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Submission to Senate Community Affairs Committee

Inquiry into the Aged Care Reform Bills 2013

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

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What's in an Act?

The National Rural Health Alliance (NRHA) takes every opportunity to press its case for action, by anyone and by any means, which will improve the health and wellbeing of people living in rural and remote Australia.

The Aged Care (Living Longer Living Better) Bill 2013 is one of five Bills amending the Aged Care Act 1997 and related legislation to give effect to the *Living Longer Living Better* reforms.

There are a number of reasons why the wellbeing of older people in rural and remote areas who are well, or who are in need of care, is a matter of particular importance. The proportion of people in rural and remote areas who are aged 70 years or over and of Indigenous Australians aged 50-69 years is higher than is the case in the major cities. Additionally they are relatively sparsely distributed - the more remote their circumstance, the sparser their numbers - so that infrastructure and services become increasingly difficult to provide for them with increasing remoteness. These are some of the consequences of 'place': the ubiquitous and unavoidable effects of distance and its impact on costs, information and access.

Another reason for particular concern is that, like those in other age groups in rural areas, older people are distinguished by particular socio-economic circumstances which tend to contribute to their being less well and less independent. So, for instance, on average they have lower incomes, experience greater levels of disability, and have lower levels of completed education (affecting things like earning capacity and health literacy).

For all of these reasons the NRHA welcomes the opportunity to contribute views on the Aged Care Reform Bills. The creation of a new Act is a major opportunity to set in place the architecture for programs that can help provide the sort of aged care which will accommodate the particular circumstances of people in rural and remote areas, providing them with something closer to the same level of access and choice enjoyed by people in the major cities.

It requires a detailed understanding of systems of national governance and of the administration of aged care services in particular to accurately comprehend which aspirations of rural and remote people can be met through the drafting of a Bill for an Act. To be clear on this matter would require detailed understanding of the niceties of legislative drafting and of the distinction between what can be done through an Act and what through regulation, administrative practice, appeals and other means.

The NRHA is not sufficiently well resourced to provide such expertise. It must therefore resort to reminding the Senate Committee and those involved with drafting of the Bill about the key issues that the delivery of aged care services needs to accommodate and the guiding principles to ensure equity for all Australia's older people.

Even without detailed understanding of legislative and administrative processes, it is clear that where consideration of a Bill is concerned there are two principles which must be observed to optimise the outcome for rural and remote people.

First, the new legislation must not prescribe things in such a way as will damage the prospects for effective, quality services to the elderly in rural and remote areas. This is, as it were, a defensive matter: to ensure that the new Act does not contain any provisions which will mitigate against the sort of flexibility of program delivery which will be necessary for rural areas; or, worse still, that it might be prescriptive of program approaches that are actually counter-productive in rural and remote areas.

The second general principle is to consider those things that might be prescribed in a new Act which will inalienably support the sort of program and administration which will benefit the relevant services in rural and remote areas. So, for instance, it may be possible and permissible for the Act to specifically include reference to cost weightings for rural services to recognise higher costs; to refer to specific provisions relating to information or representation of rural and remote interests; or to mandate and 'lock in' special provisions relating to accreditation and quality control which comprehend necessary differences between large facilities and the smaller ones that will characterise rural and remote areas.

This is the context for the presentation to the Senate Committee of this NRHA submission.

General challenges

The NRHA is pleased to note that, as for the Aged Care Act of 1997, people who live in rural or remote areas are among the groups of "people with special needs" for the purposes of the new Act. As an organisation whose work is premised on the principles of equity and access, the NRHA also supports the inclusion of other newly-identified special needs groups under the aged care reforms.

However, on its own, this special emphasis has not been sufficient to address the needs of older people living in rural and remote communities, as shown in the following Table.

