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Older People and Aged Care in Rural, Regional and Remote Australia

A DISCUSSION PAPER



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A discussion paper

June 2004

*This Discussion Paper has been prepared by Aged & Community Services Australia
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The purpose of this discussion paper

Aged & Community Services Australia (ACSA) and the National Rural Health Alliance (NRHA) have come together to promote greater national effort in the provision of appropriate care and support for older people living in rural, regional and remote Australia. ACSA and the NRHA will work together, and with other bodies, to see the proposed actions become a reality.

ACSA is the national peak body for not-for-profit church, charitable and community providers of aged and community care services. ACSA's 1400 member organisations provide residential and community care services to over 200 000 older people throughout Australia.

The NRHA is the peak non-government organisation working for good health and well-being in rural and remote Australia. It is comprised of twenty-three Member Bodies representing rural and remote health consumers and providers.¹

ACSA and the NRHA want to ensure that people living in rural, regional and remote areas are considered in the growing debate about an ageing Australia.

ACSA and the NRHA support the sentiment expressed by the World Health Organization:

Ageing is a privilege and a social achievement. It is also a challenge, which will impact on all aspects of 21st century society. It is a challenge that cannot be addressed by the public or private sectors in isolation: it requires a joint approach and strategies. (WHO, *Towards Policy for Health and Ageing*)

This Discussion Paper will contribute to the understanding of issues facing care services for older people in rural, regional and remote Australia and propose some options for ensuring that services are available locally and have a viable future.

For this to occur ACSA and the NRHA believe that new models of services and support for rural and remote areas must be developed and supported. It is clear that imposing essentially metropolitan models of services in rural and remote communities does not work.

We commend this paper for the attention of policy makers, researchers and government, and hope that it will help the rural, regional and remote aged care sector to make its presence felt as this important debate continues in Australia and around the world.

¹ The NRHA would like to give special thanks to Catholic Health Australia (Richard Gray) and members of *friends of the Alliance* for input to this paper.

Background

Everybody knows that Australia is getting older. What this means is not only that we are all individually ageing, but that the proportion of elderly in the population is increasing because of lower birth rates and increasing longevity. This situation is more prevalent in country areas than in the capital cities, partly as a result of internal migration. This paper focuses on aspects of an ageing Australia that are particular to rural and remote areas.

There has been substantial attention given to demographic change in Australia but not specifically to its rural dimensions. There is a National Strategy for an Ageing Australia but it contains very few references to rural and remote areas, and almost none to Indigenous people. The Intergenerational Report released in May 2002 raised the level of debate about the potential implications of Australia's ageing for the social security, health and aged care and taxation systems. It asked whether and how the aged care system will cope in twenty and forty years' time, and whether for example the Pharmaceutical Benefits Scheme is sustainable. This same agenda was further promoted through the release by the Treasurer of *Australia's Demographic Challenges* in February 2004.

Ageing and location

Most people would prefer to age in their own place — be that their own home or in a form of supported accommodation. Where possible an individual should be able to pass through the various stages of ageing in one location. They would make the transition from complete independence in their own home, to being at home with some care, and then potentially to low care in a residential aged care facility and to high care. They may choose to move to more convenient accommodation, such as a retirement unit, as their needs change. Ideally this can occur without having to shift from their home area and local networks. This is clearly more difficult to put into practice in rural areas where there is a smaller range of helping services and aged care homes available.

The term 'ageing in place' has been coined to refer to this ideal. Ageing in place can be a particular challenge for aged care homes. The care needs of residents often increase over time. Ideally these needs should be accommodated within the aged care home in which they reside, but the required services cannot always be provided in the same place, particularly if they involve increased staffing or changed settings. When this is the case it may necessitate the person moving to another home which can more appropriately support the resident.

Notwithstanding the practical difficulties with ageing in place, the idea does illustrate the essential challenge for ageing in rural and remote Australia. Is the system flexible enough for rural and remote areas? Will there be enough places and beds to accommodate local demand? Rural and remote services should meet the same standards of certification and accreditation as those in metropolitan areas, but because of the particular characteristics of those areas, they will need special support to achieve this.

The ageing rural population

The demographic situation

On 30 June 2002 Australia had 2.5 million people aged 65 years or more, representing 12.7% of the nation's population.²

In 2031 older people will represent 22.3% of the total population (or 5.4 million people) and by 2051 they will represent one quarter of our population.³

The increase in the older old, those over 85, will be even more marked, rising from 9.1% of those aged 65 and over in 1996, to 20.1% by 2051.⁴

A higher proportion of the population is elderly in rural and remote areas than in the cities. In the capital cities, 20.6 per cent were 55 or over in 1996, compared with 25 per cent for 'small rural centres' and 24.4 per cent for 'other rural areas'. Remote centres, in contrast, had only 12 per cent of their population over 55 years of age. This profile is largely due to two phenomena: the out-migration of young people to the cities for education, work and 'the bright lights'; and significant in-migration of older people because of lower house prices, retirement to small coastal settlements and general perceptions of the positive aspects of life in country areas ('peace and quiet', safety and security) regarded as beneficial for retirement.

There are also some rural and remote differences caused by the national distribution of the Indigenous population. While Indigenous people make up only 2% of the Australian population overall, they are disproportionately distributed in rural and remote areas. Indigenous people comprise 1% of the population of metropolitan areas, 3% of rural zones, 13% of remote centres and 26% of 'other remote areas'.⁵

Indigenous people have poorer health status (particularly because of higher rates of chronic disease) and a life expectancy that is around 20 years less than for other Australians. This results in them needing a range of support services — including aged care — at a younger age than non-Indigenous people. This means that the demographic of rural and remote areas is even more skewed because of the need for such services at an earlier age.

² *Australian Social Trends 2003*, Australian Bureau of Statistics, Cat 4102.0, 2003, p. 2.

