprehensive service already, we could not do any more: personal care, medications, physiotherapy exercises, domestic assistance, social support, medical appointments, in-home day respite.

Service 8 in Queensland delivers a relatively large number of CACPs, around ten EACH packages and around ten EACH Dementia packages. The service centre is rated as moderately accessible and has an ARIA rating of 370. It provides services to clients 55 kilometres north, 70 kilometres west, and 45 kilometres south of its service centre. All clients are out of the town region so all receive the CCVS at the rate of \$2.72.

We service regardless of where people are. We visit our CACP clients every day seven days a week for most of our clients, and five days a week for three clients. We see about half our EACH people five days a week and about half of them seven days a week. We see half of our EACHd people five days a week and half of them seven days week. The CCVS has not enabled us to deliver more services: we do them anyway. We are able to provide more staff education, especially with dementia, and high care needs, and this is partly due to the CCVS. Honestly, any extra funds would [assist us to be more sustainable]. We could do more, could have more.

Service 9 in Queensland is moderately accessible with an ARIA rating of around 500. The respite and CACP service has less than ten CACPs. The CCVS is received for all packages at \$3.27.

Our furthest client is 90 kilometres away. We are approved for [X number of] CACPs, now providing one less than our allocation. We go seven days a week to all our CACP clients. We provide approximately 52 services a week amongst the clients, which is once a day for all plus multiple services for some. Of those 52 services per week, 38 attract the CCVS. The CCVS helps us with our transport costs. It does make a difference: pays approximately for one hour's transport or one and a half hours of care for each client across a month. It is a small improvement. We don't provide more services as a result of the CCVS but it makes the visits we do more viable, in terms of cost coverage: more viable to get to clients and so we can use the money we do have to provide services, rather than transport costs coming out of the package itself. But we would like to see it increased. Fuel costs are rising, it has only helped to contribute to an hour of travel costs, we are still paying the hourly rate, so it should be doubled to about \$7.00 per day for our remote clients. For example, if we need to take a client to an appointment, doctor or allied health, it is a 50 kilometre trip from our office, but we have to get the client first, and drop them back, so it is really a 200 kilometre trip. The one thing we would really like to be able to do?: when a CACP is no longer viable, and we would like to move them on to an EACH package, or loads of extra transport (when they're at edge of CACPs) we would like to be able to provide more care; there is a delay in the formal transfer to EACH. We can't do EACH because we don't have an RN on staff. Then we need to broker it from a provider but there may be a three to six week gap: we would like to be able to provide the care needed in the interim: we do it anyway but would like more help to do it. Transport is really the big issue. We do it anyway, but it strains the service to a point, depending on how long the interim/transfer takes. We have one woman who needs to move to EACH, but we have one client on leave at the moment so we can juggle this, but if no one was on leave it would be really tricky. Sometimes we get emergency respite. The CCVS is excellent but it needs to be more. It does help us when you look at it on a monthly basis, an extra hour/hour and half service per person is good, and it does make our transport costs more sustainable, but it needs to be higher.

Service 10 in Queensland is rated as remote and delivers less than ten CACPs. All clients receive the CCVS at various rates from \$2.72 to \$3.27 and \$4.58.

We travel about 80 kilometres one way to our most remote clients. The CCVS probably would have made a difference to our service if we had enough staff but staff are very difficult to get. The CCVS has helped us to get to clients, so we can maintain our number of visits, which we could not have done with fuel cost rises, but it has not enabled any service expansion. I think it certainly helps sustainability, and helps with cost margins. We would love to be able to offer allied health: we don't offer this now. This would be the main thing: occupational therapy in particular.

Service 11 is located in a small inland Queensland town. The community care program is delivered by the local Shire Council. The service centre rates as very remote. It has a very small number of CACPs. All clients receive the CCVS at the rate of \$9.24.

We travel only three minutes, all the clients are in the town and it is only a little town. The CCVS means we do get a little extra time with clients if needed. We do bathing, visiting. We can do more visits, sometimes go twice a day now. The Council people do our books, so we don't really know whether it has made the service more financially viable, not really sure what difference the CCVS has made. We do everything for the clients, council handles the money, we don't have a waiting list, if clients need service we just do it.

Service 12 is in South Australia. The service centre is rated as moderately accessible, at ARIA 375. It delivers a small number of CACPs, EACH and EACHd packages. The CCVS is paid for all clients at rates of \$2.72 and \$3.27.