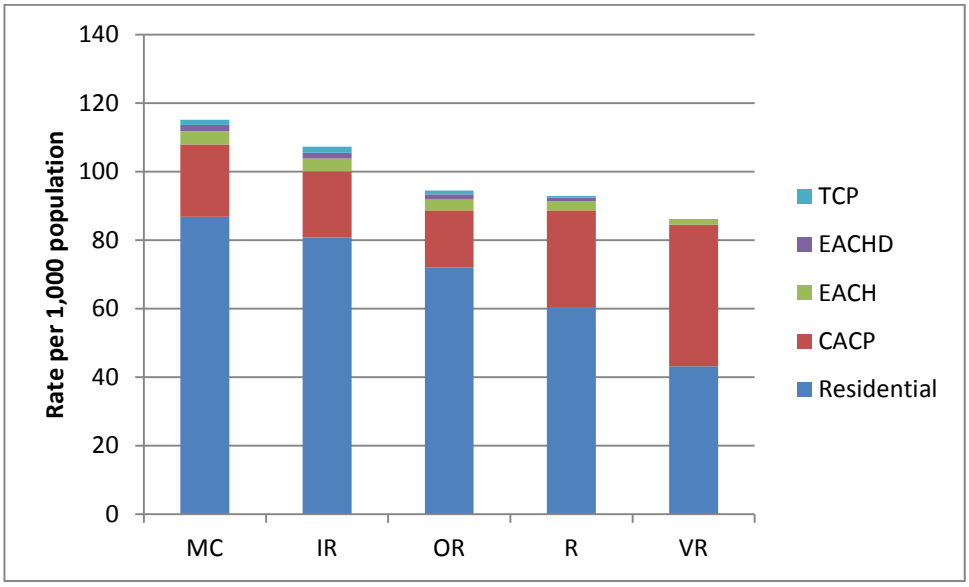
It is plain from this Table that, in general, there is still less choice for people in rural and remote areas and challenges and deficits still remain on several fronts.

The Productivity Commission reported on some of these significant challenges, including:

- the relatively high cost of establishing and delivering services;
- difficulties in attracting, retaining and professionally developing suitably qualified staff; and
- the limited availability of medical practitioners and allied health professionals to support the provision of aged care services.

This Submission will consider each of those three challenges by turn.

Rate of use of aged care packages and places per 1,000 aged population, 2011[1]



Note: 'aged' is here defined as all Australians over 70 years, plus Indigenous Australians aged 50 to 69 years

	rate per 1000 pop (70+, plus 50-69 ATSI)					
	Residential	CACP	EACH	EACHD	TCP	tot
MC	86.8	21.2	3.8	1.9	1.5	115.1
IR	80.7	19.4	3.7	1.7	1.8	107.3
OR	72.0	16.7	3.1	1.5	1.1	94.5
R	60.5	28.2	2.7	1.0	0.4	92.8
VR	43.2	41.3	1.4	0.2	–	86.0
Aus	83.2	20.5	3.7	1.8	1.5	110.7

[1] Analysis is based on:

- data on use of aged care packages drawn from AIHW 2012. *Residential aged care in Australia 2010-11: a statistical overview.* Aged care statistics series no. 36. Cat. no. AGE 68. Canberra: AIHW http://www.aihw.gov.au/publication-detail/?id=10737422821.
- relevant target population by remoteness - all Australian over 70 years plus Indigenous Australians aged 50 to 69 years drawn from Attachment Table 13A2 to Chapter 13, Aged care services in the Productivity Commission *Report on Government Services 2012*. http://www.pc.gov.au/gsp/rogs/2012

First, though, some 'late breaking news' - as it were - from the field. Over 1000 delegates attended the 12th National Rural Health Conference recently in Adelaide. One of the priority recommendations from the Conference reads as follows:

> *"Conference calls on the Living Longer Living Better legislation, with its focus on greater support for older people to live in their own homes and communities, to be adapted to closely address the particular vulnerabilities of older people living in rural and remote communities.*
>
> *These include higher costs of living, a higher proportion with low incomes, greater isolation, and greater exposure to adverse weather events (eg heat waves, fires and floods).*
>
> *Measures should include:*
> - *rural seniors' fuel vouchers to compensate for poor access to public transport; and*
> - *'safe at home' modifications that include timely access to falls prevention modifications, air conditioning, and reflective roofing.*
>
> *Pooled Commonwealth and State investment in aged and disability services should be considered in order to increase the potential for viable home services in under-served rural communities."*

The NRHA asks the Senate Committee to consider both the spirit and the content of that recommendation.

High cost of establishing and delivering services

While the population in rural areas (which of course includes those in small and medium-sized towns) is ageing more rapidly than the population in major urban and regional centres, the Productivity Commission Inquiry into Aged Care in 2011[1] found that:

> "rural and remote areas generally do not have the population density or demand to sustain many types of aged care services that are available in urban areas. The Commission's proposed reforms to increase choice may have limited applicability in rural and remote areas where there are relatively small target populations and it is generally only feasible for one or two service providers to operate."