³ *ibid.*

⁴ *ibid.*

⁵ Rural, Remote and Metropolitan Area Classification consists of three zone and seven classes. Metropolitan zones consist of capital cities and urban centres with population <100 000. Rural Zones consist of large rural centres (25 000–99 000 population), small rural centres (10 000–24 999) and other rural areas (<10 000 population). Remote zones consist of remote centres (≥5000) and other remote areas (<5000). See *Rural, Remote and Metropolitan Areas Classification 1991 Census Edition*. Department of Primary Industries and Energy, Department of Human Services and Health, November 1994.

The strong impact of ethnicity on the relationship between ageing and health status needs to be accommodated in policies for ageing — particularly for remote areas.⁶

There are considerable differences between the major types of rural area ('regional centre', 'other rural' etc) in their population profiles. Many smaller towns in agricultural areas have a marked declining and ageing population. At the same time regional centres and many smaller coastal towns are growing at a faster rate than the capital cities. In 2001, the 75 years and older age group represented 6.8% of the 'Regional and Populated Coastal' areas, compared with 6.1% in populated inland, 5.6% in metropolitan areas and 2.9% in remote regions.⁷

Women in Australia have on average longer life expectancy than men. This overall pattern exists in rural and remote areas, although life expectancies in rural areas are generally lower than in urban areas.

Health and income

The health of older people in rural and remote areas is generally poorer than that of older people living in metropolitan areas.⁸ Overall, the more remote the area in which you live, the poorer your health status. Rural older people are also more likely to have lower incomes and reduced mobility. Overall, rural regions have average incomes some 30 per cent lower than inner metropolitan areas. Twelve of the 20 least advantaged Federal Electoral Divisions and 36 of the 40 poorest areas of Australia are classified as rural or remote.⁹ Analysis of Socio-Economic Indices For Areas (SEIFA), a measure of socio-economic well-being which takes into account factors such as nutrition, housing, transport, education and economic well-being, reveals that people who live in the cities are better off than those who do not, with disadvantage increasing with increasing remoteness.

The higher proportion of people in rural areas with relatively low household income bodes ill for economic security in retirement of many people in country Australia — and for the consequential impacts on their health. It also poses problems for the ongoing viability of businesses that care for older people.

These fundamental issues have been exacerbated in recent years by a serious, widespread and prolonged drought, still not over in many parts. If anything, this has made it even harder for people who are dependent on agriculture to shift to a larger community where there may be a wider range of services, because of the differential value of real estate in smaller farming centres and larger regional cities. As for moving to Sydney: "Tell 'em they're dreaming!"

⁶ See *Population Ageing and Trends in Health and Disease*.

⁷ *Country Matters, Social Atlas of Rural and Regional Australia*. Bureau of Rural Sciences (2004).

⁸ Rural, Regional and Remote Health: A Study on Mortality, Rural Health Series No. 2, AIHW, Oct 2003.

⁹ RDAA, Budget Submission 2004-05 sourced at www.rdaa.com.au.

In summary

Country Australians are already facing, to a larger extent than their city cousins, the consequences of an ageing population broadly foreshadowed for Australia's general future. Factors such as social isolation, fewer economic means to plan for retirement, and limited access to transport, residential and community care, medical and preventive health care mean that many rural older people are coping with these consequences by themselves. To date there has been little specific policy action to assist rural communities with the impact of these trends. This joint paper is designed to help in this respect.

The healthy aged

Many older people are healthy and completely independent. The healthy aged are an essential part of our society, providing vital and invaluable services such as volunteer work, fundraising, childcare, care for family and friends, and mentorship to our young. There are many examples of rural older people working incredibly hard and providing innovative solutions to provide for themselves and their peers.

Healthy ageing requires effective assistance for people of all ages to maintain and enhance their health, to avoid preventable health problems and to cope effectively with unavoidable diseases and disabilities. Older people who may already have health problems and disabilities, or who are at risk of developing them, must be assisted to maintain their health and independence as long as possible and be cared for in ways which maintain a good quality of life when independence is no longer possible.

Key issues for the healthy ageing of older people in rural and remote areas include:

- having the option to remain in their own home for as long as possible, which may require home modifications and a level of domiciliary services;
- feeling safe in their own home and communities, free from violence, abuse and exploitation;
- avoiding loneliness and social isolation;
- having access to various types of accommodation in their home town such as independent living units, residential aged care and group housing with minimal support;
- opportunities for them to continue to use their skills in the workforce and as volunteers;
- the existence of services like Meals on Wheels, supported accommodation, community nurses for home visiting and access to a range of health providers such as general practitioners, specialists, allied health care providers and pharmacists;
- access to appropriate services and support for those people with depression and other mental disorders;
- access to appropriate leisure and recreational services which provide personal interaction, mental stimulation and physical exercise;
- educational facilities for adult learning;
- access to services for people with a disability;
- access to affordable nutritious food;
- access to appropriate services for communications (telephones, broadcasting, IT and print);

- transport to activities not available locally, eg shopping, recreation, health and welfare services; and
- access to appropriate care, advice and support on health and well-being issues including ageing, osteoporosis, falls, menopause and sexuality.

Communities with declining and ageing populations are likely to need special assistance to ensure the existence of these requirements for healthy ageing.

Given the relative shortage of formal services and facilities, carers are particularly important in rural areas in enabling older people to age at home. Over 462 000 people in Australia are primary carers. Many carers are among the poorest, most disadvantaged people in our community as they are often unable to combine their caring role with paid employment. Recent research¹⁰ has also highlighted that the ratio of carers to aged people needing care will decline dramatically over the next 30 years, from 57 to just 35 carers for every 100 people aged over 65 in need of care in the community.

¹⁰ *Who's going to care? Informal care and an ageing population*, NATSEM, University of Canberra, 2004.

Aged care services in rural, regional and remote areas

The main focus of this paper is people in rural, regional and remote Australia who are in need of some level of support as they age, whether they live in their own home, in some form of supported accommodation or in an aged care home.