We drive to clients up to 2.25 hours away. We receive the CCVS at rates of \$2.72 and \$3.27. We have used the CCVS as a fuel/travel allowance. We were paying an allowance but now we can pay more. We have also used it to improve our service in other ways. One particular client we went from one long visit to two shorter visits which suited their need better. We couldn't find staff for the two visits and the VS allowed us to. Where does the list [of what we would like to do] end? Lots we could do but no resources. The subsidy doesn't create people to do the work. Staff is the issue: there are no volunteers here because staff need to be a minimum of Certificate III. We use volunteers to drive clients to doctors appointments. And general equipment, we can't afford to purchase these items. It is \$3500 minimum for a hospital bed, the CCVS does not extend to this. Case management, 24 hour on call, weekly check visits are not part of the clients' quota. CCVS doesn't cover any of this. We put the CCVS back to the clients. We have 35 staff. It has been useful but we would like to know more about the criteria the Department considers is a distance: we have people out on farms, who are distant, but are not considered for the CCVS, whereas others we travel the same distance to do get it.

Service 13 in South Australia has an ARIA rating of around 600, and is rated as remote. It services clients across an area of some thousands of square kilometres. The service has a large number of packages with most clients currently receiving the CCVS.

We travel great distances between clients. It costs us a huge amount to get the care workers there. We are currently paying 68c per kilometre which varies in cost according to the distance travelled, the furthest being 90 kilometres each week per visit which equates to over \$60 spent per visit before the service is even provided. We are funded for [X number of] CACPs, but we are providing care to many more people than the allocated number of packages should support at this point, dividing the funding across all recipients, including Indigenous aged people. Our returns to government only include funded clients. When a package ends, we fill it immediately: we transfer the package to anyone with an ACAT assessment. So all our CACPs are in use 365 days a year. We get the CCVS at four different rates. We have provided so many unfunded services, we haven't noticed the difference since we got the CCVS. In the past 12 months all costs have increased. So we haven't noticed any great difference. Have we provided any extra

service as a result of the CCVS? No, we do it anyway, whatever the need, so no extra visits. The extra dollars help obviously but...we would hate not to have it, especially in recognition of the distances we travel. In some instances people travel voluntarily. We provide a small fuel supplement. Because of distances, we contract all our service providers across the region through established "Health Services" who then provide the hands on care workers to deliver the service to each CACP recipient as per their Care Plan. Currently we have contracts with Aboriginal Organisations and Community Health Services of which some employ all their staff (home support workers) and others use contractors only, a couple of organisations utilise both employed staff and contractors together. The two CACP staff provide all initial assessments & ongoing reviews and case management. This CACP Program does not directly employ home support workers however it pays all package expenses plus an administration fee to each contracted organisation each month as invoiced. We do case management, we would like to do more reviews more often. We [coordinator and her 0.5 assistant] do the reviews for all clients, we are on the road every month. We would like to be able to offer more social support to people, but by the time we have provided the 'necessities' people don't get the 'nice things' like church, outings: unfunded means we don't get funded for the service delivery. We have 'excess recipients', but nothing happens. We just spread the funding further. Some people have lesser cost needs, so we are able to spread the time. It is the coordinator's choice of how best to meet the needs of the clients. If people suddenly need more, we are able to be flexible. The advantage is that we can slip in an unfunded as soon as one comes available. We also have a waiting list, people just survive on HACC. [I am] confused as to how they work out amounts for each category of the CCVS: some further out get less. [When interviewer asked her if she gets paid for overtime, she says] 'No, we all do extra hours, don't we all?' [The CCVS] is helping us maintain our additional clients and it eases some of the stress on the waiting list.

Service 14 in South Australia is rated as moderately accessible, with an ARIA rating of around 400. It delivers around 30 CACP, and a small number of EACH and EACHd packages. About one third of CACP clients, one EACH and one EACHd client receive the CCVS at a rate of \$2.72.

Our most remote client is 90 minutes by road from the main centre but we have staff closer to them. The CCVS has contributed to visits structure, but not necessarily to the clients who get the CCVS. Our remote clients can now get multiple visits per day, with more oversight, we may be able to stay longer, have more visits. The problem is that it isn't applied to our most remote clients; our rural centre is [Town X] which doesn't get the CCVS but we service them from [Town Y] and they may live quite isolatedly (sic); no doctor, no chemist, can't attract workers for community care and they still don't get the CCVS, because they are within a certain radius of [Town X]. We have a sub-office a bit closer to [Town X] where we roster from, but they are very remote. We try to recruit workers who are reasonably close to the clients. When these clients need to go to the doctor, dentist, shopping, we have to program a five hour shopping trip: one staff, one client maybe, in a tiny hamlet. We have clients in [Town Y] who do get the VS, in a town where there are supermarkets, chemists, doctors etc. The way the CCVS has been designed is all wrong. If they used a population-based model it would be better: if a person lives in a town with less than 1000, can they shop in the local community? This would make more sense, rather than just a postcode cluster. The CCVS is not a huge amount: about \$800 per year per client. The sort of service we can provide to clients in [Town X], is quite different from the sort of service we can provide to remote clients. Many of our CACP clients in [Town X] or [Town Y] get two or three visits if they have medication management, but most remote clients get one only and then their carer has to manage medications. Part of the reason people stay in these small communities is because they have family/carers, whereas retirees who move to towns may not have family. There are certain advantages here but it does not balance. We have one worker who visits our most remote client: we pay her \$800 per fortnight in mileage reimbursement. We pay large mileage to others but none of these workers are visiting CCVS clients. I have felt for a long time that the rates don't cover the cost of delivery; the design of the CCVS doesn't 'hit the mark'.