It went on to suggest that:

> "where there are unavoidable and significant variations in occupancy, alternative funding models, such as supplementary block funding and capital grants in addition to mainstream funding, may be required to ensure the ongoing availability of aged care services in these locations."

[1] Productivity Commission 2011, *Caring for Older Australians*, Report No. 53, Final Inquiry Report, Canberra http://www.pc.gov.au/projects/inquiry/aged-care/report - see Chapter 11, *Catering for diversity*

Although it was acknowledged that, in general, it is more expensive to deliver aged care services in rural and remote Australia than in urban areas,[2] the Government did not include such alternative funding models in the *Living Longer Living Better* reforms announced in 2012.

However, the viability supplement paid to eligible providers on top of their other funding, to ensure access to aged care services for older people wherever they live, is to be maintained. As we understand it, the viability supplement is also to be paid to providers that care for other specific groups of highly vulnerable older Australians, including Aboriginal and Torres Strait Islander people and older people who are homeless or at risk of homelessness. The NRHA supports these inclusions.

The NRHA notes that the details about the viability supplement, to be included in the new Subsidy Principles for all care types in the *Aged Care (Living Longer Living Better) Bill 2013*, are expected to remain the same as in the *Aged Care Act 1997*.[3]

The maintenance of this supplement is welcome but there are still concerns about its quantum. The second report of the Aged Care Survey 2008 conducted by Grant Thornton shows that average facility earnings before interest, taxation, depreciation and amortisation (EBIDTA)[4], for non-urban facilities of $2,096 in 2008 was approximately 30 per cent below urban averages of $2,998.[5] Despite the fact that since 1 January 2010 the Government has increased the level of the viability supplement by more than 40 per cent in recognition of the higher costs faced by these providers, the policy goal of equitable access to aged care services for the people who live in rural and remote communities has not yet been achieved.

It is to be hoped that the new Aged Care Financing Authority established in August 2012, which is "to provide transparent advice on pricing and funding in aged care", and which "will consist of a committee of independent experts and representatives from industry, consumer groups and government", has adequate scope and resourcing to obtain expert analyses of rural and remote pricing and funding realities to inform its advice.

> ***The Alliance recommends*** that the Aged Care Financing Authority and the Pricing Commissioner be charged with paying particular attention to the adequacy and effectiveness of the viability supplements.

The Alliance strongly supports Multi-Purpose Service type flexible funding models where State and Commonwealth funding is pooled to provide a mix of acute, primary and aged care services to meet local needs and increase local service viability in small rural and remote communities.

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[2] Commonwealth of Australia 2012. *Living Longer. Living Better. Information Booklet.* http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-aged-care-reform-measures-toc

[3] Aged Care (Living Longer Living Better)Bill 2013 Explanatory Memorandum. http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22legislation%2Fbillhome%2Fr4980%22 - see Item 126

[4] the performance measure used by the Hogan Review

[5] Grant Thornton Australia, 2009. Aged Care Survey 2008 Second Report. Sourced through www.grantthornton.com.au

The draft Bill (in Schedule 1, Item 114) amends the Aged Care Act with the intention of putting it beyond doubt that a flexible care subsidy may be paid to the approved provider of a Multi-Purpose Service (MPS) based on the number of allocated places, rather than the actual number of care recipients on a particular day. This clarification is critical to ensuring a consistent level of funding to underpin the continued availability of aged care services in small rural and remote communities served by MPSs despite natural fluctuations in demand at local level.

Block funding arrangements for small rural hospitals are being developed through the Independent Hospitals Pricing Authority for implementation in July 2013.[6] It is critical that the arrangements for aged care funding components of Multi-Purpose Services remain stable at this time of change to the funding arrangements for hospital services, in order to sustain effective models of care in small but essential local services.

> ***The Alliance recommends*** that the Senate Inquiry seeks assurances from the Independent Hospital Pricing Authority that the block funding of small rural hospitals takes full account of the importance of sustaining local access to aged care through Multi-Purpose Service type block funding arrangements.