There is a range of residential and community aged care services and programs available to meet the needs of older Australians. The most significant programs are for residential care,¹¹ Home And Community Care (HACC), the Extended Aged Care at Home (EACH) packages, Community Aged Care Packages (CACP), Multi-Purpose Services (MPS), Veterans' Home Care (VHC) and Department of Veterans' Affairs community nursing services. Some further information about these services is in Appendix 2.

Aged care services in rural and remote Australia

In recent years rural and remote areas have had:

- 582 residential aged care providers, 40% of the total¹²
- 1058 aged care homes (36%)¹³
- 40 719 operational places (28%)¹⁴
- 2653 CACP recipients (11%)¹⁵
- 50 504 hours of HACC services.¹⁶

The options for care in rural and remote areas are more limited and less specialised than in the capital cities. People living in more isolated areas — even a few kilometres from a small country town — have to travel to access even basic services. Many people in rural and remote areas are eligible for community care but there are often long waiting lists with no new clients being accepted because the available services have been allocated. For those lucky enough to receive assistance, there is difficulty moving through the various levels of care as their needs change.

It is important to note that access to even a limited amount of community care is beneficial to the individual and may have “a protective effect against (a

¹¹ There are two types of residential care: High care — what used to be called ‘nursing home care’, and Low care — previously called ‘hostel care’.

¹² Review of Pricing Arrangements in Residential Aged Care, *Context of the Review*, Background Paper No. 1. Department of Health and Ageing.

¹³ *ibid*

¹⁴ *ibid*.

¹⁵ *Community Aged Care Packages in Australia 2001–02: A Statistical Overview*, Australian Institute of Health and Welfare.

¹⁶ *Report on Government Services 2004*, Productivity Commission.

recommendation for) admission to nursing home care”.¹⁷ In rural and remote areas, with relatively more limited access to residential aged care, it is important to ensure people can access community care services.

Our focus needs to be on trying to provide a comprehensive range of services in country towns. However, there are likely to be times when older people in rural areas will require specialised treatment that is only available in a regional or metropolitan hospital. Following a period of hospitalisation, consideration of issues such as time of discharge and the availability of a relative or other escort for the trip home are important for people who have travelled from rural or remote locations. A good health system will also provide continuity of care for discharged patients wherever they live. This may require special provision of outreach services, transport and support. Appropriate discharge planning involves co-ordination between the patient, hospital, GP, carers, relatives and aged care service providers.

In our community in rural Queensland there is no such thing as a nursing home. The nearest facility is about 2 hours away and the waiting list can be several years. The only other option is to move to a major centre some 6 hours away. If you are lucky enough to get a place, there is no public transport for relatives to visit. Once our elderly people leave, we usually don't see them again.

Many are eligible for a community aged care package but there are no new clients being accepted as the money has run out. There is excess funding for the town located 4 hours away but they are too far away to assist. There is an inequity in funding to agencies that deliver home help in our community.

There are many elderly people who are living out of town on properties who are struggling. These people rely heavily on family and friends living near. More funding for meals on wheels and home help would give these people the option of staying on their property for longer. The provision of a hostel would assist them and their families and friends who support them.

Rural and remote services under threat

The viability of existing residential and community care services in rural and remote areas is under serious threat. They are faced with three classes of difficulty: general issues impacting on rural and remote communities, such as centralisation and National Competition Policy; a number of changes affecting the whole aged care sector; and issues specifically affecting aged care in country areas. The most important factors are:

- underfunding of aged care in general through use of the Australian Government's Commonwealth Own Purpose Outlays (COPO) Index, which fails to take full account of cost increases faced by the sector (in 2004, COPO was 2.0% while costs faced by the industry grew by an estimated 7%);

¹⁷ *Targeting in the Home and Community Care Program July 1999 — No 37, Aged and Community Care Service Development and Evaluation Reports, Commonwealth Department of Health and Aged Care, 1998.*

- compliance costs for small facilities and accountability costs; and
- mergers of organisations and takeovers by larger (sometimes metropolitan) organisations.

ACSA and the NRHA have identified a range of issues impacting specifically on aged care facilities and services in rural and remote areas:

- the 1997 reforms (which unified the separate nursing home and hostel programs) shifted more capital funding responsibility to approved providers, without sufficient recognition of the inadequate capital streams in rural areas, often exposing smaller facilities to greater financial risks;
- the regional allocation process, which may allocate beds/packages in unviable numbers;
- the regions used for planning and service provision do not reflect rural communities of interest;
- governance difficulties for services managed by local communities as they age and reduce in size;
- particular difficulty in attracting and retaining staff in rural and remote areas; and, most importantly,
- inadequate recognition in funding regimes of the higher costs of constructing and operating facilities and other services in rural, regional and remote areas.

Government has tried to recognise some of the challenges facing rural and remote communities, through a rural and remote viability supplement for residential aged care, and by introducing service models such as Multi-Purpose Services (MPS) and Regional Health Services (RHS).

Multi-Purpose Services

MPSs are a joint Commonwealth and State/Territory initiative to deliver a mix of aged care, acute health care and community services (including the Home and Community Care Program in some cases) in rural and remote communities. As at 30 June 2003, there were 83 operational Multi-Purpose Services, with a total of 1810 flexible care places. The one MPS in the Northern Territory serves many remote Aboriginal communities which receive funds under the National Aboriginal and Torres Strait Islander Aged Care Strategy.

Aged ‘patients’ in an MPS attract an average funding rate¹⁸ for residents, rather than variable rates based on the need level. This funding approach can be a disincentive to existing residential services to convert to an MPS. For example, one 60-bed facility (with 30 high care and 30 low care places) contemplating joining an MPS would have funding reduced by \$520 000 per annum on the basis of this funding model.

¹⁸ Funding is averaged at Category 3 for high care and Category 6 for low care.

While the MPS model was meant to deliver flexibility in the provision of health care in rural and remote communities, the reality is that funds are often drained from aged care to bolster more immediate needs in acute care. The philosophy regarding aged care services providing a home-like environment can be lost due to the surrounding acute care culture.