Service 15 in Western Australia is rated as remote with an ARIA around 900. The service only delivers within the town of [X] and the surrounding Local Government Area. It has about ten CACPs and a smaller number of EACH packages. It has ten Indigenous clients. All clients get the CCVS at \$5.50.

We only travel out of town about 10 kilometres maximum. As a result of the CCVS, we are better able to absorb costs of recruitment and retention of staff, increased cost of fuel etc.,. It has been taken up by these contingent costs: no extra services but we are better able to absorb rising costs. Each client gets what they need, but they probably have not had more visits as a result of the CCVS. There have been a lot of the increased costs in the last 12 months which has chewed it up. It is still not adequate to deliver 'extra' services. In our community care program we do break even now, but would have to look at figures to see how much difference it has made to their bottom line. We would all like to provide more hours of service but staffing is the big issue, CCVS has not made us more competitive with other industries to attract staff. Tourism pays much better. At the end of the day it's all extra money but the increased cost of living over the last 12 months ... you have to question whether it's enough. It's hard for us as a remote provider in a town, let alone those delivering to actually remote clients, therefore it is not really adequate to attract and retain staff and provide more adequate service to clients.

Service 16 in Western Australia is rated remote with an ARIA around 900. It delivers [a large number of] CACPs, all to clients in remote Aboriginal communities across an area of 440,000 square kilometres. All clients attract the CCVS at a rate of \$ 7.70 or \$9.24.

Our closest client is 190 kilometres south, each way travel including about 19 kilometres off-road driving. Thirty out of the [X number of] CACPs are ATSI specific packages, but not 'ATSI Flexible'. Only one of our clients is non-Aboriginal and he is married to an Aboriginal woman. Almost all of our clients are ATSI clients. Has had a letter from State Government saying if he can't fill with ATSI clients he can fill them with non-ATSI clients. We keep hours of service by month and we average 18 hours of service for each client per month. All get the CCVS, all but two are very remote so most get the \$9.24. The state government has claimed the community is only 'remote' but we have argued for very remote at \$9.24 per client per day. Postcodes indicated 'remote' via [Town X], but where they live is 'very remote' by any reckoning. We sent them photos of where people actually live. We had the same problem in [Town Y] and [Town Z] which both have [Town Y] postcodes, but they have now changed [Town Y] rating to 'very remote'. Staff turnover is our biggest problem, we are now brokering care services from agencies outside the region, which means staff would have to fly up here and go out and stay in the community for two weeks on/two weeks off, but we have to negotiate housing. We have a budget surplus because we have not been able to attract staff, so now we can spend it to enhance the service with the fly-in/fly out program. It is not yet happening, but hopeful. The CCVS has given us the ability to employ extra staff, so now we have the ability to assist the client in the community better. The packages we have here are very flexible. We have regular contact with state office which allows us to split packages, or start a waiting list of people on social services. Central office priority is to get services to the clients and they are reasonably relaxed as to how we innovate, as long as it's in the guidelines. We have a 'grey folder' for things central office tells us they don't want to know about. We employ a lot of lateral thinking about how to make things work. We do a lot of 'hypotheticals' to see how state office feels. We often now broker services flexibly. One client was attending sorry business in town and we bought a local service for him. Some of our packages have been specific to certain areas (so we could not service this man) but we have now negotiated to make them [region]-wide to follow the person wherever they go: many of our clients are transient. State office has been easy to negotiate with. All [region] CACP providers work together, we have phone hook-ups. We would love to have a regular workforce, but 12 months is 'long service' up here. In eight years I have had four regional directors. We had trouble with the CCVS forms at first, not accepting postcodes with multiple addresses but Medicare repaid and fixed it up.

Service 17 is in Western Australia. The service centre is very remote, with an ARIA rating of around 1100. The service delivers a very small number of CACPs including one ATSI-specific (but not ATSI Flexible) package.