One of the key aspects of the *Living Longer Living Better* reform package for rural people is the increasing focus on home care. Home care makes up a higher proportion of the aged care services delivered in rural and remote communities than in the cities – but the data is quite limited and may not be sufficient to determine the frequency and level of support that is being provided through the packages in circumstances where there are workforce shortages and time has to be spent on travel.

The draft Bills do much to draw together, simplify and streamline the legislation relating to both home and residential care, with the intent of improving flexibility to better meet the needs and choices of older people. The Alliance is concerned that such simplifications should improve, not diminish, access to and sustainability of home care in rural and remote communities – again as part of flexible funding models, with recognition of higher costs and challenges with longer distances and regular access.

> ***The Alliance recommends*** that annual reports and the parameters for the Review of operation of amendments to be established in the legislation should consider the extent to which access and service viability are improving in rural and remote areas – through both home and residential care.

Other matters relating to costs

The Government has acknowledged that some aged care homes in rural and remote areas can also face higher building costs than those in urban areas and it continued to provide access to low cost finance to build or expand services in targeted areas through the one remaining round of the Zero Real Interest Loans Program. It has also streamlined its assistance to providers in these areas by combining its current aged care capital grants programs into a single Rural, Regional and Other Special Needs Building Fund.

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[6] Independent Hospital Pricing Authority, 2013. The Pricing Framework for Australian Public Hospital Services 2013-14. http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/content/pricing-framework-public-hospitals-2013-14 - see Chapter 6. Block Funding of Public Hospital Services.

Despite these special provisions, there is arguably still insufficient recognition of the special costs faced by rural and remote aged care facilities. The funding model recommended by the Productivity Commission for consideration for small rural and remote facilities has not been adopted. It has been suggested by some advocates that the accommodation subsidy be paid at the highest government subsidy level irrespective of whether the facilities meet the post 2012 eligibility condition.

> ***The Alliance still has some concerns*** about the extent to which the new Act will accommodate the particular cost challenges of providing aged care services in rural and remote areas.

Attracting, retaining and supporting suitably qualified staff

Aged care services continue to have difficulties in attracting and retaining sufficient numbers of skilled and trained workers across Australia. However, this issue is compounded in rural and remote communities. It is difficult to recruit and retain staff. There are limited training opportunities for local people. Continuing professional development and training opportunities, for example to upskill while working in a local aged care service, are scarcer and more expensive. Agency staff or other means to backfill during staff leave or to cover staff vacancies are expensive and often require travel and accommodation support as well as longer placements.

The Bill outlines the primary supplements available to services for an individual care recipient, including three existing supplements: the respite supplement, the oxygen supplement and the enteral feeding supplement. All of these supplements affect workforce demands in rural and remote communities where the proportions of older people are increasing.

In addition, the Bill establishes two new subsidies that are highly relevant to the aged care workforce requirements in rural and remote communities, in terms of recognising the more intensive needs of some care recipients – again in increasing proportions in rural and remote communities:

- the dementia supplement. This is a new supplement to provide additional financial assistance for dementia care in recognition of the additional costs involved. This supplement will commence from 1 July 2013 (enabled through amendments to Principles) but will be mentioned in the Aged Care Act 1997 from 1 July 2014 when the broader changes are being made to the sections relating to subsidy and supplements;
- the veterans' supplement. This is also a supplement that will become available from 1 July 2013. The supplement is designed to support veterans with mental health conditions.

In rural and remote communities it will be particularly important that such supplements are flexible enough to cover respite care and home care in ways that can be achieved in sparse populations. A recommendation from one of the concurrent sessions on aged care at the 12th National Rural Health Conference was about the large and growing need for innovative person-centred respite programs for people with dementia and their carers.

A third new subsidy is particularly important for overall workforce capacity for residential and home care services in rural and remote communities:

- the workforce supplement. This supplement will support providers to attract and retain sufficient numbers of skilled and trained workers. Like the dementia and veterans' supplements, the workforce supplement will be available to eligible providers from 1 July 2013, but will be included in new section 44-5 from 1 July 2014.

The Alliance supports the recommendation from UnitingCare Australia that the workforce supplement eligibility conditions be set at a lower threshold for rural and remote facilities.

In addition, further primary subsidies can be catered for that may assist with particular rural and remote challenges:

- any other primary supplement set out in the Subsidy Principles.