Overall, then, MPSs have been successful in some communities and not in others. This demonstrates that there can never be a 'one size fits all' approach to aged care service delivery in rural and remote communities.

Regional Health Services

The Regional Health Services program was designed as a successor to the MPS program as a flexible way to deliver a range of, principally, health services to communities that are too small to support stand-alone services.

The program aims to work with rural communities to identify local priorities and then to support integrated health and aged care services to address them. A wide range of services can be supported under the program, including medical services, community health care, child health services, substance misuse and abuse counselling, mental health services and aged care.

There is no specified model of care or requirement for restructure into a single management entity. This provides considerable flexibility in the model, which is most welcome.

General practice and aged care

Residents of aged care homes often have difficulty accessing appropriate medical care through GPs. There are a number of reasons why it is difficult to attract GPs to attend residents of aged care homes, including the shortage of GPs. The Australian Government has recognised this and introduced the MedicarePlus Aged Care General Practitioner (GP) Panels Initiative. This aims to ensure better access to primary medical care for residents of aged care homes and to enable GPs to work with homes on quality improvement strategies for the care of all residents. In addition a Comprehensive Medical Assessment (CMA) is also being introduced and it is hoped that the combination of these two initiatives will support greater involvement of GPs with aged care residents and homes. Both initiatives commence on 1 July 2004.

This Victorian town has 1000 people. It has a hospital with 8 acute beds and 10 nursing home beds. There is also a 30-bed community-owned low-care hostel.

There is one general practitioner in the town who has admissions rights to the local hospital. Most of the residents of the high-care facility of the rural hospital are his patients, as are most of the 30 residents of the low-care facility. He came to the town at a time when the hospital still had some procedural work and mothers still birthed in the hospital. Neither of these activities are part of the hospital activity today. The GP's major patient activity is geriatric medicine. This was not his first choice and has evolved over the time he has been in the community.

The 30-bed low-care facility was built through generous donations from the community. It has met all the fire regulations and certification requirements for a low-care facility under the new Aged Care Act. This means that it meets the Class 3 requirements for a low-care facility. However, there are design features that preclude it from meeting the 9C certification requirements for ageing-in-place facilities.

When the facility was opened in the late 1990s many of the residents were brought in to the facility with limited care needs. They were often at Resident Classification Scale 7 or 8. Most did not have to pay an accommodation bond and are classified as concessional, or they were asked for a small bond, or enough to be considered an assisted resident.

These original decisions in small communities were made based on a sense of community and recognition that the community had put so much into the building and set-up.

Five challenges to face

There are five key challenges to face in the provision of aged and community care services in rural and remote Australia.

- **Workforce** — recruitment and retention, wage rates and conditions, workload, training and support.
- **The funding system** — accommodating the situation faced by aged and community care services in rural areas.
- **Capital funding** — to acknowledge the limited capacity of rural and remote services to raise capital.
- **Planning** — based on natural local planning boundaries with greater co-ordination.
- **Assisted and/or public transport** — recognising the effect of distance and infrastructure on access to services and their costs.

Workforce issues

Workforce issues are more acute in rural and remote areas than in the capital cities. Aged and community care services are provided predominantly by personal care workers and nurses. Providers often have difficulty finding staff with experience and specialist skills in aged care. There is also a shortage of other health professionals in rural and remote areas such as: general practitioners, specialists (including geriatricians), dentists, optometrists, and other allied health professionals such as podiatrists, physiotherapists and occupational therapists. All people, including the healthy aged, use and benefit from these services as they get older.

Running services for older people in rural and remote areas poses real difficulties for skilled and experienced managers. They need support and training to assist them to negotiate the maze that arises with the governance arrangements including funding models that are in place in rural and remote areas. Funds for services can come from three levels of government as well as community and other private funding for some special programs. Managers may find that they are accountable to a range of bodies and the reporting and other arrangements can be very complex.

There is a national and international shortage of nurses. This shortage is amplified in rural and remote areas where the turnover of staff is high in some places and recruitment of experienced staff is difficult. There are instances in some remote areas where agency and other staff are flown in from capital cities and provided with free accommodation. This option significantly inflates the staffing costs, and the quality and professional development challenges facing local services.

Another barrier to recruitment of nurses into aged care work in rural and remote areas is the significant pay differential between nurses in public hospitals and in the aged care sector. The national wage differential in 2004 is 21.6% or \$170.50/week.¹⁹

The nursing workforce is ageing and this will have a significant negative impact on the availability of nurses in the next 10–15 years as the exodus associated with retirement escalates. Between 1995 and 2001 the average age increased from 39.3 years to 42.2 years.²⁰ In rural areas the average age is approximately 53 years. Currently, 57% of all aged care workers (including nurses) are older than 45 years of age. This is higher than the Australian average for all workers.²¹

Personal care workers have an important role in the team providing care to older people. A recent survey undertaken for the Australian Government found that these workers are generally older women.²² It has been recommended (by Minister Andrews) that personal care workers have a minimum qualification of Australian Qualification Framework Certificate III but this can be difficult to obtain in some rural and remote areas. This qualification can assist workers to articulate into other courses such as enrolled nursing or the bachelor level course for registered nurses. While this is used as a workforce planning strategy by some providers, it can be difficult for workers and employers outside metropolitan and major regional centres.

Education and training for workers is essential to the provision of high quality care to those using aged care services in either their own home or in a residential care setting. There is a range of scholarships provided by the Government for aged care workers including nurses in rural and regional areas,²³ and these are an important first step in making education more accessible. However lifelong learning opportunities including formal and informal education and training are not readily available to all staff in rural and remote areas. Providers indicate that they do not have the available funds necessary to purchase this education from outside the local area. Staff say that education opportunities are often not flexible enough to fit in with their working and personal lives in rural and remote areas.

The workforce issue is often exacerbated by the lack of housing provided for workers moving to rural and remote areas to work in aged care. Providers do not generally provide financial assistance to workers other than those who fly in to complete short-term work contracts.