We only provide packaged care in the town of [X]. In three years we have never had a referral outside [Town X]. If there was one, another service would take it up. We might have to but probably not, they would be serviced by [services in the major towns in the region]. We deliver five days a week, 52 weeks a year, to four clients and one gets four days a week. We may do more than one visit a day. Because we have a small number of packages, we have always provided exactly what the clients need. We're not doing anything different now since the CCVS. We visited every client once a day four days a week anyway, so we do the same now. The margins are better. We were struggling to make ends meet and now we can: we were quite often in deficit with our budget, and now we can manage it a lot better. [Auspice agency] manages the budget, we get a monthly statement and if our costs have blown out, eg a client needs more visits, we just deal with it. Going out to a community and saying we don't have the money just doesn't cut it, so we work out ways to make it work. We take money from another area, or put it under another funding umbrella. Our biggest costs are transport and meals: we do some meals, but transport is a major issue. We are a small town with a fly-in doctor, so when clients need medical attendance, they need to go to [major town] four hours away. People have to organise this themselves now. We would like to be able to organise this for them.

Service 18 is in Western Australia and rated as very remote. It has less than ten CACPs, all of which get the CCVS at the rate of \$9.24.

Our service travels two hours north-west of [Town X], about 200 kilometres, and two hours south-west of [Town Y]. Every day we deliver three meals a day, plus morning and afternoon tea, 365 days a year. It is a hostel but it is not classed as such by the government. HACC funding also combined to enable this service level. We also get philanthropic funds from the nearby mine. All packages receive the CCVS at \$9.24 because they are all very remote. It has helped, but then costs have also gone up in the last 12 months and so the CCVS has not kept up. We have not increased our level of service because we already go every day, they already get maximum service cover anyhow. Guess it all helps. Wages are very high because there is an expectation that we will provide a full service to keep people in the community for as long as possible, even when they develop high care needs. Would like to be get 'ATSI flexible' service funding, which would give us more money. We have a bus; would be nice if we could take them for bus rides, overnight visits to family at [Town Z] two hours south. A few more visits to family. We would like to have the running costs and the staff to do this. We always need more money, especially in remote areas as costs do increase. CCVS does not keep up. Staffing is a huge issue.

Service 19 in south-eastern Australia is rated as moderately accessible with an ARIA rating of around 550. It delivers four CACPs and two EACH packages.

We travel 45 minutes in all directions from [Town X], about 40 kilometres radius. We have four CACP, two EACH. On average we would see clients three days a week, for both CACPs and EACH, 52 weeks a year. All six get the CCVS. It all helps in general, for home care and property maintenance bills, personal carers training locally. But can't say anything specific that CCVS goes towards. We train workers for Certificate III HACC which is great in this remote area. We have taken on two extra personal care staff in the last 15 months which may be a direct result of the CCVS but not sure. It has probably also helped us pay higher bills in the last 12 months. We have not increased our level of service in that time because we do it as needed anyway. The service is more sustainable, certainly [a very confident answer]. We have an on-call service out-of-hours for emergencies and this has been a big help to maintain CACPs/EACH. The award rate for nursing staff for on-call nurses, we need to pay per hourly rate, we would like to be able to pay above the award rate, a certain amount per hour above: the award \$21 for 15 hours on-call is not enough to attract staff. Case management would be good, we do it ourselves, we do this out of our nursing budget to manage it, but it should be funded separately. Travel time is currently part of the eight hour day, but we don't pay a travel allowance currently. It is important to us because we have higher costs being remote and higher support costs, and costs to access other services is pretty hard work. We provide volunteer transport.

Service 20 in south-eastern Australia delivers CACPs. The service centre is moderately accessible with an ARIA rating of around 450. The service has 24 CACPs and two EACH packages. The CCVS is received by 12 clients at rates of \$2.72 and \$3.27.

We travel 45-50 minutes out to clients. We visit our CACPs client 2-3 times a week; one EACH client we see five days a week but we go twice on two days out of those five days. We see the other EACH client 11 times a week. The CCVS funds come with the normal costings per month, so we do what we have to do, regardless of the cost, but it probably does help in the overall picture. Have not added on services, it is not a huge dollar value at all, the amount is insignificant. Clients get the visits they need regardless. \$2.70 per day does not enable new programs or more visits etc. We already pay a travel allowance. We are looking at negotiating our Enterprise Bargaining Agreement and an increased travel allowance will be part of that. The CCVS will help this. We already do everything clients need but the extra money makes the service more sustainable. The furthest distance for the non-qualifying clients is 52-60 kilometres drive out to them each day (and return) another 52-60 kilometres.

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