At the 12th National Rural Health Conference, people ageing with an intellectual disability were highlighted as a group with special care requirements in rural and remote communities. A proposal was put to the Conference that the major industry peak bodies, including National Disability Services (NDS), Leading Aged Services Australia (LASA) and Aged and Community Services Australia (ACSA) develop a joint training agenda pertaining to ageing with an intellectual disability, to address common educational needs.

Limited availability of medical practitioners and allied health professionals

Some of the Priority Recommendations from the 12th National Rural Health Conference provide valuable contextual understanding of the overlap between health, aged care and disability services in rural and remote communities. Many of the professionals working across the three sectors are the same people, doing their best to meet local needs. Within their communities they are also recognised and valued as important local providers of information about reforms and changes to these systems, as well as people through whom patients and clients can gain access to other - often more specialised – support.

One of those Priority Recommendations reads as follows:

"The current focus on the NDIS highlights the key role played by allied health professionals in disability and rehabilitation services. In rural areas there is an urgent need to increase sustainable allied health services, by integrating disability, aged and health care.

- *To expand the availability of allied health services to meet the increased demand from sectoral integration (health, aged care, disability), funds should be allocated to enable local residents to undertake Cert IV in Allied Health Assistance.*
- *A supervision framework for allied health professionals, students and assistants must be provided.*

This increase in access to allied health services will enable allied health professionals to take leave and professional development entitlements, and provide local employment for local people."

Another is:

"Australia is ready for telehealth development that does not undermine the provision of face-to-face specialist services in rural and remote areas and is driven by clients' needs, not by commercial gain and efficiency at the expense of quality care.

- *Conference calls for additional program funds and a flexible approach to access which would include store-and-forward services as well as real-time consultations and would be unaffected by State and Territory borders. These telehealth services will be underpinned by broader MBS items and appropriate training and support.*
- *Telehealth developments should focus on practical, regular interactions between doctors, nurses, allied health professionals and Aboriginal Health Workers with their patients in challenging communication environments. Uses will include health monitoring, video consults, interim reviews between consultations, professional supervision sessions and new uses as they emerge.*
- *In view of the need to systematise and integrate telehealth care into rural and remote practice, Conference calls on government to continue the work of the ACRRM Telehealth Advisory Committee and other professional organisations and to provide resources for the evaluation of approaches to guide future development."*

In addition, some Conference delegates proposed that materials relating to advance care planning for older people living at home should be held electronically so that it can be shared across the continuum of care – especially as older people living in rural and remote communities are more likely to be at a distance from their families and communities if specialised care is required. Health providers in all settings need to be educated and confident to conduct conversations to identify patients' preferences and to assist in developing and modifying advance care plans.

The NRHA commends to the Senate committee for its consideration the relevant Priority Recommendations from the recent 12th National Rural Health Conference.

The new Aged Care Quality Agency (to be "responsible for monitoring the quality of both residential care and home care services") must take into account the challenges facing health and aged care professionals, service providers and older people and their families and carers in rural and remote communities. It must work to build and sustain local capacity to deliver quality services in these more challenging situations, making it easier for people to remain in their rural and remote communities as they age.

The Australian Aged Care Quality Agency Bill 2013 establishes the Aged Care Quality Advisory Council to provide advice to the CEO with regard to the CEO's functions. It is also to provide advice to the Minister in relation to the operation of the Quality Agency and matters relating to the performance of the CEO's functions. In formulating such advice the Agency must be assured of sufficient rural/remote representation and expertise.

The NRHA recommends that membership of the Aged Care Quality Advisory Council be reworded to include substantial experience or knowledge of healthy ageing and aged care in rural and remote communities.

Attachment

Member Bodies of the National Rural Health Alliance

ACHSM	Australasian College of Health Service Management
RNMF of ACN	Rural Nursing and Midwifery Faculty of the Australian College of Nursing
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare & Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRIG)	Australian Psychological Society (Rural and Remote Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CHA	Catholic Health Australia (rural members)
CRANAplus	CRANAplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
ESSA (NRRC)	Exercise and Sports Science Australia (National Rural and Remote Committee)
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group
PSA (RSIG)	Rural Special Interest Group of the Pharmaceutical Society of Australia
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RHW	Rural Health Workforce
RFDS	Royal Flying Doctor Service
RHEF	Rural Health Education Foundation
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
ROG of OAA	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia
SARRAH	Services for Australian Rural and Remote Allied Health