The major issue in central Tasmania is staff shortages. Staff sometimes have to work double shifts, with few options for holidays. There need to be more registered and enrolled nurses with practical training who want to come to small rural services.

¹⁹ Australian Nursing Federation 2004, *Nurses Paycheck*, 3(3) June–August 2004, ANF, Melbourne.

²⁰ Australian Institute of Health and Welfare 2004 *Nursing Labourforce 2002* AIHW Canberra.

²¹ National Institute of Labour Studies 2004 *The Care of Older Australians: A picture of the residential aged care workforce*, Richardson S and Martin B, Flinders University Adelaide.

²² *ibid.*

²³ see for example www.rcna.org.au.

Occupational health and safety

Sole health professionals in remote areas often become ‘all things to all people’. They are often related to or good friends with their client, making difficult decisions about their health care. They are often operating with no administration or professional support and with little opportunity for recreation or professional development leave. Their occupational health and safety is compromised when working alone late at night or when making visits.

In a town with just a nursing clinic (no hospital), the Director of Nursing (DON) is making more and more home visits. No public transport is available in the town. Each year there are more elderly people in the town requiring home visits. Most times there is no medical need, just loneliness and assistance needed for small daily living tasks.

The DON is the only health care worker in town. The clinic is open 5 days between 8 am and 5 pm but days extend into the night and would go into weekends. The DON lives out of town. She rarely gets any time off. She envisages being able to cope with the workload for 12 months, maybe 2 years. Rather than face burn out she will leave the position. These positions are always hard to fill.

If the town had more community care funding, to train locals to help the aged residents at home and supported hostel type accommodation, the DON would be able to concentrate on her main role, have more support and maybe stay longer.

Health Managers in rural areas similarly need support and professional training. Many have come through the ranks as excellent clinicians, but lack the skills, support and professional training in budgeting, staffing and cultural awareness that are necessary as a manager.²⁴

Governance

Boards of Management need additional support and training to ensure that they are always aware of their responsibilities and able to meet them. They are volunteers but must be aware of their standard fiduciary responsibilities. Aged care is no longer a cottage industry but a multi-million dollar commercial activity.

A national effort is needed to get Boards to broaden their vision and to become more responsive to having other services come in from wherever they can be sourced. Board members are ageing and more attention has to be given to transition planning.

Board members also need to be thanked and valued for the great work they do.

These are important issues for rural, regional and remote areas as for elsewhere.

²⁴ The NRHA is preparing a paper on the general needs of health service managers in rural and remote areas.

The funding system

Many rural and remote aged care service providers are facing serious viability issues. Economies of scale are much harder to realise in small organisations. Rural and remote services are most often small providers with limited staff and financial resources.

Some rural and remote residential services receive a modest viability supplement (refer Appendix 1), which is predicated principally on their distance from a major service centre or city. Some changes to the supplement, including increased funding, are being introduced as a result of the 2004–05 Australian Government Budget.

Residential Care Services in rural, regional and remote areas face higher costs than their metropolitan counterparts. They experience:

- less consistent occupancy rates due to smaller catchment areas;
- a resident mix determined by the realities of the local elderly community — they are not able to choose their patients and to balance Low and High care residents in the same way as a metropolitan service with a waiting list;
- staffing structures being set to meet the resident mix with less flexibility to accommodate changes;
- higher costs for goods and services, due to limited retail competition and the need to ship in goods:
 - they pay more for consumables such as fuels because they have to use diesel or electricity as there is no gas supply;
 - paying more for nutritious food;
 - specialised tradespeople often have to be brought in from major rural centres (eg fire service engineers; electricians for specialist tasks such as fire panels); and
 - the cost of commonly used services such as dose administration aids for medication are higher, for example \$5.00 per pack (with some residents requiring more than one per week) as opposed to some metropolitan areas offering a free or much lower cost service;
- particular difficulties in attracting and retaining staff and in upgrading their skills;
- lower (and often falling) real estate values, which means lower bond payments with which approved facilities can undertake capital developments;²⁵
- a lack of alternative providers for people in need of specialist care including care for people with mental health issues. This means that small rural providers must continue to support people for whom there are higher costs, such as dementia or challenging behaviours, without necessarily receiving additional funding;

²⁵ In rural Tasmania one provider received a \$9000 bond while some inner city areas can attract bonds in excess of \$500 000; the overall average for 2002–03 in Australia was \$98 775.

- the need to provide outreach services;
- the resistance of country people to pay a bond for Low Care accommodation when they and their families have been instrumental in building and/or funding the accommodation;
- the lack of understanding of some financial advisors of the fragile viability of residential aged care facilities, demonstrated through their encouragement of families and potential residents to undertake financial strategies which will eliminate the ability of the incoming resident to pay a bond; and
- the lack of awareness on the part of some in rural communities that bonds are refundable and important in securing the long-term viability of the facility.

Community care services experience a number of the same issues and also have their viability affected by:

- high costs of service delivery due to the widespread location of clients and the costs in travel; and
- the very small size of many services.

Capital funds

In our town there is a 10-bed hospital, which is being filled by the frail aged, with no room for acute care. There is a 10-year waiting list for nursing home beds and not enough funding for community care. We desperately need a new facility because we are a growing town and the demand for places is growing too. The current provider isn't making any money and has no prospects for expanding. Carers have few holidays with no one to replace them. There are very few options for people growing old in the town, they have to leave their community and be cared for in the nearest town some 2 hours away or even further afield. There is no public transport for relatives to visit and once they leave, you usually don't see them again.

With the introduction of the *Aged Care Act* on 1 October 1997, responsibility for achieving adequate capital income to meet capital regeneration costs of approved residential aged care services was almost fully transferred to approved providers. From this time, the Commonwealth only provided a small capital grants program to assist some rural and remote services and special needs groups, and pays accommodation charges for concessional (low income) residents.

There are two types of accommodation payments that may be payable to aged care homes:

- people entering high level care can be asked to pay an accommodation charge; and
- people entering low level care or an 'extra service' place (at high or low level care) may be asked to pay an accommodation bond.

An accommodation bond is like an interest free loan to the aged care home and most of the bond is refunded when the resident leaves. There is no fixed amount for a bond — it is agreed between the resident and the provider. Bond sizes can vary widely

between residents in an aged care home as well as between homes even in the same locality. However, residents cannot be charged a bond that would leave them with less than two and a half times the pension (\$29 000) in assets. The annual capital income flowing from an average bond of \$98 775 is between \$9000 and \$12 000 depending on prevailing interest rates.

The maximum accommodation charge that a resident can be asked to pay is \$16.25 per day (\$5931.25 per year).

Overall, then, compared to their capital city and metropolitan counterparts, rural and remote residential aged care facilities have higher construction and operating costs and significantly lower capital incomes.

Planning

A fundamental component of successfully addressing the issues for rural and remote communities is for research, development and trialling of models of service that work effectively in rural and remote areas. This will require boundaries created by Government funding programs to be lifted and local communities to be supported in identifying the best way to meet local needs. Transplanting metropolitan or standardised MPS and RHS models of service is not the answer for all communities.

There is a planning ratio of 108 beds or packages per 1000 of the population aged 70 or over. This includes residential aged care, Community Aged Care Packages and Extended Aged Care at Home Packages. In addition there is a range of planning activities affecting older people at regional and local levels.

Community care services such as HACC are not included in this ratio. HACC and other community care programs have their own methods for determining funding and service allocations to specific areas. This means that the range of inter-related services supporting older people, funded by both State and Commonwealth Governments, are not planned in a co-ordinated way.

This creates a complex maze of service planning and funding arrangements and demonstrates some of the issues which occur as a result of Australia's federated system of Government.

If there is no high-care bed in the town the family will need to look further afield to the larger regional towns and small towns at least 30 minutes away. If they are lucky enough to get a high-care bed in another town there can be other difficulties like the spouse being too old to drive and the family not close enough to transport the spouse to see the resident. No local public transport is available between the two towns.

This often means that families do not take up offers of beds in other towns; consequently the small rural hospital management is in a difficult position of having to ask the family to try harder as they are not in the position to keep their family member indefinitely in the hospital. Conflict can arise in these situations, causing anxiety for family and staff.

Transport

With no public transport available, many residents of rural and remote areas rely on family, friends and volunteers to transport them to the nearest regional centres or the capital cities for appointments. Alternatively, overworked staff take on this role, creating a reliance which is untenable. Some community services receive specific funding to run transport services or to provide volunteer drivers to take people to appointments. This is largely unco-ordinated and not always adequate to meet people's needs.

In many small rural communities there are no public transport or taxi services. Once our elderly cannot drive they are reliant on their family and friends to participate in basic, everyday activities such as going to the doctor or specialist, collecting their mail, collecting their medication, socialising with others or even accessing a newspaper. Some do not have family to drive them.

The community care worker, who does the cleaning and home care support, often takes them to specialist appointments in her own car, in her time off, at her own expense. Recently a 96-year-old woman was given a 6.30 pm appointment to a visiting hearing specialist in a town 90 km away. She had no family or friends who could take her to the appointment. The community worker took her in her own time and they arrived home at 9.30 pm. It took the older woman weeks to get over the visit and the community worker had done a 15-hour day by the time she arrived home; most of which she was not paid for.

These 'favours' occur on a regular basis. As the numbers of elderly needing help increases this worker can not run them all to their appointments and the shops without financial support. She is faced with burn-out or saying no; something she finds difficult as she feels so sorry for them.

Access to transport is a key issue for older people seeking to maintain their independence. It is vital to allow them to use services (medical, banking, shopping, social) in their local town or at more distant centres.

Rapidly developing communication technologies will offer alternatives to travelling to larger centres for some of older people's needs in the future, but visiting local and other centres will still be necessary and desirable for a range of purposes.

Many older country Australians do not have their own vehicle, whether because of disability or other impediments to their driving long distances, such as cost. Public transport is often non-existent, inconvenient or too expensive. The cost of owning and running a private motor vehicle is likely to increase in the future, unless there are major technological changes.

Government support

State Governments provide varying degrees of financial assistance for rural and remote residents who must travel large distances to have access to specialised medical and hospital services, through the Isolated Patients' Travel and Accommodation Assistance Scheme (or its equivalent). Funding for these schemes is quite limited and their administration quite complex and confusing, to the point that many of those who desperately need assistance do not seek it.

As the population ages — and given a continuation of current service patterns — more people from rural and remote areas will require assessment and/or treatment at distant specialist facilities. These financial assistance schemes will thus become more important in reducing access barriers. There is considerable concern that these schemes are already inadequate.

Community transport

Community transport can be provided in a variety of ways — using organisational or private cars (with either paid workers or volunteers), community buses (some of which may be specially funded through programs such as HACC), or vehicles located in the community primarily for other purposes (such as a school bus). Depending on the age of the vehicles used for community transport and the purpose for which they were purchased, they may or may not be fully appropriate for the transport of older people.

In some rural and remote communities there is little co-ordination between different government agencies, each of which provides transport in some form. There is an issue with some program funding arrangements and the related criteria for use of funded community transport. For example those who meet the criteria can access the community bus, but there can still be some members of the community who do not meet the criteria for access and they remain isolated from community activity if no other form of transport is available. There may be innovative ways to make more efficient and effective use of these vehicles, including some agreement about the vehicle mix best suited to the agencies' and community needs, and enabling additional use of public transport.

Healthy Horizons — Outlook 2003–2007 is the national strategy for rural and remote health services. It identifies access to transport as being a priority for inclusion in flexible funding arrangements.

In our town in Central Queensland, a community bus provides free transport for older people to attend medical appointments. The weekly services will collect any senior citizen from their home and return them to their front door after the appointment. A local casino funds the bus and the costs associated with the service it provides. Local government house the bus and provide ongoing maintenance.

This service is vital to our elderly community as many residents would not otherwise be able to make the one-hour drive to attend appointments.

A strategic approach to providing accessible, convenient and affordable transport for rural and remote communities is required. All community members would benefit from such a development, but it would be particularly valuable for older people.

Actions for consideration

ACSA and the NRHA believe that there are two key principles which should guide consideration of the issues facing aged care in rural, regional and remote communities:

- aged care services should be available locally for all Australians; and
- governments should recognise the real costs of providing rural and remote aged care services, and the fact that such services cannot benefit from economies of scale.

In line with these principles the NRHA and ACSA are proposing the following actions for consideration as a preferred way forward on rural and remote aged care issues.

Planning and funding rural models of service provision

1. Governments to provide support for research and trialling of alternative models of aged care planning and service delivery that are particularly tailored to people in rural, regional and remote Australia. Such models would accommodate the needs and characteristics of local communities, including recognition of natural geographic communities rather than current government planning regions.
2. Once the research and trialling has been completed, governments should fund and manage rural and remote aged care services as Flexible Care, with funding and quality regimes designed for the specific circumstances of each.
3. Provide tied funds for rural and remote aged care organisations to determine the long-term arrangements (eg restructure, mergers) necessary for ongoing viability and the continued provision of local services.
4. Ensure that the review of the residential care viability supplement provides adequate financial support for services, is equitable and maintains locally available services. A viability supplement for community aged care services should also be established.
5. Provide adequate capital grants to ensure that smaller homes in rural, remote and other disadvantaged areas can be built and maintained to meet appropriate certification requirements.
6. Small rural and remote aged care services should be provided with funding for administrative assistance, information technology initiatives (hardware and software) and appropriate telecommunications.
7. Consolidate quality and accountability systems to enable integrated service models to operate efficiently and effectively. This will require State and Territory Governments to eliminate duplicative and/or inappropriate requirements.

8. Further explore the use of technology (eg telemedicine) to support rural and remote service delivery.
9. To assist with capital raising, introduce an interest-free capital loans scheme to be repaid by accommodation bonds and charges and the Concessional Resident Supplement.
10. Allow for more flexibility in the application of the planning ratios to assist in the restructuring of services and in achieving viability.

Staffing, training and support

11. Introduce a funded staff support scheme for rural, regional and remote aged care services. It would potentially include e-learning (and other forms of distance education) and would give access to training for staff, support the recruitment and induction of appropriately qualified staff, and provide staff and family benefits.
12. Provide training and support (eg scholarships) for health professionals with specific geriatric and dementia training. Support could be tied to the professional's intentions to work in rural and remote communities.
13. Provide ongoing nursing scholarships targeting rural and remote Australia. To succeed in attracting nurses (or other health professionals) to rural and remote areas, the scholarships need to make provision for flexible distance learning models and support.
14. The Australian Government should provide specially targeted training support and materials to older Indigenous people and older people from culturally and linguistically diverse backgrounds in rural, regional and remote Australia.
15. Support hospitals and health services to undertake improved discharge planning and to provide appropriate support for older people returning to their own home, or to a residential aged care facility, in a rural or remote area.
16. Governments and professional bodies should introduce a management and volunteer support scheme to foster improvements in the performance of members of committees of management of aged care facilities and services.

Transport

17. We need a range of policies and program funding for improved transport services and facilities for older people in country areas, including for helping them to access services. This should include assisted transport for the elderly.

In conclusion

ACSA and the NRHA have released this Discussion Paper as a contribution to discussion of the issues facing the provision of care to older Australians in rural, regional and remote areas.

We would welcome comments on the paper, which should be sent by 30 September 2004 to psparrow@agedcare.org.au or nrha@ruralhealth.org.au in the first instance.

After comments have been considered, ACSA and the NRHA will develop a joint Policy Statement for consideration and action by Government. Your input into this important initiative will be most welcome and will result in a better set of recommendations to governments and others in a position to support older people in rural, regional and remote Australia.

Appendix 1 Viability funding

[These details are generally those current in 2004, with the numbers per State those as at 27 February 2003.]

Viability funding is provided over and above the standard residential care funding. Payments are made to eligible homes without the home needing to submit an application. Some 550 services receive the Viability Supplement. Eligibility is based on three criteria:

- the remoteness of a facility's location;
- the size of the facility; and
- whether 50% or more of a facility's residents are people who have special needs, excluding those who are financially disadvantaged and those living in rural and remote areas.

The Accessibility/Remoteness Index of Australia (ARIA) is used to assess the remoteness of the location of the home. ARIA scores each location. To be eligible for the Supplement a home must score at least 40 points out of a possible 100.

Criterion	Points
Criterion 1: Remoteness	
ARIA location	
Very Remote (ARIA score >9.08, <=12.00)	60
Remote (ARIA score: >5.80, <=9.08)	50
Moderately Accessible (ARIA score: >3.51, <=5.80)	40
Accessible (ARIA score: >1.84, <=3.51)	30
Highly Accessible (ARIA score: >=0, <=1.84)	0
Criterion 2: Size of home	
Places	
1-19 places (inclusive)	30
20-29 (inclusive)	20
30-44 (inclusive)	10
Criterion 3: Special Needs Group	
Special Needs Group	
50% or more of clients from special needs groups	10

Viability Supplement – 40 point scheme

Score	Amount of supplement
Eligibility score of 100	\$20.68
Eligibility score of 90	\$12.73
Eligibility score of 80	\$9.86
Eligibility score of 70	\$7.01
Eligibility score of 60	\$4.15
Eligibility score of 50	\$1.43
Eligibility score of 40	\$1.26

Viability Supplement – 60 point scheme

Degree of isolation	Number of places	Amount of supplement
Isolated Remote Area*	1–15	\$20.68
Isolated Remote Area*	16–29	\$12.73
Isolated Remote Area*	30 or more	\$1.26
Remote Centre*	1–15	\$9.86
Remote Centre*	16–29	\$7.01
Remote Centre*	30 or more	\$1.26
Rural Outside Large Centre*	1–15	\$4.15
Rural Outside Large Centre*	16–29	\$1.26
Rural Outside Large Centre*	30 or more	\$1.26
All Other Areas	Any	\$1.26

* 'Isolated Remote Area' refers to Statistical Local Areas classified as 'Other Remote', 'Remote Centre' refers to Statistical Local Areas classified as 'Remote Centre', 'Rural Outside Large Centre' refers to Statistical Local Areas classified as 'Other Rural' or 'Small Rural Centre' in the "Rural Remote and Metropolitan Area Classification, 1991 Census Edition." AGPS 1994.

Viability supplement details

The table below shows the number of services paid viability supplement in 2002–03.

Provider type	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total
Charitable		10	1	4	4		1	4	24
Community-based	1	77	4	53	24	13	31	18	221
Local government		17		6	1	6		6	36
Private		3		8	1		9	2	23
Religious	1	30	7	40	9	5	4	16	112
State Government		9		9	22	10	74	2	126
Grand total	2	146	12	120	61	34	119	48	542

The 23 private services are not all investor based for-profit entities. Some are operated by the non-profit Bush Nursing Association but are classified as private. Also a church and charitable public benevolent institution may hold all the shares in a proprietary limited company that is the approved provider.

Appendix 2 Aged care services in rural areas

There is a range of aged care services provided in rural, regional and remote areas. The following is an outline of the major programs.

Residential care

Aged care homes provide residential care (high care and low care) to eligible older people assessed by Aged Care Assessment Teams (ACATs). Residential care combines the provision of accommodation with nursing and/or personal care and other supports.

Aged care homes may also offer extra service and respite care within their overall service provision:

- *Extra Services Scheme* — enables residents at any level of care to access a higher standard of accommodation, food and other hotel-type services at a higher charge. High care residents can also be charged a bond for an extra service bed. Provision of extra service is capped and the level of this cap was recently increased to 15% of places within each State. On average current levels of Extra Service provision are much lower than this at 3% (national average) though some regions are closer to the new cap.
- *Respite Care* — Residential respite provides short-term care in aged care homes. It is available for planned breaks or emergency cases and provides support to carers. In 2002–03 there were 47 716 residential respite admissions and 985 000 resident days provided.

Community care

Approximately 4000 different organisations, including State and Territory government, local government, community groups, private and religious and charitable organisations, provide community care services.

The level of care needed by an individual is determined by an Aged Care Assessment Team (ACAT). These assessments are required for High Care and Low Care, for Community Aged Care Packages (CACP) and Extended Aged Care at Home Packages (EACH). The need for community care is assessed by individual organisations and anyone can refer a person to community care — including self-referral.

The major plank of community care is the **Home and Community Care (HACC)** program, jointly funded by the Commonwealth, State and Territory governments. It includes home nursing services, personal care, meals on wheels, transport and shopping assistance, home help, allied health services such as community pharmacists, podiatrists, home and centre-based respite care and social activity programs.

Extended Aged Care at Home (EACH) packages deliver care equivalent to high care level residential (or nursing home) care. The program began as a pilot in 1994 when the Commonwealth government funded the Aged Cottage Homes Group (ACHG) to ‘swap’ nursing home beds in their Milpara Residential Aged Care Facility in the eastern suburbs of Adelaide for flexible community care services in the home. The ACHG now offers EACH level packages as part of their In Home Care Services, also comprising low level home care (such as HACC and CACP packages). This enables people to move from low to high back to low level care as required. In 2003 there were 1000 places allocated nationally, with approximately 166 places in rural and regional areas.

Veterans’ Home Care (VHC) provides a similar range of services offered by HACC to veterans, war widows, and widowers with low level care needs. New services available under the Program include domestic assistance, personal care, home and garden maintenance and respite care. This extends the range of care services already purchased/provided by DVA which includes community nursing, in-home and residential respite care, allied health services, home modifications and transport for health care.

Community Aged Care Packages (CACP) are funded by the Australian Government and provide support for older people with complex needs living at home who would otherwise be eligible for low level respite care. The service provides a case manager and funding to purchase the right levels and mix of community services that will support the person at home. They provide a range of home-based services.

Commonwealth Department of Health and Ageing, **Commonwealth Carelink Centres** provide information and guidance to older people, people with disabilities, their families, carers and service providers. Services provided by Carelink Centres are free and include information about the services available to people including community care, residential care, disability services and other support services as well as availability, waiting list information, costs and eligibility criteria. There are approximately 65 ‘walk in’ shopfront Carelink Centres as well as a national freecall telephone service.

In regional centres and some smaller towns there are also **Independent Living Units (ILUs)**. These are a form of social housing for older people, often attached to residential care facilities. They are facing serious viability issues.

Flexible models of care are provided for Indigenous Australians under the **Aboriginal and Torres Strait Islander Care Strategy** and are outside the realms of the Aged Care Act. However, about 70% of Indigenous Australians have their residential aged care services needs met through the mainstream services. A number of these specifically cater for Indigenous people.²⁶

²⁶ Productivity Commission, Report of Government Services — Indigenous Compendium, 2004.

Department of Veterans Affairs Community Nursing

Community Nursing is a service provided in a person's home to:

- restore health following illness
- allow a person to maintain the best level of independence
- allow for a dignified death.

DVA will pay for these services for Gold Card holders where the person has a clinical need for the nursing and has been referred by a Local Medical Officer. For White Card holders the condition requiring nursing must also be an accepted disability.²⁷

Community nursing care does not include support activities such as companionship, shopping, cooking, cleaning, laundry or transport. People who require these services need to go through the Home and Community Care Program (HACC) or similar private services.

²⁷ http://www.dva.gov.au/health/comm_sup/cacps.htm#nursing.